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Brent, Suzanne S., The History of Alcoholism Treatment in the United States. Doctor of Philosophy (Sociology), December, 1996, 369 pp., references, 339 titles.

The treatment of alcoholism has had a unique historical development in the United States. This study provides a chronology of how the problem of alcoholism was defined and handled during various time periods in United States history. The process that evolved resulted in an abstinence based, comprehensive, multidisciplinary approach to the treatment of alcoholism as a primary disease based on the principles of Alcoholics Anonymous. This treatment modality, that developed outside of established medicine, is currently used by the majority of treatment providers.

Seven individuals who have been actively involved in alcoholism treatment were interviewed. In addition to archival research, biographies and autobiographies were examined to gain a broad perspective. Because alcoholism is both a collective and an individual problem an effort was made to include a microsociological frame of reference within a broad sociological view.

Alcoholism, or inebriety, was first perceived as a legal and moral problem. By the end of the 19th century, inebriety was recognized as an illness differing from mental illness, and separate asylums were established for its treatment. Alcoholism is currently accepted and

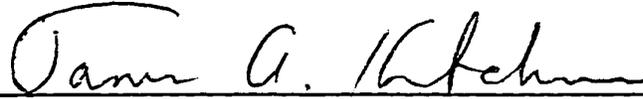
treated as a primary disease by the majority of social institutions, but the legal and moral implications remain.

National Prohibition in the early part of the 20th century targeted alcohol instead of the alcoholic delaying any progress toward treatment which was made in the 19th century. The advent of Alcoholics Anonymous brought the first widely accepted hope for alcoholics. The treatment process that developed utilized the principles of Alcoholics Anonymous in a setting of shared recovery which has been difficult to quantify. In 1970 the allocation of federal funds for treatment and research brought the involvement of new disciplines creating both conflicts and possibilities. Alcoholism recovery has elucidated the connection of mind, body, and spirit.

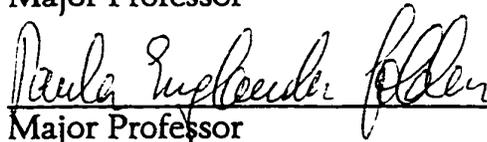
THE HISTORY OF ALCOHOLISM TREATMENT  
IN THE UNITED STATES

Suzanne S. Brent, B.A., M.H.R.

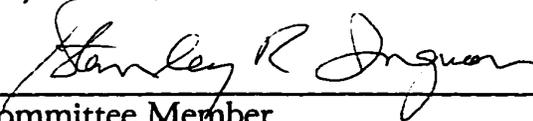
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Committee Member



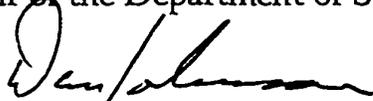
Committee Member



Committee Member



Chair of the Department of Sociology



Dean of the School of Community Service



Dean of the Robert B. Toulouse School of  
Graduate Studies



THE HISTORY OF ALCOHOLISM TREATMENT  
IN THE UNITED STATES

DISSERTATION

Presented to the Graduate Council of the  
University of North Texas in Partial  
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Suzanne S. Brent, B.A., M.H.R.

Denton, Texas

December, 1996

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This work is a reflection of my involvement for the past 12 years in the field of alcoholism. I especially appreciate Patricia and Nicholas Colangelo who were there from the beginning. Lynn Hoke was immensely helpful and encouraging both in Houston and in New York. Penny Page and Valerie Mead assisted with many details at Rutgers Center of Alcohol Studies Library. Linda Travis, Lisa Berry, and Pat Heaton of the Harrington Library of the Health Sciences, Texas Tech University Health Sciences Center at Amarillo, searched diligently for numerous requests, and I appreciate their efforts and interest.

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## CHAPTER 1

### INTRODUCTION

#### Background

Alcoholism has become an increasingly serious social problem in the United States since the early years of colonial settlement. As the population expanded and the American lifestyle became more complex, problems created by alcoholism grew. The attempts to identify and define the problem, as well as the search for solutions, have caused more contention and confusion than in any other social dilemma. Alcohol has played many roles: in religion, as a sacred symbol; in medicine, as an antiseptic and a sedative; in society, as the spirit of celebration, and in families, as the spirit of a sharing ritual. It has served as the daily wage for the worker, and it has been the manifestation of evil and sin. Alcohol has symbolized wealth and prosperity and it also has been used by the helpless and oppressed for comfort.

On few societal issues have emotions run so high or passions so deep. It is significant that the intensity of sentiments surrounding the issue of alcohol required the passage of a constitutional amendment outlawing its sale in the United States. The concept of identifying alcoholism as a disease has been a continuing source of confusion and conflict.

A paradigm shift has occurred in the 20th century regarding the manner in which society deals with alcoholism. In the colonial period alcoholism was perceived as a sin, and those afflicted were often punished and publicly humiliated. Alcoholics were candidates for the poorhouse or the insane asylum. Now, at the end of the century, alcoholism has been recognized as a medically treatable disorder with attendant legal and moral ramifications.

Kuhn (1962/1970) defined a paradigm shift as occurring at the point in the developmental process that he described as follows:

When, in the development of a natural science, an individual or group first produces a synthesis able to attract most of the next generation's practitioners, the older schools gradually disappear. In part their disappearance is caused by their members' conversion to the new paradigm. But there are always some men who cling to one or another of the older views, and they are simply read out of the profession, which thereafter ignores their work. The new paradigm implies a new and more rigid definition of the field. Those unwilling or unable to accommodate their work to it must proceed in isolation or attach themselves to some other group. (pp. 18-19)

Such a paradigm has emerged regarding the treatment of alcoholism. Alcoholism has been recognized and acknowledged as a malady that is receptive to treatment by major societal institutions: the national government, the medical establishment, institutions of higher learning, the criminal justice system, and religious institutions. For clarification, a revised definition of alcoholism was established in 1992 by a 23-member multidisciplinary committee of the National Council on

Alcoholism and Drug Dependence and the American Society of Addiction Medicine. The committee agreed to define alcoholism as follows:

[It is] a primary, chronic, disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic. (Morse & Flavin, 1992, p. 1012)

The Diagnostic Criteria From DSM-IV of the American Psychiatric Association (1994) defined alcohol dependence under Substance Abuse Dependence as having three or more of the following symptoms:

1. Tolerance is either increased or decreased.
2. There are withdrawal symptoms.
3. The substance is taken in larger amounts over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control use.
5. A great deal of time is spent in activities to obtain the substance.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The use of the substance continues despite persistent or recurrent physical and/or psychological problems (pp. 108-109).

Although the disease is chronic in nature, it is recognized that it is

possible to alter the course and the consequences of the disease by modification of the affected individual's attitudes and environment.

Alcoholism may be the cardinal disease that represents a larger paradigm shift related to the treatment of other major diseases and health problems. Actually, over time three paradigms have evolved. The first originated in ancient societies and exists today in less industrialized societies. In this paradigm disease and deviant behavior are considered spiritual ills and are treated by shamans or spiritual healers. Thus, these societies past and present have depended on a spiritual process for treating illness.

As scientific knowledge progressed, the medical establishment turned away from spiritual healing as a recognized methodology, and any condition not diagnosable under a microscope, by x-ray, or in a laboratory test was not a part of medical treatment. In this paradigm diseased and injured bodies became machines to be repaired. Scientific miracles, such as sulfa, penicillin, organ transplants, and other technological advances too numerous and complex for this discussion, served to accentuate the positivist approach.

In the past decade, scientists within recognized institutions of medicine have begun to view other major diseases from a wholistic perspective. In addition to the physical manifestations of a condition, physicians are considering the emotional and mental components not only of alcoholism, but of cancer, hypertension, and heart disease. In

recent years even spiritual components are again being acknowledged. Many individual scientists never severed the connection to the spiritual; but few acknowledged it. It was not considered professional for the physician to pray with his patient or for the scientist to pray about his experiment.

The third paradigm could occur in the 21st century which would combine scientific knowledge and spiritual orientation. This synthesis could be the most powerful of all. America has traditionally been recognized as a country of individualists; however the disease of alcoholism, by the very nature of its treatment process, has forced the individual to reach out to the group in order to recover. Recent research by Wuthnow (1994) has indicated that the support group movement is altering American society by redefining our concepts of both community and spirituality. Dossey (1989) identified a third era of medicine which he termed "nonlocal medicine" (p. 265). "Nonlocal medicine" according to Dossey cannot be understood in terms of "matter-energy" relationships (p.265).

### Rationale for the Study

This research is an attempt to detail the history of the treatment of alcoholism in the United States. The effort is to present a chronological view of the evolving nature of the attitudes toward alcoholism and of specific treatment modalities. Although a number of sociologists--Selden

Bacon, Milton Maxwell, Leonard Blumberg, James Baumohl, Harry Levine, Bruce Johnson, and Ronald Roizen--have recorded the development of alcoholism treatment within specific time periods, there was no chronicle of the development from the earliest inebriate homes and asylums to the treatment centers of the 1980s. Weisner (1983) commented on the unique historical development of alcoholism treatment, observing that perhaps some of the lack of historical data may be due to the fact that alcoholism treatment has not been a part of the mainstream medical profession. In this study, research and records from various scientific disciplines and lay treatment modalities have been examined to develop a conception of the manner in which the treatment system for alcoholism emerged. The goal was to capture and interpret from a historical perspective the manner in which society in the United States has attempted to treat alcoholism.

#### Purpose of the Study

The objectives of this study were (a) to collect information concerning how the problem of alcoholism was defined in specific time periods, (b) to identify and describe the various means employed to cope with the problem, (c) to provide a historical and sociological background of each period, and (d) to develop a chronological view of the development of alcoholism treatment.

Data collected from each major period were analyzed to ascertain the treatment modality and philosophy of each era, taking into consideration the effects of societal events and development. Societal groups that have assumed responsibility for the problem of alcoholism in individuals include (a) the legal system, (b) religious institutions, (c) medical institutions, (d) charitable organizations, (e) educational systems, (f) the family, and (g) the individuals themselves. In the treatment of alcoholism, it was finally the individuals affected who made the most significant breakthrough in confronting the problem.

### Methodology

#### Archival Research

The primary methods employed for this qualitative research consisted of archival research and oral interviews. The archival research involved the use of books and pamphlets, journal articles, newspaper and other periodical articles, treatment center brochures, and minutes of organizations. Biographies and autobiographies helped to determine the development from a microsociological perspective of how the process affected the individual. An effort was made to read accounts, both of treatment providers and of patients.

Several major research facilities were utilized. The Boston Public Library and its Rare Book Room contained original literature about the Washingtonian hospitals and 19th-century treatment. The New York

Public Library's Rare Book Room contained some of the original literature about the Washington hospitals and 19th-century treatment. The New York Public Library's Rare Boom Room contained some of the original Benjamin Rush writings as well as the Civil War Surgeon General's reports, which discussed the alcohol problems in the camps.

The New York Academy of Medicine had information about early treatment hospitals. The rare book room of the Library of Congress held material about the inebriate asylums and the formation of the Association for the Study and Cure of Inebriety. Research assistance was provided by the staff and facilities of the Rutgers Center of Alcohol Studies Library for every period examined. Articles from medical and scientific journals were studied.

Biographies and autobiographies were examined to provide specific information about events and philosophies from an individual perspective. Denzin (1988) argued that, instead of questioning the validity of such personal documents and scrutinizing them for a scientific evaluation, "the more correct approach is to read and evaluate life documents in terms of their ability to shed light on lived, human experience" (p. 206). Every effort has been made to heed this advice.

### Personal Interviews

Seven individuals who are actively involved in the field of alcoholism treatment were interviewed. These individuals were selected

to represent various disciplines, treatment contexts, and areas of expertise including psychiatry psychology, pastoral counseling, and lay therapy.

Maxwell Weisman is a psychiatrist who was the founder and director of the Maryland State Division of Alcoholism Control in the early 1960s. Working primarily in the public sector, Weisman was one of the first physicians to implement procedures for admitting the alcoholic patient to the emergency room and for utilizing quarter-way houses and half-way houses in the public treatment of alcoholism. He spent a significant amount of time working with the skid row population. Weisman was on the faculty of the Johns Hopkins School of Public Health, and he taught at the Rutgers Summer Schools of Alcohol and Drug Studies for 15 years. He is now retired.

John Wallace is a psychologist and scholar who has worked in both the public and the private sectors of alcoholism treatment. He was the editor of the Fourth Special Report to the U. S. Congress on Alcohol and Health (NIAAA, 1981) and the author of the treatment section of the Sixth Special Report to the U. S. Congress on Alcohol and Health (NIAAA, 1987). Wallace was a member of the organizational team of CompCare, a large network of treatment centers, and he was clinical director of Edgehill Treatment Center, Newport, Rhode Island. Wallace continues to be a consultant and educator in the treatment of alcoholism.

Geraldine O. Delaney is the founder and Chief Executive Officer Emeritus of Little Hill-Alina Lodge Treatment Center in Blairstown, New Jersey, which began operation in 1959. Delaney is an internationally recognized professional in the field of alcoholism treatment who has achieved success working with those patients whom others have deemed hopeless. She is noted for her structured non permissive treatment of the “the reluctant to recover” (Mrs. Delaney presented Freedom Award, 1987, p. 1). A friend of Bill Wilson, the co-founder of Alcoholics Anonymous, and of Marty Mann, the founder of the National Council on Alcoholism, Delaney provided an original historical perspective.

Joseph Harrison is an Episcopal priest who began his work in alcoholism treatment in 1973 as the clinical coordinator of the Carrier Clinic in Belle Mead, New Jersey. Robert Stuckey, a psychiatrist, was the co-author of the chapter on “The Alcoholism Rehabilitation Center” in the Encyclopedic Handbook of Alcoholism (Stuckey & Harrison, 1982). Harrison has continued to be an educator and consultant in the field of alcoholism

Patricia Colangelo has been actively involved in the treatment of alcoholism since 1978. Beginning her work in inpatient counseling, she soon began working primarily with the family members of patients. Colangelo worked with the late Robert Stuckey in opening treatment centers across the country. In 1982, with the assistance of her husband, Nicholas Colangelo, currently vice-president of Clearbrook Treatment

Center, opened one of the only free-standing residential family treatment programs in the United States. Her work was presented on the “Today Show” in the fall of 1985.

Searcy R. W. has been a member of Alcoholics Anonymous for over 50 years. He attended one of the early sessions of the Yale Summer School on Alcohol Studies, and he was involved in establishing the Yale School of the Southwest at Texas Christian University and the Southwest Clinics. He was a personal friend of both Bill Wilson and E. M. Jellinek. He helped Bill Wilson’s friend, Ebby Thatcher, regain his sobriety in the last years of his life.

Willard M. is a university professor who has 30 years sobriety. He sought help through Alcoholics Anonymous as a 21-year-old and has maintained continuous sobriety. His only means of recovery from the alcoholism that surfaced in his life as a young man has been Alcoholics Anonymous. He never received any type of treatment. In addition to serving as a representative to the General Service Board of Alcoholics Anonymous, Willard M. has influenced and assisted many individuals in attaining sobriety through the Alcoholics Anonymous program. He continues to support individuals and remains an active participant in service work.

### Significance of the Problem

The benefits of studying the evolution of alcoholism treatment are (a) to understand how the concept of alcoholism treatment emerged as

an idea and was implemented, (b) to increase understanding and knowledge so that informed decisions can be made concerning the implementation of treatment, (c) to provide information that will be helpful in understanding some of the conflicts among various disciplines involved in alcoholism treatment, (d) to portray how the particular modalities of treatment evolved, (e) to offer a historical foundation for understanding the dynamics in treating alcoholism, (f) to produce a comprehensive basis for improving the effectiveness and efficiency of treatment methods, (g) to develop an understanding of the history in order to make legislative and policy decisions, (h) to utilize historical facts in implementing programs in rehabilitation setting such as correctional facilities, and (i) to utilize the information for designing education and prevention programs.

This document will be useful in assisting those who work in the alcoholism field to understand how treatment evolved. In the 1990s the treatment of alcoholism was being challenged to create a more time efficient and cost effective modality. The reasons for adapting various techniques and an understanding of how theories developed as well as why some of the conflicts exist become more evident when viewed from a historical perspective.

Those involved in providing treatment or funds for treatment, as well as the legislators who were creating policies about alcoholism research, treatment, education, and prevention can make better decisions

with an understanding of previous events. Criminal justice providers, other public treatment providers, civic and charitable organizations, social workers, and educators can become more effective through an understanding of the historical perspective. Individuals who have been personally involved with treatment because of alcoholism in their families will also find the document helpful.

Using the concept of C. Wright Mills' (1959), a concerted effort was made to examine alcoholism treatment with a sociological imagination. The goal was to relate the intersection of the individual lives within the treatment setting in which they occurred. The examination of individual accounts and records revealed the microsociological event occurring within the macrosociological background.

Knowledge about the personal lives of individuals involved both as professionals and academicians in working with the problem and the lives of those afflicted with alcoholism was important for two reasons. The first was because alcoholism is both an individual experience and a communal circumstance. What has occurred in the personal lives of those involved has also happened in the lives of many others. The second was that society as a whole has been affected by the collective experience of the individuals. Providing a historical base of the dynamics and the individual struggles in treating the problem of alcoholism can increase knowledge and understanding for making decisions about the

implementation of treatment procedures and educational and preventative measures in the present.

### Organization of the Research

The study is divided in to seven chapters. The topic, explaining the rationale for doing the research, the methodology for collection of data, the organization for reporting the data, and the significance of the findings is introduced in chapter 1. The time period from the early colonial settlements through the Revolutionary War is discussed in chapter 2. The first discussions of alcoholism as a disease. occurred during this period.

The 60 years between 1870 and 1930 are included in chapter 3. During these years the formal, gothic inebriate institutions were built. The elegant years of the 1890s were followed by World War I, national Prohibition, and the Great Depression. Chapter 4 includes the beginnings of Alcoholics Anonymous and the years of World War II. Although it covers only 10 years, this is the longest chapter. With the inception of Alcoholics Anonymous, a new perspective on alcoholism emerged. Chapter 5 is a discussion of the concept of the alcoholism treatment center which developed and grew in the years from 1940 until 1970. The topic of discussion in chapter 6 is the expansion of treatment centers as a result of the implementation of universal insurance coverage for inpatient treatment, the emerging issues of managed care, and the

**national efforts in research and prevention following the passage of the Hughes Act in 1970. Chapter 7 is the conclusion with a discussion of the findings and the relevance of the research.**

## CHAPTER 2

### THE COLONIAL YEARS AND THE NEW REPUBLIC--1607-1870

#### The Colonial Years

From the first English settlements in the early 17th century through the Revolutionary War and the Civil War radical physical and philosophical changes occurred in the United States. Among the social difficulties emerging were those occurring from the escalating use of alcohol. Inebriety, the term commonly used for alcoholism during this period, began to be perceived as a medical problem in addition to being a legal and moral problem. One perspective did not replace another. The medical dimension was added to the legal and moral persuasion, changing some but not all of the dynamics in coping with the problems of inebriety.

#### Legal and Moral Attitudes and Beliefs

The English colonists brought with them kegs of beer more potable than water and the law of James I enacted in 1606. This law was the first law to criminalize intoxication, declaring the following in its preamble: "Whereas the loathsome and odious sin of drunkenness is of late grown into common use within this realm, being the root and foundation of

many enormous sins, as bloodshed, stabbing, murder, swearing, fornication, adultery, and such like” (cited in Hirsh, 1953, p. 967). Consequently, persons guilty of intemperance were sent to the workhouse and were often publicly punished.

Puritan philosophy encouraged moderate drinking. Increase Mather was the minister of Boston's Old North Church from 1664 until his death in 1723. In his classic sermon, “Wo to Drunkards,” he said, “Drink in itself is a good creature of God . . . and to be received with thankfulness, but the abuse of drink is from Satan; the wine is from God, but the drunkard is from the Devil” (cited in Lender, 1973, p. 353).

Both Increase's son, Cotton Mather, and Jonathan Edwards subscribed to these teachings. These ministers set the norm of hellfire and damnation for those who sinned, and drinking to excess was a sin. The Puritans also contended that under the influence of liquor drinkers tended to commit “all those Sins to which they are either by Nature or Custom inclined” (Levine, 1978, p. 149).

According to sociologist, Harry G. Levine, Jonathan Edwards's “Freedom of the Will” published in 1754 opposed the idea of John Locke that “it is possible to differentiate between ‘Desire’ and ‘Will’” (Levine, 1978, p. 149). Locke's point is one that is central to modern theories of addiction. Francis Seeburger (1993) explained this:

What distinguishes the addict from the nonaddict is not a lack of will power on the part of the addict. . . . It is no longer a temptation [desire] merely to use, but one to use again and again.

The temptation is to never stop using. (pp. 6-7)

Edwards clung to the “Old World” idea that desire and will are the same (Levine, 1978, p. 148). It is not difficult to imagine the fear in the drunkard's heart as Edwards delivered his sermon “Sinners in the Hands of an Angry God” on July 8, 1741. It began:

God has laid himself under no obligation, by any promise to keep any natural man out of hell one moment. God certainly has made no promises either of eternal life, or of any deliverance or preservation from eternal death, but what are contained in the covenant of grace. . . .

So that, thus it is that natural men are held in the hand of God, over the fiery pit of hell; they have deserved the fiery pit, and are already sentenced to it; and God is dreadfully provoked. . . . The devil is waiting for them, hell is gaping for them, the flames gather and flash about them, and would fain lay hold on them, and swallow them up; the fire pent up in their own hearts is struggling to break out: . . . all that preserves them every moment is the mere arbitrary will, and uncovenanted, unobliged forbearance of an incensed God. (as cited in Faust & Johnson, 1935/1962, p. 161)

Robert Cole, a colonist in Massachusetts, was ordered to wear a scarlet D for drunkard (Lender & Martin, 1987, p. 17). The Southern colonies also treated habitual drunkenness as a crime and punished the offender accordingly. Several early cases cited in Virginia correlated drunkenness in women and sexual promiscuity.

Colonial history revealed many statutes against drunkenness. Between 1643 and 1779 Connecticut alone passed 80 major statutes concerning liquor and its sale and abuse (Hirsh, 1953, p. 968). Prohibitions existed about the sale of liquor to Indians and drunkards as well as to minors. Other laws mandated punishment for abuse. In spite of

these restrictions, colonial drinking was a major part of community and family activities, and it is significant that the era was characterized by a “general lack of anxiety over alcohol problems” (Lender & Martin, 1987, p. 14).

Heavy drinkers continued to be placed in the same categories as the criminal and, occasionally, the insane. In the early 18th century little was understood about the treatment of the insane. Insanity was frequently viewed as a manifestation of the devil, and consequently, patients were usually treated in deplorable conditions. They were often imprisoned or relegated to poorhouses, because hospitals would not take the insane. The first general hospital in the colonies was the Pennsylvania Hospital, which opened in 1752. The petition presented to the Assembly of the Province of Pennsylvania on January 23, 1751, by “sundry Inhabitants” designated a special section of the hospital for the care of the insane, stating that “no permanent public provision had been made for the care of persons 'distemper'd in Mind and depriv'd of their rational Facilities,' or for the relief of sick and injured inhabitants” (Morton, 1973, p. 13).

The petitioners spoke of the insane as terrorizing their neighbors, “continually wasting their Substance,” causing injury to themselves and others, and taking advantage of others as well as allowing others to take advantage of them (Morton, 1973, p. 13).

The idea of a sanatorium actually originated with the ancient Greeks, who would take those who had nervous and mental disorders to the top of a mountain outside of town. They would be supplied with healthy food and told to rest and remain in the quiet and peaceful surroundings until they felt better (Joseph Harrison, personal communication, July 9, 1995). The first state hospital exclusively for the insane in the United States was established in Williamsburg, Virginia, in 1763. Known as The Public Hospital for Persons of Insane and Disordered Minds, the hospital did not admit its first patients until 1773 (Horowitz, 1977).

#### Native Americans Alcohol Use in the Colonies

The Native American population represented the "untamed wilderness" to the early settlers (Leland, 1976, p. xii). Because the Indians were considered savages, there was fear about their behavior "under the influence." This fear later caused the Federal government to prohibit the sale of alcohol to Native Americans for over a century (Westermeyer, 1974, p. 29). Prior to the arrival of the Europeans, the Native American population along the eastern seaboard had not been exposed to beverage alcohol (Lender & Martin, 1987, pp. 21-22). The tribes in the Southwest and in Central America had some previous exposure.

At the end of the 17th century a French Catholic priest, Abbé Belmont, “described the Ottawa as ‘addicted’ and ‘passionately attached’ to brandy and noted with horror the Bacchanalian excesses which occurred when they drank” (Leland, 1976, p. 1). The fur traders and others took advantage of the Indians’ vulnerability to alcohol. A prime example was the signing of the Treaty of Easton [Pennsylvania] in 1758 when the Native Americans signed over large tracts of land and the colonists kept them supplied with drink during the entire proceedings (Lender & Martin, 1987, p. 26). While some Native American populations do have a high incidence of alcoholism, their inherent vulnerability is a topic which merits further research.

Benjamin Rush: Statesman, Physician,  
Father of American Psychiatry

Benjamin Rush, American physician, Surgeon General, and signer of the Declaration of Independence, joined the staff of the Pennsylvania Hospital in 1783. At this time there were 24 patients in the “lunatic” section. His humanitarian ideas were radical departures from the notions of the time. He believed the mind able to move from healthy to unhealthy portions of the brain, and he perceived madness as the result of impressions communicated to the mind from the body (Shyrock, 1945).

Rush's qualifications as a physician and as a teacher were confirmed by an article in the New England Journal of Medicine in 1812, which read in part:

The character of Dr. Rush as an experienced, erudite, and accomplished physician, and as an eloquent and instructive lecturer, is well known to the world. . . . His medical writings, considered in regard to their extent and consequence, as well as the notice they have attracted abroad, stand decidedly before those of any other American physician. (Review [Rush's Lectures], 1812)

Because Rush believed that mental disorders could be healed as well as physical ones, he worked to improve conditions for the insane at the Pennsylvania Hospital. Ahead of his time in promoting humane treatment for the insane, he persisted until he was heard. He complained that the dank, fetid cells in which the patients were housed eradicated the other measures taken for their treatment. He took his fight to the people, publishing articles about the abominable conditions. On the last day of February 1792, the assembly appropriated \$15,000 to build a special ward for the insane. Rush referred to it as the "mad-house" (as cited in Goodman, 1934, p. 256). These efforts in America slightly preceded what was occurring in Europe. It was not until 1793 that a French psychiatrist, Philippe Pinel, advocated removing the chains of 49 mental patients in the Bicêtre asylum in Paris and began programs of counseling for them. William Tuke opened the York Retreat in England around 1796.

The west wing or “mad-house” of Pennsylvania Hospital was completed in late November 1796. In April 1798, Rush requested that two bath facilities be installed, one for cold baths and one for hot baths. At the same time he suggested a reform that has continued to the present to be a part of mental health treatment -- occupational therapy. Previously, patients were idle, and he believed they needed to be occupied when possible. Another innovation was the request for a small solitary building for patients who were highly agitated to prevent the disruption of other patients. He advocated separate floors for the sexes and intelligent companions to attend to the patients, to assist with their reading and writing, and to encourage conversation (Goodman, 1934).

Rush was interested in his patients and respected them as suffering human beings. He preceded Freud in encouraging his patients to talk to him. He listened to them and did not laugh either at them or with them. Rush believed that “[the doctor] should hear with silence their rude or witty answers to his questions and upon no account ever laugh at them or with them” (as cited in Wittels, 1946, p. 160). Rush also recognized that forgotten experiences could lead to mental illness. Rush taught:

Many diseases take place in the body from causes that are forgotten, or from sympathies with parts of the body that are supposed to be in a healthy state. In like manner depression of the mind may be induced by causes that are forgotten; or by the presence of distress with which it was at one time associated, but without reviving the cause of it in the memory. (as cited in Wittels, 1946, p. 162)

Rush was the first American to expound on drunkenness as a disease in his treatise, An Inquiry Into the Effects of Ardent Spirits Upon the Human Body and Mind With an Account of the Means of Preventing Them and of the Remedies for Curing Them, which first appeared in the 1780s. He wrote:

This odious disease (for by that name it should be called) appears with more or less the following symptoms and most commonly in the order in which I shall enumerate them.

1. Unusual garrulity.
2. Unusual silence.
3. Captiousness, and a disposition to quarrel.
4. Uncommon good humor, and an insipid simpering laugh.
5. Profane swearing, and cursing.
6. A disclosure of their own and other people's secrets.
7. A rude disposition to tell those persons in company whom they know, their faults.
8. Certain immodest actions. I am sorry to say, this sign of the first stage of drunkenness, sometimes appears in women, who, when sober, are uniformly remarkable for chaste and decent manners.
9. A clipping of words.
10. Fighting; a black eye, or a swelled nose, often mark this grade of drunkenness.
11. Certain extravagant acts which indicate a temporary fit of madness. (Rush, 1814/1943-1944, pp. 325-326)

With this list Rush developed a progression of the symptoms of alcoholism defined by E. M. Jellinek almost 2 centuries later.

Rush illustrated the progression of temperance to intemperance, using a “Moral and Physical Thermometer” (Rush, 1823, n.p.). The thermometer listed each liquor and its particular effects as well as the resulting vice, disease, and punishment. Rush was not an abstainer. His

thermometer illustrates cider, wine, porter (port), and strong beer resulting in cheerfulness, strength, nourishment when taken only at meals and in moderate quantities (Rush, 1823).

In his work at the Pennsylvania Hospital, Rush became aware of the magnitude of the problems of inebriety. Waters, house pupil and apothecary of the Pennsylvania Hospital, assured Rush that one-third of the patients were confined by insanity that had been induced by ardent spirits (as cited in Cassedy, 1976). In the Report of the Pennsylvania Hospital for the Insane for 1870, it was stated that of 5,796 cases of insanity, only 446 were attributed to intemperance (Report of the Pennsylvania Hospital for the Insane, for 1870. Quoted in "Accidental inebriates." Quarterly Journal of Inebriety, 1872, p. 69). This disparity could be attributed to differences in diagnosis. It is, however, a significant difference from what was popularly assumed at the time.

Rush's dissertation was the first American treatise on psychiatry. In this work he included the following suggestions for the treatment of inebriety:

The remedies for this disease have hitherto been religious and moral, and they have sometimes cured it. They would probably have been more successful, had they been combined with such as are of a physical nature. . . . To that account of physical remedies I shall add one more, and that is, the establishment of a hospital in every city and town in the United States, for the exclusive reception of hard drinkers. They are as much objects of public humanity and charity as mad people. They are indeed more hurtful to society, than most of the deranged patients of a common hospital would be, if they were set at liberty. Who can calculate the extensive influence of a drunken husband or wife upon the

property and morals of their families? . . . Let it not be said, that confining such persons in a hospital would be an infringement upon personal liberty, incompatible with the freedom of our governments. . . . To prevent injustice or oppression, no person should be sent to the contemplated hospital, or sober house, without being examined and committed by a court. . . . Within this house the patient should be debarred the use of ardent spirits, and drink only, for a while, such substitutes for them, as a physician should direct. Tobacco, one of the provocative of intemperance in drinking, should likewise be gradually abstracted from them . . . and all the religious, moral, and physical remedies, to which I have referred, should be employed at the same time, for the complete and radical cure of their disease. (as cited in Szasz, 1973, pp. 26-27)

Benjamin Rush's ideas were innovative and progressive. He is considered to be the father of American psychiatry for his medical focus on the mentally, physically, and emotionally impaired. Rush discussed the use of such concepts as (a) a conversion experience and (b) conditioning by associating the idea of ardent spirits with a painful or disagreeable impression. Both of these ideas later became a part of more formalized alcoholism treatment. Rush's treatise on the effects of ardent spirits was championed by the burgeoning temperance movement (Rush, 1814/1943-44, pp. 338-339).

Although some of Rush's ideas such as blood-letting and his "tranquilizer or strait jacket" to alleviate violence were abandoned, many of his views in regard to the need for combining physiological and psychological methods in the treatment of the mentally ill are still used (Goodman, 1934, p. 267). He advocated "listening sympathetically and seriously to the patient . . . to relieve the subconscious mind and

frequently asked patients to write down an account of their symptoms” (as cited in Goodman, 1934, p. 265). Fritz Wittels’s critique of Rush's contributions emphasized Rush's belief of the “therapeutic power” of the physician:

This man believed in his therapeutic force, in contrast with the classical medical schools that came after his time. They were strong in their diagnostic laboratories and clinical observations, but were rightly called “nihilists” in the field of therapeutics. Even today we do not believe that we can contribute considerably to shortening the process of genuine melancholia. (Wittels, 1946, p. 157)

Another important concept Rush initiated was occupational therapy. He often quoted two lines by the poet, William Cowper:

Absence of occupation is not rest  
A mind quite vacant is a mind distress’d. (as cited in Wittels, 1946, p. 163)

Rush believed the patients should not languish in idleness but needed to be constructively occupied when at all possible. He suggested spinning, sewing, and churning for the women and weaving, gardening, and woodworking for the men. He also advocated intelligent companions who could encourage conversation and assist with reading and writing. It would be years before Rush's ideas were implemented to any great extent, but he provided a framework to begin.

Although “Rush had referred to alcohol addiction as a disease,” a few years before Thomas Trotter published his dissertation, Essay, Medical, Philosophical, and Chemical, on Drunkenness in England in

1804 (as cited in Jellinek, 1941, p. 584), it was probably Trotter who first discussed the question in a “medical sense.” Trotter stated:

In medical language, I consider drunkenness, strictly speaking, to be a disease. . . . Drunkenness itself, is a temporary madness. . . . Again are not the habits of drunkenness more often produced by mental affectations than corporeal diseases? . . . The habit of drunkenness is a disease of the mind. (as cited in Jellinek, 1941, pp. 584-587)

Trotter went on to describe a treatment similar to the ones used in America: a cold bath, exercise in the open air, “vigorous diet,” and gentle cleansing of the bowels. He, like Rush, was not a prohibitionist, but supported moderate use of wine from middle age forward, writing thus:

No man of health can need wine until he arrives at age forty. He may then begin with two glasses in the day, at fifty he may add two more, and at sixty he may go to the length of six glasses per diem, but not to exceed that quantity even though he should live to an hundred. Lewis Conaro, the Venetian nobleman, who lived upwards of a hundred, used fourteen ounces of wine in the day. The stimulus of wine is favorable to advanced age. . . .

Let it be remembered that I apply this quantity to the abstemious man who has never indulged in wine. (as cited in Jellinek, 1941, p. 591)

In his Medical Inquiries, Rush (1812/1972) delineated many manias in addition to dipsomania that are the precursors of the more than 206 addictive/obsessions addressed in the United States today. Rush mentioned “land-mania, horse-mania, liberty-mania, donation-mania (in which people impoverish their families by extravagant contributions to public undertakings) . . . military-mania, dueling-mania, hunting-mania, and gaming-mania,” among others (as cited in Wittels, 1946, p. 164).

Benjamin Rush set the stage for many 20th century theories about alcoholism. He was the first American to identify alcoholism as a disease that could be treated. The corroboration a few years later in Trotter's (1813/1941) Essay was influential, if for no other reason than the colonists valued European knowledge even if they had rejected their control. Rush was also the first to advocate a sober house for the treatment of alcoholism. He identified alcohol as the catalyst and perceived the compulsion as manifesting a "loss of control." He also recommended total abstinence as the only means to alleviate the problem. In identifying the many manias, Rush understood that alcohol was not the only agent of addiction. His recommendation of abstinence has continued to the present time to be the primary goal of treatment by the majority of professionals in the field.

### Post Revolutionary Years

#### The Cry for Temperance

The celebration of the establishment of the new republic was clouded by economic depression, mounting issues of slavery, arguments over states' rights, and problems in the territories of the West. The use of alcoholic beverages skyrocketed. According to Rorabaugh (1979), "Americans between 1790 and 1830 drank more alcoholic beverages per capita than ever before or since" (p. ix). In 1818 the editors of the Medical Repository noted the following:

The quantity of ardent spirits drunk by our people exceeds everything of the kind that the world can produce; the appetite for inebriating drink seems to be increasing and insatiable. The “dread of water (a species of hydrophobia)” is the widespread epidemic of the land. So few and small are the restraints to drunkenness imposed by the government, that the labourer swallows as much strong drink as he pleases. A quart a day is no uncommon quantity. (as cited in Cassedy, 1976, pp. 405-406)

Later reports indicate that the consumption of 3 quarts daily was not uncommon, with 1 quart being consumed before breakfast (as cited in Cassedy, 1976, p. 406). In New York City an 1803 inquiry revealed a tavern for every 53 persons, including children. This widespread use of alcohol became an increasing concern as the “means by which diseases from hard drinking and venereal virus are promoted” (Cassedy, 1976, p. 406).

Between 1790 and 1830 Americans had a “veritable national binge” (Rorabaugh, 1976, p. ix). Americans believed at this time that liquor was healthy, nutritious, stimulating, and relaxing. Due to the grain glut in the Midwest, whiskey was 25¢ a gallon, cheaper than milk or coffee. In addition to the mood-altering effects of whiskey, it also helped to wash down greasy, salty, sometimes even rancid food. After 1830 whiskey and cider consumption fell to 1 gallon per capita. This reflected the temperance movement and the redirection of impulses to a religious persuasion (Rorabaugh, 1976, p. 362).

As early as 1812 Lyman Beecher, father of Harriet Beecher Stowe, proposed to his fellow Congregationalist ministers that they organize in

the spirit of temperance. In May 1813 Beecher founded the Connecticut Society for the Reformation of Morals and he began elaborating the idea of salvation. While maintaining the Calvinist position that salvation occurred through the grace of God, he asserted that man's own actions could both impede him from attaining salvation and by his good behavior influence God to award it to him (as cited in Winkler, 1972, pp. 951-952). In 1825 Beecher preached his "Six Sermons," defining intemperance not only as drunkenness but as the "daily use of ardent spirits" (as cited Maxwell, 1950, pp. 410-411). He stated "regular tippling led to drunkenness," and "drunkards, no more than murderers, shall inherit the Kingdom of God" (as cited in Winkler, 1972, pp. 951-952).

In 1826, Lyman Beecher and Justin Edwards founded the American Society for the Promotion of Temperance (American Temperance Society) in Boston. Taking its doctrine from Benjamin Rush, who was later known as the Father of Temperance, the leadership consisted of prominent citizens and clergy who promoted abstinence from ardent spirits and permitted the use of nondistilled beverages (as cited in Lender & Martin, 1987, p. 68). By 1834 there were 5,000 local societies with an acclaimed membership of 1 million. In 1836 this group merged with the American Temperance Union to take a stand of "total abstinence from all that can intoxicate" (Maxwell, 1950, p. 411).

The clergy, the medical community, and the military were all areas targeted as needing temperance. A scandal about the alcohol consumption of the clergy occurred before the war of 1812. The army has long been known to foster the camaraderie of drinking activity. In 1834, after the army ended whiskey rations, Surgeon William Beaumont at Jefferson Barracks, Missouri, reported that soldiers' inebriety caused more than three-quarters of the diseases and injuries at the post (as cited in Cassedy, 1976, p. 411). By 1843, there were temperance societies in most military posts and communities in the country.

Physicians were also known as heavy drinkers. "He is an excellent doctor when sober," was a frequently quoted phrase. The free flow of liquor at a large medical banquet at the Astor Hotel in New York in 1848 was especially adversely noted because it was held to benefit the widows and orphans of physicians (Cassedy, 1976, p. 410). Medical students at the University of Pennsylvania organized a medical students temperance society, and in 1840, Daniel Drake and his colleagues formed the Physiological Temperance Society at the Louisville Medical Institute (as cited in Cassedy, 1976, p. 410).

Certainly not all physicians joined in the cry for temperance, but, as one doctor reported, the profession was to be commended for its "disinterested self-sacrifice, in joining the general crusade against our best patron [the drinker] and thus cutting off the most prolific source of our support" (Cassedy, 1976, p. 407). Although they correlated drinking and

disease, few physicians at this time considered excessive drinking itself as a disease.

John James Bound of New York prophetically wrote the following in a pamphlet published in 1820:

Cures have frequently been observed for most of the disorders that human nature is incident to . . . but never for the most abstinent and fatal in its consequences ever afflicted the human race . . . a vitiated appetite, usually known as intemperance or more harshly, drunkenness. . . . Considered a vice, treated with ridicule and contempt . . . people do not dream of it being a disorder, or think it to be within the reach of medicine. . . . Experience has taught us mere persuasions are insufficient. (Bound, 1820, pp. 3-4)

Bound (1820) recognized the power denial held for the alcoholic: “the disposition of the intemperate is to deny the real power it has over them” (p. 7). He also perceived abstinence as the only means of reversing the course of the disease, but a more profound insight was that “‘energies of the soul are called into operation’ for the mind to be enlarged and elevated” (p. 26). Bound (1820) acknowledged the relapsing nature of the problem in his recommendation that “if relapse occurs - ‘don’t give up the ship’” (pp. 32-34). Another suggestion was the use of aversion conditioning to “mix an Emetic Tarter in the liquor most craved . . . will loathe [it] for a long time (Bound, 1820, p. 37).

Bound (1820) recognized the power of denial in the alcoholic and that both medical care and a spiritual experience would be necessary for recovery. He also acknowledged the reality of relapse as a part of the problem and suggested aversion conditioning as a partial solution. All of

these realizations became a part of alcoholism treatment in the 20th century.

### The Washingtonian Movement

Rush's work and the temperance movement undoubtedly provided insight that fostered the progression of two movements that evolved almost simultaneously to change the course of treating inebriety. The first of these was the organization of the Washingtonian Total Abstinence Movement. On Thursday evening, April 2, 1840, six friends were drinking in Chase's Tavern on Liberty Street in Baltimore. Their conversation moved to the temperance lecture that was to occur that evening. They decided for some of them to attend and report to the others. Four attended, and on Sunday, April 5, as they were walking and drinking, they decided to quit drinking and organize a total abstinence society. They chose the name Washington Temperance Society to honor George Washington. They continued, however, to hold their meetings at Chase's Tavern. Eventually the group was so large that it moved to a carpenter's shop and later rented a hall. In an effort to make the meetings more interesting, the president suggested that each member relate his own experiences with excessive drinking. This increased both interest and attendance. By November the group decided to hold a public meeting and share their personal experiences. This meeting was held on

November 19, 1840, in the Masonic Hall on St. Paul Street (Maxwell, 1950).

The first venture noted outside of Baltimore was the speaking engagement of John H. W. Hawkins in Annapolis in February 1841. By April 5 of the same year the society membership numbered about 1,000 "reformed drunkards" and 5,000 other members (Maxwell, 1950, p. 414). Progress was rapid, and in 1841 meetings were held in New York, Boston's Faneuil Hall, Cincinnati, and Pittsburgh. On February 22, 1842, Abraham Lincoln addressed the Springfield Washington Temperance Society. The words he spoke would ring through the years. They were spoken with a compassion that is rare for one personally unafflicted. The concluding paragraphs of the address were printed on the first page of the 1982 edition of Al-Anon Faces Alcoholism:

I have not enquired at what period of time the use of intoxicating drinks commenced; nor is it important to know. It is sufficient to all of us who now inhabit the world, the practice of drinking them is just as old as the world itself. . . . It is true, that even then, it was known and acknowledged that many were greatly injured by it; but none seemed to think the injury arose from the use of a bad thing, but from the abuse of a very good thing. The victims to it were pitied, and compassionated, just as now are, the heirs of consumptions, and other hereditary diseases. Their failing was treated as a misfortune, and not as a crime, or even as a disgrace. (as cited in Basler, 1946, pp. 135-136)

Lincoln never drank, and he blamed society, not the drinker nor the merchant who sold the liquor, for the problems liquor created. He believed it was society who "demanded the traffic" and society was

responsible for its “curse and wreckage” (as cited in Inglehart, 1917, p. 155). In the last portion of temperance address on February 22, in Springfield, which is also in Al-Anon Faces Alcoholism, Lincoln stated:

In my judgment, such of us as have never fallen victims, have been spared more from the absence of appetite, than from any mental or moral superiority over those who have. Indeed, I believe, if we take habitual drunkards as a class, their heads and their hearts will bear an advantageous comparison with those of any other class. There seems ever to have been a proneness in the brilliant, and the warm-blooded, to fall into this vice--the demon of intemperance ever seems to have delighted in sucking the blood of genius and of generosity. What one of us but can call to mind some dear relative, more promising in youth than all his fellows, who has fallen a sacrifice to his rapacity. (as cited in Basler, 1946, p. 139).

By May 1842, the Washingtonians had strong groups in Baltimore, New York, Boston, Philadelphia, Pittsburgh, Washington, Cincinnati, and St. Louis (Maxwell, 1950, p. 423). The movement also included an organization of women called the Martha Washington societies. The first women's group met in a church at the corner of Delancey and Chrystie Streets in New York on May 12, 1841. In May 1844 the Washingtonians were the sponsors of the largest temperance demonstration ever to be held at that time. Approximately 30,000 attended this Boston meeting (Maxwell, 1950, p. 424). The societies probably peaked at this time, as they declined and were barely functioning by the advent of the Civil War.

### The Washingtonian Homes' Moral Treatment of Inebriety

The development of residential institutions, initially called homes, was a significant contribution of the Washingtonians. The first of these homes was located in Boston in 1841. Initially, this consisted of a few members caring for inebriates in rented rooms (Blumberg, 1978b, p. 1595). The original idea was to care for the reformed men until they were able to care for themselves. Women were occasionally allowed, but the homes were fundamentally for men. This was a makeshift situation. In August 1857 a group of men rented some space on the corner of Fulbright and Richmond Streets in Boston to temporarily house inebriates. They called it The Home for the Fallen. This was the first Washingtonian Hospital (Shattuck, 1942, pp. 36-37). On February 1, 1858, the home moved to 1 Franklin Place, and Albert Day became superintendent. In 1859 the institution was incorporated by the state as the Washingtonian Home (Arthur, n.d., p. 169). It retained that name until February 7, 1939, when it became the Washingtonian Hospital.

In the following years the hospital gradually declined, becoming a "flop house for drunks in the South End" (Shattuck, 1942, p. 36). Reputable physicians refused to refer patients there. Application was then made for monies from the Community Fund, and in 1938 the hospital staff was reorganized to include a resident physician. After receiving an unfavorable report from the Council of Social Agencies, the directors added a psychiatrist and a social worker and made adaptive

changes to the building (Shattuck, 1942, pp. 36-37). When the facility finally closed in the 1980s after going through a variety of changes, it was a detox unit, essentially performing the same purpose for which it had originally opened.

### Moral Treatment Defined

Early treatment in the Boston Home was known as moral treatment. Moral did not simply imply ethical, but consisted of seeking to control patients by decency, kindness, and goodwill rather than physical restraint, as utilized by the asylums for the insane during this period.

Inductive reasoning began to emerge in the late 17th and early 18th centuries. Consequently, mental and emotional illness began to be perceived as having a worldly, physical etiology rather than a supernatural etiology. Because life events and traumas (rather than possession by supernatural forces) were the causes of the illness, the individual deserved respect and understanding instead of condemnation. As a disease, mental illness would then respond not only to pharmacological treatment but to nonmedical methods as well.

When Philippe Pinel's 1801 Medico-philosophical Treatise on Mental alienation, or Mania was translated into English in 1806, his phrase, traitement moral, literally translated moral treatment, continued to be used into the 20th century (as cited in Carlson & Dain, 1960, p.

519). The term included all nonmedical measures, but specifically referred to therapeutic means to affect the patient's psychology. The “most famous symbol of this new movement” was the unchaining of the European mental patients in the 1780s and 1790s (Carlson & Dain, 1960, p. 519). Pinel in France, William Tuke in England, and Benjamin Rush in the United States are credited with the almost simultaneous discovery that the “traditional mechanisms of social control, chains, could be replaced with fear and guilt” (Levine, 1978, p. 163) and the insane could be taught to constrain themselves.

“Moral treatment is the application the faculty of intelligence and of emotions in the treatment of mental alienation” (Esquirol [1805], as cited in Carlson & Dain, 1960, p. 519). In the 19th century, persons who treated the mentally ill were often referred to as alienists from the theory that the mentally ill were not only alienated from society, but from their “own true natures” (Carr, 1994, note in frontispiece).

Moral treatment had three basic components: (a) the doctor-patient relationship, (b) the development of self-control and the elimination of symptoms through reward and punishment, and (c) the practice of psychotherapy. It is significant to note that lay personnel, superintendents and attendants, were frequently the ones responsible for the nonmedical aspects of the treatment (Carlson & Dain, 1960, p. 520). A basic tenet of this approach was that “firmness should be tempered

with kindness, and that control was possible without abuse” (Carlson & Dain, 1960, p. 520).

The type of treatment found in the Washingtonian homes was probably adapted from the “mild, moral treatment of insanity” (Baumohl, 1986b, p. 397) usually associated with the Quakers at Samuel Tuke's York Retreat in England (established 1796) and the Hartford Retreat in Connecticut (established 1824). The inmates (patients) were treated respectfully as family members, and the institutions even resembled homes in structure. Moral treatment included a regulated diet, gentle opening of the bowels, and the use of mild herbal and opium sedatives to promote rest. No bleeding or strong cathartics were used.

The concept was one of “an eternal, immaterial, incorruptible mind--God's presence in man--distinct from the body” (Baumohl, 1986b, p. 412). Pliny Earle, a Quaker physician and the superintendent of the Northampton Asylum, wrote:

My ideas of the human mind are such that I cannot hold for a moment that it can be diseased. . . . That implies death as its final consequence, but Mind is eternal . . . it was created for immortality. Consequently, it is superior to bodily structure, and beyond the scope of wear and tear and disorganization and final destruction of the mortal part of our being. (as cited in Baumohl, 1986b, p. 412)

The disease then existed in the brain, which was the mind's bodily faculty. Earle lectured to his medical students about the correlation between societal progress and the increase of mental disorders (Rothman, 1971). Moral treatment also included “providing cheerful associations

and amusements, intellectual occupations, and the powerful influences of religious sentiment” (Blumberg, 1978b, p. 1601). Measures were taken to redirect the thought processes through scripture reading and meditation.

Albert Day was a significant figure in the moral treatment of the inebriate. He was a Boston citizen, an early temperance motivator, and one of the originators of the Washingtonians in the city. When he decided to take the job of superintendent of the home in Boston, he enrolled in the medical school at Harvard University to study. He served at the Boston home for 9 years, and then he was selected to replace Joseph Turner as superintendent of the asylum at Binghampton. He revised the physical control type of treatment employed by Turner to a version of moral treatment. Day served for 3 years at Binghampton. The moral treatment and voluntary participation advocated by Day were not well received by the board, and he was replaced by Daniel Dodge, who supported legal restraint of the patients (as cited in Brown, 1986, p. 548).

#### Expansion of Washingtonian Homes

The second Washingtonian home was established in Chicago in January 1864. The Chicago group quickly realized the need for a home for women. In June 1869, rooms were made available in the home of Charles Hull. This building, given to Jane Addams in 1869, was known

as Hull House (Blumberg, 1978b, p. 1600). In May 1870 the women's group was moved to the men's building, and it was discontinued in 1872. In 1882 the board purchased a boys' military academy in northwestern Chicago. It became known as the Martha Washington Home and continued to operate until the 1920s combining with the men's unit and becoming the alcoholism treatment unit of the Martha Washington Hospital, a general hospital for the neighborhood (Blumberg, 1978b, p. 1600).

Another member of the Washingtonian association of homes was the Franklin Reformatory Home in Philadelphia, established in 1872. The name is attributed to the fact that Benjamin Franklin was more popular than the Federalist, George Washington, in the Democratic-Republican city of Philadelphia. In 1935 the Franklin Reformatory Home merged with the Sunday Breakfast Association, a Skid-Row gospel mission. The Franklin Home differed from the other Washingtonian homes in that its policy did not regard intemperance as a disease that could be cured through hygienic or medical treatment but as a sin, "which must be repented of, resisted and overcome through the help of God" (Arthur, n.d., p.183).

In January 1879, Boston opened The New England Home for Intemperate Women. Three years later it was incorporated as the Massachusetts Home for Intemperate Women, and in 1917 it became the Massachusetts Home and Hospital, providing long-term alcoholism

and drug addiction treatment for women. Undergoing numerous reorganizations and name changes, it continued as a home for needy women until 1964. Initially Washingtonian, it continued to align itself with the Martha Washington Home in Chicago, but also with the Isaac T. Hopper Home in New York, established by the Female Department of the New York Prison Association. The Sophia Little Home in Providence was established by the Women's Society for Aiding Released Female Prisoners. The latter changed its orientation in 1915, and operated until the late 1970s as a home for delinquent girls. The Washingtonian Association also included the Kings County Home in Brooklyn (established 1867) and the Pennsylvania Sanitarium at Media (established 1867) under the supervision of Joseph Parrish (Blumberg, 1978b).

### Contributions of the Washingtonians

The Washingtonians provided an innovative vehicle in treating inebriety: the sharing of experiences, weekly meetings and the support of a continually available group, a reliance on God, and total abstinence. The fact that a moralistic (considering drunkenness a sin) rather than a psychotherapeutic approach was used may have contributed, along with the alignment in the cause of temperance, to the rather speedy demise of the movement. Maxwell (1950) cites the alignment with the temperance movement as being the primary cause. Bill Wilson, co-founder of

Alcoholics Anonymous, cited four flaws in the Washingtonian Movement that caused its decline: (a) “overdone self-advertising--exhibitionism,” (b) “couldn’t learn from others and became competitive,” (c) dissipating original simple purpose of “reclamation of drunkards,” and (d) allegiance to other causes, mainly temperance. (Bill W., 1988, pp. 1, 4)

Blumberg (1980) stated that the different “societal contexts” in which the two groups developed may also account for the greater stability and success of Alcoholics Anonymous (p. 38). While the Washingtonians were a moral reform movement associated with temperance and prohibition, Alcoholics Anonymous grew within the medical and public health arenas. The Washingtonian homes provided a lasting influence. T. D. Crothers (1911), a Hartford psychiatrist, wrote:

The Washingtonian Movement . . . was a great clearing house movement, breaking up old theories and giving new ideas of the nature and character of inebriety. . . . This was the beginning of the hospital system of cure, and was the first means used to give practical help to the inebriate, in a proper home, with protection, until he was able to go out, with a degree of health and hope of restoration. (p. 428)

Some attribute the origins of self-help, of which the Washingtonians were a prime example, to the moralistic writings of Benjamin Franklin (Mel B., 1991). When the French historian and theorist, DeTocqueville, visited America in 1831, he observed the citizens’ meeting for various causes, noting especially the gathering of the temperance group. He was impressed with the concept of self-help and

noted that “if despotism ever came to be established in the United States it would find it even more difficult to overcome the habits that have sprung from freedom than to conquer the love of freedom itself” (DeTocqueville 1848/1966, p. 243).

### Other Homes for the Inebriate

#### The San Francisco Home

Established in 1859 and operated until 1870, the San Francisco Home for the Care of the Inebriate was not actually a part of the Washingtonian group but it was a variation of moral treatment. The project of the Dashaway Association, a group of 17 volunteer firemen, the name came from their pledge taken to “dash away from their lips the cup that intoxicates” (Baumohl, 1986b, p. 401). This home was more like the Washingtonian homes than an asylum. It was a community project. In Boston, the Washingtonians had ward committees which were groups of men who searched their particular areas for drunkards to treat. The Dashaways first saw this methodology in Boston and brought it to California. By 1860 there were 3,000 members in San Francisco and approximately 5,000 more in northern California.

The Dashaways refused any religious or political involvement and took no position on prohibition. They admitted saloonkeepers and liquor salesmen to their group (Baumohl, 1986b, p. 405). An investigating committee held several trials a week to confront members who had been

accused of breaking their pledge. A black list was kept in the Howard engine house and later in other headquarters. There were several stages of deviance. To be convicted was not to be blacklisted, and to be blacklisted was not to be expelled. Each case was considered separately (Baumohl, 1986b, pp. 409-410).

California was isolated during the Civil War years, and rough and questionable persons began to appear. Arrests for drunkenness escalated, and vagrants and paupers appeared on the streets. The home was attacked on two counts. First, it was accused of being a revolving door by sobering patients, only to have them drink again and return. The home was small and did not hold patients against their will. Second, fewer than half of the patients became members of the society after leaving. Those who favored the asylum model of restraining patients and holding them against their will appealed to the citizens who were frightened of the disruptive element appearing on their streets. Asylums would be able to keep the patients until a more stable cure was maintained. According to Baumohl (1986b), "The inebriate asylum doctors were in the business of correcting habits, not curing souls" (p. 434). In 1876, legislation was achieved to modify the home and transform it into a "probationary asylum" for those awaiting hearings for involuntary commitment. The home had deteriorated into a "scandal-ridden, private prison" when it closed in 1898 (Baumohl, 1986b, p. 435).

### Jerry McAuley's Skid Row Mission

Jerry McAuley's Helping Hand for Men was founded on New York's Water Street in October 1872. It was an evangelical city mission in the revivalist temperance tradition (Baumohl, 1990). Jerry McAuley was born in Ireland in 1837 and immigrated to the United States as a young boy. He grew up on the streets of New York, becoming a river thief and a heavy drinker. He was sentenced to Sing Sing Prison at the age of 19 for a term of 15 1/2 years. He was converted by Awful Gardner. McAuley had known Gardner, a noted prize-fighter, before going to prison, and Gardner's stories of his life and the change he experienced impressed him. The young McAuley began working with his fellow prisoners, and, in 1864, he received a gubernatorial pardon for his evangelical work while in prison (as cited in Pittman, 1988, p. 80).

McAuley realized that his drinking had been a major factor in his problems and that he needed to continue his sobriety. When he was released after serving more than 7 years of his sentence, he experienced loneliness and rejection from the community. He took a room over a lager "bier" saloon (Mel B., 1991, p. 129). This was a new drink introduced by German immigrants to the slums. Told that it was harmless and similar to root beer McAuley drank some, reviving the old craving. He began drinking every night and returned to his former ways of crime. After several failed attempts to regain his faith and sobriety, he

finally succeeded. McAuley was converted at the Howard Mission in New York in 1871 (as cited in Blumberg, 1977, p. 2133).

It was some time before citizens believed in McAuley's change. In 1872 he was able to pursue his idea of developing a mission for the homeless (as cited in Blumberg, 1977, p. 2133) Companionship could provide the hope and support he had lacked, and he could help others begin new lives. He believed in public confession (sharing experience and hope) and conversion for the drunkard. With the help of his wife, Maria, who was a reformed drinker and prostitute, he created the mission, which incorporated some of the therapeutic temperance of neo-Washingtonianism (Baumohl, 1990, p. 1187).

In 1877 prominent evangelical businessmen backed McAuley in founding the New York Christian Home for Intemperate Men. This home, along with the Franklin Reformatory Home in Philadelphia, which was similar to the gospel mission of the 1880s, was a favorite object of ridicule of renowned inebriate asylum physician Thomas Davidson Crothers, superintendent of Walnut Lodge asylum in Hartford, Connecticut (Baumohl, 1990, p. 1197). Crothers was one of the founders and the longtime editor of the Quarterly Journal of Inebriety. His position was one eminently respected among the medical inebriety specialists.

In the bawdy environment of the New York Christian Home, a drunkard, named Samuel Hopkins Hadley was converted one evening in

1882. Hadley later recounted the following to the psychologist James

Leuba:

Jerry [the famous Jerry McAuley] made the first prayer.

“Dear Savior, won’t you look down in pity on these poor souls? They need your help, Lord; they can’t get along without it. Blessed Jesus, these poor souls have got themselves into a bad hole. Won’t you help them out? Speak to them, Lord, do for Jesus sake--amen!” Then they were asked to pray for themselves.

How I trembled as he approached me! Though I had knelt down with the determination to give my heart to God, when it came to the very moment of grand decision, I felt like backing out. The devil knelt by my side and whispered in my ear crimes I had forgotten for months: “What are you going to do about such and such matters if you start to be a Christian tonight? Now you cannot afford to make a mistake; had not you better think this matter over and try to fix up some of the troubles you are in, and then start?” Oh what a conflict was going on in my poor soul! A blessed whisper said, “Come!” The devil said, “Be careful!” Jerry’s hand was on my head. He said, “Brother, pray.” I said, “Can’t you pray for me?” Jerry said, “All the prayers in the world won’t save you unless you pray for yourself.” I halted but a moment and then with a breaking heart, I said: “Dear Jesus, can you help me?” Dear reader, never with the mortal tongue can I describe that moment. Although up to that moment my soul had been filled with indescribable gloom, I felt the glorious brightness of the noonday sun shine into my heart; I felt I was a free man. Oh, the precious feeling of safety, of freedom, of resting on Jesus! . . . From that moment till now I have never wanted a drink of whiskey. (as cited in Leuba, 1896, pp. 331-332)

William James (1902/1936) also discussed Hadley’s conversion in The Varieties of Religious Experiences (pp. 198-199). In the same work, James elaborated on the work of California professor, E. D. Starbuck, who identified two types of conversion experiences: volitional and self-surrender. The volitional type is a gradual new learning of moral and spiritual habits. In the volitional type, the self-surrender is present but as

a “voluntary built-up regeneration.” The self-surrender type is a more dramatic and radical change. In either case, according to Starbuck, “The personal will must be given up” (as cited in James, 1902/1936, pp. 204). James (1902/1936) stated that McAuley’s mission “abounds in similar circumstances to the ones related. . . . The only radical remedy I know for dipsomania is religiomania,” is a saying James heard “quoted from some medical man” (p. 263).

Samuel Hadley became the superintendent of the Water Street Mission. One night in 1886, he enticed his brother, Colonel Henry Harrison Hadley, also a drunkard, to the mission. The colonel was converted and later ran the St. Bartholomew Rescue Mission in New York (Pittman, 1988, p. 81). Samuel Hadley participated in the Great Bible Conference, along with representatives from other missions, and became a popular speaker. After he died, the conference declared S. H. Hadley Day on which a representative from Water Street would always open the conference.

In 1926 Samuel Hadley’s son, Henry Harrison Hadley II, also a missionary, helped Samuel Shoemaker open the Calvary Mission in New York City. Many drinkers found help at the Calvary Mission, which was attached to Calvary Episcopal Church. On December 7, 1934, a drunken William Griffin Wilson appeared at Calvary Mission. Four days later he checked into Towns Hospital for his last detoxification (Pittman, 1988). In the next year he would become the co-founder of a movement that

would bring recovery to millions of alcoholics worldwide--Alcoholics Anonymous.

As the depression of the 1890s enveloped the country, missions were a familiar part of the urban scene. The best known mission was the Salvation Army. James Royce specifies in his extensive study that, through the years of the temperance movement, the focus shifted from the person affected by alcoholism to alcohol itself. He remarked that only the Washingtonians and later the Salvation Army “showed concern for the person affected” (Royce & Scratchley, 1996, p. 35).

#### Inebriate Asylums

The second significant movement that occurred during the latter part of the 19th century was the development of separate asylums for the treatment of inebriety. Inebriates, when confined to asylums for the insane, were usually sane and relatively well in a short period. They were therefore inappropriate patients and were even disruptive if they continued to be confined. They often relapsed rather quickly after their release. The inebriate asylums were modeled after the insane asylums, and were primarily run by public or semi-public management. They possessed the power to confine patients against their will, often for lengthy periods.

It is important to note that medical training was not clearly defined in the 19th century. Some physicians attended medical school,

and others did not. There was no standard profile for apprenticeships, and professional association was minimal. The competition focused on acquiring socially prominent patients and being appointed to hospitals and medical colleges. A convention was held in New York City in 1846 to establish a national medical association for the United States. This eventually became the American Medical Association (AMA) although it failed to attract many of the leaders in the profession at that time (Starr, 1982, pp. 89-90).

The first formal study on the subject of measures to treat the inebriate was conducted more than a decade prior to the formation of the AMA, when in 1830 a committee of the Connecticut Medical Society met to discuss an asylum for inebriates ("Hospitals," 1948, p. 29). In 1831 Samuel Woodward, superintendent of the Worcester Asylum for the Insane, wrote a series of essays expounding his ideas about inebriate asylums. According to Woodward (1836), the Boston Daily Mercantile Journal published the essays in 1831 (p. 1). Woodward began his essays by stating his experience in the care of the mentally ill and the inebriate as qualifications for his hope of curing inebriety.

Woodward (1836), recognizing the problem was more than a matter of willpower when he stated: "Intemperance, when established as a habit, is a physical evil, depending on certain diseases or modifications of the functions of the system important to life, and is not under the control of the will" (p. 1). The differences in the manifestations of

inebriety were unclear to many persons. Woodward (1836) succinctly stated: "Intoxication and intemperance are not the same thing. A man may be intoxicated many times in his life, and not be intemperate. So also he may be intemperate without ever having shown signs of intoxication" (p. 4).

The struggle to accept abstinence as a solution for the alcoholic has continued. Woodward (1836) wrote:

The grand secret of the cure of intemperance is total abstinence from alcohol in all its forms. This fundamental truth, so simple, and so extremely natural and rational, it required years to discover. . . . By means of total abstinence, and such remedies as the particular symptoms of the case may call for, most cases of intemperance may be radically cured. (pp. 8-9)

Woodward (1836) then charged the citizens and the physicians to take action:

Shall we then sit idle and see the mighty evil, witness the ruin and wretchedness it entails upon man, and not make an effort for its cure?

"Is there no balm in Gilead, and is there no physician there?"

Let the experiment be fairly tried; let an institution be founded; let the means of cure be provided. (p. 11)

Woodward's writing was a significant motivation in the asylum movement, and it was influential in establishing separate asylums for inebriates. He was a prominent member and president of the Association of Medical Superintendents of American Institutions for the Insane organized in 1844 (as cited in Baumohl, 1990). Jellinek (1960) acknowledged Woodward, the Connecticut Medical Society, and Eli

Todd of Hartford as making significant contributions to the asylum movement (p. 1).

In November 1840 the citizens of Philadelphia held a meeting to consider the establishment of an Asylum for the Cure of Inebriates, with Alexander Henry as chairman. It was stipulated that such an institution should have lodging rooms, a library, a gymnasium, and healthful amusements and that it should operate under the direction of a physician.

On April 7, 1854, an act of incorporation was passed by the Legislature of the State of New York for the purpose of establishing the “United States Inebriate Asylum” in the city of New York. A sum exceeding \$35,000 had been collected from private donations. This was to be a national hospital built by “popular subscription” (Rypins, 1949, p. 127). The primary promoter of this activity was Joseph Edward Turner from Bath, Maine. Turner’s interest in inebriety was the result of the loss of a close friend, a drinker, who was both talented and cultured. Turner believed that his efforts to save his friend had failed for “want of the power of restraint to be found only in an asylum” (as cited in Mason, 1876, p. 8). Turner began his study of inebriety by taking a tour of Glasgow, Edinburgh, London, and Paris, where he visited with physicians and toured many hospitals (Brown, 1985, p. 51; Crothers, 1914, p. 40).

Through several years of negotiations and applications for funds, the project was scaled to a state rather than a national asylum. The

citizens of Binghampton, New York, donated 250 acres in the valley at the fork of the Susquehanna and Chenango Rivers. At this beautiful spot, despite a rainy and disagreeable day, several thousand people gathered for the laying of the cornerstone of the New York State Inebriate Asylum at noon on September 24, 1858 ("The state asylum for inebriates," 1858, p. 4).

The New York Times' article reporting the ceremony related the following:

The Asylum is under State auspices, but it is largely indebted to private benevolence. It has indeed enlisted to an extent no less extraordinary than gratifying the interest of the general public. A fortunate decision has been made in respect to its site, the credit of the selection being mainly due to the liberality of the Binghampton people, who made a donation of ample grounds on one of the eminences which surround that delightful town. There is no more healthful or beautiful spot in the State. . . . Several thousand citizens were present in testimony of their interest in so novel and humane an enterprise. . . . We trust their anticipation in its behalf may be fully realized.

We are not of those who hold that a change of circumstances or the removal of outward temptation can be relied on to eradicate the evil which is in human nature. That theory, founded in error, has ever resulted, and must continue to result, in failure; but we are, nevertheless, fully convinced that the institution at Binghampton is destined to prove most beneficent in its operation. It will measurably supply a great public want, by affording a hope of rescue to thousands who have no other hope. . . . We have had enough, perhaps more than enough, of censure upon the drunkard. Let us now try kindness and the gentle compulsion which induces reform. Let us give him an asylum where he will be safe against the solicitations of evil companions and erring appetites. The enterprise has enlisted in an unparalleled degree the interest of the medical profession--a class of men who necessarily understand the peculiar needs of the inebriates better than any other. ("The state asylum for inebriates," 1858, p. 4)

The history of the construction process of the “First Inebriate Asylum in the World” is outlined in the book written by the founder, J. Edward Turner. The first application for the charter was made in 1852, designating it as the United States Inebriate Asylum (Turner, 1888, p. 43). Sixteen legislative sessions were required before the charter was granted by the state legislature of New York. Turner supported the theory of alcoholism as a treatable disease, comparing it in his writing to yellow fever, in which not all who are exposed contract the disease, and poison ivy, where not all are affected. He also referred to the “chronic insanity of inebriety” (Turner, 1888, p. 37). Before the building was completed, 2,800 persons had applied for admission (Cassedy, 1976, p. 413). Among those applying for a patient to be admitted were wealthy and influential families. The building was equipped to accommodate 300 patients (Crothers, 1914, p. 48). According to Mason (1876) the first patients were received in 1864 (p. 9).

The New York asylum had a turbulent history. A fire destroyed a wing of the building in 1864. Turner was later accused of arson, and the building was closed. A controversy ensued between the board and Turner who resigned in 1867. The asylum was reopened that same year under the supervision of Albert Day. The trustees transferred the property to the state but retained control and management (Mason, 1876). A local lawyer, Ausburn Birdsall, led the anti-Turner faction, demanding more freedom for the patients.

Day entered the position with 10 years of positive experience at the Washingtonian Home in Boston. He served for 3 years, during which he too experienced controversy with the board. He moved to eliminate involuntary patients as far as possible and treated patients who were willing to submit to “mild restraints” until they could prove their “courage” and “honour” (as cited in Brown, 1986, p. 547). Another fire occurred in 1869, and Day was also accused of arson. He resigned, and Daniel Dodge succeeded him as superintendent (as cited in Rypins, 1949, p. 132). Dodge was a vehement supporter of legal restraint (as cited in Brown, 1986, p. 548).

In 1888 Turner published a 500-page volume entitled The History of the First Inebriate Hospital in the World by Its Founder. This was not really a history but a conglomeration of opinions, case histories, and explanations of Turner's struggles with Parker and Birdsall. Turner died in 1889 without opening the Women's National Hospital in Wilton, Connecticut, which he had been planning. The Binghampton Asylum later became the Binghampton State Hospital.

In the Proceedings of the American Association for the Cure of Inebriates second annual meeting held in New York City November 14 and 15, 1871, it was noted that the Asylum at Binghampton received 360 patients for treatment during the 18 months from May 1, 1870, to November 1, 1871. Of these, 42 were the children of intemperate parents. On inquiring why so small a proportion were the victims of an

inherited disease, it was answered that a large number of those whose parents were intemperate were to be found in insane asylums and in penal and charitable institutions (McDermont, 1861).

During the latter part of the 19th century inebriate asylums were being developed in several urban centers. A report on inebriate asylums by Clark McDermont abstracted from the transactions of the American Medical Association stated that previous measures for the suppression of drunkenness had utterly failed. Reference is made of Turner's (of the Binghampton Inebriate Asylum) letter to Governor Morgan: "It is no longer problematical that inebriety can be cured by an asylum (insane), experience in insane asylums, and in private practice demonstrates this fact beyond a doubt." (as cited in McDermont, 1861, p. 9). Turner further contended that "the institution will have more of the elements for the treatment of the inebriate than any lunatic asylum has for the treatment of the insane" (as cited in McDermont, 1861, p. 9).

The report ended with the following resolutions:

Resolved, That this Association recommend the establishment of Inebriate Asylums in the various States of the Union.

Resolved, That the State and County Medical Societies, and all members of the medical profession, be requested to unite in diffusing among the people a better knowledge and appreciation of the important benefits that would be conferred upon society by the establishment of such asylums throughout the various sections of our country.

The above was referred to the mover as a special committee, with the request that he would report thereon at the next meeting of the Association. (McDermont, 1861, p. 13)

### Summary

Two significant insights about alcoholism emerged from the early colonial settlements at the beginning of the 17th century to 1870. The first was that alcoholism or inebriety, as it was named during this period, was an illness to be treated. The second insight was that the illness differed from insanity and the inebriate needed to be in a separate institution from the insane. The early English colonists brought to this country the concept from the law of James I that drunkenness or inebriety was a crime to be punished. This law was the first time that criminal implications were implemented in drunkenness. In the span of 250 years the idea that drunkenness might be a disease was added to the criminal and moral associations but it did not replace them.

The Puritans believed the alcohol to be the “good creature of God” but the abuse of alcohol to be from Satan (Lender, 1973, p. 353). The drunkard was a criminal and a sinner. The idea that alcoholism could also be an illness did not replace these ideas but surfaced as another possibility. The American most popularly associated with the belief that alcoholism was a disease to be treated was the physician and statesman, Benjamin Rush (1790). Rush did not originate the idea nor was he the only American during this period to discuss the concept. The belief that alcoholism was a disease can be traced to antiquity in the writings of Pliny and Seneca (as cited in Rolleston, 1927). The Swedish

physician Huss was the one who coined the term alcoholism in 1849 (as cited in Jellinek, 1943b).

The first formal study on the feasibility of an inebriate asylum in the United States was in Connecticut in 1830. The essays of Samuel Woodward (1836), superintendent of the Worcester Asylum for the Insane, were a significant contribution in the understanding of inebriety. Woodward (1836) recognized that the problem involved more than mere willpower and that intoxication and intemperance were not the same thing. These essays, published in the Boston Daily Mercantile Journal, were an influential motivation in the asylum movement.

Turner's (1888) asylum at Binghamton provided the first hope of a cure for inebriety. This was evidenced by the large number of applications for admittance before the asylum opened. The inebriate asylum was not a success as a solution to the problem of the inebriate in society. It did however serve as a vehicle to medicalize inebriety. As a result a new medical specialty in inebriety was created in 1870. One of the Philadelphia members of the American Association for the Cure of Inebriety (AACI) later changed to the American Association for the Study and Cure of Inebriety (AASCI) stated:

Let us have hospitals for our inebriate! Let us teach our medical students the importance and the means of battling with that disease, then in a few years we will have a faculty of physicians prepared to do for inebriety what has been done for insanity.  
(Bradner, 1891, p. 1189)

It would be another century before this occurred in the United States. Thomas Davidson Crothers (1884, 1902) who was an assistant superintendent at the Binghamton Asylum and later superintendent of the Walnut Hill Asylum at Hartford, Connecticut, has been considered by some to be the Jellinek of his day. As the editor of the Quarterly Journal of Inebriety and a prolific writer about the disease and treatment of inebriety for a period of over 40 years he was a significant in altering attitudes about alcoholism during these early years. Crothers was a professor of nervous and mental diseases at the New York School of Clinical Medicine where he developed "Spirit and Drug Neurosis" as a special topic for study. In 1887 he was honored at a dinner of the International Congress of Inebriety in London and made an honorary member of the organization (Gaynor, 1902).

Some important concepts of treatment arose during the latter part of the 19th century: (a) Foxborough implemented working with the families of the alcoholics; (b) the concept of surrender as an essential element of catharsis was evidenced in the work of Jerry McAuley; and (c) the idea of humane, wholistic treatment and the impact of the group in the treatment process was amplified by the Washingtonians.

The Washingtonians focused on the suffering alcoholic and not the alcohol during a time when the removal of alcohol was seen as the solution to the problem. As Crothers stated in 1911, the Washingtonian Movement was a clearinghouse for some new ideas to begin to be

established regarding inebriety (p. 428). The Washingtonians provided the beginning of a hospital system of humane care for the alcoholic (Crothers, 1911).

Several contributions made by the Washingtonians were later utilized by Alcoholics Anonymous: (a) complete abstinence from any alcohol, (b) group sharing of personal experiences and storytelling, (c) the need for alcoholics to provide mutual support, and (d) regular meetings of the group for sharing and support (Maxwell, 1950). The Washingtonians also provided an example of what not to do, and these mistakes were noted by the founders of Alcoholics Anonymous. Establishing the principle of anonymity as an integral concept for the benefit of the group and maintaining a central focus on sobriety as the goal for the individual and the group.

From the 17th century to the end of the 19th century the concept of alcoholism was in a dialectical process between being a legal/moral issue and a medical problem. The dialectics continued into the 20th century. Alcoholism and addiction would be rediscovered by the medical profession in the middle of the 20th century. An important indoctrination for the dialogue was established in the latter part of the 19th century with the opening of hospitals to treat the inebriate.

## CHAPTER 3

### TEMPERANCE, DEPRESSION, AND WORLD WAR I--1870-1930

In the 40 years between 1860 and 1900 the population of the United States more than doubled and three times the amount of land was cultivated (Nevins & Commager, 1992, pp. 313-314). Two factors, the development of industry and the expansion of the frontier, were responsible for this rapid growth. Another factor that contributed to the relaxation of manners and morals was the absence of an established hierarchy of neighborhoods, churches, and extended family (Bacon, 1967, p. 5). The expansion increased many social problems, with excessive drinking being one of the major dilemmas.

#### The Temperance Movement and the Creation of Denial

The American Temperance Movement, which formally began in the early 19th century, was only the beginning of a powerful change that was to have a profound and enduring impact on attitudes about alcoholism and its treatment throughout the 20th century. Selden Bacon, Professor of Sociology at Yale University, Director of the Yale Center of Alcohol Studies and Chairman of the Connecticut Commission on Alcoholism, attributed the lingering attitudes of the temperance

movement to the development of both public and private denial concerning alcoholism. This denial prevented the focus needed in the United States for research, treatment, and even for record keeping for decades (Bacon, 1967, pp. 5-18). Bacon (1967) delineated four characteristics of the century from 1820 until 1920, which he designated as a period of reform: (a) moral righteousness, absolute right versus absolute wrong; (b) laws viewed as solutions to problems; (c) simplistic educational approaches conceived as the force in changing the population's beliefs and actions; and (d) women's roles became increasingly prominent, especially when compared to those of women in Europe and Latin America (pp. 5-18).

Bacon (1967) defined the Classic Temperance Movement as emerging in the late 1820s and dominating the scene by 1840. The American Temperance Movement was a moderation movement. In the philosophy of Benjamin Rush, the American Temperance Movement rallied against distilled spirits but not against all use of alcohol. The Classic Temperance Movement sought the total obliteration of all alcohol. Bacon (1967) described the Classic Temperance Movement thus:

The Movement, later to be stereotyped as the most arch-conservative and narrowly concerned force in society, started as a radical, dynamic, and fiercely aggressive group with extraordinarily broad social concerns--for example, world peace, rights of labor, universal education, and the rights of women. (p. 8)

The new temperance movement, or the Classic Temperance Movement, according to Bacon (1967), adopted the following positions:

1. All alcohol is the target.
  2. All alcohol is evil.
  3. The Bible defines all alcohol use as evil.
  4. "Moral suasion," although a noble ideal, was downgraded as a means of resolution of the problem.
  5. Legislation must be passed to eliminate alcoholic beverages.
  6. Education of youth must move from a position of moderation to one in which all alcohol use is sinful, unpatriotic, and criminal and results in disease, degradation, and death.
- (pp. 8-9)

The leadership of this movement came primarily from Protestant church groups and women's groups.

By the time of World War I, two-thirds of the country, predominately the rural areas, "lived under dry laws" (Nevins & Commager, 1992, p. 345). On January 17, 1920, the Volstead Act went into effect, prohibiting the manufacture or sale of liquor. This law was not repealed until 1933. In the ensuing years, the "roaring twenties," the illegal and dammed liquor flourished in the speakeasy and at the cocktail party. H. L. Mencken, American newspaperman and literary critic, noted that cocktail, possibly referred to the liquor barrel drippings mixed into a single container and sold at a lower price (Lanza, 1995, pp. 7-8). The word first appeared in print in 1806, and the Webster's dictionary of that year defined it as a "kind of liquid medicine" (Lanza, 1995, pp. 9-10).

Women were awarded the vote in 1920, which paved the way for the right to attend college, be employed, and exercise social equality. They cut their hair, shortened their skirts, and joined men in smoking and drinking. "Once drinking was forbidden, women emerged not as teetotalers but as the cocktail culture's supreme adherents. Previously barred from male drinking rituals, women became speakeasy showcases" (Lanza, 1995, p. 25). For the first time, Americans of all classes and socioeconomic status blatantly and knowingly broke the law and patronized criminals. "Cocktail parties may have flaunted high-society pretensions, but ultimately they stayed successful by reinforcing middle-class notions of 'the good life'" (Lanza, 1995, p. 33).

Another change was in the types of liquor used. The colonists had used primarily beer and some wine. Bacon (1967) attributed the change to distilled spirits to the following factors: (a) soils hostile to viticulture; (b) poor roads and lack of other efficient transportation; (c) British restrictions on importing wine; (d) superb resources for cultivating grain; and (e) the Triangle Trade--slaves from Africa, sugar cane from the West Indies, and distilled spirits from New England. By 1840 90% of all liquor sold was in the form of distilled spirits (Bacon, 1967, p. 12). Another shift took place after World War II, and by 1950 beer again accounted for the largest percentage of liquor sold. Wine usage also increased.

Even after the 18th Amendment was repealed, the position that alcohol was evil remained. The evil depended on availability, and

therefore availability must be controlled. Most profoundly affected by this mindset were the users of alcohol themselves. Americans became “anxious, confused, ambivalent, and at times even guilt ridden about their attitudes towards drinking” (Bacon, 1967, p. 11).

Bacon (1967) divided the citizens into three groups: the pro-temperance, the anti-temperance, and the avoiders. This last group displayed a “bland denial of reality” (p.13). In the beginning this group was comprised of the elderly, the less educated, and the “mystically oriented” (Bacon, 1967, p. 13). They wanted to avoid the problem. There was “dislike, fear, and even hatred” of those exhibiting the problem, and the avoiders wanted to hide them in jails, workhouses, religious missions, and mental hospitals (Bacon, 1967, p. 13). It is as if it were said, “It is their own fault and they should be punished” (Bacon, 1967, p. 14).

The medical profession, the social agencies, nurses, public health officers . . . all manifested these avoidance reactions. Hospitals refused admission to persons with this problem. Social agencies had by-laws rejecting responsibility. The subject of alcohol problems was not discussed at their conferences. The subject of alcoholism was not incorporated in their training for new members of the group or profession. In relation to alcoholism, records (medical and therapeutic and rehabilitation) were not kept.

Legislatures . . . restricted themselves to violent fights about controls of the availability of alcohol. . . .

Research . . . pulled a curtain across the stage as far as alcohol and its use was concerned. . . . Sociologists would make studies of communities or colleges or recreation or youth or income, but in many instances one would judge from these studies that alcohol had not yet been discovered in the United States. Even as late as 1960, psychologists studying humans and their

behavior would make hundreds of researches dealing with the newly emerging tranquilizers or of hypnosis or even of heroin, . . . but studies dealing with alcohol were almost unknown.

As late as 1960 the head of the department of physiology of one of the most prestigious medical schools in the country formally announced that the metabolism of alcohol was completely understood and was therefore not an appropriate subject for research.

This magnificent pattern of avoidance was supported by and was in turn supportive of the intensive and extensive control of all aspects of alcohol problems. . . . The two trends, one of absolute monopoly and the other of absolute avoidance, fitted as hand and glove. (Bacon, 1967, p. 14)

From 1880 to 1950 many social problems improved, but, in each area where alcohol was involved, problems remained. Tuberculosis was practically eliminated, except among chronic drinkers; the number of beggars on the streets declined except for the drunkards; and automobile fatalities decreased except for drunk drivers. Bacon (1967) pointed to the fact that the “systems of response” in the area of alcohol-related problems were seen as failures (p. 16). In 1950 the United States was 30 years behind in addressing alcohol problems.

### Organized Efforts to Treat Inebriety

#### The American Association for the Study and Cure of Inebriety

The American Association for the Cure of Inebriates was organized in 1870. Later, the name was changed to the American Association for the Study and Cure of Inebriety, which signified its dedication to establishing scientific research in the field (Blumberg, 1978a, p. 235).

The innovator behind the association was Joseph W. Parrish, superintendent of the Pennsylvania Inebriate Asylum at Media. The son of a physician and a graduate of the University of Pennsylvania Medical School, he wanted to establish a society that would “advocate the disease approach to inebriety” (Blumberg, 1978a, p. 235). Parrish enlisted the support of Willard Parker, President of the Board of the New York State Asylum at Binghamton, to organize the group. The first meeting was held at noon on Tuesday, November 29, 1870, in the parlor of the New York City Young Men’s Christian Association (YMCA). Sixteen men were present. Ten were physicians; one was an asylum superintendent who was also a preacher; and one was a judge.

This society stated in its first declaration of principles:

1. Intemperance is a disease.
2. It is curable in the same sense as are other diseases.
3. Its primary cause is a constitutional susceptibility to the alcoholic impression.
4. This constitutional tendency may be inherited or acquired.
5. Alcohol has its true place in the arts and sciences. It is valuable as a remedy, and like other remedies, may be abused. In excessive quantity it is poison, and always acts as such when it produces inebriety.
6. All previous methods hitherto employed having proved insufficient for the cure of inebriates, the establishment of asylums for such a purpose, is the great demand of the age. Every city should have its local or temporary home for the treatment and care of such persons.
7. The law should recognize intemperance as a disease, and provide other means for its treatment than fines, stationhouses and jails. (Blumberg, 1978a, p. 235)

The majority of the group's members were physicians who were heads of the various inebriate asylums. The lay persons who were members primarily represented the Washingtonian Homes in Boston, Chicago, and Philadelphia (Blumberg, 1978a, p. 235). The leadership of the society perceived the Association to be a "therapeutic social movement" and "the pioneer of a new viewpoint and a new medical specialty" (Blumberg, 1978a, p. 235).

The association argued that inebriety was a constitutional weakness which could be prevented. It advised: "Avoid strain, get plenty of rest and eat good food, don't smoke or chew tobacco, avoid inebriating drugs, especially alcohol--and the constitutional weakness could be avoided" (Blumberg, 1978a, p. 236).

Robert P. Harris, attending physician of the Franklin Reformatory Home in Philadelphia, opposed this viewpoint, stating drunkenness to be "the effect of a diseased impulse and insisted it is a habit, a sin, and a crime" (Blumberg, 1978a, p. 236). The Franklin Home had been one of the founding members of the association. Because the association was a small group (membership never exceeding 500), an effort was made to include divergent views. Eventually, the Franklin Home withdrew from the group (Blumberg, 1978a, p. 236).

Some physicians treating nervous and mental disorders also opposed the association's view of inebriety as a disease, stating that it was a matter of willpower. Either the person could decide to drink (a

vice) or decide not to drink. A third point of opposition came from the temperance societies and the clergy, who saw the disease theory as irresponsible and as an excuse to drink (Blumberg, 1978a, p. 236).

In order to provide a platform for discussion of the association's views, as well as a format devoted exclusively to the study of inebriety, the society established the Quarterly Journal of Inebriety in 1876. Thomas Davidson Crothers was appointed editor of the journal, the first such publication in the world (Wilkerson, 1967, p. 148). Crothers was an influential physician in the treatment of inebriety. He grew up in New York and graduated from Albany Medical College in 1865. In 1870 he became clinical assistant to the chair of medicine at Albany and in 1875 he was appointed assistant physician at Binghamton. Then in 1878 he became superintendent of Walnut Hill Asylum. The name was changed to Walnut Lodge Hospital in 1880 (Gaynor, 1902, pp. 97-98)

In his anniversary address at the seventh annual meeting of the association, Theodore L. Mason explained "how the initial opposition to the first inebriate homes and asylums had been handled," as follows:

sin was no less sin because it was followed by disease as its direct consequence, so disease was no less truly disease because it was caused by a sin or a vice or both; or than it would be were it the effect of causes over which the sufferer had no control whatever. (as cited in Wilkerson, 1967, pp. 149-150)

The concept of the inebriate asylum was a uniquely American phenomenon. Europeans were greatly interested in America's progress in this area. By the end of the 19th century there were more than 50

institutions in the United States and 60 had been opened in Europe (Wilkerson, 1967, p. 150).

In 1872 Donald Dalrymple, Chairman of the House of Commons Select Committee on Habitual Drunkards, invited Joseph Parrish and Daniel Dodge from the American Association for the Cure of Inebriety to testify about the American treatment of inebriety. Dalrymple, a Norwich surgeon and proprietor of the Heigham Lunatic Asylum, believed alcoholism and mental illness were closely related. He made a trip to the United States in 1870, and when he returned he entered a bill to provide for institutional care of “habitual drunkards” (as cited in MacLeod, 1967, pp. 218-219). Dodge, who was appointed superintendent of the Binghamton Asylum when the board relieved Albert Day, was a strong proponent of legal restraint of the inebriate. He expressed to the Englishmen that “one of the greatest difficulties [in the management of inebriates] is that we do not have the power to detain these patients” (cited in Brown, 1986, p. 548). Parrish, whose own philosophies were closer to those of Day than Dodge, related to the British committee that he sought only to restrain those patients he considered incurable, and he stated that the cure rate was higher among the voluntary patients at his Medina, Pennsylvania, asylum (as cited in Brown, 1986).

The real significance of laws to restrain the inebriate was that they would validate inebriety as a medical problem and grant physicians the same authority that they had over the insane. When the Habitual

Drunkard's Law was passed in England in 1879, it provided for the licensing and inspecting of inebriate asylums and protected the rights of the alcoholic patient (Brown, 1986, p. 548). In 1884 The Society for the Study of Inebriety was founded in England under the leadership of Norman Kerr.

### The Committee of Fifty

The Committee of Fifty was formed in 1893 to study the problems of inebriety from a multidisciplinary approach (Page, 1988, p. 1097). The primary focus of the Association for the Study and Cure of Inebriety was on the medical treatment of inebriety. The Committee of Fifty was composed of scholars from various disciplines charged with studying and compiling objective reports in a specific area. Four subcommittees were developed, one for each of the areas to be studied: physiological, legislative, economic, and ethical. As a result of this research, four volumes of material were published, and the committee was dissolved in 1905. Prohibition was enacted 15 years later, and discussions about alcohol vanished from the literature (Page, 1988, p. 1097).

### Treatment Modalities

#### The Keeley "Bichloride of Gold" Cure

By the year 1902 there were over 100 institutions and sanatoria for the treatment of inebriety in the United States. These institutions

catered to those who could afford to pay. The success of these endeavors also brought in their wake a number of quick cures and quack remedies. The Keeley Cure, also known as the Gold Cure, was the most successful from a monetary and business perspective (Baumohl & Room, 1987).

Leslie Keeley was born in St. Lawrence County in 1832 and grew up in New York (Preble, 1932). He graduated from Rush Medical College and served in the army as a surgeon until the end of the Civil War. He moved to Dwight, Illinois, after the war and practiced general medicine. He is said to have begun his treatment of alcoholism and drug addiction in 1879.

In 1890 Keeley published A Popular Treatise on Drunkenness and the Opium Habit, and Their Successful Treatment with the Double Chloride of Gold, the Only Cure. He opened his first sanatorium in Dwight in this same year, advertising that his secret compound could break addiction. The best method was by a series of injections at one of his institutes. Keeley never divulged his formula, but he was not the only purveyor of this method. J. L. Gray of Chicago also offered a gold cure, and Haines' Golden Specific was another (as cited in Lender & Martin, 1987, pp. 122-124). Apparently, Keeley's competitors would administer treatment on an outpatient basis or even by mail-order.

Keeley's organization was what made his operation such a success. In 1891 he began publishing a weekly newspaper, the Banner of Gold. The most significant component in the success of the Keeley cure was the

joining of his patients into support groups called the Keeley Leagues. The fellowship was instigated by the patients themselves. When they gathered at the clinic or returned to the clinic for their injections, they congregated in a room off the lobby and began visiting and supporting new patients. This grouping evolved into the Keeley League, with 359 chapters and a total of 30,000 members. There was even a group for the wives of members, the Ladies Bichloride of Gold Clubs. The league staged Keeley Day at the Colombian Exposition in Chicago in 1893 and hundreds of the Keeley graduates paraded in his honor. The cost of the treatment was only \$25 a week for a minimum of 4 weeks. Patients were given rooms and required to board out (as cited in Dictionary of American Biography, 1932). Even though they had free access to the best liquor, they claimed to have “lost all desire after two days of treatment” (as cited in Dictionary of American Biography, 1932). By 1895 Keeley claimed 250,000 cures, with institutes located throughout the United States and in foreign countries.

Keeley's treatment received government sanction. It was used by soldiers' homes, on army posts, and even on the Indian reservations. The Keeley Cure also received the approval of church and temperance workers (as cited in Dictionary of American Biography, 1932). Keeley always employed graduate physicians.

Keeley's belief was that the disease was acquired during the process of drinking. He perceived alcohol as the cause of the disease.

Many of the germ diseases were believed to be “dispensations of Providence” and punishments for violation of Divine laws. This state of the public mind existed because the etiology of diseases, or their causes, was unknown. Science has not ventilated the cause of typhoid, consumption, small pox, scarlet fever, and infectious diseases. These things are now better understood: and it is the analogy of some of these diseases to drunkenness that has finally suggested to the medical mind that drunkenness is a disease and is curable.

I may say, however, that many of the writers on this subject, with whom I am acquainted, have rather ignored the fact that alcohol causes its own disease; although they have succeeded in clearly proving that drunkenness is associated with and, in one sense, caused by various and numerous diseases of the nervous and general system. (Keeley, 1892, p. 27)

Keeley (1892) did not agree with Crothers and other medical leaders of the time about the hereditary nature of inebriety. He compared alcoholism to consumption in inherited disposition.

The children of drunken parents are likely to be inebriated, and are said to inherit the disease or the habit. . . .

The greater quantity of alcohol manufactured is drunk by the fashionable drinkers--the people who keep sideboards and wine cellars and who drink, but are not known as drunkards. They do not become drunkards, because they drink wine and not the stronger alcoholic liquors. They can “control their appetites,” as people say. They can drink moderately.

But why do the children of drunkards drink? They do so, to a certain extent, by the force of example. . . .

It is an old and common observation that consumption is a hereditary disease . . . the only inheritance which predisposes to consumption is that of a weak resistance to the poison. . . . I think the question then must be clear in its solution that alcoholism, or drunkenness, is not always hereditary; but that people who become drunkards inherit sometimes a weak resistance to the poisoning power of alcohol. (Keeley, 1892, pp. 30-31)

Keeley’s (1892) statement is consistent with the present consensus that a predisposition to alcoholism can be inherited. He also addressed

the issue that alcoholics drink because of a craving, which is a symptom of a process of ingestion of alcohol different from that of other drinkers. Keeley's major work, The Non-Hereditary of Inebriety, was published in 1896 (as cited in Preble, 1932). By the turn of the century every state had a Keeley Institute.

Keeley moved to Los Angeles around 1898, and he died there in 1900. According to the New York Times' account of his death he was 68-years-of-age and was survived by his wife. He had no children. He left an estate valued at \$1 million ("Author of Keeley Cure Dead," 1900, p. 3). The institutes continued to flourish and the one in Dwight was still operating in the 1980s although it dropped all pretension of a cure (Lender & Martin, 1987, p. 124). The decline of the institutes (only 11 remained by 1920) was attributed to the fact that the sanatoria could offer the same results without the notoriety attached to the Keeley Cure. Keeley offered hope and shared experience for a problem most citizens perceived as hopeless (as cited in Baumohl & Room, 1987).

### State Inebriate Asylums

The first state inebriate asylum to begin operation was at Foxborough, Massachusetts in 1893. The asylum at Binghamton, while it was approved by an act of the New York State legislature, was not a state asylum in the sense that it did not primarily serve the indigent and court committed. It catered to the professional and upper-class inebriate,

the dipsomaniac. The term dipsomania was introduced by William Wood, a British alienist and Binghampton superintendent, Joseph Turner. It connoted a specific type of inebriety, often hereditarily transmitted and usually found among the prominent classes (Tracy, 1992, p. 29).

Foxborough, according to alcoholism historians Jim Baumohl and Robin Room, was “one of the closest approximations of the industrial hospital to be realized outside the correctional system” (Baumohl & Room, 1987, p. 154). Crothers (cited in Baumohl & Room, 1987) made the following statement in his proposal for an industrial hospital:

Arrest and commit all drunkards to such hospitals for an indefinite time, depending on the restoration of the patients; also commit all persons who use spirits to excess and imperil their own lives and the lives of others; put them under exact military, medical, and hygienic care, where all the conditions and circumstances of life and living can be regulated and controlled; make them self-supporting as far as is possible; and let this treatment be continued for years if necessary. The recent cases will become cured, and the incurable will be protected from themselves and others, and made both useful and self-supporting. Who can estimate the relief to the taxpayer by the removal of the perils to both property and life from drunkenness? (p. 153)

The problem with the inebriate hospital, as stated by Baumohl and Room (1987) was “not in its extremity but in its superfluity. Jails, prisons, and almshouses performed the same function for paupers at far less cost” (p. 153). There were differing ideas about what Foxborough should be. “Foxborough,” said panel member Charles Putnam, “was founded to provide the same sort of care ‘the rich’ received for

drunkenness to ‘people who are not rich’” (as cited in Tracy, 1992, p. 134).

In July 1884 the Massachusetts State Board of Health, Lunacy, and Charity considered again the concept of a state inebriate asylum. Problems surrounding the legality of confinement for extended treatment were the focus of the discussion. Dipsomania was defined as inclusive of both chronic and periodic drunkenness and not only as a precursor of insanity but as a separate form of insanity itself. Using this definition, the protocol applied to the insane would also be applicable to the inebriate (Tracy, 1992).

In July 1889 the Governor of Massachusetts appointed the first board of trustees for the Massachusetts Hospital for Dipsomaniacs and Inebriates to be located at Foxborough. The failure of the Binghampton asylum was the result of financial and physical mismanagement, political opposition, and, possibly, arson. The Foxborough Hospital therefore had to formulate its own model for management (Tracy, 1992).

The board of trustees selected Marcello Hutchinson as superintendent and William Noyes as his assistant. Both were graduates of Harvard Medical School. The board was initially faced with three basic issues:

1. how to secure the “right clientele” for the hospital;
2. how to treat the variety of patients who were committed to the hospital; and
3. how to convince the public, particularly the legislature, of the worthiness of the enterprise. (as cited in Tracy, 1992, p. 59)

The Annual Report for 1894 divided the patients into three classes: intractable, somewhat trustworthy, and trustworthy (Tracy, 1992, p. 65). There was a process of educating the courts about the appropriateness of patients to be committed for treatment.

Concerning treatment protocol, the Committee on Public Health was charged with investigating the use of treatments in private asylums, specifically the Keeley Gold Cure, and then to make recommendations to the staff at Foxborough (as cited in Tracy, 1992, p. 65). The quick claims of the cure were impressive to the legislators. Hutchinson, like other members of the American Association for the Cure of Inebriates, viewed the gold cures as quackery. It was a dilemma for Hutchinson to appease the legislators, whose political support he needed, while keeping his treatment true to his medical principles.

A typical treatment included a physical examination for injuries and diseases that might be present, a bath, and seclusion for a period of approximately 1 week to treat withdrawal symptoms. No use of alcohol was permitted, and withdrawal symptoms were treated with bromides, laudanum, and other sedatives (Tracy, 1992, p. 70). Patients were then assigned to work in the broom shop. This was a transitory step before being allowed the freedom to walk the grounds unsupervised.

Hutchinson believed the broom shop to be an important step in preparing the patients for the farm work, which was considered the most refreshing and restorative of all hospital occupations. He also encouraged

the patients to continue their individual trades within the hospital, even the physicians (as cited in Tracy, 1992, p.70).

Considerable emphasis was placed on the therapeutic relationship between physician and patient. Weekly entertainments and lectures occurred around various themes. These activities were considered essential to the therapy program. It was difficult, however, to convince the legislature of their benefits. In 1894 the American Association for the Cure of Inebriates praised Foxborough as being “one of the most promising and practical institutions of the country . . . one of the great pioneering asylums of the country” (Tracy, 1992, p. 73).

The major parts of the therapeutic program included rest; nutritious, regular meals; exercise; light entertainment; and the cultivation of industrious habits. Those legally committed patients unable or unwilling to participate were frequently dismissed, which may have been one reason for the public perception of the failure of the experiment.

In late 1899 Hutchinson was replaced as superintendent by Charles Woodbury. Under Hutchinson, per capita weekly patient expenses had declined from \$11.18 to \$5.80. Escapes had also declined by one-third, and the patient population had almost tripled. The legislature had at last approved expenditure for the construction of a gymnasium and complete hydrotherapeutic facilities (Tracy, 1992).

Escapes continued and became a mounting problem under Woodbury. In 1900 the board petitioned the legislature to make an escape punishable by 3 to 6 months at the State Farm, the State Reformatory, or the county jail. The trustees at first feared that families would be reluctant to send patients to the asylum if it was a “doorway to the penitentiary.” In 1902 the legislature considered several petitions from citizens who wished to close the hospital (Tracy, 1992, p. 84). The same year in an article in the Quarterly Journal of Inebriety editor Thomas Crothers (1902) wrote:

The first exact treatment ever attempted for inebriety as a disease began in Binghampton in 1864. From this time the medical study and treatment of inebriety has been along lines of scientific exactness.

There are now about thirty asylums devoted in whole or in part to the medical treatment of these cases in this country, and an equal number in Europe. Already there is beginning to be some classification of the inmates, also some settled plan of treatment founded on exact scientific study. As in all other new fields, there have been failures. Inebriates are difficult to treat, requiring special surroundings and conditions and great expertness and judgement in their management. A number of asylums have been abandoned, owing to the difficulties of treatment and control. In reality the inebriate is more curable than the insane, but the treatment must be based upon knowledge gained by accurate study of the conditions which both cause these toxic disorders and follow them. (p. 131)

Foxborough was experiencing some of the difficulties Crothers mentioned. Problems continued to multiply. According to Tracy (1992), “While the inebriate hospital had been proposed as an alternative to the insane asylum and jail, its terms of confinement resembled both of those

institutions” (p. 130). In 1907 Governor Guild received two reports, citing patient abuse, poor food, and mismanagement calling for an investigation of practices at Foxborough (as cited in Tracy, 1992, p. 146). As a result of these charges, and also political timing, a new board was appointed. In doing so, the governor noted that necessary expertise was missing from the old board. “It contains no professional sociologist, no authority on penology, no trained attorney, let alone a physician” (as cited in Tracy, 1992, p. 149). Irwin Neff, a specialist in psychiatry and neurology, with medical credentials and fine recommendations, was chosen as the new superintendent.

Neff unlocked the wards and began “a new system of graded care long term custodial, short term remedial, and infinite aftercare--for the Commonwealth’s habitual drunkards” (as cited in Tracy, 1992, p. 158). Neff also employed discharged patients, “giving hopeful cases the opportunity of self-support in an atmosphere free from liquor” (as cited in Tracy, 1992, p. 162). This also created an economic advantage to the state. These patients, with their varied experience and their “wits intact,” were significantly more efficient employees than the insane (Tracy, 1992, p. 164).

In 1910, Foxborough’s board of trustees published Drunkenness in Massachusetts. Conditions and Remedies. The tract was written for “social welfare bureaucrats, judges, probation officers, and physicians alike” (as cited in Tracy, 1992, p. 173). James Ford, of Harvard’s

department of social ethics, was commissioned to conduct the study. The “originality of the study was in a medico-legal classification system for public drunkards and a plan for statewide inter-institutional cooperation” (Tracy, 1992, p. 175).

In 1909, recognizing the need for support upon return to society and family, Foxborough established an outpatient department. The purpose of hospital treatment was to “permit reconstruction of the drunkard apart from his old associates and influences” (Ford, 1910, p. 52). The hospital “at best is an artificial environment and therefore a protracted stay is inadvisable” (Ford, 1910, p. 52). The purpose of the outpatient physician was to become acquainted with the patient while he was still in the hospital and to meet with his family to instruct them about the disease of inebriety and prepare them for a proper reception of the patient. They were not to be “in any way querulous” or its opposite, indulgent, of the drinker, but understanding of his “strengths and weaknesses” (Ford, 1910, pp. 52-53). This plan is an early version of an essential part of present treatment.

In 1911 the state selected a 1,000-acre tract of farmland on which to construct a cottage-colony for inebriates. The new facility was to be called Norfolk. It was designed to relieve some of the institutional pressure at Foxborough. In 1913 another study was commissioned by the governor. Again, James Ford, now a full professor at Harvard, was to

prepare the findings (as cited in Tracy, 1992, p. 182). The main points of the report are excerpted as follows:

The report denounced the use of penal methods in dealing with drunkards--habitual, accidental, and occasional--and called for 1) a women's hospital, 2) expanded men's facilities to accommodate the estimated two to three thousand cases in need of medical or detention care, and a metropolitan branch of the new Norfolk State Hospital to treat delirium tremens cases (who were refused admission at the Psychopathic and Massachusetts General hospitals).

The majority of the report advocated preventative measures against drunkenness . . . a seven step plan of action: 1) state prohibition; 2) eliminating any private profit associated with the sale of liquor; 3) enforcing existing legislation regulating the sale of liquor more tightly; 4) amending the liquor laws to a) prohibit the sale of liquor by druggists, b) test intoxicating liquor for adulterants, and c) ban bartenders from "treating" customers; 5) improving and augmenting public temperance instruction for both children and adults via schools, poster campaigns, and pamphlets; providing alcohol-free substitutes for the saloon, neighborhood centers where working men could meet for recreation; and removing the general causes of drunkenness, such as "evil heredity, bad housing conditions, long hours of labor, poverty, and other predisposing causes. (Tracy, 1992, pp. 184-185)

The statements for prevention and education were significant. Neff saw the role of the hospital as extending beyond treatment of the inebriate to include "re-education, medical-social work and preventative medicine" (as cited in Tracy, 1992, p. 186). Neff went on to make the following statement which could be made about many treatment centers today:

The time has now come when there should be a much more general recognition of the fact that a hospital for inebriates is fundamentally an agency for preventative medicine, and does not

exist merely to assist those persons who are already suffering from inebriety. (as cited in Tracy, 1992, p. 186)

In the summer of 1914, all of the inebriates were moved to the Norfolk facility. Finally, Massachusetts had a “hospital for inebriates in which situation and character is suitable for the purpose for which it is employed” (Tracy, 1992, p. 186). Neff published an article about treatment at FoxNor, as it came to be known, in the Boston Medical and Surgical Journal. Physician referrals and exchanges began to increase and patients were also referred by the recommendation of other patients. “Boston’s Emmanuel Movement, led by [the] Rev. Elwood Worcester, advocated mental and moral healing for non-organic disease and referred many of its followers to Foxborough” (as cited in Tracy, 1992, p. 240). Employers sent valued employees for treatment. The Springfield outpatient department worked with these patients after their release as well as with referrals from the Associated Charities of Boston.

As an institution, FoxNor achieved some measure of success in dealing with the problems of inebriety. The work at FoxNor

- (a) identified the problem of inebriety as being multifaceted in scope;
- (b) began to address the areas of aftercare, outpatient treatment; employer/employee relations, and, to a limited extent, the family and
- (c) assumed the responsibility for education as a measure of prevention.

A state farm for inebriates was also established in Iowa, and there were others (Ford, 1910, p. 55). Tracy’s (1992) research revealed that “The

states of Iowa, Wisconsin, Minnesota, and Connecticut, and the cities of St. Louis and New York, all modeled their own reform programs for inebriates after Foxborough and Norfolk” (p. 5).

## Lay Therapy

### The Emmanuel Movement

During the period when the state inebriate asylums were struggling to survive, the Emmanuel Movement began in Boston. In 1904 The Reverend Elwood Worcester became rector of Boston’s Emmanuel (Episcopal) Church on Newbury Street (Powell, 1909, p. 4). Worcester, a native of Ohio, received his doctorate of philosophy from Columbia College in 1866 and his doctorate in divinity from the General Theological Seminary of the Protestant Episcopal Church in 1887. Subsequently, he received a doctorate in philosophy magna cum laude from the University of Leipzig after 3 years of studying philosophy under Gustav Fechner and psychology under Wilhelm Wundt. He served as Professor of Philosophy at Lehigh University and as rector of St. Stephen’s Church in Philadelphia before coming to Emmanuel in Boston (Powell, 1909).

The concepts of the Emmanuel Movement began to emerge in Worcester’s mind in Philadelphia during a conversation with one of his most distinguished parishioners, the eminent neurologist, S. Weir Mitchell. Worcester began to conceive all diseases as having physical,

mental, and spiritual components. He decided to test this premise by holding a class for indigent tuberculosis patients to treat the mental and spiritual aspects of their disease in addition to the physical. This home treatment was so successful that it surpassed the sanatoriums with a 75% recovery rate. This use of relaxing the mind even received the attention of the Japanese government. In the fall of 1906, after consulting with medical experts, Worcester announced his willingness to “treat nervous troubles by mental and spiritual agencies” (as cited in Powell, 1909, p. 5). Fortunately he had an assistant particularly suited for this work, the Reverend Samuel McComb.

“Members of all faiths or of none” were treated without charge (Powell, 1909, p. 6). In all cases, treatment did not begin until the patient had been examined and diagnosed by a reputable doctor. Richard Cabot, after carefully examining the case studies said that “great good had been done and no harm that he could find” (as cited in Powell, 1909, pp. 7-8). Powell related that in alcoholism while a sense of disease existed this was not emphasized with the patient. The consideration was in reinforcing a sense of personal responsibility to God and to fellow man (Powell, 1909, p. 118). According to McCarthy (1984), Worcester and McComb were primarily recognized for their work in suggestion and auto-suggestion (p. 62). Worcester believed the subconscious was more receptive to outside influence when in a relaxed condition (McCarthy,

1984, p. 62). The following passage from Worcester and McComb (1908) described their use of auto-suggestion:

“The education of the will,” says Emerson, “is the object of our existence.” And there is no better aid in this education than the practice of auto-suggestion. For what, after all, is the will? It is simply the effort to concentrate our attention and thus select one idea rather than another. Now in auto-suggestion the predominant element is the concentration of thought on, or the narrowing of consciousness to, a single idea. So that in a sense we might say that auto-suggestion is simply the will in action. It is a roundabout way of getting the will to work. And the blessed path which auto-suggestion takes is that of the removal of inhibitions or checks on the activity of the will. Here is to be found the secret of that new sense of power which has come into so many lives to-day through the medium of Christian Science, Faith-healing, Metaphysical Healing, the Raja Yoga of Indian theosophy and other forms of mental gymnastics. (as cited in Worcester, McComb, & Coriat, 1908, p. 3)

Neff also practiced personal suasion and auto-suggestion therapy at FoxNor using techniques similar to Worcester’s (as cited in Tracy, 1992, p. 263).

The Emmanuel Church sponsored a club for alcoholics. It began operating in 1910 and members met on Saturdays in the church basement. Non-alcoholic members attended as well and the “club’s relationship to alcoholism was disguised in church reports” (McCarthy, 1984, p. 64).

In a discussion of the characteristics of the Emmanuel Movement, Powell (1909) addressed what he identified as the Trilogy, as follows:

I. Christian Science--“the merits and demerits of a cult which is attracting wide attention.”

II. The Art of Natural Sleep--“the application to the cure of sleeplessness the principle of suggestion . . . in cases due to psychical rather than physical causes.”

III. Emmanuel Movement--

1. “to show the possibilities of the principle applied . . . to a wide range of so-called nervous, functional disorders.”

2. “to indicate that far wider reach of the whole Emmanuel movement, which in one way or another is destined, I believe, to re-energize the entire Christian church and to make it more useful to society.” (pp. v-vi)

Worcester and McComb (1931) were influenced by the work of Carl Jung. In Body, Mind, and Spirit the authors discussed Jung’s contributions to the study of individual psychology. They believed that Jung’s archetypes significantly augmented the knowledge of human nature.

These functions, Thinking, Feeling, Intuition, and Sensation, exist and co-exist, it is true, in every individual, but Jung was the first to point out that their effect will vary enormously as one or the other is predominant and is linked with extrovert or with introvert tendencies. (Worcester & McComb, 1931, p. 52)

The authors also stated that, while Freud was more realistic, tenacious, and practical, they believed Jung to be infinitely more cultivated, idealistic, and ethical (Worcester & McComb, 1931, p. 53). Freud concentrated on the physical and Jung, the spiritual (Worcester & McComb, 1931, p. 71). This perspective was especially noted because of the link between Carl Jung and the program of Alcoholics Anonymous.

Robert MacDonald (1908), another author of the period, included in his book a series of questions and answers in an attempt to explain the Emmanuel Movement. Question 4 asks, “Is it the human or the divine

mind that cures?" (p. 337). The answer given was that mental healing cannot be considered religion, but at the same time it was powerfully enhancing to the process:

You see, the mind force that is driven on its way to the near-by or the distant person is a tremendous dynamic force. Walls do not impede it; distance does not exhaust it. It is superior to time and space. It is divine manifesting itself in and through a so-called human mind. It is hard to define it. Science has not yet named it. It is mysterious. It works miraculously. I guess we had better say it is of God. (MacDonald, 1908, p. 340)

The Emmanuel Movement was a pioneer effort in the mind-body medicine which is presently moving to the forefront.

It is significant to note the atmosphere in which the Emmanuel Movement evolved. In the same city of Boston, the Christian Science movement began about 25 years earlier. The New Thought movement developed in this area in the late 19th century. New Thought, a movement based on religious and metaphysical concepts, was attributed to the work of Phineas P. Quimby of Portland, Maine. Quimby was considered to have influenced the work of Mary Baker Eddy who founded Christian Science. The name, New Thought, has also been applied to other movements in New England, such as transcendentalism. Transcendentalism was the system of thought espoused by Emerson, Thoreau, and Bronson Alcott, the father of Louisa Mae Alcott. This group was in the Concord area just outside of Boston. Transcendentalism was essentially the belief that all creation was unified. Emmanuel Swedenborgian, the late 18th century mystic, held similar beliefs. Henry

James, Sr. the father of William James, was a Swedenborgian. The Emmanuel Movement took its name from the Emmanuel Church in Boston.

One major difference between Christian Science and the Emmanuel Movement was the strong involvement of medical specialists in the Emmanuel Movement. Leslie Weatherhead (1950), prominent minister of the City Temple in London and chaplain to the Royal Forces, in his book Psychology, Religion, and Healing stated that he regarded the work of Worcester and McComb “of the greatest importance, for it recognized at the same time the value of both science and religion in the cure of body, mind, and spirit, and sought to use both in the art of healing” (p. 221). Weatherhead wrote a constructive criticism of Christian Science; he was not quite as blunt as Mark Twain, who devoted an entire book to the subject. An example of Twain’s (1907) thoughts follows:

Mrs. Eddy is the only official in the entire body that has the slightest power. . . . The member who thinks, without getting his thought from Mrs. Eddy before uttering it, is banished permanently. . . . Mrs. Eddy is the entire Supreme Church, in her own person, in the matter of powers and authorities. (pp. 346-347)

About 1911, Worcester and McComb had a patient, Courtenay Baylor, who was a problem drinker. Baylor achieved sobriety through the Emmanuel clinic, and in 1913 he joined the group as an alcoholism specialist. According to researcher Dwight Anderson (1950), he was probably the first paid alcoholism therapist in the country (p. 152).

“After a period of sobriety he retired from the business world to become a paid 'friendly visitor' in the Church's Social Service Department” (McCarthy, 1984, p. 60). After Worcester retired from the church, he and Baylor practiced together as the Craige Foundation of Boston. According to all information, Courtney Baylor died sober.

### Richard Peabody and the Common Sense of Drinking

One of Courtney Baylor's patients was a young man from an old and prominent Boston family. Richard Peabody, was a graduate of Groton where his uncle, the Reverend Endicott Peabody, was headmaster. Peabody failed to complete his work at Harvard and despite the period of prosperity after the war, he lost his share of the family shipping fortune. His wife, a niece of J. P. Morgan, divorced him in 1921. In the winter of 1921, depressed and desolate, he began to attend the Emmanuel Clinic classes. As he improved, he continued to be involved with the work. His name was listed in the Emmanuel's Department of Community Services in 1924 (McCarthy, 1984, p. 60). In the last half of the 1920s he opened his own office. In 1933 the New York Telephone Directory listed his office at 24 Gramercy Park (McCarthy, 1984, p. 60).

Often referred to as “Dr. Peabody,” he built a large practice, with patients coming to him from as far away as California. He read a paper, “Psychotherapeutic Procedure in the Treatment of Chronic Alcoholism,”

before the Harvard Psychological Society and the Boston Society of Psychiatry and Neurology. This was published in the January 1930 issue of Mental Hygiene. In the same year he also published articles in several medical journals, including the New England Journal of Medicine in June and the British Journal of Inebriety in October (Peabody, 1930/1936, p. x).

In 1930, Peabody also published The Common Sense of Drinking, which he dedicated to Courtenay Baylor. In the introduction Peabody stated that certain individuals have an abnormal reaction to drinking. He wrote that there are those “who find in alcohol a relief from the burden of their moods; who find in its real effect the release from inhibitions; a reason to drink beyond the reach of reason; and lessened tensions” (p. xi). According to Peabody (1930), the feeling of inferiority that the alcoholic suffers was one of the most painful of mental conditions. In his book Peabody (1930/1936) outlined six steps in working to help patients recover from alcoholism:

1. Surrender. In this explanation Peabody quoted Samuel D. Schalmansen.

The surrender to the fact that alcohol can no longer be indulged in without bringing disastrous results is of such importance that it requires extremely thoughtful consideration. This surrender is an absolute starting point as far as the conscious mind is concerned. Experience has shown, however, that an intellectual surrender by no means settles the question, because there are unconscious motivations working in opposition which the patient must be made aware of and upon which he must devote considerable reflection in

order that a distorted pride may be expelled from the darkest recesses of the mind. (as cited in Peabody, 1930/1936, p. 74)

2. Future drinking Elwood Worcester told Peabody that he was 100% unsuccessful in early attempts to teach drunkards to drink “like gentleman” (as cited in Peabody, 1930/1936, p. 81). The same point was taken by Courtenay Baylor, who stated that in 17 years of successful work with alcoholics he believed, “Once a drunkard always a drunkard or a teetotaler” (as cited in Peabody, 1930/1936, p. 82). Peabody (1930/1936) said, “The carefree days when the nerves were strong are gone forever for the man who has abused his system (p. 83).

3. Economic freedom. It is not possible to work with a man who doesn't know where the next meal is coming from.

4. Family. Unless the man is entirely on his own, a preliminary interview with the family or an intimate friend is most important.

5. Patient. The patient must take great precautions against lying ingeniously (rationalizing) to himself.

6. Self-persuasion. “Halfway measures are of no avail,” the alcoholic should realize he himself does the actual work (Peabody, 1930/1936, p. 99).

In an article in the New England Journal of Medicine, Peabody (1930) stated:

Perhaps the most essential element in the work consists in the control and direction of the thought processes. A person literally thinks himself out of his habit, for in the long run sheer will power, no matter how strong, is relatively impotent against misdirected

thinking. Day dreaming--past, present, and future--about the "joys" of drinking must be avoided at all costs as it is certain to result in action sooner or later. The alcoholic is not asked to repress the problem, but he must consider it as it actually is, and not as it may have been long ago or as he wishes it might be now. What his friends can drink is of no importance to him as he is psychologically in a different category and will always remain so. (p. 1200)

Peabody (1930) emphasized that the alcoholic needed to make a schedule for himself and to adhere to it rigidly. He recommended home reading--bibliotherapy, as it is presently known and utilized. He also recommended that passages which appealed to the patient should be copied into a notebook. Some of the books that Peabody recommended for home reading were William James' monograph Habit and Coster's Psychoanalysis for Normal People. The books listed in his bibliography were The Human Mind, Karl Menninger; Why We Misbehave, Samuel D. Schmalhausen; Remaking A Man, Courtenay Baylor; The Human Machine, Arnold Bennett; The Beloved Ego, William Stekel; and Understanding Human Nature, Alfred Adler.

Peabody (1930) trained several of his patients to become lay therapists including Francis T. Chambers, Samuel Crocker, James Bellamy, William Wister, and William McKay. According to McCarthy (1984), "Peabody and his co-workers apparently did not share Baylor's personal success at remaining sober. According to all reports Baylor maintained continuous sobriety. A common opinion is that Peabody died intoxicated, although the evidence is not conclusive" (p. 60). According

to his biography Wister relapsed in 1941, and after he became sober did not continue his work as a therapist. Other reports indicated that Crocker and McKay both relapsed. Faye R., who had been a patient of Baylor, Cracker, and McKay, stated: “They [the Peabody therapists] had many wonderful ideas but they just didn’t have the magic of AA [Alcoholics Anonymous]” (as cited in Mel B., 1991, p. 125).

### The Lay Therapist and the Psychiatrist

Francis T. Chambers later worked with psychiatrist Edward Strecker at the University of Pennsylvania, and in 1938 they wrote Alcohol, One Man’s Meat. It is important to give attention to the work of Strecker and Chambers because theirs was perhaps the first alliance of a psychiatrist and a lay therapist. The title of their book, Alcohol: One Man’s Meat, emphasized that alcohol was not poison to all (Strecker & Chambers, 1953, p. 37). This book provided insight into present therapy and treatment. Included in the book are several credits to Peabody, one being the following statement about the inheritability of alcoholism:

What unquestionably is inherited is a nervous system which proves to be non-resistant to alcohol, though this same nervous system is more often acquired from neurotic parents who have expressed their nervousness in some other manner than that of chronic intoxication.” (as cited in Strecker & Chambers, 1953, p. 83)

The authors presented a clearly written progression of the development of alcoholism:

He becomes very sensitive about his drinking and any casual jocose remark made by a friend about his behavior at some alcoholic party is resented. Such a state of mind may exist for a long while, becoming progressively worse as more alcohol is consumed to combat the initial feeling of inferiority. . . . It is a beginning of the disorganization of a personality which has become dependent upon a narcotic. When this disorganization begins, self-respect is shattered and is relieved only by drinking. (Strecker & Chambers, 1953, p. 90)

According to Strecker and Chambers (1953), the rationalization always includes something in the environment as the reason for beginning to drink again, and without insight into his problem (Strecker & Chambers, 1953, p. 96). This point has been the continued observation of therapists through the years. These authors observed the crucial point when alcoholic drinking begins.

The first and true breakdown may occur early or late in the history of alcoholism. No one, not even the patient, knows just when it has been consummated. It is a silent tragedy. It happens at that instant when the individual is no longer able to face reality unless he has drugged his mind with alcohol. (Strecker & Chambers, 1953, p. 114)

Another point which Strecker and Chambers (1953) reiterated was the attitude of the therapist. The sensitivity of the alcoholic has long been noted. If the therapist cannot share a true hope of recovery the alcoholic is quick to ascertain this and assumes a posture of hopeless himself.

The attitude of the therapist about the possibility of a non-alcoholic readjustment is of the utmost importance. Unless he is convinced that it is possible to bring about a state of mind in his patients that desires not to drink any more, then he is better not to

attempt treatment. We say this advisedly, knowing that the alcoholic patient is amazingly sensitive. He is quick and unerring in sensing a defeatist attitude on the part of the therapist, and at once turns it into an argument for prolonging his addiction. . . . “This man doesn’t really think that I can get well. Therefore, what’s the use of making the attempt?” And he drowns his disappointment in more alcohol. (Strecker & Chambers, 1953, pp. 136-137)

Another area in which Strecker and Chambers (1953) were ahead of their time was in addressing relapse as a part of treatment, and in assisting the alcoholic to recognize cues or triggers to relapse.

Relapses, when they occur, are at once incorporated into the treatment, and, as we have said, the patient is made to analyze each step leading up to the relapse, so that in the future he may be forewarned and forearmed against a like contingency. (Strecker & Chambers, 1953, p. 203)

Strecker and Chambers (1953) “recognized that physical resistance is at a minimum when one is exhausted” (p. 206). Individual members of Alcoholics Anonymous later incorporated the awareness into the warning slogan: HALT--hungry, angry, lonely, tired.

### Contributions of Lay Therapists

Howard Clinebell (1968) defined a lay therapist as “a nonmedical practitioner who specializes in helping alcoholics professionally” (p. 106). He also noted that three outstanding lay therapists came from the Emmanuel Movement Baylor, Peabody, and Samuel Crocker. Peabody and Baylor had different approaches in working with alcoholics. Baylor took a low-key, one-alcoholic-to-another approach. He did not

pretend to be a scientist. “In the introduction to his book, Remaking a Man, he apologized for the lack of technical terminology” (as cited in McCarthy, 1984, p.67).

Baylor utilized the mind, body, spirit approach espoused by Worcester and McComb. Worcester and McComb worked from their clerical status although both held doctorates in psychology. They were “severely criticized by both physicians and fellow clergy for daring to invade medical territory” (as cited in McCarthy, 1984, p. 61). In 1906 the medical profession lacked both the organization and the public acceptance to force them out (McCarthy, 1984, p. 61).

Peabody and his followers used the approach of “mini-psychiatrists” (as cited in McCarthy, 1984, p.61). Peabody assumed a professional status and charged high fees for his work. He made significant philosophical changes and added psychiatric terminology (as cited in McCarthy, 1984, p. 61). In their attempt “to imitate the prestigious intellectual ideas of 1930s, Peabody and his followers essentially gutted their method of the vital substance that had made Worcester and Baylor so successful in earlier decades” (McCarthy, 1984, p. 61).

The Peabody Method was adapted by several metropolitan medical facilities in the 1930s. Three prominent physicians in the business of treating alcoholics who used lay therapists were Norman Jolliffe, at Bellevue Hospital in New York; Merrill Moore, at Boston City Hospital;

and Edward Strecker, at the University of Pennsylvania Hospital in Philadelphia. In 1944 the Yale Center of Alcohol Studies opened the first free clinic exclusively for the treatment of alcoholism. Individual and group therapy was directed by Raymond G. McCarthy, a Peabody-trained therapist (McCarthy, 1984).

In writing about the development of the lay therapist, Dwight Anderson (1944) considered two examples of lay therapists working with medical professionals: (a) McCarthy, at the Yale Plan Clinic, and (b) Chambers, at the University of Pennsylvania. Former patients were utilized at Shadel Sanitariums where they were executives, field workers, and other employees (Anderson, 1944, p. 262).

The concept of the lay therapist was not new to this period. Crothers discussed the subject in an editorial of the Quarterly Journal of Inebriety in 1897. Crothers was noted for maintaining a dogmatic, hard line within the boundaries of science. Some of his observations of the lay therapist included valid warnings:

It is confidently asserted that a personal experience as an inebriate gives a special knowledge and fitness for the study and treatment of this malady. While a large number of inebriates who have been restored engage in the work of curing others suffering from the same trouble, no one ever succeeds for any length of time or attains any eminence. The exception to this are traveling lecturers and moralists, who depend upon emotional appeal as remedies. Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of the higher defects of mentality. . . .

The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably

followed by relapse, if they continue in the work for a length of time. (Crothers, 1897, p. 79)

Crothers astutely observed that the recovering alcoholic working as a therapist is at risk for relapse. For this reason most treatment centers require 2 to 3 years sobriety as a minimum. Continuing Alcoholics Anonymous participation provides additional support for recovering therapists that was not available when Crothers made the observation. Alcoholics Anonymous suggests several years sobriety before sponsoring another person. Crothers's (1897) hard line with science was evident in the following statement: "Inebriety is a question of scientific facts and their meaning; there can be no theories or opinions no sentiments or personalities" (p. 81).

Dwight Anderson (1944) consulted with lay therapist Francis Chambers in writing his article. In a letter to Anderson, Chambers relayed the following suggestions:

The lay therapist should have gained deep insight because of his own alcoholic dependency and recovery. . . . The lay therapist working without medical support exposes himself to risks that might make him directly or non directly responsible for tragic consequences. . . . His qualifications should be a two-year period of abstinence, during which he has adjusted satisfactorily, in his social life and vocational field. If after a two-year period of abstinence, he wishes to become an associate in therapy, he should have at least a year's special training. If he progresses satisfactorily, he should be permitted to work with a certain number of alcoholic patients under the supervision of an experienced therapist. (as cited in Anderson, 1944, p. 263)

Anderson (1944) then added his own thoughts: to Strecker's suggestions:

A lay therapist would have an advantage if he possessed at least an academic bachelor's degree. This requirement could be relaxed in instances where high intelligence, combined with a pronounced record of successes in helping bring about recoveries, clearly demonstrates fitness. . . . A little knowledge is not a dangerous thing, if it is known to be little. (pp. 263-264)

The author then discussed the real need and advantage of the lay therapist:

Few psychiatrists are sympathetic to the need for treating people whose behavior is within what is considered to be the normal range . . . but who spend much of their time getting into or out of trouble with alcohol. These persons are ready-made material for the lay therapist, and they form a considerable portion of all the cases of problem drinking. (Anderson, 1944, p. 264)

What lay therapists provided more than anything else is hope. As they sit before the patient and share their experience and strength, they are hope personified. It has taken almost 55 years for the suggestions in Anderson's article to become a reality. A large number of alcoholics are relatively normal persons who exhibit abnormal behavior due to their assimilation of alcohol. At the present time, the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) has just begun to recognize advanced educational degrees for alcoholism therapists.

## Private Sanitoriums and Hospitals

### Private Sanitoriums

Private medical establishments or sanitoriums were the only remaining source of medical support for the alcoholic during the first part of the 20th century. Prohibition was, as historian Kenneth Davis (1990) stated, “America’s grandest attempt at a simple solution” for a complex problem (p. 256). It did not solve the problem of alcoholism. The state inebriate hospitals all eventually closed. If there was no alcohol, how could there be alcoholics? But there were still alcoholics, and private sanitoriums and hospitals existed for the alcoholic and the addict who could pay. According to Johnson (1973) “National prohibition had a greater impact among the lower classes in the inner-city than any other segment of the population. The use of alcoholic beverages (beer in particular) among the urban poor sharply declined during the Prohibition Era” (pp. 165-166). There may also have been a significant decline in inebriety among the wealthy after World War I, although it would be practically impossible to document. The increased incidence of problem drinking occurred among the members of the middle class (Johnson, 1973, pp. 166-167).

### Walnut Lodge Hospital

Under the supervision of T. D. Crothers Walnut Lodge Hospital, in Connecticut, was one of the private sanitoriums that continued

operation during prohibition. Opened during an earlier period, it operated on the asylum model of restraint and control of the patient. C. B. Pearson of Maryland was another physician who operated a sanitarium. His perspective was different from Crothers in that he opposed restraint, believing that cures could be effected by slow withdrawal, good food, and an understanding physician. He asked of his patients only a willingness to be cured, and he achieved some success (as cited in Musto, 1987, p. 78).

#### Towns Hospital

Towns Hospital was operated by Charles B. Towns, who was not a physician but a businessman. He was a Georgia farm boy who became a successful life insurance salesman in the South. Towns came to New York City in 1901, excited about the possibilities of working in the stock market. From 1901 to 1904 he became a partner in a large brokerage firm that eventually failed (as cited in Musto, 1987, pp. 79-80). Approached by an acquaintance who claimed to have a cure for drug addiction, Towns consulted his own physician, who claimed it was ridiculous. Still interested, Towns slowly experimented through newspaper advertisements and treating the addicts in a hotel room. The medical profession shunned him; a few years later, however, he was able to interest Alexander Lambert, a distinguished Cornell Medical School physician, who was Theodore Roosevelt's personal physician. Lambert

introduced Towns to government contacts as a “straightforward, honest man--no faker” (Musto, 1987, p. 80). Lambert became president of the New York State Medical Society in 1918 and of the American Medical Association in 1919.

With Lambert’s support, Towns was able to use his treatment in China where, in 1908, he had great success and claimed to have cured 4,000 opium addicts. His treatment was also reported as a success by the Philippine government. In 1909 the Towns’s method of treatment for addiction was presented to the medical world under the endorsement of the federal government, Lambert, and the American Medical Association (Musto, 1987, p. 82). This treatment was known as the Towns-Lambert method. The methodology consisted of three steps: (a) using cathartics until a green mucous stool was produced, (b) using sedation to promote relaxation during the withdrawal period, and (c) using strychnine in small doses to combat exhaustion. This treatment was referred to by its detractors as “diarrhea, delirium, and damnation” (Musto, 1987, pp. 81-82). Others referred to it as being “purged and puked” (Pass It On, 1984, p. 101). Essentially, the same procedure was used with alcoholics.

Towns’s understanding of the addictive qualities of drugs was prophetic for his time. He opposed the use of almost all stimulants and greatly feared the effects of opiates. Contrary to public opinion, Towns believed that anyone could become addicted to morphine. “Codeine was

especially dangerous, and as for cannabis, ‘there is no drug in the Pharmacopoeia today that would produce the pleasurable sensations you would get from cannabis . . . and of all the drugs on earth I would certainly put that on the list’” (as cited in Musto, 1987, p. 47). Towns believed that complementing federal and state laws could combat the sale of drugs and control their availability to the public. He testified for the passage of the Harrison Act in 1914, which would regulate the sale of all narcotics.

Actually, for those who could not pay the entire amount for their treatment, Towns created a graduated payment scale. He believed that assuming responsibility for the payment of treatment was a part of the treatment process.

I always insist that the man who has no means but is sent to me for treatment at the expense of somebody else, shall always pay for his treatment by some arrangement with his “backer;” that whenever it is possible he shall make the cost of his treatment a financial obligation and that when he begins to earn money, this money must by degrees be paid back to his friend. There is little good going to come out of believing that in trying to reclaim men of this type it is all-sufficient to run them through a medical mill and charge up to profit and loss whatever financial expense may be involved. You’ve got not only to treat a patient, but deal with a man! And if this isn’t one of the big jobs for the American nation to tackle, I miss my guess! We have spent millions educating people to booze; how much are we willing to spend to show them how to live? (Towns, 1917, p. 29)

Towns Hospital became the leading hospital for alcohol and narcotic treatment during the 1920s and 1930s and remained well known in later years because Bill Wilson, the co-founder of Alcoholics

Anonymous, was a patient there three times. Towns Hospital is where he had his last treatment in December 1934, and where the beginning of his healing transformation took place, with William Silkworth as the attending physician (Pass It On, 1984).

Silkworth was a graduate of Princeton and received his medical degree from New York University-Bellevue Medical School. During World War I he was a member of the psychiatric staff of the United States Army Hospital at Plattsburgh, New York, and he was an associate neurologist at the Neurological Institute of Presbyterian Hospital in New York from 1919 to 1929 (Blumberg, 1977, p. 2124). Silkworth achieved some success in private practice in the 1920s but lost his entire savings in the crash of 1929.

Desperate, Silkworth went to work at Towns Hospital in 1930 for \$40 a week plus board. This was a turning point in his life. "Seeing the miserable wreckage that floated through the place, he resolved to do something about it" (Pass It On, 1984, p. 101). He served as physician-in-charge at Towns Hospital until his death in 1951. From 1945 on he also served as director of the alcoholism treatment center of Knickerbocker Hospital in New York (Blumberg, 1977, p. 2124). "He was 59 years old when he began his full-time commitment to treat alcoholics" (Blumberg, 1977, p.2125).

When Bill Wilson arrived as Silkworth's patient he had already formulated his allergy theory. Three years later the doctor published an article describing his ideas:

No other disease entails such far-reaching suffering and disaster to families and friends, nor is there any other with which the physician has been less able to cope with reasonable assurance of at least minimizing its ravages . . . heretofore alcoholism has been considered a vice . . . true alcoholism is a manifestation of an allergy . . . alcoholism is not a habit . . . drunkenness and alcoholism are not synonymous. (Silkworth, 1937, p. 249)

Silkworth wanted both the family and the alcoholic to understand that the patient had lost control of the effects that alcohol had on his life.

This spree is characterized by certain definite symptoms in all such cases . . . he may not, in many cases, actually be taking any more liquor on the average than one of his associates who does not get into the same state as himself . . . very little alcohol has an effect on him altogether out of proportion to the amount taken.

I cannot emphasize too strongly the point that this man does go on a spree from pure deviltry or desire. (Silkworth, 1937, pp. 250-251)

Silkworth was consistently described as a kindly man with a great shock of white hair (as cited in Pass It On, 1984, p. 99). Affectionately known as "Silky," his genuine concern and care for the alcoholic earned him the title, "The Little Doctor Who Loved Drunks" (Thomsen, 1975, p. 227). It has been estimated that he treated over 50,000 alcoholics.

Silkworth published eight articles, including the introductory chapter to Alcoholics Anonymous in 1935. His earliest writing was the 1937 article in Medical Record, which is previously quoted. The latest

article he published was in 1950. In appreciation for all that he had done for them, Bill W. and his friends made an appeal for funds in order for Silkworth to retire in New Hampshire (as cited in Blumberg, 1977, p. 2124).

Geraldine O. Delaney, currently Chief Executive Officer Emeritus and founder of Alina Lodge Treatment Center in Blairstown, New Jersey, was a patient at Towns Hospital seven times. She referred to it as “Mr. Towns’ Emporium.” Delaney, well educated and from a prominent family, was head of the Pediatric Board in New York. During prohibition she smuggled whiskey across the Canadian border in hot water bottles strapped between her legs (Delaney, personal communication, July 11, 1995). She realized her brother was a “moral reprobate” and needed help so she consulted with a Newark child psychiatrist she knew, James Plant. He told her that he had heard Bill Wilson speak several months earlier at a medical society meeting in New York, and offered to call Wilson. Bill Wilson called on her brother and later became his sponsor. “Although,” she said, “we did not have sponsors in those days. We had people who looked after us” (Delaney, personal communication, July 11, 1995).

Geraldine Delaney met Bill Wilson in 1940. Her own alcoholism continued for another 6½ years, and she had several more stays in Towns Hospital. During one of these times Delaney threw Silkworth out of her room when she heard he was a psychiatrist. After learning that he was Bill’s doctor, she asked him to come back, but he declined. She said,

“The pills had just come out. They were unregulated, merely dehydrated alcohol, seconal, phenobarbital. I kept a handful with me in case I got nervous.” (Delaney, personal communication, July 11, 1995). She said that Alcoholics Anonymous was not a part of the treatment regime in Towns Hospital at that time (Delaney, personal communication, July 11, 1995).

Describing his hospital, Towns (1916) wrote:

It surprises me to note how little the drug and alcoholic patient is understood by the medical world as a whole. This is no reflection, however, on the medical profession. They have had few means of studying this type of patient from a clinical standpoint; in many cases they have had none at all; and there is nothing in their medical education to give them any knowledge whatsoever of this medical problem. (p. 4)

Towns did not believe that alcoholism was a disease in the early years of his work. He wrote in 1917:

Medical men have been largely responsible for making the alcoholic believe that alcoholism is a disease. Stop and think for a moment and you will see how ridiculous this is! The only extent to which a man can be alcoholically diseased is the extent to which he has been taking alcohol, in such quantities . . . that he has established a certain definite tolerance. . . . A man who has a poisoned father . . . probably would inherit a defective nervous system. But he would not inherit a craving for drugs or drink. (pp. 26-27)

By 1932 Towns expressed the belief that the need for total abstinence was an essential part of treatment philosophy. He also placed no moral judgment on the alcoholic.

There is no more disgrace in being treated for alcoholism than in being treated for pneumonia. The person who is an alcoholic must be impressed with the fact that he is a very sick person and that he should feel no stigma attached to his going to a reputable hospital for help. (as cited in Blumberg, 1977, p. 2127)

### Sunnyside Hospital

Edward C. Mann operated Sunnyside Hospital in an elegant brownstone near Prospect Park in Brooklyn. According to its brochure, the hospital treated the inebriety of dipsomania as a nervous disease using electrotherapeutics when indicated and desired. "Tranquil surroundings . . . wholesome exercise of body and mind have thus far been eminently successful in leading patients to a better and higher life" (Sunnyside, 1883, p. 7). The brochure also reported "surprising results from the use of electricity to the brain and spinal cord" (Sunnyside, 1883, p. 14).

### Cabot's Brookline Sanitorium

The Brookline sanitarium was opened in 1910 by Richard C. Cabot. A distinguished physician who has been credited with implementing social work in American hospitals and pioneering social work training, Cabot (1911) adopted the Towns's method for the treatment in his sanitarium.

### Bellevue Hospital

From 1902 to 1935, inclusive, Bellevue Hospital in New York City recorded 256,755 separate alcoholic admissions. The admissions ranged from the lowest level, 5,830 in 1902, to the highest level, 11,307 in 1910. The downward trend began in 1911. Prohibition went into effect on January 17, 1919, and there was a drastic fall to 2,091 in 1920. From 1922 the trend began moving upward and in 1933 there were 9,542 admissions. Prohibition was repealed December 5, 1933, and in 1934, the first full year after the repeal, there were only 7,649 admissions. Then, in 1935, the upward trend began again with an increase to 9,139 (Jolliffe, 1936, p. 306).

### Government Hospitals for Addiction Treatment

From the 1920s into the 1940s, Lawrence Kolb, Sr., of the United States Public Health Service, represented the highest level of medical research in addiction. In the 1920s he believed that normal persons did not choose to become addicted; therefore the addict by choice was a psychopath. Addiction was only one aspect of the psychopath's life, which included other criminal activity and social ineptness. Kolb stated that the joy of a morphine injection would be felt only by the psychopath; a normal person would feel little or nothing. In his opinion, the accidental case of addiction, whether it stemmed from patent medicine or a physician's malpractice, had been greatly reduced as a

result of the Harrison Act so that in the 1920s only psychopaths were seeking the pleasure of opiates. In 1925 Kolb summarized some of his research:

Opiates apparently do not produce mental pleasure in stable persons except a slight pleasure brought about in some cases by the reflex of acute pain.

In most unstable persons opiates produce mental pleasures during the early period of addiction. The degree of pleasure seems to depend upon the degree of instability. (as cited in Musto, 1987, p. 84)

In 1929 Congress established two “farms” for the treatment of addiction one in Lexington, Kentucky, and one in Ft. Worth, Texas. The reason behind this federal aid to treatment was not the interest of the government in finding a cure for addiction; rather it was to alleviate the overcrowding of federal penitentiaries because of jailed addicts. According to Musto (1987), in the process of acquiring approval for the passage of the legislation, the “warm hope was expressed that through these hospitals effective treatment or a new discovery would begin to wipe out the addiction menace” ( p. 85).

### Summary

The era between 1890 and 1930 was one of progressive action in the form of temperance and the enactment of prohibition in January of 1920. The American Temperance Movement was a moderation movement which rallied against the use of distilled spirits and not all alcohol. The Classic Temperance Movement which emerged in the late

1820s and was a dominant force by 1840 opposed all use of alcohol. Bacon (1967) described this movement as “the most archly conservative and narrowly concerned force in society” (p. 8). This group, according to Bacon (1967), fostered the growth of a denial that was to have a profound effect upon American society where alcohol was concerned.

The American Temperance Movement cultivated a rigid moral righteousness especially where the use of alcohol was concerned. Laws were viewed as solutions along with simplistic educational approaches. Alcohol and all alcohol use was seen as evil and the drunkard as a sinner. The salvation of the souls of sinners in this campaign was a different dynamic than the conversion experience described by Starbuck and James. The conversion experience was a profound internal change with self-surrender of the will. The saving of souls was often an external process or only an intellectualization with expectations on the part of the one being saved. Samuel Shoemaker (1952) made this distinction in an article about the 12 Steps of Alcoholics Anonymous in the publication of the Calvary Church in New York: “Self-surrender is man’s part in his own conversion. We cannot and do not convert ourselves” (p. 20).

The American Association for the Cure of Inebriety founded in 1870 had great hopes of finding a cure for inebriety. Later the name was changed to the Association for the Study and Cure of Inebriety. The Quarterly Journal of Inebriety was started in 1876 and published until

1914. This journal served as a sounding board for the superintendents of the inebriate asylums, the Washingtonian homes, and others involved in treating inebriety.

In the private sector there was some hopefulness concerning the development of treatment for alcoholism and other drug addictions, specifically in the form of lay therapy. Hospitals were opened, and different avenues of treatment were explored. The medical profession developed a vested interest in the problem of alcoholism. Between the Civil War and World War I, the disease concept of alcoholism was beginning to be accepted in the medical community (Blumberg, 1977, p. 2141).

Lay therapy expanded to have a positive effect on the treatment of alcoholism. Beginning with some few who recovered in the inebriate asylums helping other patients, the real growth of lay therapy occurred as the result of the Emmanuel Movement originating at the Emmanuel Church in Boston. From the work of Worcester and McComb their patients Courtenay Baylor and Richard Peabody (1930/1936) developed a significant following. Richard Peabody's method was explained in his book, The Common Sense of Drinking.

The private sanitoriums which expanded during this period catered primarily to the middle and upper classes. Drug addiction was an ever increasing problem. Towns Hospital on Central Park West in New York was a unique 20th century model for the treatment of addiction.

Towns traveled to China to treat opium addiction and continued to be considered an expert in the treatment of addiction into the 1950s (Macfarlane, 1913).

National Prohibition was enacted January 17, 1920, with the passage of the Volstead Act, and it remained in force until it was repealed on December 5, 1933. An amendment to the Constitution was required to both pass and repeal prohibition. According to Johnson (1973), prohibition affected the use of alcohol in the lower classes by decreasing the use of alcohol, especially of beer, in this group. An increased use of alcohol was reported during this period for the middle class.

The Harrison Act (1913-1915), restricting the sale of narcotics, passed in 1914, without an amendment to the Constitution. Organized medicine opposed the act in the 1920s and several Supreme Court decisions were closely debated in upholding its constitutionality. Even in 1937 a separate law was used to prohibit the sale of marihuana because the Treasury Department did not want to threaten the Harrison Act.

Musto (1987) explained the situation as follows:

Why did the Supreme Court agree that a federal statute could outlaw narcotics, when the Constitution itself had to be amended to outlaw alcohol? One answer to this may be that in the case of narcotics the consensus was almost absolute; everyone appeared to agree on the evils of these drugs. For alcohol, there was no such agreement. (p. 247)

The hope of finding a cure for alcoholism and other addictions ended with the 1920s. The state inebriate asylums all closed, and the only recourse for the inebriate who could not afford a private hospital or sanitorium was the state insane asylum. These insane asylums continued to admit the most hopeless and destitute for custodial care. Prohibition was not completely responsible for the closing of the state inebriate asylums. According to Brown (1985), there were only three state inebriate asylums by 1909.

The desolate, hard times of the approaching 1930s brought with them an even more profound hopelessness about alcoholism. Government pronouncements, such as the one made by Lawrence Kolb, reinforced the notion that only the weak and the psychopathic became alcoholics and addicts. The Classic Temperance Movement had created a focus on the alcohol itself which resulted in prohibition. The moral condemnation would have a long lasting effect.

## CHAPTER 4

### DEPRESSION, HOPE, ANOTHER WORLD WAR--1930-1940

This chapter covers the time period from the Great Depression to the beginning of World War I. These were desperate years in the history of the United States. During this interval Prohibition ended with a higher incidence of alcoholism than when it began. Lifestyles were altered overnight and the country was in a turmoil. Levine (1984) stated that Prohibition was not responsible for any of these changes, “just as it did not cause the growing acceptance of alcohol in the middle class” (p. 114).

Ronald Roizen (1991) traced the origins of the modern alcoholism movement to two institutions, Alcoholics Anonymous and the Research Council on Problems of Alcohol (RCPA) (p. 94). Harry Levine (1984) traced the origins to three groups, Alcoholics Anonymous, the Yale Center of Alcohol Studies (now Rutgers Center of Alcohol Studies) which emerged through the RCPA, and the National Council on Alcoholism (NCA) (p. 117). Bruce Holley Johnson (1973) wrote a complete account of the beginnings of the RCPA and was able to personally interview many of the key participants. Of all the above

entities, Alcoholics Anonymous has had the most immediate and profound effect on the treatment of alcoholism.

### Alcoholics Anonymous

Alcoholics Anonymous is considered by the majority of treatment and medical professionals to be the most effective recovery process for alcoholism which exists at this time. Barbara S. McCrady and William R. Miller, psychologists, who have completed extensive research on Alcoholics Anonymous stated in 1993: "With an estimated 87,000 groups in 150 countries (Alcoholics Anonymous, 1990) and over 1.7 million members world-wide, AA [Alcoholics Anonymous] is far and away the most frequently consulted source of help for drinking problems" (p. 3). George Vaillant (1995), Harvard psychiatrist, explicitly stated, "while controlled studies of AA have proven too difficult to carry out, naturalistic studies offer evidence that AA is effective" (p. 268).

Sociologist Milton Maxwell (1951) concluded over 40 years ago: "Alcohol addiction is a sociogenic personality disorder, and that a permanent 'arresting' of alcohol addiction requires personality changes which enable a more objective and satisfying interaction with other persons and other aspects of the environment" (p. 448). Maxwell's study revealed that as a result of participation in the Alcoholics Anonymous program the subjects increased their ability to "interact more satisfyingly

with other persons” and to experience “increased enjoyment and appreciation of other aspects of life” (p. 448).

Physician Donald Goodwin (1979) stated, “demonstrating scientifically that Alcoholics Anonymous helps alcoholics is about as hopeless as showing scientifically that radical mastectomies cure cancer of the breast” (p. 318). Being unable to prove the effectiveness of Alcoholics Anonymous has been problematical for many scientists. The fact remains that no single approach has worked unequivocally. There has yet to be found a panacea for alcoholism. Alcoholics Anonymous has worked the best for the largest number of people, and “To deny an alcoholic AA would be viewed as close to criminal” (Goodwin, 1979, p. 318).

Rosenberg (1979) explained that the “doctrinal rigidity” of Alcoholics Anonymous is basically the difference between the scientific and the lay approaches to treatment (p. 331). Rosenberg (1979) further stated,

In many aspects of health care (e.g., the treatment of infections, cancer, heart disease) the scientific approach is now the dominant force, but it is still less certain that professionalism and the scientific methods have improved the treatment of alcoholism. (p. 318)

#### The Four Founding Moments of Alcoholics Anonymous

Ernest Kurtz (1979) received his doctorate in the History of American Civilization from Harvard in 1978 after professional years

spent in both religion and psychology. Sociologist Selden Bacon stated that Kurtz's (1979) book Not God a history of Alcoholics Anonymous, was the best book he had seen about the subject. In that book, Kurtz (1979) delineated the four "founding moments" in the history of the idea behind the development of Alcoholics Anonymous:

Dr. Carl Gustav Jung's 1931 conversation with Rowland H.; Ebby T.'s late November 1934 visit with Bill Wilson; Wilson's "spiritual experience," and discovery of William James in Towns Hospital in mid-December 1934; and the interaction between Wilson and Dr. Bob Smith through May and June 1935. (p. 33)

The composition of these events revealed not only the conception of Alcoholics Anonymous but also the ongoing process of its growth.

#### Jung's 1931 Conversation With Rowland Hazard

In beginning the discussion of Rowland's visit to Jung, it is important to understand what Jung meant by the term synchronicity.

Jung (1938) stated:

"Synchronicity," a term for which I am to blame, is an unsatisfactory expression in so far as it only takes account of time phenomena . . . the phenomena of synchronicity, which are associated with the activity of unconscious operators and have hitherto been regarded, or repudiated, as "telepathy," etc. Skepticism should however, be leveled only at incorrect theories and not at facts which exist in their own right. No unbiased observer can deny them. Resistance to the recognition of such facts rests principally on the repugnance people feel for an allegedly supernatural faculty tacked on to the psyche, like "clairvoyance." As soon as a psychic content crosses the threshold of consciousness, the synchronistic marginal phenomena disappear, time and space resume their accustomed sway, and consciousness is once more isolated in its subjectivity. (pp. 101-102)

Mel B. (1991) defined synchronicity as “Jung’s term for two or more simultaneously occurring events that exhibit a significant, meaningful, yet noncausal, relationship” (p. 10). The experience Rowland Hazard, an alcoholic, was such a synchronistic occurrence. According to Mel B., he was the first alcoholic in the relay process that brought spiritual truths to Bill Wilson. Hazard’s family lineage traced back to 1635. Among his family members were industrial pioneers, scholars, writers, a philosopher, the naval hero Oliver Hazard Perry, and an aunt who was president of Wellesley College. Hazard graduated from Yale in 1903 and he served in the Rhode Island Senate from 1914-1916. He was a Captain in the United States Army during World War I (as cited in “Rowland Hazard,” 1945, p. 1).

Hazard’s only surviving son, Charles, of Louisville, Kentucky, recalled that his parents divorced in 1929, presumably because of his father’s alcoholism, and, they later remarried. The son recalled traveling to Europe on the Ile de France and staying in France with his brothers and sister while his parents went to Switzerland for his father to consult Jung (as cited in Mel B., 1991, p. 16).

Having exhausted all avenues of help for alcoholism in the United States, Hazard had originally decided to consult Freud, who was at that time considered the most eminent of the European psychiatrists. Ill with cancer since 1923 and convalescing from recent surgeries, Freud could not see him (as cited in Mel B., 1991, p. 14). Had Freud been available,

the sequence of events might have unfolded quite differently. Freud's orientation was psychoanalysis and the search for the underlying meanings of the drinking.

Hazard then decided to consult Freud's former student and colleague, Carl Jung, about his alcoholism. This first visit presumably occurred in late 1927, and the Hazards probably lived in Zurich for a little over a year. During the time Hazard was under Jung's care, the doctor had a lakeside home in nearby Kusnacht (as cited in Mel B., 1991, pp. 16-17). Writer Elizabeth Sargent (1931) described what it was like for a patient to visit Jung:

Doctor Jung's patients must take a little steamboat at a landing haunted by gulls and wild ducks, and then walk a good ten minutes to a yellow country house standing well within walls and gardens on the edge of Zurichsee. They must pull a shining brass bell, of old fashioned mold. and while its fateful ring resounds through the house . . . meet the inspection of a group of skirmishing dogs.

Yoggi, the Doctor's special intimate, always manages to slide into the upstairs study behind the visitor, to take his silent, attentive share in the conversation. I noticed at my first interview that Jung's hand--the sensitive, strong hand, with the Gnostic ring--reached down now and then to the shaggy back.

It was comfortable, too, that as he discussed intimate problems, his face now very sober and concerned, Jung tramped the floor, fed the fire, lighted a meditative pipe; common clay and spirit were all one. When he sat stiffly in his chair for a moment and gulped down his tea, he suddenly turned into a German professor. . . . The actual Jung, solid and vital in his middle fifties, humorous and skeptical, refuses to stand on a pedestal or to take on any white-bearded Old Testament air. . . . One leaves Jung's presence feeling enriched and appeased, as by contact with a pine tree in the forest--a life as much below ground as above." (pp. 740-741)

Hazard believed that with his new insight he could remain sober. After the extended stay for therapy, he and his family returned to Rhode Island. In a short time he was intoxicated again. This was apparently the time of his divorce. After another period of drinking and in complete desperation, he returned to Jung in 1931, asking for more help. He later discussed his encounter with Jung in great detail. Years later, Bill W. (1958) related Hazard's experience in a talk before the New York Medical Society:

He asked Dr. Jung what the score was, and he got it. In substance, Dr. Jung said, "For sometime after you came here, I continued to believe that you might be one of those rare cases who could make a recovery. But I must now frankly tell you that I have never seen a single case recover through the psychiatric art where the neurosis is as severe as yours. Medicine has done all that it can do for you and that's where you stand."

Mr. R's depression deepened. He asked: "Is there no exception; is this really the end of the line for me?"

"Well," replied the doctor, "there are some exceptions, a very few. Here and there, once in a while, alcoholics have had what are called vital spiritual experiences. They appear to be in the nature of huge emotional displacements and rearrangements. Ideas, emotions and attitudes which once were the guiding forces of these men are suddenly cast to one side, and a completely new set of conceptions and motives begin to dominate them. In fact, I have been trying to produce some such emotional rearrangement within you. With many types of neurotics, the methods which I employ are successful, but I have never been successful with an alcoholic of your description."

"But," protested the patient, "I'm a religious man, and I still have faith." To this Dr. Jung replied, "Ordinary religious faith isn't enough. What I am talking about is a transforming experience, a conversion experience, if you like. I can only recommend that you place yourself in the religious atmosphere of your own choice, that you recognize your personal hopelessness, and that you cast yourself upon whatever God you think there is." (pp. 10-11)

Hazard returned to America. Mel B. (1991) believed that he may have affiliated with the Oxford Group while he was in Switzerland because they had an active group at that time. It is known that when Hazard returned to the United States he became involved with the Oxford Group at the Calvary Mission of Sam Shoemaker's Calvary (Episcopal) Church (as cited in Mel B., 1991, p. 19). According to a 1954 interview with Cebra Graves, also a friend of Ebby Thatcher, Hazard was driving in Massachusetts from South Williamstown to Pittsfield when he heard an inner voice say, "You will never take a drink again." He then threw the pint he always had with him into the roadside bushes (as cited in Mel B., 1991, p. 19). Hazard maintained continuous sobriety until his death (Dick B., 1994, p. 254).

When he died on December 19, 1945, in Waterbury, Connecticut, Rowland Hazard was 64 years old. He was Vice President and General Manager of Bristol Manufacturing Company in Waterbury. He was the son of the late Rowland G. and Mary Pierrepont (Bushnell) Hazard. He maintained a legal residence in Peace Dale, Rhode Island. According to Dick B. (1994), "In Calvary Church today there are two stained glass windows to the south of the center street doors. These were given in memory of Rowland Hazard" (p. 54)

The Oxford Group. Ernest Kurtz (1979) provided a concise description of the Oxford Group in his book, Not-God:

The Oxford Group was a non-denominational, theologically conservative, evangelically styled attempt to recapture the impetus and spirit of what its members understood to be primitive Christianity. Begun as “The First Century Christian Fellowship” in 1908, its popularity under the name “Oxford Group” peaked in the late twenties and early thirties; after 1938 it was known as “Moral Re-Armament.” (p. 9)

In February 1926 the Calvary (Episcopal) Church, through its Calvary Rescue Mission, became the access for the Oxford Group’s message to thousands of alcoholics by providing the physical structure in which Alcoholics Anonymous began to take form. In 1936 the Oxford Group was at its peak in America. In August of that same year, the leader, Frank Buchman, was quoted in a newspaper as being pro-Hitler. At the same time other changes were occurring. The group was becoming more focused on national and world issues, whereas Bill Wilson realized that the alcoholics needed to focus on the single purpose of maintaining sobriety. In 1937 Alcoholics Anonymous withdrew from the Oxford Group. In 1938 Oxford University requested that the group no longer use its name, and it then became the Moral Rearmament (MRA). With the escalated focus on mass methods a number of other members withdrew (Pass It On, 1984, p. 171). The Oxford Group was never associated with the Oxford Movement, a liturgical movement within the Anglican Church (Kurtz, 1979, p. 9).

Exchange of letters between Wilson and Jung. On January 23, 1961, Bill Wilson decided to write to Jung to thank him for the message

he had given to Rowland Hazard and to let him know what a critical role he had played in the founding of Alcoholics Anonymous. Wilson reminded Jung about Hazard, who by this time had been dead almost 20 years, and he related the chain of events which had occurred. At the end of the letter he told Jung that many Alcoholics Anonymous members report psychic phenomena, “the cumulative weight of which is considerable” (Bill W., 1988, p. 279). Wilson also reported that many others, following their recovery, have “been much helped by your practitioners” (Bill W., 1988, pp. 279-280)

On January 30, 1961, Wilson received the following letter from Jung:

Dear Mr. Wilson,

Your letter was very welcome indeed.

I had no news of Roland H. anymore and often wondered what has been his fate. Our conversation which he has adequately reported to you had an aspect of which he did not know. The reason, that I could not tell him everything, was that those days I had to be exceedingly careful of what I said, I found out that I was misunderstood in every possible way. Thus I was very careful when I talked to Roland H. But what I really thought about was the result of many experiences with men of his kind.

His craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God.

How could one formulate such an insight in a language that is not misunderstood in our days

The only right and legitimate way to such an experience is, that it happens to you in reality and it can only happen to you when you walk on a path, which leads you to higher understanding. You might be led to that goal by an act of grace or through a personal and honest contact with friends, or through a higher education of the mind beyond the confines of mere

rationalism. I see from your letter that Roland H. has chosen the second way, which was under the circumstances the best one.

I am strongly convinced that the evil principle prevailing in this world, leads the unrecognized spiritual need into perdition, if it is not counteracted either by real religious insight or by the protective wall of human community. An ordinary man, not protected by an action from above and isolated in society, cannot resist the power of evil, which is called very aptly the Devil. But the use of such words arouse so many mistakes that one can only keep aloof from them as much as possible.

These are the reasons why I could not give a full and sufficient explanation to Roland H. But I am risking it with you because I conclude from your very decent and honest letter that you have acquired a point of view above the misleading platitudes one usually hears about alcoholism.

You see, alcohol in Latin is “spiritus” and you use the same word for the highest religious experience as well as the most depraving poison. The formula therefore is: spiritus contra spiritum.

Thank you again for your kind letter.

I remain

yours sincerely

C. G. Jung

The original of Jung’s letter is in the archives of Alcoholics Anonymous. (Bill, W. 1988, pp. 280-281)

Bill Wilson inadvertently misspelled Hazard’s name (Roland) when he wrote to Carl Jung. Copies of Jung’s letter have been widely circulated through the years, and this accounts for the confusion. Because of the tradition of anonymity Alcoholics Anonymous members use only the first initial of the last name. Thus in many Alcoholics Anonymous references Rowland H. is Roland H.

### Ebby Thatcher's November 1934 Visit to Bill Wilson

Ebby (Edwin) Thatcher was the son of a prominent family in Albany, New York, who had maintained a summer home in Manchester, Vermont. In the foothills of Mount Equinox, it is still today well known as a summer resort. The Equinox House continues to equal the grand hotels in Saratoga Springs and Newport. Robert Todd Lincoln summured there at his home, Hildene. Thatcher's father was one of the founders of the elegant Ekwanok Country Club, founded in 1899, as was Clark Burnham, a physician from Brooklyn and the father of Bill Wilson's wife, Lois. Thatcher and Wilson first met in 1911 when Wilson played baseball in Manchester (Pass It On, 1984, pp. 33-34). Bill Wilson grew up with his maternal grandparents who lived in East Dorset, Vermont, a few miles from Manchester. Thatcher and Wilson were classmates for one season at Burr and Burton Seminary in Manchester. Burr and Burton was established in 1829 as a training school for ministers, but it soon became coeducational and served as the main high school for the area.

The Thatcher family business failed in 1922, and for a time Ebby Thatcher sold insurance and then worked for an investment house. His brother, who was mayor of Albany, helped him for a while. As his drinking increased Ebby became a problem for his family in Albany. He and Bill Wilson continued to drink together. In the summer of 1934, in near destitution and in legal trouble from his bouts of drinking, he was

living in the family's summer home in Manchester. Thatcher was threatened with a 6-month term in Vermont's Windsor Prison because of his drinking. The judge in Bennington agreed to release him to the custody of Rowland Hazard, who maintained a real estate office in Shaftsbury, Vermont, and spent the summers there. The judge was the father of Cebra Graves, another of the recovering alcoholics from the Oxford Group (Mel B., 1991, p. 20).

In 1954, Thatcher recorded his memories of his friendship with Rowland Hazard. Alcoholics Anonymous sponsorship and "carrying the message" had not developed at this time. Hazard, as an Oxford Group member, was practicing these "by helping others and seeking guidance through quiet times" (Mel B., 1991, p. 20). He went to the Thatcher's old summer home where Thatcher was living and helped him clean the place. He took Thatcher with him on a trip through Texas and New Mexico to a ranch he owned. There Hazard had discovered "substantial deposits of high-grade clay on the land," and he had organized the La Luz Clay Works in La Luz, New Mexico ("Rowland Hazard," 1945, p. 8). He and Thatcher spent several weeks on the ranch where he told Thatcher about his visit with Carl Jung. The two continued to take trips together through New England where Hazard had business. Thatcher related the guidance Hazard shared with him:

When we took trips together, we would get up early in the morning and before we even had any coffee, we would sit down and try to rid ourselves of any thoughts of the material world and

see if we couldn't find out the best plan for our lives for that day and to follow what ever guidance came to us.

I'm grateful for all that Rowland did for me. . . . He impressed upon me the four principles of the Oxford Group, which were Absolute Honesty, Absolute Purity, Absolute Unselfishness, Absolute Love. He was particularly strong in advocating the Absolute Honesty--honesty with yourself, honesty with your fellow man, honesty with God, and these things he followed himself and thereby, by example, he made me believe in them again as I had as a young man. (as cited in Mel B., 1991, p. 21)

With Hazard's help Thatcher had 2 months of sobriety. In the fall of 1934, when he and Hazard were in New York Thatcher stayed for a while with another Oxford Group member, Shep Cornell. Thatcher then went to live at the Calvary Mission in lower Manhattan. He heard about the troubles his old friend, Wilson, was having. Wilson related the following story:

Near the end of that bleak November, I sat drinking in my kitchen. With a certain satisfaction I reflected there was enough gin concealed about the house to carry me through that night and the next day. My wife was at work. I wondered whether I dared hide a full bottle of gin near the head of our bed. I would need it before daylight.

My musing was interrupted by the telephone. The cheery voice of an old school friend asked if he might come over. He was sober. It was years since I could remember his coming to New York in that condition. I was amazed. Rumor had it that he had been committed for alcoholic insanity. I wondered how he had escaped. Of course he would have dinner, and then I could drink openly with him. Unmindful of his welfare I thought only of recapturing the spirit of other days. There was that time we had chartered an airplane to complete a jag! His coming was an oasis in this dreary desert of futility. The very thing--an oasis! Drinkers are like that. The door opened and he stood there, fresh-skinned and glowing. There was something about his eyes. He was inexplicably different. What had happened?

I pushed a drink across the table. He refused it. Disappointed but curious, I wondered what had got into the fellow. He wasn't himself.

Come, what's all this about? . . . He looked straight at me. Simply, but smilingly, he said, "I've got religion."

I was aghast. So that was it--last summer an alcoholic crackpot; now, I suspected, a little cracked about religion. He had that starry-eyed look. Yes, the old boy was on fire all right. But bless his heart, let him rant! Besides, my gin would last longer than his preaching.

But he did no ranting. In a matter of fact way he told how two men had appeared in court, persuading the judge to suspend his commitment. They had told of a simple religious idea and a practical program of action. That was two months ago and the result was self-evident. It worked! (as cited in Alcoholics Anonymous, 1981, pp. 8-9)

Wilson could see a difference in Thatcher. He realized Thatcher had something he could share.

He had come to pass his experience along to me--if I cared to have it. I was shocked, but interested. Certainly I was interested. I had to be, for I was hopeless. He talked for hours. Childhood memories rose before me . . .

I had always believed in a power greater than myself. I had often pondered these things. I was not an atheist, few people really are. . . . Despite contrary indications, I had little doubt that a mighty purpose and rhythm underlay it all. . . . I simply had to believe in a Spirit of the Universe, who knew neither time nor limitation.

But my friend sat before me, and he made the point blank declaration that God had done for him what he could not do for himself. His human will had failed.

Had this power originated in him? Obviously it had not. There had been no more power in him than there was in me at that minute; and this was none at all .

My ideas about miracles were drastically revised right then. (as cited in Alcoholics Anonymous, 1981, pp. 10-11)

In spite of what he saw in Thatcher, Wilson still had his old prejudice about God.

My friend suggested what then seemed a novel idea. He said, "Why don't you choose your own conception of God?" It was only a matter of being willing to believe in a Power greater than myself. (as cited in Alcoholics Anonymous, 1981, p. 12)

### Bill Wilson's "Spiritual Experience" and Discovery of William James

Wilson's spiritual experience. A few days after Thatcher's November visit with Wilson he returned with Shep Cornell, who aggressively gave Wilson the full Oxford Group message. Wilson did not like it at all: "When they were gone I took to the bottle and really punished it" (as cited in Pass It On, 1984, p. 116). The turning point came on an afternoon in early December when Wilson decided to visit Thatcher's mission. Getting off the subway too far from the Calvary Mission, he had to pass a number of bars on the way. When Wilson reached the mission it was afternoon. A man working in the kitchen told him Thatcher would return around supper time. When Thatcher arrived the cook, Spoons, told him a very drunk man in an expensive suit had called for him. He and the "down-and-outer" he was with were too loud, and the cook asked them to leave. The "expensive suit" was a Brooks Brothers suit Lois's mother had bought for Wilson at a rummage sale. It was the Depression, and the mission was a place for indigents (as cited in Pass It On, 1984, p. 117).

Bill Wilson told the assembled group that he had been at Calvary Church the previous evening and had listened to Thatcher, who had been

sober for several months. If Thatcher received help there, he was sure he could too. It was agreed that he should go to Towns Hospital, and that Thatcher and the others would come and talk to him there. But Wilson was not quite ready. He drank for a few more days and pondered what was happening. His illness had made him as helpless as if he had cancer. If he had cancer and the recovery involved praying with others, wouldn't he do it? What was different about alcoholism? It was destroying him. He could finally see that he was in a helpless, hopeless condition (as cited in Pass It On, 1984, p. 119).

Wilson decided to go to Towns. Stopping to buy four bottles on credit on the way, he arrived in "high spirits." It was exactly 1 month before that he had started drinking again. Silkworth put him to bed and began the usual treatment routine. In a few days Thatcher visited him. After he left, Wilson fell into an even greater depression. He felt that nothing was ahead for him but death or madness. In agony he again thought of the cancer of alcoholism. He cried out, "If there be a God, let him show Himself" (as cited in Pass It On, 1984, pp. 120-121).

According to Wilson what happened next was electric. Suddenly the room was ablaze with an indescribable white light. Every joy was pale by comparison. He was on a mountain; he stood on the summit. A great wind blew, a wind, not of air, but of spirit. Then came the blazing thought, "You are a free man." Finally the light subsided, and he could see the wall of his room. A great peace overcame him, and he was

conscious of a Presence, which seemed like a “veritable sea of living spirit” (as cited in Pass It On, 1984, p. 121). He remained in this state for a long time. For the first time he felt he was loved and could love in return. He felt he belonged. “Even though a pilgrim upon an uncertain highway, I need be concerned no more, for I had glimpsed the great beyond” (as cited in Pass It On, 1984, p. 121). Wilson was 39 years old. After that experience he never again doubted the existence of God, and he never had another drink.

Wilson called for Silkworth. He feared he had been hallucinating. Silkworth listen to his story. Finally Wilson asked if it could be real. Was he sane? Silkworth replied:

Yes, my boy, you are sane, perfectly sane in my judgement. You have been the subject of some great psychic occurrence, something that I don’t understand. I’ve read of these things in books, I’ve never seen one myself before. You have had some kind of conversion experience. What ever the experience. . . . You are already a different individual. So, my boy, whatever you’ve got now, you’d better hold on to. It’s so much better than what you had a couple of hours ago.” (as cited in Pass It On, 1984, p. 123)

Most recovering alcoholics do not experience the sudden spiritual awakening that happened to Bill Wilson, who later wrote in the AA Grapevine:

I fail to see any great difference between the sudden experiences and the more gradual ones--they are certainly all of the same piece. And there is one sure test of them all: “By their fruits, ye shall know them.”

That is why I think we should question no one’s transformation--whether it be sudden or gradual. Nor should we demand anyone’s special type for ourselves, because our own

experience suggests that we are apt to receive whatever may be the most useful for our needs. (Bill W., 1988, p. 276)

Wilson's discovery of William James. Ebby Thatcher came to see Bill Wilson on his 3rd day at Towns Hospital and brought him a copy of William James's (1902/1936) The Varieties of Religious Experience. Thatcher told him that he had not read the book, but that it was recommended by other Oxford Group members. Wilson began to read the book as soon as Thatcher left:

It was rather difficult reading for me, but I devoured it from cover to cover. Spiritual experiences, James thought, could have objective reality; almost like gifts from the blue, they could transform people. Some were brilliant illuminations; others came on very gradually. Some flowed out of religious channels; others did not. But nearly all had the common denominator of pain, suffering, calamity. Complete hopelessness and deflation at depth were almost always required to make the recipient ready. The significance of all this burst upon me. Deflation at depth--yes, that was it. Exactly what had happened to me. Dr. Carl Jung told an Oxford group friend of Ebby's how hopeless his alcoholism was and Dr. Silkworth passed the same sentence on me. Then Ebby, also an alcoholic, had handed me the identical dose. On Dr. Silkworth's say-so alone maybe I would never have completely accepted the verdict, but when Ebby came along and one alcoholic began to talk to another, that clinched it. (Alcoholics Anonymous Comes of Age, 1984, p. 64)

William James is known as the Father of American Psychology. From a prominent, highly educated family James completed his training as a medical doctor at Harvard. He taught physiology and anatomy at Harvard, and in 1875 he taught the first psychology course in America. He was also a scientist and a painter. His father was an independently

wealthy Swedenborgian philosopher who traveled extensively in Europe often taking his family with him for extended periods (Lewis, 1991).

The Varieties of Religious Experience was compiled from a series of lectures, the Gifford Lectures, which James presented at the University of Edinburgh in 1901-1902. It is an accounting of a number of cases of conversion experiences and the nature of those experiences. James's purpose was to "combine the religious impulses with other principles of common sense," in other words to prove their validity (James, 1902/1936, p. xvi). Included in the book is a detailed narrative and interpretation of Samuel Hadley's conversion experience at Jerry McAuley's Helping Hand Mission in New York. In his preface James urges the reader who wishes to know his purpose in writing the book to read the conclusion and the postscript first.

He outlined his conclusions:

1. That the visible world is a part of a more spiritual universe from which it draws its chief significance;
2. That union or harmonious relation with that universe is our true end;
3. That prayer or inner communion with the spirit thereof--be that spirit "God" or "law"--is a process wherein work is really done, and spiritual energy flows in and produces effects, psychological or material, within the phenomenal world. (James, 1902/1936, p. 475)

As Wilson read the book he saw three common denominators in the experiences given: (a) calamity--each person was at a point of utter desperation, (b) admission of defeat--each person acknowledged absolute defeat, (c) appeal to a Higher Power--each person made a cry for help to

a source outside of themselves. Sociologist Milton Maxwell (1984), long time researcher of Alcoholics Anonymous, emphasized that recognizing that the concept of Higher Power in Alcoholics Anonymous includes the inner resources of the individual is vital to understanding Alcoholics Anonymous (p. 85). The inner resources were also identified by psychologist Carl Rogers “the latent, inner resources of the individual”; by psychiatrist Harry Stack Sullivan as “an intrinsic tendency toward maintaining or achieving mental health”; and by psychiatrist Karen Horney as “the retrieval of the patient’s inner springs of spontaneity and creativity” (as cited in Maxwell, 1984, p. 85). Maxwell (1984) quoted a 7-year Alcoholics Anonymous member as describing spirituality thus: “To me, spirituality is a feeling of acceptance of myself, of loving the other human being, and accepting what goes on in my life. It is the spirit of giving, the spirit of living” (p. 85).

Some had dramatic experiences, as did Bill Wilson; others had a gradual transformation (Pass It On, 1984, pp. 124-125). James’s (1902/1936) book provided Wilson with not only a validation of his own experience, but a clear methodology for helping others to move through the same transforming process.

In considering Jung’s synchronicity, James’ conclusions about conversions, and Jung’s suggestion to Rowland Hazard; all indicate the process of connecting to something larger than self and also within the self. It was almost 30 years later when Bill Wilson received Jung’s letter

confirming the validating Wilson received through the process of these events. Chronicling these four events not only presents the history of the idea of Alcoholics Anonymous, but also how it works. The way it worked for these men is the way it has worked for thousands of others.

Wilson related what happened when he was released from Towns Hospital on December 18, 1934. He wrote, "I started out after drunks on jet propulsion" (Alcoholics Anonymous Comes of Age, 1984, p. 64). He spent 6 months chasing drunks. It was not working for him. They were not getting sober. It was a talk with Silkworth that turned him in a new direction. Silkworth told Wilson:

You're having nothing but failure because you are preaching at these alcoholics. You are talking to them about Oxford Group precepts of being absolutely honest, absolutely pure, absolutely unselfish, and absolutely loving. This is a very big order. Then you top it off by harping on this mysterious spiritual experience of yours. No wonder they point their finger to their heads and go out and get drunk. Why don't you turn your strategy the other way around? . . . You've got the cart before the horse. You've got to deflate these people first. So give them the medical business, and give it to them hard. Pour it right into them about the obsession that condemns them to drink and the physical sensitivity or allergy of the body that condemns them to go mad or die if they keep on drinking. Coming from another alcoholic, one alcoholic talking to another, maybe that will crack those tough egos deep down. (as cited in Alcoholics Anonymous Comes of Age, 1984, pp. 67-68)

#### Interaction Between Wilson and Bob Smith

After Wilson's release from Towns his wife worked while he was being a missionary to alcoholics. He decided it was time to try to earn a living again. In May of 1935 Wilson went to Akron, Ohio, as part of a

proxy row for a machine tool company. His new business associates in the proxy fight became discouraged and left him. It was the Saturday before Mother's Day, and he was all alone in the lobby of Akron's Mayflower Hotel. He could hear conversation in the bar across the lobby and he suddenly realized he was going to start drinking. He panicked. He had never before panicked at the thought of alcohol.

Then Wilson remembered that in trying to help others stay sober, he had stayed sober himself. He realized that he needed to talk to another alcoholic. Choosing randomly from the church directory in the lobby, after several absent responses, he reached an Episcopal priest, Walter Tunks. Wilson told Tunks that he was "a rum-hound from New York," and that he needed another alcoholic to talk to him. He asked if he knew any Oxford Groupers in Akron. Tunks gave him a list of about 10 names (as cited in Pass It On, 1984, p. 136).

It was Saturday afternoon, and no one was at home. The last name on the list was Henrietta Seiberling. He vaguely recalled from his Wall Street days that Mr. Seiberling was the founder of the Goodyear Rubber Company. He could not imagine calling his wife and telling her he was an alcoholic, so he continued to walk. Something kept telling him, "You'd better call her." He finally did. Even though she was not an alcoholic, she seemed to quickly grasp his dilemma and told him to come to the gatehouse of the Seiberling estate. When Wilson told her his story, she said she knew whom he should see--a doctor who had tried

hard to stay sober and could not do so. She called his wife who agreed they would come the next day at 5 o'clock (Alcoholics Anonymous Comes of Age, 1984, p. 66).

When he arrived the next afternoon, Robert Smith was shaking badly. He said he could only stay for 15 minutes. When Wilson told him that he looked like he needed a drink, Smith brightened. After dinner they talked until 11 o'clock (Alcoholics Anonymous Comes of Age, 1984, pp. 65-68).

Smith related the following story about what happened for him:

He gave me information about the subject of alcoholism which was undoubtedly helpful. Of far more importance was the fact that he was the first living human with whom I had ever talked, who knew what he was talking about in regard to alcoholism from actual experience. In other words, he talked my language. He knew all the answers, and certainly not because he had picked them up in his reading. (Bob S., 1939, p. 192)

Wilson's backers in the proxy fight wanted him to continue.

Smith's wife, Anne, was concerned about her husband and invited Wilson to stay with them while he was in Akron. Smith had not had a drink for the 3 weeks or so since their talk. One morning he said that there was a medical convention in Atlantic City that he had never missed. Anne did not want him to go, but Wilson said that he would have to learn to be around alcohol sometime. He returned several days later, obviously drinking heavily. A few days later he was late coming home from the hospital. When he arrived he told Anne and Wilson he had been calling on his creditors. Smith had his last drink on June 10,

1935, and from that day until his death 15 years later he never had another drink (Alcoholics Anonymous Comes of Age, 1984, p. 71).

From that time on, Smith spent a great deal of time passing on what he had learned from his own alcoholism. He listed the following four reasons he helped others:

1. Sense of duty.
2. It is a pleasure.
3. Because in so doing I am paying my debt to the man who took time to pass it on to me.
4. Because every time I do it I take out a little more insurance for myself against a possible slip. (Bob S., 1939, pp. 192-193)

Alcoholics Anonymous started on June 10, 1935, with one sober alcoholic reaching out to help another alcoholic who was still drinking in order to stay sober himself. From that day, 61 years ago, with two men, Alcoholics Anonymous has grown to over 2 million world wide. It has had a profound effect on the treatment of alcoholism and on the entire field of mental health. The disease concept of an earlier era was transmitted to Alcoholics Anonymous through Silkworth (Blumberg, 1977, p. 2141).

While Alcoholics Anonymous advocates what some consider radical measures (i.e., abstinence), it is not Prohibitionist. Milton Maxwell (1984) , who served for many years on the General Service Board of Alcoholics Anonymous, was neither an alcoholic nor an abstainer (p. vii). According to L. Blumberg (1977), "AA advocates moral

suation, and it avoids political controversy” (p. 2141) Prohibition was discredited with the repeal of the Volstead Act in 1933. Although the movement still exists in the United States it is not viable. The abuse of alcohol has persisted, and the rejected moral suasion of the Washingtonians has been “rediscovered and reapplied” in a new, sociopolitical context through Alcoholics Anonymous (Blumberg, 1977, p. 2141).

### Intervening Years

The first member of Alcoholics Anonymous was Bill D. In late June of 1935, Robert Smith and Bill Wilson called Akron City Hospital to see if they had a patient who might also be an alcoholic. The nurse had such a man, an Akron lawyer who had been admitted to the hospital 4 times in 6 months. Wilson gave the following account of the visit:

Soon Dr. Bob [Robert Smith] and I saw a sight which tens of thousands of us have since beheld, the sight of the man on the bed who does not yet know he can get well. We explained to the man on the bed the nature of his malady and told him our own stories of drinking and recovery. But the sick one shook his head, “Guess you’ve been through the mill boys, but you never were half as bad off as I am. For me it’s too late. I don’t dare go out of here. I’m a man of faith, too; used to be deacon in my church. I’ve still faith in God but I guess he hasn’t got any in me. Alcohol has me, it’s no use. Come and see me again though. I’d like to talk with you more.”

As we entered his room for our second visit a woman was sitting at the foot of his bed saying, “What happened to you, husband? You seem so different. I feel so relieved.” The new man turned to us. “Here they are.” he cried. “They understand. After they left yesterday I couldn’t get what they told me out of my mind. I lay awake all night. Then hope came. If they could find

release, so might I. I became willing to get honest with myself, to square my wrongdoing, to help other alcoholics. The minute I did this I began to feel different. I knew I was going to be well.” Continued the man on the bed, “Now, good wife please fetch me my clothes. We are going to get up and out of here.” Whereupon AA number three arose from his bed, never to drink again. The seed of AA had pushed another tendril up through the new soil. Though we knew it not, it had already flowered. Three of us were gathered together. Akron’s Group One was a reality. (Bill W., 1988, p. 358)

The Oxford Group had tried and mostly failed with the alcoholics. Wilson’s friends there told him to forget about working with alcoholics. He spent long hours at the Calvary Mission and at Towns Hospital where, at the risk of his professional reputation, Silkworth allowed him to talk to some of his patients. Bill and Lois Wilson began to allow alcoholics to stay in their home until they could recover. There was now a small group of recovered alcoholics. In March 1937 Charlie Towns offered Wilson a position as a paid therapist at Towns Hospital. Desperately poor, he was tempted by the offer. There was even a precedent for lay therapists with Baylor and Peabody. Wilson’s Alcoholics Anonymous friends helped him to see the light:

You can never become a professional . . . we can’t tie this thing up with his hospital or any other. . . . This is a matter of life and death . . . nothing but the very best will do . . . sometimes the good is the enemy of the best . . . this is a plain case of it. . . . Don’t you see that for you, our leader, to take money for passing on our magnificent message, while the rest of us try to do the same thing without pay, would soon discourage us all? Why should we do for nothing what you’d be getting paid for? We’d all be drunk in no time. (as cited in Pass It On, 1984, pp. 176-177)

Wilson knew that they were right. Alcoholics Anonymous has never been involved with any treatment program (Pass It On, 1984, p. 177). The members as individuals have become both trained and paid professionals, and Alcoholics Anonymous meetings are often taken voluntarily into treatment centers, hospitals, and prisons; however, these are voluntary actions of the individual groups, and they are not sponsored by Alcoholics Anonymous.

The example above illustrated the Second Alcoholics Anonymous Tradition, “For our group purpose there is but one ultimate authority--a loving God as he may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern” (Alcoholics Anonymous Comes of Age, 1984, p. 98). Another example was when Time magazine wanted to make Bill Wilson “Man of the Year,” and he turned it down (Pass It On, 1984, p. 314). He knew that the success was a group effort and that he could not take credit.

### The Development of Other Methods of Alcoholism Treatment

#### Aversion Conditioning Therapy

During the late 1930s and early 1940s when Alcoholics Anonymous was being established in the East and the Midwest, another group was working on the problem of treating alcoholism in the Northwest. Charles A. Shadel founded the Shadel Hospital in Seattle

and provided a colonial mansion to offer the “warm and personal comforts of home to society’s outcasts . . . the alcoholics” (as cited in Schick Health Services Bulletin, 1989, p. 7). This hospital was the first member of the American Hospital Association devoted exclusively to the treatment of alcoholism (Royce & Scratchley, 1996, p. 38). These authors stated that Walter Voegtlin, the longtime director, pioneered research on the liver and heredity, which was years ahead in the alcoholism field. Shadel employed a medical model of aversion conditioning therapy, an ancient method of treating alcoholism.

In 1943 Shadel opened a second hospital in the Raleigh Hills section of Portland, Oregon. This was later sold and developed into the Raleigh Hills system, which operated throughout the United States. Raleigh Hills employed the same type of aversion conditioning. The Raleigh Hills hospital system had 13 hospitals in six states in 1982, (Smith, 1982, p. 875). The system was completely closed in the mid-1980s.

In 1964 Patrick J. Fawley, Jr., Chief Executive Officer of Schick Safety Razor Company, was persuaded by his wife to seek treatment for his addiction. The Paulist Fathers in Los Angeles recommended the Shadel Hospital in Seattle to lose the craving. Fawley was astounded that he lost the desire to drink. In 1965 Schick Safety Razor Company formed Schick Laboratories, with Fawley as chairman. James W. Smith, chief of staff of the hospital, became director of research. The Schick

Laboratories, became completely separate from Schick Safety Razor. The Schick Laboratories, operated a hospital system of Schick Chemical Dependency Units. The hospitals became known as the Schick Shadel Hospital System. The system had several units (Schick Health Services Bulletin, 1989, pp. 9-11). There were three hospitals in 1982. Today there is only one hospital, the original Shadel Hospital in Seattle, now known as the Schick Shadel Hospital.

Aversion conditioning may be the “oldest approach to abstinence-oriented alcoholism treatment” (Smith, 1982, p. 875). The ancient Romans put spiders and other offensive objects in the bottom of the wine cup. Other methods included drinking hot wine in which an eel had died or wine in which an owl’s eggs had been soaked. Having the “person to be reformed sit on a sharp pointed seat with a mug of ale in his hand is another” (Dent, 1941, p. 11). Kantorovich reported using electric stimulus in aversion treatment in 1929. Aversion conditioning includes pairing a stimulus (e.g., sight, smell, or taste of an alcoholic beverage) with an aversive (e.g., nausea or an electric shock). At Shadel the average patient receives five aversion treatments in the initial 10-day intensive stay. The treatments are alternated with a pentothal interview. Some patients develop an adequate aversion in three treatments, and others require six or more (Smith, 1982).

The purpose of aversion conditioning is (a) to provide a time period free of craving for the patient to reorient his life and (b) to break

down conditioned reflexes to drink (e.g., the 5 o'clock cocktail, drinking when angry). When adequate aversion is reached these associations are no longer present (Smith, 1982). The pentothal interview was initiated in the mid-1940s in the Schick Shadel Hospital program. Fardic, or electrical aversive therapy, became a part of the Shadel regime in the 1970s. It was instituted because of a "perceived need for a less physically strenuous aversive technique," and research indicated it to be potentially useful in alcoholism treatment (Smith, 1982, p. 878). The electrostimulus occurs randomly throughout the process, from reaching for the bottle to tasting the alcoholic drink.

As adjuncts to treatment, patients receive a psychiatric evaluation, hear lectures about the physiologic effects of alcohol, and are taught relaxation techniques as a drug-free method of alleviating stress and tension. Patients with significant psychopathology are referred for additional therapy as indicated after treatment. The hospital also maintains an aftercare department, and appropriate referrals are made for marriage and vocational counseling and Alcoholics Anonymous. The first published reports of treatment results were made in a study done by Voegtlin in 1940, in which he reported a 64% success rate with 538 patients abstinent 4 years after treatment (Smith, 1982, p. 880).

An article in Alcoholism and Addiction in December of 1988 reported the following concerning aversion therapy:

Although chemical aversion therapy (CAC) is currently used in less than 1% of cases where patients are treated for alcoholism, the Public Health Service has recommended that chemical aversion conditioning be reimbursed by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and Medicare, when it is used in a multi-modality program of alcoholism treatment and after less intrusive therapies have failed. . . . The panel concluded that while the effectiveness of CAC has not been proven unequivocally, it is no less effective than any other treatment. ("Medicare to Reimburse for Aversion Treatments," 1988, p. 10)

### Private Psychiatric Treatment of Alcoholism

#### Robert Knight: Menninger Clinic

During the 1930s a number of psychiatrists began to specialize in the treatment of alcoholism. One of these was Robert Knight, at the Menninger Clinic in Topeka, Kansas. In a 1938 article written in the Journal of the American Medical Association, Knight stated that there existed more confusion and pessimism surrounding the treatment of alcoholism than any other mental health issue. His study was based on 20 male alcoholics who had pseudovoluntary admissions to Menninger's Clinic. Because the patient clientele is limited to those who can afford to pay relatively expensive fees 19 of the patients were admitted under pressure from their families. When a patient does apply for voluntary admission he is clearly told of the restrictions and "bluntly" warned that he will not like the program and will desire to leave. Any adequate treatment will require several months, most from 18 months to 4 years.

With these, unwilling patients, the struggle begins after immediate withdrawal. Patients are angry, demand their freedom, and agree not to continue drinking. Knight (1938) generalized the psychiatric approach as follows:

It is recognized by all psychiatrists who have studied persons chronically addicted to alcohol that the alcoholism is only a symptom, not a clinical entity, and that while there are certain personality traits common to most alcoholic addicts, the drinker's deeper psychologic conflicts and environmental distress are strictly individual and vary as widely as do similar factors in various neuroses and psychoses. Superficial impressions to the contrary, no excessive drinker is normal and well adjusted when sober. . . . Combined institutional treatment and psychoanalysis is the treatment of choice in most cases of intelligent addicts who sincerely want help. (p. 1444)

In response to the article, Karl Menninger made the following remarks:

In my earlier years in psychiatry I looked on alcohol addiction as a bad habit and a little later as a neurotic manifestation, one which was peculiarly annoying to relatives and self destructive to the individual but one which ought to be accessible to various types of psychotherapy. Now I regard it as a near psychosis. . . . I think that the prognosis in schizophrenia is better than the prognosis in alcoholism. (as cited in Knight, 1938, p. 1447)

In the same year Menninger's (1938) Man Against Himself, was published. He wrote the following about the treatment of alcoholism:

The effective treatment of alcoholism is, of course, the treatment of that which impels it. This means the gradual elimination of the tendency of over-reaction to frustration, and the progressive relief of those deep, inner feelings of anxiety, insecurity, and of childlike expectation and resentment which so regularly determine it. . . . So far as I know, there is only one treatment technique which even attempts to accomplish this, and that is psychoanalysis. I do not say that alcoholism cannot be cured by other means. . . . I have

known it to occur as the result of religious conversion. . . . But, on the other hand, I have never seen an alcoholic cured by confinement alone. (pp. 159-160)

### Merrill Moore: Boston Washingtonian Hospital

Merrill Moore was a Harvard psychiatrist who began treating alcoholic patients at the Washingtonian Hospital in Boston. When the hospital established a psychiatric staff in 1940, Moore became the medical director. He had an eclectic approach to treatment, but his main emphasis was to address the problem as a medical issue rather than a moral issue (as cited in Johnson, 1973, p. 230).

Moore (1939) wrote in the New England Journal of Medicine: “Today, it is recognized that alcoholism is a symptom of underlying psychologic or social adjustments. Psychotherapy, in properly selected cases, is in many cases curative” (p. 489). This was the approach of most psychoanalytically trained psychiatrists. In the same article Moore (1939) continued:

Before psychotherapy is begun, it is essential that the a patient should have become alcohol-free following such symptomatic measures as will calm him, enable him to rest, restore normal elimination and permit him to regain normal fluid balance. . . .

A number of separate trends in the treatment of alcoholism are now being followed by psychiatrists, psychoanalysts and specialists in internal medicine who are interested in the application of psychology in therapy with particular reference to personality factors and the “mind-body” problem. Patients with neurotic personalities and immature emotional development are the ones who respond most favorably to psychological treatment. . . . One of the chief errors in the past has been to consider the problem of drinking as an entity without

consideration of the patient's total personality in its situation.  
(p. 491)

Moore was ahead of his time in his insight into the family dynamics of alcoholism. He was also open to additions and changes to the psychoanalytic method as the following passage indicated:

Occasionally the family is the greatest obstacle in the progress of treatment. Often its members must be educated not only to the present condition but to the more mature development of the patient.

Some therapists treat patients by first changing or simplifying the environment. Interesting results have been obtained by Wayne Sarcka on his ranch at Cuttingsville, Vermont, by this method. . . . The question of voluntary or forced treatment is also important. . . . It may be advisable in some cases to force treatment, unless the need of a dramatic change is unconvincing. . . . The problem of alcoholism is complex, and the statement of William James that no generalizations are better than the details on which they rest must be kept in mind as an epigram of definite significance where alcoholism is being considered.  
(Moore, 1939, pp. 489, 491, 493)

Moore, later became a prominent member of the Research Council, and as the above statement testified was a force in eliciting the prominence of psychiatric persuasion on the board.

#### Harry M. Tiebout: Blythewood Sanitarium

Harry M. Tiebout was the medical director of Blythewood, a private sanitarium in Greenwich, Connecticut. He was "the first psychiatrist to see AA as a significant approach to the treatment of alcoholics" (Pass It On, 1984, p. 296). Marty Mann, one of the first women in Alcoholics Anonymous and the founder of the National

Council on Alcoholism, was his patient at Blythewood. He was also a member of the Research Council, and was later Bill Wilson's psychiatrist.

Tiebout's (1944) article, "Therapeutic Mechanism of Alcoholics Anonymous," was read before a meeting of the American Psychiatric Association in Detroit in May 1943. Tiebout was a respected member of this organization. A specialist in the treatment of alcoholism, he had experienced some success with the Alcoholics Anonymous approach and wanted to share with his colleagues how this mystery worked. Tiebout (1944) outlined the physical aspects of the Alcoholics Anonymous program: "1. weekly gatherings where experiences are related and problems discussed, 2. read the book, Alcoholics Anonymous, 3. work with prospects who are making their initial contact with the group."

Tiebout (1944) observed that his first experience with Alcoholics Anonymous was a 34-year-old woman whose character structure was blocking any help she might receive. He used the terms narcissistic egocentric core, defiant individuality, grandiosity to describe the character structure:

Inwardly the alcoholic brooks no control from man or God. He, the alcoholic, is and must be master of his destiny. He will fight to the end to preserve that position.

Granting then the more or less constant presence of these character traits, it is easy to see how the person possessing them has difficulty in accepting God and religion. Religion by its demand that the individual acknowledge the presence of a God challenges the very nature of the alcoholic. But, on the other hand, and this point is basic to my paper, if the alcoholic can truly accept the presence of a Power greater than himself, he by that very step, modifies at least temporarily and possibly permanently his deeper

inner structure and when he does so without resentment or struggle, then he is no longer typically alcoholic. (Tiebout, 1944, p. 469)

Tiebout (1944) labeled the cathartic experience a “psychological awakening” stating, “The central effect therefore of Alcoholics Anonymous is to develop in the person a spiritual state which will serve as a direct neutralizing force upon the egocentric elements in the character of the alcoholic” (p. 472).

Perhaps Tiebout’s (1953) greatest contribution was the concept of “Surrender Versus Compliance in Therapy” (p. 58). He originally presented the idea to the New York Psychiatric Association in 1944 and published it as a journal article in 1949. The article published in 1953 in the Quarterly Journal of Studies on Alcohol is presently required reading in many treatment centers (Tiebout, 1953). Tiebout described conversion as “a psychological event in which there is a major shift in personality manifestation” (Tiebout, 1949, p. 48). The patient moves from one being effected “by a set of predominately hostile, negative attitudes” to a set of “predominately positive, affirmative ones” after the conversion process occurred (Tiebout, 1949, p. 48).

Tiebout (1949) stated that surrender is an unconscious event and cannot be willed by the patient even if he so desires (p. 49). Tiebout identified the two qualities which prevent the surrender process in the alcoholic as defiance and grandiosity. Defiance is an “effective tool for managing anxiety, or reality which is so often the source of anxiety”

(Tiebout, 1949, p. 51). Defiance “says, in essence, ‘Nothing can happen to me because I can and do defy it’” (Tiebout, 1949, p. 51). Grandiosity originates in the infantile ego of the alcoholic.

In a 1954 article for the Journal of Studies on Alcohol, Tiebout explained three ego factors as central to the development of the qualities of defiance and grandiosity in the alcoholic:

1. Omnipotent self-centeredness; Tiebout used Freud’s phrase “His Majesty the Baby” in describing the infant as “born ruler of all he surveys” (p. 612).

2. Poor toleration of frustration, defiance, the individual who “simply does not expect to be stopped; as he wills, so will he do” (p. 612).

3. The “tendency to do everything in a hurry” is the last factor. Young children run instead of walk; they do not have long attention spans, and they do everything at a “tempo allegretto” (p. 612).

Tiebout (1949) also described the events of a patient at Blythewood over a period of time when Tiebout was able to work with the man’s wife and employees to effect what would today be termed an informal intervention. Over time the man was physically becoming more debilitated and frustrated by his drinking lifestyle, Tiebout was able to help the wife make some decisions about her own well-being and his co-workers to make some decisions in the interest of preserving their business.

During all this time, however I was working on his life situation so that ultimately it would provide the necessary dynamite to jar him loose from his whirlwind of self-centeredness. Gradually his wife gave up her protectiveness and, before the time of his last admission, nearly two years ago, she had determined to leave him if his drinking continued. Moreover, as a result of some discussion with me, his business partner, who was really a junior in the firm, had decided that he with several key members of the company would tender resignations if the patient did not make a real effort to mend his ways. (Tiebout, 1949, pp. 49-50)

When the patient was confronted by Tiebout that he must agree to stay in treatment for 30 days or go elsewhere he agreed. In a later discussion with Tiebout (1949) the patient related:

You did something to me when you made me sign that card. I knew you meant business. I knew my wife was getting sore and that Bill [his partner] was fed up; but when you showed me you were through fooling, that was the clincher. You knew I needed help and couldn't get out of it by myself. So I signed the card and felt better right off for doing it. I made up my mind I wasn't going to run my own case any longer, but was going to take orders. (p. 50)

In 1961, Tiebout outlined four principles for ego reduction which grew out of a study of the conversion process first witnessed in AA.

1. The need to hit bottom.
2. The need to be humble.
3. The need to surrender.
4. The need for the primary ego to be reduced.

Bringing them all together but slightly transposing their order, we can say that a conversion occurs when the individual hits bottom, surrenders, and thereby has his ego reduced. His salvation lies in keeping that ego reduced, in staying humble. (p. 65)

Tiebout (1954) also emphasized the importance of humility.

Appropriately, Alcoholics Anonymous stresses humility. The opposite of impatience is the ability to take things in stride, to make an inner reality of the slogan, "Easy does it." The opposite of

drive is staying in one position, where one can be open-minded, receptive, and responsive. (p. 618)

Tiebout was the first psychiatrist to use the principles of Alcoholics Anonymous in his practice (as cited in AA Everywhere--Anywhere, 1995, p. 19). He earned the trust and respect of Alcoholics Anonymous and served as a Class A trustee of the General Service Board. Tiebout (1951) was aware of the conflicts between psychiatry and alcoholism treatment professionals in general. He explained the problem that the animosity treatment professionals have held toward psychiatry originates in the “belief that psychiatry has too little to offer to merit consideration” (p. 53). Tiebout (1951) cited as an example the complete omission of any discussion about psychiatry in the pamphlet “Principles for Public Action on Problem Drinking” that was issued in 1947 by the Research Council on Problems of Alcohol (p. 53).

Tiebout (1951) cited the problem as being that psychiatry has held alcoholism as an underlying symptom of another condition “which must be uncovered before rational treatment can begin” (p. 53). Using the analogy of a fever Tiebout (1951) stated, “To continue to focus on the cause in the face of the immediate threat to life would be therapeutic folly” (p. 54). The Alcoholics Anonymous program, attacking the drinking directly, is similar in effect to the operation for cancer” (Tiebout, 1951, p. 56). Tiebout concluded with the hope that psychiatry would realize their responsibility in the field of alcoholism treatment and

move forward “with wisdom and a growing degree of first-hand knowledge” (Tiebout, 1951, p. 57).

Robert Stuckey, a Columbia University psychiatrist, who was also an alcoholic, stated 25 years after Tiebout made his appeal that he never had a problem admitting he was an alcoholic, but it took him 5 years to admit he was a psychiatrist (J. S. Harrison, personal communication, July 9, 1995). Harrison related that even in 1973-1974 psychiatrists were still using a “career diagnosis” of depressive reaction for alcoholism (J. S. Harrison personal communication, July 9, 1995).

#### Robert V. Seliger: Johns Hopkins

Robert V. Seliger (1938), a Johns Hopkins psychiatrist, became interested in the treatment of the alcoholic as a member of the community. In June 1938, he read a paper entitled, “The Alcoholic in the Community,” before the American Psychiatric Association. He began by reading a story told by the Swiss physician, Forel (1900), at the turn of the century. Forel related an episode about his own unsuccessful treatment of an alcoholic patient who later attained sobriety at an asylum at Basel run by a temperance society. The patient maintained his sobriety for 15 years at that point. Forel stated:

This made a deep impression on me. Here I was paid and employed by the state to cure my patients and failed to do it, while medically untrained people succeeded. In this case we did not deal with one of those numerous cases of spontaneous cure of a mental or nervous disease which the ignorant ascribe to their quackery. It

was an undoubted effect of the treatment. (as cited in Seliger, 1938, p. 701)

Forel (1900) later made arrangements to send his alcoholic patients to the society. There were many successes, and the only recompense was the patient's recovery. Forel asked the man whom he had contacted what he was doing:

Well, dear friend, it is nearly two years now that you have devoted yourself in such a disinterested way to my alcoholics, and that many get well is something that I never saw before. Please explain to me how it is. I am paid by the state to cure these people, and I cannot do it. You are the one who cures the drinkers, not I. Why can I not do it? I am deeply ashamed. He answered briefly with a smile: "It is very simple, Director; I am an abstainer and you are not. That is the secret. You cannot teach others convincingly that which you do not do yourself." (as cited in Seliger, 1938, p. 702)

From that day in 1886 Forel became an abstainer, and he further related:

One must have gone through such a change to fully appreciate the power of example and of the force of one's own conscience in action. Hundreds are the number of drinkers and drinkers' families which I have cured since then and led from the deepest misery to the happy and useful existence. (as cited in Seliger, 1938, p. 703)

In an article in the American Journal of Insanity Forel observed the American attempts at alcoholism treatment of the period:

The country where Dr. Benjamin Rush first proved, about the beginning of the century, that alcoholism is not a vice, but a disease depending on intoxication, was also the pioneer of reform. . . .

A scientific alcoholic movement independent of religion and politics is almost completely absent. This is a serious defect. This explains why, for instance, in asylums like Foxboro and the Washingtonian Home, which I visited, absolutely no scientific anti-literature is given to the patients and there is practically

nothing done for the after treatment and later maintenance of abstinence, although this is just the chief point. One does not even grasp the fact that only an abstainer from conviction can successfully direct such an institution. . . . Foxboro fulfills almost all the conditions of a model institution, yet the leading thought of decided permanent abstinence is missing. It is not right to make the religious prohibitionists responsible for this. The blame rests on the sin of omission of those who have a scientific education. (Forel, 1900, p. 312)

Seliger (1938) further emphasized this point with a statement by Oskar Diethlem:

A physician who is a total abstainer will achieve better results than a physician who has one attitude for himself and another for his patients. The totally abstaining physician carries much more conviction in his advice and exerts a strong, suggestive influence. (p. 707)

Seliger (1938) believed that each case should be evaluated separately and that “total abstinence for life” was the goal of therapy (p. 712). He recommended that a patient who was involved with the alcohol industry as an occupation should be placed in a rest home farm. Seliger used the term psychobiological allergy, an acquired sensitivity, in explaining alcoholism. He believed that it was productive for the patient to understand the condition as an illness to move beyond a personal moral defeat. In addition to the work of Forel (1900) and Diethlem, Seliger used the work of Richard Peabody (1930, 1936). Seliger worked actively with social workers in the Baltimore area in helping them to address the issues of alcoholism. Later Johns Hopkins, established a School of Community Health and a training program for alcoholism counselors (M. N. Weisman, personal communication, January 5, 1996).

Ruth Fox, M.D.

According to Johnson, (1973), Ruth Fox was a psychiatrist in private practice in New York. She grew up in privileged circumstances but when she was a young adult her father experienced financial reversals from which he never recovered. She held various jobs during her early years and was later successful in obtaining her medical degree and her psychiatric specialty. "Very early in life, Ruth Fox developed an unusually strong sympathy for the victims of discrimination" (Johnson, 1973, p. 263). Her husband, McAlister Coleman, was active in the Socialist Party in New York. When he later developed a drinking problem, Ruth Fox sought the help of Marty Mann and they became friends (Johnson, 1973, pp. 262-263).

Ruth Fox became interested in alcoholism and maintained an active private practice for over 50 years. She was also the medical director for the National Council on Alcoholism. In 1949 she went to Copenhagen to study the use of Antabuse (diasulfiram) in treating alcoholics (Royce, 1989, p. 37). It had been accidentally discovered in 1947 by the realization that workers in the rubber industry who absorbed the sulphur compound disulfiram became hypersensitive to alcohol (Royce, 1989, p. 249). Fox then brought it back for use in the United States. Antabuse is a non psychoactive, non-addictive drug. Ruth Fox was an ardent admirer of Alcoholics Anonymous and believed that

the use of Antabuse could buy time until a stable sobriety could be maintained (Royce, 1989, p. 249).

Royce explained that for those who call Antabuse a crutch, “a crutch is good medicine while a broken leg heals” (Royce, 1989, p. 250). M. Weisman (personal communication, January 5, 1996) believed this use of Antabuse was valid, stating that he also recommended using it as a preventative measure especially if a stressful event was anticipated (i.e., a board examination).

According to Royce (1989) disulfiram was widely used in the United States by 1950. “Antabuse is not a psychoactive drug, so there is no danger of substitute addiction. It blocks the enzyme action necessary for the breakdown of acetaldehyde, a product of alcohol metabolism” (Royce, 1989, p. 249). Because it takes 5 days to be eliminated, it serves as a protection against drinking. The alcoholic knows that nausea, vomiting, a severe headache, sweating, blurred vision, flushing, rapid pulse, and difficulty breathing will result if alcohol is taken. Royce (1989) noted the original prescribed dosage was too high and caused serious side effects.

Fox (1967b) believed the use of disulfiram (Antabuse) was “helpful in deterring the well motivated, not too neurotic alcoholic from drinking” (p. 773). She continued to stress using the drug as only one part of the therapeutic program which should also include counseling, group therapy, Alcoholics Anonymous, and family intervention (Fox, 1967b).

Fox (1967b) believed that alcoholism was a complex problem with an equally complex etiology. She said, "We must not lose sight of the fact that there is surely an underlying biochemical disturbance in alcoholism" (as cited in Madsen, 1974, p. 45). She believed that a multidisciplinary approach was essential for treatment. In an article in the American Journal of Psychiatry, Fox (1967b) discussed some of the methods used during the 1960s:

Of first importance is Alcoholics Anonymous. . . .

AA is a pragmatic, simplified, spiritual approach to life, a prescription for living. . . . For patients who can accept it may be the only form of therapy needed. How one refers to AA. Just to say, "You need AA," is not sufficient. and may make the patient feel that you too are rejecting him. I make a personal contact with an individual member known to me, introducing the patient to him over the telephone. There can be an amelioration of symptoms as the isolated alcoholic feels there is hope for him.

It is wise for you the doctor to keep contact with the patient even after he goes to AA, for there may still be problems to iron out and of course, not all persons are amenable to the AA type of experience. (p. 772)

In discussing the use of other techniques, Fox (1967b) stated :

Psychoanalysis alone as a technique has produced meager results with the alcoholics. Group therapy is perhaps the most effective type of treatment. . . .aside from AA. There is almost immediate identification and mutual support, which makes the alcoholic feel immediately accepted. Psychodrama has been found to be especially effective for many patients. (p. 773)

Fox (1967b) was also hopeful about the use of lysergic acid diethylamide (LSD) in the treatment of alcoholics. She related her experience with the use of LSD:

Although my experience with lysergic acid diethylamide (LSD) in alcoholism has been limited to only 20 cases, the results are sufficiently promising to lead me to hope that it can be studied with much larger groups. It does seem that LSD, by breaking down the barriers between the conscious and the unconscious mind and by uncovering early traumatic events in their lives, allows patients to reassess and reevaluate many of their experiences. Many get a new concept of themselves and others, giving up many of their rigid defenses in favor of a more open and optimistic view. . . .

It cannot be over stressed that a patient undergoing LSD treatment must not be left alone for at least eight to ten hours while under the drug and must be given constant support during the treatment. (p. 775)

During the 1950s it was hoped that LSD would provide a breakthrough in alcoholism treatment. LSD was manufactured by Sandoz, a Swiss pharmaceutical company. In 1954 two British psychiatrists, Humphrey Osmond and Abram Hoffer, were working with schizophrenics in Saskatoon, Saskatchewan. They were trying to accomplish the same breakthrough chemically that Alcoholics Anonymous accomplished through ego deflation at depth and spiritual surrender (as cited in Pass It On, 1984). The physicians heard about Bill Wilson's experience and went to New York to talk with him.

Wilson was enthusiastic about the possibilities of LSD working with alcoholics. He invited several of his colleagues to experience the drug with him. Father Dowling, a Catholic priest who was Wilson's spiritual advisor, accepted and Jack Norris who refused. Some precognition researchers from Duke University were also present (Pass It On, 1984, p. 371). Later others, including Sidney Cohen, a psychiatrist at the Veteran's Administration Hospital in Los Angeles and Kenneth

Ditman a research psychiatrist at the University of California began experimental studies (Pass It On, 1984, p. 371).

Norris was less enthusiastic than Wilson. He corresponded with Osmand and Hoffer who were guarded and warned that the drug required a controlled setting for administration. In 1961 Timothy Leary and Richard Alpert (later known as Ram Dass) used the drug at Harvard resulting in two students experiencing severe flashbacks. Leary had approached Wilson to be included in the first experiments and Wilson refused. By 1963 Canada banned the drug and Sandoz withdrew it from the market (Pass It On, 1984, pp. 376-377).

Fox (1967b) investigated aversion therapy and especially the new use of succinylcholine:

Aversion treatment still continues in a few places in the United States and more generally in England and Russia. A new type of conditioning is being carried out in a few places using succinylcholine. This preparation causes muscle paralysis so that the patient is unable to breathe for 30 or 40 seconds. Just preceding paralysis of breathing is associated with profound fear. (p. 775)

Family therapy was just coming to the forefront in 1967 and Fox (1967b) was aware of its implications for the family of the alcoholic:

The treatment of the families of alcoholics has been found to help greatly in the recovery of the patient . . . the alcoholic "disturbs" his own family, so that he helps to pass on a neurotic heritage--a kind of "social contagion." Probably no family in which there is an alcoholic can be considered a happy one . . . a number of studies have shown her [the wife] to be often almost as neurotically ill as her husband. Some of the neurotic needs of such a wife may be to be dependent, to control, to dominate, to punish, or to be the long

suffering martyr--character traits which make such a woman not only a poor wife but generally a poor mother as well. . . .

Group therapy for her own neurotic problems, or Al-Anon or both, may give her the insights she needs to help him recover. (p. 776)

Ruth Fox stayed abreast of new techniques used in alcoholism treatment. As the medical director of the National Council on Alcoholism she was in a position to be aware of current information and studies. Her continued involvement and assessment provided useful information to clinicians.

### Robert Fleming

Robert Fleming (1937a, 1937b), a colleague of Merrill Moore's (1939) at Harvard, was a graduate of the Harvard Medical School and was an instructor in psychiatry there from 1933 through 1938. Fleming, who worked at Boston City Hospital was interested in "persuading the hospitals in the Boston area to accept problem drinkers for short term detoxification" (as cited in Johnson, 1973, p. 230). During the spring and summer of 1936, Fleming visited several clinics and laboratories in Europe to ascertain the methods being used for the treatment of alcoholism. He outlined the following areas of his investigation: (a) restriction and limitations on the sale of liquor, including psychological, moral, and educational measures to decrease use; (b) means by which the patient is put into a treatment situation; and (c) actual methods used to treat the disease (Fleming, 1937a, p. 279).

In France, Fleming attributed the lack of facilities for treatment to the importance of the liquor industry in the national economy and the drinking habits of the French people. No public or private asylums existed. He stated that the severe alcoholic would be treated similarly to the alcoholic described by Zola (1990) in L'Assomoir which was written in 1877. Fleming reported that in England, the majority of treatment was at private, voluntary institutions such as Rendelsham Hall and Caldecote Hall. He wrote, "There is no attempt at an adequate follow-up system and the tendency to relapse is frequent," (Fleming, 1937a, p. 280). There were no public institutions exclusively for alcoholism treatment in England at this time. He also visited the Salvation Army's home for women at Denmark Hall and observed J. Yerbury Dent's conditioning or aversion therapy (Fleming, 1937a, p. 281).

In Sweden Fleming (1937a) found 10 state hospitals devoted exclusively to the treatment of chronic alcoholism. He also visited an institution for male inebriates in Kurön, which was originally founded by the Salvation Army in 1912. The state began subsidizing it in 1916 as a part of the state system for alcoholism treatment, but the Salvation Army continued to operate it. It was run as a farm with special shops, farm work, games, good food, and religious influence. The acting director gave a 40% cure rate (Fleming, 1937a, p. 283).

In Germany he found that community and race were everything (Fleming, 1937a, p. 284). Due to the "biologic orientation," an alcoholic

whose alcoholism was determined to be derived from a hereditary defect was sterilized as a means of prevention, and beyond that he was left “to drink himself to death” (Fleming, 1937a, p. 284). He wrote that the walls of the assembly room at Wittenauer Heilstätten, “the former fountainhead of German temperance work, are now lined by sullen psychopaths, imbeciles, and staring schizophrenics awaiting occlusion of their spermatic ducts” (p. 284). Apart from this scene the medicolegal laboratory of R. Hey at the University of Frankfurt interested Fleming because he was working on a blood alcohol determination test to be used by the police.

Fleming (1937a) went to Austria with the specific purpose of visiting Am Steinhof and its director, Ernest Gabriel. According to Fleming Gabriel was “one of the most prolific writers on chronic alcoholism in the German literature” (p. 285). Only the “most promising patients” were selected for the alcoholic division of the hospital. Most of the other alcoholic patients were treated on the psychiatric wards (Fleming, 1937a, p. 285). Moderate drinking was considered an impossibility for anyone who had been an excessive drinker. The consumption of alcohol was stopped immediately upon admittance. Some places in both the United States and Europe at this time slowly tapered the drinker from alcohol.

The patients at Am Steinhof “adhered to a strict therapeutic routine directed toward absolutely total abstinence for the rest of his life”

(Fleming, 1937a, p. 285). When patients left the hospital to visit their homes, their blood alcohol level was checked on their return, using the Widmark method. Widmark was a Swedish physiologist who developed the Widmark factors to estimate blood alcohol concentration (as cited in Keller, 1982, pp. 268-269). The patients are said to develop a healthy respect for this test," (Fleming, 1937a, p. 286).

An alumni organization of former patients of Am Steinhof was founded in 1926 by Rudolph Wlassak, the physician who started the alcoholic division in 1922. He was the director until his death in 1931, when he was succeeded by Gabriel. The alumni group provided "an alcohol-free social life and fellowship" (as cited in Fleming, 1937a, p. 286). About 1,000 patients were treated from 1922 until 1933, and of these, 32% had remained abstinent for at least 2 years (Fleming, 1937a, p. 286).

In Switzerland, Fleming (1937a) visited the private alcoholic colony at Ellikon started by Forel (1900) in 1889. Fleming dated the modern era of alcoholism treatment to this method of institutional treatment begun by Forel (Fleming, 1937a, p. 287). At Ellikon, located about 40 miles from Zurich, the patients were accepted only voluntarily. The attractive setting was a farm operated as "one big family" (Fleming, 1937a, p. 287). It is supervised by a resident director, who was trained in social work, and his wife. The majority of the work for the entire community of 40 patients was done by the patients themselves.

Another innovation Fleming (1937a) discovered in Switzerland were the “alcohol-free” restaurants and temperance hotels. Fleming (1937a) described these facilities:

The existence of these institutions, which are in no respect inferior to ordinary public houses, being conveniently located and well-appointed, with good service, good food, and reasonable prices, permits one to eat in public without feeling obligated (or tempted) to drink as a concession to custom . . . since social forces and conventions are perhaps stronger, so far as drinking habits are concerned, on the Continent than in England or America. . . . The largest organization . . . owns and operates a chain of eighteen restaurants in Zurich . . . he system is able, in free competition, to make a substantial annual profit which is contributed to the Swiss Foundation of Temperance Communal Houses. (p. 286)

Fleming (1937a) also found the Swiss system of treatment to be unofficial and loosely organized, but to operate similarly to the Swedish. He described the Swiss treatment as follows:

The first Swiss dispensary or Fürsorgestelle für Alkoholkranke was started in Zurich in 1911. It was to deal mainly with the large mass of habitual drinkers that do not realize that they are drunkards and, being unaware of their own decreasing physical and mental efficiency, see no need for institutional treatment. Created entirely by nonofficial private initiative, without religious or political affiliations, its social value was almost immediately appreciated by the city authorities, who have made annual contributions from the city funds toward its support . . . other Fürsorgestellen have been started in other Swiss cities and towns, . . . until today there are about seventy of them. . . . First of all the Fürsorgestelle, or dispensary, is an information office where the families of a habitual drunkard can go for free advice without setting into action official, often cumbrous and inflexible machinery. . . .

The first and best known of the private alcoholic colonies is Ellikon, with the founding of which in 1889 by Professor Forel, the modern era in the treatment of chronic alcoholism may be said to have commenced. It is largely due to the influence of Forel and Bleuler and the Zurich group and their experience at Ellikon that the present day methods of institutional treatment of alcoholism in

Scandinavia and Central Europe have been developed. (Fleming, 1937a, pp. 286-287)

In summarizing his findings, Fleming (1937a) believed there should be pooled resources, citing the example of Widmark, Hey, and Gabriel. He believed that alcoholism was a complex entity, and that no one treatment methodology would fit for all drinkers. He wrote, "The drinker who is reformed by the Salvation Army is not the type that a psychoanalyst could help" (p. 288). Fleming (1937a) found in Europe no standard of treatment, but a conglomeration of methods which could not be compared. Fleming (1937a) concluded:

If there could be created an Institute for the Study of Alcoholism where the biochemist, the internist, the psychologist, the anthropologist, the psychiatrist, and possibly the theologian, working cooperatively could each bring to a common focus on the manifold problems of alcoholism, his own special knowledge, then it should be possible to remove from this field some of the ignorance, prejudice and charlantry that characterize it today. Such an institute would provide a place where under standardized conditions, the different methods of handling drunkards could be tested and compared." (pp. 288-289)

Fleming (1937b) formulated some ideas about alcoholism treatment after his exposure to the European systems. He said that he was "struck again and again by the irrational behavior of relatives" (Fleming, 1937b, p. 781). He also believed that moderate drinking was not possible for the alcoholic and that total abstinence was essential.

He described religious conversion as an almost ideal substitute for alcohol:

especially the red-blooded Salvation Army variety--because it supplies in a socially acceptable form so many of the satisfactions which drinking itself supplies: companionship, music, a feeling of personal importance, spiritual exaltation, and above all a follow-up system that presumably extends throughout eternity. No other substitute does more than approach religious conversion in effectiveness; in many patients, however, this method cannot be applied, and recourse must be had to new occupations, hobbies, and interests that incorporate some of the essential emotional elements of conversion. (Fleming, 1937b, p. 781)

Fleming was able to make some contributions along the lines he sought. He was asked to lecture at the Yale School of Alcohol Studies Summer School in the summer of 1944. He and Harry Tiebout were the only two psychiatrists asked to lecture at Yale; neither was psychoanalytic in practice. He also became involved in some of the activities at the Yale Center on Alcohol Studies (as cited in Johnson, 1973).

### Charles Durfee

Charles Durfee (as cited in Parkhurst, 1938, p. 160) was a popular psychologist who provided a type of farm treatment. Durfee himself practiced moderation, as he explained in an open letter he wrote to his son in Parents' Magazine in 1937. He called his patients problem drinkers. Beginning in 1932 he treated problem drinkers on his farm in Wakefield, Rhode Island.

Durfee stated, "Alcoholism is not the result of a sickness, nor the sign of moral degradation, but a pathological expression of an inner need which requires treatment as any physical disease" (as cited in Jellinek,

1960, p. 55). Durfee practiced a different approach. He believed that the “greatest mistake of most alcoholic therapy is to emphasize staying away from the bottle” (“Problem Drinkers,” 1938a, p. 44). All of his patients voluntarily sought his help. He left liquor out at his farm and his patients served cocktails to guests. “But even when their psyches are patched up, none of Dr. Durfee’s patients are supposed to touch alcohol again” (“Problem Drinkers,” 1938, p. 44). The magazine reporter also commented that “after years of curing drunks, Dr. Durfee has an extraordinarily good-looking farm” (“Problem Drinkers,” 1938, p. 44).

Durfee’s eminence in the area of alcoholism treatment was indicated by the fact that as a psychologist he was asked to address the Connecticut Medical Society in October 1938. In this address he described his theories about treatment:

To get a significant picture of the excessive drinker’s problem, it is necessary to study his body, mind, heredity and environment, which may require the cooperation of physician, psychiatrist and educational psychologist. . . .

As the term “psychologist” has sometimes been abused, I prefer to place the emphasis on the educational aspects of my work and to think of myself primarily as a teacher, an educator of the emotions. . . .

I called this paper “Re-education of the Problem Drinker” instead of the perhaps the more usual “Treatment of the Alcoholic.” I wished to make it quite clear that we would be dealing with a learning process--a process of unlearning and relearning if you will--and I feared the term treatment might be ambiguous. . . . I actually do to treat them at all, do not “do” something to them, but rather give them an opportunity for self government under guidance, much in the manner of our progressive schools. . . .

I preferred the term “problem-drinker” because of the pessimism with which the cure of the alcoholic is generally regarded. (Durfee, 1938, pp. 486-487)

Durfee (1938) defined the typical problem drinker and his philosophy for the re-education process:

Who constitute suitable subjects for re-education? They are to be recruited from the ranks of the psycho-neurotics and those who might be described loosely as poorly organized personalities. In the main, they are individuals who have never grown up emotionally, who find in alcohol escape from the responsibilities of adult life. . . .

For re-educating the man emotionally is no different from educating a child’s mind. You cannot simply shovel facts in. There must be assimilation and active participation on the part of the pupil or the process is meaningless, mechanical, to be forgotten as quickly as it is over.

The process is greatly facilitated by a complete change of scene and time-out from the routine of his daily life. . . .

The simple life, the return to nature, the outdoor work, the challenge to responsibility and cooperation, all lead to most encouraging results. (p. 488)

Many of the tenets Durfee espoused are relevant to treatment process in the 1990s. He had an understanding of the firm compassion necessary in working with alcoholics.

If we could read the problem-drinker’s thoughts, we would probably find he is dwelling, a good part of the time, on ideas of self-pity, anxiety, inadequacy, resentment--and on alcohol. Constructive steps lie in two directions: in non-practice or forgetting of the faulty emotional attitudes and behavior, and in practice of wholesome attitudes and behavior. . . .

Further, that the important thing for the problem-drinker is not to remember to abstain, but to forget to drink. (Durfee, 1938, p. 492)

Durfee developed a unique and practical treatment model and was relatively successful. In providing his student of re-education an

opportunity to connect with nature and allowing them an opportunity to experience responsibility. He believed problem-drinking was “a learned, inadequate way of responding to life’s difficulties” (Durfee, 1938, p. 519).

### Development of Research Council on Problems of Alcohol

The Research Council on Problems of Alcohol (RCPA) had a rather complex development, originating from the integration of several fledgling projects. In order to understand the background and the philosophy of the Rockefeller Foundation’s support, several seemingly unrelated groups are discussed. Roizen, who studied the development of the Research Council in 1991, stated that the records of the origins of the RCPA were lost after their transfer to the National Research Council (Roizen, 1991, p. 94). This accounts for some of the confusion. The following are corroborating narratives from various sources.

### Howard Haggard: Laboratory of Applied Physiology at Yale

The Laboratory of Applied Physiology was founded in 1923 by Howard W. Haggard and Yandell Henderson. Both had been professors in the Yale Medical School, and they had both been asked to leave. They then developed the Yale Laboratory of Applied Physiology (Johnson, 1973, p. 231). Initially, the two were involved with respiratory physiology. Haggard became director in 1930 and began conducting

experiments in alcohol metabolism. Fond of controversial topics, he was one of the most popular lecturers at Yale (Johnson, 1973, p. 232). An example of Haggard's love of controversy is that, at the peak of Prohibition he began to research the effects of alcohol.

A vocal supporter of moderate drinking, Haggard believed that a distinction between normal and pathological drinking would support his position. If only a certain number of drinkers were afflicted with some illness which resulted in inebriety then the rest of the population could drink with impunity and allay the grim admonitions of the temperance advocates (Johnson, 1973).

#### Council for Moderation

Another project was Everett Colby's Council for Moderation. This project serves as a backdrop for understanding the others. Colby was a lawyer and former state senator who had also been John D. Rockefeller, Jr.'s college roommate. Rockefeller was, as his father had been, an abstainer. He supported Prohibition, and some asserted that he bought the 18th Amendment for the country (Roizen, 1991, p. 58). Rockefeller was concerned about the alcohol-related problems which continued and even escalated after the amendment was passed and he supported the Social Science Research Council (SSRC) which was to study the effects of Prohibition. Then, in the mid-1930s, Rockefeller switched and came out for repeal (Roizen, 1991, p. 58).

“The repeal of the 18th Amendment reawakened the interest of research workers in alcoholism” (Jellinek, 1960, p. 7). Jellinek made the preceding statement retrospectively, but there is no doubt to its veracity. Prohibition had not solved the problem of inebriety; it had not even been able to deny it. After repeal, the Rockefeller Foundation made donations to the work of Jolliffe at Bellvue and Robert Fleming at Boston City Hospital. In an astute move on Rockefeller’s part, a donation of \$5,000 was also made to the struggling Alcoholics Anonymous group. He placed the money in the treasury of Riverside Church, stating that there would be no further donations and that the group should become self-supporting. Bill Wilson always gave Rockefeller credit for helping Alcoholics Anonymous to be non-professional (Pass It On, 1984, pp. 187-188)

Everett Colby’s group was to be a mass media type of project, using new techniques of persuasion to “infuse alcohol education with a moderation theme” (Roizen, 1991, p. 68). The message itself was to be almost subliminal so that no one would perceive it as temperance oriented (Roizen, 1991, p. 70). Colby planned a dinner at the Waldorf-Astoria Hotel to launch his project. The event took place on May 2, 1935. The contributions received barely met the required \$3,000 for the Rockefeller match and the expenses for the dinner were \$7,500. Harry Flagler, son of John D. Rockefeller, Sr.’s partner, Henry Flagler, gave the largest donation-- \$1,000. Edsel Ford gave \$200 and Lammont du Pont

gave \$250. They were the largest of the 17 donors (Roizen, 1991, pp. 73-74). Even after Rockefeller and Edsel Ford agreed to support the project for another year, it failed. Walking the fine line between the wets and the dries was tenuous at best. The dries saw no use in supporting moderate use of a poison. They were, however, supportive of educational information about consequences, drunk driving, and industrial accidents. The failure to define a clear message was probably the final blow to this faltering group.

Jolliffe: Bellevue: Medical Science  
Research Project

Norman Jolliffe, a physiologist, was interested in the study of alcoholism. In 1933, John Wycoff, head of New York University College of Medicine, established a new 5-year post-graduate program in psychiatry. Norman Jolliffe was named chief of the medical service unit of the psychiatric division at Bellevue Hospital. At that time it was the policy for the New York Police Department to bring chronic inebriates to Bellevue where they remained for a 30-day treatment. They also served as subjects for various research projects (Johnson, 1973, pp. 233). (This conflicts with a statement Jolliffe later made in report to the Rockefeller Foundation.)

Keller (1975) related a conversation with Jolliffe when he was pondering the treatment of alcoholics:

You know, I must be doing the wrong thing. I send these people out cured; and the same ones keep coming back in! They go on drinking the same way, and getting the same diseases over again. I know why they are getting those diseases. But why are they drinking that way? That's the real question. It's the alcoholism we should be studying! (p. 136)

Initially, Jolliffe was interested in the nutritional deficiencies of chronic alcoholics. In this area, in 1937, he completed the seminal research identifying vitamin B1 as the essential factor in the physical recovery of chronic alcoholism. Jolliffe's encephalopathy, named after Norman Jolliffe, is an "eponym for nicotinic-acid-deficiency encephalopathy," a disease that often occurs in chronic alcoholics (as cited in Keller, 1982, p. 151).

In 1935, Jolliffe proposed a major project to study the etiology of chronic inebriety. He estimated the cost of the project to be \$500,000 and proceeded to seek funding from the Rockefeller Foundation. The chief advisor to the foundation believed that Jolliffe did not have adequate credentials for such an ambitious project. The foundation decided to send Jolliffe to Europe on a tour of major medical institutions in order for him to become an "international authority on alcoholism" (as cited in Johnson, 1973, p. 234).

On March 1, 1937, Jolliffe sailed for Southampton on the Hamburg (Roizen, 1991, p. 105). A week later he became acutely ill, required surgery, and was confined to the University Hospital in London for 2 weeks. Able to travel in April, he went to Cambridge, Dublin,

Belfast, Edinburgh, Glasgow, Amsterdam, Oslo, Stockholm, Copenhagen, Berlin, Leipzig, Vienna, Budapest, Munich, and Zurich. He consulted with over 100 specialists in alcoholism (as cited in Roizen, 1991, p. 106).

Jolliffe also planned to inspect a number of German hospitals that were being funded by the Rockefeller Foundation. Three months later he was notified that Wycoff had died, and he was recalled. The Rockefeller Foundation had funded the project only on Wycoff's recommendation. When Jolliffe returned, Karl Bowman, head of the Department of Psychiatry in the College of Medicine since 1935, became interested in Jolliffe's research, and Jolliffe was invited to become a member of the New York Academy of Medicine (as cited in Johnson, 1973, p. 235).

Back in New York in September 1937 Jolliffe submitted his report that began with a review of the statistical article he had published earlier in Science and described the poor treatment the alcoholics at Bellevue received. They were simply released after a 2- to 5-day drying out period. Jolliffe wrote, "That's the way it's been done for 35 years" (as cited in Roizen, 1991, p. 108). Jolliffe's final conclusion was that "nowhere was the problem in its several aspects being studied in a coordinated, objective, and scientific manner" (as cited in Roizen, 1991, p. 108).

Jolliffe suggested that there were several "isolated and uncoordinated studies" that might "serve as a nucleus for more extended and correlated investigations" (as cited in Roizen, 1919, p. 108). He then listed the three areas of research he had examined. The first was medico-

legal--noting that in Sweden, Denmark, Holland, and Germany blood alcohol levels were used in court. The second was physiological--citing Widmark's experiments at Lund that involved feeding dogs large doses of alcohol over a 2 year period. The third was area was clinical--stating that Gabriel in Vienna was doing some good work, but believed most alcoholics constitutional, and, therefore, hopeless. He also described the aversion therapy being done by J. Yerbery Dent in London. However, Jolliffe failed to find any serious studies in the field of alcoholism (as cited in Roizen, 1991, pp. 110-111). The Rockefeller readers were skeptical of Jolliffe's report, and when Jolliffe submitted his list of research proposals for Bellevue, he was thanked for sending the copy, and nothing more was said. Jolliffe's observations and conclusions were a contrast to Fleming's very detailed observations of the same European facilities.

#### Beginnings of the Research Council on Problems of Alcohol

Karl M. Bowman, Chief of Psychiatry at the Medical College, was interested in Jolliffe's proposed research and offered to form an advisory committee. Keller, who was the first staff member hired for the project, intimated that the Research Council grew out of the advisory committee established by Wycoff to support Jolliffe's initial research in the fall of 1937 (as cited in Roizen, 1991). Roizen (1991) doubted that such a committee existed and traced the origins to the integration of several

smaller groups (p. 118). In the spring of 1937 plans were made in Washington to establish an organization to begin an exchange of ideas between clinicians and scholars in the study and treatment of chronic inebriety. A secondary agenda would be to encourage both the medical profession and society to accept the medicalization of problem drinking (Johnson, 1973, p. 235). The purpose of this committee, the Sponsoring Committee of the National Conference on Alcohol (SCNCA), was not to foster research but to stage a national conference to review and resolve factual issues concerning alcohol (Roizen, 1991, pp. 128-129). According to Roizen (1991), Jolliffe and Bowman joined forces with this committee in mid-1938 (p. 128). The SCNCA was an educational, not a scientific endeavor, begun under the auspices of Harry Hascell Moore. Moore (as cited in Roizen, 1991) was a "health economist and sociologist" who started the work on the Research Council on Problems of Alcohol (RCPA) after completing his Study of the Costs of Medical Care in the United States in 1927-1932 (p. 96).

Those involved in the early discussions were Winfried Overholser, superintendent of St. Elizabeth's Hospital; Earl B. McKinney, dean of George Washington Medical School; Forrest R. Moulton, permanent secretary of the American Association for the Advancement of Science; and Edward Strecker, Professor of Psychiatry at the University of Pennsylvania Medical School. It was decided to call the organization the Research Council on Problems of Alcohol. "In order to assure maximum

scholarly acceptance,” sponsorship would be sought from the American Association for the Advancement of Science (Johnson, 1973, p. 236).

The following resolution was adopted:

The Research Council on Problems of Alcohol is an associated society of the American Association for the Advancement of Science. The Scientific program of the Council has been endorsed by the executive committee and Council of the Association and will be carried out under the general direction of the Association. All funds of the Research Council on Problems of Alcohol will be administered and disbursed by the Association. (Johnson, 1973, p. 236)

Lack of funding was a major concern. Karl Bowman offered free office space at the New York Academy of Medicine. Karl Bowman and Merrill Moore were strongly involved in the organization on the move from Washington to New York . The next agenda was to obtain funds for Jolliffe’s research. A committee was formed for this purpose, the Scientific Committee of the Research Council. The duties of this committee would be to secure research funds and to review research proposals. Prominent scientists were also asked to serve on the newly formed committee, with Karl Bowman as chairman. Other members were Edward Strecker; Walter B. Cannon, Professor of Physiology at Harvard; Harold Himwich, Professor of Physiology at Albany Medical College; and Norman Jolliffe. Three sociologists were also members of the committee: Howard W. Odum, the University of North Carolina; William F. Ogburn, the University of Chicago and Thorsten Sellin, the University of Pennsylvania (as cited in Johnson, 1973, p. 237).

Johnson (1973) also listed Howard Haggard and Yandell Henderson of the Applied Physiology Laboratory at Yale. Roizen (1991) stated that they were asked to join the group later as their names did not appear on the original roster (Roizen, 1991, p. 120). The first annual meeting of the Research Council was held in New York in September 1938. It was poorly attended, and the business focus was on establishing the organization (Johnson, 1973, p. 241).

The second meeting of the Research Council was held in New York in September 1939. Merrill Moore, a psychiatrist, took a prominent position, and the main topic of discussion was the “task of overcoming public rejection of alcoholism as a medical problem” (as cited in Johnson, 1973, p. 242). A resolution was made, as follows: “As a result of the action thus taken, the Research Council on Problems of Alcohol hopes to take a place with the public health agencies now combating tuberculous, syphilis, poliomyelitis, cancer, and other major diseases” (Johnson, 1973, p. 242). The resolution passed easily despite the fact that the members were confused about the exact definition of alcoholism.

A grant was obtained from the Carnegie Foundation for \$25,000, and the project began in the spring of 1939 (Keller, 1979). The first staff member hired for the project was Mark Keller. Jolliffe had hired Keller the year before as a typist and editor. Although Keller had only a high school education, he was a gifted writer and editor. Keller moved to a

small office at the New York Academy of Medicine, near the extensive medical library housed there.

The next person to be hired was Elvin Morton Jellinek. Jellinek was born in New York City in 1890, the son of Hungarian immigrants. He studied in France and in Germany and received a master's degree in education from the University of Leipzig in 1914. He was later awarded an honorary doctor of science by the same university. He worked in plant research at Elder Dempster in Sierra Leone and from 1925 to 1930, for United Fruit Company in Honduras (as cited in Johnson, 1973, pp. 378-379). In 1931 he came to the United States, where he was associate director of research and chief biometrician working on a neuroendocrine research project in schizophrenia at Worcester State Hospital. In January 1939 Jellinek was beginning a new project at Worcester to study the effects of alcohol.

Jolliffe went to see Jellinek about assuming the responsibility of reviewing the literature. The job was funded for only 18 months by the Carnegie funds, and it was difficult to understand why Jellinek accepted Jolliffe's offer. Keller and Efron later said Jellinek had a tendency to be careless about the use of research funds. There were no implications of dishonesty, simply of careless management. They said that he had conflicted with Hoskins at Worcester about this issue, and soon he conflicted with Jolliffe. He agreed to come and in February 1939 he joined Keller in the small office at the New York Academy of Medicine

(as cited in Johnson, 1973, pp. 238-239). The secretarial assistant, Vera Effron, was fluent in five languages (Johnson, 1973, p. 239). Keller (1979) said that she was not originally on the staff, but did some work for them (p. 24).

Keller later wrote about his friend Jellinek, "It was Jellinek who imaginatively created the tools, projected the researches, stimulated the studies, guided the analyses, enriched the reporting, which made the scientific approach a reality" (as cited in Page, 1988, p. 1095).

Johnson (1973) wrote:

One of Jellinek's greatest strengths was his ability to develop original and highly imaginative solutions to problems. Soon after he joined the project, he formulated a storage and retrieval system based on the McBee filing cards. He constructed an extensive list of subject headings for use in classifying books and articles related to the subject of alcohol. It is interesting to note that more than thirty years later this system was still in use and Keller and Effron were continuing to abstract all of the literature in the field. It is unlikely that there is any other subject area in which there is a more comprehensive literature archive. (p. 239)

The Scientific Committee met in January of 1940 and spent the entire meeting discussing the topic, "What Is Alcoholism." Jellinek and Bowman had almost completed a comprehensive review of the literature on the effects of alcohol on the individual for the year 1939. They illuminated the discussion by informing the participants, mostly psychiatrists, that Trotter, in his 1804 essay, made a distinction between alcohol addiction and chronic alcoholism. Alcoholism, from the scientific literature, indicated the physiological changes caused by "prolonged and

excessive use of alcohol,” and alcohol addiction referred to the “uncontrollable craving for alcohol” (as cited in Johnson, 1973, p. 243).

The committee rejected Jellinek and Bowman’s distinction between chronic alcoholism and alcohol addiction. They adopted a statement defining an alcoholic as “a person who cannot or will not control their drinking,” and alcoholism as “a disease due to the excessive and continued use of alcohol, so serious as to require thorough and systematic treatment” (Johnson, 1973, p. 243). This statement left open the possibility that a person could be an alcoholic and not be the victim of alcoholism (Johnson, 1973, p. 243). This could also account for the medical profession’s inability to diagnose alcoholism in its early stages before physical damage had occurred.

The Scientific Committee consisted primarily of psychiatrists who were involved in the treatment of alcoholism. Keller remembered that Jellinek enjoyed being an authority on alcoholism, and lecturing to the psychiatrists when he had known little about the subject before he became involved with Jolliffe and Bowman (as cited in Johnson, 1973, p. 243). In composing their statement, the psychiatrists may have also been influenced by A. J. Rosanoff who used the term pathologic alcoholism for both conditions. The final statement of the group read:

Whether the disorder is caused by an abnormal reaction to alcohol, whether its mainly the result of a maladjusted personality, how important relatively are the physical and mental factors, the

relation of nutrition to the disorder, the extent to which its beginnings may reach back into childhood, the role of heredity--are controversial questions on which additional research will provide more knowledge. An alcoholic should be regarded as a sick person, just as one who is suffering from tuberculosis, cancer, heart disease, or any other serious chronic disorder. He should be looked upon as a person needing medical care instead of one who is guilty of a moral or criminal offense. (as cited in Johnson, 1973, p. 244)

Winfred Overholser, chairman of the Executive Committee of the Research Council, presided over the special professional conference that Merrill Moore had organized. Albert F. Blakeslee, president of the American Association for the Advancement of Science, was the guest of honor. Fifty professional men from the New York area attended. There was no press coverage (as cited in Johnson, 1973, p. 244). The Scientific Committee adopted a statement defining the alcoholic as "a person who cannot or will not control his drinking, and needs thorough and systematic treatment" (as cited in Johnson, 1973, p. 243).

Following the meeting of the Scientific Committee, Merrill Moore began arranging a conference for doctors, lawyers, clergymen, and other professionals to be held in New York City on May 16, 1940. Winfried Overholser, chairman of the Executive Committee of the Research Council presided over this conference of approximately 50 professional men. Albert F. Blakeslee, president of the American Association for the Advancement of Science, was the guest of honor (as cited in Johnson, 1973, p. 244). Thomas Parran, the United States Surgeon General at the time, made the following statement regarding the gathering: "The

Research Council on Problems of Alcohol, made up as it is of distinguished scientists, promises to supply a long-felt need. It has a promising program and I welcome it into the field of research and preventative medicine” (as cited in Johnson, 1973, p. 245).

#### Quarterly Journal of Studies on Alcohol

The Research Council’s research projects resulted in a number of publications. In 1940 Jellinek and Jolliffe completed their literature review, and Bowman and Jellinek published a paper on the treatment of alcohol addiction. During this project, Jellinek and Howard Haggard of the Yale Laboratory became good friends. Jellinek proposed to Haggard that there should be a scientific journal to publish research in the field of alcohol studies. The Research Council did not have the funds for such an endeavor. Haggard, was popular and influential with the Yale trustees, so he had a sizable budget. Haggard was able to fund the journal, which he named the Quarterly Journal of Studies on Alcohol. It was to be the official journal of the Research Council (as cited in Johnson, 1973, p. 252).

The first issue of the new journal was published in June 1940. It contained the literature review by Jellinek and Jolliffe. As the Carnegie funds began to come to an end, Haggard offered Jellinek an appointment in the Applied Physiology Laboratory at Yale. Haggard and Jellinek (1942/1954) were already co-authoring a book, Alcohol Explored, which

was published in 1942. Haggard also hired Keller and Effron. All of the material from the abstracting project and the literature review was moved to Yale. Haggard was listed as the editor of the journal but Keller actually prepared the work. His desire to be the editor of a scientific journal had almost come to fruition (as cited in Johnson, 1973, p. 241).

#### Continued Work of the Research Council on Problems of Alcohol

The third annual meeting of the Research Council on Problems of Alcohol was held on October 15, 1940, at the Commodore Hotel in New York City. The New York Times covered the meeting. Harry M. Tiebout, medical director of the Blythewood Sanitarium in Greenwich, Connecticut, led one of the discussion groups. Also attending were Bill Wilson, one of the founders of Alcoholics Anonymous, and Marty Mann, a former patient of Tiebout's (as cited in Johnson, 1973, p. 245).

In December 1940 Merrill Moore held a 3-day symposium in conjunction with the annual meeting of the American Association for the Advancement of Science in Philadelphia (as cited in Johnson, 1973, p. 246). Papers were presented at this meeting by E. M. Jellinek, Norman Jolliffe, Robert Seliger, Karl Bowman, and Lawrence Kolb. Charles Durfee and Harry Tiebout also participated. Johnson (1973) remarked that although Durfee was not a physician he was one of the best known participants at the conference (p. 246). Again, Surgeon General Thomas Parran was present. The symposium participants wanted to have

alcoholism recognized as a public health problem. This did not occur until 1966, when the National Center for the Prevention and Control of Alcoholism was organized within the National Institute of Mental Health (as cited in Johnson, 1973, pp. 246-247).

The topics submitted for funding consideration from the Research Council ranged included: "An experimental study for the ultimate purpose of discovering how a craving for alcohol is established from Johns Hopkins University" to "A study of liquor taxes and the bootlegger" to be updated from the study made in 1934 by the National Municipal League ("Activities of the Research Council," 1940, pp. 399-400). In 1940, the lack of treatment facilities for alcoholism in the United States was discussed in an early issue of the Quarterly Journal of Studies on Alcohol:

Facilities in the United States for the treatment of alcoholism are conspicuously inferior to those of Sweden, Switzerland, and Holland. It is doubtful if we have even 1 state hospital devoted exclusively to the treatment of alcoholism. We do not have even 1 government dispensary, where the alcoholic can go for advice, like the 70 dispensaries in Switzerland and the consultation bureaus of Holland.

Wealthy alcoholics may go to private institutions. For an alcoholic psychosis, a majority of patients, both rich and poor, are sent to state mental hospitals; these state mental hospitals also accept a limited number of alcoholics. In some cities alcoholics are taken to a city hospital for casual, temporary "treatment"--an opportunity to "sober up" for the time being. Many such cases are repeaters.

In most communities, the only public institution willing to accept an alcoholic is the jail. ("The Dearth of Facilities," 1940, p. 407)

In the fall of 1941 the Research Council lost two of its most enthusiastic members. Merrill Moore was inducted into the army, and Karl Bowman went to the University of California School of Medicine. Bowman later became the director of the Langley Porter Clinic in San Francisco (as cited in Keller, 1979, p. 23). The council was having fundraising problems and in April 1942 a Committee on Public Relations was formed. Dwight Anderson, public relations director of the New York State Medical Society was selected to lead the new committee. Anderson (as cited in Johnson, 1973) had a serious drinking problem and was able to attain sobriety through the help of a psychiatrist (pp. 248-249). Anderson formulated four “fundamental principles” as the main concerns of the Research Council:

1. The alcoholic is sick.
2. He can be helped.
3. He is worth helping.
4. Treatment of the alcoholic is the responsibility of the doctor. (as cited in Johnson, 1973, p. 249)

One year later, in April 1943, 5 years after its beginning, a meeting of the Research Council was held in New York City on the treatment and prevention of alcoholism. There was no presentation of scientific research, and there were no discussions of the meaning of alcoholism (as cited in Johnson, 1973, p. 250). The participants were a group unlike those who had attended any other meetings. Those attending were representatives of The Alcoholic Foundation of Alcoholics Anonymous, the Allied Liquor Industries, the Greater New York Federation of

Churches, the New York Academy of Medicine, the Conference of Alcoholic Beverage Industries, the Department of Beverage Control of New Jersey, the Hospital Association, the Welfare Council of New York City, and others. The common concern was the “influencing of public attitudes toward the consumption of alcohol” (as cited in Johnson, 1973, p. 250).

Although a program was approved, none of the organizations were willing to support the implementation. National Distillers Products, Frankfort Distilleries, Inc., and Joseph E. Seagram and Sons, Ltd. offered financial support to the Research Council. The leaders of the liquor industry did not like the term alcoholism. They argued there was not a term sugarism to refer to diabetes (Johnson, 1973, p. 251). The liquor industry wanted to replace alcoholism with problem drinking, and they made it clear their support would be contingent on the deletion of alcoholism from all of the Council’s publications (Johnson, 1973, p. 251).

The Research Council continued to be supported by the liquor industry until 1949. The president that year was Anton J. Carlson, Professor of Physiology at the University of Chicago. He decided that things were not going well because the Research Council had become a spokesman for the liquor industry. The Research Council was then disbanded and abolished (Keller, 1979, p. 26). Keller (1979) explained:

As far as the Research Council in general is concerned, yes, they just slipped into it. But I think the industry's [liquor industry] public relations people deliberately used the office of the Council as a mouthpiece for the industry, in the last two or three years of its existence. . . . At about the time the Council fell the industry set up their own research fund and got the National Academy of Science to establish a review process. Unfortunately, this relatively modest program may well have delayed or prevented something more significant being done at the federal or private foundation level in the way of research support. One significant point that is worth reiterating is that most of the leading foundations at that period of time, whenever they were asked for research support in this field, indicated that they had a formal policy against supportive work in the alcohol field. (p. 26)

Keller (1979) wrote that in the 1950s when he was looking for funds to support his Dictionary of Words about Alcohol, the industry's scientific advisory committee was supporting research. This was after the National Academy of Science committee was abolished. The industry formed a committee of scientists to support research on alcohol and paid handsomely for the work, grants of \$100,000 a year plus expenses for 10 years. However the money for research was only \$5,700 per year, of which they supported 18 or 19 studies. Keller approached the committee and was offered the entire \$70,000. He believed that the National Institute of Mental Health was also interested, and he "had the pleasure of saying, 'No thank you' to them" (Keller, 1979, p. 27).

#### The Yale Center for Studies of Alcohol

Haggard and Jellinek decided to withdraw from the Research Council. The work at Yale, unlike the Research Council, was solidly funded. The research program at the Laboratory of Applied Physiology at

Yale had been growing consistently. Haggard had set up the Section on the Study of Alcohol within the laboratory in the early 1930s. The Quarterly Journal of Studies on Alcohol, which served as the official organ of the Research Council, had been solely funded by the laboratory from the beginning. Because the activities of the Section on the Study of Alcohol provided the focus of the work, it was decided to change the name to the Yale Center for Studies of Alcohol (Keller, 1979).

In relating the story of the Yale Center, Keller (1979) wrote that, because of the journal, a research interest developed in the subject of alcohol (p. 25). This was responsible to a great extent for making alcohol and alcoholism respectable topics in the scientific and academic communities. Keller (1979) observed that, more than anyone else, the people in the liquor industry “swallowed the propaganda of the temperance people” (p. 25). They assumed that if the subject was illuminated through study only bad things would appear, and therefore they were opposed to the subject’s being researched. Haggard and Jellinek did not want the Research Council to accept funds from the liquor industry. Haggard was the editor of the journal. Keller (1979), who was the assistant editor at the time, related that Haggard said, “Take that official organ thing off the Journal and take that special editorial board off too” ( p. 25). This ended the relationship with the Research Council.

### Yale School of Alcohol Studies

The first Yale School of Alcohol Studies was held in the summer of 1943. In the spring, plans were already made for the school when a sociologist, named Selden Bacon was added to the staff of the Yale Center for Studies on Alcohol. Bacon had come to the center in the fall of 1942 for assistance on a research project for the Connecticut War Council. He established contact with Haggard and Jellinek and was invited to join them in the spring. Bacon and Haggard established a strong friendship, a “father-son” relationship (as cited in Johnson, 1973, p. 254).

The Summer School, like the journal and the literature archive, was Jellinek’s idea (as cited in Johnson, 1973, p. 254). Haggard had wanted a method of presenting the information that had been processed on a new view of alcohol in an educational, unemotional format to a variety of persons. The Research Council’s symposia had a scientific professional focus. The Summer School was designed to reach a variety of disciplines.

Eighty people attended the first session. In August, looking back over the Summer School experience Jellinek (1943a) wrote in the journal:

Education as a means of prevention of inebriety was suggested as far back as in 1838, by Grindrod in his famous Bacchus. [Ralph B. Grindrod was an American who extended the Englishman, Thomas Trotter’s, thesis of alcoholism as an illness. He wrote Bacchus, an essay on the effects, nature, and cure of intemperance in 1840.]

The same idea has been reiterated, in the course of the last hundred years, by numerous writers on the subject. Some temperance societies turned this suggestion into practical use, particularly in the United States. That every state in the union requires by law the teaching of the effects of alcohol in elementary or high schools, or both, is entirely the merit of the Women's Christian Temperance Union. The latter organization created a division devoted to education on alcohol and narcotics which has trained many workers in the field.

The staff of the Laboratory had come to the conclusion that while popular scientific literature on the effects of alcohol would cover the need to a certain degree, the most effective way to convey modern scientific knowledge on this subject to the general public would be the scientific training of men and women whose activities pre-eminently fitted them for the dissemination of such knowledge. These considerations led to what a national news magazine has described as "one of the most unusual courses in the history of American education." (p. 187)

The Summer Schools continue today. They have operated every summer except the summer of 1949 when the Summer School was held at Trinity University in San Antonio, Texas, and the staff was too exhausted to hold the one as planned at Yale (Johnson, 1973). (The Summer School is now held at Rutgers University and the summer of 1996 will be the first time a Summer School will also be held in Europe.)

#### Yale Plan Clinics

After the first Summer School on Alcohol Studies was successfully completed, Jellinek began plans to open two outpatient clinics, one in New Haven and one in Hartford. Raymond G. McCarthy, who had been a student in the Summer School was selected to be the director. McCarthy held a master's degree in social work and had been the

Superintendent of Schools in Kingston, Massachusetts. He frequently counseled alcoholics, using a method based on the theories of Courtenay Baylor and Richard Peabody. McCarthy had been a student at the first Summer School. McCarthy and Jellinek became friends during the school session (as cited in Johnson, 1973, p. 256).

According to Johnson (1973), a major factor influencing McCarthy's selection was that his view of alcoholism was compatible with the medical model espoused by Jellinek and Haggard. It is important to clarify exactly what is meant by the medical model as espoused by Jellinek and Haggard. Both Haggard and McCarthy refer to habit in discussing alcoholism. According to McCarthy (1946), "It is probable that there are in this country more than a million excessive drinkers who require assistance in learning how to eliminate their drinking habit" (p. 500). Haggard (1945) wrote, "this pessimism is not justified. It is based mainly on a misconception of alcoholic as contrasted to alcoholism; one concerns the man, the other his habit" (p. 213).

Keller (1990) discussing models of alcoholism, stated that the psychiatric-psychological model espoused by Jellinek and Bowman in 1941 was now considered historic (p.6). In this essay Keller identified 23 models of alcoholism. Four were identified as classical-historic, 18 as modern, and the last, a wholistic model, which is the 1990s version (Keller, 1990, pp. 1-9).

McCarthy (1946) further stated, "The treatment of alcoholism is a medico-psychiatric problem . . . here are three concomitant factors . . . of physical disabilities; of marital and social inadequacies; of economic, educational, occupational, and religious factors. (p. 500). McCarthy believed these factors were an integral part of the alcoholism.

McCarthy (1946) outlined a plan of three stages which the clinic used in treatment. In the 1st stage, diagnostic impressions were made to rule out any psychiatric disturbances either in the past or in the present. Individual characteristics of the patient were assessed to establish (a) the level of intelligence, (b) the drive for security and approval from family and friends, and (c) the need to be accepted. At this point the patient may be referred to a lay therapist or to Alcoholics Anonymous if group participation would be beneficial. The second stage was a trial or testing period. Anxiety often surfaced after several weeks of sobriety. In the second stage the psychiatrist may be able to treat the psychiatric problem with a minimum amount of time, and the patient has learned to be more objective about himself. McCarthy (1946) emphasized that the personality of the worker was crucial to the outcome. Training for clinic workers was available at the Yale Plan Clinics (pp. 510-514).

According to Johnson (1973), Haggard and Jellinek basically took a humanitarian approach to alcoholism, or "alcohol addiction" as they preferred to call it (p. 243). They wanted to disprove the moralism that had become so prevalent. They believed that the alcoholic was a sick

person who could get well. They also advocated moderate drinking, but not for the alcoholic. David Myerson (1957) in a historical perspective on treatment wrote:

No review can be complete without stressing the tremendous importance and impact of the program evolving from the Laboratory of Applied Biodynamics at Yale University . . . as an experimental program for the purpose of the diagnosis and later the treatment of alcoholic patients referred from the community, social agencies, and the courts. . . . Clinics patterned after the Yale Plan Clinic have been established throughout the state of Connecticut, with the result that this state has the most extensive therapeutic program in the nation.

The Yale group has had so widespread an influence that 34 other states have established similar clinics on smaller or larger scales. (p. 823)

Myerson (1957) also mentioned that “the suggestion clinical teams move into the prison is all the more understandable on the basis and hope that the more patients exposed to treatment, the greater the number who will recover (p. 824).

The Yale Plan Clinics embodied a new approach to alcoholism treatment. Instead of institutionalization, the emphasis was “to disseminate scientific information on the causes and treatment of alcoholism” and to establish “diagnostic and treatment centers for alcoholics” (as cited in Johnson, 1973, p. 277). This may be where the name treatment center originated. On January 31, 1945, Connecticut passed a bill based on the Yale Clinic Plan and for the first time a “non-moralistic interpretation of problem drinking” was part of a state law

(Johnson, 1973, p. 278). Other states followed. A new attitude was evolving.

After the Yale Plan Clinics were taken over by the state in 1945, Ray McCarthy continued to direct the clinics for only a short period. He was the director of the Summer School in 1955, and in 1959 he became the director of the Massachusetts Division of Alcoholism. Later he was the head of the New York program. In 1962 he was the president of the North American Association of Alcoholism Programs. He died in 1964 (Johnson, 1973, p. 398 ).

#### The National Council on Alcoholism

In April of 1944 Jellinek received a letter from a woman he had met at several meetings sponsored by the Research Council. Her name was Marty Mann. She was eliciting his assistance in organizing a national campaign to educate the American public about the medical condition of problem drinking and the help that was available (as cited in Johnson, 1973, p. 259). Marty Mann was the daughter of the manager of Marshall Field Department store in Chicago. She had a privileged upbringing, including a debut and a European education. When she was 24 her father lost his fortune, and she moved to New York to look for a job. She reviewed books and then became a magazine editor ("Marty Mann," 1962, p. 8). In addition to being an assistant editor at International Studio, she also wrote for Town and Country (Johnson, 1973, p. 259).

According to Johnson (1973) Mann was “an exceptionally attractive and intelligent woman and seems to have never lacked for friends or business contacts” (p. 260). After inheriting a small sum from her grandmother, she moved to London. There, her alcoholism, which had begun going to speakeasies during Prohibition days, worsened to the point that she was spending the day on a bench in Hyde Park drinking from a flask. She was penniless, and at this point a friend purchased a ticket for her to return to the United States.

Mann went to several psychiatrists, who refused to take her as a patient when they learned of her severe drinking problem. Finally, Harry Tiebout agreed to admit her to Blythewood Sanitarium without charge. After a year’s work she was beginning to lose hope of any recovery (“Marty Mann,” 1962, p. 9). One morning, in the spring of 1939, Tiebout brought her a manuscript. “This was written by people like you,” he told her. “They seem to have found their way out of trouble. Perhaps it can help you. I don’t know. Read it and let me know what you think about it” (“Marty Mann,” 1962, p. 9). Harry Tiebout had been sent an advance Multilith copy of the Big Book of Alcoholics Anonymous for review (Pass It On, 1984, p. 211)

Mann discovered that what she had was called alcoholism, and that it was a disease.

What was the answer?

It came with stunning simplicity; she must discard attempts at moderate drinking; she must give up ALL drinking. But wasn’t

that beyond her power? The manuscript spoke of God's help, but through the recent hellish years she had lost God. But now suddenly as she read these words, she knew for a certainty He could help her. ("Marty Mann," 1962, p. 9)

Mann attended her first meeting of Alcoholics Anonymous at the Brooklyn home of Bill and Lois Wilson at 182 Clinton Street. It was one of the last meetings to be held there. She went upstairs to leave her coat and was so intimidated by the gathering of 30 or 40 people downstairs that she could not return to the first floor. Lois Wilson came up to get her. Lois put her arms around her and told her that everyone wanted her to come downstairs. She recalls she had never felt such love before (Pass It On, 1984, pp. 211-213). She became the first woman to maintain sobriety in Alcoholics Anonymous.

After reading the biography of Dorthea Dix by Helen Marshall, Marty Mann was convinced that she could develop a crusade for treatment of the alcoholic similar to the one Dix had waged against inhumane treatment of the mentally ill. She developed a three part strategy: (a) a program of lectures on the disease of alcoholism for professional groups, doctors, nurses, social workers, and ministers, throughout the United States; (b) the establishment of "alcoholism information centers" in every major city; and (c) to work with hospitals to encourage them to provide beds for alcoholics (as cited in Johnson, 1973, pp. 265-267).

Marty Mann went to Bill Wilson, the co-founder of Alcoholics Anonymous, with her plan. He felt her greatest hurdle was her lack of scientific credibility. Bill Wilson had made talks to groups, but he was not comfortable doing this. He also believed that Alcoholics Anonymous would thrive even if the public did not accept the position that alcoholism was a disease (as cited in Johnson, 1973, p. 268).

Mann's friend Ruth Fox suggested that she contact Austin MacCormick, who was executive director of the Osborne Association and was also on the board of the Research Council. MacCormick was a friend of Thomas Rennie, who was a psychiatrist and a close friend of Ruth Fox. Rennie had also been active on the Research Council. These two men suggested she contact Haggard and Jellinek at Yale. Although she had met Jellinek, she was not familiar with the program at Yale, and Ruth Fox offered to send her plan to Jellinek. Several days later Jellinek came to New York to visit with them (as cited in Johnson, 1973).

Jellinek was enthusiastic about Mann's plan. He was convinced that the American public was ready to be responsive to the idea of habitual drunkenness as a disease (as cited in Johnson, 1973, p. 269). This meeting with Jellinek was held in the apartment of Grace Bangs, who was the director of the New York Herald Tribune's Club Women's Service Bureau. She had sought Mann's help for her son's drinking problem. Although Bangs's son did not recover, Marty Mann helped her to understand the problem. Mann was a dynamic spokeswoman for the

Alcoholics Anonymous philosophy, and her winning personality attracted people to her. According to Johnson (1973), Bangs had urged Mann to quit her job and to undertake a public speaking career to help people better understand alcoholism. She offered to arrange engagements for her through the Tribune's Women's Service Bureau (p. 265).

Also present at the meeting with Jellinek were Edgar Lockwood of the Guaranty Trust Company of New York and a member of the Research Council, Priscilla Peck of Vogue magazine, and Ruth Fox. This gathering was the right group of people at the right time for such an endeavor to begin. Mann was an attractive, and compelling speaker. She had experience and contacts in journalism. She had also lived her subject matter and she shared her experience, strength, and hope. Mann was also unencumbered by career or family. She moved to New Haven and lived with Jellinek and his family for 5 months. That summer, 1944, she attended the Yale Summer School. One of the students was D. Leigh Colvin, who was president of the Women's Christian Temperance Union (WCTU). The WCTU had viewed alcoholism as a moral failing and not a medical problem. Mann was able to convince Colvin that it was a disease. This was her first success (as cited in Johnson, 1973, p. 271).

Mann, Jellinek, and Haggard decided to call the new organization the National Committee for Alcohol Education. It would be an outreach of the Yale Center and would be funded by the Center. The goals would be to educate the public in accepting five basic facts about alcoholism:

1. Alcoholism (compulsive drinking) is a disease and not a moral shortcoming.
2. The alcoholic is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is a major public health problem. (as cited in Johnson, 1973, p. 272)

A prestigious and well-represented board of directors was willing to serve: Harry Emerson Fosdick, minister of New York's Riverside Church; LaFell Dickinson, president of the National Federation of Women's Clubs; Broadway producers, Arthur Hopkins and Marcus Heiman; Lawrence Kolb, Assistant Surgeon General; and Karl Menninger, Mary Pickford, Dorothy Parker, and Harry Tiebout. October 2, 1944 at the Biltmore Hotel in New York the formation of the National Committee for Education on Alcoholism was announced (Johnson, 1973, p. 273).

The major news services, the Christian Science Monitor, and reporters from all of the New York papers attended the announcement at the Biltmore. Articles began to appear in magazines and newspapers all over the country. In December of 1944 an Associated Press article appeared in 42 newspapers stating that Leigh Colvin, President of the WCTU, had endorsed the concept of alcoholism as a disease. Between October and March Marty Mann made 49 speaking engagements in 13 states. She dispelled the myth of the alcoholic bum; she was an attractive, articulate, appealing upper class woman, and she was an alcoholic. Geraldine Delaney knew Marty Mann and worked with her. Delaney started the Essex County Council on Alcoholism in response to

Mann's plea. "She was not someone you said no to" (Delaney, personal communication, July 11, 1995).

### Summary

In the 10 years covered in this chapter more information and insight about alcoholism surfaced in the United States than in all the previous years combined. Individual struggles become a collective problem. The problem of alcoholism is experienced both on the individual level and collectively. The complex nature of alcoholism has required a multidimensional perspective. Alcoholics Anonymous began in 1935 just 2 years after the repeal of prohibition. This simple program brought hope to hundreds of alcoholics in a few short years and to thousands in a decade. By 1950 the membership was more than 96,000 (Bill W., 1988).

The hope of effective recovery from alcoholism that materialized with Alcoholics Anonymous was experienced by only a small nucleus. The escalation of alcohol problems that occurred with Prohibition, the turmoil of the country in the depression, and the aftermath of the repeal of Prohibition in 1933 all provided a milieu for another search for solutions to the alcohol problems by the medical and scientific communities. Even if the premise of Alcoholics Anonymous that alcoholism was a treatable illness was rejected, the realization that some action needed to be taken was evident. Individuals, scientists, physicians,

and laymen worked singularly and together to assess new ways of addressing the problem of alcoholism.

The Research Council on Problems of Alcohol provided a respectable setting with academic and scientific credentials to begin research on alcohol problems. The Research Council provided a format for discussions about alcohol problems and for physiological and psychological research. From the Research Council evolved the Yale School of Alcohol Studies, now at Rutgers University. The early reviews of the literature provided the base which eventually became the Center of Alcohol Studies Library housed in Smithers Hall on the Rutgers University Busch Campus. This library houses the largest collection of alcohol literature in the world.

The Yale Plan Clinics provided a vehicle for the diagnosis and treatment of alcoholics in community based clinics instead of in institutions. The Connecticut law in 1945 was the first time a legislature enacted laws to treat alcoholism on a non-moralistic basis. The Quarterly Journal of Studies on Alcohol was the first scientific journal concerned with alcohol problems and research. The comprehensive paper published by Karl Bowman and E. M. Jellinek in 1941, "Alcohol Addiction and Its Treatment," contained discussions of the knowledge at that time on almost every known aspect of alcoholism treatment. Included were compilations of the definitions of alcoholism and alcohol addiction from

varied scholarly sources. The struggle of the semantics of alcoholism and alcohol addiction continues to the present time.

The National Council on Alcoholism (originally the National Committee for Education on Alcoholism) for the first time promoted education about alcoholism that was not moralistic. It has provided a format for educational programs and the dissemination of educational materials recognizing alcoholism as a major public health issue. The National Council on Alcoholism continues to be a viable force in the area of alcohol education and it has furnished the structure for state and local councils on alcoholism.

Jellinek proved to be a unique catalyst of the forces of Alcoholics Anonymous and the research structure that was developing. He was a likable, relaxed, creative man. The recovering alcoholics liked him and he was liked by his colleagues at Yale. Bill Wilson described Jellinek:

[He was] a live wire, Dr. E. M. Jellinek. He wasn't an MD, but he was a "doctor" of pretty much everything else. Learning all about drunks was just a matter of catching up on his back reading. Though a prodigy of learning, he was nevertheless mighty popular with us alcoholics. We called him a "dry alcoholic" because he could identify with us so well. Even his nickname was endearing--his Hungarian father had dubbed him "Bunky" which, in that language, means "little radish." The "little radish" got down to business at once. (Bill W., 1988, p. 188)

Bill Wilson related that Haggard and Jellinek had a task before them to sort out a plan of action from every faction that dealt with the alcohol problem--"a strangely assorted crowd" (Bill W., 1988, p. 188). This included prohibitionists, the liquor industry, and "sandwiched in

between these were a sprinkling of clergymen, social workers, judges, cops, probation officers, educators, and a certain number of us drunks” (p. 188). The National Committee was a success. Movies and books began to appear with themes about alcoholism (Bill W., 1988, p. 188).

In addition to providing a congenial platform for discussion and research Jellinek made significant contributions to establishing a base for research. Jellinek and Jolliffe (1940) reviewed the literature up to 1939 on the effects of alcohol on the individual. This research was completed with the Carnegie Corporation grant under the auspices of the Research Council and the Department of Psychiatry of New York University. In addition Jellinek (1942) completed a statistical on death from alcoholism in the United States in 1940. Other written contributions include Alcohol Explored (Haggard & Jellinek, 1942) which he wrote with Haggard and his own book The Disease Concept of Alcoholism (Jellinek, 1960) which became the classic text about the disease. The progression chart from this book was later modified by other scientists and is commonly referred to as the Jellinek Curve. In addition to being the catalyst of the many factions involved in alcoholism research and treatment Jellinek made seminal contributions to the research.

Individual psychiatrists were working in a variety of areas. Fleming’s (1937a) excursion to Europe was enlightening (a) in the scientific advances he observed Widmark’s test for blood alcohol concentration; (b) in the conclusion that alcoholism was complex

requiring “pooled resources” (p. 288); (c) in noting that moderate drinking was not possible for the alcoholic and total abstinence was essential; and (d) in the repeated observance of the “irrational behavior of the relatives” (1937b, p. 781). The absence of any standard of treatment in Europe was also recorded, (Fleming, 1937a, p. 288).

Tiebout (1944) provided a basic understanding for incorporating the process of Alcoholics Anonymous into the medical treatment. Tiebout’s explanation of the mechanism of surrender became the seminal article of this phenomenon in the education of both patients and practitioners. Tiebout (1944) worked diligently to help his fellow psychiatrists to understand the mechanisms of Alcoholics Anonymous and how to utilize it’s tenets for their patients.

Charles Durfee’s (1938) farm approach and the popular reception of his non-judgmental, firm and compassionate work with alcoholics was successful and progressive in implementing procedures for a restoration to physical and mental health. Alcoholics Anonymous provided the methodology for a spiritual catharsis and the change of perspectives on life from desperation and hopelessness to a peaceful acceptance of the present. The need was for a vehicle for combining all three components, (a) physical, (b) mental/emotional, and (c) spiritual or as Milton Maxwell (1962) stated, connecting the individual to his inner resources.

Knight (1938) recommended institutional treatment with psychoanalysis to search out the unconscious conflicts. The methodology

consisted of assisting the patient to realize his “emotional tensions” and other maladjustments which caused him to drink (Knight, 1937, pp. 547-548). Menninger (1938) stated, “The aim of treatment must be to help the individual achieve a psychosexual maturity with an insight into the nature of his previous methods of attempted solution of conflicts” (p. 103).

Two separate entities began emerging, the shared recovery model of Alcoholics Anonymous and the psychiatric model of which Menninger and Knight were representative. The psychiatric model brought the tenets of Freudian underlying causes with a focus on why. The shared recovery model brought the spirituality of Jung with an existential belief in purpose and a focus on how. The two groups spoke separate languages. An entirely new culture would have to be created to combine these forces.

## CHAPTER 5

### DEVELOPMENT OF THE ALCOHOLISM TREATMENT CENTER--1940-1970

Alcoholics Anonymous brought the first reliable hope to alcoholics, but many alcoholics were too ill physically, emotionally, and spiritually to be able to achieve recovery by staying in the routine of their daily lives and attending Alcoholics Anonymous meetings. For a sizable number this meant staying in the environment in which they had become ill. The 5- to 10-day hospital detoxification period was not sufficient for change to stabilize.

The first concept to be implemented was a simple country retreat run by recovering alcoholics where the process of recovery could be shared. From this practice the treatment center or rehabilitation center evolved. The format for treatment which developed in Minnesota, the Minnesota Model, became the standard for the majority of treatment centers in the United States (Yoder, 1990). Rehab has been the term often used in the 1990s to refer to the alcoholism treatment center.

## The Farm Concept--Shared Recovery

### High Watch Farm

High Watch Farm, located on the “Hill of Hope” in the Berkshire foothills of Kent, Connecticut, was the first residential treatment center to implement the principles of Alcoholics Anonymous. Ethelred Helling, following the example of St. Francis, renounced her wealth and operated a group of farms as shelters for the indigent. She was known as “Sister Francis” (Robertson, 1988, p. 28). Originally, there were three farms, one for the aged, one for children, and one for drifters (Alcoholics Anonymous Comes of Age, 1984 , p. 181). During the Depression, Sister Francis lost all of her farms except the one called the Ministry of High Watch. Recovering alcoholics from Alcoholics Anonymous stayed on this farm from time to time, and Sister Francis later acknowledged being “shocked as well as captivated by her early alcoholic visitors” (Alcoholics Anonymous Comes of Age, 1984, p. 181).

Nona W., an early Alcoholics Anonymous member, stayed at the farm. During the summer of 1939 Marty Mann sponsored a project called “Nona W,” and she took a group from Alcoholics Anonymous to the farm to establish a separate board of directors to operate the farm for the convalescence of alcoholics after hospitalization. High Watch Farm was established as a nonprofit institution and later licensed by the State of Connecticut Department of Health. High Watch Farm continues in

operation today, where a cross-section of recovering alcoholics share a simple existence and live the Alcoholics Anonymous program of recovery. “There is no beginning or ending to [the] program. At the time of admission each new guest is exactly where everyone else is at that moment of the day” (High Watch Farm, n.d., p. 10).

### Beech Hill Hospital

Beech Hill Farm was established in 1948 by “Johnny Appleseed” Supple as another “post-hospitalization facility” (Stevens, /n.d./, p. 2). Supple, a Remington Arms factory supervisor in Bridgeport, Connecticut, joined Alcoholics Anonymous in 1942 and he became an assistant manager at High Watch. He attended the Yale School of Alcohol Studies and became manager of High Watch and another facility, Bentley Brook Farm in Tolland, Massachusetts. In 1948 he began a search for his own retreat for alcoholics. With the financial help of Lillian Mahoney, the operator of a private sanitarium, Aldworth Manor in Harrisville, New Hampshire, Johnny Supple purchased the summer home of a Washington, DC, attorney, Grosvenor Backus. No guest under the influence was admitted, but a year later Marian T. Johnson began Birch Acres as a detox facility. She referred patients to Beech Hill for further treatment.

William Silkworth was 78 years old and ready to end his responsibilities at Towns and Knickerbocker hospitals when Bill Wilson

appealed to several affluent members of Alcoholics Anonymous to contribute funds to Beech Hill Farm, both to create a retirement position for Silkworth and to improve the facilities to serve as a rehabilitation center for recovering alcoholics called The Silkworth Foundation. Silkworth would be able to retire in the New Hampshire hills and continue to work with recovering alcoholics. Before the plans were completed, “the little doctor who loved drunks” died of a heart attack (Pass It On. 1984, p. 106).

An infirmary was built in 1951, and Beech Hill began accepting patients for detoxification. In June of 1972, a fully-staffed hospital was added. Ninety percent of the patients were covered by Blue Cross and other private insurance. Industrial employers accounted for 50% of the admissions. In addition to patients, the facility accommodated 70 sober guests for renewal and recuperation. Sleeping quarters for many of the 77 employees were provided at Birch Acres, which was purchased in 1973 (Stevens, n.d.).

A treatment center review in 1988 described Beech Hill as follows:

*The counseling staff is very effective, but it is the overall support personnel down to the kitchen help (all recovering) that permeate the program with a sense of health and hope. At Beech Hill one gets the sense that everyone pitches in to help each patient. . . . The education is first rate, the atmosphere will sneak up on you. The environment at Beech Hill is its trump card. (Hart, 1988, p. 299)*

According to Knapp (1996), the start of her recovery at Beech Hill began with a personal awareness: “The gift of desperation has a spiritual

quality. At some point, if you are very lucky, it dawns on you that you really might kill yourself if you keep living the way you're living" (pp. 210-211). After treatment centers became established many were willing to enter the treatment process who had been unwilling to try Alcoholics Anonymous, Knapp (1996) related:

I never considered the possibility of quitting drinking without going to rehab, never considered just buckling down and joining AA [Alcoholics Anonymous] at home. In fact, I never thought I'd end up in AA at all. I still associated AA with old men in smoke-filled rooms, images from that meeting I'd gone to five years earlier; I'd also developed a semiconscious bias against the whole concept of twelve-step programs. . . . The analogy is ridiculous, but rehab almost felt like camp to me, the way we were shuttled from activity to activity and meal to meal, the way we formed alliances, the sense of shared history and experience. Rehab sparked the good student in me, the good camper. (p. 222-223)

Knapp (1996) discussed her perspective of the "brainwashing" so often referred to as a treatment center modality.

The rehab was like an AA boot camp: . . . but I welcomed the sense of brainwashing. I felt like my brain could use good scouring out by then . . . and every time I heard someone tell his or her story at an AA meeting, I connected with some part of it, saw a piece of myself.

Rehab, in the form of AA's twelve steps, also seemed to provide a blueprint for living, something I'd always felt I needed and lacked, as though I'd missed some crucial hand-out years ago in a personal conduct class. . . . I was astonished to discover that only one of the twelve steps, the first one, mentions the word alcohol. The other eleven all have to do with getting by, with learning to be honest and responsible and humble, to own up to your mistakes when you make them, to ask for help when you need it. I remember sitting in one of many lectures that described the twelve steps and thinking, Oh! So that's how you are supposed to live. The serenity I heard at meetings seemed not only available at that moment, but attainable. (Knapp, 1996, pp. 228-229)

Rehab became the aphorism for substance abuse treatment. The sequence of events involved in incorporating the philosophy of Alcoholics Anonymous into residential centers in New England began happening across the United States. These farm rehabilitation retreats were established outside the confines of traditional medicine.

### Medicine and Alcoholics Anonymous

#### The Psychiatric Approach

Kurtz (1979) related that the “first hints of the medical profession’s acceptance of Alcoholic’s Anonymous as a respectable therapy occurred in 1943-1944” (p. 117). During an 18-month period, Bill Wilson addressed the Mental Hygiene Commission of the State of Maryland, the Neuropsychiatric Section of the Baltimore City Medical Society, and the Section on Neurology and Psychiatry of the Medical Society of the State of New York.

Bill Wilson outlined his theory of Alcoholics Anonymous to the Medical Society of New York in May of 1944:

At the very outset we would like it made ever so clear that AA is a synthetic concept--a synthetic gadget, as it were, drawing upon the resources of medicine, psychiatry, religion, and our own experience of drinking and recovery. You will search in vain for a single new fundamental. We have merely streamlined old and proven principles of psychiatry and religion into such forms that the alcoholic will accept them. And we have created a society of his own kind where he can enthusiastically put these very principles to work on himself and other sufferers. (as cited in Basic Concepts, 1944, p. 4)

In January of the same year, Harry M. Tiebout (1944) spoke before the American Psychiatric Association:

One final comment. Present day psychiatry is properly chary of purely emotional cures. Until any change is firmly linked up with the mind and the intellect, the cure is considered suspect. The emphasis today is one analysis which relies on the mind to ferret out the causes for the failure to achieve a state of synthesis, which is actually an emotional condition of feeling free of conflict and strain. It is presumed that, as the blocking emotions are uncovered and freed through analysis, positive, synthetic ones will appear instead. It is just as logical, though, to change emotions by using emotions and then after the change has been brought about, to bring the mind and intellect into play to anchor the new set of emotions into the structure of the personality. . . .

My second patient, in reference to this point, said this: "I feel all of one piece now. I feel all together, not rushing around in all directions at once."

The lesson for psychiatrists is clear, it seems to me. Although we admittedly deal with emotional problems, we, as a group which tends to be intellectual, distrust emotions too much. We are self-conscious and a little ashamed, when we are forced to use them, and always apologetic with our confreres if we suspect they have reason to think our methods are too emotional. In the meantime, others less bound by tradition, go ahead to get results denied to us. . . . We may be wearing bigger blinders than we know. (p. 473)

### The General Hospital Approach

In 1945 Knickerbocker Hospital in New York was one of two hospitals in the city providing an Alcoholics Anonymous ward. The other program was at Towns Hospital, and both were supervised by William A Silkworth (Alcoholics Anonymous Comes of Age, 1984, p. 206). The program was described in an article in Trustee:

Physicians and officials at Knickerbocker were skeptical that day in April 1945, when representatives from local Alcoholics Anonymous groups asked their help in providing care for prospective members. . . .

Many thought it inadvisable to admit inebriates because they are reputedly noisy and unruly patients. Some said that alcoholics do not belong in the general hospital because their affliction involves more than physical illness. . . .

For its part, the hospital offers an individualized course of treatment to each patient. One physician devotes his time to medical therapy; another is concerned with the mental and emotional problems unique to alcoholism. The average length of stay is five days.

By April 1946, over 1,000 chronic drinkers had received treatment . . . today 16 to 18 beds are reserved for alcoholics.

In the past few could afford the expensive rates of private sanitoriums and they avoided even more the stigma attached to mental hospitals. ("Help for the Chronic Drinker," 1948, p. 13)

Visitation restrictions were strictly enforced, and no family, friends, or business associates were allowed to visit the patient. There was no visiting between the sexes, including visiting Alcoholics Anonymous members. Marty Mann (1948), in an article written for Southern Hospitals discussed the reasons for general hospitals to admit alcoholics under the correct diagnosis:

There is probably no hospital in the country which has not had alcoholic patients at one time or another, even though the cause of their admission may read "bronchitis," "neuritis," "gastric disturbance" or some other ailment. The danger in this sort of double-talk lies in its ineffectiveness to the patient and its possible eventual nuisance to the hospital . . . the undercover method does not allow the treatment to have any constructive direction, or to lead anywhere at all, save perhaps to the creation of a repeater who will come to use the hospital as a convenient and comfortable sobering-up place. (Mann, 1948, p. 3)

The hospitals utilized information from the Yale Plan Clinics in implementing the program. Three groups of alcoholics were identified in clinic research at Yale: (a) those who drink as a symptom of another disorder, epilepsy, psychosis, or psychopathic personality, estimated to be 40%; (b) those who use alcohol as a way of life--most prevalent is the decadent-type personality that results from generations of inbreeding; (c) those of average or better intelligence who have some degree of intelligence and were fairly well adjusted before the addiction ("Help for the Chronic Drinker," 1948, p. 14). The general hospital provided a place for treatment for many who were unable to afford the expensive private sanitariums.

#### International Doctors in Alcoholics Anonymous

International Doctors in Alcoholics Anonymous (IDAA) began in 1949 in the garage of Clarence P. in upstate New York. Geraldine Delaney stated that it was one of the most significant factors in acquiring medical support and care for alcoholics (G. O. Delaney, personal communication, July 11, 1995). Early attendance by three doctors from Canada as well as a psychologist made the group both international and interdisciplinary.

Since 1949, IDAA meetings have been held in major cities around the continent. These meetings have had a family focus, with strong Al-Anon and Ala-teen components since 1975. There are small group

sessions, with special recovery interests, couples, communication, and state-of-the art scientific presentations in the field of alcoholism, which often precede the main meeting.

The basic purpose is to carry the message of recovery to other alcoholics, especially alcoholic doctors and their families. There are weekly meetings and regional yearly meetings as well as the national meeting in August. As of 1996 the group numbers over 5,500 women and men who hold doctorates in the health care professions, physicians of every specialty, dentists, and educators. The membership of this group lends itself to being able to work for continued improvement of care for the alcoholic and the family of the alcoholic (C. R. Mc. K., personal communication, April 16,1996).

Maxwell Weisman was made an honorary member of IDAA many years ago for the significant contributions he made in the treatment of alcoholism. Although not an alcoholic himself, he is one of those individuals who has been able to grasp the essence of the disease to help others to recover. It has not been possible to evaluate the therapeutic energy of an individual in the treatment of alcoholism or in any other medical situation, but it is known that some individuals possess a therapeutic understanding that is positively translated to the patient.

The treatment of alcoholism has created a bilingual population: those who speak the language of science and those who speak the language of recovery. Members of IDAA are bilingual, and this has

provided valuable assistance in all aspects of treatment, research, and outcome study (M. N. Weisman, personal communication, January 5, 1996).

### Alcoholics Anonymous and the Lasker Award

The American Public Health Association presented the Lasker Award to Alcoholics Anonymous in 1951 for its approach to the public health problem of alcoholism. The award, stated in part:

Alcoholics Anonymous works upon the novel principle that a recovered alcoholic can reach and treat a fellow sufferer as no one else can. . . .

This is not a reform movement, nor is it operated by professionals who are concerned with the problem. It is financed by voluntary contributions of its members, all of whom remain anonymous. There are no dues, no paid therapists, no paid professional workers. It enjoys the good will and often the warm endorsement of many medical and scientific groups --no mean achievement in itself for any organization run entirely by laymen. (Alcoholics Anonymous Comes of Age, 1984, p. 301)

This award recognized the impact that Alcoholics Anonymous has had and continues to have on the problem of alcoholism in the public sector. It also acknowledged Alcoholics Anonymous' ability to cooperate with other entities, both professional and civic, to more effectively confront alcoholism.

## Public Clinics: Indigent and Outpatient Treatment

### The Public Clinic

Connecticut was the first state to enact legislation to provide for education, treatment, and support for recovery from alcoholism. The Connecticut Law of 1945 provided for a separate board to administer these services on behalf of the state's inebriates (Bacon, 1945/1946). The state was the first, in 1830, to issue a report concerning the feasibility of institutional treatment of alcoholism. Walnut Hill Lodge opened in 1878, first as a workhouse hospital for alcoholics and later was a private hospital operated under the supervision of T. D. Crothers. In 1941 the Connecticut State Farm for Inebriates was closed because the expenses could not be justified by the outcome.

Reasons for reconsidering the issue of closing the farm were outlined by sociologist, Selden Bacon (1945/1946):

1. drastic need for workers following the closing of the farm
2. increasing publicity about the success of AA
3. the program of research and teaching at Yale
4. the cooperation of the state prison system in the Yale

#### Clinics

5. the creation of the National Committee for Education on Alcoholism. (pp. 190-191)

The Connecticut law provided for the creation of a multidisciplinary state authority to handle the problems of alcoholism, recognizing that alcoholism should include experts from many disciplines:

It is noteworthy that those psychiatrists most successful with alcoholics make full use of non-medical therapists and Alcoholics Anonymous. If a successful attack is to be launched against the complicated problem of alcoholism, the cooperating skills of physicians, psychiatrists, social workers, lay therapists, ministers, vocational counselors, judges, sheriffs, probation and parole

officers, family counselors, psychologists, former alcoholics and many others will be needed. (Bacon, 1945/1946, p. 197)

The Connecticut legislation was financed by an increase of liquor license fees and grants. The board to administer the new law was given great latitude of action, and the medical and executive functions were separated in order not to encumber an excellent physician with operational details that might be outside his or her area of expertise. The Yale Plan Clinics provided experience to advise the board's course of action.

The Blue Hills hospital facility in Hartford, Connecticut, was the first publicly supported facility for the treatment of alcoholism in this country. It operated in conjunction with five community outpatient facilities in outlying areas. Opened by the Connecticut Commission on Alcoholism on April 17, 1950, its primary function was in "assisting the alcoholic to reorient himself under medical supervision . . . or at time when emotional tension is mounting and control in sobriety is threatened" (Walcott & Straus, 1952, p. 61). The program maintained cooperation with Alcoholics Anonymous, community agencies and members of the clergy.

According to Johnson (1973), "In 1947, Congress passed the Alcoholic Rehabilitation Act providing for the establishment of alcoholism treatment clinics in the District of Columbia," stating that "alcoholism was an illness" and that "appropriate medical, psychiatric,

and other scientific treatment” should be provided instead of criminal punishment (p. 104). Under the Truman administration, no funds were appropriated for the clinics. The funds were not appropriated until the Johnson administration in 1966. In 1958 Eisenhower’s Secretary of Health, Education, and Welfare, Arthur Fleming, issued a formal statement declaring alcoholism to be the fourth major health problem in the nation; no funds were appropriated and no policies or programs initiated (Johnson, 1973, pp. 104-105).

### The Salvation Army

The Salvation Army alcoholism treatment program and the Washingtonians were the two earliest groups to “show concern for the person affected” (Royce & Scratchley, 1996, p. 35). Originating in London’s East End in 1865, the Salvation Army spread rapidly throughout Britain and to the United States in the latter part of the 19th century. The Salvation Army has consistently dealt with the alcoholic through its several institutions. The Men’s Social Service Centers were the most active branch in treating the alcoholic during this period. In addition to providing the basic necessities and mission evangelism, the centers kept abreast of the development of treatment methods (Judge, 1971). According to Katz (1964), in 1961 there were 124 service centers in the United States, and over 57,000 men, 80% of whom were estimated to have alcohol problems, participated in these programs. This is a

significant figure as Katz's figures indicated that, in 1959, only 20,000 to 30,000 men were treated throughout the United States.

Judge (1971) described the program:

The treatment effort is multifaceted, involving detoxification services, milieu, group and individual psychotherapy, didactic sessions designed to change attitudes, reorientation to a "new way of life" through counseling and religious programs, and a conditioning of the resident, through work therapy, to the responsibilities of holding a steady job. . . .

A client is said to have "worked" the program, at least minimally, if he attends the 12-week series of didactic sessions and participates in at least one other treatment activity decided upon in consultation with a staff member. (p. 463)

Katz (1964) attributed the lack of research about the Salvation Army program to the self-sufficient character of the organization and the fact that the majority of the personnel were nonprofessional. Judge (1971) found that during this period physicians, nurses, psychologists, sociologists, and lay alcoholism counselors were all a part of the treatment team.

Blumberg, Shipley, and Shandler (1973) perceived the relationship between the missions, including the Salvation Army, and the inhabitants of Skid Row to be one of "mutual exploitation" (p. 87). The mission's goal was religious, and the men resented being forced to participate in the services in order to have the benefit of the facilities. Due to the lack of hospital beds for the indigent, when men suffering from alcoholism, who were not in a medical emergency condition, appeared at the hospital they were referred to the Sally (Salvation Army). Residents of the

Salvation Army were attending Alcoholics Anonymous meetings in the earliest years when the first meetings were being held in the Wilsons' Clinton Street house (Pass It On, 1984).

### Differing Attitudes About the Meaning of Alcoholism as a Disease

Marty Mann and the group at Yale--Howard Haggard, Ray McCarthy, and Selden Bacon--had different purposes for their endeavors. Haggard, McCarthy, and Bacon were interested in the way alcohol and the problems associated with it were viewed by the public. Marty Mann was interested in popularizing the disease concept. Mann approached the problem with the simplistic view that the physiological basis for alcoholism was an established, scientific fact. Both groups continued to travel across the country speaking at educational programs (Johnson, 1973, p. 290).

Jellinek was popular with Alcoholics Anonymous audiences, and he gave his full support to the causes presented in the book he wrote with Haggard. He stated that the first truly medical view of the disease was that of Thomas Trotter in 1804 (Haggard & Jellinek, 1942/1954, p. 142). Trotter (1813/1941) said that "the habit of drunkenness is a disease of the mind. The soul itself has received impressions that are incompatible with its reasoning powers" (p.584).

Haggard and Jellinek (1942/1954) held that the two great misconceptions were that all habitual excessive drinking was a disease

and that it was the same disease (p. 143). They also pointed out that the alcoholic is more selfish, conceited, and hence more antisocial than the average normal individual (p. 154).

Haggard's view was stated in an article in the May 1947 issue of The Federator:

When alcoholism is regarded as a volitional act, as a bad and vicious habit, the alcoholic is treated accordingly. . . . The majority of medical institutions refuse to admit him except for the treatment of concomitant diseases and offer no therapy for alcoholism. . . .

The rise and popular acceptance of the concept of insanity as an illness constituted one of the great humanitarian and medical reforms of the 19th century. We must have a similar one in this century for the alcoholic.

Insanity is now without reserve, accepted as an illness. This acceptance has not waited upon the establishment of a somatic, a physical basis for the symptoms from which the psychosis are diagnosed. Insanity is an illness, but many of the symptoms shown by the psychotic in the form of anti-social behavior may also be exhibited by the non-psychotic. Misbehavior in general is not excused because misbehavior is based on illness, and all drunkenness is not to be forgiven on the basis that drunkenness is an illness. It is not; only alcoholism--or if you prefer, compulsive drinking, is an illness. (as cited in Johnson, 1973, pp. 291-292)

According to Johnson (1973), Bacon believed that Alcoholics Anonymous was the answer for only a small percentage of alcoholics, and he became "increasingly disenchanted with the emphasis of Alcoholics Anonymous" (p. 307). By the late 1940s Bacon was openly critical of Alcoholics Anonymous and promoted the pursuit of a variety of different approaches to the alcohol problem.

### The Minnesota Model

The term, Minnesota Model, has evolved to exemplify the multidimensional, comprehensive, abstinence-based treatment based upon the principles of Alcoholics Anonymous. Hazelden in Minnesota is credited with originating this particular treatment modality. The origins were in several separate treatment centers and Hazelden was the focal point where all of these converged. Hazelden is probably the most widely known treatment center in the world. Hazelden, with its giant publishing arm, training facilities, and large patient capacity exemplifies alcoholism treatment (Toft, 1995).

On December 12, 1872, Charles N. Hewitt, Secretary of the Minnesota Board of Health, first declared alcoholism to be a public health problem in Minnesota in a report entitled "The Duty of the State in the Care and Cure of Inebriates." This report emphasized the need for treatment rather than punishment and the necessity for prevention, especially with young people. ("Minnesota Mobilized to Combat Alcoholism," 1955, p. 1)

The Minnesota Model originated through the endeavors of three separate Minnesota treatment facilities: Pioneer House (established in 1948), a city alcoholism rehabilitation facility; Hazelden (established in 1949), a small private treatment facility; and Willmar State Hospital (established in 1950), a public mental institution. "Each was destined to become a model of effective, economical treatment" (Anderson, 1981, p.

6). Engelmann (1989) wrote that, according to an article in the Journal of the American Medical Association, “almost 95% of treatment centers in the United States are based, albeit some loosely, on the ‘Minnesota Model’ approach. That model was originally developed . . . at Willmar State Hospital, and later refined at the Hazelden Foundation Treatment Center” (p. 4).

#### Pioneer House: 1948

The beginnings of modern alcoholism treatment in Minnesota, like those in the East, started with recovering alcoholics. Patrick Cronin was a full-fledged alcoholic by the age of 36. In the summer of 1940 he read a review of the Alcoholics Anonymous (1939) and wrote to the General Service Office to see if there were any Alcoholics Anonymous members in Minnesota. There were none, and it was suggested that he contact the group in Chicago. On November 9, 1940, two members of the Chicago group to whom his name had been given “barged in” on him. A blizzard hit the next day, and they had 4 days to spend with him. His sobriety date was November 11, 1940, and 450 groups in Minnesota trace their beginnings to his influence (McElrath, 1987, p. 11). In 1948 Cronin was also instrumental in founding the first treatment center to combine the philosophy of Alcoholics Anonymous and the moral concept of treatment in the state of Minnesota--Pioneer House.

Pioneer House was established by the Division of Public Assistance, Board of Public Welfare of the City of Minneapolis. Recognizing that alcoholism was a major contributory factor to poverty, juvenile delinquency, and crime, the relief department in Minneapolis was aware that no consistent program existed for rehabilitation of alcoholics. The case of one man who had been on the welfare rolls for 10 years and was rehabilitated through Alcoholics Anonymous in 1942 was the impetus to instigate such a program. Since his rehabilitation in 1942, the man had remained sober and the entire family was self-supporting (Shepherd, 1950, p. 351)

The program consisted of the combined efforts of several entities, the Vocational Guidance Service of the Department of Welfare, the Union City Mission and the Mission Farms, and Alcoholics Anonymous. Originally, property for the facility was purchased in a residential district. When the residents heard that the "Bowery Boys" were moving in, the purchase was canceled (Shepherd, 1950, p. 354). It was at this juncture that plans were made to utilize facilities on the Mission Farms. A cash fund was established by "Cronin's Cronies" to purchase incidentals needed by the men.

A member of Alcoholics Anonymous with 9 years sobriety was hired as director. The new director went to New York to consult with the Alcoholic Foundation, the governing board of Alcoholics Anonymous. The foundation approved of the idea and suggested methods to remain

consistent with the traditions of the fellowship, meaning that members of Alcoholics Anonymous participated as individuals and that all persons were welcome at their meetings. Inquiries were also made about Bridge House, a similar facility in New York, and Portal House, in Chicago. The first client was accepted in October 1948, and occupational therapy began immediately (Shepherd, 1950, p. 354).

From October 5, 1948, through December 31, an unduplicated count of 237 guests participated in the program; 22 repeated once and 1 repeated twice. The average age was 43.6; about 50% were married; and more than 50% were either skilled, clerical, professional, or high semiskilled workers. As of December 31, 1949, 22 were still guests, 166 had left cooperatively, and 49 left uncooperatively. Of the total who left 34.9% were sober and fully supporting and another 25.6% were sober and fully self-supporting after one relapse (Shepherd, 1950, pp. 356-357). According to McElrath (1987), Pioneer House later built an extension, which was purchased by Hazelden in 1981 (p. 160).

#### Hazelden--1949

After Cronin became sober he helped many others to attain sobriety. One person he helped was a Catholic priest, named Father M., who had been a patient at Willmar State Hospital in 1942. Father M. referred to the hospital as a "swill hole." Cronin introduced Father M. to Austin Ripley, a prominent journalist and a convert to Catholicism.

Ripley, also recovering, had helped many priests, and he became interested in providing some assistance for alcoholic clergy. In 1947 visiting with Lynn Carroll, a recovering lawyer, and Robert McGarvey, owner of McGarvey's Coffee the plan for a treatment center for priests began. Carroll and McGarvey wanted a center for all professionals, but Ripley prevailed. He went to Cardinal Spellman in New York, who believed the problem of the alcoholic priest should not be acknowledged to laymen. Archbishop Cushing in Boston received Ripley's idea with encouragement but no financial support (McElrath, 1987, pp. 13-14). Archbishop Murray of St. Paul, who believed in the disease concept and had compassion for alcoholic priests, wanted to help. Ripley wanted to name his center Guesthouse, presumably after the Cistercian Guesthouses in the monasteries in Europe (as cited in Daly, 1989).

Carroll, McGarvey, and Jack Kerwin found the Power estate as an ideal site for the center. Charles Power of North Branch, Minnesota, had purchased the property in 1925, the year he married Hazel Thompson whose family owned Pioneer Press Publishing Company. From that time on, the farm was called "Hazel"-den after Power's wife. When Carroll, McGarvey, and Kerwin decided it was premature for the Catholic church to accept an Alcoholics Anonymous-oriented treatment center, Ripley withdrew. Because Ripley had already appropriated the name Guest House, the corporation simply used Hazelden as the official name (as cited in McElrath, 1987).

Austin Ripley continued to work with alcoholics and later established Guest House for Catholic priests in Lake Orion, Michigan. The facility opened to women, and another Guest House was opened in Rochester, Minnesota. The facility in Lake Orion closed to men in 1994, and today it operates exclusively for women in Catholic religious orders.

Richard Coyle Lilly was a well-known Midwestern banker. After an automobile accident in which he ran off a bridge, he decided to stop drinking. In 1947 he was interested in building a treatment center for clergymen of all denominations. He arranged for the money to purchase the Power farm and became the first president of Hazelden (McElrath, 1987, pp. 16-27). Hazelden officially opened its doors May 1, 1949, although one patient was admitted in April. Because of his outstanding work with other alcoholics in Alcoholics Anonymous, Lynn Carroll was asked by Lily to be the director.

Carroll, a lawyer, was a member of the first Alcoholics Anonymous group in Minneapolis. Logical, dedicated, and intelligent, he was both an excellent lecturer and counselor. There was no model to follow for a program. Carroll's idea was to provide an environment where the men could learn about Alcoholics Anonymous after they were dry. He confronted the issue of not having a psychiatric or psychological background:

There were a lot of problems I hadn't learned to work out quite right. And then I got to think--what the dickens! I had psychiatrists and psychologists and they didn't do me any good and I didn't

know any other alcoholic that they ever did anything for. (Carroll, as cited in McElrath, 1987, p. 31)

According to McElrath (1987), Carroll's concerns about the "insidious intrusion of psychological principles into the AA program" continued to be a problem between him and Hazelden, despite the center's strong growth (p. 31). Outcome evaluation was important from the beginning at Hazelden. Carroll reported to the board that, as of December 15, 1950, 156 men had been to Hazelden. There had been 300 admissions. Hazelden was and continues to be a "haven for repeaters, especially today when it is often seen as the resource of last resort" (McElrath, 1987, p. 32). In the first year and a half one man was admitted 15 times, not because he relapsed, but to avoid relapse. Later the aftercare and renewal programs provided for these needs. Of the 156 men, 78% had recovered. Carroll related:

Our means of determining and keeping in touch with patients who have left is an excellent one as our AA contacts usually report on those men from time to time. This includes men from neighboring states who have been directed to Hazelden by their doctor, or by AA contacts. Some of the men as far away as Montana have returned for visits while they are in the city. There are a few however, whom we have been unable to trace and those number fourteen, or 8.8 percent of the men who have been patients at Hazelden.

In some cases there seems to be an inclination to have one experimental drinking bout after leaving Hazelden, but this seemed definitely and finally to decide for the patient that he could never drink again. (as cited in McElrath, 1987, p. 32)

Another interesting point was Carroll's comparison of the success ratio between the recipients of the Lexington-Hill Grant and the private-

pay patients. Louis Hill was a railroad industrialist who provided funds for patients who could not pay. The men on the Hill Grant stayed 4 weeks and the others stayed 2 weeks and 5 days. The chances of recovery significantly increased with the extra week or two. Of the 12 men receiving grants 10 recovered, 1 relapsed and recovered, and 1 was still drinking. Eleven of the 12 were active in Alcoholics Anonymous (McElrath, 1987, p. 33).

A. A. Heckman was one of the original incorporators of the Hazelden Foundation. He was a “personal friend, consultant, and advisor to R. C. Lily” (McElrath, 1987, p. 33). It was Heckman who saw the benefits to the community of excellent alcoholism treatment, and he suggested the grant proposal to Hill. Heckman also believed from the beginning that the treatment needed to be multi-disciplinary. At the beginning Heckman stated, “Alcoholics Anonymous should be a part of the program, but not all of it” (as cited in McElrath, 1987, p. 34).

Two years after the program began, Heckman determined three factors to account for the success: Carroll’s skills as a lay therapist, the incorporation of the Alcoholics Anonymous philosophy, and the special environment. Heckman stated:

I think we all agree that the effectiveness of the treatment at Hazelden is due, to a large extent, to the unusual skill of Lynn Carroll. This is fine, except that we do not know to what extent the skills possessed by Carroll can be taught to others. Unless this is determined, Hazelden faces a big risk and is in a dangerous position should anything happen to Carroll. One always should

feel insecure about a program the success of which is dependent solely upon one person.

If it can be discovered that Carroll's techniques and skills are transmittable to others through teaching and understudying, then steps should be taken to develop several understudies--not only for the sake of Hazelden, but to aid other programs such as Pioneer House and the program at the state hospital in Willmar.

It would seem to me that it would be wise to start now trying to identify those elements in Carroll's skills which can be taught to others. Here again the University of Minnesota might well be the source of such professional research assistance. (as cited in McElrath, 1987, p. 36)

Heckman urged collaboration with the University of Minnesota, not only for training, but for developing a relationship with the medical school and the departments of psychiatry, sociology, and psychology for research purposes. Heckman was a visionary who encouraged and supported expansion and development. Lilly, Carroll, and Heckman were the "triumvirate" on which Hazelden was built. Lilly supplied the initial financial backing, Carroll provided the fundamental philosophy and long-term effort, and Heckman had the vision of continued growth and challenge (as cited in McElrath, 1987, p. 37).

The initial medical component at Hazelden was "present but primitive" (McElrath, 1987, p. 44). The detox routine was to let them sleep it off. "Convulsions were common. Staff and patients would sit on a man and put a clothes pin in his mouth" (McElrath, 1987, p. 45). Group conscience and peer pressure were used as a deterrent to men sneaking in contraband.

Only half of the operating costs were covered by patient revenue. In January 1950 there had been four or fewer patients per week, and seven to eight were needed to cover costs. As a result, the payment could not be made to the Coyle Foundation, as Richard Coyle Lilly had arranged when the property was purchased. Lilly was disappointed that priests were not coming to Hazelden, and he was generally dissatisfied that the facility was not able to make the payment. Lilly believed that the Sisters of St. Joseph could manage the focal program and the recovering alcoholics could implement the Alcoholics Anonymous education.

Lawrence Butler was the first patient admitted to Hazelden, on April 21, before the center officially opened in May of 1949. Lawrence was elected to the board of trustees shortly after his release. His brother Patrick was a patient once in 1949 and once in 1950. Emmett Butler, the father of Lawrence and Patrick, had stopped drinking himself in 1945. He was interested in Hazelden because of his sons. Lawrence and Patrick encouraged Carroll to meet with their father for financial assistance. The three held a conference in the elder Butler's office while Carroll waited outside. The Butlers agreed to assume the financial responsibility and also to be actively involved in the operation. Patrick Butler had been interested in the work that was going on in alcoholism treatment at Willmar State Hospital, and he decided to form an advisory council for Hazelden. According to McElrath (1987), through Patrick Butler's

support and interest, Hazelden became a household word in the Midwest, and by 1952, it was in a “secure and settled stage” (pp. 54-56).

Patrick Butler originated the halfway house concept with the establishment of the Fellowship Club in 1953. This idea evolved from his work with Nelson Bradley at Willmar. Orv Larson, who operated Fellowship Club, created an outstanding job-referral network. In May 1956 property was purchased to establish a treatment center for women. Butler chaired the Minnesota Advisory Board on Problems of Alcoholism. He believed that women alcoholics were not receiving assistance and treatment and that they needed a dignified environment for recovery. Much later a family treatment and a renewal center were added to the Hazelden facilities.

In 1953 at a dinner in his home, Butler proposed to Nelson Bradley and Dan Anderson that he would help finance their educations if they would work to assure the future of Hazelden. Anderson completed his master’s degree in clinical psychology at Loyola University in Chicago while working on his doctorate at the University of Ottawa in 1956 and 1957. He became an important member of Bradley’s team at Willmar. Anderson recalled: “All I know is in the early days of alcoholism [treatment] I was considered an inferior professional person working with alcoholics--and was looked down upon” (as cited in McElrath, 1987, pp. 84-85).

Hazelden's venture into publications began early in its development. The first brochure about Hazelden, Guesthouse, was written by Austin Ripley before the decision was made to broaden the scope of the patient population, and was never really used. The second brochure, Inspiration for Recovery, was published in 1952. Hazelden's publishing empire was launched by a recovering alcoholic named Richmond Walker of Daytona Beach, Florida. Rich was a magna cum laude graduate of Williams College and a successful businessman in Boston. By 1939, because of his alcoholism, he had lost his home on Beacon Hill, his summer cottage on Nantucket, and his family. He discovered the Oxford Group and abstained for 30 months. After relapsing, Rich became involved with Alcoholics Anonymous and was sober for 23 years until his death in 1965 (as cited in Toft, 1994, p. 1-2).

Rich attributed his sobriety to the Alcoholics Anonymous philosophy of taking life in 24-hour doses. To enhance this process he wrote Twenty-Four Hours a Day with a reflection, meditation, and prayer focused on a single theme for each day. In the original forward to the book he wrote, "If we don't take that first drink today, we'll never take it, because it's always today" (as cited in Toft, 1994, p. 2). Few books had been published for recovering persons at this time; Alcoholics Anonymous was the primary resource. Rich had printed and distributed about 18,000 copies himself. He approached Alcoholics Anonymous World Services to take over the publication and they declined.

When Rich W. approached Patrick Butler in 1954, Butler had the vision to accept. Hazelden printed 5,000 copies, which vanished in a year. By 1994 there were 8 million copies in 13 countries. From this beginning, the Hazelden Publishing empire began. "The earnings from the sale of the Twenty-Fours Hour a Day book were considered as balancing out the Fellowship Club's deficit" (McElrath, 1987, p. 117).

By 1967 the Hazelden's Publishing and Distributing Department was a part of the Business Division. During the 1970s Hazelden's Mission Statement also included "education (literature) and training" (McElrath, 1987, p. 138). Profits from publications later accounted for Hazelden's ability to survive the drastic cutbacks that treatment facilities experienced in the late 1980s and early 1990s. Bibliotherapy has consistently been a major component of the alcoholism field; as Nelson Bradley observed, alcoholics are readers.

Patrick Butler continued to be closely involved with the activities of Bradley and Anderson at Willmar. According to McElrath (1987), in 1957 Butler asked Dan Anderson to lecture at Hazelden 1 day a week and, in 1961 Anderson became vice president of Hazelden and the chief executive officer. This was a challenge to Lynn Carroll, whose charisma had brought Hazelden into being. According to McElrath (1987), Anderson represented psychology and the Yale School of Alcohol Studies, and from 1957 to 1961 Anderson's presence had been "tolerated but not appreciated" (p. 103). The Hazelden Newsletter made no

announcement of Anderson's position. McElrath attributed this to Anderson's modest and retiring nature and to the negative reaction to a psychologist's being hired as a full-time executive officer.

### Willmar State Hospital

Willmar State Hospital originally opened as a state inebriate hospital, accepting inebriates from the entire state of Minnesota with the exception of the northeastern counties. As it did with other inebriate hospitals, the passage of the Volstead Act in 1919 suspended alcoholism treatment (Corwin & Cunningham, 1944). While continuing to accept commitments, there was no treatment. The hospital began accepting mental patients and was primarily a custodial hospital when Nelson Bradley came there in 1950. Bradley described the initial physical situation:

It had become essentially a custodial mental hospital. The total number of patients is currently 1,300, of whom approximately 1,100 are mental patients and 200 are inebriates [totalling 1,960]. The average daily inebriate population ranges from 150 to 200 men and from 15 to 20 women. The inebriate treatment program . . . has been in operation, in expanding form, since July 1950. (as cited in Rossi & Bradley, 1960, p. 432)

As young medical student Nelsen Bradley was driving from Saskatchewan, Canada, to complete the last year of his residency in a Michigan hospital, car trouble and a shortage of funds caused him to take a position at Hastings Hospital in Hastings, Minnesota. There he became friends with a college student, Dan Anderson, who was working

as a night attendant. Both men were impressed with the ideas of the hospital superintendent, Ralph Rossen, who was later Commissioner of Mental Health in Minnesota. Rossen's philosophy was "to focus on each single day in the life of a patient, always trying to improve the quality of that life" (as cited in McElrath, 1987, p. 71).

Bradley took the superintendent's position at Willmar State Hospital in 1950 and persuaded Dan Anderson to come with him as recreation director. Bradley said:

It's a 1,600 bed hospital, still a snake pit, but I think we can fix it up. They also have 30 to 40 "inebs" [inebriates] there. He asked Anderson if he knew anything about "inebs."

As expected of a young college student, Anderson replied: "No, we'll look it up though and see what it is." (as cited in McElrath, 1987, p. 71)

Bradley's first move was to unlock the doors to the alcoholic ward. Before this 22% were running away, and after the doors were unlocked, only 6% left. In the fall of 1951, Bradley began a series of workshops, and invited physicians, nurses, clergy, social workers, and members of Alcoholics Anonymous. Bradley also started lectures to educate the patients about Jellinek's stages of alcoholism. By the end of 1952, Alcoholics Anonymous people were coming to the hospital after work to lecture and visit with the patients. According to McElrath (1987), Bradley "surreptitiously" hired Mel B. of the Midwest Alcoholics Anonymous group as one of the hospital's "employed Patient Agents" (p. 73). In 1953 Bradley requested the Minnesota Civil Service

Commission to hire recovering alcoholics as alcoholism treatment counselors, and in 1954 the commission created the position of Counselor on Alcoholism.

Now, in 1954, the hospital had nondegreed Counselors on Alcoholism who were lay people--recovering alcoholics--sharing responsibility for a treatment program and having an equal say with psychiatrists, psychologists, and physicians. It is difficult today to imagine how radical a change this was, to go from a physician-oriented, psychoanalytic hospital to a treatment program conducted by "drunks." (as cited in McElrath, 1987, p. 74)

The peer group, a small, leaderless group of patients, was another treatment strategy which began at Willmar. The mutual assistance and support of patients facing similar problems was found to be beneficial (McElrath, 1987, p. 74). Hazelden later developed the peer evaluation or "hot seat," in which the peer group evaluated and helped an individual member to become more aware of all of the facets of his or her person. According to Yalom (1985), in the 1960s the Johari window, developed by Joe Luft and Harry Ingram, illustrated the "four-celled personality paradigm which clarified the function of feedback and self-disclosure" (pp. 493, 573).

Jean Rossi [clinical psychologist at Willmar] recalled that everyone was willing to give up their professional elitism in a common cause. They could not take their professionalism (which is not the same as their professional knowledge) too seriously. As the group personality developed, it maintained a principal ingredient: survival depended upon a sense of humor.

The group camaraderie was a unique experience. According to [Dan] Anderson:

Everybody called everybody else, patients and staff alike, by their first names; drinking experiences and alcoholic histories were

dramatically revealed at the slightest provocation; advice was freely given based on one's own experiential background of alcoholism and recovery; hope and enthusiasm were openly expressed about the good prospects that most patients had for recovery; and coffee was consumed day and night. (McElrath, 1987, pp. 76-77)

In 1956, in an interview with S. R. Laycock, retired Dean of Education at the University of Saskatchewan, Nelson Bradley outlined the program at Willmar and shared some of his insights in working with alcoholics:

The first step . . . is to restore body functions. Sedatives of one kind or another are used. . . . The hospital starts with a minimal amount and then ups it to a proper dose--not just one shot.

The next step is replacement therapy by the use of vitamins, minerals, fluids, and even plasma and whole blood. . . .

Once the patient is on his feet the hospital starts on its program. It has faith in its 30 orientation lectures which it repeats every six weeks. . . .

The hospital has a Toastmaster's Club (part of a state-wide club) where patients give two- and five-minute speeches, act as guest speaker and chairman. They can discuss any subject other than alcoholism.

The hospital doesn't use art therapy with alcoholics; rather it is used with schizophrenics. The alcoholic is meticulous and self-demanding. If he gets into art work and isn't satisfied, he defeats himself again and again. A good avocation for the alcoholic is not art but possibly music, and certainly music and art appreciation. Gardening is suitable for alcoholics who like beautiful things but are not really creative persons. They get satisfaction in gardening. A rose is beautiful without too much fussing. Alcoholics are very interested in reading. They should have a regular reading room with leather chairs, etc. Alcoholics are excellent speakers. They are in many ways like kids. There is no evidence that, in male alcoholics, there is more homo-sexuality than in the ordinary population. This may not be true for women. Actually male alcoholics are sexually naive, in spite of being promiscuous. The alcoholic's excuse for drinking is often denying that he does drink. He denies his problem (denial is one of the chief mental mechanisms to handle anxiety). (as cited in Laycock, 1956, pp. 2-3)

Bradley also considered the family. He classified the wives of alcoholics into three groups: (a) the “heroic wife”--whose character, stamina, and stability meet the challenges of her husband’s increasing inadequacy; (b) the “secondarily neurotic wife”--self-pitying, whining, demanding, dependent, aggressive; and (c) the “primarily neurotic wife”--(accounts for one third of the wives); it was thought that something was wrong with them that caused them to be attracted to the alcoholic (Laycock, 1956, p. 4).

According to Laycock (1956), Bradley advised the wives in the first group to give up their jobs when their husband returned to earning a living. The second group he believed was susceptible to counseling and help. About the primarily neurotic, he was very pessimistic. These were the wives who would have their husbands committed and return the next day to demand their release. About these primarily neurotic wives, research was being undertaken.

The hospital had a rule, “three times and out.” Bradley thought that the odds after three attempts were significantly lowered. The hospital’s experience with criminal alcoholics was poor. Bradley stated that criminals should remain in prison and receive rehabilitation there. He believed that the “real satisfaction” for the alcoholic was in the “reduction of their anxiety” (as cited in Laycock, 1956, p. 4).

When asked about the pre-morbid conditions of alcoholism Bradley stated that it could range from feeble-minded, to psychotic, to normal:

A so-called normal person can become an alcoholic. If there is a predominant group, it is the neurotic group. There is a big element of psychopathic behavior and especially character disorders, and problems of dependency and aggression. Some successful businessmen and politicians suffer from a character disorder. The difference in the alcoholic, possibly lies in the level of anxiety. They are tremendously anxious people. (Problems of insecurity and inadequacy.) Ordinary anxiety reducing mechanisms are not adequate for the alcoholic. Sedation is not adequate. The smart thing for him to do is to deny his anxiety. This he does by anaesthesia, since alcohol is an anaesthetic agent. . . . The magic of alcoholism is that the individual cannot discriminate anymore.

Why does the alcoholic drink when he knows it means disaster for him? Dr. Bradley explains this by a simple learning theory. In order to have a learning situation, you must have motivation, practice, and reward or punishment. For the alcoholic the motivation is anxiety. He gets practice in his drinking. His reward is release from tension--not the other rewards claimed. . . . The hangover is a punishment, it is true, but it comes twenty-four hours later. One attempt at immediate punishment . . . is Antabuse. . . . The hospital at Willmar does not use Antabuse. It can do as well with its general program. Antabuse may be an easy method of dealing with large numbers. The hospital drums on the principle--"Let's practice sobriety. Let's not talk drink or think drink." An attempt is made by the educational program to make release from tension less rewarding. The real job is to get at the anxiety and remove it. Dr. Bradley feels that AA has the most all-embracing program to date. . . .

Dr. Bradley thinks alcoholism is only one of the major addictions. The major addictions are first work, then food, then alcohol, then barbiturates. The so-called addictions to heroin, etc., are minor compared to the above. . . . The alcohol alibi starts in our own culture when, as a teenager, he has to slink behind a billboard for his first drink. The work addict builds up more elaborate rationalizations than the alcoholic. . . . He is delusional that everything depends on him. . . . The food addict is more dishonest than the alcoholic. (as cited in Laycock, 1956, p. 5)

By 1956 an aftercare program was established, and Dan Anderson became director of the Willmar Alcoholic Follow-Up Clinic. More than any other facility to date the Willmar Program was multidisciplinary. The emphasis was on a “cross-fertilization between these fields” (Rossi & Bradley, 1960, p. 446). It also involved a “dynamic approach,” which included treatment, research, and training. The follow-up revealed effective treatment in 45% of “an unselected population,” with continuous sobriety “observed in 30%” (Rossi & Bradley, 1960, p. 446).

Nelson Bradley was later hired as chief of psychiatry at Lutheran General Hospital in Park Ridge, Illinois, with the understanding that he would head the alcoholism treatment program. The hospital opened on December 31, 1959, and during the 1st week of 1960, held a 4-day clergy seminar. Jean Rossi joined the staff as chief psychologist in 1961, and The Reverend John Keller, who was a clergy member in staff training at Willmar, joined the team in 1963.

### The Evolving of The Minnesota Model

Dan Anderson’s explanation of the process has remained significant in its application:

What happened at Willmar in 1950 with Dr. Bradley was that we realized all kinds of good people, good professionals, had tried to help alcoholics. Good physicians, psychiatrists, social workers and clergy. They all failed . . . not necessarily because they were doing something wrong, but because what they were doing was done in isolation. What alcoholics needed was help on all of these levels,

and especially they needed help in recognizing and understanding the power of addictive need. Nobody fully understood that. The only people we could find who really understood were recovering alcoholics. They had been there, knew it and knew they had to work on it to try to stay well.

So we tried to put all these factors together: good physical, psychiatric, social and spiritual treatment. And we included recovering alcoholics as part of our staff. This was a first. Nobody had ever thought of providing a structured, intense program with intensive patient involvement to help alcoholics.

We deliberately blurred the doctor-patient relationship. We said the patient was going to be part of the therapeutic alliance. Patients were going to help each other. And this is still not an accepted approach in many medical and scientific circles today. (as cited in Engelmann, 1989, p. 4)

In an analysis of the Minnesota Model for the British Journal of Addiction, Christopher Cook (1988a) identified four key elements in the philosophy: (a) the possibility of change, (b) the disease concept, (c) treatment goals--abstinence and improved lifestyle, and (d) the principles of Alcoholics Anonymous and Narcotics Anonymous (pp. 625-626). Therapeutic mechanisms which Cook (1988b) observed are (a) Alcoholics Anonymous and Narcotics Anonymous, (b) the disease concept, (c) group therapy, (d) recovering counselors, and (e) family therapy (pp. 742-744). Cook observed that the model operated through the processes of conversion and persuasion. He noted:

Perhaps its most powerful tool, however, is its comprehensive and dogmatic ideology. This acts to counter the pathological cognitive tendencies of the chemically dependent patient while providing release from past guilt and tangible hope of future recovery. Isolation from the sub-culture of alcohol or drugs and immersion in the social environment of AA/NA [Alcoholics Anonymous/Narcotics Anonymous] are associated with profound attitude change which closely parallels religious conversion

experiences. . . . While some may view this ideology as a 'myth' it has provided a miracle of hope for many patients who were drug/alcohol dependent. We serve these people better by learning to understand how they have been helped rather than trying to tell them why they are wrong. (Cook, 1988b, p. 746)

Cook (1988a) stated the first Minnesota Model treatment center to open in Britain was Broadway Lodge at Weston-Super-Mare in 1974. Others are Broadreach House, Clouds House, Charter Clinics, Farm Place, the Priory, and, in 1986, Promis in Kent.

The term Minnesota Model has been used to describe a multidimensional, abstinence-based, comprehensive therapy founded on the principles of Alcoholics Anonymous. Cook addressed the fact that Weisman (1978), in the introduction to Alcoholism Rehabilitation, which discussed the treatment methods of 13 separate treatment centers, including Hazelden, never once mentioned the term Minnesota Model. What is the Minnesota Model, and how many criteria does a center have to have to be considered a Minnesota Model? (Cook 1988a, p. 631).

Jerry Spicer, current president of Hazelden, answered in one sentence: "The Minnesota Model represents a social reform movement that has humanized the treatment of people addicted to alcohol and other drugs" (as cited in Toft, 1995, p. 2). Using this definition, many different models would qualify as Minnesota Models. Anderson, in the same article, stated that the model is not a set of procedures. It is a "core of perspectives" that include the following:

Treat alcoholics and addicts with dignity and respect.

Treat alcoholism as a primary illness, not a symptom of another condition

Treat alcoholism as a chronic illness--one that calls for coping, not curing.

Treat alcoholics and addicts as whole persons . . . physical, psychological, social, and spiritual.

Offer a continuum of care ranging from diagnosis and detoxification to aftercare and family services.

Treat alcoholics and addicts with the talents of people from many disciplines--physicians, psychologists, counselors, clergy, recovering people themselves and more.

Offer treatment based on the Twelve Steps of Alcoholics Anonymous, which calls for lifelong abstinence. Include other compatible approaches as needed.

Allow addicts to learn from their peers in recovery. (as cited in Toft, 1995, p. 1)

These were radical ideas in 1949. The idea that alcoholism could be successfully treated was radical at that time. The term Minnesota Model could be applied to a variety of treatment modalities, and it could also include various components, such as biofeedback, relaxation exercises, nutrition management, and numerous others. Not all treatment centers offer diagnostic and detoxification services. Alina Lodge does not offer these services and, therefore, would not qualify as a Minnesota Model-type treatment.

Robert M. Morse, Director of Addictive Disorders Services at the Mayo Clinic in Rochester, Minnesota stated:

The Minnesota Model is widely misunderstood and unfairly represented. . . . Historically it represented a very important step forward in its insistence on alcoholism as a primary disease. The model flourished in the absence of real alternatives. It remains a treatment model most predictive of success. (as cited in Toft, 1995, p. 1)

Another criticism has been that the model is inflexible and forces everyone into Alcoholics Anonymous. The response from Niki Moyer, who has taught the Minnesota Model at Rutgers Summer School was, “When people say they don’t get what they need from Alcoholics Anonymous we listen to that. Often times that’s a key to what it is they do need in their program to get sober” (as cited in Toft, 1995, p. 2). The multidisciplinary model utilizes the work from many disciplines, Jungian psychology, Skinner’s peer group therapy, Ellis’ Rational-Emotive Therapy, and others (Toft, 1995). The model has also been adapted for outpatient treatment.

#### Other Areas of Development

##### The Therapeutic Community

In outlining the components of the Minnesota Model, Anderson mentioned the “intensity of treatment,” which he described as living in a therapeutic community that included lectures, group meetings, individual sessions with professionals, and aftercare (as cited in Engelmann, 1989, p. 4). The therapeutic community was a new approach to mental health at the time Bradley and Anderson were developing the program at Willmar. The type of therapeutic community to which Anderson referred was similar to the one developed by Maxwell Jones, an English physician, as a model for residential psychiatric treatment.

As early as 1947, a psychiatric facility was evolving as a social system and the term therapeutic community came into being. This was essentially an attempt to evolve an open system, as a reaction against the traditional closed systems of psychiatric hospitals. . . . The social structure of a therapeutic community is characteristically different from the more traditional hospital. The term implies that the whole community of staff and patients is involved, at least partly, in treatment and administration. (Jones, 1976, pp. 86-87)

In the United States, the term therapeutic community has primarily been applied to the treatment of narcotic addicts. The long-term, intensive habilitation and rehabilitation efforts were implemented to create an atmosphere of recovery in confronting the drug culture. Individuals addicted to drugs obtained illegally on the street as opposed to those addicted to the legal, socially acceptable drug, alcohol, created a separate identity with a separate culture. The drug-free therapeutic community movement can be primarily traced to Synanon, which was started by Charles E. Dederich, an alcoholic who recovered through Alcoholics Anonymous. The origins of Synanon go back to the Oxford Movement and the early practices of the Christians as described in the Dead Sea Scrolls. (Glaser, 1981).

They are called therapeytæ and therapeutrides . . . because they profess an art of medicine more excellent than that in general use in the cities; for that only heals bodies, but the other heals souls which are under the mastery of terrible, and almost incurable diseases, which pleasures and appetites, fears and grief, and covetousness, and follies, and injustices, and all the rest of the innumerable multitude of other passions and vices, have inflicted upon them. (Philo Judæus as quoted in Glaser, 1981, p. 13)

Synanon was both a “pioneering response” to drug addiction and a warning of what could go wrong (Deitch, 1981, p. 289). Daytop (Drug Addicts Treated on Probation), Phoenix, Gaudenzia, Gateway, Awareness House, Walden House, and many other drug-free therapeutic communities evolved from the concept of Synanon. According to Deitch (1981), before Synanon “acquired wealth and converted itself into a religion,” it had some significant accomplishments in the areas of energy conservation, ecology, and employment efficiency as well as innovations for drug rehabilitation (p. 301).

What went wrong? The first factor that Deitch (1981) suggested was lack of accountability. Most drug treatment therapeutic communities are accountable to a board of directors comprised of non-affiliated members. Synanon was accountable to no one. Boards of directors, in spite of slowing the administrative process contribute diversity of expertise and opinion. The second factor involved the reentry of the members to society. According to Deitch (1981), “Reentry forces therapeutic communities to interact with less arrogance” with supporting community agencies (p. 302) also, “reentry demands have provided a variety of models for members of therapeutic communities to look at, a variety of life styles to try out” (p. 302).

Deitch’s (1981) points were elaborated when early in 1964, Monsignor O’Brien and psychiatrist, Dan Casriel, approached Synanon to operate Daytop. O’Brien and Casriel outlined five objections to Reid

Kimball, Dederich's aid. Dederich himself did not appear for the conference as he had agreed to do. O'Brien and Casriel outlined the following changes to the Synanon program: The program would not be "for life"; methods would be scrutinized by outside researchers; a team of helping professionals would be provided; harsh disciplinary techniques and humiliation would not be permitted; and the organization would have to come to New York. The previous modality had been for Synanon to use a recruiting center like Westport House to refer members to the West Coast center (as cited in O'Brien & Henican, 1993).

Deitch (1981), a native of Skokie, Illinois, recovered from heroin addiction in Synanon and became one of Dederich's esteemed lieutenants. He managed the Westport recruiting center in Connecticut, he saw what was happening, and left Synanon. Later, Monsignor O'Brien and Dan Casriel recruited Deitch to become the first director of Daytop Village. Under his direction, Daytop Village became a model for drug and alcohol rehabilitation. The drug-free therapeutic community has been used in the corrections system for rehabilitation of inmates imprisoned for drug-related crimes as well as in probation center halfway like Daytop (O'Brien & Henican, 1993).

Cook (1988a) noted that the therapeutic community approach to mental health was widely accepted by the middle of the 20th century. He differentiated the models as the "professional democratic" model being the work of Tom Main and Maxwell Jones in England and the

“concept-based” model as the one used in drug rehabilitation in the United States. It is possible that the Minnesota Model developed separately from either one (Cook, 1988a, p. 631).

In discussing the organization of an alcoholic ward at Patton State Hospital in California, Cahn (1970) quoted Maxwell Jones, who visited the ward, as saying “A therapeutic community was not in itself a treatment method; it was merely a climate in which therapeutic methods could be pursued” (p. 213). The hospital staff was apparently equating therapeutic with permissive.

#### Confrontation Therapy: An Outgrowth of Synanon?

Royce and Scratchley (1996) observed that “the Synanon ‘hot seat’ approach may or may not be effective on hardened street addicts, but it is inappropriate for most alcoholics” (p. 246). Patricia Colangelo recalled the “fish bowl” that they were doing at the Hazelden in the 1970s. The family came to the treatment center and sat with the patient group. The family members told the patient what he/she had done to the family while they were drinking. Colangelo’s response was that the feeling of that isolated event stayed with one person for a long time. This model for family treatment was widely utilized in the 1970s and 1980s. She did not believe it was positive therapy, either for the family or for the patient (P. C. Colangelo, personal communication, May 28, 1996). Fitzgerald (1990), former Chairman and Chief Executive Officer of the

Book-of-the-Month-Club, in a chronicle of his treatment at the Johnson Institute's St. Mary's Hospital program in Minneapolis, related his experience with the combined patient family group as a part of his treatment in 1988.

In developing a residential family treatment program, Colangelo kept the family members separate from the patients in order for them to work through their own issues in regard to having an alcoholic family member. According to Fitzgerald's (1990) observation, Hazelden had adapted a completely separate program for the family, with no interaction with inpatient treatment.

Another version of confrontation is the peer evaluation that also originated at Hazelden. Joe Harrison related that the Carrier Clinic sent one of their counselors to Hazelden and he returned with the peer evaluation. "Hazelden later dropped it and we modified it and continued to use it" (J. S. Harrison, personal communication, July 9, 1995).

Stuckey (n.d.) stated the following concerning the peer evaluation:

The Peer Evaluation or Hot Seat is the most effective tool . . . to produce client recovery. It motivates patients to rely on each other, to be tough on each other, to encourage each other and to make each other laugh. Each client has his moment in the sun. Each begins to feel compassion for himself. Each tells age old secrets and enjoys a new clean feeling. The Hot Seat encourages a client to look closer at himself than he ever has before. It reflects behavior back to him of which he was totally unaware. It brings massive feed-back and confrontation to him if he is still in denial. It brings solidarity and a sense of effectiveness to the peer group. (p. 91)

### Pastoral Counseling

Pastoral counseling was another therapeutic area that was developing in the United States during the 1950s and 1960s. R. Finley Gayle (1956) discussed the issue of pastoral counseling in his presidential address at the annual meeting of the American Psychiatric Association: "Some psychiatrists are as apprehensive about clergymen 'doing therapy' as some clergymen are about catching psychiatrists in the act of 'forgiving sins'" (p. 4).

In response to Gayle's statement, Abraham Fransblau (1960) wrote:

While psychiatrists "forgiving sins" exist largely in the imagination of people who write articles in this area of cooperation between psychiatry and religion. In reality, they are as rare as hen's teeth, if they are to be found at all. (p. 583)

Fransblau (1960) accused religion of expecting to be the teacher rather than the pupil where new depth psychology is concerned. He proceeded to say that while psychiatry had made numerous contributions to religion, the contributions of religion to psychiatry were yet to be made. Fransblau enumerated the contributions that religion could make to psychiatry: being "man-fostering rather than man-flagellating," replacing original sin with the idea of man's ultimate worth; having a "robust rather than a puritanical sexual code although stressing the importance of fidelity in the marital relationship"; relating guilt to behavior rather than to "ecclesiastic considerations" being "God-seeking

rather than God-fawning” and “moving outward from the ‘I’ to the ‘Thou’ rather than inward to the individual soul and its salvation” (Fransblau, 1960, p. 584).

Fransblau (1960) stated the following about religion:

[It should be] more universal than parochial, more democratic than sacerdotal, and more dynamic than static. . . . It is one extreme to say ,as Freud did, that religion is the “universal obsessional neurosis of humanity,” but quite the other to accept all religion uncritically as of equal validity. . . .

Many of us, it should not be forgotten, were reared in homes in which religion was an ever present reality, and in the course of our development to maturity were alienated partially or wholly from our ancestral faith. (p. 584)

The Diagnostic and Statistical Manual of Mental Disorders

(DSM-IV), fourth edition, which was published in 1994, had a new classification under the V code heading:

**V62.89 Religious or Spiritual Problem**

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religion. (American Psychiatric Association, 1994, p. 300).

The authors of the new code in the DSM-IV stated that scientific research in recent years had clearly identified near death experiences (NDEs) as a psychological phenomenon not related to a mental disorder.

### Intervention and Training the Johnson Institute

Intervention became a part of the alcoholism treatment model. Intervention was first utilized in the workplace through employee assistance programs and later with individual families. Most large treatment centers and some smaller ones assist families and employers in intervention work. Councils on alcoholism as well as private assessment, referral, and aftercare centers also provide intervention support.

#### Intervention

Vernon Johnson (1980), an Episcopal priest, was a patient at Hazelden. After recovering from his alcoholism Johnson continued to return to Hazelden to lecture in the treatment program. In 1962 he assembled a study group in an Episcopal church in Minneapolis to develop ways to assist parishioners in addressing personal problems, specifically those problems related to alcoholism. Johnson believed that the alcoholic could be brought into treatment before he “hit bottom” if his “delusion could be overcome” (Johnson Institute, 1995). The group began to experiment in creating an atmosphere to motivate the alcoholic to change.

From these simple beginnings, the Johnson Institute was organized in 1966. It was established as a nonprofit educational venture to research and design programs for alcoholics and to educate families, communities, and professionals about alcoholism and the intervention process. By

employing a multidisciplinary team composed of members from the fields of medicine, theology, psychology, and sociology, a pilot program was developed. The first program to utilize the Johnson Institute in developing a treatment program was St. Mary's Hospital in Minneapolis. The program, which opened in 1968, provided not only alcoholism treatment but also offered a program for dual-diagnosis patients (concurrent alcoholism and mental illness diagnosis) (Johnson, 1980).

Vernon Johnson (1980) described the progression of alcoholism with the Feeling Chart, a straight-line graph representing the range of human emotions from total despair to euphoria. By demonstrating with the chart, Johnson illustrated the process of using a chemical to change feelings. In I'll Quit Tomorrow, Johnson (1980) described alcoholism in layman's terms. More than 100,000 copies of the original edition were sold before the book was revised in 1980. The feeling chart concept was created for children as a teaching tool for prevention. In 1986 V. Johnson wrote Intervention, outlining the intervention process. By this time the procedure had been widely adopted.

Johnson (1986) described the intervention process as follows:

Intervention is a process by which the harmful, progressive, and destructive effects of chemical dependency are interrupted and the chemically dependent person is helped to stop using mood-altering chemicals and to develop new, healthier ways of coping with his or her needs and problems. It implies that the person need not be an emotional wreck (or "hit Bottom") before such help can be

given . . . presenting reality to a person out of touch with it in a receivable way. . . .

By “presenting reality” we mean presenting specific facts about the person’s behavior and the things that have happened because of it. A “receivable way” is one that the person cannot resist because it is objective, unequivocal, nonjudgemental, and caring. (p. 61)

John Norris, associate medical director of Eastman Kodak, began informally intervening with alcoholic employees in 1948 (AA Everywhere--Anywhere, 1995). Norris quoted Clarence Pierson as saying, “People have three bottoms--economic, social, and psychological. Some people have to hit all three but everybody has to hit their psychological bottom” (J. L. Norris’s letter to Delaney, personal communication, July 11, 1995). Norris related that it used to be said in Alcoholics Anonymous that a person must really hit bottom before they can be helped. Norris learned through his experiences that the authority of the employment situation could be used as leverage to break the denial of the alcoholic.

The Johnson Institute served as consultant in establishing a number of treatment programs, including Bethesda Hospital; Scripps Memorial in LaJolla, California; and the Betty Ford Center. Designing the first Student Assistance Program was another project. The Alcoholism Report, Digest of Addiction Theory and Application (DATA), now at Brown University, and other educational projects

originated at the Johnson Institute. In 1992 the Johnson Institute reorganized its operations “to concentrate on grantmaking and advocacy” (Johnson Institute, 1995, p. 1).

Johnson was honored by the National Council on Alcoholism and Drug Dependence “for his role in developing intervention as a technique for treating alcoholism and other drug addiction” (“Newsmaker,” 1996, p. 38). Johnson (1980) summarized his theory of alcoholism in the following statement:

Physical complications, mental mismanagement, and emotional disorder are accompanied by a similarly progressive spiritual deterioration in chemically dependent people. Remember, people cannot become alcoholics unless there is a conflict between behavior and values. To sum up: guilt, shame, and remorse exact their inevitable and immobilizing tolls as time goes on. Feelings of self-worth consistently decline. As meaningful relationships wane or wither, the growing estrangement’s lead eventually to spiritual collapse. At the end, intense despair and hopelessness produce suicidal moods. To the question, “Can’t you see you are drinking yourself to death?” the alcoholic answers, “So what?” or “Who cares?” And is, in fact, committing slow suicide. . . .

Ultimately , the crux of the problem for the alcoholic and other guilt-ridden people is characterological conflict, and this basic cause is at the root of most symptoms of the disease. (pp. 114-115)

### Intervention and Treatment: One Man’s Experience

Fitzgerald (1990) wrote about his experiences with intervention at the Freedom Institute in Manhattan prior to his treatment at St. Mary’s Hospital. He said that no one goes to treatment voluntarily; they go because the jig is up and there is no place else to go. Fitzgerald related

that he first went in for outpatient treatment in the summer of 1987. The following summer, he was admitted to the inpatient program. “This time, to borrow from Richard Farina, I was down so far the Rehab looked like up to me” (Fitzgerald, 1990, p. 3).

Fitzgerald (1990) discussed his feelings about being in treatment and about Alcoholics Anonymous:

My experience going to Alcoholics Anonymous meetings, beginning three years before I got to St. Mary’s, and listening to men and women scattering their gifts of evangelism and piety with the fervor of a cockney communist on a soapbox at Hyde Park Corner made me wary of joining any group that would have the likes of them for members. I hated AA with a fierce passion and had viewed the countless meetings I’d gone to since drinking became an open problem for me after my retirement at the end of 1984 as a combination of penance and punishment. That’s probably redundant, maybe tautological, but what the hell. I expected the worst and I thought the only way to stay sane and out of trouble while I was here was to keep my mouth shut as much as possible. I wasn’t hostile, just wary. (p. 8)

#### The Non-Permissive Model: Little Hill--Alina Lodge

Alina Lodge, or The Lodge, as it is often called, began because of the gratitude of a German refugee who recovered from her alcoholism and wanted to provide a renewal or vacation spot for alcoholics.

Geraldine Delaney described Ina Trevis as having the intelligence of a woman and the heart of a child. She was married to Neumar Trevis, who became Curator of the Huntington Art Museum in Pasadena after they arrived in the United States (G. O. Delaney, personal communication, July 11, 1995).

Ina Trevis's drinking worsened during the war when she used it as a ruse with the border guards between Holland and Germany to assist Jewish couples in escaping. After fleeing to Holland, she and her husband helped many others, including several scientists to reach safety. She would pretend she was drunk, even if she were not, and the guards would let her cross even though she had "lost" her papers.

Neumar Trevis moved his wife back to New York from California, believing that the change would help her drinking problem. She became sober in Alcoholics Anonymous after he died. She spent some time at High Watch and appreciated the quiet rest and renewal. She took a job as a cook at Ailanthus Hall, a "place" for alcoholics. She loved her association with recovering alcoholics and was able to obtain some property at Kenvil, New Jersey, in 1949. During this period when most hospitals would not accept an alcoholic patient, she and her staff lovingly cared for many alcoholics who should have been hospitalized. When the American Medical Association acknowledged alcoholism to be a disease, Trevis believed the "home" business would end. She then set out to establish a country retreat for alcoholics. In 1957 she purchased the property at Blairstown, New Jersey, known as Little Hill. Hospitals were not anxious to take alcoholic patients, and Trevis was helping to dry them out and teach them about their disease.

By 1959 Trevis could no longer run the property alone, and she enlisted the financial and administrative support of Geraldine O. and

Thomas F. Delaney, both recovering alcoholics. Geraldine Delaney was a professional who had been head of the Pediatric Board in New York. Alina Lodge was initially a short term center, when insurance began paying for treatment, Delaney saw a need for those who required more, the “reluctant to recover.” Treatment was for a minimum of 3 months, with many patients staying for a year or more if necessary (G. O. Delaney, personal communication, July 11, 1995).

The goal of the program is “comfortable abstinence,” achieved through “learning or relearning self-discipline” (Delaney, 1978, p. 65). Time is the ally, and Delaney identified the need of the “tincture of time” as well a “tincture of studied neglect.” Patients are referred to as students. No patient on any kind of medication is accepted. Rules are simple, strictly observed with decorum. Men must wear coats and ties to dinner, and women must wear a skirt or dress. Everyone must be well-groomed and clean-shaven. Students remain horizontal for 8 hours each evening. The body rests, and sleep will come when needed. Three low-fat, low-sugar, low-starch, high-protein meals are served daily, along with water-soluble vitamins. Lectures are given three or four times daily; students take notes and do written assignments on each lecture. Punctuality is required, and students must be in the classroom 10 minutes before the scheduled hour (G. O. Delaney, personal communication, July 11, 1995).

[The students must learn] how to live in a world that worships at the shrine of the instant cure without [using] chemicals. . . . What's in their brain needs to be washed out so they can put in new and positive material. . . . The combination of drugs lasts a long time in our system. With drugs the system uses half and stores half, and when you get a combination of drugs, one never knows what the chemical combination is . . . if I had only one hour to spend with the families . . . or the alcoholic or addict, I would take the family because we must give them more help.

What is our recovery rate? One to a customer, if they want it. We can do our best to motivate, but we cannot do it for them. When they leave the sheltered care of treatment, if they go on and follow the proper guidelines, they will not only stay abstinent but become productive, wonderful individuals. I believe in the ability of the addict to perform outstandingly. (G. O. Delaney, personal communication, July 11, 1995)

### The Yale School in the Southwest

#### Yale Institute of Alcohol Studies at Texas Christian University

By the end of 1947 over one-third of the local affiliates of the National Committee for Alcohol Education were in the state of Texas (Johnson, 1973, p. 303). In February of 1947 Marty Mann attended a meeting in Texas. Three oil men, Earl North, Allen Badger, and Zed Emerson pledged \$50,000 to support the National Committee in 1947-48 (as cited in Johnson, 1973, p. 304). Later in the month, Jellinek gave lectures in Dallas, Ft. Worth, Houston, and Waco. He was extremely popular with Texas audiences, and he was invited to help organize the Yale Plan Clinics in Dallas and Houston with a research laboratory at Texas Christian University. A Yale Institute on Alcohol Studies was

announced for the following summer at Trinity University in San Antonio.

Marty Mann met M. E. Sadler, President of Texas Christian University, in October of 1946, when she was speaking in Houston, Texas, to assist in forming a local Committee for Education. Sadler was enthusiastic about the movement to transform public opinion concerning alcoholism, and in the following 3 years he pursued establishing a program similar to the Yale program at Texas Christian University. (as cited in Johnson, 1973, p. 289).

The Yale Institute of Alcohol Studies officially opened on the Texas Christian University campus Friday, May 14, 1948. J. Lee Johnson, president of the Cicero Smith Lumber Company, was chairman of the advisory board and represented the board at the opening. Other speakers were Selden Bacon, E. M. Jellinek, Marty Mann, and Horace Fort, who was an independent consultant to the program ("Dinner to Open Alcohol Study," 1948).

According to Johnson (1973), E. M. Jellinek moved to Dallas in the spring of 1949 and began the program on the Texas Christian University campus June 6, 1949. The entire faculty of the Yale Summer School came to Texas for the summer session in July. The site for the school had originally been set for Trinity University in San Antonio. The summer school was well accepted and attended (160 persons attended), but the budget was not met. Bacon decided that it was physically

impossible to return to Yale for the second session, and so for the first time since it opened in 1943, the Yale Summer School for Alcohol Studies at Yale was not held. By mid-1949 there were government-sponsored alcohol programs in 12 states, the District of Columbia, and Ontario. All were supervised by Yale Summer School graduates.

Jellinek's move to Texas solidified Selden Bacon's aspirations to become head of the Yale Center. With Haggard accepting a full-time position as a fundraiser for the Yale Development office and Jellinek, although officially still head of the Center, moving to Texas, Bacon would inherit the position (Johnson, 1973).

#### The Yale Clinics in Texas

Searcy W., a member of Alcoholics Anonymous in Dallas, attended the Yale School in New Haven in 1948 and became acquainted with Jellinek. When Jellinek moved to Ft. Worth, Searcy W. and Horace Fort helped with some of the clinic work. Searcy W. determined that the greatest need of alcoholics in Texas at this time was a place where they could go for detoxification and then go into Alcoholics Anonymous. Records show that in 1936 there were 14 hospitals in Texas for the treatment of drug and alcohol addiction. Among those listed were the Rountree Sanitariums in Mineral Wells and Ft. Worth (established in 1907) and the Hagey Institution in Austin and the Glenwood Sanitarium in Amarillo (established in 1908) ("Patterns of Development," 1986,

p. 58). In addition to the clinic at Texas Christian University, and with Jellinek's assistance, Searcy W. was able to establish four clinics, in Dallas, Lubbock, Houston, and Carlsbad, New Mexico (Searcy R. W., personal communication, August 28, 1995).

Bill Wilson made many trips to Texas in the late 1940s and early 1950s to assist Alcoholics Anonymous groups in becoming established. When Searcy W. became sober in 1946, there was an Alcoholics Anonymous meeting at 912½ Main in Dallas. Some members traveled from the outlying areas once a month for meetings. On his visits to Dallas, Bill Wilson stayed at the Melrose Hotel. Searcy W. met Bill Wilson in the fall of 1946 at the Texas state conference (Searcy R. W., personal communication, August 28, 1995).

During one of these visits, Searcy W. asked Bill if there was anything he would like to see happen, and Bill said that he would like for Ebby Thatcher to have another opportunity to become sober. Thatcher brought the message of Rowland Hazard's experience with Carl Jung to Bill Wilson in Towns Hospital. Thatcher had relapsed several times and was at that time living in the Bowery in New York, drinking heavily. Thatcher came to Searcy W.'s Southwest Clinic in Dallas in 1953 and remained sober until his death 2 years later (Searcy R. W., personal communication, August 28, 1995).

### Yale Southwest Institute Closed

The Yale Institute at Texas Christian University closed because of lack of capital funds on October of 1951. "As a representative of the United States, Jellinek took leave last fall to attend the first world meeting on alcoholism in Switzerland" ("Alcohol Institute Closes Down Here," 1951, p. 8). Jellinek worked with the World Health Organization following his time at Texas Christian University and did not return to Yale. He died in his office on October 22, 1963. Selden Bacon (1963) wrote in his obituary, "Jellinek was an expert in words and the use of words. He had a reading knowledge of perhaps 12 modern languages and could converse easily in 6 or 7" (p. 587).

Texans were eager for information about alcoholism but reluctant to commit to any long-term endeavors. This lack of any concentration in the field of alcoholism in the state of Texas continues to the present time and merits further study. The 1996 confused condition of the Texas Commission on Alcoholism and Drug Abuse and the lack alcoholism treatment statewide attests to this ambivalence and is an area for future research.

### Legislative and Civic Development

#### R. Brinkley Smithers

In 1954 the son of one of the wealthiest men in the United States was lying in Towns Hospital in New York City, the very city where

Alcoholics Anonymous was solidly established, experiencing his fifth detoxification in the facility. R. Brinkley Smithers was the son of Christopher D. Smithers, founder of IBM (International Business Machines). Towns Hospital, at this time, apparently had three floors, one for those who wanted to be detoxed only, one for those who wanted to recover, and the third for morphine addicts, many of whom were prominent physicians in the city (Scott, 1988, p. 15). Smithers called a man who had previously worked for him who had been successfully abstinent. This man asked Yev Gardner to visit Smithers and tell him that he had a disease. Smithers heard the message and from that day he made it his mission to carry the message, to other alcoholics.

Smithers was in a position to carry the message in a meaningful manner, and he continued to do so. He established a foundation in honor of his late father, and through this foundation he made a grant of \$10,000 to the floundering National Council on Alcoholism. He financed a major research project by Jellinek (1960), which resulted in the book, The Disease Concept of Alcoholism. The foundation funded the Physician's Alcohol Newsletter, which evolved into the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD).

In 1968, the foundation also funded the establishment of a treatment program in Roosevelt Hospital in New York. The service was jointly sponsored by the departments of medicine and psychiatry and

used the “scatter-bed” system. Roosevelt Hospital, an urban general hospital and a teaching hospital for Columbia University Medical School, estimated about one-third of the patient population to be alcoholic. The rationale for the system was that isolating a few patients and labeling them as alcoholics risked obscuring the alcoholism in other patients. As a teaching hospital, the system would also maximize staff education in both departments (Bissell & Deakins, 1978).

In 1973 the Rehabilitation Unit of the Smithers Alcoholism Center moved to the old Lowe mansion on East 93rd Street (Bissell & Deakins, 1978). Although one factor in creating the center was to provide New Yorkers with a treatment program, the staff observed, “There is no question that patients who come for treatment from other cities stay more consistently than do those who live nearby” (Bissell & Deakins, 1978, p. 103). Smithers expanded treatment possibilities in the New York metropolitan area by funding an out-patient program at Bronx-Lebanon Hospital Center. In 1969 this was the only treatment facility in the Bronx.

Harold Hughes also became personally involved, serving on the executive committee of the International Council on Alcohol and Alcoholism, which later became the International Council on Alcohol and Addictions. In 1962 the Yale School of Alcohol Studies was moved to Rutgers University, and Smithers provided generous funding for the building to house the Center of Alcohol Studies (Nathan, 1987).

### Harold Hughes and the Hughes Act

Harold Hughes grew up on a farm in Ida Grove, Iowa in a loving but poor family. He married young, and when he left for the European front of World War II he had one child and another on the way. He returned to a family he barely knew, but he was a family man. Hughes worked hard eventually driving a truck and trapping for extra money. His drinking increasingly created problems with his family, but he was consistent in his work. When a colleague suggested that he try Alcoholics Anonymous, he laughed it off, but thought to himself, "Alcoholics Anonymous; that was for bums and down-and-outers, the guys who hit the skids" (Hughes, 1979, p. 87).

Several weeks later Hughes received a subpoena at work that his wife had filed to have him committed to the Iowa state asylum as an inebriate. He promised to not drink for a year if the charges were dropped. He kept the promise. He drank after 14 months and was drunk for 2 days awakening, in a blackout. Hughes reached the point of suicide and had a conversion experience with the gun in his mouth. He did not drink for 2 years and in the meantime, became active in the Truckers' Association. He relapsed again, this time in Florida, and was arrested for driving under the influence. He put up bail and left the state. The arrest caught up with him and he lost his driver's license in the state of Iowa. Hughes started attending Alcoholics Anonymous meetings but did not participate. When he was about to drink again, he experienced a chance

meeting with a friend. After this he became involved with Alcoholics Anonymous and a lay reader in his church. From this point he began to experience a new direction to his life. Hughes became an advocate for the truckers and eventually chairman of the Iowa Commerce Commission. He was elected governor of Iowa for three terms. He went on to represent Iowa in the United States Senate, where in 1969 he was appointed chairman of the first congressional subcommittee on alcoholism and narcotics (Hughes, 1979).

The groundwork was in place--Alcoholics Anonymous, the Research Council on Problems of Alcohol, the National Committee for Education on Alcoholism, the Yale School on Alcohol Studies, the American Medical Association, the World Health Organization; Hughes was the right man in the right place at the right time. Thomas P. Pike (1969), a wealthy, Los Angeles businessman, who was also a recovering alcoholic, spoke of Hughes in his autobiography as an extraordinary man who convinced him it was possible to surmount the public ignorance and the stigma of alcoholism (p. 237). Hughes had a strong belief that the knowledge of recovery must be made public.

The 11th tradition of Alcoholics Anonymous stated that the “names and pictures as AA members ought not be broadcast, filmed or publicly printed” (Alcoholics Anonymous, 1981, p. 567). This presented a problem in the testimony for the hearings of The Special Subcommittee on Alcoholism and Narcotics. Judge Ray Harrison of Des

Moines testified that he had been a hopeless alcoholic confined to his own jail on 18 occasions. Marty Mann, who had testified about her recovery in talks across the country, testified. The committee especially wanted a well-known person to testify. It was suggested that they contact Academy Award winning actress, Mercedes McCambridge. Hughes warned her:

Your appearance could hurt your career. . . . I told her of the criticism I had received for opening the alcoholic can of worms, of abuse even from alcoholics who considered our investigation a threat.

“Well, how do you stay above it?” she asked.

There is no choice. . . . If one person lives who might have died, I feel it will be worth it. But I can’t ask you to take that risk, and I won’t blame you if you say no. I have to tell you that I’ve been turned down by a dozen other people.

The phone was silent for a moment. Then in that husky voice, “OK, I’ll do it.”

“Nobody need die of this disease,” . . . “We are eminently salvageable. We are well worth the trouble. We are eminently equipped to enrich this world. We write poetry, we paint pictures, we compose music, we build bridges, we head corporations, we win the coveted prizes for the world’s great literature, and too often, too many of us die from our disease, not our sin, not our weakness.”

(Hearings before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare, United States Senate, 91st Congress, July 23-25, 1969, as cited in Hughes, 1979, p. 280-281)

Numerous persons--young people, housewives--testified. Bill Wilson, in respecting the anonymity of Alcoholics Anonymous testified as Bill W. He related the story of Rowland H.’s experience with Carl Jung and how it had been relayed to him. Pike (1979) stated that Wilson’s testimony was “historic and it was electrifying. The members of

the Subcommittee listened to him with respect and rapt attention” (p. 240). Hughes (1979) stated, “One statement that burned into me deeply was by Bill Wilson” (p. 281).

The special subcommittee held 14 hearings across the country in the summer of 1969. It heard testimony from religious leaders, scientists, alcoholism treatment providers, and individuals from numerous backgrounds and orientations. On May 14, 1970, Senate Bill 3835 was introduced to provide \$1.7 million for alcoholism treatment and prevention (Hewitt, 1995). The bill had to pass both congressional houses and be signed by President Nixon. It had to pass by the end of the 1970 session, which was midnight December 31, 1970, or the entire process would have to begin again. On December 15, 1970, a version passed the House which placed the proposed National Institute of Alcohol Abuse and Alcoholism under the National Institute of Mental Health. Hughes accepted this because of the time constraint. Hughes (1979) remembered:

But funding our fight against drugs and alcohol was always a problem I blamed much of this opposition on those who surrounded President Nixon, men like Robert Haldeman, John Erlichman and Charles Colson, powerful, manipulative men whom I felt were careless of the forgotten unfortunate. (p. 293)

Pike (1979) gathered a group of businessmen to meet with the president in an effort to persuade him to sign the bill. The group included James Kemper, of the Kemper Insurance Company; R. Brinkley Smithers, of the Smithers Foundation; and Donald Kendall,

of Pepsi Cola. On New Year's Eve 1970 Nixon signed Public Law 91-616 ". . . establishing NIAAA as a component of the Health Services and Mental Health Administration under the National Institute of Mental Health" (Pike, 1979, p. 241).

The mission statement instructed NIAAA (National Institute of Alcoholism and Alcohol Abuse) to: "Develop and conduct comprehensive health, education, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics" (P.L. 91-616, p. 1, as cited in Hewitt, 1995, p. 15).

Specific portions of the law required the following: alcoholism programs for federal civilian employees; grants to the states for . . . prevention, rehabilitation, and treatment programs; prohibition against discrimination in the hiring and firing of recovered alcoholics in non-security jobs; authorization of grants for education and training; required any hospital, public or private, which received federal funds, to admit alcohol abusers and alcoholics based on medical need and could not discriminate because of alcoholism; confidentiality of all patient records in alcoholism treatment; and a National Advisory Council on Alcohol Abuse and Alcoholism to advise the Secretary of Health, Education, and Welfare in the field of alcohol abuse and alcoholism (Hewitt, 1995). The original law did not include a specific provision to implement research, and until 1974 research was provided under the broad authority of the

Public Health Service. In 1974 Public Law 93-282 created a separate division of the Public Health Service titled the Alcohol, Drug Abuse, and Mental Health Administration. Under this department were the separate departments of the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Mental Health, and the National Institute of Drug Abuse (Hewitt, 1995).

A group drafted Harold Hughes (1979) to announce as a dark horse candidate for the Democratic nomination for president in 1972. It was the first time an acknowledged recovered alcoholic had run for president. Hughes was honored. He had received a landslide victory in his race for governor, and he was a popular senator. Hughes accepted and later, after deep consideration, he believed he would be more effective as a senator and withdrew his name.

During his years in the United States Senate, Hughes was a member of a small prayer group seeking guidance in their work. Members of the group in addition to Hughes, were Al Quie, Republican congressman from Minnesota, and Graham Purcell, Democratic congressman from Texas. Hughes decided not to seek another term in the Senate. Of partial Native-American descent, he had a special interest in the North American Indian nations, and part of his outreach was through this focus. He counseled with tribal leaders throughout the country (Hughes, 1979).

In 1990 Hughes established SOAR (The Society of Americans for Recovery Foundation), an advocacy group for citizens in recovery. In 1992 this group held public hearings on addictive disease health care. The issue of anonymity and the continuing stigma accorded addictive diseases by the general public brought about the demise of this group. Hughes strongly believed that recovery must be shared at the public level in order to save lives. He had many conversations with Bill W. over this issue, and he stated on the Johnson Institute Alcohol Awareness Hour that he often received letters from the General Services Office of Alcoholics Anonymous reminding him of an occurrence when he had broken his anonymity at the public level (Hughes, n.d.).

Hughes was particularly interested in groups who had been neglected in the initial movement for treatment, women, Native-Americans and other minorities. His desire to create a force for recovery at the national public level continued to be a major focus of his energy. Hazelden is presently creating a grass roots organization for awareness of public issues affecting recovering Americans. Other major health issues have such volunteer support groups, the American Cancer Society, the American Heart Association, and the Arthritis Foundation are examples.

### Summary

Two factions of alcoholism treatment evolved during the years from 1940 through 1970: the shared recovery centers, which were usually operated by recovering alcoholics, and the medical model mental health facilities utilized multidisciplinary teams. Finally these two groups began moving in the same direction (Stuckey & Harrison, 1982, p. 867). The recovery farms began utilizing more medical services for detoxification, and the hospital-based psychiatric programs began to recognize the positive effects of Alcoholics Anonymous as well as the hope exemplified by the recovering counselors.

A wholistic view of alcoholism began to emerge. The emphasis was moving away from the concept of underlying causes, which had been the original psychiatric approach, to a multidimensional approach of addressing the problem itself and not the cause. Pastoral counseling, which was just beginning added another dimension to the treatment modality (J. Harrison, personal communication, July 9, 1995). Other models of therapy were also emerging, and these all influenced the growing ideas about alcoholism treatment. Systems theory, coming out of the work of Talcott Parsons at Harvard, influenced a new realm of therapy including reality therapy, Gestalt, and psychodrama, as well as the entire sphere of family therapy. All of these factors were a part of the climate in which the alcoholism treatment center began to flourish.

The therapeutic community addressed the use of other drugs and was primarily directed at hard-core addicts and criminals. The concept of the therapeutic environment was utilized in both mental health facilities and alcoholism treatment centers. Bibliotherapy was first utilized in alcoholism treatment with the Big Book of Alcoholics Anonymous and expanded to a gigantic publishing industry of self-help literature (Alcoholics Anonymous: The Story of How More Than One Hundred Men, 1939).

The Minnesota Model of treatment set the standard for combining the various models of treatment. Originating from a farm style center, and utilizing the work of the multidisciplinary team from the Wilmar State Hospital and a mission-type Alcoholics Anonymous program at Pioneer House, Hazelden became a focal center for alcoholism treatment. Daniel Anderson (1981), a non-alcoholic psychologist became the director of this comprehensive treatment program. Cook (1988a) identified four significant factors in the Minnesota Model: (a) the possibility of change, (b) the disease concept, (c) the treatment goals of abstinence and improved lifestyle, and (d) the principles of Alcoholics Anonymous.

Vernon Johnson, a former Hazelden patient, developed a process of intervention which by addressing the alcoholism in an earlier stage, would create a new dimension of alcoholism treatment. When this

process was utilized by families, employers, and professionals, it created an overwhelming demand for treatment.

The stigma attached to alcoholism, while still a significant factor, was changing slowly. Recovering persons were becoming more accepted, although a knowledge of personal alcoholism continued to carry serious repercussions on the individual and societal level. A recovering alcoholic, Harold Hughes, was elected governor of Iowa and served three terms. He was then elected to the United States Senate. Open about his recovery, Hughes worked at the national level to obtain insurance benefits for treatment and research. The National Council on Alcoholism was also making meaningful progress in educating the public about the disease of alcoholism, but physicians continued to be wary of the spiritual elements surrounding alcoholism.

Brinkley Smithers's personal recovery from alcoholism brought funds and support for treatment, research, education, and intervention. The Smithers Foundation, which he established in memory of his father, Christopher D. Smithers, provided the funds for the Rutgers Center of Alcohol Studies Library housed on the Busch Campus at Rutgers University. It holds the largest collection of literature about alcohol and alcoholism in the world.

The development of a treatment process made recovery possible for those who needed more than Alcoholics Anonymous. The cost of this treatment was prohibitive for the average citizen. Even after the

American Medical Association acknowledged alcoholism as a disease to be treated, most hospitals were reluctant to admit alcoholics, and few did so on a routine basis.

## CHAPTER 6

### TREATMENT, CORPORATE INTERVENTION, BIG BUSINESS, AND RESEARCH--1970-1996

The Hughes Act of 1970 created funds for various treatment and rehabilitation programs, as well as monies for research and prevention. The definition of the appropriate patient was more broadly identified, and new treatment facilities began to appear. The National Institute of Alcoholism and Alcohol Abuse (NIAAA) defined alcohol abuse as drinking which caused detrimental effects for the individual, physically or socially or both. Alcoholism was defined as “a disease characterized by abnormal alcohol-seeking behavior that leads to impaired control over drinking” (Linnoila, Colburn, & Petersen, 1995, p. 67). The definition of alcohol abuse included a significant number of individuals whose problems were not previously identified as alcoholism. An awareness began to develop of the functioning alcoholic--the alcoholic who was still employed versus the chronic alcoholic who was often unable to maintain a job.

With research funds available, groups and individuals not previously involved in the treatment of alcoholism became active in research projects. Boscarino (1980) found in a national survey of

alcoholism treatment centers less than 24% were involved in any type of evaluation or research. He also noted the most common referral was from the criminal justice system--22.5%; with self referrals second--21.9%; alcoholism agencies, including Alcoholics Anonymous were 15.3%; and family referrals--12.2%, (p. 409). Therefore the largest referral group was from the private sector and the same report showed the majority of treatment personnel were alcoholism counselors. Kalb and Propper (1976) outlined the development of the tensions which began to arise between the professional "alcoholologist" who operated from a scientific model and the alcoholism treatment personnel or "craftsman" who had learned his skill from observation and experience (p. 641).

## Treatment

### Private and Psychiatric Hospital Treatment

In the early 1970s, Joseph Harrison, clinical coordinator of the Carrier Clinic in Belle Mead, New Jersey, observed that two groups began to emerge: (a) the shared recovery model of Alcoholics Anonymous and the farm treatment, and (b) the medical-psychiatric model (J. Harrison, personal communication, July 9, 1995). According to Harrison, the shared recovery model was drawn "kicking and screaming" into the healthcare system. These two groups spoke different languages one the language of Alcoholics Anonymous recovery, and the other, the language of science. Only a few people were bilingual. One of the bilingual groups

was the recovering physicians in International Doctors in Alcoholics Anonymous (IDAA).

When the healthcare system became involved, a diagnosis was required. In the early 1970s the psychiatric model was submitting the diagnosis of “depressive reaction” instead of alcoholism for insurance reimbursement. Alcoholics Anonymous never diagnosed anyone an alcoholic, as the following statement explained:

And be careful not to brand him an alcoholic. Let him draw his own conclusion. If he sticks to the idea that he can still control his drinking, tell him that possibly he can--if he is not too alcoholic. But insist that if he is severely afflicted, there may be little chance that he can recover by himself. (Alcoholics Anonymous, 1981, p. 92)

According to Harrison (personal communication, July 9, 1995), treatment changed rapidly because patients were now coming into treatment in full denial through the actions of employee assistance programs and other areas of healthcare. Three goals became necessary in the treatment process: (a) overcoming denial, (b) surrendering for help, and (c) developing a commitment to Alcoholics Anonymous. Alcoholics Anonymous in itself is not a treatment, it is a process for making lifestyle changes. Treatment has provided the means for those medically, psychologically, and emotionally indisposed to begin to make the transition into Alcoholics Anonymous. Miller and Kurtz (1994) wrote:

The language of defense mechanisms is from psychoanalysis, not from AA, and the word “denial” does not even appear in Wilson’s major writings. He characterized alcoholics as resistant to pressure and reluctant to admit alcoholism while drinking, but no

implication is made that alcoholics as a group--before, during, or after drinking--are characterized by generally primitive defensive styles. This idea and the notion of "breaking down" defenses are concepts from psychotherapy, and are characteristics of confrontational programs such as Synanon, rather than AA. Although Synanon was pioneered by an AA member, Dederich started Synanon precisely because there seemed no room in AA for the confrontation he deemed essential. (p. 162)

The Carrier Clinic was an example of a 1970s alcohol rehabilitation unit. The alcohol rehabilitation unit was established in 1971 at the clinic, a 245-bed psychiatric facility operated by a psychiatrist, R. Carrier. Many psychiatrists opened their own clinics because, in psychiatry, hospital admitting privileges were often restricted in psychiatry. According to Harrison (personal communication, July 9, 1995), Carrier was also alcoholic and became interested in alcoholism recovery. The alcohol rehabilitation unit had 70 beds. Lockett (1978) related that most alcoholics coming into treatment had serious learning impairments because of their addiction, and dynamic presentations with concealed repetition were required to overcome these deficits. Harrison (personal communication, July 11, 1995) said that most alcoholism treatment facilities had a charismatic leader or director who made these presentations.

The essential components in the alcoholism treatment center were listed in an article written by Stuckey and Harrison (1982):

1. Strong AA orientation.
2. Skilled alcoholism counselors as primary therapists.
3. Psychological and psychosocial testing. Medical and psychiatric support for coexisting problems.

5. Therapists trained in systematized methods of treatment, including Gestalt, psychodrama, reality therapy, transactional analysis, behavior therapy, activity therapy, and stress management.
6. Use of therapeutic community and crisis intervention.
7. Systems therapy, especially with employers and later including a strong family component.
8. Family and peer-oriented aftercare. (p. 867)

Many of the treatment centers across the United States looked to Hazelden for training. J. Harrison (personal communication, July 9, 1995) related that one of the counselors from Carrier went to Hazelden and came back with the peer evaluation: "Hazelden ended up discarding it, and we revised it for our own use." According to Grimm from Hazelden, "Sharing knowledge was the natural thing to do in the late 1960s and 1970s, when Hazelden became known as the model for treatment centers. There was so much interest in helping alcoholics then" (as cited in Duda, 1995, p. 5). People from other treatment centers came to Hazelden to learn. Hired at Hazelden in 1965; Grimm started the Clinical Pastoral Education Program. From 1966 to 1992 over 500 clergy members were trained (Duda, 1995).

When Grimm was hired in 1965, Hazelden was "a bunch of wooden buildings, no health insurance, no license, no JCAOH [correction mine] accreditation . . . too many patients and not enough staff" (Duda, 1995, p. 4). The accreditation process of the Joint Commission on Accreditation of Hospitals (JCAOH) was another factor in the catalysis of the medical model and the shared recovery mode. Hazelden quickly

expanded from 35 to 139 beds. In 1987 the capacity was over 400 beds (Phalon, 1987). What was happening at Hazelden began happening all over the country. General hospitals were opening alcoholism treatment units. Large conglomerates were forming to implement centers across the nation. General hospitals were opening alcoholism treatment units, and large conglomerates were forming to implement treatment centers across the nation.

### Community-Based Treatment

#### Cambridge Hospital Program

Vaillant (1981) described the treatment program at Cambridge Hospital in Boston as an “alternative to psychotherapy” (p. 49). Vaillant stated that the program was operated under the administration of the Department of Medicine, but it had its own non-psychiatric community board. “A cornerstone of this program,” according to Vaillant (1981), “is to avoid sustaining therapeutic alliances with alcoholics so as to avoid transference: and it is hoped, thereby to avoid the lion’s share of the ensuing countertransference” (p. 50). The staff is “deliberately psychodynamically naive” and is requested to attend Al-Anon on a regular basis to help them to “let go” of patients in order to be able to welcome them on their return (Vaillant, 1981, p. 50).

Although the Cambridge Hospital program avoids psychotherapy, in 1981 more alcoholics were treated there than in any other facility in

Massachusetts. The walk-in services are operated 16 hours per day, 7 days per week and patient needs for welfare, shelter, detoxification, and referral are attended to day and night. The first goal of the program was to sustain an alliance to Cambridge Hospital as an institution and, the second goal was to encourage an alliance to Alcoholics Anonymous. Vaillant (1981) cited one of the advantages of both a walk-in program and of Alcoholics Anonymous was that they do not expect the alcoholic to be in control.

Vaillant (1981) cited six reasons psychotherapy was a danger to the alcoholic:

(a) Alcoholism is a disorder with unexpected relapses and intense needs for help at unexpected times. The patient literally not is under his own control.

(b) It is important to avoid therapeutic relationships leading to intense transference and countertransference.

(c) Dynamic treatment can serve to increase, rather than lessen, the patient's denial that he has a problem with alcoholism.

(d) Alcoholism is sometimes preceded and always followed by profoundly low self-esteem.

(e) Some alcoholics have suffered early maternal neglect which may impair their capacity to care for themselves. . . . The fact that the subject never had an adequate mother becomes amplified by the transference rather than relieved.

(f) Alcoholics must learn that their drinking behavior is not a reflection of their dynamic unconscious, but just the reverse. (pp. 51-53)

Vaillant (1981) differentiated between a psychotherapeutic alliance and the sponsor relationship of Alcoholics Anonymous and explained why the latter was preferable:

Psychotherapy asks that the patient admit helplessness to his doctor, encourages him to say how little he has to be grateful for, but insists that he be independent enough to pay for the privilege. AA costs the patient nothing but shows him that he is independent enough to help others and encourages gratitude for the smallest blessings. (p. 52)

### Public Health Programs

Weisman (1973) became the Director of Community Psychiatry for the State of Maryland in the early 1960s after completing his psychiatric residency. Alcoholism immediately surfaced as a major problem in his patients; they were not responding to any protocol he had learned in medical school because nothing about alcoholism was taught. Then Weisman read an article about Alcoholics Anonymous in “that wonderful medical journal, Readers’ Digest” and immediately attended an Alcoholics Anonymous meeting (M. Weisman, personal communication, January 5, 1996). Weisman broke orthodox psychiatric protocol and personally accompanied his alcoholic patients to meetings. When he first asked them to go to Alcoholics Anonymous meetings they often stopped at a bar on the way and never made it to the meeting. Weisman observed that alcoholics need directive treatment. The first Alcoholics Anonymous meeting in Maryland was in a synagogue and has continued. Later an Alcoholics Anonymous meeting house in Baltimore, Weisman House, was established in Weisman’s honor (M. Weisman, personal communication, January 5, 1996)

From an NIAAA appropriation, Weisman received \$30,000 to start a community program for alcoholics (M. Weisman, personal communication, January 5, 1996). At that time, alcoholics were beginning to be admitted to emergency rooms, and the emergency room staff did not know how to handle them. As Director of the Division of Alcoholism Control for the State of Maryland, Weisman (1969), in an effort to assist bewildered medical personnel, provided the following suggestions to successfully work with alcoholic patients:

1. A non-judgmental attitude characterized by a genuine professional acceptance of the patient as suffering from an addictive illness, and
2. A thorough knowledge of the dynamics of alcoholism as a complex, socio-medical illness so that an objective evaluation can be made of the patient's needs and capacity for recovery, and
3. Knowledge of other agencies involved in follow-up care . . . .

While the most effective and most experienced community resource often is the local AA group together with the associated fellowships of Al-Anon for the spouse and Al-Ateen for the children of the alcoholic, other agencies may be of help. (pp. 103-104)

Weisman (1969) stressed the follow-up as necessary "to prevent the revolving-door" (p. 101). Johns Hopkins established a quarter-way house attached to the hospital for immediate post-emergency-room care, later transferring the patient to a half-way house. Weisman (1988) explained the progression:

Average length of stay in quarterway houses therefore tended to be increased beyond the time needed for detoxification. A more effective didactic program was added to the quarterway house regimen after research demonstrated that alcohol toxicity persists after withdrawal and can prevent full cognitive recovery. Family

members also were introduced into quarterway house programs to strengthen their understanding and emotional support. In time, then, such quarterway house programs came to resemble the programs of the private 28-day inpatient rehabilitation and treatment centers that sprang up around the country after the founding of NIAAA. (p. 287)

In the 1970s Abraham Schniedmuhl, at the John's Hopkins School of Public Health, received a grant from NIAAA to train counselors. Private funding was obtained to train medical students, 10 from John's Hopkins and 10 from the University of Maryland. From these educational programs Father Joseph Martin (1982) developed his well-known "Chalk Talk" lectures. Weisman gave Father Martin his first job in the field.

Weisman lectured at the Rutgers Summer School for 15 years. During the early 1970s sensitivity training was creating an awareness of improving group interaction. Weisman lectured on group dynamics, and he used biography therapy with patients (M. Weisman, personal communication, January 5, 1996). Writing a life story in treatment has become a regular component of therapy. Weisman, speaking from personal experience, encouraged those who work with alcoholics to enrich their skills through Alcoholics Anonymous attendance.

Developing a profound understanding of the dynamics of alcoholism, Weisman defined denial as "unawareness of a diseased condition" (personal communication, January 5, 1996). In explaining the denial of alcoholism, he used an analogy to the disease anosognosia, in

which a lesion of the right thalamus of the brain causes a paralysis of the left side. "Here the limbs themselves seem to pass out of the patient's consciousness as though they did not exist and the paralysis is consequently denied" (Weisman & Robe, 1983, p. 17). Weisman and Robe (1983) stressed the need for utilization of the Alcoholics Anonymous program as a key factor in successful recovery: "While other involvements, such as churches and civic organizations, may also provide these same elements, AA focuses specifically on the needs of alcoholics, hence, is infinitely more successful" (p. 22). Weisman and Robe (1983) continued:

Another remarkable phenomenon may occur as the psychotherapist, working with an alcoholic patient by himself or herself, attends AA meetings in order to learn how to prevent a relapse or how to cope with one which has just occurred. Aside from the possible discovery of one's own alcoholism, the psychotherapist begins to recognize his or her own role in the alcoholic's support system, even to the extent of having exercised a possible negative influence as an "enabler." (pp. 29-30)

The resistance of health care professionals is due partially to ignorance and lack of training and to personal attitudes about drinking. Weisman stated that the 12-step programs are appropriate and useful for psychiatry (M. Weisman, personal communication, January 5, 1996).

Weisman testified at the congressional hearings in 1970 for the Hughes Act. He continued to be active in the field even after his retirement. He was the opening speaker at Freedom '87 in Philadelphia,

a national conference for alcoholism treatment professionals sponsored by Marworth Treatment Center.

Harrison spoke of two models of treatment: (a) shared recovery and (b) the medical/psychiatric model (J. Harrison, personal communication, July 9, 1995). Weisman perceived the same dynamic in terms of language; one entity spoke the language of recovery and the other the language of science (M. Weisman, personal communication, July 9, 1995). There were few people who were bilingual. Weisman was one.

Weisman made significant contributions in the public sector, especially with the problems of Skid Row. Weisman was instrumental in the Baltimore Public Inebriate Program, which began after Maryland passed the Comprehensive Intoxication and Alcoholism Control Act of 1968. Maryland was a pioneer in implementing this particular legislation, a portion of the law stated, "There are some chronic alcoholics for whom recovery is unlikely. For these supportive services and residential facilities shall be provided so that they may survive in a descent manner" (as cited in Blumberg, Shipley, & Shander, 1973, p. xvii).

Weisman (1973) was asked by the authors to write the forward for the first scientific study of Skid Row and its attendant alcoholism. Weisman quoted the above excerpt from the Maryland law in the forward. The work began in 1960 with a comprehensive, statistically

controlled study of Philadelphia's Skid Row. In the introduction to this study, Weisman (1973) wrote:

The simple truth, however, is that no alcoholic sets out to become an alcoholic nor does he want to suffer from this devastating illness. He is no more "responsible" for having succumbed to alcoholism than cardiac patients are responsible for having coronary infarction or diabetic patients for their altered carbohydrate metabolism. He has succumbed somehow to a condition whose causes are not known but whose progress seems inevitable, leading to early death if not treated. (p. xvi).

Myerson (1956) studied the Skid Row alcoholic at the Boston program of the Long Island Hospital and advised that the problem of the indigent alcoholic was a complex sociopsychiatric issue. Catering to this population, he believed, was as futile as punishing them. Myerson (1956) recommended that anything except a long-term approach with consistent follow-up would be a wasted effort.

Denying their inability to give in their human relations, they placed themselves over and over again in situations in which only rejection could result and became enmeshed in what appeared to be an endless cycle of drinking and isolation. (p. 1172)

### Corporate Intervention

Harrison related that it was the United States Navy that actually had the first employee assistance programs (EAP), which were followed by a program at Kennecott-Copper (personal communication, July 9, 1995). Pursch (1992) was the director of the United States Navy Alcohol Rehabilitation Program at Long Beach Naval Hospital. Roman

(1981) cited the Dupont Corporation as being one of the earliest efforts to address alcohol problems in the workplace.

John Norris, who was the associate medical director of Eastman Kodak, began investigating Alcoholics Anonymous as a source of help for alcoholic employees as early as 1948 (AA Everywhere-Anywhere, 1995). Norris was supportive of the Alcoholics Anonymous program, and later served many years as a non-alcoholic trustee on the General Service Board. Norris was one of the early employee assistance professionals, and he was not a member of Alcoholics Anonymous.

In 1946 Clemens Mortenson, personnel manager for the American Hardware Company in New Britain, Connecticut, wrote an article in the Quarterly Journal of Alcohol Studies stressing the responsibility of industry for employees where alcoholism was concerned. Mortenson (1946) wrote:

Alcoholism is revealed by research to be a public health problem. Thus the industrialist when approached on the problem of alcohol does not have to fear he is being "roped in" for a political campaign nor need he suspect a "touch" for a good cause. . . .

It is imperative for industrial management to consider the question of alcoholism among its employees, I do not imply that by all means industry must do something about it. . . .

Industry has obligations in many directions. It has obligations toward its employees, its stockholders, the community in which it functions and society in general. . . .

Industry has quite naturally given its attention primarily to accident prevention and to the prevention and treatment of diseases arising from occupational hazards. . . . By the same token alcoholism--having been shown to be an ailment--may be regarded as a legitimate concern of industrial management. (pp. 205-206)

Steele and Trice (1995) noted there were significant contributions by individual Alcoholics Anonymous members and from Alcoholics Anonymous philosophy in establishing programs in the workplace. Factors were (a) the emphasis on intervening with problem drinkers as part of the mission of individual members, (b) populist ideology and the socialization of alcoholism workers in industry as a result of the experiential support of individual Alcoholics Anonymous members collectively, and (c) the confrontational and peer support strategies implemented by Alcoholics Anonymous members involved in industry (Steele & Trice, 1995, p. 402).

The development of employee assistance programs was a significant factor in the rapid expansion of alcoholism treatment centers. Steele and Trice (1995) attributed the development of EAPs to the influences of Alcoholics Anonymous, the National Council on Alcoholism, NIAAA, and the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA). The implementation of group health insurance in 1971 created a dramatic rise in the number of alcoholism treatment programs (Steele & Trice, 1995). "By 1980, ALMACA had emerged as the leading workplace movement organization, supplanting AA, NCA, and NIAAA" (Steele & Trice, 1995, p. 399).

Roman (1981) stated that before 1970 three organizations were involved in promoting programs in the workplace: (a) the group at the

Yale School on Alcohol Studies--Henderson offered courses and served as a consultant to industry, and Maxwell (1960) worked with Bacon and others in research projects reported in the Quarterly Journal on Studies of Alcohol; (b) the group at Cornell University where Trice directed research with support from the Christopher D. Smithers Foundation; and (c) the group at the National Council on Alcoholism (NCA) with Presnall in charge of workplace intervention.

Steele and Trice (1995) stated the National Council on Alcoholism “can be considered the oldest organized program to promote job-based programs” (p. 402). In 1959 the National Council on Alcoholism hired Lewis Presnall to promote these programs with a large grant from R. Brinkley Smithers. Presnall’s program then generated knowledge about alcoholism in the workplace and strategies for intervening. Smithers’s funding also created industrialized consultants, who were trained specialists. These specialists were located in National Council on Alcoholism centers in New York, Pittsburgh, St. Louis, San Antonio, and Los Angeles. The National Council on Alcoholism then trained practitioners who later became the leaders of ALMACA.

NIAAA’s first director, Chafetz, established an Occupational Programs Branch during 1971. NIAAA provided training to over 200 Occupational Program Consultants from 1972-1976 (Steele & Trice, 1995). Many of the persons trained became Employee Assistant Persons in the private sector. NIAAA also provided ALMACA with a 3-year grant,

including the funds to hire a full-time director and making it autonomous from the National Council on Alcoholism (Steele & Trice, 1995).

According to Roman (1981) when NIAAA became involved in the early 1970s the focus changed from employee alcoholism programs to employee assistance programs, and there was a deemphasis on prevention and alcohol problems. NIAAA had a goal to change the American stereotype of the Skid Row alcoholic and developed its Occupational Alcoholism Programs Branch to help the 95% of American alcoholics who were not on Skid Row. The program was called "Project 95" (Roman, 1981, p. 247).

Prior to NIAAA involvement employee assistance specialists had worked under two basic principles: (a) the best method of identifying employee alcohol problems was through supervisory attention to declining job performance, and (b) after reasonable supervisory effort a "constructive confrontation" would be held (Roman, 1981, p. 248).

After NIAAA provided assistance in developing ALMACA a "broad brush approach" was adapted encompassing other mental health and medical problems, and the term occupational alcoholism program was changed to employee assistance program (Roman, 1981, p. 249). The emphasis was directed as an employee counseling service that responded to problems other than alcoholism including marital complications, financial issues, and public health problems.

By 1975 ALMACA was almost solely and independently responsible for all job-based programs. In the beginning, when job-based programs emphasized early identification, confrontation, and behavioral change, there was no strong direction to outside treatment programs. As ALMACA adopted the broad-brush approach to employees, mental health and social work professionals were attracted to the field and a referral network developed.

Alcoholics Anonymous as an organization never became involved in any way with promoting occupational alcoholism programs or employee assistance programs. Individual members of Alcoholics Anonymous were a significant force behind the movement. Alcoholics Anonymous as an organization never aligns itself with any group; according to its sixth tradition, “an AA, group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose” (AA Everywhere--Anywhere, 1995, p. 81).

Steele and Trice (1995) stated that the death of Bill W. in 1971 “removed a leader who might have pressed the issue within Alcoholics Anonymous. In a very real sense, ALMACA emerged from the interaction between NIAAA and NCA with the acquiescence of AA” (p. 407). Based on past historical investigation of Bill W.’s strict adherence to the sixth tradition, the reality was that Bill W. almost certainly would not have pressed the issue within the confines of Alcoholics Anonymous.

Newspaper accounts related stories of the intervention process. On the front page of a 1983 Wall Street Journal was an article describing an intervention on behalf of an executive:

They called a surprise meeting, surrounded him with colleagues critical of his work and threatened to fire him if he didn't seek help quickly. When the executive tried to deny that he had a drinking problem, the medical director . . . came down hard. "Shut up and listen," he said. "Alcoholics are liars, so we don't want to hear what you have to say." The man then a \$65,000-a-year executive, recalls the scene:

"They said I had no choice. Either they would send me to a facility for treatment or. . . They never had to finish it. I picked up on the message immediately."

The executive, who has since joined another company, credits the office confrontation and his subsequent treatment with saving his career. "Whatever they did to me," he says "it took." (Greenberger, 1983, p. 26)

An article in the New York Times several years later gave the point of view of a patient whose family did an intervention for him.

James B., now about half-way through the long recovery process, looks back at the crisis intervention with bitter gratitude. "They stripped me of my skin and I'm still bleeding, but they saved my life," he says. "A person I haven't known for years is taking the place of alcohol. I like and respect him, and I never want to lose him, or my family again." (Franks, 1985, p. 48)

As group insurance coverage expanded, the number and types of alcoholism treatment programs increased. Both outpatient and inpatient programs were included in the expansion. Many of these programs adapted Alcoholics Anonymous-oriented philosophies and utilized strategies first implemented in the early treatment models.

## Big Business

As insurance coverage and intervention strategies increased the demand for treatment investors from the business sector became interested. Pursch (1992) wrote an article in a California newspaper describing the ramifications for the patient of the takeover of alcoholism treatment by entrepreneurs:

In the early 1960s, entrepreneurs in search of new business ventures decided that "hospitals are nothing but poorly run hotels." With tight management and clever marketing, they concluded, "we could make a lot of money in the hospital business."

By 1965 several entrepreneurs were busy forging golden chains out of failing hospitals. Health care became a product. "We care for patients" was changed to "we care for census," that is numbers. By getting "heads into beds." Converting 880-number inquiries into hospital admissions and "using" (read: exploiting) doctors to legitimize the enterprise, hospital chains were able to reap lavish profits for executives and stockholders.

Chemical dependency and psychiatric beds showed the biggest return.

But in the 1980s, to slow the rising cost of hospital care, health insurance companies developed their own brand of telemarketing--with a twist: Their goal was to keep patients out of hospitals.

The result is a telephone battle of wits between the insurance company's bonus-driven "Tele Doc" (usually a retired nurse, psychologist or social worker) and the hospital's census-driven "Bedside Doc" (the physician in the hospital)--while the patient falls through the cracks. (p. B8)

The change in the responsibility for personal health care from the employee as an individual to the employer made corporate health insurance a major investment. Alcoholism treatment, covered by insurance in the Hughes Act of 1970 became big business. A 1987 article

in Forbes, "Sobering Facts on Rehab," discussed the "big business" of alcoholism treatment: "Treating alcoholism and drug abuse these days has become big business--some of it very profitable--leaving both individuals and corporations with soul-searching choices to make about where to send those in need of help" (Phalan, 1987, p. 140).

Ruth McLean, medical director of New York Telephone Company, is quoted as saying:

There is a lot of money being made in drug and alcohol treatment. Unless you are dealing with major medical or psychiatric problems, I see nothing whatever to justify anything like \$6,000 a week. The price of a program is no indication of quality. (as cited in Phalan, 1987, p. 140)

Phalan (1987) listed 12 residential treatment centers recommended by employee assistance counselors as providing quality programs for a reasonable cost. Many of the centers which were discussed in this study were also included in the list: Hazelden; Little Hill-Alina Lodge; Parkside Medical Services in Parkridge, Illinois; and Edgehill in Newport, Rhode Island. It is of interest to note that most of the centers included in the list cost only \$6,000 for a total 28- to 30-day stay. Most of the centers listed are currently in operation. Only 2 of the 12 listed are large networks of centers, one of 50 centers and another of 34.

An article in Forbes, September 1996, explained some reasons for the high costs of treatment:

In the late 1970s the U.S. government classified alcoholism as a disease. Gosman (Abe Gosman, Massachusetts investor) started building alcohol and drug abuse treatment centers. By 1986 his Mediplex Group had 27 long-term care and substance abuse treatment centers. Gosman's sense of timing is superb. In 1986, when demand was heavy for psychiatric and alcohol outpatient treatment centers, Gosman sold Mediplex to Avon products for \$245 million, or 22 times earnings. He pocketed more than \$100 million in cash, built himself a \$30 million mansion in Palm Beach, Fla. and bought a 142-foot yacht. . . . Mediplex went from \$3.7 million profit in 1987 to an \$8.2 million loss in 1989. (Upbin, 1996, p. 108)

In a September 1996, The Wall Street Journal some of the pressure placed on treatment providers by Health Maintenance Organizations (HMOs) to use outpatient treatment were discussed:

Many patients find the path to treatment complicated by a growing rift within the health-care industry over the most cost-effective way to treat addiction.

Until about five years ago, the treatment of alcoholism was fairly cut-and-dried. A patient requiring more help than Alcoholics Anonymous could provide often was shipped off to a 28-day inpatient program. Rehabilitation became a bonanza for hundreds of private treatment facilities where individual monthly bills sometimes topped \$30,000--much of it covered by insurance. . . .

Coverage for traditional long term residential care is becoming a rarity; shorter, less-intensive therapy is now generally the rule for all but the extremely wealthy or extremely sick. . . .

Today, fewer than 10 private programs in the U. S. have average stays of more than 20 days, down from about 400 programs five years ago, says John Schwarzlose, president of the Betty Ford Center in Rancho Mirage, Calif. More typical is the approach of MCC Behavioral Care, a Cigna Corp. managed-care subsidiary in Eden Prairie, Minn. The average stay for patients it manages is seven days, and outpatient care averages about seven visits. (Pollock, 1996, p. B1)

There are still different opinions on the issue. Quality intensive treatment early in the recognition of the problem can avert costly

complications. Complications are measured not only in dollars but in human costs to families and individual suffering. In the same article the other sides of the problem were aired:

Managed-care supervisors often approve inpatient care only after an addict has failed as an outpatient. But many health workers argue that intensive treatment the first time a patient seeks help can actually be cost-effective, by preventing relapse. . . .

General Motors Corp.'s Hughes Electronics unit in Los Angeles has a separate plan under which employees and their dependents can get residential care at Phoenix House. . . .

St. Paul, Minn.-based adhesives company has lowered employee copayments for addiction treatment and now offers the option of residential care at Hazelden. Quality of care has improved as well, . . . because treatment is easier to get and often occurs before a crisis becomes full-blown. (Pollock, 1996, p. B8)

Who is to blame? Pursch (1992) answered, "Both sides," in the following statement:

For too long, hospitals were making too much money and treating patients unnecessarily. That was good business but bad medicine. Insurance companies understandably began to trim expenses--and there was much fat to be trimmed.

But now the trimming has come down to the bone, and until the pendulum swings back to a healthy medium, patients are paying with their health and sometimes, their lives. (p. B8).

Alcoholism treatment faces many challenges entering the 21st century, among them to be more efficient, to be more effective, and to be less costly. The answers are as multifaceted as the problems.

### Research

Until the establishment of NIAAA, most of the research on alcoholism treatment and alcoholism as a disease was done by

sociologists. The real conflict about the overall concept of the disease itself and the most effective way to treat it arose as a result of the research funds that suddenly became available. Several issues were paramount. First, was alcoholism a disease or merely a habit to be behaviorally changed? Second, was abstinence an appropriate goal or was controlled drinking possible? Third, was Alcoholics Anonymous effective? The most intense protests against affirming any of the concepts came from members of the American Psychological Association and from one philosophy professor. With research funds available, the race began. A number of those who were doing the research had often never worked with alcoholics in a clinical situation. Research issues of the 1990s continue to be the above as well as neuroscience research and Project MATCH which is based on the concept of individualized treatment.

#### Quantifying the Spiritual: The Effectiveness of Alcoholics Anonymous

In February of 1992 a national conference, "Research on Alcoholics Anonymous: Opportunities and Alternatives," was sponsored by the University of New Mexico and Rutgers University (McCrary & Miller, 1993). Ernest Kurtz captured the essence of the problem inherent in research on alcoholism as being the differences between quantitative and qualitative research. "The explosion of quantitative studies and the burst of insistence on operationalizing directly correlate in time with the availability of funding dispersed by bureaucratically administered

institutions” (Miller & Kurtz, 1994, p. 20). The differences are between the approaches to the problem: “between those who believe the truth is best found by maintaining distance from the object of study, and those who think truth is best approached by immersion in the subject of interest” (Kurtz, 1993, p. 22). These differences are as basic as two separate cultures, each believing that the one way is the only way. The crux of measurability is how to quantify the spiritual.

There exists no proof of the efficacy of Alcoholics Anonymous--this despite descriptions by hundreds of thousands of members of Alcoholics Anonymous who attest that AA has saved their lives and made it possible for them to live lives worth living. Again there are two different languages being spoken. (Kurtz, 1993, pp. 20-21)

The challenge remains to be able to construct research in such a way as to honor the Alcoholics Anonymous belief that it is not possible to separate the Alcoholics Anonymous program and the spiritual. Kurtz (1993) believed this to be possible if demands that require the spiritual to be materially measured can be set aside. Two research possibilities he identified are the affiliation process and content-analysis.

“Capacity for the spiritual” is not a new research category . . . only one person, a hobbyist rather than a scholar, is currently researching how early AA’s bibliotherapy worked--the practice of assigning certain books to be read, which was seen as an effective way of “opening to the spiritual.” (Kurtz, 1993, p. 21)

The hobbyist to whom Kurtz referred in the above quotation was Dick B. (1992). Kurtz (1993) suggested the point to investigate in order to research the spiritual is “the relationship that is AA sponsorship as

evidence of the capacity to learn by listening and of a potential for the classic virtue of humility“ (pp. 21-22).

Miller and Hester (1986) decided to read every published study on the effectiveness of alcoholism treatment in every language they could read. The results of the controlled research outcomes indicated that the following therapies are effective: “aversion therapies, behavioral self-control training, community reinforcement approach, marital and family therapy, social skills training, [and] stress management (Miller & Hester, 1986, p. 162).

The following is a list of the standard treatment methods used in the majority of alcoholism treatment programs: Alcoholics Anonymous, alcoholism education, confrontation, disulfiram, group therapy, [and] individual counseling (Miller & Hester, 1986, p. 162).

The two lists are significantly different. The treatment modality that has worked the best for the greatest number of patients is not the one which has survived the scrutiny of scientific, quantitative research. Miller stated in the first chapter of the book he edited with McCrady in 1993, “It is difficult to find an American alcohol/drug abuse treatment program that does not embrace a 12-step approach and recommend AA attendance, or a professional with no opinion about AA” (p. 3).

### Controlled Drinking for Alcoholics

Wallace (1985a) was an early bilingual in the alcoholism field. A scientist, an academician, and a writer, he was able to translate research about the brain chemistry of the disease of alcoholism for his colleagues. A man of great versatility, in addition to being an alcoholism treatment professional he is also an author and a jazz musician. Wallace's treatment experiences have ranged from a respected private treatment center to the streets of Harlem. He has contributed to the basic understanding of the manifestation of a disease. A graduate of the Northwestern University psychology program, with a special interest in learning theory, he was first a professor at Stanford University and then at the University of California at Irvine (J. Wallace, personal communication, December 6, 1995).

Wallace did not plan to be involved in alcoholism treatment. Zink, from Long Beach Naval Hospital and Carnes, the first president of Comprehensive Care Corporation (CompCare) convinced him to join them in establishing the first CompCare hospital treatment unit for alcoholism at South Coast Community Hospital in South Laguna, California. Wallace said that none of them had read the Minnesota Model or visited Hazelden. Carnes and Zink wanted to have a multidisciplinary team. Newsom was the physician and the group wanted Wallace as the psychologist. Later when CompCare became generalized Wallace moved to New York (J. Wallace, personal communication,

December 6, 1995). CompCare developed into an alcoholism treatment conglomerate that included a publishing arm.

Wallace (1982) stated some of his beliefs about alcoholism treatment:

Although some people do recover from active alcoholism without undergoing some sort of spiritual transformation, I am of the strongly held opinion that to ignore the inner, spiritual condition of the majority of alcoholics is to neglect one of the most critical common elements of the disease. . . .

I do not regard anxiety (or anxiety reduction) as the principal cause of alcoholism. . . . In the hands of a highly skilled therapist for example, an alcoholic patient can be brought to see his use of tactical denial in an amazingly short period of time. . . .

I neither regard alcoholism as one of the neuroses, nor do I regard alcoholism and the coping tactics associated with it as symptoms of anything other than themselves. Alcoholism is the disease. Alcoholic coping tactics are predictable outcomes of it. (p. 12)

Author of the classic text, Practical Approaches to Alcoholism Psychotherapy, first written in 1976, Wallace (1985b) articulated a technique for therapists to understand and work with the alcoholic's preferred defense structure (PDS). Wallace (1985b) took the approach of positively using the alcoholic's defenses:

Traditional and even contemporary psychotherapies are largely inappropriate for the recovering alcoholic precisely because they have failed to recognize the value of this alcoholic preferred defense structure. Therapeutic ideologies that consist largely of disguised moralistic stances concerning certain behaviors called "defenses" are likely to do more harm than good in the early stages of treatment. The central problem in early alcoholism therapy is not one of exposing, uncovering, and modifying the alcoholic PDS. The central problem is one of discovering ways of swinging the PDS into the service of achieving and maintaining sobriety. (p. 35)

Wallace (1985a) also wrote Alcoholism: New Light on the Disease in which he described new research on the physiological basis of the disease. He gave a practical definition of alcoholism: "Alcoholics are people who cannot consistently control their drinking over time, and who cannot guarantee their personal and social behavior once they start to drink" (p. 10).

According to Wallace (1985a) alcoholism can be explained as a fourfold disease, physical, psychological, social, and spiritual. He presented new biochemical research on brain chemistry and electrical activity in the brain to corroborate the physical dimension. The evidence does not imply causation by psychological factors, but painful psychological states that must be dealt with for recovery. Attitudes significantly affect recovery. In the area of social factors, Wallace (1985a) stated:

Many of us chose or drifted into occupations in which heavy drinking was not only accepted but often rewarded. Popular musicians--rock, jazz, and country--are notorious drinkers. So are house painters, poets, and novelists. Salesmen, career soldiers, and sailors, and coal miners are often heavy drinkers. Perhaps less well-known is the fact that college and university professors are too. . . . If we happen to be fated for alcoholism by our genes and body chemistries, then our social surrounds can constitute the environmental match that ignites the biological gasoline.

Spiritual development is the key to achieving these more positive states of mind and existence. (p.16)

According to Wallace (1990) because of recent research in the areas of cell membranes, brain enzymes, information-processing systems,

and brain condensation products, a new disease model has emerged.

Alcoholism has come to be recognized as a biopsychosocial disease:

Alcoholism is not only a psychosocial and sociocultural problem but a biologic problem as well. Given genetic predispositions and a psychosocial environment that encourages repeated exposure to alcohol, illness predictably results. Appreciating the underpinnings of the disease and the sociocultural contexts in which it gets expressed is clearly necessary if we are to understand alcoholism fully and guide its victims to recovery.

Alcoholism is a multidimensional illness; it is a biopsychosocial disease involving the body, mind and society. This new disease model of alcoholism is a reminder that if alcoholism is to be understood, it must be seen as a human problem, one that affects all of society and not this or that part in isolation from the rest. The recent research, however, in genetics, neurochemistry, and pharmacology emphasizes the importance of biologic factors in alcoholism. Rather than a problem of will power, character, or morality, alcoholism is an illness with critical biologic dimensions that must be appreciated if its devastating effects on individuals and the societies in which they live are to be stopped. (Wallace, 1990, pp. 504-505)

As a member of the American Psychological Association Wallace has maintained the stance that abstinence is the desired goal for treatment. He believed that controlled drinking is an unsafe and unethical recommendation for any alcoholism professional to make regarding an alcoholic patient. This stance has consistently been at odds with the consensus of the American Psychology Association (J. Wallace, personal communication, December 6, 1995).

Gitlow (1979), a physician at New York's Mount Sinai School of Medicine addressed this adversarial group in the following statement:

Although there is little doubt that this chronic, recidivistic illness responds to therapeutic intervention, its effective treatment at

present depends upon an ethical and spiritual program rather than drug therapy. Unfortunately, a small group of behaviorists (8) has failed to understand the clinical characteristics of the illness and has therefore aimed toward the development of training programs designed to assist the alcoholic to continue so-called controlled drinking. This has been partially based upon the ludicrous assumption that the “medical model” of alcoholism implies that the first drink inevitably and invariably leads to uncontrolled drinking by the alcoholic. Of course, such a circumstance characterizes extremely few of these patients. Rather, the alcoholic can never be certain as to which first drink will eventually lead to loss of control. The fact that such an individual continues to tempt fate in such a disadvantageous manner serves as a measurement of his compulsive behavior. As with any compulsive acting out, the opportunity to resist is always greatest at the initial moment. [(8) Marlatt, G. A., and Nathan, P. E. Behavioral Approaches to Alcoholism. New Brunswick, N. J.: Rutgers Center of Alcohol Studies, 1978.] (p. 2839)

Wallace was asked by NIAAA Director (1979-1981) John DeLuca to be the consulting editor for the Fourth Special Report to the U. S. Congress on Alcohol and Health from the Secretary of Health and Human Services, January 1981 which was mandated by the provisions of the Hughes Act of 1970. Wallace wrote most of the report (J. Wallace, personal communication, December 6, 1995). In the section on Treatment Goals the report read as follows:

While particular investigators have continued to show an interest in the possibility of nonproblem or controlled drinking as a viable alternative treatment goal for some alcoholics (e.g. Miller and Caddy 1977; Nathan and Briddell 1977; Nathan et al. 1978; Pattison et al. 1977; Polich et al. 1980; Popham and Schmidt 1976; Sobell and Sobell 1978), the large majority of clinical workers in the field of alcoholism treatment continue to perceive abstinence as the ideal treatment goal for alcoholics.

Wallace (1979) reanalyzed Armor et al.'s [sic] data and argued that the samples were biased and that measurement of normal drinking was invalid. Wallace concluded that the normal

drinking rates reported by Armor et al. (1976) were in serious error and could not be generalized to any population. (NIAAA, 1981, p. 149)

The sixth special report was quite controversial. Wallace received a call from NIAAA to rewrite the section submitted on treatment as the document submitted was not acceptable. The submitted document stated that (a) there was no such thing as alcoholism; (b) not all alcoholics needed to abstain, only the chronic; (c) controlled drinking was fine for the majority of alcoholics; (d) alcoholism was not a disease; and (e) inpatient treatment was not necessary. Wallace rewrote the section. Three contributors, P. Nathan, B. McCrady, and R. Longabaugh resigned in protest (J. Wallace, personal communication, December 6, 1995).

The controversial research conducted by the Sobells at the Addiction Research Foundation in Toronto in 1973 essentially stated that gamma alcoholics (the type described by Jellinek as physically dependent; acquiring tissue tolerance, experiencing withdrawal, craving, and loss of control) could be trained in controlled drinking, and that this was an effective therapy for gamma alcoholism. At the time they began the study, L. Sobell was an undergraduate and M. Sobell was a graduate student (as cited in Maltzman, 1989, p. 466).

Maltzman, of the University of California at Los Angeles, and Pendry, of the University of California at San Diego conducted a 10-year follow-up of the Sobell's 20 original subjects. Pendry, Maltzman, and West (1982) discovered that only 1 subject had been able to maintain a

pattern of controlled drinking; 8 continued to drink excessively, 6 gave up the controlled drinking and became abstinent, 4 died of alcohol-related causes, and 1, certified a year after discharge from the program as seriously affected by alcohol, was missing. When Maltzman attempted to publish his research concerning the Sobell study, several lawsuits by the Sobells ensued.

Peter Nathan (1989), editor of the Journal of Studies on Alcohol, refused to print Maltzman's article because "it raises no new issues and provides no new insights" (p. 465). The following excerpt from The Chronicle of Higher Education explained the sequence of events:

Mr. Maltzman said one of his papers had been rejected last year by the British Journal of Addiction after the Sobells threatened a lawsuit. A second British Journal, Behavior Research and Therapy, rejected another of his papers in 1984 after its legal experts considered it libelous, he said while a U.S. journal, the Bulletin of the Society of Psychologists in Addictive Behaviors, rejected a third paper in 1985 because of concern over the possibility of legal action.

Mr. Sobell acknowledged that and his wife, Linda, had threatened lawsuits against the British journal and the journal at Rutgers after reading advance copies of Mr. Maltzman's papers, but maintained that it was "utter nonsense" to suggest that they had sought to intimidate the editors of the journals to prevent their publication. (McDonald, 1989, pp. A5, A13)

The article was published in September 1989; Nathan subsequently resigned his post at Rutgers and went to the University of Iowa.

Two earlier studies of controlled drinking, Davies (1962) and the Rand study (Armor, Polich, & Stambul, 1976) according to Wallace (1989) both proved to have faulty methodology. Vaillant (1983) stated

that clinicians and researchers viewed abstinence and alcohol abuse differently, and in discussing the Rand study he made the following observation:

Armour, Polich, and Stanbul (1978) put the upper limit of “social drinking” as drinking regularly for a month (or 6 months) without exceeding three ounces of absolute alcohol (the equivalent of 7 martinis) in a day. A clinician or a relative might suggest that such a definition could embrace many alcohol abusers. (pp. 220-221)

Miller (1995) observed that “actual controlled drinking is associated with a poorer outcome” (p. 14). In discussing the Sobell and Sobel study, Miller (1995) stated: “In this particular study, these alcoholics had significantly greater numbers of abstinent days than controls, indicating that abstinence rather than controlled drinking led to better outcomes early on” (p. 15).

Royce and Scratchley (1996) addressed the issue, confirming Wallace’s position that it is both unsafe and unethical for the clinician to recommend controlled or moderate drinking for the alcoholic patient:

The concept of alcoholism as a compulsive addiction raises questions of professional ethics about attempts at controlled or moderate drinking for alcoholics. For both psychological and physiological reasons, the safe choice is to avoid drinking. Behavior modification can help them choose not to drink, but it is vapid to “choose” to change the nature of alcoholism. (p. 301)

Father Joseph Martin (1982), a Catholic priest and an alcoholism treatment professional, summed it up in a simple statement: “Normal drinkers have nothing to control! They neither know nor care very much about when or where they drink, because it is not a problem” (p. 78).

NIAAA Educational Format Responsible  
Drinking or Responsible Decisions

Educational information generated from NIAAA during its first years were pro-alcohol use in nature. Morris Chafetz (1959) the first director of NIAAA, was previously the director of the Alcohol Clinic at Massachusetts General Hospital in Boston, a Freudian psychoanalytically oriented outpatient treatment center. According to Wallace (1989), Chafetz was also a sponsor of the Rand report (p. 297). In defense of the Rand report Chafetz stated, "To the many devoted workers in the field of alcoholism who are themselves recovered alcoholics, it is upsetting to learn that the abstinence to which they adhere may not be necessary" (as cited in Wallace, 1989, p. 297). Room (1978) commented on Chafetz's 5 years at the helm of NIAAA:

In its public career, notably during Morris Chafetz' five-year tenure as Director of the National Institute on Alcohol Abuse and Alcoholism, the ambivalence image has been clearly associated with the "wet" alcohol policy, as expressed in the campaign for "responsible drinking." Under Chafetz successor, Ernest Noble, the adoption of a drier line was signalled by the shift to the slogan, "responsible decisions about drinking," intending to include as a possible choice the decision not to drink. (p. 112)

Royce and Scratchley (1996) discussed "responsible drinking" as an example of a prevention approach to avoid:

This slogan sounds good, and this approach certainly would make a lot of fifth graders happy. But there are many reasons for rejecting it. It puts a premium on drinking as proof of responsibility and subtly implies that nondrinking is a mark of irresponsible people.

Rather than how to drink, what is needed is to teach how to live in a drinking society, how to make responsible decisions or personal choices about use and nonuse of alcohol. Young people need to develop refusal skills. Instead of just saying NO, which seems like a lifetime or moralistic stance, they can say, "Not now" or "Not tonight" or "I'll have a Coke, please." They need to learn how to have fun without drinking and still keep their friends. (pp. 202-203)

The Say It Straight Training Program was developed by Paula Englander-Golden Ph.D. based on the communication styles of Virginia Satir. Say It Straight is an experiential prevention program which teaches honoring the deepest yearnings of the individual and learning to make choices and give appropriate expressions to these yearnings (Englander-Golden et al., 1996). This program has been proven to be an effective tool in prevention and treatment by empowering the individual to make choices for self-care.

Integration distinguishes wisdom from knowledge. It involves focusing on solutions and taking constructive action on your own behalf, rather than focusing on other peoples behavior and manipulating them to change. With this wisdom, we can become aware of our automatic behaviors even in difficult situations. . . . Having this special awareness of our internal processes, we can make conscious, intentional choices to stop our automatic sequences and behave in a way that reflects our deepest yearnings. (Englander-Golden & Satir, 1990, p. 295).

### Project MATCH

According to Gordis (1996) Project MATCH is based on the assumption that no one treatment modality has been successful for all persons and that individualized treatment would be more effective This

NIAAA project is the “largest, most complex randomized clinical trial ever undertaken in alcoholism treatment” (Gordis, 1996, p. 20). Four treatment models are being tested: 12-Step Facilitation, Cognitive Behavioral Therapy, Coping Skills Therapy, and Motivational Enhancement (Gordis, 1996). MeeLee (1995) stated that “there is not full agreement on how to assess addiction severity and thus to identify the best match to the most effective treatment” (p. 120).

### Neuroscience Research

NIAAA, which has been a part of the National Institute of Health (NIH) since 1992, “supports about 90 percent of all alcohol-related research in the United States” (Gordis, 1996, p. 19). Neuroscience research is a priority of 1990s research with fetal alcohol syndrome and the Collaborative Project on the Genetics of Alcoholism (COGA). “NIAAA’s major goal for neuroscience research is the development of new medications for treatment, such as medications that can interrupt craving, thereby reducing the risk of relapse” (Gordis, 1996, p. 20). A second goal is to identify genetic markers of high risk individuals in order that interventions can be preventative.

Wallace (1990) made the following comments on some of the neuroscience research: (a) a “genetic influence” is known; the specific genetic risk factors are unknown; (b) serotonin level fluctuation with ethanol consumption is known to occur, and studies of other

neurotransmitters “suggest involvement” of other brain chemicals; (c) some persons relapse in reaction to stress and stimulation, and others relapse in reaction to boredom and “an inability to experience pleasure” (p. 503). Neuroscientific research is only one important piece of the entire picture that is alcoholism.

In discussing the new disease model Wallace (1993) wrote:

Psychologists will simply have to come to terms with the reality of biological factors of many kinds in alcoholism and chemical dependence. On the other hand, traditional disease theorists will have to make more room in their conceptual maps for psychological theories and techniques. Both groups will need to learn greater openness to the societal and cultural levels of analysis where much work remains to be done. (Wallace, 1993, p. 85)

### Summary

Alcoholism treatment came into its own during the 1970s as a viable method of alleviating alcoholism for many individuals. The Minnesota Model was the model primarily adapted with some variations. This was an abstinence based multimodal treatment with strong Alcoholics Anonymous orientation; utilizing alcoholism counselors as primary therapists; providing medical, psychiatric and psychological components; with a peer-oriented treatment group and aftercare; and a strong family systems oriented treatment. This treatment was primarily available to the middle- and upper-class through private programs until the passage of the Hughes Act in 1970.

Identifying the problem of the individual in the workforce with alcohol problems began in the 1940s. Henderson and Bacon (1953), and Maxwell (1960), all at the Yale Center on Alcohol Studies, did considerable research in the area as did Trice at Cornell and Presnall at the National Council on Alcoholism (as cited in Roman, 1981). The Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) was created in 1971 by funding from the Smithers Foundation and the support of the National Council on Alcoholism. When NIAAA began an early focus on employee assistance programs with the goal to change the American stereotype of the alcoholic as a Skid Row bum and to create an awareness of the functioning alcoholic in the workplace. In 1972 ALMACA had less than 100 members and was supported by the National Council on Alcoholism and a grant from NIAAA (Steele & Trice, 1995). By 1980 ALMACA had over 2,200 members and was independent of both NIAAA and the National Council on Alcoholism (Steele & Trice, 1995).

With the implementation of health insurance coverage for alcoholism, treatment programs began to expand. Entrepreneurs began investing in alcoholism treatment and many centers expanded, becoming costly operations. At the end of the free spending 1980s insurers began to limit coverage for all healthcare and the availability of alcoholism treatment sharply declined.

The availability of research funds after the passage of the Hughes Act in 1970 brought new disciplines into the alcoholism field. Before 1970 little research had been done, and the field was populated by lay therapists and some physicians, sociologists, and psychologists who were knowledgeable about the recovery program of Alcoholics Anonymous. The most controversial studies were those attempting to prove abstinence was not a necessary goal for treatment and controlled drinking was a possibility for alcoholics. In 1962 a British physician, D. L. Davies (1962), had reported normal drinking in recovered alcoholics at Maudsley Hospital in London. Challenges to his study were published in the Quarterly Journal on Studies of Alcohol (Davies, 1963). Guarded in his comments Davies stated all patients should be advised to be abstinent as only a few may be able to drink.

Two of the most publicized American studies were Sobell & Sobell (1973) and the Rand report (Armor, Polich, & Stambul, 1976). The Rand report was sponsored by NIAAA and conducted with patients in the federal treatment centers (Wallace 1989). The original report was later modified (Royce & Scratchley, 1996). A libelous dispute followed the exposure of the invalidity of Sobell and Sobell (1989) by Pendry, Maltzman, and West (1982).

The original educational material generated by NIAAA used the campaign slogan responsible drinking which pleased the liquor industry but was not a healthy or helpful message for American youth (Room,

1978). Englander-Golden & Satir (1990) demonstrated a means of empowering an individual with an awareness of the inner self to enhance self-esteem and to develop the ability to make choices.

New research for treatment from NIAAA, Project MATCH has problems according to David MeeLee (1995) because there is not agreement on the methodology of assessing addiction severity. Neuroscience research holds promise if kept in the perspective of accepting alcoholism as a multidimensional, biopsychosocial disease (Wallace, 1993, p. 76).

## CHAPTER 7

### SUMMARY AND CONCLUSIONS

Perhaps in no other division of psychiatry are the prevailing ideas as to the etiologic factors and therapeutic methods and results so obscured by controversy, prejudice, ignorance and commercialized charlantry as in the general field of alcoholism and drug addiction. (Tillotson & Fleming, 1937)

These words written in 1937 could have been written today, almost 60 years later. Miller and Kurtz (1994) stated that they left the national conference on research and Alcoholics Anonymous in February of 1992, with “the realization that the essential nature of an AA model of alcoholism and recovery is often misunderstood” (p. 159). The research of this conference was compiled by McCrady and Miller (1993) in Research on Alcoholics Anonymous: Opportunities and Alternatives.

Norman Miller (1995) wrote

Effective treatment for alcohol and drug addictions has been available in the United States for years. Thousands of patients have achieved and maintained recovery as measured in long-term abstinence and enhanced quality of life. The benefits of structured abstinence-based treatment programs have been available in both public and private sectors. Despite this fact, the myth still lingers that current treatments are ineffectual in treating addictions. In part, this may explain why so few individuals are referred to treatment by physicians. (p. 42)

In summarizing, three questions come to mind (a) what has happened thus far in alcoholism treatment in the United States?, (b) Has

progress been made?, and (c) What lies ahead? America is now only a decade away from entering the 4th century since the first English colonists settled on these shores. Over these almost 400 years tremendous progress has been made. In the first 200 years alcoholism, or inebriety as it was known then, evolved from being a crime to be punished to an ill to be treated. In those years it was first recognized as a mental illness and then as a separate illness with its own etiology. Separate inebriate asylums were established and the Association for the Study and Cure of Inebriety provided a base for physicians to begin to develop ideas concerning the condition of inebriety. The Quarterly Journal of Inebriety provided a vehicle for the distribution of various theories and thoughts about treating inebriety.

Prohibition brought this work to a standstill. Bacon (1967) chronicled the effect The Classic Temperance Movement, which gathered force in the 1820s, had on attitudes affecting research and action in the area of alcohol and alcoholism. The fact that emotions surrounding the issue of alcohol use were intense enough to require a constitutional amendment to outlaw its sale provided a clue to present ambivalence and misunderstanding about treatment. A significant contribution of the Washingtonians was that they shifted the focus from alcohol to the alcoholic.

Prohibition did have the effect of lowering alcohol use in the lower classes, especially in the urban areas. Alcohol use among the middle-class

grew. Prohibition, the moral repercussions and resulting denial halted the progress of the treatment of alcoholism. The complexities of life in the aftermath of World War I and the burgeoning industrialization created a greater disparity between the rich and the poor and contributed to a hopelessness in many areas.

It was after the repeal of Prohibition in 1933 and in the midst of the greatest economic depression the country has yet seen the first real hope for alleviating the problem of alcoholism came in 1935 with Alcoholics Anonymous. About 10 years after Alcoholics Anonymous: The Story of How More Than One Hundred Men and Women Have Recovered From Alcoholism (1939) was published, a multidisciplinary concept of treating alcoholism began to evolve in Minnesota. This model with continuing innovations became the standard for alcoholism treatment in the United States. The uniqueness of this model was that it stressed physiological, psychological, sociocultural, and spiritual factors.

The treatment center or rehab that emerged in the 1950s was primarily a middle- and upper-class development. Alcoholics Anonymous, while it evolved through an upper-middle-class group, was and continues to be classless. In a critique in The New Yorker in 1995, it was noted that when Alcoholics Anonymous began, “it was the last stop before the abyss,” and that today one would not find such desperately ill individuals at Alcoholics Anonymous meetings (Delbanco & Delbanco, 1995, p. 51).

With the passage of the Hughes Act of 1970 alcoholism treatment became more available. The treatment center has changed the character of Alcoholics Anonymous. Joseph Harrison (personal communication, July 9, 1995) recalled, "Rehab patients came to AA cleaned up and spouting the Big Book." Rarely today is there orange juice in the backroom or are newcomers walking off intoxication in the parking lot. Court ordered attendance has also changed some of the dynamics. Electronic capability has changed everything, including Alcoholics Anonymous. There are now meetings on-line, with two kinds of meetings on the Internet, E-Mail Groups, and Internet Relay Chat.

How did Marty Mann's (1962) treatment differ in 1939 at Blythewood Sanatorium in Greenwich, Connecticut, from Ed Fitzgerald's (1990) almost 50 years later at St. Mary's Hospital in Minnesota? Mann (1962) was treated alone by a progressive and firmly compassionate psychiatrist. Mann read the Big Book of Alcoholics Anonymous and went to Alcoholics Anonymous meetings. Fitzgerald (1990) spent the majority of his time with his peer group. Psychiatric and psychological examinations were utilized for testing and evaluation. The recovering alcoholism counselor was the primary focus and role model in Fitzgerald's experience. Both Mann and Fitzgerald had the benefit of time away from daily environment and routine. By the time she entered treatment Mann had no family, and so Alcoholics Anonymous and recovering alcoholic friends became her family. On the other hand,

Fitzgerald described returning to the same family situation although his family had participated in the family program at St. Mary's.

The interaction of the peer group in the treatment setting is a powerful component of the treatment process. The power of healing lies in the group. The peer process may have originally come from the multidisciplinary group at Willmar, fostered by Rossi and Bradley (1960) and Anderson (1981). Another dynamic of the process is that by learning to rely on the peer group in the treatment setting, the patient is prepared for relying on the aftercare group and the Alcoholics Anonymous group. Alcoholism is an isolating disease and the non-judgmental, supportive group interaction with a common goal is a new dynamic for the alcoholic.

Miller and Kurtz (1994) stated that four models of alcoholism combined in the United States: (a) the moral-volitional model, (b) the personality model, (c) the dispositional model, and (d) the Alcoholics Anonymous model (p. 159). All of these perspectives effect the perception of alcoholism treatment and research. The multidimensional model of alcoholism treatment of which the Minnesota Model is the cardinal example utilizes three of the models. The moral/volitional model is excluded. Alcoholics Anonymous and alcoholism treatment both stress that while the individual is not responsible for having the illness each person must assume full responsibility for acts committed while under the influence. The dialogue about whether or not alcoholism is a disease has not been empirically determined either way. According to Nicholas

Colangelo (personal communication, October 3, 1996), who has been treating alcoholism for that past 20 years, the significant factor is that when alcoholism is treated as a disease people respond and recover, and when it is treated as a moral-volitional problem they perish.

Several points surfaced as the concept of alcoholism treatment emerged.

1. The model of treatment which has worked most effectively for the largest number of people is not the same model that appears in the black box of scientific scrutiny, as evidenced by the Miller and Hester study (1986).

2. No single model works for all patients. Keeping abreast of new physiological data and integrating it within a basic structure which has proven successful may enhance the effectiveness of both. Some of the neurochemical research could provide a crutch for those now unable to maintain sobriety.

3. Some populations (e.g., the Skid Row population) will continue to be a challenge. As with every other major illness there are degrees of severity and complications.

4. Until a great deal more is understood about brain chemistry it continues to be ethically inappropriate and physically dangerous to recommend controlled drinking for alcoholics.

5. The dialectical process between medical and psychological factions can provide positive awareness and challenges to those involved

in treatment. The dialectical process is a part of healthy growth, and changed attitudes can utilize the positive forces.

6. The problem created by the involvement of business in the health field in general, particularly at the level of treatment, involves a significantly larger scope. Alcoholism treatment is only one area of healthcare that has been affected.

7. In looking back through the historical evolution of alcoholism treatment, two areas that were successful and continued to be were the shared recovery farms and the simple recovery centers which evolved in the 1960s and early 1970s. Significant progress has been made in the treatment of alcoholism in the United States.

The problem addressed by this research has been to present a detailed history of the treatment of alcoholism in the United States.

C. Wright Mills (1959) emphasized the relevance and the importance of such an historical study in sociology when he stated:

Social science deals with problems of biography, of history, and of their intersection within social structures. That these three--biography, history, society--are the coordinate points of the proper study of man has been a major platform on which I have stood when criticizing several current schools of sociology whose practitioners have abandoned this classic tradition. The problems of our time--which now include the problems of man's very nature--cannot be stated adequately without the consistent practice of the view that history is the shank of social study, and recognition of the need to develop further a psychology of man that is sociologically grounded and historically relevant. Without the use of history and without an historical sense of psychological matters, the social scientist cannot adequately state the kinds of problems that ought now to be the orienting points of his studies. (p. 143)

Authors Rubin and Rubin (1995) referred to the richness and depth of information acquired from qualitative interviews as opposed to survey interviews. Survey interviewers are “trying to generalize relatively simple information,” and qualitative interviewers are trying “to capture some of the richness and complexity of their subject matter” (p. 76). According to Rubin and Rubin (1995), depth can be achieved “by asking questions that unravel issues backward in time” (p. 77). Another point made by these authors is that “Life is lived in details; the evidence for the generalizations you draw is in the specifics” (p. 78).

“Discovery often occurs precisely when an imaginative mind sets itself down in the middle of social realities” (Mill, 1959, p. 70). The interviews in this study provided an introspective dimension into the areas of treatment experienced by the individuals as well as an abundance of detail that provided documentation for the hypotheses. The use of biographies added a depth to the understanding of the particular era and treatment as it was experienced by the individual, either as provider or patient.

This study has utilized the three points of the history of man suggested by Mills (1959)--“biography, history, and society” (p. 143). In examining the macrosociological perspective, the three paradigms in the treatment of illness and malfunction emerged: (a) spiritual treatment,

(b) scientific treatment, and (c) a combination of scientific-spiritual or mind-body treatment. Several coincidences also came to light.

Thomas Crothers (1884) wrote in the February Journal of the American Medical Association:

A careful study of cases of inebriety from any point of exact science will always lead to the same conclusion that inebriety is always a positive physical affection, with distinct ætiology and symptomatology.

The theory of half vice and half disease, to be remedied by moral means at first, then, when these fail, resort to physical and medical appliances, has no support from scientific study and the natural history of cases.

Often alcoholic excess or intoxication follows the first use of spirits, then a long period will follow in which no spirits are used, or, if any, in great moderation.

But an inebriate soil has been prepared, and only awaits a favoring germ cause to spring into activity. (p. 5)

It is significant that Crothers (1884) used the word germ. The germ theory of disease was refuted in the same journal (JAMA) in an editorial in July of the same year (1884) reported as follows, “The popular germ theories and associate doctrines of contagiousness, greatly exaggerated by the newspaper press, are adding to the terror of all classes of people, and will correspondingly increase the destructive of the epidemic wherever it makes its appearance” (p. 46). The germ theory was accepted more easily than the theory that alcoholism was a disease. More than 70 years later in the same Journal of the American Medical Association an editorial made the following historical statement about alcoholism:

Simply because there is a moral and social aspect to this disease does not give physicians the right to deny its existence as a disease any more than they would be able to deny the existence of venereal disease, which is usually quite obvious. ("Queries and Minor Notes," 1957, p. 506)

The hypothesis concerning the first paradigm shift into the paradigm of scientific knowledge occurred even with alcoholism. Today, almost 40 years after the American Medical Association recognized it as a disease, alcoholism is medically accepted as a disease. The move into the third paradigm shift remains to be seen. Marcia Angell (1985), editor of the New England Journal of Medicine rebutted the mind-body connection in disease in the following statement:

I do not wish to argue that people have no responsibility for their health. On the contrary, there is overwhelming evidence that certain personal habits . . . can have a great impact on health, and changing our thinking affects these habits. However, it is time to acknowledge that our belief in disease as a direct reflection of mental state is largely folklore. (p. 1572)

In the research process, the treatment of alcoholism has progressed into the neuroscientific stage. The present search is for the correct "medications that can interrupt craving, thereby reducing the risk of relapse" and for genetic markers to predict "who will be at high risk for alcohol-related disorders" (Gordis, 1996, p. 20). While these drugs may provide ancillary support in treatment, Wallace (1990) urged keeping a multidimensional perspective with this complex disease.

As we have come to understand, alcoholism is not only a psychosocial and sociocultural problem but it is a biologic problem as well. Given genetic predispositions and a psychosocial

environment that encourages repeated exposure to alcohol, illness predictability results. Appreciating the underpinnings of the disease and the sociocultural contexts in which it gets expressed is clearly necessary if we are to understand alcoholism fully and guide its victims to recovery. (Wallace, 1990, p. 504)

Many of those who poorly understand are professionals from various disciplines, physicians, nurses, social workers, marriage and family therapists, sociologists, and psychologists, who encounter the alcoholic professionally everyday. Miller and Kurtz (1994) made the point that as the “treatment of alcoholism becomes increasingly professionalized, and as the interest in research on AA grows, it is important for treatment and research professionals to have a clear, accurate understanding of the essential nature and tenets of AA” (p. 159). As the alcoholism field has become more professionalized many persons working with alcoholics have never attended a meeting of Alcoholics Anonymous. It was interesting to note that both Fitzgerald (1990) and Knapp (1996) were more willing to go to treatment than to become involved in Alcoholics Anonymous.

Because the alcoholism counselor originated from a nonacademic background, there is not a body of knowledge about the history of treatment. The history of alcoholism treatment is vague and piecemeal even for those who are studying to be alcoholism counselors. In order to develop an understanding it is important to have knowledge about the involvement of the various disciplines and insight, not only into the conflicts which have arisen, but about the contributions that have been

made. Psychiatry has made significant contributions to alcoholism treatment beginning with Benjamin Rush. An understanding of the training of psychiatrists in the early years as well as the present explains some of the disparity. In spite of the millions of words that have been written about alcoholism we need to have a better understanding of how the treatment process developed.

If past history is proof, then the announcement in the New England Journal of Medicine refuting the mind-body theory might in actuality be taken as a prophecy that the third paradigm is, indeed, in the future (Angell, 1985). Miller and Kurtz (1994) suggested that the “encompassing implicit model [of alcoholism] might be called spiritu-bio-psycho-social” (p. 161). Alcoholism treatment has made it mandatory that the spiritual be included. The third paradigm will be acknowledging the spiritual in every area.

Thus, from a scientific point of view, it is no longer appropriate to separate the body from the mind. Nor, in my thinking, may we separate the two from the spirit. We are not speaking correctly when we say that we are a mind that has a body attached to it and that perhaps a spirit exists somewhere. The trichotomy of body, mind, and soul divides one part of ourselves from another. It is a concept in need of rethinking. We are a body-mind-spirit, an interconnected and interrelated set of parts that support and mutually affect one another. No one part by itself is complete, and no one section is superior to the other. (Kitchens, 1994, p. 86)

## APPENDIX

## Record of Interviews

- A. Patricia Caralon Colangelo Interviewed on 5/28/96  
 Vice-President/Family Program--Marworth Treatment Center  
 Currently private consultant
- B. Geraldine O. Delaney Interviewed on 7/11/95  
 C.E.O. Emeritus and Founder of Little-Hill Alina Lodge, NJ
- C. Joe S. Harrison Interviewed on 7/9/95  
 Episcopal Clergyman  
 Clinical Coordinator at Carrier Clinic--Belle Meade, NJ, 1973  
 Program Director at Fair Oaks Hosp-Summit, NJ, 1975-1984  
 Currently retired
- D. Williard M Interviewed on 7/22/96  
 College Professor, Texas  
 30-year Alcoholics Anonymous Member
- E. John Wallace, Ph.D. Interviewed on 12/6/95  
 Psychology Professor--Stanford University, University of California  
 at Irvine  
 Comprehensive Care Corporation  
 Clinical Director--Edgehill Treatment Center, Newport, RI  
 Author and Jazz Musician  
 Currently private consultant
- F. Maxwell N. Weisman, M.D. Interviewed on 1/5/96  
 Director of Alcoholism Control Administration for the  
 State of Maryland  
 Currently retired
- G. Searcy R. W. Interviewed on 8/28/95  
 50-year Alcoholics Anonymous Member  
 Attended early session of Yale School of Alcohol Studies  
 Assisted with Yale School of the Southwest  
 Established Southwest Clinics

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