The Big Book Primer

a teaching aide for sponsors in A.A.

by

Steve S.

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'And fools, who came to scoff,

remained to pray.'

excerpt from "The Deserted Village"

by Oliver Goldsmith, published 1770

THE DOCTOR'S OPINION[1]

We of Alcoholics Anonymous believe that the reader will be interested in the medical estimate of the plan of recovery described in this book. Convincing testimony must surely come from medical men who have had experience with the sufferings of our members and have witnessed our return to health. A well-known doctor[2], chief physician at a nationally prominent hospital specializing in alcoholic and drug addiction, gave Alcoholics Anonymous this letter:

To Whom It May Concern:

I have specialized in the treatment of alcoholism for many years.

In late 1934 I attended a patient who, though he had been a competent businessman of good earning capacity, was an alcoholic of a type I had come to regard as hopeless[3].

In the course of his third treatment he acquired certain ideas concerning a possible means of recovery[4]. As part of his rehabilitation he commenced to present his conceptions[5] to other alcoholics, impressing upon them that they must do likewise with still others[6]. This has become the basis of a rapidly growing fellowship of these men and their families. This man and over one hundred others appear to have recovered.

I personally know scores[7] of cases who were of the type with whom other methods had failed completely.

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[1] *play audio 01 thru 04*

[2] *refers to Dr. Silkworth, who worked at Towns Hospital in New York City.*

[3] *The patient he regarded as hopeless was Bill Wilson.*

[4] *play audio 05*

[5] *conception - the forming or devising of a plan or idea*

[6] *play audio 06*

[7] *scores - groups or sets of twenty or about twenty*

These facts appear to be of extreme medical importance; because of the extraordinary possibilities of rapid growth inherent[8]in this group they may mark a new epoch[9] in the annals[10] of alcoholism. These men may well have a remedy for thousands of such situations.

You may rely absolutely on anything they say about themselves.

Very truly yours,
William D. Silkworth, M.D.

The physician who, at our request, gave us this letter, has been kind enough to enlarge upon his views in another statement which follows. In this statement he confirms what we who have suffered alcoholic torture must believe that the body of the alcoholic is quite as abnormal as his mind. It did not satisfy us to be told that we could not control our drinking just because we were maladjusted[11] to life, that we were in full flight from reality, or were outright mental defectives. These things were true to some extent, in fact, to a considerable extent with some of us. But we are sure that our bodies were sickened as well. In our belief, any picture of the alcoholic which leaves out this physical factor is incomplete.

The doctor's theory that we have an allergy[12] to alcohol interests us. As laymen[**13**], our opinion as to its soundness may, of course, mean little.

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[8] *inherent - existing as a natural and permanent quality of something or someone*

[9] *epoch - a period of time in which there are developments and great change*

[10] *annals - historical records*

[11] *maladjusted - failing or unable to cope with the demands of a normal social environment*

[12] *allergy - occurs when a person reacts to substances in the environment that are harmless to most people.*

[13]*laymen - a person without professional or specialized knowledge*

But as ex problem drinkers, we can say that his explanation makes good sense. It explains many things for which we cannot otherwise account.

Though we work out our solution on the spiritual as well as an altruistic[14] plane[15], we favor hospitalization for the alcoholic who is very jittery or befogged. More often than not, it is imperative[16] that a man's brain be cleared before he is approached, as he has then a better chance of understanding and accepting what we have to offer.

The doctor writes:

> The subject presented in this book seems to me to be of paramount[17] importance to those afflicted with alcoholic addiction.
>
> I say this after many years' experience[18] as Medical Director of one of the oldest hospitals in the country treating alcoholic and drug addiction.
>
> There was, therefore, a sense of real satisfaction when I was asked to contribute a few words on a subject which is covered in such masterly detail in these pages.
>
> We doctors have realized for a long time that some form of moral psychology[19] was of urgent importance to alcoholics, but its application presented difficulties beyond our conception.
> What with our ultra-modern standards, our scientific approach to everything, we are perhaps not well equipped to apply the powers of good that lie outside our synthetic[20] knowledge.
>
> Many years ago one of the leading contributors[21] to this book came under our care in this hospital and while here he acquired some ideas which he put into practical application at once.

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[14] altruistic - *having or showing an unselfish concern for the welfare of others*
[15] *plane - a level of existence, thought, or development*
[16] *imperative - of vital importance; crucial*
[17] *paramount - more important than anything else; supreme.*
[18] *"many years' experience" meant nine years that Dr. Silkworth had been there.*
[19] *moral psychology - read letter to Dr. Jung (Appendix 1A)*
[20] *synthetic - having truth or falsity determinable by recourse to experience*
[21] *"one of the leading contributors to this book" referred to Bill Wilson.*

Later, he requested the privilege of being allowed to tell his story to other patients here and with some misgiving, we consented. The cases we have followed through have been most interesting; in fact, many of them are amazing. The unselfishness of these men as we have come to know them, the entire absence of profit motive, and their community spirit, is indeed inspiring to one who has labored long and wearily in this alcoholic field. They believe in themselves, and still more in the Power which pulls chronic alcoholics back from the gates of death.

Of course an alcoholic ought to be freed from his physical craving for liquor, and this often requires a definite hospital procedure, before psychological measures can be of maximum benefit.

We believe, and so suggested a few years ago[22], that the action of alcohol on these chronic alcoholics is a manifestation[23] of an allergy[24][25]; that the phenomenon [26]of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all; and once having formed the habit and found they cannot break it, once having lost their self-confidence, their reliance upon things human, their problems pile up on them and become astonishingly difficult to solve.

Frothy[27] emotional appeal seldom suffices[28]. The message which can interest and hold these alcoholic people must have depth and weight[29]. In nearly all cases, their ideals[30] must be grounded in a power greater than themselves, if they are to re-create their lives.

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[22] "*refers to two articles posted in 'The Medical Record' in 1937. (Appendix 1B)*
[23] *manifestation - an event or action that clearly shows or embodies something*
[24] *play audio 07*
[25] *allergy- see Joe and Charlie transcript (Appendix 1C&D)*
[26] *phenomenon - a fact or situation that is observed to exist or happen*
[27] *frothy - unsubstantial; trifling; shallow; empty.*
[28] *suffices - to be enough; be sufficient or adequate*
[29] *play audio 08*
[30] *ideals - a standard of perfection; a principle to be aimed at*

If any feel that as psychiatrists directing a hospital for alcoholics we appear somewhat sentimental, let them stand with us a while on the firing line, see the tragedies, the despairing wives, the little children; let the solving of these problems become a part of their daily work, and even of their sleeping moments, and the most cynical[31] will not wonder that we have accepted and encouraged this movement. We feel, after many years of experience, that we have found nothing which has contributed more to the rehabilitation of these men than the altruistic movement now growing up among them.

Men and women drink essentially because they like the effect produced by alcohol. The sensation is so elusive that, while they admit it is injurious, they cannot after a time differentiate the true from the false. To them, their alcoholic life seems the only normal one. They are restless, irritable and discontented, unless they can again experience the sense of ease and comfort which comes at once by taking a few drinks–drinks which they see others taking with impunity[32] [33]. After they have succumbed[34] to the desire again, as so many do, and the phenomenon of craving develops, they pass through the well-known stages of a spree, emerging remorseful, with a firm resolution not to drink again. This is repeated over and over, and unless this person can experience an entire psychic change there is very little hope of his recovery.

On the other hand–and strange as this may seem to those who do not understand–once a psychic change has occurred, the very same person who seemed doomed, who had so many problems he despaired of ever solving them, suddenly finds himself easily able to control his desire for alcohol, the only effort necessary being that required to follow a few simple rules.

Men have cried out to me in sincere and despairing appeal: "Doctor, I cannot go on like this! I have everything to live for! I must stop, but I cannot! You must help me!'

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[31] *cynical - believing that people are motivated purely by self-interest; distrustful of human sincerity or integrity*

[32] *impunity - exemption from the injurious consequences of an action*

[33] *play audio 09*

[34] *succumbed - to lose the determination to oppose something; to accept defeat*

Faced with this problem, if a doctor is honest with himself, he must sometimes feel his own inadequacy[35]. Although he gives all that is in him, it often is not enough. One feels that something more than human power is needed to produce the essential psychic change. Though the aggregate[36] of recoveries resulting from psychiatric effort is considerable, we physicians must admit we have made little impression upon the problem as a whole. Many types do not respond to the ordinary psychological approach.

I do not hold with those who believe that alcoholism is entirely a problem of mental control. I have had many men who had, for example, worked a period of months on some problem or business deal which was to be settled on a certain date, favorably to them. They took a drink a day or so prior to the date, and then the phenomenon of craving at once became paramount to all other interests so that the important appointment was not met. These men were not drinking to escape; they were drinking to overcome a craving beyond their mental control.

There are many situations which arise out of the phenomenon of craving which cause men to make the supreme sacrifice rather than continue to fight.

The classification of alcoholics seems most difficult, and in much detail is outside the scope of this book[37]. There are, of course, the psychopaths who are emotionally unstable. We are all familiar with this type. They are always “going on the wagon for keeps". They are over-remorseful and make many resolutions, but never a decision.

There is the type of man who is unwilling to admit that he cannot take a drink. He plans various ways of drinking. He changes his brand or his environment. There is the type who always believes that after being entirely free from alcohol for a period of time he can take a drink without danger. There is the manic-depressive type, who is, perhaps, the least understood by his friends, and about whom a whole chapter could be written.

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[35] *inadequacy - an instance of being inadequate; a failing or lack of*
[36] *aggregate - form or group into a class or cluster*
[37] *play audio 10*

Then there are types entirely normal in every respect except in the effect alcohol has upon them. They are often able, intelligent, friendly people.

All these, and many others, have one symptom in common: they cannot start drinking without developing the phenomenon of craving. This phenomenon, as we have suggested, may be the manifestation of an allergy which differentiates these people, and sets them apart as a distinct entity[38]. It has never been, by any treatment with which we are familiar, permanently eradicated[39]. The only relief we have to suggest is entire abstinence.

This immediately precipitates[40] us into a seething [41]caldron[42] of debate. Much has been written pro and con, but among physicians, the general opinion seems to be that most chronic alcoholics are doomed.

What is the solution? Perhaps I can best answer this by relating one of my experiences.

About one year prior to this experience a man was brought in[43] to be treated for chronic alcoholism. He had but partially recovered from a gastric hemorrhage and seemed to be a case of pathological[44] mental deterioration[45]. He had lost everything worthwhile in life and was only living, one might say, to drink. He frankly admitted and believed that for him there was no hope. Following the elimination of alcohol, there was found to be no permanent brain injury. He accepted the plan outlined in this book.

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[38] *entity - a thing with distinct and independent existence*
[39] *eradicated - destroy completely; put an end to*
[40] *precipitates - to make something happen suddenly or sooner than expected*
[41] *seething - extremely angry but unable or unwilling to express it clearly*
[42] *caldron - a large kettle or boiler*
[43] *the man brought in to be treated for chronic alcoholism was Hank Parkhurst. He authored 'To Employers'*
[44] *pathological - unable to control part of their behavior; unreasonable*
[45] *deterioration - the process of becoming progressively worse*

One year later he called to see me, and I experienced a very strange sensation. I knew the man by name, and partly recognized his features, but there all resemblance ended. From a trembling, despairing, nervous wreck, had emerged a man brimming over with self-reliance and contentment. I talked with him for some time, but was not able to bring myself to feel that I had known him before. To me he was a stranger, and so he left me. A long time has passed with no return to alcohol.

When I need a mental uplift, I often think of another case brought in by a physician prominent in New York[46]. The patient[47] had made his own diagnosis, and deciding his situation hopeless, had hidden in a deserted barn determined to die. He was rescued by a searching party, and, in desperate condition, brought to me. Following his physical rehabilitation, he had a talk with me in which he frankly stated he thought the treatment a waste of effort, unless I could assure him, which no one ever had, that in the future he would have the "will power' to resist the impulse to drink.

His alcoholic problem was so complex, and his depression so great, that we felt his only hope would be through what we then called "moral psychology,' and we doubted if even that would have any effect.

However, he did become "sold' on the ideas contained in this book. He has not had a drink for a great many years. I see him now and then and he is as fine a specimen of manhood as one could wish to meet.

I earnestly advise every alcoholic to read this book through, and though perhaps he came to scoff, he may remain to pray.

William D. Silkworth, M.D.

[46] *physician - ???*

[47] *the man who had hidden in a barn was Fitz Mayo. His story in the BB is "Our Southern Friend."*

APPENDIX 1

A. Letter to Dr. Carl Gustav Jung

1/23/61

My dear Dr. Jung:

This letter of great appreciation has been very long overdue.

May I first introduce myself as Bill W., a co-founder of the Society of Alcoholics Anonymous. Though you have surely heard of us, I doubt if you are aware that a certain conversation you once had with one of your patients, a Mr. Rowland H., back in the early 1930's, did play a critical role in the founding of our Fellowship.

Though Rowland H. has long since passed away, the recollections of his remarkable experience while under treatment by you has definitely become part of AA history. Our remembrance of Rowland H.'s statements about his experience with you is as follows:

Having exhausted other means of recovery from his alcoholism, it was about 1931 that he became your patient. I believe he remained under your care for perhaps a year. His admiration for you was boundless, and he left you with a feeling of much confidence.

To his great consternation, he soon relapsed into intoxication. Certain that you were his "court of last resort," he again returned to your care. Then followed the conversation between you that was to become the first link in the chain of events that led to the founding of Alcoholics Anonymous.

My recollection of his account of that conversation is this: First of all, you frankly told him of his hopelessness, so far as any further medical or psychiatric treatment might be concerned. This candid and humble statement of yours was beyond doubt the first foundation stone upon which our Society has since been built.

Coming from you, one he so trusted and admired, the impact upon him was immense.

When he then asked you if there was any other hope, you told him that there might be, provided he could become the subject of a spiritual or religious experience – in short, a genuine conversion. You pointed out how such an experience, if brought about, might remotivate him when nothing else could. But you did caution, though, that while such experiences had sometimes brought recovery to alcoholics, they were, nevertheless, comparatively rare. You recommended that he place himself in a religious atmosphere and hope for the best. This I believe was the substance of your advice.

Shortly thereafter, Mr. H. joined the Oxford Groups, an evangelical movement then at the height of its success in Europe, and one with which you are doubtless familiar. You will remember their large emphasis upon the principles of self-survey, confession, restitution, and the giving of oneself in service to others. They strongly stressed meditation and prayer. In these surroundings, Rowland H. did find a conversion experience that released him for the time being from his compulsion to drink.

Returning to New York, he became very active with the "O.G." here, then led by an Episcopal clergyman, Dr. Samuel Shoemaker. Dr. Shoemaker had been one of the founders of that movement, and his was a powerful personality that carried immense sincerity and conviction.

At this time (1932-34) the Oxford Groups had already sobered a number of alcoholics, and Rowland, feeling that he could especially identify with these sufferers, addressed himself to the help of still others. One of these chanced to be an old schoolmate of mine, Edwin T.("Ebby"). He had been threatened with commitment to an institution, but Mr. H. and another ex-alcoholic "O.G." member procured his parole and helped to bring about his sobriety.

Meanwhile, I had run the course of alcoholism and was threatened with commitment myself. Fortunately I had fallen under the care of a physician – a Dr. William D. Silkworth – who was wonderfully capable of understanding alcoholics. But just as you had given up on Rowland, so had he given me up. It was theory that alcoholism had two components – an obsession that compelled the sufferer to drink against his will and interest, and some sort of metabolism difficulty which he then called an allergy.

The alcoholic's compulsion guaranteed that the alcoholic's drinking would go on, and the allergy made sure that the sufferer would finally deteriorate, go insane, or die. Though I had been one of the few he had thought it possible to help, he was finally obliged to tell me of my hopelessness; I, too, would have to be locked up. To me, this was a shattering blow. Just as Rowland had been made ready for his conversion experience by you, so had my wonderful friend, Dr. Silkworth, prepared me.

Hearing of my plight, my friend Edwin T. came to see me at my home where I was drinking. By then, it was November 1934. I had long marked my friend Edwin for a hopeless case. Yet there he was in a very evident state of "release" which could by no means accounted for by his mere association for a very short time with the Oxford Groups. Yet this obvious state of release, as distinguished from the usual depression, was tremendously convincing. Because he was a kindred sufferer, he could unquestionably communicate with me at great depth. I knew at once I must find an experience like his, or die.

Again I returned to Dr. Silkworth's care where I could be once more sobered and so gain a clearer view of my friend's experience of release, and of Rowland H.'s approach to him.

Clear once more of alcohol, I found myself terribly depressed. This seemed to be caused by my inability to gain the slightest faith. Edwin T. again visited me and repeated the simple Oxford Groups' formulas.

Soon after he left me I became even more depressed. In utter despair I cried out, "If there be a God, will He show Himself." There immediately came to me an illumination of enormous impact and dimension, something which I have since tried to describe in the book "Alcoholics Anonymous" and in "AA Comes of Age", basic texts which I am sending you.

My release from the alcohol obsession was immediate. At once I knew I was a free man.

Shortly following my experience, my friend Edwin came to the hospital, bringing me a copy of William James' "Varieties of Religious Experience". This book gave me the realization that most conversion experiences, whatever their variety, do have a common denominator of ego collapse at depth. The individual faces an impossible dilemma. In my case the dilemma had been created by my compulsive drinking and the deep feeling of hopelessness had been vastly deepened by my doctor. It was deepened still more by my alcoholic friend when he acquainted me with your verdict of hopelessness respecting Rowland H.

In the wake of my spiritual experience there came a vision of a society of alcoholics, each identifying with and transmitting his experience to the next – chain style. If each sufferer were to carry the news of the scientific hopelessness of alcoholism to each new prospect, he might be able to lay every newcomer wide open to a transforming spiritual experience. This concept proved to be the foundation of such success as Alcoholics Anonymous has since achieved. This has made conversion experiences – nearly every variety reported by James – available on an almost wholesale basis. Our sustained recoveries over the last quarter century number about 300,000. In America and through the world there are today 8,000 AA groups.

So to you, to Dr. Shoemaker of the Oxford Groups, to William James, and to my own physician, Dr. Silkworth, we of AA owe this tremendous benefaction. As you will now clearly see, This astonishing chain of events actually started long ago in your

consulting room, and it was directly founded upon your own humility and deep perception.

Very many thoughtful AAs are students of your writings. Because of your conviction that man is something more than intellect, emotion, and two dollars worth of chemicals, you have especially endeared yourself to us.

How our Society grew, developed its Traditions for unity, and structured its functioning will be seen in the texts and pamphlet material that I am sending you.

You will also be interested to learn that in addition to the "spiritual experience," many AAs report a great variety of psychic phenomena, the cumulative weight of which is very considerable. Other members have – following their recovery in AA – been much helped by your practitioners. A few have been intrigued by the "I Ching" and your remarkable introduction to that work.

Please be certain that your place in the affection, and in the history of the Fellowship, is like no other.

Gratefully yours,

William G. W.

Co-founder Alcoholics Anonymous

B. Dr. Silkworth's Article On The Allergy (1 of 2)

Alcoholism as a Manifestation of Allergy

W. D. Silkworth, New York, N.Y.

293 CENTRAL PARK WEST
THE MEDICAL RECORD MARCH 17, 1937

Alcoholism is considered by many physicians a chronic condition that gradually unfolds itself to a dismal end. They feel that it is a state of mind and advise these patients that it is up to them to discontinue their accustomed drug, which it is assumed they can do by merely making up their minds to do so. Proper attention is not given to the psychological problem as well as the physical condition of these people.

Partly as a result, the economic and social importance of alcoholism is astounding, and only those in close touch with this phase of medicine realize that the situation is a direct challenge to the physician, worthy of his best efforts. It is rendered more acute by the invasion of public bars by women and young girls, the vicious institution of the “cocktail hour” and the “new freedom” that have resulted from general demoralization during the post-war era. The subject now, concerns both sexes and all ages to a degree never before experienced, and its importance will not be fully realized until the present generation has reached middle life.

A heavy responsibility, therefore, rests upon the physician. No other condition has attained such general and widespread proportions. 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.

The reason for this lies not only in the influences we have noted already, but in the fact that heretofore alcoholism has been considered a vice within the control of the relatively few individuals concerned and not as a disease entity in its more subtle and damaging aspects; and all that has been expected of the physician has been the administration of sedatives, purges and emetics to control acute stages.

It is our purpose to show that there is a type of alcoholism characterized by a definite symptomatology and a fixed diagnosis indicative of a constant and specific pathology; in short, that true alcoholism is a manifestation of allergy. If the arguments adduced appear to upset traditional ideas on the subject, it is because the major points of diagnostic importance as well as the fundamental basis of the physical and mental alterations that occur in the victims, have not heretofore been correlated or analyzed with the same interest that attaches to other conditions that are no more serious but elicit more sympathy. As the result of observations of numerous cases at Towns Hospital, New York City, over a period of years, clinical constants have been derived and data have been accumulated which indicate that the subject must be considered from the constitutional and serological point of view.

We may set it down as a fundamental proposition that alcoholism is not a habit. Second, drunkenness and alcoholism are not synonymous. Intoxication with alcohol, as commonly observed, is a purely superficial manifestation of no diagnostic importance whatever in itself; nor is the desire to take a drink, which is common to many. The majority of people who drink alcohol apparently do so with impunity. Prohibition revealed, among other things, how much people desire to use alcohol on all sorts of occasions, and that this desire, and intention, are not limited to chronic alcoholics.

The judge, the senator, the preacher, all want their alcohol on occasion. The merchant or the broker closes transactions over a highball and frequently indulges several times daily for many years. The clubman and the society matron, the daily laborer, the high and the low alike may drink daily more or less liberally of any and all sorts of liquor during much of their life time.

They may, and do, become intoxicated; but note that in the majority of such cases alcohol exhibits only the immediate effects of the drug, and recovery is prompt and uncomplicated. Copious elimination, with a cold pack on the head and a brisk shower bath on the “morning after” end the matter. Also note, for later comparison, that if, for any reason, this type of drinker decides to “swear off”, he experiences no more physical or mental pang than accompanies the abandonment of any other habitual mode of living. There is no “problem”, no struggle, no psychic complications to be met, nothing but the transient inconvenience of interruption in his usual customs. For one reason or another he has decided that the inducements to stop drinking are greater than those to continue it. He has had a one hundred percent change of mind and his will is one hundred percent free to act accordingly.

Such people drink from choice and not from necessity. They find in alcohol a pleasant stimulation, a relief from anxieties, an increased warmth of conviviality. It is not a dominant factor in their lives. They are normal people, mentally and physically, to all intents and purposes. We must keep in mind, also, the fact that the multitude of persons who exhibit misbehavior conduct through faulty upbringing or complexes, who are oppressed by a sense of humiliation or inferiority because of unfriendly or disapproving associates or because of some physical defect, and find that a few drinks enable them to consider themselves the equals of any or even superior to all others, are not to be classed as chronic alcoholics merely because they indulge in alcohol regularly.

A change of environment, a new mental attitude, or the restoration of confidence in themselves may suffice to bring about a totally new policy on their part.

The significant point is that under such circumstances, if they desire to stop drinking they can do it without a struggle. They have no need to lean upon anyone else or anything outside of themselves for support. Alcohol is not necessary for them.

This, we believe, is a fair view of the general drinking public, and constitutes a familiar background against which to contrast a very different picture. These people are not true alcoholics, but they may become so; and it is from among them that the real alcoholics are derived.

Let us now contrast with this kind of drinker an entirely different type. He is, as we have noted, a development of the class we have just described, his history may be quite like that of the average. But sooner or later there comes a time when he manifests changes that place him in a classification characterized by symptoms that were entirely lacking before, and unequivocally set him apart from the average drinker. Whereas he formerly drank for pleasure, he now has to drink from necessity in order to keep going. He cannot take his liquor or leave it, as he used to do.

Yet, even if he is more or less soaked with it all day, his mind at first functions fairly well, he transacts his business with fair efficiency and keeps up with his obligations to his associates and the community. But he discovers that a change has occurred in him. He finds that he has to have a drink in the morning. Then he finds, after a little more time, that his hand shakes; when he signs his name, for example. Later, irritability and lack of concentration supervene. He is not the man temperamentally that he used to be. In order to meet these changes and increasing symptoms, he is compelled to increase the amount he consumes, and a prolonged spree replaces a short intoxication.

PHYSICAL SYMPTOMS OF ALCOHOLISM

The spree is characterized by certain definite physical symptoms in all such cases. The phenomenon of craving is prominent; there are complete loss of appetite, insomnia, dry skin and hyper motor activity. He has a feeling of anxiety which amounts to a nameless terror. He presents the picture of a person who has just finished a race but must have more stimulation to start again at once. Alcohol in itself does not produce these symptoms in the average individual any more than the daily use of alcohol produces a chronic alcoholic in the absence of constitutional allergy.

But note that, in sharp contrast to the progress of these developments, 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, in whom the phenomenon of craving is not present. His friends and family remark the alterations occurring in him. He himself, notices them and also what is apparent to everyone else, that a very little alcohol has an effect on him altogether out of proportion to the amount taken, and different from what he used to expect. It is not at all unusual, in fact it is the rule, for such a person to say, for example: “I drank for twenty years but it never affected me this way before.” It is to be noted here that it does not take twenty years to form a habit.

One case epitomized the whole clinical picture in these words: “I can make more money in a day than you can in a year. I can, and do, handle big things. I carry on transactions that keep two or three telephones on my desk busy all day. But I can’t take a drink any more. What is the difference between you and me? A psychiatrist tells me it is in here (indicating his head); that I can’t face reality.” That particular person does nothing else. He lives in and faces reality all day.

These changes mark the early stages of true alcoholism, and the beginning of a chain of symptoms that show a remarkable constancy. They occur in comparatively rapid sequence during a period of from four to six months in the course of what had been ordinary drinking habits for perhaps many years previously. At this point, even during periods of partial or complete sobriety, he develops a state of anxiety amounting to a vague fear, then depression and lack of concentration, with gradually growing indifference or complete apathy toward his former interests.

Unreliability, changes in personality, loss of appetite, insomnia and tachycardia follow. He is under such tension in the effort to control himself that he has to have a drink in order to hold himself together. At the same time, and we have observed few exceptions to this, these individuals will tell you that they not only have no liking for liquor but dread to take it; and, to anyone who has watched such a person, it is obvious that this is true. But he believes he must have it, even though he realizes that, in his particular case, a single drink will plunge him into such a condition that a prolonged spree will be the inevitable result. After the first drink, and only then, does he experience the physical phenomenon of craving.

I cannot emphasize too strongly the point that this man does not go on a spree from pure deviltry or desire. He often has important engagements or appointments or decisions to make the following day, to which he has given serious consideration. The situation cannot be duplicated in what we may call the "normal" or nonalcoholic drinker, who is accustomed to his few drinks a day, year in and year out, and never goes on a spree.

When a man gets into this state, it is a remarkable and noteworthy fact that he needs only a comparatively small amount to keep him more or less interested in affairs. All he wants, and must have, is a drink every so often.

It is as if these small pushes were enough, in contrast to the ordinary "drunk" who finishes the bottle at one sitting, becomes intoxicated and goes on his way again, apparently none the worse, after the drug has been eliminated. These small pushes that propel the true alcoholic through his day, are one phase of a vicious cycle, apparently, culminating in complete debauch, after which the cycle begins again.

ALCOHOLISM A TRUE ALLERGIC STATE

The inevitable conclusion is that true alcoholism is an allergic state, the result of gradually increasing sensitization by alcohol over a more or less extended period of time. The constancy of the symptoms and progress is too fixed to permit any other explanation. Some are allergic from birth, but the condition usually develops later in life. The development and course of these cases are quite comparable with the history of hay fever patients in many respects. One may enjoy absolute freedom for many years from any susceptibility to pollen. Year after year, however, there gradually develops a sensitivity to it in certain individuals, culminating at last in paroxysms of hay fever that persist indefinitely when the condition is fully established.

It is noteworthy also, that such patients may be deprived of liquor altogether for a long period, a year or longer for example, and become apparently normal. They are still allergic, however, and a single drink will develop the full symptomatology again.

There is another class of allergics who exhibit periodicity. At certain regular intervals, predictable in a given case almost to a day, varying from a few months to a year, these patients desire liquor. After a prolonged spree, they are apparently normal during the succeeding interval.

These alternating cycles have a tendency to shorten the intervals between debauches, and these patients, also, deny any craving. Certainly it seems absurd to think that a man should have a craving only on certain fixed dates. Rather, we must take into consideration the fact that a manic depressive cycle is normal to all individuals. The ordinary person "down in the dumps" cheers up on a drink or several drinks, if that mode appeals to him, gets into a merry, or mellow, mood, takes a cold shower in the morning and is done with it.

The manic-depressive type who is allergic, however, goes on a spree and must carry it, willy-nilly, to a finish that may require a week or more, until a complete nerve and mental demoralization brings it to a termination through sheer exhaustion and inability to stand anymore abuse for the time being. We also have the constitutional psychopaths who become allergic to alcohol, and are emotionally unstable and inadequate. The prognosis in these cases is most unfavorable.

PHYSICAL AND PSYCHOLOGICAL TREATMENT

The physical treatment of these patients has heretofore been unsatisfactory. But if we recognize the condition as a species of anaphylaxis occurring in persons constitutionally susceptible to sensitization by alcohol, the problem resolves itself into two factors. First, the revitalizing and normalizing of cells, and second, the energizing of the normalized cells into producing their own defensive mechanism. As long ago as 1916, Professor Bechhold of Leipzig University, in his textbook on Colloids in Biology and Medicine, said: "Someday, chronic alcoholism may possibly receive a physicochemical explanation from the change in the condition of the body colloids." On the mental side, from our point of view, the situation is a practical one and must be met through the medium of intelligence and not emotion.

Nothing is to be gained by substituting one emotion for another. The patient cannot use alcohol at all for physiological reasons. He must understand and accept the situation as a law of nature operating inexorably. Once he has fully and intelligently grasped the facts of the matter he will shape his policy accordingly.

It is true, of course, that psychologically much assistance can be given. Wrong methods of thinking can be corrected. Extroversion rather than introversion can be encouraged; but fundamentally this individual must stand on his own platform, come what will – social and financial troubles, heredity, etc., notwithstanding.

In a subsequent paper, we shall discuss special therapeutics applicable to the treatment of the allergic type of case, describe some of the outstanding results that we have seen from this line of approach in this hospital and discuss moral psychology, the necessity for discriminating between those who must be hospitalized and those who can be treated at home. The complications to be met and other factors influencing treatment are so numerous and require so much space that it is not practicable to include a discussion of them in this paper.

C. Joe & Charlie - More On The Allergy

(30:20)

"The Doctor's Opinion is no longer just an opinion, it's actual truth now."

" I want to stress that this is not A.A. information. A.A. won't get involved into why we're allergic because that might bring controversy. This information presented to us a few years ago by members of the medical profession is so interesting and has such depth and meaning for people like us, I think we would be remiss if we didn't look at it. So let's look at it for just a moment. In the center of that picture there's nine people there that drink safely, they are at ease with alcohol. They take a drink or two (and) the mind and body senses it. The enzyme production starts and the enzyme detects the alcohol, breaks it down into acetaldehyde, then to diacetic acid and then to acetone.

In the final stages it becomes a simple carbohydrate made up of water, sugar and carbon dioxide. The water will be dissipated through the urinary intestinal tract. The sugar is calories, energy, empty calories, none of the amino acids, none of the vitamins, but a form of energy. The body will burn them and store the excess as a fat, to be used at a later date. The carbon dioxide will be dissipated to the lungs.

In the normal social drinker this takes place at the rate of approximately one ounce per hour. I know it'll vary with different people, but the average is one ounce per hour. If they don't drink more than an ounce per hour, they can't get drunk. Their body metabolizes it, burns it up and gets rid of it at that rate.

Very seldom do you see a social drinker drinking more than an ounce per hour. If you're with one of them and they're drinking more than an ounce per hour, you better get out of the way because they're going to puke on you. They'll either go to sleep or they'll puke on you, one of the two every time.

We alcoholics put it in our body the same thing happens, the enzymes attack the alcohol, break it down to acetaldehyde, then to diacetic acid and then acetone. It seems as though in our bodies the enzymes necessary to complete the metabolism , breaking it down from acetone to the simple carbohydrate are not there in the same qualities and/or quantities as they are in the body of the non-alcoholic.

Therefore it stays in our body for a longer period of time as acetone. It is proven today that acetone, ingested into the human system, that remains there for an appreciable period of time will produce an actual physical craving for more of the same. In the non-alcoholics body it goes through that stage so rapidly the craving never occurs. In our body it stays there long enough that the craving develops and that demands a second drink.

Now just think you have most of the acetone from the first drink, now you add that to the second drink and the acetone level goes up. If the acetone is what causes the craving then the craving becomes harder with the second drink. Now you put in the third drink, you got most of the first drinks acetone, and all of the second drinks. When you add in the acetone from the third, the craving goes up and that demands the fourth. Then you have most of the first drinks acetone, nearly all the second drinks and all from the third drink now you put in the acetone from the fourth and as the acetone level increases the craving becomes harder.

D. NIH - Alcohol Metabolism

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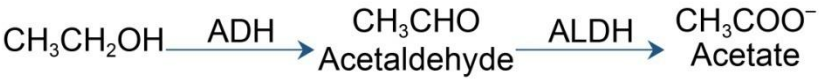
The Chemical Breakdown of Alcohol

Alcohol is metabolized by several processes or pathways. The most common of these pathways involves two enzymes—alcohol dehydrogenase (ADH) and aldehyde dehydrogenase (ALDH). These enzymes help break apart the alcohol molecule, making it possible to eliminate it from the body. First, ADH metabolizes alcohol to acetaldehyde, a highly toxic substance and known carcinogen.[1] Then, acetaldehyde is further metabolized down to another, less active byproduct called acetate,[1] which then is broken down into water and carbon dioxide for easy elimination.2

Other enzymes

The enzymes cytochrome P450 2E1 (CYP2E1) and catalase also break down alcohol to acetaldehyde. However, CYP2E1 only is active after a person has consumed large amounts of alcohol, and catalase metabolizes only a small fraction of alcohol in the body.[1] Small amounts of alcohol also are removed by interacting with fatty acids to form compounds called fatty acid ethyl esters (FAEEs). These compounds have been shown to contribute to damage to the liver and pancreas.[3]

The Chemical Breakdown of Alcohol



The chemical name for alcohol is ethanol (CH3CH2OH). The body processes and eliminates ethanol in separate steps. Chemicals called enzymes help to break apart the ethanol molecule into other compounds (or metabolites), which can be processed more easily by the body. Some of these intermediate metabolites can have harmful effects on the body.

Most of the ethanol in the body is broken down in the liver by an enzyme called alcohol dehydrogenase (ADH), which transforms ethanol into a toxic compound called acetaldehyde (CH3CHO), a known carcinogen. However, acetaldehyde is generally short-lived; it is quickly broken down to a less toxic compound called acetate (CH3COO-) by another enzyme called aldehyde dehydrogenase (ALDH). Acetate then is broken down to carbon dioxide and water, mainly in tissues other than the liver.

Acetaldehyde: A toxic byproduct

Much of the research on alcohol metabolism has focused on an intermediate byproduct that occurs early in the breakdown process—acetaldehyde. Although acetaldehyde is short-lived, usually existing in the body only for a brief time before it is further broken down into acetate, it has the potential to cause significant damage. This is particularly evident in the liver, where the bulk of alcohol metabolism takes place.[4] Some alcohol metabolism also occurs in other tissues, including the pancreas[3] and the brain, causing damage to cells and tissues.[1] Additionally, small amounts of alcohol are metabolized to acetaldehyde in the gastrointestinal tract, exposing these tissues to acetaldehyde's damaging effects.[5]

In addition to acetaldehyde's toxic effects, some researchers believe that it may be responsible for some of the behavioral and physiological effects previously attributed to alcohol.[6] For example, when acetaldehyde is administered to lab animals, it leads to incoordination, memory impairment, and sleepiness, effects often associated with alcohol.[7]

On the other hand, other researchers report that acetaldehyde concentrations in the brain are not high enough to produce these effects.[7] This is because the brain has a unique barrier of cells (the blood–brain barrier) that help to protect it from toxic products circulating in the bloodstream. It is possible, however, that acetaldehyde may be produced in the brain itself when alcohol is metabolized by the enzymes catalase[8,9] and CYP2E1.[10]

For more information, please visit: **https://www.niaaa.nih.gov**

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E. Treatment of Opium Addiction - 1908

Notes of the Jungle Plant
(Combretum Sundiacum)

Exhibit of Cases.
By W. Duncan Silkworth, M.D.,
New York,
Member of the Medical Society of the County of New York.

The various manifestations of chronic morphine and opium poisoning are conditions so well known that further reference to them is not necessary in calling attention to the antiopium plant which has been used with apparent success in the Far East. In passing, however, I should like briefly to allude to the term morphinomania, as commonly used and placed in the same category with dipsomania, which as a disease is almost universally considered uncurable. The vast majority of those addicted to morphine would, beyond doubt, discontinue its use promptly were it not for the physical torture which would almost immediately supervene. They use the drug from necessity, not from desire. There are unfortunate cases where neurasthenia or some peculiarity of constitution renders a permanent withdrawal of the drug almost impossible, and to this limited class may be attributed the origin of the term morphinomania, a morbid craving for morphine. In opium smoking, the pipe itself, the lamp, and associations are powerful factors in considering the possibilities of a permanent cure. There are many who, long after they have discontinued the drug, will continue to light each night the small lamp used in preparing the opium for smoking, so that after a few years' use of the drug these are the habits they crave possibly more than the opium itself. A more healthy and humane conception by physicians of drug addiction will do much toward eliminating the habit and will turn to legitimate channels the thousands of dollars which now fill the pockets of advertising frauds.

A party of Chinese wood cutters were presumedly the first to discover the properties of the drug which is now used extensively as a cure for the opium smoking habit in the Federated Malay States. The plant is a large climber, with a long woody stem often reaching a height of one hundred or more feet.

Read to the New York County Medical Society, February 24, 1908. Reprinted with permission of the Silkworth family.

In the *Materials for a Flora of the Malayan Peninsula* it is described botanically by Lieutenant Colonel Sir George King and is shown to belong to the order *Combretum sundiacum*. Sir George Watt, in a dictionary of the economic products of India, mentions two species of the genus as being used in native Indian medicine, but with no details as to their uses or properties.

In preparing the drug, the branches and leaves are chopped into pieces about one and a half inches in length; after drying, the woody portions are separated from the leaves, and both the bark and the leaves roasted, the leaves to a less extent than the bark. Upon completion of this process the two portions are mixed together again.

The infusion is prepared by taking, for example, ten ounces avoirdupois of the roasted drug and mixing with about four gallons of water. This solution is kept boiling for three hours, being loosely covered to prevent too rapid evaporation. The liquid is then strained and is ready for use. I do not believe that a fixed rule for prescribing can be laid down, but in general the method of administration to an opium smoker would be as follows:

Whatever the daily amount of opium the person habitually smokes, that amount is to be mixed with the infusion. The average allowance would be from sixty to one hundred and twenty grains, although beyond doubt a considerable quantity of the alkaloids are not absorbed into the system of the smoker. If, for example, one hundred and twenty grains had been the daily allowance, then two twenty-five ounce bottles of the infusion A and B are used. Into A is put one hundred and twenty grains of burnt opium (that is prepared the same as if for smoking). From the bottle A one and a half ounces is given to the patient and one and a half ounces from bottle B is put into bottle A. This is repeated each time a dose is taken, usually three times a day. Bottle A maintains its bulk, although continually decreasing in its opium contents until bottle B is exhausted. At the end of this course a second treatment is given, beginning with about one third the initial amount of opium used, and upon completion of this the patient should be cured. With twenty-five ounces in the bottle and one and a half ounces at each dose, there would be about sixteen doses in each bottle. Each dose would represent a decrease of one sixteenth of the total amount of opium left from each succeeding dose up to the seventeenth dose on the sixth day, or until bottle B is exhausted. There would then be no further change to the thirty-second dose, when the entire one hundred and twenty grains would have been taken and the contents of the two bottles exhausted.

The remedy, while not a panacea, seems to offer the best medium of reduction thus far given to the profession, and while my experiments have been confined solely to the practical demonstration of the plant, I am led to believe that there may be present in the remedy an active ingredient, antiopium in its properties. The burnt opium in gradually decreasing doses certainly plays an important role in the treatment, but this alone, or in combination with any other form of medication heretofore known, has been, on the whole, unsatisfactory.

Both physician and patient must work together in harmony, and the suffering incident to the discontinuance of a powerful drug must be mitigated as much as possible, if permanent results are to be obtained.

I wish to acknowledge the great assistance which was given by the Rev. W. E. Horley, of the Methodist Episcopal Mission at Kuala Lumpur, and L. Wray, Esq., I. S. O., whose paper in *The Journal Federated Malay States Museums* has formed the basis of my investigations. The Rev. Mr. Horley writes me that "thousands have been cured, but, alas, many have returned to the drug. Will power and the grace of God are needed in conjunction with the remedy."

CASE I.—Mrs. M. had used the drug continuously for sixteen years, the habit having been acquired at the age of fifteen; the daily amount of opium taken by the patient varied from sixty to one hundred and twenty grains. No other drug or stimulant had been used.

The condition of the patient was critical, melancholia was pronounced, accompanied by a state of mental and physical collapse. Not being acquainted with the action of the new remedy, it was considered best to first improve the general condition of the patient, and a short preliminary treatment under the usual methods was given, during which the daily amount of the drug was somewhat reduced. The remedy was then prepared and administered as follows:

The initial amount of the solution prepared was equivalent to fifty ounces; with twenty-five ounces of this was dissolved one hundred grains of burnt opium; three doses were given a day, about one and one half ounces at each dose, the remaining twenty-five ounces being used to dilute the first solution in like proportion as each dose was taken. The reduction of the opium during the first five days amounted to about one sixteenth of the total amount at each dose. From the fifth to the seventh day the reduction remained con-

stant. During the eighth day the dose was slightly increased, this change of administration being necessary to relieve headache, accompanied by restlessness and to frequent attacks of sneezing; the distressing gastrointestinal symptoms so often connected with the withdrawal of opium or morphine not occurring during the entire treatment. Improvement in condition on the ninth day being apparent, the initial dose was again resumed and the course completed on the tenth day. The symptoms, however, not having sufficiently abated, a second course was commenced, beginning with one third of the initial amount of opium. The reduction was then continued without interruption to the eighth day of the second course, when the remedy was discontinued without further inconvenience.

In connection with this case, it may be of interest to add that in investigating the past history of the patient, it was found that James McNally, a one time famous green goods man and now in the New York City Almshouse, was the first to initiate Mrs. M. in the use of the drug at the early age of fifteen, and that practically from that time until the treatment was given she was an absolute slave to the habit, devoting almost her entire time to its use or as attendant to other users of the drug, to many of whom she is well known.

CASE II.—Miss F., a trained nurse, apparently very desirous of being cured, had used morphine, ten grains subcutaneously for ten years. Accomplished three quarters of the treatment with apparent success, but for reasons not clear to me, relapsed, although stoutly denying the same.

CASE III.—Mr. M. first acquired the opium smoking habit in Boston, fourteen years ago. After two years of smoking shifted to morphine subcutaneously, which has since been used continuously in amounts varying from fifteen to sixty grains in twenty-four hours. A preliminary treatment was given and with the intelligent cooperation of the patient, the drug was reduced from fifteen grains subcutaneously to four grains internally. One hundred and twenty grains of burnt opium were then dissolved with twenty-five ounces of the solution and three doses were given a day, following closely the procedure of the first case. Three courses were given and the treatment voluntarily discontinued. [Mr. M. here reported his own story to the society.]

CASE IV.—Mr. H. L. Opium smoking habit of fourteen years' duration. General condition fair for this class of case. Some emaciation and quite marked nervous twitching. Patient used about eighty grains of opium in twenty-four hours. Under a short preliminary treatment the drug was

reduced slightly and the general condition somewhat improved. Sixty grains of burnt opium were then dissolved with twenty-five ounces of the solution. Three doses were given a day, one and a half ounces at each dose, with no variation in the regular scale of reduction up to the sixth day. The number and amount of the doses were then voluntarily decreased by the patient and finally discontinued on the twelfth day. During the entire treatment no other drug or stimulant was used. As in the former cases, attention to hygiene and diet were insisted upon.

CASE V.—Mr. E. W. Morphine habit of seven years' duration. Daily amount nine grains internally. Regular toxæmic symptoms with very pronounced pallor and emaciation. Tonics were given, and with the earnest cooperation of the patient the drug was reduced from nine grains to four grains a day. The treatment was administered as in the previous cases, two courses completing the cure, covering a period of twenty-one days.

CASE VI.—Mr. E. M. Morphine habit of eight years' duration. Daily amount eight grains internally. Condition fair. The regular course of treatment was followed and the drug reduced to two grains in twenty-four hours. Two courses of the treatment completed the cure, which has just been accomplished within the past few days.