A. A. HISTORY
BEFORE 1935

The Emmanuel Movement and Richard Peabody
Includes articles and a reprint of Courtenay Baylor's book,
REMAKING A MAN
THE EMMANUEL MOVEMENT
AND
RICHARD PEABODY
THE EMMANUEL MOVEMENT

AND

RICHARD PEABODY
FORWARD

The Emmanuel Movement and Richard Peabody. Who were they? What was their method of treating alcoholism? These are questions which every student of Alcoholics Anonymous and its precursors would ask.

This collection of papers is presented in a sequence which will allow the reader to understand the history and principles of the Emmanuel Movement and the evolution of lay-therapy and their role in the treatment of alcoholism.

The book Remaking A Man by Courtenay Baylor has been reproduced as it is long out of print and will be of great interest to the reader.

It is our hope that this volume will inform and educate the reader in the history of the treatment of alcoholism during this period of history.
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Alcoholics and those who treat them have been of necessity present oriented. The day-to-day effort of maintaining or promoting abstinence in living people leaves little attention for reflection on the history of treatment. This history can, however, provide much needed perspective on the problems and limitations of treatments; it permits us to learn from both the success and failure of earlier work and philosophies.

This article will outline the history of what is usually called the "Peabody Method" of recovery from alcoholism. Its best known practitioner, Richard Peabody, began treating alcoholics individually in the early 1920s; his followers continued until the 1950s. As with the later Alcoholics Anonymous program, its roots were in Protestant religious thought rather than in medicine. Its later practitioners imitated the psychiatric model of professional practice, but their ideas stemmed from pre-Freudian, characteristically American Progressive thought.

Peabody's book The Common Sense of Drinking, first published in Boston in 1931 was widely read and influenced several medical and lay practitioners. The basic strategy did not originate with Peabody, however, he refined and "professionalized" ideas that he had learned in the Emmanuel Movement from Dr. Elwood Worcester and Courtenay Baylor.

The Emmanuel Movement began in Boston in 1906 in the Emmanuel (Episcopal) Church. The movement's founder, Dr. Elwood Worcester, practiced a method of healing for assorted forms of "nervousness" including alcoholism and other addictions. Worcester and his assistant, Dr. Samuel McComb, operated a free clinic supported by the church for about 23 years. The movement was widely reported in the press, and Worcester and McComb became well known for their success with alcoholics as well as other types of patients.
In 1913, Courtenay Baylor began to work for the Emmanuel church as a specialist in alcoholism; he was probably the first paid alcoholism therapist in this country. Originally an insurance agent he had come to Worcester in 1911 for help with his drinking problem. After a period of sobriety he retired from the business world to become a paid "friendly visitor" in the church's Social Services Department. He remained at the Church until Worcester's retirement in 1929, after which the two practiced together at the Craigie Foundation of Boston. Worcester died in 1940. In 1945, by now an old man, Baylor resumed his old job at the Emmanuel Church. By all accounts he died sober. Baylor described his treatment technique in the book Remaking a Man (1919) as did Anderson in his book titled The Other Side of the Bottle (1950).

Baylor's most famous patient was Richard Peabody, son of a well known Boston family, who came to the Emmanuel church for help with his alcoholism in about 1922. Peabody survived his World War I service unscathed, but after several years of heavy drinking found that his life was falling apart. He had lost his share of the family fortune in shipping at a time when everyone else was becoming rich from the war. In 1921 his wife (later known as Caresse Crosby) obtained a divorce; she had become so afraid of him that she would not stay alone with him and had appealed to her uncle, J.P. Morgan for financial and moral support. Peabody suffered from acute depression and was hospitalized more than once.

Despite his family's wealth and prestige, Peabody was not prepared for a career and supporting a family. He had graduated from Groton preparatory school (where his uncle, Rev. Endicott Peabody, was headmaster) but never finished Harvard. When he married in 1915, his wife's family was already worried about his drinking. Peabody quickly escaped from family life by signing up for military service at the Mexican border. Soon after, he left again for the war in France, having barely seen his two children. Military life was apparently a preoccupation with the men in his
family; Mrs. Crosby described his parents' home as having a "family atmosphere of eau de cologne and tiptoe discipline.... The household ticked on a training schedule." Major and Mrs. Peabody lived a "militaristic" existence, "a strange, muted life, uneventful and unjoyful;" everything was highly polished with "implements of war laid out like precious objets d'art." According to Mrs. Crosby, Mrs. Peabody spent most of her life in nightclothes. Peabody was an only child "who had never been allowed to play or cry, for both these exercises disturbed his parents," quite a different picture from the "overindulged, pampered childhood" that Peabody later insisted was the primary cause of alcoholism.

Peabody attended the Emmanuel Church's clinic and weekly health classes in the winter of 1921-1922 and by 1924 was listed in one of its publications as a volunteer assistant in the Social Service Department (Emmanuel Church, Department of Community Services, 1924). Sometime during the 1920s he established his own office on Newbury Street in Boston. During this period he "effected some remarkable cures" and became known to some as "Dr. Peabody": patients came to him from considerable distances. It is likely that Baylor referred patients to him from the church, since there were probably more applicants than Baylor himself could handle. A few years earlier Baylor had observed in a Church report that alcoholics were coming for treatment from as far as Santa Barbara, Denver, Mobile, Washington and Philadelphia, "while -New York is a suburb from which we have many commuters." By 1933, Peabody was practicing in New York at 24 Gramercy Park.

In the 1930s Peabody was publishing articles in both the medical and lay literature on his method: The New England Journal of Medicine (1930), Mental Hygiene (1930), The American Mercury (1931) and American Magazine (1931). His book, The Common Sense of Drinking (1931) was republished in 1935 as an Atlantic Monthly Press book. By the late 1930s, several physicians interested in the new "scientific approach" to alcoholism were using his technique, including Norman Jolliffe at Bellevue Hospital in New York, Merrill Moore at Boston City Hospital and Edward Strecker
at the Institute of Pennsylvania Hospital in Philadelphia. In 1944, the Yale Center of Alcohol Studies opened the first free clinic exclusively for the treatment of alcoholism; the Yale plan Clinics in New Haven and Hartford offered individual and group treatment under the direction of a Peabody therapist, Raymond G. McCarthy.

Before his death in 1936, Peabody had trained several of his sober patients to become lay therapists like himself, including Samuel Crocker, James Bellamy, Francis T. Chambers Jr., William W. Wister and Wilson Mckay. Wister's experience of treatment with Peabody is described in detail in a book by Bishop titled The Glass Crutch, with an epilogue by Wister himself. Strecker and Chambers also published a book detailing their version of the method.

Peabody and his coworkers apparently did not share Baylor's personal success at remaining sober. A common opinion is that Peabody died intoxicated, although the evidence is not conclusive. Samuel Crocker, who had once shared an office with Peabody, told Faye R. that he was intoxicated at the time of his death. The personal copy of Peabody's book belonging to Bill Wilson (one of the founders of A.A.) now in the A.A. Archives, contains the following inscription; "Dr. Peabody was as far as is known the first authority to state, "once an alcoholic, always an alcoholic," and he proved it by returning to drinking and by dying of alcoholism - proving to us that the condition is uncurable." This copy was originally owned by Rosa Burwell of Philadelphia. Some early A.A. members share the opinion that Peabody died intoxicated. The published sources contradict each other. Wister quoted Peabody's second wife to the effect that he died of pneumonia. The editors of Scribner's magazine, which published an article of his posthumously, claimed that he died of a heart attack. Mrs. Crosby did not say.

Wister's authorized biography reports that he became drunk in 1941 after seven years of sobriety, and although he became sober again, he did not resume therapeutic work. Faye R., who knew Baylor, Crocker and McKay also resumed drinking. Faye R. was
at different times a patient of Baylor, Crocker and McKay. She has been abstinent in A.A. for 40 years. Her summary of the Peabody therapists is: "They had many wonderful ideas but they just didn't have the magic of A.A."

Marty Mann described the Peabody Method as being primarily for the well-educated or the well-to-do, a description that also characterized patients of Freudian analysis of the time. William Wister's family was as well known in Philadelphia as Peabody's was in Boston: Francis Chambers belonged to Philadelphia's most exclusive men's clubs. Faye R. reported that Baylor, Crocker and McKay were also from well-to-do Boston families.

Few but the well-to-do could afford Peabody's fees. Wister was broke and in debt when he appeared on Peabody's doorstep in 1934, so the therapist offered to reduce his fixed fee of $20 per hour to $10. Peabody told Faye R. that his fee was $10 per session for seven visits per week; she went to Crocker instead, then newly established in practice, for $5 per session. According to Faye R., Baylor scorned such exorbitant rates even when he was himself in difficult financial straits.

It appears that the considerable majority of patients of the Peabody practitioners were men, although Baylor and Peabody occasionally referred to "men and women" as potential patients. Peabody's method, however, was clearly geared to the needs and interests of men, and Baylor's was much less so, as will be described below. The age distribution of Peabody's patients is not known. Peabody once remarked to Faye R., then about 27, that if she remained sober, she would be the youngest person that he had known of to do so. Peabody himself was probably only a year or two older than that when he stopped drinking. Probably the great majority of the alcoholic patients of those practitioners were white, since their race was not mentioned. Worcester did point with pride to the success of his church's self-help tuberculosis program with blacks, but did not refer to them among the clinic patients.
Peabody made important philosophical changes in and added some psychiatric terminology to the treatment method although it had as its original model quite a different conception of the relationships among body, mind and spirit than those used by Peabody's contemporaries. Worcester and McComb based their claims as healers on their qualifications as clergymen; coincidentally, both had doctorates in psychology. The later practitioners, however, had serious problems of establishing professional identification; Peabody and his followers therefore made serious compromises in their work in the hope - ultimately *unfulfilled* - that they could be accepted as mini-psychiatrists. The Emmanuel Church clergy began their work at a time when almost no one had heard of Freud, a time when the whole notion of psychotherapy and "functional" nervous disorders was still very new and open to various eclectic treatments. Worcester and McComb were severely criticized by both physicians and fellow clergy for daring to invade medical territory, but in 1906 the medical profession had neither the organization nor the public acceptance to force them out of the field. By the 1930s, however, this had changed considerably. In 1940 Wister was actually threatened with arrest for practicing medicine without a license. In trying so hard to imitate the prestigious intellectual ideas of the 1930s, Peabody and his followers essentially gutted their method of the vital substance that had made Worcester and Baylor so successful in earlier decades.

In 1935 a new rival to Peabody was quietly being born in Akron, Ohio. By 1942, A.A. had grown enough in size and popular reputation to be a viable alternative to the Peabody Method in some urban areas. As with the patients of the earlier method, A.A. was initially composed primarily of the well-to-do and well educated. Because it was free and nonprofessional, however, it quickly spread to a much wider group. Additionally, A.A. in its basic concepts of healing and suffering, was much more similar to the Emmanuel Movement than to the professional therapists. Organizationally, it was quite different from both, but Elwood
Worcester would certainly have recognized its basic beliefs as very harmonious with his own. Faye R. reported that, near the end of his career, Baylor attended an A.A. meeting and loved it: he enthusiastically recommended it to her. Bill Wilson and his wife Lois (later to become the founder of Al-Anon) both read The Common Sense of Drinking in the early days of his sobriety and were very interested in it. However, only a few phrases and helpful hints from it were incorporated into the A.A. program.

The Emmanuel Church like thousands of other American churches now houses a large A.A. meeting: it meets on Wednesdays in the old parish house, the same place where Worcester and McComb gave Wednesday night classes for up to a thousand "nervous sufferers."

**THE EMMANUEL APPROACH**

Worcester and McComb were not alcoholics. Their therapeutic method was originally designed to treat the condition then called "neurasthenia," a term covering an assortment of neurotic symptoms, psychosomatic problems, phobias, extreme worry, anxiety, addiction and other problems then considered nonorganic. In a follow up study of clinic patients during part of 1906-1907, Cabot reported that only 12% were alcoholics. In the Emmanuel Church 1909 Yearbook, McComb described a cured patient - a young, well educated, "refined" woman who had been irritable, self-conscious, preoccupied with morbid thoughts and uninterested in life: "It is mainly, through not exclusively for sufferers of which this young woman is the type that our health conference has been inaugurated." The considerable majority of the nonalcoholic patients were women. Worcester and McComb reported three rules for accepting alcoholic patients:

1. They must come voluntarily from their own desire to stop drinking, not solely because of pressure from others.
2. They must be willing to accept the goal of total abstinence, for "the attempt to convert a drunkard into a moderate drinker... cannot be done once in a thousand times."
3. They must be dry during the first interview and pledge to be
abstinent for one week. The brief pledge apparently had some value: "In the course of many years experience very few patients have broken this promise."

Worcester believed that all diseases had physical, mental and spiritual components - some problems might be primarily physical, such as a broken leg, but the patient's attitudes could still promote or retard healing. Many problems were more obviously related to a person's mental state. A case of deafness, for example, might be purely organic and should be treated first by a physician, but some cases were also of psychological origin and could be relieved by psychotherapy. Many of Worcester's patients had primarily moral problems or habits that required a new way of life: addictions, anxiety, or excessive fear or worry. The realms of the body, mind and spirit interacted in a delicate balance in each person; an improvement in one area might lead to improvements in another. Severe pain from an intractable physical ailment could be relieved by changes in attitude; the physical craving for alcohol or morphine could be eliminated by a more spiritual way of life. All nervous sufferers could be helped by redirecting their attention away from themselves to a life of service to others. Exercise, proper breathing and natural sleep would ultimately promote a proper spiritual balance.

The concept of the unity of body, mind and spirit that Baylor inherited from Worcester was probably unique in American thinking of the time. Worcester acquired his ideas from the German psychologist, Gustav Fechner, with whom he had studied at the University of Leipzig. Fechner was renowned for his early work in experimental psychology, but his lifelong philosophical interest was in developing a true Geistwissenschaft, or a science that would include both the material and the spiritual worlds. He believed that the relationships between these two realms could be understood through mathematical formulas that would explain both without reducing either to the terms of the other. Worcester explicated Fechner's ideas and claimed that he was unable to
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disentangle Fechner's ideas from his own commented: "The modern temperament finds the union of the mystical and the scientific difficult to understand. Yet Fechner's mystical grasp upon the unity of life and the world lives on, and in each generation finds a welcome from a few."

Worcester and McComb were best known for their use of suggestion and autosuggestion. They employed hypnosis with a small number of alcoholics to keep them sober long enough to receive treatment, but in most cases they merely put the patient in a state of relaxation. With the patient seated in a comfortable chair in a dim and quiet room, the therapist would give directions for systematically relaxing each limb and slowing down racing thoughts. Baylor would ask the patient to imagine that he was sailing in a small boat toward an island, at first quickly, then more slowly until the person ended up lying comfortably on a sunny shore.

Worcester believed that a person's subconscious mind was more amenable to outside influence while he was in this relaxed condition. He could then suggest to an alcoholic, for example, that the desire to drink would soon pass, that he would soon sleep better and that he could begin to make progress in his life. Worcester believed that in this way powerful healing forces of the subconscious mind (a term that he intentionally retained after Freud's "unconscious" became popular) could be brought into play to support a person's conscious desire to recover. Worcester saw the subconscious mind as an essentially positive force: it was the source of enormous strength, creativity, inherited memory and communication with the spiritual realm. It was, in short, the spirit of the soul. Consistent with his view of the unity of the soul and body, he saw the subconscious as the regulator of elementary physical processes, including the heartbeat, circulation, respiration and time keeping; thus positive suggestions directed to it could affect physical health.

For Worcester, the redirection of attention was a very basic element of therapy. Nervous sufferers and alcoholics became
morbidly preoccupied with their destructive habits and sufferings; the therapeutic effort was to redirect that attention toward higher goals - the development of a spiritual life and service to others. Misdirected attention, produced often by physical pain or bad habits, caused much avoidable suffering; "A large part of the sorrow, failure, sickness and discouragement of life comes from this one source, the anticipation of evil. If we could disregard all pain and misfortune but the actual, we should deliver ourselves from about eight-tenths of the sorrow of this life." (This is the same principle as A.A.'s injunction "don't project" - or assume a future possibility to be present fact.)

Attention could be redirected at first by a therapist through suggestion while the patient was in the relaxed state, but the patient must be taught to practice autosuggestion until new mental habits were learned. The latter technique made the healing power of the subconscious available in daily life; it consisted of "holding a given thought in the mental focus, to the exclusion of all other thoughts." The patient learned autosuggestion and other techniques (proper breathing, hints on obtaining restful sleep, etc.) not only in individual treatment sessions but in the Wednesday night classes in which the clergy and others lectured on such topics as habit, anger, worry and fear.

The theological basis of Worcester's belief in redirected attention rested on the Biblical "resist not evil" which he interpreted to mean that constructive psychological change could be promoted more effectively by building up a person's strengths than by directly attacking the problem or bad habit itself. For example, Baylor reported successfully treating a woman with a phobia about open spaces by engaging her in a deep conversation about her work while walking with her, for the first time in many years, through Boston Public Gardens. He had already done the ground work, however, with many sessions of relaxation and suggestion and by gradually weaning her away from sleeping medications.
The Emmanuel clinic used prayer as an essential vehicle for acquiring the power of attention, just as some holistic healing strategies today often employ meditation for related purposes. Worcester's theory went well beyond that of simple meditation, however: for him, the therapeutic dynamic was that "surrender implied in sincere prayer is always followed by the consciousness of peace and inner freedom." The mechanism here, as with attention, is paradoxical: "Only by surrender to the All Holy and All Powerful are the potentialities of the self realized." What follows is a process of conversion: "Whereas the sinful tendency about which (the patient) was in the main concerned is robbed of its attractive quality and the thought of it finds no entrance to his imagination." New sources of energy from the subconscious are thereby tapped. These paradoxes had long been familiar to religious thinkers, but they were not described in the psychiatric literature until the 1940s with Tiebout's analyses of the therapeutic mechanisms of A.A.

Worcester also saw the benefit of group support and the service that afflicted could render each other, an idea that A.A. developed to a much greater extent years later. The Emmanuel Movement prescribed not only individual therapy, lectures and reading, but provided social hours after the weekly classes at which the patients were expected to talk to each other their growth and progress. Following the principle of redirected attention, however they were not supposed to dwell on their ailments. The Church also ran a well-staffed Social Service Department that provided "friendly visitors" to call on patients and provide moral support, assist in finding jobs and occasional financial help. Some staff members, such as Baylor, were paid former patients: others were volunteers.

The "guiding principle" of the Social Service Department, according to the Emmanuel Church 1909 -Yearbook, was to turn the thoughts of each sufferer from himself to others. In all troubles of mental origin, one of the most successful curative agencies has been to get one person to help another suffering from exactly
from his own trouble. How can we ask another to make efforts which we will not make ourselves? In this way moral strength is passed on from one to another."

An important off-shoot of this arrangement was the Church sponsored club for alcoholics. Founded in 1910 by a nonalcoholic parishioner, Ernest Jacoby, the club held meetings in the church basement on Saturdays and its space was used for socializing on most other nights. Nonalcoholics also attended and the club's relationship to alcoholism was disguised in Church reports, but the evidence is that its purpose was to help newly abstinent patients reinforce each other's abstinence. Its motto was "A club for men to help themselves by helping others." There were no membership fees. The only requirement for membership was "an expressed desire to lead an honorable life and a willingness to aid other men less fortunate." Worcester added one other requirement: "They should not come to the Church drunk." A followup committee sought out those who failed to appear for meetings. A system resembling A.A. sponsorship was created, called "special brothers," in which each member was expected to look out for another. Saturday night meetings included food, entertainment and lectures on topics of current interest. "The broadest religious tolerance was observed, and many faiths were represented." In the 1910 Church report, 20 persons were listed by name as officers and members of the club. No women's names were included.

By 1912, the club announced that it had "already accomplished results beyond our farthest hopes." The club had grown, and most of its original members were still attending. It was arranging for a better system of record keeping and was soliciting contributions for a new clubhouse; one was reported from a little girl who gave a benefit fair. The club moved out of the Church in about 1914; nothing is known of it after that time except for Greene's report that it maintained good relations with the Emmanuel Church, which continued to send it new members.
The ideas of self-help and mutual support as alcoholism treatment were not original to the Emmanuel Movement. The best known historical antecedent was the Washingtonian Movement of the 1840s, a large group of abstinent alcoholics and nonalcoholic temperance advocates who achieved brief but spectacular success at "reforming" drunkards. Some recent authors have noted that other temperance groups in the following decades also employed the group-support principle. According to Levine, "In the latter half of the 19th century the Sons of Temperance, the Good Templars, and a host of smaller fraterpal groups, functioned in much the same manner that A.A. does today. They provided addicts who joined their organizations with encouragement, friendship and a-social life free from alcohol. They went to inebriates in time of need, and in some cases offered financial support as well." It is difficult to determine at this distance whether the founders of the Jacoby Club were familiar with the earlier organizational forms. The major difference in the Emmanuel Church work was that it rejected temperance preaching as a means to attract or help' alcoholics.

Although Worcester was himself a supporter of the idea of temperance, he had an approach to the problem of the moral status of alcoholism different from that of his temperance predecessors or scientific successors. Worcester had no doubt that alcoholism was both a disease and a moral problem. Addiction involved habit, for him clearly a moral category, yet he unhesitatingly ranked alcoholism along with tuberculosis, cancer and syphilis as the four major diseases of his time. To Worcester, the question of will was irrelevant to alcoholism and neurasthenia; both were diseases of the whole person in body, mind and spirit, not merely problems of the faculty of will. According to Levine, "In 19th and 20th century versions, addiction is seen as a sort of disease of the will, an inability to prevent oneself from drinking." For temperance advocates, this meant that moral exhortation addressed to the will would be sufficient to keep a person from drinking. Other historians have described the remedy for alcoholism
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espoused by the late nineteenth-century Reform Clubs and the Woman's Christian Temperance Union as "gospel temperance" - a moral suasionist attempt to spark a spiritual rebirth in alcoholics and to get them to keep a pledge of total abstinence. The task as the Union Signal put it, was analogous to "Peter preaching to the gentiles." This same view characterized the mission approach of the Salvation Army and other turn-of-the-century mission efforts.

By comparison, Worcester's approach was more modern in totally rejecting moral suasion as a healing strategy. Worcester believed that sermons were for normal people: "Something more than exhortation, argument, or persuasion is necessary.... They may provoke opposition on the patient's part or they may even be dangerous." Something more was needed because more than one aspect of the personality was involved: like A.A., Worcester felt that the individual's entire life was affected and that an appeal solely to the strengthening of the will would thus be inadequate. He saw evil as a more basic, pervasive condition in the individual's life than did most of his contemporaries, such as the mind-cure practitioners and those with various scientific approaches, including the most recent. For Worcester, recovery must come from surrender to both an external force (as in conversion) and to the healing capacities within the subconscious.

According to Clinebell, one secret of the Emmanuel Movement's success lay in this effort to reduce an alcoholic's guilt rather than to increase it as did the other strategies of the time: "Emmanuel therapy apparently was frequently able to convey this experience. When guilt is reduced, the energies previously employed in the guilt and self-punishment process are freed and made available for therapeutic ends. The alcoholic's inferiority is reduced... by (his) becoming aware of his 'higher and diviner self' which is his real self."

Like others of the Progressive Era, Worcester had great faith that the human race was improving and that an enlightened
science could help reduce human suffering. He did not believe that his method was antagonistic to medicine or that it was a "mind-cure"; on the contrary, he believed his method to be more scientific than that of contemporary physicians who could understand only the body, without any theoretical comprehension of the importance of mind and soul. He believed that clergy and physicians working together could accomplish far more than either alone. Worcester and McComb firmly believed in the essential goodness of human nature, even of the unconscious mind: for them the ideal life was a balance of natural inner forces, not a constant struggle with instincts and impulses. For Worcester, feeling in itself was never a problem; even painful emotions such as fear had their useful functions. Kurtz (Not-God, A History of Alcoholics Anonymous) noted that Bill Wilson also had a basic acceptance of human instincts, which for him only became a problem when alcohol permitted them to "run riot."

In defense of the reality of his patients' nervous sufferings, Worcester once stated that he would rather break both thighs than undergo the pain that some of them experienced. Worcester and McComb never hesitated to speak of fear, faith, hope and the spirit; Peabody would not even mention the word "suffering." His book was, of course, an offer of hope and help to alcoholics, but Peabody could not bring himself to name the feelings.

Worcester was writing primarily for and working for women, although he never publicly acknowledged this. In 1908, he earned the equivalent of a year's salary writing five enormously successful articles - including one on alcoholism in women - for the Ladies Home Journal. Peabody was writing self-consciously for men. His examples of schools, clubs and recreational activities were exclusively those of upper-class men. He worried about the "manly complex" that might drive a man back to drink; he urged his readers to remember that "it is the manly thing to do to give up drinking because the weakling cannot do it." His ambivalence about stereotypically female feelings and expressiveness runs through his work and accounts for many of the
ways in which his methods diverged from those of Worcester and Baylor.

Courtenay Baylor

Courtenay Baylor must have been a remarkable man. Constance Worcester and Faye R. spoke of him with great personal affection, even many years later. Peabody dedicated his book to him. Anderson described him: "He had a soothing, beautiful voice that lulled you but at the same time gave you confidence. It was a voice you could trust." On Baylor's effectiveness, he commented: "If I had been one of those skeptics who say it is not the therapy but the therapist that gets results, he would have been a shining example, for he was one of the most illuminating and persuasive personalities I have ever met. However, the results of his work for four decades of practice and the success of the people whom he had trained give solid proof that in this case the value lay in the therapy as well as the man." Baylor did not confine his work to alcoholism; his book (Remaking a Man) was intended to help various types of nervous sufferers, including the shell-shock victims with whom he began working in 1917.

Baylor did not see alcoholics as being fundamentally different from other people. Every person who drinks, however moderately, "has a 'true alcoholic neurosis' to the extent that he drinks," since he makes up excuses for drinking and will not stop without a struggle. Like Worcester, he was willing to blame alcohol for alcoholism rather than finding the fault in the individual's early history. He believed that all neurosis took the form of alternating periods of rationalization and excuses. Therefore, the treatment for alcoholism was not significantly different from the treatment for other forms of nervous suffering.

Baylor fully accepted the Emmanuel Church's model of social service and mutual helpfulness for his own work; he did not
foster professional distance between himself and his patients. According to Constance Worcester, he did not discuss the fact that he was an alcoholic with outsiders, but, unlike Peabody, he was direct about this with his patients. He required mutual confidentiality as a condition of his work: "Before we get through, I shall have to reveal as much about myself as you do about yourself." He insisted that the patient take increasing responsibility for the work. At the beginning of treatment the patient was informed that: "You will act in a double capacity: you are to be patient and physician at the same time." The patient and instructor "are to study out together certain fundamental psychological laws, the knowledge of which will enable them to get to the bottom of that trouble." Baylor's goal with a patient was "to so help him to help himself that his reconstruction will be permanent." Faye R. reported that his methods were much less formal than those of Crocker and McKay.

According to Baylor, all neuroses, including alcoholism, resulted from mental and physical "tenseness." He believed that "the taking of the tabooed drink was the physical expression of a certain temporary but recurrent mental condition which appeared to be a combination of wrong impulses and a wholly false, though plausible, philosophy. The cause of this mental state was a condition of the brain "akin to physical tension" during which it "never senses things as they really are." For example, the person believes that his troubles are entirely the fault of other people or circumstances, and does not realize the extent to which his own depression, fear or irritability color his perceptions and may actually change the attitude of others toward him. This leads to more practical problems and to greater tenseness, which will be expressed in further drinking or neurotic behavior: "literally a circle of wrong impulses and false philosophy each a cause and a result of the other."

The solution, therefore, was first to promote physical and mental relaxation, and then to examine in a calm frame of mind those "false, though plausible" attitudes. Ultimately, the
patient should learn permanent relaxation by practicing the techniques that he has learned. Anderson described this state as "a combination of suppleness, vitality, strength and force - a certain definite intentional elasticity." Baylor called it peace of mind and stated: "Peace of mind will do wonders."

Baylor believed that his failures resulted from his inability to gain a patient's attention; some remnant of spiritual capacity must be present in order for him to break the "vicious circle of neurasthenia" - or the patients endless brooding attention to his troubles. "I fail to get this attention either because the patient has an innate lack of desire to change his life and ideas and no spiritual element out of which to build such a desire, or because he has an actual mental defect, or because his illness is so deep-seated and his spiritual side so buried that the stimulus dynamic enough to reach and arouse him or the time and personal attention necessary to get through to him have been lacking."

Baylor's strategy was to supply the person with a "new point of attention, a new philosophy of life, and a new courage with which to face life." The complex interaction of body, mind and spirit can be seen here: "attention" was for Worcester and Baylor both a spiritual and a mental concept, with both cause and effect in the physical realm. To attend to good rather than to resist evil, and also to develop a new sense that life is worthwhile would not only promote spiritual growth but actually keep some patients alive.

One way to redirect a patient's attention was to provide a new time focus. The new interest and new point of view should be "so big and so different that they occupy the present moment fully and make all of life seem worthwhile." One strategy that he used for adjusting the patient's time sense to a normal pace was to speed up or slow down his own thinking during a therapeutic session to match that of the patient; he would then take the lead in adjusting the speed of the patient's thoughts to a more normal level.
Baylor made no direct reference to the "subconscious" but it is clear that he regarded it as a vital spiritual force in redirecting a patient's attention. Interviews with patients were "one hundred per cent suggestion, direct or indirect." There is nothing "weird" or "uncanny" about this, he explained: it is as natural as the fact that a salesman's cheerfulness has a positive effect on a customer. (Those who believe that the theory of suggestion is dead might take another look at modern advertising.) The reeducational work itself, however, is logical and rational; it proceeds through discussion of the patient's past to "analysis and explanation and definite instruction." Baylor described the results to be anticipated by the patient as the awakening of a new part of the mind or spirit: "Because you have recognized a new function, or another sense perhaps, you will have a hope that you can handle life instead of having life handle you." Success with the method would lead to new confidence, efficiency and happiness: but happiness, he believed, could not be directly sought.

Applying Worcester's principle of "resist not evil," Baylor did not address phobias directly but worked to eliminate the background reasons for fears in general; otherwise the phobia might recur in altered form. Relaxation would make an alcoholic able to cope with "tense" periods of his life before they actually leads him to a drink. (The actual practice of A.A. meetings resembles this "resist not evil" principle, without using that language: the bulk of a recovering alcoholic's effort is to establish a foundation of "sober thinking" rather to confront the alcohol itself directly. A.A. teaches its members to avoid the recurring periods of "alcoholic thinking" or "dry drunks" that resemble Baylor's "tenseness."

After a few years of experience, Baylor began to realize that a longer course of treatment was necessary for alcoholics than what Worcester had provided. Worcester had seen most alcoholics several times a week for a few weeks or months. A newspaper ("Preacher-Healer tells of his cures") reported the
case of a woman addicted to alcohol, chloral and morphine who had been "cured" by Worcester in seven visits. There was a form of follow-up, however: she was thereafter required to write him a letter whenever she felt like taking a drink or a drug. Baylor did not mention follow-up to treatment, although Faye R. reported that he and the Peabody therapists were always willingly available by telephone.

In the Annual Report of the "Men's Department" (Emmanuel Church 1916 Yearbook), Baylor announced: "We have come to feel that it is unwise to attempt to accomplish the work in a few interviews, and an agreement is made with those who come that they will abide by our instructions for a year. This means that they see us frequently at first. Periods between visits are then lengthened, a course of reading is taken up and various exercises are carried through." A typical interview lasted a half-hour. He described the long-term difficulties as follows:

"Getting the man to stop drinking is only the first step in a very long march. All the negative traits induced by alcohol must be eliminated and the positive traits put in their places. Irritability, self-pity, fear, worry, criticism of friends, bitter hatred of enemies, lack of concentration, lack of initiative and action, all these must be worked out of the character. The entire mental process must be changed, a new sense must be grown, one that can recognize the soul; when this is accomplished we have the man himself cured from alcoholism."

According to some sources, Baylor was "more worldly" than Worcester and paid more attention to practical problems, including the effects of alcohol on the family. Worcester had enlisted the cooperation of the family in accepting the goal of sobriety for both the patient and themselves. Baylor went much further in discussing the specific problems that family members developed as a result of living with an alcoholic in the practical, mental and spiritual areas. Much of Baylor's time was spent working with relatives; he recognized the difficulty that they experienced in accepting an alcoholic who had changed
greatly by becoming sober. He compared the difficulty of this task to a "delicate surgical operation." He also worked directly with employers to try to change negative attitudes. Faye R. reported that he later developed a considerable practice in divorce counseling. His Social Services Department often provided material assistance to families of alcoholics, whether or not the alcoholic was in treatment.

Baylor did not consider himself a scientist. He felt that his work was "more than a science: it is also an art." In the introduction to Remaking a Man, he apologized for the lack of technical terminology. Peabody, however, took quite a different tack. In the introduction to his book he explained that he had simplified his "somewhat technical vocabulary" so that the average layman can read it without reference to a dictionary." Neither man had a college degree. Each brought vital experience to the problem of alcoholism, but they chose to use it in quite different ways.

Baylor had none of Peabody's professional pretensions, yet his claim to competence was broader: he believed that he could understand and influence not only the mind, but the body and spirit as well. The originators of the Emmanuel Method did not consider their work to be subordinate to that of medical professionals; the Rector of Emmanuel Church initially hired physicians to do routine diagnostic work, then took over the task of healing when they had failed.

We know somewhat more about Worcester and Baylor's therapeutic success. In 1908, Dr. Richard C. Cabot of the Harvard Medical School published a report on the outcome of 178 cases of all types, including alcoholism, seen by Worcester and McComb in a six-month period of 1907. Of 22 alcoholics, 11 were listed as "much improved" or "slightly improved"; seven had unknown outcomes. These rather vague terms do not reflect the fact that Worcester, during the early months of this period, was using a technique that he later reported to Peabody was a total failure...
trying to teach his patients to "drink like gentlemen." Exactly when his approach changed is not clear.

Clinebell concluded: "It seems possible that the Emmanuel Movement enjoyed a relatively high degree of success in providing at least temporary sobriety," based on Worcester's long-term reputation and his own statements. Baylor reported in 1919 that, of about 100 cases that he had seen personally in the previously seven years, about two-thirds had been successful. His annual reports from 1913 to 1916 also refer to significant numbers of "successful cases" each year. We do not know how long the patients of either Worcester or Baylor were able to maintain their abstinence, but Worcester referred to several who had "stood like rocks in their place for years."

In the early years of the Emmanuel Movement there was almost no interest within the medical profession in "spirit" or feeling as healing resources. The great majority of psychiatrists and neurologists were concerned exclusively with somatic explanations for mental and emotional problems; they believed that all such problems would ultimately be explained by reference to "lesions" of the nervous system. As Grob has noted, late-nineteenth-century and early-twentieth-century psychiatrists, "having rejected as subjective and unscientific such affective sentiments as humanity, love and compassion....found their own supposedly objective and scientific approach to be barren."

Part of the great influence of Freud on American thinking was of course his recognition of the role of feelings in various types of illnesses, both psychosomatic and purely psychological ones. For Freud, feelings and their conflicts were usually problematic and the cause of endless human difficulties. For Worcester, however, the awakening of new spiritual feeling was essential to the cure of many troubles; positive feelings in themselves constituted a cure. Freud and his followers also cultivated a dry and austere language, quite the opposite of the sentimentality of the clergy. By the post-World War I years, the kind of language of feeling that Worcester and McComb had used
seemed insufficiently "professional" for physicians: in fact, it was rarely used as a form of public statement outside the churches.

The differences in the two approaches to alcoholism were summed up by Freud himself in comments he made to a reporter when visiting this country in 1909. When asked his opinion of the fact that Worcester and others "claimed to have cured hundreds of cases of alcoholism and its consequences by hypnotism, Freud replied, "The suggestive technique does not concern itself with the origin, extent, and significance of the symptoms of the disease, but simply applied a plaster-suggestion-which it expects to be strong enough to prevent the expression of the diseased idea. The analytical therapy on the contrary...concerns itself with the origin and progress of the symptoms of the disease."

(Hale, Freud and the Americans: The Beginning of Psychonalysis in the United States. 1971) According to Hale, "he implied that hypnotism also was a morally doubtful kind of trickery that resembled 'the dances of pills of feather-decorated, painted medicine men.' He criticized the clergy and others who practiced without medical degrees: 'When I think that there are many physicians who have been studying methods of psychotherapy for decades and who yet practice it only with the greatest caution, this undertaking of a few men without medical, or with a very superficial medical training, seems to me at the very least of questionable good.' He implied that such people might affect the reputation of his own method: 'I can easily understand that this combination of church and psychotherapy appeals to the public; for the public has always had a certain weakness for everything that savors of mysteries and the mysterious, and these it probably suspects behind psychotherapy, which, in reality has nothing, absolutely nothing, mysterious about it.' Hale concluded: "Admitting that he knew little about the Emmanuel Movement, he promptly condemned it."

Granted that the question was somewhat inaccurate (Worcester rarely used hypnotism), Freud's response still shows not only his
ignorance of addiction but his lack of interest in the actual relief of suffering. Rieff (Freud: The Mind of the Moralist) noted: "Clearly no one so unsentimental as Freud can be accused of loving humanity, at least not in the ways encouraged by our religions and their political derivatives....He was interested in problems, not patients, in the mechanisms of civilization not in programs of mental health.

As Hale described it, "Freud at once constructed a counter-image that became in turn an important psychoanalytic stereotype psychoanalysis was austere and difficult, requiring extraordinary expertise but promising radical cure."

Richard Peabody

Such was the narrow model of professional practice available to Peabody as a therapist of the 1920s. He did not attempt to imitate the particular techniques of a psychiatrist, but he systematically eliminated from his terminology and concepts anything that hinted of the church and "feather-decorated, painted medicine men." The acknowledgments in his book include Baylor and six physicians, but he did not mention the Emmanuel Church. Like the psychoanalysts, Peabody kept an extreme professional distance from his patients; Wister reported that all he had ever learned about Peabody personally was that "Peabody had learned much in Boston from two noted psychiatrists and that he had married twice." Wister also noted that he spoke objectively, as though he were discussing the proper treatment for a broken leg and that he never discussed the moral aspects of alcoholism.

Since Peabody had no credentials and chose not to use his own experience as the basis for his claim to be a teacher, he was in a difficult position to justify his fees. The nearly total lack of interest of the medical profession in working with alcoholics should have given him a wide field in which to work, but the only formal reason he could give patients for coming to
him for treatment was that it might speed up recovery. He quoted a patient approvingly: "I went to Peabody on the same theory that I would have gone to an instructor of mathematics had I found it necessary to learn calculus. Probably I could learn calculus by myself out of books, but it would take me a great deal longer than if I went to a competent teacher."

Peabody promised in his book to avoid "moralizing"; his was strictly a "scientific approach." By 1931, moralizing about alcohol was certainly out of favor, within his social class at least. The excesses of some of the Prohibition advocates and the difficulties of enforcing Prohibition had embarrased most advocates of such laws into silence. It was becoming fashionable now to blame the drinker, not the social institution of drinking, for alcoholism. Peabody wrote an article on "Why Prohibition Has Failed," in which he claimed, in effect, that drinking is a normal human activity (for men, at least) and should not be tampered with by mere moralizers.

Peabody went a step beyond the anti-Prohibition logic. It was one thing to claim that ordinary drinkers should not have to feel guilty for their indulgence, yet quite another to imply that alcoholics themselves have no problem with guilt or shame about their addiction. Nowhere did Peabody recognize the fact that alcoholics do feel much guilt and remorse about the trouble that they have caused themselves and others. Peabody provided no mechanism by which forgiveness and acceptance could be attained, either in a religious sense or through a group of similarly afflicted individuals.

The men of the Jacoby Club bonded together "to lead a more honorable life," but Peabody did not use even such indirect references to guilt or self-esteem. Since neither morality nor feeling was an acceptable topic of discussion for Peabody, the only justification he could give for the effort to become sober was, in effect, "efficiency." A man must be impressed with the fact that he is undergoing treatment for his own personal good and because he believes it to be the expedient thing to do."
The major practical drawback to excessive drinking cited specifically by Peabody was its "supreme stupidity." His explanation was designed to appeal to the patient's respect for his own masculinity: "Just as all normal boys are anxious not to be considered incompetent in athletics, so to be thought stupid is the last thing that a full-grown man with any pretense to normality wishes. Even in prisons drunkards are held in low repute by criminals because they are where they are as a result of inferior intelligence rather than a distorted moral point of view."

It seems curious now that Peabody did not attempt to resolve the moralizing problem by calling alcoholism a disease or an illness. The disease concept was certainly available to him—the Emmanuel Movement had used it freely, and it had been current in some circles of temperance workers and physicians since the late nineteenth century. Diseases, however, are ordinarily understood to have some connection with the body and Peabody's basic philosophical orientation seemed derived from the mind-cure movement, including Christian Science, which essentially denied the significance of the body and was interested only in the mind as a means for controlling an individual's life. Many of Peabody's therapeutic suggestions resemble a secularized version of the writings on mind-cure and self-help dating from the 1890s. His work was thus a strange amalgam of these ideas and the quite different philosophical and psychological ideas of Worcester and McComb.

Worcester had begun his clinic work partly in response to the apparent healing successes of Christian Science. He viewed their theology and that of New Thought as shallow and materialistic, however, and little resemblance existed between his tripartite view of the person and the idea in mind-cure that pure thought can be used to eliminate disease and to produce increased efficiency and business success. Christian Science denied the reality of bodily suffering altogether and of course had no use for the medical profession. Mary Baker Eddy did not
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believe in the existence of the unconscious, and other mind-cure writers "far from teaching an open-door policy toward the subconscious...taught absolute denomination over it."

According to Meyer (The Positive Thinkers. Religion as Pop Psychology from Mary Baker Eddy to Oral Roberts) the central tenet of mind-cure was that "God was Mind....The crucial aim in this characterization was that it should guarantee a self-enclosed and coherent existence....Mind was above all the realm in which people might feel that life came finally under control." Christian Science, and later mind-cure expressed no interest in human service (a fact commented on quite sarcastically by both Mark Twain and Elwood Worcester), which might account for Peabody's lack of interest in it.

Peabody continued to use several important ideas he had learned from Baylor: surrender, relaxation, suggestion and catharsis. His development and reformulation of some of these - particularly surrender and suggestion - was much more specific to and useful for an alcoholic's particular situation than the formulations of Worcester and Baylor.

Peabody was very clear about the new priorities for a reordered life: "The first step to sobriety is surrender to the fact that the alcoholic cannot drink again without bringing disastrous results" and "this surrender is the absolute starting point. The conviction of its supreme importance is an absolute necessity. With surrender, halfway measures are of no avail." This was undoubtedly the source of Bill Wilson's better known phrase: "Half measures avail us nothing." Peabody noted that an "intellectual surrender by no means settles the question," but he did not discuss the emotional aspect of such surrender. He did detail some of the obstacles to it, included "distorted pride" and the conviction that drinking is "smart" or "manly."

The patient must also have a conviction that he needs help. Peabody sometimes made a prospective patient convince him of the fact that he was truly an alcoholic. He would not accept a patient unless "he can say that he would like to be shown how to
reconstruct his mental processes so that in due time he will no longer want to drink."

Peabody used the same relaxation technique employed by Worcester and Baylor, although he was somewhat defensive about it: "I appreciate that this relaxation-suggestion phase of the treatment may sound like hocus-pocus to those who have never tried it." He justified relaxation in part on the grounds of efficiency - on the grounds that a person could accomplish more work in a day with less effort if the exercise were done daily. They could also be used as mental training to avoid "displays of temper, baseless apprehensions, shyness, and other unpleasant moods, not by trying to support them, but by finding out why they exist and anticipating occasions which might create them." The regular practice of relaxation would prevent the "accumulation of emotional tension." He devoted only one page to the physical aspects of the treatment, including exercise.

Suggestion had wider uses, Peabody defined its most useful form for alcoholics as "driving home platitudes as if they were profundities over and over again." (It is very likely not a coincidence that this is the basic organizational principle of A.A. meetings) The therapist supplied these suggestions during relaxation sessions and the patient was to repeat them nightly at bedtime. Peabody also assigned readings and the daily copying out of simple statements that he supplied one at a time as the patient was ready.

Like his predecessors, Peabody appreciated the significance of catharsis, although none of the three used that term. They all provided an opportunity for a patient to discuss his drinking history and earlier life experiences. Peabody saw this as a more formal task of analysis (in a somewhat Freudian sense) than did the others; it was not merely an emotional purging for the patient, but an opportunity for the therapist to point out the causes of the individual's drinking. Peabody's ideas about the causes of alcoholism will be discussed further below.
Unlike Worcester and Baylor, Peabody did not regard the unconscious as necessarily helpful. It was the repository of excuses, denial and other obstacles to permanent abstinence, as well as the ever dangerous emotions; it was the mental scrap heap to which the desire to drink must ultimately be relegated. The unconscious also needed to be "taught," and the method of teaching it was through thought control. "The most important element in the work (is) the control and direction of the thoughts toward the ultimate logical goal." All negative thoughts must be stopped and positive ones substituted; "When at length the mind is diverted, the unconscious, which is supposed to retain all memories, must be left with a true picture of the whole situation and the individual's intellectual attitude toward it."

The most distinctive aspect of Peabody's method was his plan for time control. He described it:

Before going to bed the patient should write down on a piece of paper the different hours of the following day, beginning with the time of arising. Then, so far as can be determined beforehand, he should fill in these hours with what he plans to do. Throughout the day notations should be made if exceptions have occurred in the original plans, and it should be indicated whether these exceptions have been due to legitimate or rationalized excuses.... Small as well as larger'activities that are taken up should not be dropped until completed unless they are in a sense unknown quantities, entered upon for the purposes of investigation only.

Several pages of instructions follow. Peabody emphasized that the spirit in which the time plan is followed was more important than accuracy. Its functions were to (1) give the patient something concrete to do to change his condition, (2) provide the patient with "training in executing his own commands" and (3) prevent idleness. Regarding this last point he quoted Stekel: "Earthly happiness... is primarily dependent upon our relationship to
time." Following this regimen might well have helped the patient to develop a new sense of responsibility, since he had to be accountable to his therapist for his actions every day. Peabody, however, did not discuss responsibility.

Faye R. recalled that her therapists told her to break down the schedule into 30-minute units. Marty Mann reported that one Peabody patient whom she knew carried time cards with him in his shirt pocket so that he would never be far from his schedule.

In his discussions of time and impulse control, Peabody appeared less like the psychiatrist and more like the industrial engineer perfecting his efficiency and productivity. He is also the military officer planning in advance so that his troops would not mutiny while he slept. He compared the time exercises to "close order drill"; discipline, not character, was his security. "In battle it has been proved over and over again that large hordes of individually brave but untrained men can accomplish little when opposed by a smaller but disciplined military group - so with the alcoholic and his temptation. He cannot expect consistently to conquer his emeny in every drawing room and country-club porch if he has made no advance preparation."

Peabody apparently expected the self to remain deeply divided; balance of any sort must have seemed unattainable to him because he recommended that constant vigilance be exercised against endlessly threatening feelings. 'Wister reported that Peabody had told him: "I want you to begin thinking of yourself as two selves. There's your intellectual self and your emotional self. This intellectual self is a good self, the logical self. Its your best self...Now there's the other self, the emotional self. It's always there and it is right that it should always be there. But it is the side that wants to drink....But thought control will shrink it down so that it becomes much smaller than the good self. You must reconcile both selves. But you must permit the intellectual side to dominate."

Peabody, the factory manager, again noted: "Every phase of this therapy is governed by a time element. You will eventually
learn to master your emotions and you will sit, intellectually, in the driver's seat. For a time, however, you will have to direct your mental processes by hand. Later they will operate "automatically." (This statement is exactly the opposite of A.A.s recommendation: "Get out of the driver's seat.") Nowhere did Peabody speak of patients acquiring new feelings, desires or interests other than "hobbies"—his limited aim was that they be free of one destructive desire. Alcoholics must "train their minds so that they no longer wish to drink." Clearly, Peabody "resisted evil" as strongly as he could.

It is difficult to imagine that efficiency, expediency and time management could provide sufficient inspiration to transform active alcoholism into a lifetime of sobriety. It was a far cry from Worcester's promise of reawakened spiritual powers or Baylor's hope for "recognition of the soul." A life of mere efficiency and the systematic suppression of feelings, organized in hours or half-hours, certainly resembles Crosby's description of the atmosphere in which Peabody grew up: a "strange muted life, uneventful and unjoyful" and a "tiptoe discipline (which) ticked on a train-like schedule." Such an arrangement might achieve freedom from alcohol, but it is much less clear what that freedom was for.

For Peabody, indulgence of feeling and lack of discipline were the causes of alcoholism. He discounted heredity as causative, claiming instead that improper family circumstances lead to a "nervous condition," which "in turn induces alcoholism." He described his typical patient as a first or only son, suffering from a fear of maternal domination: he was "pampered and overprotected" as a child and drank to resolve his conflicts about achieving manhood. The patient "had unconsciously to choose between becoming a timid mother's darling, completely surrendering his own personality, or putting up an exaggerated opposition. Of the two he unquestionably chose the wiser course." The typical mother was "domineering and prudish" and the typical father was shy, with periods of despondency. Ultimately, the
parents were responsible for the child's alcoholism. "The resulting character is the fault of the parents, though in the use of the word "fault" we do not wish to conjure up an ethical concept so much as one of ignorance and lack of self-control."

Later writers on this topic were not as delicate about the use of the "ethical concept." Much of Bishop's fictionalized biography of Wister is an essay on his mother's faults, on how she caused and encouraged his alcoholism. Strecker and Chambers were much more pointed in their insistence that mothers be blamed for the sins of their sons. Peabody did not single out mothers in particular. In a series of writings employing Peabody's ideas, Strecker and Chambers's denunciation of women and their insistence that men control women became increasingly shrill. In the book Their Mother's Sons, the psychiatrist Strecker reached new depths in denouncing mothers for virtually every faulty male act of the World War II era, much like Philip Wylie's better known Generation of Vipers. None of these writers informed us what the cause of alcoholism in women might be.

Although Peabody's method was widely practiced for about two decades, little is known of its overall therapeutic success, and an accurate guess is impossible at this date. Marty Mann concluded that Peabody and his therapists "accomplished a heroic work during the 1930's, when little else was being done for alcoholics" and that the method "was effective with a considerable number" of patients. It is known that a few remained abstinent and professionally active in the field of alcoholism. Others who failed at the Peabody method were known to have joined A.A. in its early years, but it is impossible to determine how many remained quietly sober without joining A.A. or professional groups. The fact that several of the Peabody method's major practitioners - apparently including the founder - were not able to maintain their sobriety, however, does not bode well for other patients with whom contact was lost.
Conclusions

The major significance of Peabody's work was probably not its long term therapeutic success but the hope that it gave, both to the researchers in the early scientific study of alcoholism and to early A.A. members, that alcoholism was a treatable condition and a worthy topic for further research and investigation. In their review of the treatment literature, Bowman and Jellinek concluded, "In this country, Peabody has probably exerted more influence than anyone else on the psychotherapy of alcohol addiction." The writings of Peabody and of Strecker and Chambers reached a far wider audience than Baylor's book ever had. By the 1930s, the Emmanuel Movement had almost been forgotten. Even if the physicians and other professionals of the late 1930s and early 1940s had known of Worcester and Baylor's work, they undoubtedly would have rejected it as too religious for their own use. A.A. methods could not be used directly by professional therapists, since these methods depended on a group of recovering alcoholics. The tone and style of Peabody's writing was undoubtedly far more agreeable to professional practitioners by the end of Prohibition. The Peabody model was actively used in the Yale Plan Clinics, which employed both individual therapy and the class method of teaching similar to what Worcester had originally used. These class sessions were published verbatim in several issues of the Quarterly Journal of Studies on Alcohol and were very likely influential in the practice of other early clinics.

The difference between Worcester's and Peabody's work is in part accounted for by the spirit of the times when they developed their work. Elwood Worcester was 50 years old when World War I began: Richard Peabody was 20. Although Worcester incorporated some psychoanalytic concepts in his later work, he never altered his conviction that human nature was basically good and that the "subconscious" was a useful ally of consciousness. For Peabody, who had fought at Chateau-Thierry, those assumptions had become
untenable. More congenial to his generation were the ideas of Freud, for whom the mind was an endless battleground of life and death instincts that could be kept in check only by the eternally vigilant forces of civilization. Peabody's understanding of human life was thus more modern than Worcester's. For the younger man, life was an endless struggle, not so much between conscious and unconscious forces, but between sober reason on the one hand and feeling (equated with intoxication) on the other. A tone of postwar despair and depression permeated his work. Writing in 1919, Baylor used relatively little of Worcester's inspirational religious language, although he retained his basically spiritual view of the recovery process. Writing in 1930, Peabody had abandoned the spiritual language and concepts altogether.

Curiously, the postwar pessimism did not similarly affect Bill Wilson, who was Peabody's close contemporary and who also fought in World War I. Wilson's writings retained the language of another turn-of-the-century Protestant source, the Oxford Groups, through which he had initially stopped drinking. Many people, including new A.A. members and professionals, have reacted to his language in Alcoholics Anonymous, the primary A.A. sourcebook, as anachronistic and overly sentimental. It is essentially the same kind of style that was popular in Worcester's time, with the same indomitable optimism and confidence in the efficacy of spiritual ideas. It contrasts sharply with today's professional therapeutic language.

It is hard for us now to accept Worcester's optimism about the human race or his conviction that our inner impulses are always beneficent ones. There are still no more than a few of us, as Murphy (Historical Introduction to Modern Psychology) noted, who can understand his vision of the unity of the mystical and material worlds; our culture has trained us for so long to keep them rigidly separated. Worcester also could not give us an explanation of suffering. Like A.A., he had only a theory of progress and improvement not a theory of evil.
It is probably unfortunate from the long-term point of view of treatment that the "scientific" interest in alcoholism that developed in the 1930s could find professionally acceptable only the rather limited approach of Peabody. The International Bibliography of Studies on Alcohol (Keller) does not even list the writings of Worcester and Baylor. Apparently, its definition of "science" was not broad enough even to include the Emmanuel Movement, at least in the English speaking world. Perhaps, if we had adopted the broader concept of a Geistwissenschaft as Worcester - and perhaps also Freud - understood it, we would not be embroiled in such continuing problems with understanding the proper scope of the terms "science" and "disease."

Indirectly, one can conclude that the Emmanuel approach probably deserved its reputation for greater therapeutic success, since it used several of the major strategies that were later proved successful in related form by A.A. From the point of view of recovery, far more has been accomplished in the past 50 years by those who appreciated Worcester's paradox - that the unmanageability of life may be turned around by relaxing control, not by ever more frenzied efforts to regain it.
THE EMMANUEL CLINIC

Rev. Francis W. McPeek

The Role of Religious Bodies in the Treatment of Inebriety in the United States.

Alcohol, Science and Society, 1945.

Illustrative of a later development in the use of religious elements in the treatment of inebriety is the work of the Rev. Dr. Elwood Worcester and Samuel McComb, together with that of the physician, Isador H. Coriat, at Emmanuel Church in Boston. Begun shortly after the turn of the century, the so-called Emmanuel Movement had a lively impact on the thinking of churchmen and church workers in this country.

The center of the work was the clinic operated under the auspices of the church. The philosophy was that both medicine and religion have essential places in the treatment of any disease, but most particularly in the treatment of the functional illnesses. In the first book published by these three men, Religion and Medicine, they strive to inform the public on what they are attempting:

"We believe in the power of the mind over the body, and we also believe in medicine, in good habits, and in a wholesome, well regulated life. In the treatment of functional nervous disorders, we make free use of moral and physical agencies, but we do not believe in overtaxing these valuable aids by expecting the mind to attain results which can be effected more easily through physical instrumentalities."

Scientific procedures were employed in diagnosis and case records were kept. The use of specialists was frequent. When physical medicine was indicated, it was given, but it was accompanied by skilled religious counseling. The then current knowledge and opinions on the nature of the unconscious mind were
freely drawn upon by specialists. Suggestion and autosuggestion were frankly employed.

In connection with inebriety, many of the viewpoints expressed by these workers have been subsequently rejected. They accepted the theory of reproductive germ damage: they held that children of drunkards suffer to an almost incredible extent from various forms of mental and nervous diseases; that these children will inherit enfeebled or defective physical constitutions because of their parents constant tippling, and so on. The only differential diagnosis was between the chronic alcoholic and the dipsomaniac, by which they distinguished between the steady drinker and the periodic. The principal form of treatment, when abstinence was agreed to, was hypnosis and suggestion. All this was in 1908. By 1931, Worcester and McComb, again writing jointly, their book this time called Body, Mind and Spirit, had seen, and had liberally used, many advances in the field of medical psychology. The older doctrines of Charcot and Coue had given way before those of Freud, and much was taken from the latter. But the firm belief in the instrumentality of religion remained unshaken, and the equally firm belief that religion and medicine must go hand in hand:

"From the beginning we have associated ourselves with competent medical men and surgeons. Indeed, had such cooperation been refused, I should not have dreamed of assuming responsibility for the sick in mind and body. For many years most of our patients have been sent to us by physicians, and in all cases which involved more than the need of moral and spiritual advice we have left no stone unturned to procure the best diagnosis and medical care obtainable."

In dealing with the inebriate, three conditions were laid down. The alcoholic must wish to stop of his own volition and not simply because his wife or someone else requires him to submit to treatment. Only those who seriously propose total abstinence for the rest of their lives are accepted for treatment. And no discussions are held with persons who are in a state of intoxication.
The treatment process, after these conditions have been satisfied, is partially in the field of therapeutic analysis of the patients problems, the use of suggestion, and sometimes hypnosis. Suggestion is used only when the patient has been relaxed and is in condition to respond to it. Specifically, something like this is said:

"You have determined to break this habit, and you have already gone...days without a drink. The desire is fading out of your mind, and the habit is losing its power over you. You need not be afraid that you will suffer, for you will not suffer at all. In a short time liquor in any form will have no attraction for you. It will be associated in your mind with weakness and sorrow and sickness and failure..."

The patient is built up physically by the use of nourishing food, exercise, outdoor living, and so on. There is a search for new occupations and interests. "On the whole, our successes have been far more frequent than our failures," the authors report.

Out of the Emmanuel Movement has grown a very definite interest in the alcoholic. Mr. Courtenay Baylor, whose name is familiar to students of the treatment of inebriety, was long associated with Drs. Worcester and McComb. Those who wish to know more about his views and methods may read Dwight Anderson's article "The place of the lay therapist in the treatment of alcoholic." The principle elements in the treatment of alcoholics are catharsis, surrender, and relaxation - and these are carried out or induced through the use of religion.
The Emmanuel Movement is of salient importance to anyone who would help alcoholics. Though it is no longer in existence as a movement, it is anything but a mere ecclesiastical museum piece. Its goals, working philosophy, understanding of man, conception of alcoholism, and even some of its methods are worth emulating today. Here was perhaps the earliest experiment in a church-sponsored psychoreligious clinic. Here was the first pioneering attempt to treat alcoholism with a combination of individual and group therapy, the first attempt to combine the resources of depth psychology and religion in a systematic therapeutic endeavor. During its course the movement attracted many alcoholics and became well known for its success in treating them.

The movement came into being on a stormy evening in November, 1906, at the Emmanuel Episcopal Church in Boston, when the first "class" for those with functional illnesses was held. The guiding genius of the movement was a brilliant Episcopal clergyman named Elwood Worcester. His associate throughout most of its course was the Rev. Samuel McComb. Both men had had extensive graduate study in psychology and philosophy. Worcester had a Ph.D. from Leipzig where he studied under Wilheim Wundt, founder of the first psychological laboratory, and physicist-psychologist-philosopher Gustav Fechner.

For a long time before 1906, Worcester had had a growing conviction that the church had an important mission to the sick, and that the physician and clergyman should work together in the treatment of functional ills. As a preliminary step he consulted several leading neurologists to ascertain whether such a project as he had in mind, undertaken with proper safeguards, would have
their approval and cooperation. A favorable response was received, and the plan was launched.

The Emmanuel program of therapy consisted of three elements: group therapy administered through its classes, individual therapy administered by the ministers and staff at the daily clinic, and a system of social work and personal attention carried on by "friendly visitors." The growth of the movement was phenomenal. Three years after its inception, a California disciple could write:

The work, begun as a parish movement, has grown so that the local demands have overtaxed a large corps of workers while importunate calls from many cities in this and other lands for knowledge of the work, and pitiful calls for help from sick ones everywhere have to be put aside....Meanwhile, in two years the work has been taken up by ministers of many faiths who see in the new movement a' return to the faith and practice of the Apostolic Church. These...are finding new power in their work.

This disciple also described the manner in which plans were being put into operation for training ministers who wanted to use the Emmanuel technique in their parishes, and for setting up the movement in large centers. By 1909 the movement had spread abroad and was represented in Great Britain by a committee under the title "Church and Medical Union." The Emmanuel clinic in Boston was deluged by patients. During one six-month period nearly five thousand applications were received by mail alone. Of these only 125 could be accepted. Hundreds of clergymen and many physicians were visiting Boston to study the methods. Influential physicians like Richard C. Cabot gave their support to the movement.

The first definite book on the movement was Religion and Medicine, The Moral Control of Nervous Disorders, which appeared in 1908. Demand for this book was so great that it went through nine printings in the year of publication. For twenty-three years Worcester continued as rector at Emmanuel. The movement continued to flourish there and in other parts of the country. The need for
help was so great that often a line of patients cued outside the church. In 1929 Worcester resigned from his parish in order to give full time to the movement. A considerable sum of money had been received to carry on the work, so the movement was incorporated as the Craigie Foundation. In addition to the patients which he saw at his home, Worcester accepted many invitations to conduct week long clinics and lecture series in prominent eastern churches. In 1931 Worcester and McComb produced Body, Mind and Spirit, a book which showed clearly the development of their thought following the earlier books of the movement. For all practical purposes the Emmanuel Movement as such came to a close with Worcester's death in 1940.

It is noteworthy that three outstanding lay therapists for alcoholics in this country, Courtenay Baylor (who carried on the work at the Emmanuel Church for a time after Worcester's death), Richard. Peabody, and Samuel Crocker, were products of the movement. A lay therapist is a nonmedical practitioner who specializes in helping alcoholics professionally. For a description of the method of treatment used by Courtenay Baylor, see Dwight Anderson's "The Place of the Lay Therapist in the Treatment of Alcoholics," Q.J.S.A., September, 1944.

The Method of Treating Alcoholics

The Emmanuel classes were held once a week. In this group experience, alcoholics were lumped together with patients suffering from other functional illnesses treated by the clinic. A disciple of the movement, Lyman P. Powell, who had tried the technique in his own church, describes the procedure:

Any Wednesday evening from October until May you will find, if you drop in at Emmanuel Church, one of the most beautiful church interiors in the land filled with worshipers...A restful prelude on the organ allures the soul to worship. Without the aid of any choir several familiar hymns are sung by everyone who can sing and many who cannot. A bible lesson is read. The Apostles' Creed is said in unison. Requests for prayer in special cases are
gathered up into one prayerful effort made without the help of any book. One Wednesday evening Dr. Worcester gives the address, another Dr. McComb, still another some expert in neurology or psychology. The theme is usually one of practical significance, like hurry, worry, fear, or grief, and the healing Christ is made real in consequence to many an unhappy heart.

Other subjects discussed at the classes included: habit, anger, suggestion, insomnia, nervousness, what the will can do, and what prayer can do. The class was always followed by a social hour in the parish house. Reporting on the results of these group experiences, Powell says: "Though the mass effect of the service...is prophylactic, it is not uncommon for insomnia, neuralgia and kindred ills to disappear in the self-forgetfulness of such evenings."

The heart of the Emmanuel therapy was the clinic. Before a patient was accepted for treatment, he was required to have a careful diagnostic examination by a physician and in some cases, a psychiatrist. If psychosis or organic pathology was disclosed, the individual was not accepted. If the disease appeared to be simply functional, the applicant was registered for treatment and directed to the rector's study. In the case of alcoholics, it was felt by Worcester that they should be seen every day, especially in the early phases of their treatment. The new, nonalcoholic habits which the "psychotherapy" was implanting were to be treated as tender shoots until they took firm root. The patient was felt to need the daily support of the therapist until these new habits were firmly rooted, after which the therapist met the patient once or twice a week. Just how long the average alcoholic treatment took is not clear from the literature. No cases of alcoholism were listed among the quick cures - i.e., those effected in one or two sessions. A treatment period of at least several months seemed to have been involved in most of the cases cited.

The treatment itself included "full self-revelation" in which the patient poured out all the facts - physical, mental,
social, moral, and spiritual - which might have any bearing on the sickness. This catharsis was felt to have a curative effect in itself often serving to "unlock the hidden wholesomeness" of the patient's inner life. The second phase of the treatment consisted of "prayer and godly counsel." This apparently was aimed chiefly at teaching the patient the techniques of prayer and helping him strengthen his spiritual life, rather than praying for the individual. The third phase was the use of relaxation and "therapeutic suggestion," the latter administered in some cases while the patient was under mild or deep hypnosis. It is noteworthy that although Worcester began by using hypnosis in many different types of difficulties, he eventually limited it to use with some alcoholics. Apparently he felt that the alcoholic needed the more powerful effect of hypnotic suggestion.

"The patient is next invited to be seated in a reclining chair, taught to relax all his muscles, calmed by soothing words, and in a state of physical relaxation and mental quiet the unwholesome thoughts and untoward symptoms are dislodged from his consciousness, and in their place are sown the seeds of more health-giving thoughts and better habits."

During the course of the movement there occurred a highly significant transition in the thought and methodology used. The change consisted of the gradual incorporation of psychanalytic techniques, as Worcester began to learn of the dynamic psychology of Freud. This was accompanied by diminishing dependence on suggestion, the therapeutic device in vogue in the early days of the movement due to the influence of Worcester's European training with the physiological psychologists. Worcester stoutly defended the method of psychanalysis. In 1932 he wrote: "I cannot agree with Stekel who advises that analysis be attempted in alcoholic cases only after other means have failed. I have found it helpful to begin my treatment with an analysis of childhood and youth." Worcester used standard psychoanalytic techniques such as dream analysis and the probing of early memories as a part of his therapy.
Like others who have attempted to use such techniques with alcoholics, Worcester had encountered the problem of breaking the addictive cycle long enough to allow the therapy to have some effect. He developed his own unique solution which he felt was responsible for his success in keeping the patient sober while therapy got a foothold. The solution consisted of two parts: (a) making the analysis relatively brief; (b) combining analysis with his earlier method, therapeutic suggestion.

From insight gained through analysis of alcoholics, Worcester arrived at a profound understanding of alcoholism:

"The analysis, as a rule, brings to light certain experiences, conflicts, a sense of inferiority, maladjustment to life, and psychic tension, which are frequently the predisposing causes of excessive drinking. Without these few men becoming habitual drunkards. In reality drunkenness is a result of failure to integrate personality in a majority of cases. Patients, however darkly, appear to devine this of themselves, and I have heard some fifty men make this remark independently: "I see now that drinking was only a detail. The real trouble with me was that my whole life and my thoughts were wrong. This is why I drank."

He went on to say:

"It is this consciousness of crippling dissociation of powers, of inhibition and repression which predisposes men to drink. In alcoholism in its early stages they find release of their faculties, the dissociation of their fears and inhibitions, as so many have said, "A short cut to the ideal."

The aim of Emmanuel therapy was the reconstruction of the inner self so that the alcoholic could remain abstinent - Worcester had no illusions about alcoholics becoming social drinkers. There was a conviction that this reconstruction of personality must utilize the resources inherent in the person. Psychonalysis was an important technique for releasing these resources.
While Worcester came to regard analysis as essential, he also observed that "few drunkards have been cured by analysis alone." He recognized that their are two levels to the alcoholics problem – the underlying psychic conflicts and what he called the "habit itself," the effect on the nervous system of continued inebriety and the craving resulting therefrom. Analysis, he had found, had little effect on the latter, whereas suggestion often "supplied immediate help and permanent immunity from the return of the habit." His working hypothesis was that analysis relieved the psychic problems, "reducing the problem presented by the drunkard largely to a physical habit." Suggestion effected a strengthening of the will and a distaste for liquor so that the physical habit could be controlled.

Fortunately Worcester gives a sample of how he administered therapeutic suggestion to alcoholics:

"Most alcoholics are highly suggestible and I have found a few who failed to respond to the technique intended to induce mental repose and abstraction and physical relaxation. When the patient had obtained this condition, I should address him in low monotones and offer him repeated suggestions, positive and negative, somewhat as follows: "You have determined to break this habit, and you have already gone ___ days without a drink. The desire is fading out of your mind, the habit is losing its power over you. You need not be afraid that you will suffer at all. In a short time liquor in any form will have no attraction for you. It will be associated in your mind with weakness and sorrow and sickness and failure. These thoughts are very disagreeable to you and you turn away from them. You wish to be free, you desire to lead a useful, happy life. Liquor is your enemy, but you are overpowering it and in a short time it will have no power over you at all." Then as a person accustomed to depend on alcohol for sleep, when deprived of it, are apt to suffer from insomnia, I should add suggestions as to sleep and rest."

In addition to the suggestions given by the therapist, the patients were taught autosuggestion so that their treatment could continue between sessions.
The third phase of the Emmanuel program consisted of the "friendly visitors," whose purpose was "to give the environment of the patients care similar to that provided for their bodies by the physicians, and for their minds by the clergymen."

"Very often patients....need more than anything else a friend to show personal sympathy and interest, to encourage them, and to make sure they are following the prescribed directions. Victims of alcohol especially need this assistance to prevent relapse after the conclusions of treatment before they have acquired full self-reliance."

Worcester and McComb reported that the system was very successful. They pointed out that alcoholics profited from becoming friendly visitors to other alcoholics who were beginning their treatment and that they made very effective visitors. One thinks immediately of the A.A. system of sponsorship and the principle of Twelfth Step work in this connection.

"Our patients....need occupation to keep them from being self-centered. Clerical work has been found useful, but the best results have come from sending them as friendly visitors to others less fortunate. Not only does this have a good effect on the visitor, but new converts are proverbially enthusiastic, and the alcoholic who finds himself released from his bondage is a most valuable assistant in encouraging and keeping up to the mark patients who have just begun."

The friendly visitor system was administered by a committee which included several trained social workers. Through this system the alcoholic was aided in finding employment and, if neccessary, given a financial loan for a limited time while he adjusted his life. The friendly visitors often helped the patient readjust in the area of his family life.

Philosophically the Emmanuel Movement stands in contrast to the approaches studied previously. All of Worcester's writings reflect the conception that all life is permeated by the devine
spirit, a belief which had its roots in the panpsychism of his teacher, Fechner. In discussing "Mabn's Life in God," Worcester wrote:

"The Secret Of all Spiritual religion is the union Of the human soul with the divine soul, the belief that man's spirit and God's spirit are in their essence one. Without this belief man's relations with God become formal and external. The world, robbed of the haunting presence of the indwelling deity, becomes irreligious and profane."

Because he held that the spirits of God and man are in their essence one, Worcester did not think of man as depraved or lost in sin. Man's spirit is a part of God: his realization and healing consist not in surrender to an external Power, but in the redirecting, releasing, and reeducating of the inherent powers — the hidden wholesomeness — of the spirit within. This positive conception of man contrasts vividly with mission and Salvation Army doctrines of the impotent, sinful man who can be saved only by surrender to an external Power. Rather than seeing man's beatitude in the abnegation of self, Worcester felt that the purpose of therapy was to help the person "find freedom and to discover a better way of life for himself." Prayer was considered an important means of releasing the divine energies within the soul trapped by one's neurosis.

Worcester felt that many religious workers in the field of healing had made the mistake of supposing that God can cure in only one way. God cures by many means. An act of healing, whatever the means used, is religious, since the divine spirit permeates all of life. The healing of bodies and spirits by medicine, rest, kindness, and self-understanding is just as much an act of God as healing which depends on prayer and suggestion. Further, healing of the mind and spirit is not some sort of divine magic but is the divine spirit working through the orderly forces of nature. This general orientation provided the basis for a thoroughly cooperative relationship between the various healing disciplines involved in Emmanuel therapy.
In his view of man Worcester (in contrast to previous approaches) held to a thoroughly unrepressive attitude toward man's desires and feelings. He recognized that the tendency, especially among Christian thinkers of the past, has been to deny these factors in human life. Concerning the conflict between reason and conscience on the one hand, and emotion and desires on the other, he writes:

"The first step toward a possible solution of this fundamental problem of human life...is to recognize the legitimacy of both these elements of our being. In our disposition to do this lies whatever superiority we possess over former generations and our chief hope for the future."

This handling of the problem reflects Worcester's psychoanalytic orientation.

The problem of responsibility, a key problem whenever religion and psychology meet, was handled in a realistic manner by this approach. Worcester could not have fallen into freewill moralism concerning alcoholism. For one thing, from the beginning of the movement, he recognized alcoholism as an illness. Further his training in psychology had acquainted him with the role played by the subconscious mind in all behavior, including alcoholism. In 1908, long before the idea had become generally accepted, Worcester wrote:

"We believe that there is a subconscious element in the mind and that this element enters into every mental process. Our daily life is influenced far more than the shrewdest of us suspect by the subconscious activity which is at work, exercising a selective power even in apparently accidental choices. Hence the real cause of our acts are often hidden from us."

Worcester was convinced that "it is the subconscious that rules in the mental and moral region where habit has the seat of its strength." Further, he believed that therapeutic suggestion was able to influence and guide the subconscious mind into paths of health. As the influence of Freud grew in his thinking, the
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importance of subconscious factors was further enhanced.

There was another reason why Worcester avoided a moralistic conception of alcoholism and human ills in general. As early as 1908 he had recognized that the first six years of a child's life are the most important and determinative of his life. It was therefore relatively easy for him to accept the findings of the psychanalysts in this area. In his last book he wrote: "The great psychological thinkers and workers, Freud, Jung, Adler, 'and others, were quick to perceive the significance of childhood as the chief determinant of life."

An Evaluation of This Approach

How effective was the Emmanuel therapy in breaking the addictive cycle and providing initial sobriety? And how successful was it in providing longterm sobriety? It is impossible to answer these questions with certainty, since the movement no longer exists and apparently there are no quantitative records. For several reasons, however, it seems probable that the Emmanuel movement enjoyed a relatively high degree of success in providing at least temporary sobriety. We know that the Emmanuel workers accepted for treatment only those who wanted to stop drinking and who came on their own volition. A.A. experience has shown that these mental attitudes on the part of the alcoholic are essential prerequisites for successful therapy. These Emmanuel requirements meant that only patients who were "at bottom" and who would accept responsibility in asking for help would be treated. Second, we know that the Emmanuel therapists had the advantage over "straight religious" approaches of having medical assistance - a valuable aid in effecting initial sobriety. Third, we know that suggestion administered as in this therapy by a person with status, exercises a powerful control over behavior. This is especially true in the case of insecure and dependent people, such as alcoholics frequently are. Fourth, we know from various reports that suggestive therapy has produced impressive results with alcoholics. Prior to the Emmanuel
movement, Charcot treated 600 cases over a twenty-year period and reported 400 "cures." Tokarsky of Moscow reported that 80 percent of the 700 alcoholics he had treated were cured, and Wiamsky of Saratow claimed about the same percentage of cures out of the 319 cases he treated. Unfortunately, no definition of "cure" was given in these reports.

It seems probable that many of those who gained temporary sobriety through Emmanuel therapy stayed sober for an extended period. The fact that Worcester and McComb over the years acquired a reputation for success in treating alcoholics indicates that many of their patients must have stayed abstinent. In 1932 they were able to report: "It is well known that we have obtained as good and as permanent results in these fields as any other workers." If most of their cures had been short-lived, they would not have enjoyed this reputation.

Several cases are presented in Emmanuel literature which show that sobriety extended over long periods. Worcester tells, for instance, of treating a very difficult alcoholic with homicidal tendencies who had been given up as hopeless by the doctors. At the time of writing the man had enjoyed seven years of sobriety. Worcester reported having little success in treating "dypsomaniacs" - apparently the equivalent of periodic alcoholics as contrasted with "ordinary alcoholics" (steadies). In spite of this, he tells of successfully treating a woman "dypsomanic," who had been judged hopeless by two psychiatrists. Worcester writes: "As I have kept in contact with this woman, I can say that she was cured in the sense that for twenty-two years there has been no return of the fatal cycle, not a drop of liquor has passed her lips." That a good deal of success was enjoyed by the movement, even in cases where relapses occurred, is shown by Samuel McComb's statement: "There are other cases of alcoholism where a relapse has occurred, but it has only been temporary: and fathers and sons have been restored to their families with what a joy only those who have felt the curse of intemperance can realize."
Writing in 1931, the Emmanuel leaders could report, "On the whole our successes have been far more frequent than our failures." This statement was made with the perspective of twenty-five years of experience in the movement.

There are many points at which the Emmanuel approach was superior in theory and practice to the evangelistic approaches. While recognizing the importance of group experience, the Emmanuel approach also supplied individual psychotherapy. This combination of individual and group therapy represents an obvious advance over the mass evangelistic approaches. As the Emmanuel approach came to incorporate psychonalytic procedure in its therapy, it dealt to some degree with the underlying causes of inebriety, rather than simply relieving or changing symptoms. Worcester's observation that alcoholics respond best to relatively brief therapy concurs with modern findings.

The Emmanuel approach achieved an integration of the healing resources of medicine, psychology, social work, and religion. In the Salvation Army we saw a certain eclecticism in which the resources of other professions were drawn on as supplements to the basic religious approach. In contrast, the Emmanuel workers saw medicine, psychology, and social work as integral parts of a total "religious" approach to healing. The medical and psychiatric screening of patients not only protected the church clinic but also improved the possibility of a favorable outcome.

The goal of Emmanuel therapy - to promote the freedom and growth of the individual by releasing inner resources, in contrast to authority-centered approaches, - is in keeping with the healthy needs of the alcoholic. We have seen that alcoholics often have neurotic needs which encourage the formation of immature dependency relationships. Their healthy needs are for increased self-esteem and constructive autonomy. In contrast to previously studied approaches, which encouraged dependency and surrender to authority, Emmanuel thought encouraged independence and growth in responsibility. Worcester shunned the use of
exhortation and persuasion as being "wholly out of place in treatment." They may provoke opposition on the patient's part, or, they may even be dangerous, because they impose the teacher's personality and philosophy on the patient instead of allowing him to find freedom and to discover a better way of life for himself."

Instead of depending on religious thrill and a sudden, dramatic conversion, Emmanuel therapy relied on the gradual type of religious change. It seems clear that Emmanuel's psychotherapy offered greater possibility of lasting change than was true of the evangelistic approaches. The Emmanuel workers recognized that evangelistic approaches have value for some alcoholics: they also saw that many alcoholics cannot be reached by those approaches. Powell, an Emmanuelite, wrote: "While men like Gerry McAuley and the Salvation Army leaders have done something, the emotional motive which they use does not avail in every case."

The Emmanuel approach recognized fully that the alcoholic needs individual and group support during his recovery. The "friendly visitor" system combined the principle of A.A. sponsorship with the resources of a social caseworker. Undoubtedly this friendly, individual attention and help were major factors in the success of the approach.

The approach was well equipped to help the alcoholic find real self-acceptance and release from guilt. Its superiority lay in its splendid conception of alcoholism and its understanding of the psychodynamics of human behavior. Twenty-seven years before A.A. began, this approach was regarding alcoholism as a disease to be treated like other functional diseases. In this early period there was a degree of moralism connected with the conception of all functional illnesses. The influence of psychanalytic concepts gradually removed this moralism, revealing the manner in which behavior is conditioned by early experiences and by unconscious forces which are not subject to the will.
The therapy sought to reduce the alcoholics' guilt rather than to enhance it as in the previous approaches. It achieved this by its disease conception of alcoholism and its positive conception of man, allowing the therapist to establish a nonjudgmental relationship with the patient. By means of his acceptance of the patient, the therapist was able to help the patient achieve self-acceptance. Self-acceptance, it is well to remember, implies a sense of being accepted by life. This the Emmanuel therapist was well equipped to convey because of the positive, life-affirming philosophy and theology of the movement. There is a sense of course, in which the experience of "accepting oneself as being accepted," to use Paul Tillich's description of salvation, results from any psychotherapy which is successful. Emmanuel therapy apparently was frequently able to convey this experience. When guilt is reduced, the energies previously employed in the guilt and self-punishment process are freed and made available for therapeutic ends.

Forgiveness was achieved in Emmanuel therapy not by petitioning an authoritarian Deity, but by modifying 'the unmerciful superego of the patient. McComb wrote as follows concerning what he called the "New England or Quaker conscience": "The great need here is for a new conception of God. The mind must be taught to rest in his fatherly love, in his tenderness and grace....By the constant presentation to the mind of these ideas the conscience is gradually lightened of its morbidity and the will is set free to act."

Rather than concerning itself with specific "sins," the Emmanuel approach focused attention on the underlying causes of these symptoms -- namely, the sick personality. This also aided in reducing the alcoholic's guilt load. In addition, the psychonalytic concept that alcoholic behavior is determined in large measure by subconscious factors (beyond the realm of willpower) had a tremendous guilt-reducing effect. The positive conception of man and the recognition that his drives and
feelings are not inherently evil both contribute to healthy self-acceptance on the part of the patient. Likewise the conception of the healing process as resulting from the release of inner resources (as contrasted with external divine intervention) tends to enhance self-esteem by enabling the patient to feel a sense of achievement in his improved condition. It also serves to keep the responsibility for healing with the patient. The alcoholic's inferiority is reduced not by identifying with a powerful authority-figure, but by becoming aware of his "higher and diviner self" which is his most real self.

The Emmanuel workers recognized clearly that religious symbols can be employed in ways that promote maturity and health. They threw their influence behind the latter. As a result we do not find the emphasis on fear and guilt which was present in the previous approaches.

With only minor changes, the mature Emmanuel concept of alcoholism would be acceptable in the most enlightened circles today. In one way it was superior even to the A.A. conception. Because of its orientation in depth psychology, it recognized that the selfishness and egocentricity of the 'alcoholic are actually symptoms of deeper problems and conflicts. This is in contrast to the A.A. position which does not seem to recognize the symptomatic nature of selfishness. (It should be added that many individual A.A.'s, particularly those who have had psychotherapy, do recognize the nature of selfishness.) Because of deeper understanding of personality, the Emmanuel therapy was beamed more accurately at the roots of alcoholism than is the A.A. therapy. Its use of psychoanalytic techniques in its therapy provided it with the practical means of getting at these underlying causes. Such techniques are not present to any great degree in A.A. The Emmanuel approach was superior to A.A. in that it made individual as well as group therapy available to the alcoholic. Further, because of its psychoanalytic grounding, it was less repressive than A.A. in its attitude toward the self.
In spite of its areas of theoretical superiority, it seems probable that from a practical standpoint, Emmanuel was less effective than A.A. Its therapy was less adequate than A.A. in that it lacked an all-alcoholic support group. Further, it did not capitalize fully on the recognition that helping other alcoholics help the alcoholic patient to stay sober himself. Nor did it capitalize on its recognition that one alcoholic has a natural entree to another. Even though its goal was nonauthoritarian, its therapy was dispensed by an authority figure. It lacked the advantage of A.A.'s self-help orientation, particularly the feeling on the part of the A.A. member - "We're licking this thing ourselves" and "This is our fellowship." Since the Emmanuel approach was dependent on professionals, the number of alcoholics who could be helped was quite limited as compared to A.A.

The central weakness of the Emmanuel approach to alcoholism would seem to be the use of suggestion. Although Worcester's therapeutic aim - increasing the freedom of the patient - was psychologically sound, his method actually defeated his aim. The thing that was not recognized was that suggestion is an essentially authoritarian tool, that it substitutes the authority of the "suggester" for the autonomy of the individual, thus establishing an unconstructive dependence on the therapist. The Emmanuel workers did not realize that the "strengthening of the will" which they observed in alcoholic patients was actually the result of the projection of their authority on the patient. Carl R. Rogers includes suggestion under "Methods in Disrepute" in his discussion of counseling. He writes:

"The client is told in a variety of ways, "you're getting better," "You're doing well," "you're improving," all in the hope that it will strengthen his motivation in these directions. Shaffer has well pointed out that such suggestion is essentially repressive. It denies the problem which exists, and it denies the feeling which the individual has about the problem."
It should be noted that suggestion was generally accepted as a therapeutic device during the early period of the Emmanuel movement. In fact, medical schools were teaching the technique as a healing tool. As we have seen, the Emmanuel workers put decreasing emphasis on suggestion as their knowledge of psychoanalysis increased. Though their methodology became relatively less repressive, it would seem probable that the effectiveness of their psychoanalytic procedures must have been vitiated in part by the continued use of suggestion.

Worcester was insightfully accurate in recognizing the two levels of alcoholism and in his belief that something had to be done to hold the addiction in check while psychotherapy sought to deal with the underlying causes. Unfortunately, the device he employed (suggestion) impeded the effectiveness of the psychotherapy.

Why did this movement not survive? First, it was centered around two strong and unusual personalities. There were few clergymen with the kind of training and general qualifications possessed by Worcester and McComb. Apparently the movement was not successful in training younger men to carry on the tradition. Second, the fundamental methodological weakness of the movement may have contributed to its demise. The continued use of a repressive device like suggestion over a long period of time may have resulted in diminishing enthusiasm and decreasing therapeutic return. Of course there is a sense in which the movement continues in its influence on the clergymen whose interest in psychotherapy and healing was stimulated by their contacts with the movement, its literature, or others who had felt its influence.

What We Can Learn from the Emmanuel Approach

The Emmanuel Movement was the first organized attempt to apply the joint resources of psychology and religion to the problem of alcoholism. Its degree of success suggests the
possibilities that lie in this direction. It was the first approach to understand and seek to treat the underlying causes of alcoholism. In spite of its methodological error, its general orientation was positive and life-affirming, so much so that its critics labeled it "hedonistic." The practical values as well as the psychological validity of this outlook have been discussed in our evaluation.

This approach provides an impressive demonstration of the importance in dealing with alcoholics of one's conception of alcoholism and the human situation in general. In its understanding of the psychodynamics of alcoholism and its incorporation of psychanalytic insights and methods, this approach was decades ahead of its time. In these regards, as in the handling of the problem of guilt and responsibility, the Emmanuel Movement has a great deal to teach many religious leaders today. Among other things it provides an example of the way in which a psychoanalytic orientation can mediate the acceptance of God, thus enhancing self-acceptance. As we have seen, it did this, not by encouraging surrender to an external deity, but by resolving inner conflict, thus releasing God-given resources within the personality. The resolving of inner conflict was achieved through psychanalytic techniques which were based on a recognition of the dynamic significance of the unconscious and by an actual accepting relationship with one of God's children, the therapist.

The Emmanuel Movement pioneered in the field of church-sponsored psychotherapeutic clinics. Its story should cause organized religion to reflect on its general role in a society plagued by widespread neurosis and inadequate facilities for treatment. Startled by the overwhelming influx of patients, the Emmanuel leaders wrote:

"The mere fact that disinterested clergymen and physicians were willing to be consulted....has brought persons to us in such numbers that, although we have a good-sized staff, it is
impossible for us to see one person in five for a single conversation. This one fact should cause the Church to reflect. Why should there not be adequate assistance for men and women who desire and need personal, moral and spiritual help?"

Although this was written many years ago, the question is still relevant and pressing in our day. A partial answer is emerging in the pastoral counseling movement and the two hundred or so church-related counseling services which have been established in recent years.

Reproduced in whole from the book Understanding and Counseling the Alcoholic by Howard J. Clinebell, Jr. (1956)
THE PLACE OF THE LAY THERAPIST IN THE TREATMENT
OF ALCOHOLICS

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When the history of the treatment of problem drinking comes at last to be written, the pioneer contributions of the layman will be seen to have been greater than is now generally supposed. It is intended here to indicate in general what this contribution has been, and to inquire why certain laymen as therapists have been able to produce results often denied to professional persons. The treatment and prevention of this ailment, in the future, will benefit by an inquiry regarding the nature of the lay therapists qualifications and techniques. Such an examination begins with the personalities who have already been outstanding in this field of effort.

The late Richard R. Peabody made a notable contribution to therapy. Through his students, many of whom became lay therapists themselves, his techniques have been perpetuated. Most of them are embodied in his book, The Common Sense of Drinking. These techniques functioned to bring about-reactions in the patient which can be classified as surrender, relaxation and catharsis. Peabody did not call them by these names, but an examination of his writings, including the "notes" which he supplied to alcoholics studying with him, shows plainly that these three responses from his subjects were the effects of his instruction. How these three elements are to be found also in the Program of Alcoholics Anonymous, and in the work of other therapists, is described by the author of this article in another place. Peabody and his followers worked out, with their students, nine steps described by Bowman and Jellinek as follows:

1. A mental analysis and removal of doubts, fears, conflicts, created in the past.
2. Permanent removal of tension, which is only temporarily released by alcohol, by formal relaxation and suggestion.

3. Influencing the unconscious mind by suggestion "so that it cooperates with the conscious to bring about a consistent intelligent course of action."

4. Control of thoughts and actions.

5. Hygiene.

6. Daily routine of self-imposed schedule to keep the patient occupied, to train his will power and efficiency and to give him the feeling that he is doing something about his problem.

7. Warning the patient against unexpected pitfalls.

8. Providing the patient with some means of self-expression.

9. Realization that the same force which drove the patient to disintegration will, under conditions of sobriety, carry him beyond the level of average attainment.

Courtenay Baylor of Boston was specifically credited by Peabody as his preceptor. Peabody stated: "The treatment...has been carried on by Courtenay Baylor for seventeen years. I can never sufficiently acknowledge my debts to him for being able to write it." In his book Peabody quotes directly from Baylor;

To substantiate the theory I have described, quotations from Mr. Courtenay Baylor's book, "Remaking a Man," are pertinent. "I recognized," he writes, "that the taking of the tabooed drink was the physical expression of a certain temporary but recurrent mental condition which appeared to be a combination of wrong impulses and a wholly false, though plausible philosophy. Further, I believed that these strange periods were due to a condition of the brain which seemed akin to a physical tension and which set up in the processes a peculiar shifting and distorting and imagining of values; and I have found that with a release of this "tenseness" a normal coordination does come about, bringing proper impulses and rational thinking."
And again, "Underlying and apparently causing this mental state (fear, depression or irritability), I have always found the brain condition which suggests actual physical tenseness. In this condition a brain never senses things as they really are. As the tenseness develops, new and imaginary values arise and existing values change their relative positions of importance and become illogical and irrational. Ideas at other times unnoticed, or even scorned become, under tenseness, so insistent that they become controllong impulses. False values and false thinking run side by side with the normal philosophy for a time: and then with the increasing tenseness the abnormal attitude gradually replaces the normal in control. This is true whether the particular question be one of drinking or of giving way to some other impulse: the same indecision, changeability, inconsistency, and lack of resistance mark the mental process. In fact, the person will behave like one or the other of two different individuals as he or she is not mentally tense."

Peabody then continues to amplify Baylor's thought:

"We must not overlook one very important but little-recognized stimulus to drinking. Emotional instability (tension) can be created by legitimate excitement (such as attending a football game where the home team is victorious or, for that matter, by any other form of pleasant emotional stimulation) just as surely as it can by worry and unhappiness. In fact, it would be no exaggeration to say that the alcoholic has to learn to withstand success just as assuredly as he does misfortune, strange as this statement may seem. Many drunkards claim that they do not use alcohol as a refuge but as a means of celebration, and they are probably right as far as their conscious minds are concerned."

"When a man under pleasant emotional stimulation seeks narcotic escape from reality in the same manner as he does from unpleasant emotions is an interesting question but difficult to answer. My own theory is that a neurotic is unconsciously, and possibly consciously, afraid when his emotional equilibrium is
disturbed, no matter what the quality of the disturbance may be. When he is in a state of euphoria (happiness) he evidently feels the need of a stabilizer to the same extent as he does in dysphoria (unhappiness). Just as he is bored when he looks inward, so he is frightened when he looks outward, if the customary scene has changed even a little."

That these ideas, first promulgated by Baylor thirty years ago, have proved their validity down to the present time, is one of the interesting facts in the history of the lay therapist. Extensive quotations from Peabody and Baylor appear in Alcohol - One Man's Meat, by Edward A. Strecker, professor of psychiatry at the University of Pennsylvania, and Francis T. Chambers, Jr., a lay therapist, published in 1941.

THE LAYMAN'S SPECIAL QUALIFICATIONS

These contributions to theory do not fully explain the layman's success in practical application of the principles. Every recovered alcoholic will acknowledge that the key ideas which caused the revolutionary change in his outlook and behavior had been presented to him without effect a number of times, but until he met the right therapist, and perhaps until he had struck the "rock-bottom" of desperation, they failed to "click." Since most contemporary lay therapists are former alcoholics, we do not have far to seek to learn the reason for the layman's ability to get his ideas accepted by the subject. It has been explained by Foster Kennedy, Director and Chief of the Department of Neurology and Neuro-Psychiatry, Bellevue Hospital, New York, in these words:

"I have no doubt that a man who has cured himself of the lust for alcohol has a far greater power for curing alcoholism than has a doctor who has never been afflicted by the same curse. No matter how sympathetic and patient the doctor may be in the approach to his patient, the patient is sure to feel, or to imagine, either condescension to himself, or get the notion that he is being hectored by one of the minor prophets."
No mere spectator of compulsive drinking can substitute hearsay knowledge for the conviction born of experience. If a man has never experienced the joys of alcohol he cannot have an understanding of its sorrows. Thus, what the lay ex-alcoholic says to the patient comes with double the force it would have if said by a psychiatrist, no matter how great his prestige. In fact, the greater the prestige, perhaps the greater the resistance of the patient. Rapport can be, and often is, instantaneous when a former alcoholic acts as a therapist. What the layman lacks in technique and understanding can be supplied by training and supported by the continuous help and supervision of the psychologist, the physician, and the psychiatrist. What cannot be supplied is his kinship with the compulsive drinker. He is ideally equipped to break down the wall of resistance which every alcoholic interposes to treatment even when he sees it.

William James has explained this personality barrier, although in quite another connection:

"The psychology of individual types of character has hardly begun even to be sketched as yet - our lectures may possibly serve as a crumblike contribution to the structure. The first thing to bear in mind (especially if we ourselves belong to the clerico-academic-scientific type, the officially and conventionally "correct" type, for which to ignore others is a besetting temptation) is that nothing can be more stupid than to bar out phenomena from our notice, merely because we are incapable of taking part in anything like them ourselves."

An impulse to heal others is characteristic of almost every recovered alcoholic by whatever means his abstinence has been brought about. It would appear that the alcoholic's excessive need for importance, praise and attention, described by Dr. L. S. Sillman of the New York Psychiatric Institute as a "defiant grandiosity," becomes modified and converted during and after recovery into a desire to help those who are suffering as he has suffered. He is further benefited by learning how to share with
others the new and unexpected values which life now holds for him. This changed attitude away from egocentricity is reflected in his other relationships with accompanying benefits which soon become apparent.

Foster Kennedy referred to this factor in his comments on the procedures of Alcoholics Anonymous, previously mentioned. He said:

"The sick man's association with those who, having been sick, have become, or are becoming well, is a therapeutic suggestion of cure and an obliteration of his feeling of being a pariah; and this tapping of deep internal forces is shown by the great growth of this sturdy and beneficent movement. Furthermore, this movement furnishes an objective of high emotional driving power in making every cured drunkard a missionary to the sick. These men grow filled with a holy zeal and their very zealousness keeps the missionary steady while the next man is being cured."

Another advantage possessed by the recovered alcoholic, which is of the highest value, is that he will never give up hope. The vagaries of the patient's behavior, which are often difficult for the physician to cope with, are instantly understood by the layman who "has been there himself." He cannot forget the numberless times that his friends and relatives gave up hope for him, to say nothing of the occasions, still more numerous, when he had no hope himself. But when the time was right, and he himself was ready, he became accessible, and this memory is an unfailing source of encouragement as he encounters the inevitable vicissitudes of his cases. So he never gives up the battle and will stay with the most difficult cases longer than any other person. His insight is derived from seeing in the patient before him a mirror of his own past. This is no place to delve into the realm of the mystical, but all who have watched recoveries from this ailment have observed that the faith of the therapist is a vital part of the treatment.
When we come to fit lay therapists into a formal, organized scheme of treatment, there will be no lack of candidates. Up to now, the successful ones have worked independently of Alcoholics Anonymous, and whose own recovery was otherwise accomplished, have developed their clientele in a normal and natural way by producing results which became talked about. First, their own success with themselves became known to their friends who, surprised, asked, "How did you do it?" and thereafter sent alcoholics to hear the story. Of the many who were called upon to help others, some failed, and some succeeded. Those who succeeded found, in time, that they had gained acceptance from medical men and others; and with increasing referral of cases to them, they often gradually came to devote more time to this work. It is doubtful whether those who failed did any serious harm to the few whom they tried to help; for if their approach was wrong, it apparently had little effect on the subject either for good or ill. No man who continuously fails to accomplish his end continues long on a course of activity. So there has been a weeding out of the unfit by the course of events.

The ideal arrangement for lay therapy would appear to be the one existing at the Institute of the Pennsylvania Hospital, where a layman, Chambers, works with a psychiatrist, Strecker, and has easy access to him. This does not appear to exist in just this way anywhere else except at New Haven, Connecticut, where Mr. Raymond G. McCarthy is a member of the staff of the recently formed Yale Plan Clinic, with medical and psychiatric services available. At the latter clinic as well as its counterpart in Hartford, each patient receives both a medical and psychiatric examination as early as is possible.

At the two Shadel Sanitariums located in Seattle, Washington, and Portland, Oregon, former patients are used as executives, employees, and field workers. Laymen conduct the original interview, and the last one on departure. The conduct of the establishments is under the constant supervision of medical men. Psychiatric care can be made available if required,
but cases with pathological conditions are avoided. The conditioned-reflex or "aversion treatment" is the basis of the procedures at these establishments, supported by the psychotherapy of the executives, and of the field men who call upon patients who have returned to their homes in the intervals of a year's treatment during which patients come back periodically for reconditioning. Social workers have not been found to be as effectual for this purpose as patients who have made recoveries at the Shadel establishments.

Every recovering alcoholic needs help with such problems as what to say to friends who invite him to take a drink, what to tell employers on returning to the job, whether to avoid previous haunts or go to them from time to time, and, as one man put it to a recovered alcoholic, "What in hell do you do on pay day?" The problem of going through the festive Christmas and New Years season is often fraught with difficulty. One who has had to find answers to these questions for himself is the best person to advise another. One lay therapist is responsible for a suggestion which has proved of great value with patients after a period of hospitalization; it is to change the furniture around so that the home looks different. It is found that this device assists in disrupting some of the associations of the former way of life.

NATURE OF TRAINING

As Mr Chambers' connection with the Pennsylvania Hospital as lay therapist was formed in the year 1935, his opinion was sought on the preparation of this article. In a letter dated May 31, 1944, he writes:

"The intelligent lay therapist should have gained deep insight because of his own alcoholic dependency and recovery. The therapist who has overcome his drinking problem acts as a constructive suggestion element. The reeducational treatment plan that he uses, if it is sound, should afford insight and stimulation toward readjustment."

"The lay therapist working without medical support exposes himself to risks that might make him directly or indirectly
responsible for tragic consequences. From a commonsense angle, he
should not attempt unsupported therapy."

"As a associate in therapy, he can greatly relieve the heavy
caseload of the already overworked physician in clinic and
hospital."

"His qualification should be a two-year period of
abstinence, during which time 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. This training
should include courses in a reeducational treatment plan. He
should attend lectures on psychiatry, such as are given to third
year students of medicine at the University of Pennsylvania by
Dr. Strecker. He should attend lectures given by psychologists so
that he would have an appreciation and understanding of
psychometric testing. A period of nursing would be an invaluable
experience in order to familiarize him with the difficulties of
alcohol-withdrawal symptoms. He should attend selected medical
lectures so that he would have an appreciation of the medical
aspects of the problem. If he progresses satisfactorily, he
should be permitted to work with a certain number of alcoholic
patients under the supervision of an experienced therapist. When
undertaking a reeducational treatment plan he should consider
himself as an assistant to the psychiatrist in charge, and make
use of the psychologist's reports. He should also be familiar
with the facilities offered by the laboratory."

"The graduate would have benefited himself in many ways. He
would have had experience under the discipline of science, and
learned to respect and depend on the scientific procedure. He
would learn to work with others, both depending on them and
contributing to their effort. More than this, he would personally
benefit by subduing his often exaggerated craving for importance
to a more healthy level."

"IT is obvious that choosing the right calibre person is
important. Emphasis should be laid on quality rather than
quantity."
In line with Chambers' suggestions, additional attention may be paid to educational qualifications. As a candidate for training, 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 success in helping to bring about recoveries, clearly demonstrates fitness."

It will be excellent if work with alcoholics, or at least observation of them, continues during the period of instruction, so that the words and definitions which he is taught in the classroom will have meaning to him in their manifestations in human beings.

Students can learn how to take case histories by actual contact with patients. Lectures may be accompanied by seminars, and discussions of these case histories. A social worker will have placed at the disposal of the therapist studies of the environment and family relationships. The physician's findings, as well as the psychiatrist's, will be interpreted to the student at the time they are made available to the therapist in charge of the patient, and they are made to mean more to the student if he is allowed to come in contact with the patient. The teaching should be done as much as possible with the participation of the student, giving him little of theory, but reiterating that little, time after time, by group discussion and contact with individual patients.

An invaluable part of the therapist's education will be to bring home to him a realization of how little he knows of the subject matter he has studied. A little knowledge is not a dangerous thing, if it is known to be little. With this will come to him also an appreciation of how little anybody knows, or can ever know, of the psychic mysteries of the wellsprings of human behavior. He will respect himself and his colleagues when he finds that those who know the most make the least claims for what they can do in the treatment of the psyche. For what is not known is vastly greater than what is known, and the most experienced psychiatrists often do not understand just how they produced a
favorable result in one case, or why they failed in another. There is no machine that will give us an X-ray of the soul. No intelligence test can tell us what use a person's emotions will make of his intelligence. This may be approached some day when we have a means of determining an emotional quotient comparable to the intelligence quotient. The Rorschach Test is a step in this direction for the few who have the education, training and experience to apply it.

SCOPE OF THE LAYMAN'S ACTIVITIES

Few psychiatrists are sympathetic to the need for treating people whose behavior is within what is considered to be the normal range, insofar as psychoneurosis or psychosis is concerned, but who spend much of their time either 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. The layman will fail, doubtless, with many patients who are definitely psychopathic, just as the psychiatrist frequently fails. Hervey Cleckley, of the University of Georgia School of Medicine, has provided a series of fifteen case histories diagnosed as "psychopathic personalities, without psychosis" and mostly complicated by excessive drinking. He devotes chapters to the psychopath as a business man, as a man of the world, as a gentleman, as a scientist, as a physician, and as a psychiatrist. Repeated hospitalization accomplished little with these persons. The lay therapist cannot hope to succeed with many of these.

What the competent lay therapist does is to make an analysis after his own fashion, following a series of interviews and a study of the history of the case. These judgements have little in them of formal science, but much of the intuitive art of influencing human behavior. The competent therapist looks for the areas of emotional structure in which the alcoholic's responses are impaired, confused, or even wholly absent. To use a homely comparison, the patient is like a jangling piano. The case, the outer appearance, the apparent behavior, often appears fine and competent.
But touch the keys of C and E. No sound comes forth, part of the personality gives no response whatsoever, although all the keys are there and most of the strings respond with notes of good quality. When the lay therapist finds that a patient lacks certain "strings"—due to a congenital defect or to disease, trauma or degeneration—he promptly sends that patient to a psychiatrist. Perhaps the psychiatrist can stop the deterioration or repair the damage. This is a last hope. If he does nothing more, the psychiatrist may organize a nontaxing environment, write a simple score for the patient to play.

If, on the other hand, and as so often happens, the lay therapist gets a response too faint or too loud from the disordered alcoholic, or the one that is sharp or flat, he knows that the fundamental mechanism is still intact, and that eventually he can repair the instrument. Perhaps the hammers need new felt, or the damper pedals should be regulated, or a string here or there needs to be adjusted.

To continue the analogy, pianos are made to stand great stress; the tension of the strings exerts between 15 and 20 tons of pressure upon their frames. People in the world today are subjected to severe and continuous tensions and shocks. Many merely get out of tune. They use alcohol to create a feeling of inner harmony. But the alcohol causes more discord. They are the very ones whom the lay therapist can most readily tune up so that they are again acceptable for the orchestra of society and may play well for the great dance of life.

At the Yale Plan Clinics it has been found that a number of inquiries have come from persons who are not alcoholics, but who have reason to think alcohol is having an increasing serious effect upon them, and are worried. Groups of Alcoholics Anonymous also are often called upon to answer the question, "Am I in danger of becoming an alcoholic?" A lay therapist is as well qualified to answer such questions, for all practical purposes, as a psychiatrist, and he can be used in this way to economize the time of the latter. Common sense, practical suggestions are
often all that are needed to help the baffled patient over what seem to him insuperable hurdles; often a quiet talk with the wife, mother or mother-in-law helps tremendously. The intervention here of a 'social worker is often useless; her suggestions are not so acceptable as those which come from a person who tears a leaf out of his own diary and says, "Well, here is what was done in my case." To marshal to the resolution of these problems the powers of the psychiatrist would be like bringing up a pile-driver or a steam hammer to drive a nail. While these difficulties are simple, they are also crucial, and successful therapy often begins, and sometimes ends, with their happy solution.

CONCLUSIONS

1. Lay therapists have made a significant contribution to the treatment of compulsive drinking.

2. Their chief qualification derives from the fact that they themselves have made a recovery from this ailment.

3. They can be made increasingly of use in the future if we learn how to select them, how to train them, and, recognizing the scope of their function, learn how to use them in cooperation with the social worker, the psychologist, the physician and the psychiatrist.
Belief in the possibility of recovery is growing apace today, but it had a slow and feeble beginning not so very long ago. In the years following the first World War, word got around in certain circles (mostly wealthy) that a man named Courtenay Baylor in Boston was having some success in treating alcoholics. He was not a doctor, nor a formally trained psychologist: he was what is called a lay therapist, and he worked in a clinic which was part of Emmanuel Church, the seat of the Emmanuel Movement. The methods he used were both psychological and spiritual, combining to re-educate the alcoholic to a life without alcohol; he described them fully in his book Remaking a Man, published in 1919. The Emmanuel clinic was for all kinds of nervous disorders, and did not specialize in alcoholism, so that there was no great flood of recoveries to startle the world. Nevertheless a little hope was generated, and some alcoholics got well. A start had been made.

Richard Peabody, also of Boston, was the next name to be associated with recoveries from alcoholism. Himself a product of Baylor's teaching, he turned what he had learned wholly onto the problem of alcoholism, and specialized in the treatment of alcoholics. His book The Common Sense of Drinking, containing a description of his method, was published in 1931. A few of his successful cases entered the field as therapists, and by the mid-thirties still more recoveries were giving the lie to the alleged "hopeless of alcoholism."

Francis T. Chambers, Jr., of Philadelphia, was a follower of Peabody who in turn went a step further than his teacher. Under the guidance of Dr. Edward A. Strecker, one of America's leading
Belief in the possibility of recovery is growing apace today, but it had a slow and feeble beginning not so very long ago. In the years following the first World War, word got around in certain circles (mostly wealthy) that a man named Courtenay Baylor in Boston was having some success in treating alcoholics. He was not a doctor, nor a formally trained psychologist: he was what is called a lay therapist, and he worked in a clinic which was part of Emmanuel Church, the seat of the Emmanuel Movement. The methods he used were both psychological and spiritual, combining to re-educate the alcoholic to a life without alcohol; he described them fully in his book Remaking a Man, published in 1919. The Emmanuel clinic was for all kinds of nervous disorders, and did not specialize in alcoholism, so that there was no great flood of recoveries to startle the world. Nevertheless a little hope was generated, and some alcoholics got well. A start had been made.

Richard Peabody, also of Boston, - was the next name to be associated with recoveries from alcoholism. Himself a product of Baylor's teaching, he turned what he had learned wholly onto the problem of alcoholism, and specialized in the treatment of alcoholics. His book The Common Sense of Drinking, containing a description of his method, was published in 1931. A few of his successful cases entered the field as therapists, and by the mid-thirties still more recoveries were giving the lie to the alleged "hopeless of alcoholism."

Francis T. Chambers, Jr., of Philadelphia, was a follower of Peabody who in turn went a step further than his teacher. Under the guidance of Dr. Edward A. Strecker, one of America's leading
psychiatrists, Chambers took some formal training at the University of Pennsylvania Medical School, and entered the Institute of Pennsylvania Hospital, as associate Therapist, specializing in alcoholism, but working in conjunction with a team of 'medically trained personnel.' Alcohol, One Man's Meat, published in 1938, is the book written jointly by strecker and Chambers about their work. Out of their hands has flowed a small but steady stream of recoveries ever since.

The methods of all the above have been generally lumped together under the heading of "lay therapy," a type of treatment which has had considerable success. One of its greatest contributions, however, was the proof it furnished that alcoholics could recover. This fact was a stimulus to other workers and researchers, and helped provide a nucleus of favorable opinion to experimenters with other methods. Most important of all, word began to reach alcoholics that there was not only a name for what ailed them, but hope that they might recover.
LAY THERAPY

MARTY MANN

The following is taken directly from PRIMER ON ALCOHOLISM, by Marty Mann, 1950. Chapter 12, pages 139-145.

The term "lay therapy" means, literally, treatment by laymen. In the field of alcoholism, it is a term which usually means a particular method of treating alcoholics, a method which is also known as the "Peabody method," after the man who developed it and described it in his book The Common Sense of Drinking. Peabody himself was taught by Courtenay Baylor, to whom his book is dedicated, but so far as is known he was the first to devote himself entirely to the treatment of alcoholics, and to achieve considerable success in this field in the late 1920's and early 1930's.

The treatment, like all treatments which have had any success, is predicated upon the assumption that, while alcoholism cannot be "cured," it can be successfully arrested if the alcoholic can be helped to eliminate drinking from his life completely. The Peabody method of achieving this goal is a system of psychological re-education, designed specifically to teach the alcoholic to accept the fact that he can never drink again, and to further teach him ways and means by which he can adapt himself to a life without drinking. Peabody summarized his technique as follows:

The treatment consists in instructing a man how to train his mind so that he carries out a sustained course of conduct consistent with the theories of his most mature intellectual self, how to form new habits and stick to them, and conversely how to eliminate the unsatisfactory method of trying to adapt himself to his environment through the medium of alcohol. The re-re-education is comprised of the following steps:-
1. A mental analysis is made wherein the drinker learns that certain actions and systems of thinking, past as well as present, have directed him on the unfortunate course he has been pursuing, by creating doubts, fears, and conflicts. When these are removed his energy is, free to take up more interesting and constructive occupations.

2. Various factors contribute to an abnormal state of tension which drink temporarily, releases, only to aggravate it in the long run. This tension can be permanently removed by learning formal relaxation and suggestion.

3. The unconscious mind can be influenced by suggestion so that it co-operates with the conscious to bring about a consistent, intelligent course of action.

4. Actions (where they are not mere reflexes) are the direct result of thoughts. Experience has proved over and over again that thoughts can be definitely controlled and directed when it seems desirable to do so.

5. As the body and the mind are indivisible parts of the same organism, the mind is naturally much more efficient in the execution of new ideas if it is functioning in a sound body. To this end the elements of a normal, healthy hygiene should be followed. If there is any actual or suspected disability it should be attended to by a competent physician.

6. The alcoholic is to a large extent demoralized and disintegrated. To overcome this condition a direct attack must be made on the small habits of daily efficiency. Alcohol is too strong an enemy to fight with untrained forces. To this end living by a self-made and self-imposed schedule will accomplish three very important results: (a) The individual is continuously occupied: (b) he is conscious that he is doing something concrete about his problem (in contrast to mere intellectualizing); (c) he trains himself constantly in minor ways to obey his own commands. This develops an ability to say "Yes" when he means "Yes," and "No" when he means "No."
7. Various unexpected pitfalls into which people have previously slipped are carefully explained so that the drinker is forewarned and forearmed as much as possible against the future.

8. Some means of self-expression, some outlet or hobby to satisfy the urge to create, some means of absorbing the will-power must be energetically sought. The mind cannot dwell on the subject of not drinking all the time, important as it may be. It must be diverted, intrigued, and if possible, inspired. This does not always happen until the cure is completed, but if it can take place earlier it is a good assistance to rapid recovery.

9. The individual is only an inferior person as long as he continues to drink. The same driving force that has brought disintegration, if given a chance under conditions of sobriety, will carry him beyond the level of achievement attained by his average contemporary. He has an energy within which must be utilized constructively or it will destroy him.

What DR. Milton Harrington says of people with strong instinctive tendencies, seems to be equally applicable to alcoholics. Instinctive tendencies, he says, "drive some upward to success, while in others, who are unable to direct them into satisfactory channels, they are dammed up, find outlet in unhealthy ways, and so, instead of doing useful work, react on the mind to distort and destroy it."

It is obvious that this method requires time and effort on the part of both therapist and patient. Peabody himself calculated that it took from 60 to 100 hours, stretched over a year or more. It is equally obvious that the patient must be not only willing, but ready to give full co-operation to such a process. Peabody defined those to whom his method was applicable as follows:

"Scientific treatment for the eradication of the drink habit can be successfully applied to sane men who have come to realize that drink has definitively disintegrated them to a point where they are no longer able to control themselves, but who would
sincerely like to eliminate the habit if they could be shown how to do so."

This is clear enough, but there is something else which Peabody nowhere states in his book. There is an X-factor in this method, and it 'lies in' the personal qualifications of the therapists who teach the method. Peabody was an alcoholic who had recovered through a similar method taught by Courtenay Baylor. Peabody's followers who became therapists were men who had recovered by this method. Therein, perhaps, lies one of the secrets of the success which the method attained. Peabody undoubtedly knew that no one else was quite as likely to have the necessary attitude of sympathetic understanding, the complete knowledge of the tortuous workings of the alcoholic mind, and the essential patience, which are primary requisites for dealing with these difficult cases. Naturally, the mere fact that a man was an alcoholic who had recovered was not enough to make him a therapist of a technique as complicated as this one: only a few of Peabody's patients were trained by him to teach the method. But these few accomplished a heroic work during the 1930's, when little else was being done for alcoholics.

This work showed that the Peabody Method was effective with a considerable number of alcoholics. It is still effective today with some alcoholics, for it has a particular appeal to certain types, and they and their families should know of its existence. Especially in the middle and upper income brackets there are many alcoholics who still hold jobs, who still have what they think of as "a position to keep up." These people often find it extremely difficult, if not impossible, either to consult a psychiatrist or to seek help from a group such as Alcoholics Anonymous. In the first instance they fear that going to a psychiatrist means an admission of mental weakness or abnormality; in the second, any group approach is repugnant to them, for many reasons. The reasons for such hesitations may be invalid, but are nevertheless very real barriers, which effectively prevent some alcoholics from getting the help which they desperately need.
In the use of alcohol as a beverage there is a descending scale of mental as well as physical reaction, increasingly pathological, beginning with almost total abstinence and ending with delirium tremens, alcoholic dementia, and death. Just where on this scale chronic alcoholism begins is open to a variety of opinion, but for practical working purposes I draw the dividing line between those to whom a night's sleep habitually represents the end of an alcoholic occasion and those to whom it is only an unusually long period of abstention. The former class, which will be referred to as normal, includes the man who limits himself to a casual glass of beer, as well as the man who is intoxicated every evening. But at worst they are hard drinkers, going soberly about their business in the daytime, seeking escape from social rather than subjective suppressions, and to be definitely distinguished from the morning drinkers who are, to all intents and purposes, chronic alcoholics, inebriates, or drunkards. There are normal men who occasionally indulge in a premeditated debauch, and who sometimes start the next day with a drink; but by and large, the men who can drink and remain psychologically integrated avoid it the next day until evening (midday social events excepted).

At first glance such a division would seem to be a quantitative one, but I believe this would be a superficial judgement. In reality there is a clearly defined qualitative mental reaction in chronic alcoholism, more closely associated with narcotics than with the normal use of alcohol.
It does not appear that the original impulse to drink is much, if any, stronger in the chronic alcoholic than it is in the hard drinker, and I believe that the latter would have almost as much difficulty in giving up his habit in spite of his boasting to the contrary: but when it comes to stopping temporarily, the situation is entirely different. Once he has entered into it the drunkard has a pathological dread of leaving the alcoholic state.

A man said to me the other day, "That first drink in the morning is the best of all. It makes you feel as if you were coming back to sanity." Normal drinkers know nothing of such an experience as that.

So it is with the individual to whom alcohol has become a narcotic that this article is concerned.

II

Of course people are not born drunkards, except potentially. Havelock Ellis states that it is no easy matter to make a drunkard out of the average man. This transition is often subtle and slow*. It may take place within a year of the initial indulgence or it may be postponed for twenty years. The first definite and generally fatal step is taken when the discovery is made that the mind rather than the body is suffering from alcoholic excess, and that a drink is good medicine for this mental suffering. A man then conceives the idea that he can avoid a nervous depression which he has become too cowardly to face. If he originally felt the necessity to escape from reality by getting intoxicated, reality plus a "hangover" must be avoided at all costs. I do not believe that the average alcoholic wants to remain in a state of intoxication, in the same sense, at any rate, that he wanted to drink in the beginning. He is constantly rationalizing that he is "tapering off" and is seldom enjoying his spree after the first or second day: but he cannot stand the nervousness and depression that set in when the narcotic is stopped or even cut down. He talks of "needing" a drink rather than of "wanting" one, and when a man "needs" alcohol, he has definitely reached a pathological stage of drinking.
The behavior of the alcoholic is, I believe, better explained as an abnormal search for ego maximation or self-preservation than in terms of repressed libido - using libido in the Freudian sense. There is invariably an inordinate craving for power in an organism that has proved totally incapable of realizing its cravings. The alcoholic state takes on the aspect of a simple wish-fulfilment dream. For the time being - i.e., while drinking - the individual has caught up with his imagination. In fact, much can be learned about him by asking him to describe what constitutes to his mind an ideal debauch. On the other hand, mental analyses have rarely disclosed anything abnormal or suppressed in the conscious sex lives of the patients, though I realize that psychanalysis has uncovered strong evidence of latent homosexuality in the unconscious minds of alcoholics. There is almost always, however, some degree of inferiority feeling and often it is extreme. It is a separate and more fundamental inadequacy than that which alcoholic misconduct itself creates, through dissipation and shame form such an exceedingly vicious circle that the whole problem on the surface seems confined to the symptom itself. The alcoholic is often unconsciously glad of what he considers a manly excuse to escape his responsibilities and conceal his weakness. A sober ineffective personality is unbearable, but there is something heroic about a drunkard. So he regresses to an infantile state of irresponsibility in which he imagines himself to be safe, and it is this regressive factor that accounts, I think, for much of the childish behavior in those under the influence of liquor.

Originally I tried to explain alcoholism in terms of extroversion and introversion - i.e., as a disease of introversion. There were enough alcoholic extroverts, however, to make such a position untenable, further than to say that alcoholics who are predominantly introverted outnumber the extroverted by three or four to one.

To digress slightly, while I agree with Professor McDougall that the introvert drinks to extrovert himself, I must add that
the extrovert drinks for the same reason - that is, further to extrovert himself, but I disagree with McDougall when he says that a person is hard-headed in withstanding the effects of alcohol in proportion as he is introverted. Better to say that he is light-headed in proportion to his psychological disintegration.

In searching for causes, it is necessary to distinguish between those that merely influence the individual to take up drinking and those that make him a chronic alcoholic. The former are too obvious and of too little interest to be a part of this article. As for the latter, the question of inheritance naturally arises first. I do not believe and have never seen it stated that the direct craving for alcohol was transmitted from one generation to another. In nearly every case, however, my patients have referred to at least one of their parents as being nervous or temperamental, and often their abnormal behavior seems to have been extremem. Therefore, we can reasonably say, it seems to me, that a nervous system that cannot function properly under alcoholic stimulation is definitely inherited, but that is as far as we can hold the parents responsible, genetically speaking, regardless of their habits.

Much more important is the early home environment. It is difficult to say just what part an alcoholic setting plays in the formation of the child's character. My own theory is that it is of less importance than one would imagine. It may influence him to drink when he matures, but his tendency to pathological drinking depends on whether he has been taught to believe in and rely on himself or whether he has been frightened, neglected, or pampered, thereby growing up inadequately adjusted to his environment, with attending feelings of inferiority. Cases of chronic alcoholism in which the parental attitude toward the child was intelligent are rare: more frequently it was decidedly abnormal. Where exceptions to this theory have been noted, I must confess I have been at a loss to explain the etiology of the habit.
The reason we so seldom find alcoholism combined with a pronounced phobia, hysteria, or combination is, I think, because alcoholism has fortuitously occurred as a symptom of an underlying condition which might just as well have been expressed in another kind of neurosis. If, as Freud says, the neurosis is the negative of a perversion, I do not see why it would not be equally truthful to say that chronic alcoholism is the negative of a neurosis.

I say fortuitously, but as a matter of fact it is a rather natural method of escape from disturbing conflicts because it is arrived at by a quasi-normal route. An alcoholic is only doing in an exaggerated way what a large portion of the normal male public has done for centuries, and he is not conscious of his pathological condition until its symptomatic expression is fully developed.

While chronic alcoholism is just as definitely a symptom of an abnormal mental condition as claustrophobia, the analysis of alcoholics as a group brings out different states of mind from those found in more commonly recognized psychoneurotic conditions.

For instance, that exaggerated concentration on self which characterizes most neurotics is much less apparent in alcoholics. They are more interested in life objectively, even though this interest may be of a non-participating nature. A very large majority are intellectually as well as morally honest. (Incidentally, where they are not morally honest when sober, the prognosis is exceedingly unfavorable.) While they are less fearful of their condition, they are far less courageous in their efforts to overcome it. If the average alcoholic had half the bravery and perseverance of the average neurotic, his problem would soon be a thing of the past. This statement is made because of the apparent ease with which the inebriate indulges himself, once his mind is made up. There seems rarely, if ever, to be that heroic struggle so often found in those suffering from the
various psychoneuroses. The point of view is merely changed and action automatically follows. That is why, in the treatment of alcoholism, the mental synthesis must be stressed in contrast to the analysis that has proved so important in the more typical neuroses.

V

Once a man has become a drunkard, it is no easy matter to rehabilitate him even under the best conditions. It takes at least fifty and generally nearer one hundred hours of work on the part of the instructor and an almost perpetual concentration on the part of the subject. He is taking a course in mental reorganization and he must never forget it. Therefore, certain types can be eliminated as unsuitable for treatment. This includes those who are in any way psychotic, as well as those who wish to recover temporarily for some ulterior motive, as, for instance, the pacification of irate parents by sons eager for an opportunity to renew their excesses, or of discouraged wives by husbands anxious to keep out of the divorce court. Another futile group are those who wish to be taught to "drink like gentlemen," as the saying goes. There is only one thing a drunkard can be taught and that is complete abstention forever, and it is only to those who are sincere and intelligent enough to comprehend this that the treatment is applicable.

Between the sane, sincere group and that just referred to there exists a rather large number of people for whom the prognosis is most uncertain, further than to say that a cure will be effected only after a very long and discouraging course of treatment, if at all. This group I can only designate by those vague terms "constitutional inferior," psychopathic personality," and "peculiar personality." These people are obviously sane and in their own way sincere, but they never have been well integrated even before they indulged in alcohol. They seem to lack sufficient driving force (libido as the word is used by Jung) to sustain any plan of constructive thought or action long
enough to have it crystallize into permanently fixed habits. even though rarely cured in the strictest sense of the word, the alcoholic outbreaks of these individuals are often restricted to relative infrequency if they are kept under more or less permanent supervision.

VI

Before describing what the treatment is, mention should be made of one thing that it is not, and that is ethical exhortation. patients have invariably been surfeited with preaching, and they must be reached by some new approach if their attention is to be gained and held. Appeals to their self-respect, warnings as to future mental and physical disasters seldom do any good. Nor are patients encouraged to give up their habit for the benefit of anybody else. It may strike a romantic note in the beginning, but sooner or later the person for whom it is given up does something or is imagined to have done something which gives unconsciously the longed for excuse to drink. The patient's' problem is to overcome his habit because he himself believes it to be the expedient thing to do.

There have been cases where the individual has been persuaded that he wanted to stop drinking as well as shown how to do it, but it is more satisfactory to deal with people whose moral problems have been previously settled.

VII

The treatment may be subdivided as follows: (1) analysis; (2) relaxation and suggestion; (3) auto-relaxation and auto-suggestion; (4) general discussion, which might be called persuasion in the manner of Dubois or readjustment after McDougall; (5) outside reading; (6) development where possible of one or more interests or hobbies; (7) exercise; (8) operating on a daily schedule; (9) thought direction and thought control in the conscious mind.
On the first interview I try to gain the confidence of the patient by showing him that his pathological drinking is thoroughly understood and that he is not going to be treated by prayer or abuse.

The patient is encouraged to give a full account of his past history and present situation. I try to make the analysis as thorough as possible, but do not go into the unconscious. There are cases of compulsive periodic dipsomania which would unquestionably require a psychoanalysis, but I have not met one of them yet. Stekel, I believe, is authority for the statement that psychoanalysis should be used only when other methods have failed. As many worries as can be are removed by helping the patient to come to definite decisions, or at least partially relieved by making as concrete plans as possible. Some conflicts tend to disappear under confession, discussion, and explanation, and many more are considerably diminished. This is a most necessary preliminary, but only a preliminary to the work.

VIII

The second phase of treatment, relaxation and suggestion, is, as far as I can determine, what Boris Sidis has called hypnoidal suggestion, and has been referred to as being particularly effective in the treatment of alcoholism. The patient is put into a state of abstraction. He is asked to close his eyes, breathe slowly, and think of the more prominent muscles when they are mentioned as becoming relaxed. The cadence of the voice is made increasingly monotonous, ending with the suggestion that the patient is drowsier and sleepier. This lasts for five minutes, and then an equal amount of time is spent in giving simple constructive ideas.

More important also is the application of the same measures by the individual himself before going to sleep at night. Ideas that occupy the mind at that time have a particularly effective influence on the thoughts and actions of the succeeding day.

The importance of this part of the treatment is all out of proportion in its effect to the time that it takes. Not only does
it have a direct bearing on alcoholism, but it gives the patient a method of control that is extremely helpful in creating other changes in his personality, once his habit has been conquered. In other words, the alcoholic habit being only a symptom, its removal is only a part of the work. Treatment of the underlying conditions reorganizes the entire character, with benefits extending far beyond the negative one of alcoholic abstinence.

While on the subject of relaxation, which has been considered in its application for the purpose of influencing the unconscious mind - that is, in a special sense - I might add that it has a general bearing on the immediate causes of drinking. Courtenay Baylor in an excellent little book called Remaking a Man, now unhappily out of print, sets forth as his central theme the idea that drinking before all else gives an artificial release from a tense state of mind, and when this mental tenseness is removed, the apparent necessity for drinking disappears.

It is undeniable that two definite states of mind are sought after by the drinker - calmness and happiness. The childish pleasure that the alcoholic attains in the early stages of intoxication can be easily dispensed with when the desire to give up drinking is genuine, but the release from nervous tension is a different matter. When a person has been taught relaxation, he is treating the immediate cause rather than the symptom itself, which is the first step in removing the primary conscious cause - i.e., the feeling of inferiority and fear. The imagined fascination of alcohol lies in the fact that it is a stimulant and a narcotic at the same time, psychologically speaking. In other words, drink soothes as it elates and it elates largely because it soothes - i.e., relaxes. Barbitol will soothe, but in a purely negative manner and without any accompanying idea of elation. Strychnine and coffee will stimulate, but with so much nervous excitation that their stimulation has little relationship to escape from reality. Alcohol in the preliminary stages produces simultaneously the two longed for states of mind in a
way that is unfortunately most seductive to those who can the least afford artificial stimulation or relaxation.

It is an interesting point that alcoholics as a class, no matter how cynical they may be, respond to relaxation even more enthusiastically than other neurotics, though it would seem that the latter were more in need of it and therefore would be more impressed by it.

IX

Development of new interests is obviously a most important part of any therapeutic treatment. The only way to remove destructive ideas from a person's mind is to introduce constructive ones. For a man to occupy himself solely with the thought that he is not going to drink would be such a sterile performance that it would probably not be true, for long at any rate. An alcoholic has one idea of pleasure, and it is of the greatest importance that he discover as soon as possible that he can enjoy life in many ways outside of intoxication if he will lift himself to a more intelligent plane of thought and action. Furthermore, a drunkard has little by little withdrawn himself from his natural environment, his acquaintance is apt to be the dregs of society, and drunk or sober, his constructive interest in things of any value is nil. He must be made to reach out in many directions to divert himself from his former negative stereotyped habits.

The reason that long periods of being on the conventional "water wagon" have not changed a man's point of view is because the idea of eventual indulgence has kept the alcoholic conflict alive and thus prevented the creative urge from becoming attached to some worth-while interest. It is essential that this normal urge be given adequate expression. Where it is inhibited through fear or laziness, its force is not extinguished, but turned inward, creating a conflict which symbolically expresses itself in fear, worry, or boredom. Thus a mental situation is produced that needs to be soothed and forgotten, and it is perfectly
obvious how the alcoholic is going to soothe and forget it. Until he rearranges his life so that he no longer perpetually craves to escape from his inner turmoil, he feels that he is up against a temptation which he cannot resist, though he thinks of the temptation as an entity in itself and not as a symbolic defense against an underlying mental condition. The creative urge must be legitimately satisfied. Jung, referring to neurotics in his essay The Ego and the Unconscious, remarks: "As a result of their narrow conscious outlook and their too limited existence, they spend too little energy. The unused surplus gradually accumulates in the unconscious, and finally explodes in the form of a more or less acute neurosis." For "neurosis" I think we should substitute "debauch" without changing the validity of the statement.

While on the subject of interest development, a case recently finished might be mentioned in which the patient was encouraged to develop his literary proclivities. One night, while writing an essay, he became so absorbed in his work that he experienced the same vital intensity that he had found previously only in intoxication, and he stayed awake until four o'clock in the morning to finish it. I felt then for the first time that sooner or later he would be cured. It proved to be true. In a short time he obtained research work in a library and supplemented that by writing book reviews for the newspapers. As he expressed it, "I am enjoying life for the first time without rum."

One method, obviously, of arousing a normal interest is reading. There is a short list of books that patients are asked to read carefully, marking the passages that appeal to them. These passages are later copied into a notebook along with some typewritten sheets that are given them, the most important of which I shall outline when I come to the topic of persuasion. These books are self-help essays of a practical rather than a religious or sentimental nature. Arnold Bennett's Human Machine, Cosrer's Psychoanalysis for Normal People, and James's monograph on habit are typical examples.
The importance of a reasonable amount of exercise each day, as well as obedience to the ordinary rules of hygiene, cannot be overemphasized. A mind can function properly only in a well regulated body, and an alcoholic in process of reorganization needs to have his mind function as near 100 per cent properly as he can all the time.

While on the subject of hygiene, I might add that precautions are taken to find out if the individual is as physically healthy as possible, and if he has not recently been examined, he is urged to get in touch with his physician. At any rate, I disclaim any responsibility on the physical side and never under any circumstances suggest even the simplest medicines.

We now come to the most important phase of the treatment, the central feature to which all others are expected to contribute. That is thought direction and control. A person literally thinks himself out of his alcoholic habit, and his ability permanently to control or direct his thoughts is the determining factor in his success or failure. A drunkard is invariably lost when he takes his first drink, or perhaps it would be better to say when the determining thought to take the drink becomes crystallized in his mind. Back of this thought are a long series of thoughts leading up to it, which, had they existed in opposite form, would have produced correspondingly different action.

As one alcoholic expressed it, "Sometimes I actually find myself at the bootlegger's almost without knowing how I got there, and without, I am sure, intending to go there." When I showed him his habitual thought processes, he readily saw how this apparent somnambulism had taken place.
To be more explicit, patients are advised to divert their minds as much as possible from the whole subject of drinking. When this diversion amounts to downright suppression - when it is impossible of accomplishment, as is always the case in the beginning - then they are most emphatically told to think of the subject in its entirety, as it exists in fact. If they are reflecting on some "wonderful party" that they have had, then they must pursue it to its conclusion, and recall as vividly as possible the remorse, the sickness, and the trouble that came after it, bringing the question down to the present time. Before leaving the subject, they must have a complete view of the whole dismal picture. Nothing is more harmful than thinking or daydreaming in the past, present or future on the pleasant side of alcoholic excesses. Whereas, if the alcoholic will review the entire scene, he will reject the dangerous suggestion that alcohol produces a truly pleasurable occasion.

Some drinkers give up trying to justify their behavior, but the reasoning processes of the great majority are a series of rationalizations. The excuses range from inheritance to a cold in the head, and they are all equally futile. The alcoholic must understand that there are no excuses for his taking even one glass of beer. If a man takes a drink, it is because he wants to take it and not because he is impelled to do so by some exterior event.

XII

The following ideas form the substance of what I have designated as discussion or persuasion. These thoughts are repeated over and over again to the patient in one form or another.

The first thing to impress on his mind is the fact that he is a drunkard and as such to be deliberately distinguished from his moderate or hard-drinking friends; furthermore, that he can never successfully drink anything containing alcohol. These points have been already explained, as has thought direction and control.
In spite of much pretense, no work of a serious nature is ever accomplished until the alcoholic surrenders completely to the fact just mentioned in regard to never drinking alcohol in any form or quantity. This surrender to its full depth is apt to be a difficult thing to accomplish because of the interference of a distorted pride. A man who is bold enough to enter a condition that he knows is disgracing him is ashamed to admit to himself and to his friends that he has given up the cause of his disgrace. On three occasions this year I have made inquiry into the sudden favorable change of attitude on the part of the patient, and each time I received the answer, "Well, I really never made up my mind to stop for good before. I never really gave up on the idea that I couldn't and wouldn't drink some day in the distant future." My reply to this is that one attitude toward drinking which at first seems reasonable, but which from long experience has proved to be disastrous, is that of stopping for only a limited period of time, no matter how long that period may be. If a person could refrain from drinking for five years while diligently reconstructing his thought processes, it would be sufficient. Unfortunately it has been thoroughly proven that five years can and does become five minutes under emotional excitement in a manner that would seem impossible in moments of calm reasoning.

While the theory of treatment is not predicated on will power except in so far as it applies to carrying out instructions, it is necessary that the will be used in the early stages while the new methods are getting thought power upon its feet. Obviously, new ideas cannot make much headway in a mind that is constantly befuddled with alcohol. Because in the long run people tend to do as they wish, will power sooner or later loses in the conflict with desire. Win or lose, a perpetual conflict in the mind is almost as much of a handicap as its
outward expression in a habit. The proper control of thinking, therefore, must be established to obviate the necessity for will power by redirecting the psychic processes.

The greatest difficulty in trying to accomplish this is to find enough things for patients to do when they are absent from the office. They should consider that they are taking a course, but because of the simplicity of the work it is difficult for them to keep their mind on the seriousness of what they are doing.

It is impressed upon them that they must play the part of self-instructor as well as of student. It is really this instructor element in them that stimulated their interest in the beginning, and they must continue to cooperate with me and not expect that I can do all the work with them in the role of passive listeners. Regardless of their past record, they must be made to feel as self-reliant as possible, for in the last analysis it is they who must reorganize themselves while I am only their associate instructor. The reverse of this necessary self-reliant attitude is, of course, the main argument against confining a person to an institution. He is sober there because he cannot be otherwise. His power of choice is removed by compulsion, with attending humiliation. Incarceration should never be employed until everything else has failed and the desperateness of the situation requires that society be considered first and the individual second. A situation in which careful physical supervision is necessary to enable a man to recuperate from long continued excesses would of course constitute an exception to this statement. Where the individual willingly goes to an institution as a means of checking an irresistible compulsion to drink, the effect is entirely different - i.e., beneficial.

It has been found that a most useful aid to reintegration is to make out a schedule each evening and then follow it faithfully
the next day. It prevents idleness, assists in making the work concrete, and, what is most important, trains the individual to execute his own commands. If a person cannot do simple things and in the manner planned, he has little chance of overcoming his major temptation. If, on the other hand, he forms the habit of carrying out his own instructions, he creates thereby a disciplined will and an executive state of mind, so that when the idea of drinking comes to his attention, there is every chance of it being diverted. An alcoholic is a specialist at avoiding life, but it is as rarely his fundamental philosophy to do so, he is in a constant state of conflict and dissatisfaction; so it is our first duty to build up a moral that will take care of normal responsibilities and give him a legitimate feeling of power. Incidentally, a schedule discloses the limits of laziness and insincerity. When you find a subject who will not and cannot keep a schedule that he makes himself, with the understanding that it can be changed for honest reasons, you can be pretty sure that you are going to be unsuccessful with him until he changes his attitude, and you may be somewhat skeptical that he can change it.

Wise planning is a most important preliminary to a course of conduct, and for most people it is comparatively easy. But the majority of alcoholics, in common with neurotics, find the execution of a plan difficult, even through to a normal person the plan itself may seem short and simple. As William James has stated in his essay on habit, once a course of action has been determined upon, execute it. This applies to the small things of the alcoholic's life as well as the central theme. Many nervous troubles have a common denominator exaggerated introspection, and the greatest defense against this weakness is sustained action. The alcoholic must be able to observe concrete, positive results of his efforts as a means of maintaining his interest in the work.

XVI

Of the various methods discussed for combatting chronic alcoholism, it is impossible as well as unnecessary to say which
is the most or the least important. That would vary with the individual. Each element has its place, and it would not be fair to several of the elements if one or two were neglected. The surest way to prolong the work is to avoid the more distasteful part and then become depressed because the rest of it does not produce better results.

In no case where a relapse has occurred has it been found that a person has been cooperating conscientiously. In fact the usual answer to my query is, "Yes, I must admit that I have only been making about half an effort. I thought I was going ahead all right and didn't need it." To which I reply that he is getting out of the work just what he put into it, and that the same ratio will continue in the future. Hard, faithful work cannot be avoided, as the habitual thinking of many years is not going to be reversed in a month or two.

After certain progress has been made, there is one bit of sophistry that the alcoholic has to guard against, and that is the idea that he is entitled to a vacation. He knows that he has shown improvement, so he imagines that if he falls temporarily, those who are interested in him will still feel encouraged, and such action will not prove fatal to the eventual cure. There is enough truth to this reasoning to make it a serious impediment to recovery if it is acted upon.

Much of this persuasion obviously aims at prevention through anticipation. Difficulties of which one is forewarned are not apt to be so dangerous where one is sincerely desirous of embarking on a new course of behavior. In this connection there are three points that I wish to bring out.

It is generally understood that the best excuses for drinking are those of an unpleasant emotional nature - anger, worry, and sorrow. It is not so well recognized, but equally true, that the pleasant emotions have just as contagious an effect and in many cases more so. An alcoholic has to learn to
face success with the same fortitude, strange as it may seem, as he does disaster. Any emotional stimulation has to be guarded from spreading into the alcoholic sphere in order to avoid the return to humdrum reality. It is only when reality has been made constructively interesting and the fear of it thereby removed that a patient can stand normal excitement. Just as one drink leads invariably to another, so an emotion seems to take the place of the first drink by producing the same mental condition. This emotional contagion is an exceedingly important point. It is the cause of a great deal of unaccounted for alcoholic behavior, behavior which is often the hardest to control.

Why a man under pleasant emotional stimulation seeks narcotic escape from reality in the same manner as he does from unpleasant emotions is an interesting question, but difficult to answer. My own theory is that a neurotic is unconsciously, and possibly consciously, afraid when his emotional equilibrium is disturbed, no matter what the quality of the disturbance may be. When he is in a state of euphoria, he evidently feels the need of a stabilizer to the same extent as he does in dysphoria. Just as he is bored when he looks inward, so he is frightened when he looks outward, if the customary scene has changed even a little.

An individual who was prematurely confident of his self control fell from grace at a recent football game. "When your team made its first score, you had your first drink," I said. He started to tell me it was not until the half was over, but saw my point before he had finished. "Yes." he said. "I never thought of it that way before, but it is perfectly true. Between the halves that first actual drink went down with as little compunction as if it had been the third or fourth ordinarily. I lost my emotional balance when the team scored and got into the alcoholic frame of mind before I knew it."

XVIII

Much trouble is caused by men trying to force themselves into an uncongenial environment on the plea that they like it when intoxicated. As a matter of fact, they like almost any thing
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XVIII

Much trouble is caused by men trying to force themselves into an uncongenial environment on the plea that they like it when intoxicated. As a matter of fact, they like almost any thing
when intoxicated, and nothing when sober. Somewhere in them is a supposedly genuine discrimination. When a natural interest is unearthed or a new one acquired, they find that it is not necessary to enjoy everything, or even many things, if they will soberly and sincerely expend their energy on the few things that catch their imagination and hold their attention. Where there is no real interest and none can be created, the difficulty of the problem is tremendously increased. These obvious truths are mentioned because it seems to be a part of the treatment to drive home platitudes as if they were profundities.

XIX

Moral victories, strange to relate, have to be watched carefully or they turn into defeats. Apparently the resistance of the individual is exhausted by the struggle, and he falls prey to the suggestion absorbed during it, though the provocative situation is over. Often a patient bravely resists the "occasion" itself only to yield a day or two afterwards in a most unexpected manner. If he does not actually give in to the temptation, he is more apt to be depressed than elated in spite of his triumph — that is, of course, temporarily. In the long run these moral victories are not only helpful, they are the stepping stones to final success.

Last year a man asked my opinion about going to a class reunion. I had misgivings, but I thought I might as well test his resistance, so it was suggested that of course he could go. The results were unfortunate, but interesting. The first two days he drank nothing and was scarcely tempted. The third day, as he expressed it, "I was taken suddenly drunk before lunch almost without realizing that I was doing anything wrong."

XX

What attitude should the family take while the treatment is going on, is a question that is invariably asked. The answer is that friends and relatives should cooperate with the patient in
his own way. If he wants to tell of his work, then show an interest in it, but if he keeps it to himself, then let him alone. Avoid all dramatic gestures such as pouring away the liquor in the house. If it has been his custom in the past, he should continue to offer drinks in moderation to his friends as a means of keeping up his self-esteem, until it is definitely proven that he cannot stand the temptation. The environment should be made as helpful to the patient as is practical, but he need not be spoiled or coddled.

Of course disturbances in the external life that would depress or worry the normal man have in some cases a decisive influence on the alcoholic situation and must always be carefully considered. The environment, however, is not stressed as much as might be expected because many men show a surprising ability to cope with unpleasant conditions while completing the work, and as many others seem incapable of appreciating an admittedly satisfactory external situation.

XXI

How does the work proceed? As may have been gathered from what has been said, very far from smoothly in the beginning, even with the most intelligent and ambitious subject. It is essential to caution those immediately concerned that the friend or relative undergoing treatment will probably slip several times, and that the size of the slip does not matter in point of view of time or quantity of liquor consumed. In fact, if the patient is going to drink at all, he had much better make a thorough job of it. Anything is preferable to a "successful one-night stand" from which he derives the idea that perhaps after all he can drink and get away with it, or at least learn to drink. As long as this idea is in his head, the reeducation is brought to a standstill. I had a patient last year who continued to get intoxicated at least once a week for two months. This exaggerated situation was due to the youthfulness of the subject, and to the fact that he really did not want to stop when he first undertook the work. But
the same thing to a less degree is liable to happen to any patient in the beginning, and it does not necessarily mean that the case is hopeless. If the patient evidences a sincere desire to continue the work. This discouraging prognosis must on no account be made to the patient, as he would then be absolutely certain to live up to what was expected of him. Everything must be done to make him think that his recent indulgence was actually the last one.

In other words, the alcoholic craving is modified gradually rather than stopped instantly. This is depressing to all concerned and particularly to those who have no basis for comparison and thus hoped that a complete conversion would take place on the first interview. However, a man who is willing to make a sincere effort over a sufficient period of time, even though he cannot be called a very strong character, seems to develop resistance to alcoholic temptation by eliminating his tense state of mind and permitting the dissolution of the temptation in other interests. If, however, he is unwilling or unable to help himself, then there is nothing that I can do for him. So it is to the sincere and intelligent, though not necessarily highly educated, individual that I am anxious to give my attention.

Read before the Boston Society of Psychiatry and Neurology, April 18, 1928, and before the Harvard Psychological Clinic, December 14, 1928. The treatment outlined in this article has been carried on by Courtenay Baylor for seventeen years. I can never sufficiently acknowledge my debt to him for my ability to write it. In rewriting the paper helpful suggestions were received from Dr. G. C. Caner, Dr. H. A. Murray, Dr. Martin W. Peck, and Dr. Morton Prince.
The Danger Line of Drink

By Richard R. Peabody


What are the signs which indicate that liquor is "getting" a man? Is it the "hair of the dog" as salutary as it is supposed to be? Here are five rules by which to judge whether the road to alcoholism is open.

Well-groomed, erect, clear of voice and eye, certainly he did not look the part of the man who had been "got" by whiskey. Yet he told me that during the first year of the depression, when his business fell off seriously, he had been resorting to alcohol to buck up his spirits and relieve his worry. There came a time, he said, when he took a drink in the morning because he was jittery, and these jitters he knew were different from business worries because they seemed to come from the previous night's indulgence. One day, even though his business had begun to pick up, he found he could not stop.

"If a fire gets big enough," he explained, "it creates its own draft."

Though he had no idea of it, that man had stepped over the danger line when he took his first morning drink. He called it an "eye opener," but it would be more exact to describe it as a drug to soothe his nerves.

Let me state once and for all that I have no prejudice against alcohol as a beverage, and little sympathy for the well-meaning reformers who run around with sharp sticks chasing Demon Rum. I recognize that "the cup that cheers" has advantages of social value. It relieves self-consciousness, promotes good-fellowship, and in general contributes to the gaiety of many occasions. What I would like to do here is to indicate to those
who are accustomed to drink, and who know how to handle alcohol (or believe they do), certain signs by which they may be warned when they are entering the twilight zone of danger. These signs I have learned from long observation. It is an old story for me to hear; "If only I had known ten years ago as much about the effects of drinking on nervous systems like mine as I do now, I certainly would have saved myself and my family an enormous amount of suffering."

Most everybody knows of some person, too often an intimate friend or relative, who has "gone to hell" from drink, and they may know more than one: yet how many people stop to think of this danger in connection with their own conduct?

Of course the great majority are so relatively abstemious that this reflection is not necessary, but there are nevertheless a great many men who might profitably pause to consider whether or not drink has become a potential danger to them. Certain ways of drinking indicate a morbid interest in it. Sometimes small parties, and even small drinks taken during certain states of mind are not as innocent as they may seem.

Unfortunately, there is no clear-cut difference between what might be called normal drinking and alcoholism, the way there is between a broken leg and a whole one. In dealing with mental states it is not nearly so easy to make a definite diagnosis as it is in the physical field when the organs can be examined by various mechanical methods. So to avoid wasting our time in hair-splitting we will have to make certain statements, and then discuss the exceptions.

Despite the opinion of prohibitionists the man who is somewhat under the influence of liquor every evening is by no means an alcoholic problem, provided he goes about his business soberly in the day time and is reasonably sensible while drinking. he may be a drunkard in the making but he is not one at the moment.

At what time then in a man's drinking career does he show definite signs of alcoholism, either in process or in fact? One
answer is when he begins in the morning. This is an unmistakable
danger signal. When he needs "the hair of the dog that bit him"
to restore his nerves so that he can get on with the day's work
without "going crazy" from an indescribable state of depression
and jitters, then he is a drunkard real or potential, the latter
depending' on how much the alcohol that he consumed on the
following day after affects him. In other words, at this point
drink has become a drug, and a major drug at that. A man who
cannot go out with the boys in the evening and return with them
to their work the next day because he is drunk again is a drug-
addict, and if he is returning with the help of a pick-me-
up he is a drug-addict just the same.

Normal drinkers, no matter how much they may have imbibed
the night before, carry on the day without "eye-openers," and
they do this not because of will power but because the idea
physically disgusts them. Their unhappy friend is going to have a
drink because he is suffering from a painful mental reaction
which they know nothing about, for if they felt the way he did
did they would have one too.

While my work is confined to treating those who are
disturbed by their excessive indulgence I make it a point to go
into the matter with normal drinkers from time to time in order
that I may be informed as to how, when, and in what manner they
drink. They invariably tell me that, no matter how intoxicated
they may have been the night before, the last thing in the world
they want is a drink the next morning.

When I asked a certain patient how he started to drink in
the morning he replied, "About four years ago I went on a party
with a man who was in somewhat the condition that I am now. The
next morning we awoke very much the worst for wear nervously.
This was extremely unfortunate for me as I had an important and
difficult engagement which I seemed absolutely incapable of
keeping. When I told my friend of my predicament he said, "A hair
of the dog that bit you is all that you need," and forthwith set
the example by having one himself. I had one too, though the
idea was distasteful to me, and in the course of a few minutes I felt all right. "Now," I said to myself, "I have found a way to beat hangovers!" And I had for a while: but as my nerves got worse I had to keep increasing the dose, until I found I was more or less drunk all the next day."

Those then who wish to enjoy moderation, interspersed with occasional parties, would do well to avoid drinking anything until lunch time, and if they can wait until after dinner so much the better.

At this point I realize that certain readers are reflecting on the exceptions that they know of, and as a result are wondering whether I am an extremist who does not know his business. Are there any exceptions to these somewhat dogmatic statements? Yes, there are. In fact I once had a patient whose father took only one drink a day and that was before breakfast. Nevertheless none of these exceptions is strong enough to vitiate the fundamental symptoms of chronic alcoholism as set forth here. However we will take up the most common for consideration.

For instance, there are a relatively few older men who can and do take a pick-me-up in the morning, not habitually, but after particularly big parties. These men, because of their age, cannot be considered alcoholics, past, present or future. If a man under thirty-five or forty is doing this he'd better look out, but if he is fifty or sixty and is not increasing the dose then his habits have unquestionably crystallized and such ills as result from drinking will be those of the body. Men who could drink slowly all day long (and still be a success in the office and home) without doubt existed a century ago; but high speed business and high speed pleasure have made such demands on the nervous system that it can no longer withstand an all-day-every-day ration of alcohol. Drinking does not help under any condition; but in this era of keen social as well as economic competition, the nerves must have frequent respites or we may expect alcoholic breakdowns on the part of those who persist in abusing it.
Another exception is the reunion common to college men, business associates, and war veterans, to mention just three groups. Here large bodies of respected men may set out to become intoxicated for the better part of two or three days or longer. Conservative people may question the good taste of these performances, but those who indulge in them cannot be considered abnormal by any stretch of the imagination. The obvious reason is that too many normal men do it.

Now the discouraging part of this change from normal social drinking to abnormal drug addiction which wrecks so many lives is that its onset is often insidious. A man may have a full-blown case of alcoholism before he is really aware that he is the victim of a dangerous narcotic. He is drinking the same beverage that he always drank and that his friends are still drinking with impunity. If he had to retire to the privacy of his room in order to give himself a hypodermic injection he would realize that he was doing a thoroughly abnormal and dangerous thing the first time he did it. But when he is only drinking a little more of the same old stuff for a little longer period of time, he fails to realize that he too is a "hophead," and it sometimes takes what might be termed a prolonged catastrophe to educate him.

Taking a drink in the morning as a relief from the excesses of the night before is only one danger signal. Another one is using alcohol as a means of escape from a disagreeable reality. Life itself, particularly in these days, provides a good many reasons for nervousness and depression and so the desire to escape into a pleasanter world of fancy is pretty strong for many people. But alcohol is intended to be used for purposes of celebration and not consolation, for in the long run it makes a poor if not disastrous nerve medicine. Drink if you like to make a good time better but never to make a bad time good. Boring social functions may be excepted from the latter part of this statement. It may be all right to blow off steam on Saturday night, but the person who deliberately and with increasing frequency seeks refuge in the bottle is headed for serious
trouble. The cause may seem justified, but that does not prevent the end from being tragic. Drinking to escape from the hardships of life then is the second danger signal.

Incidentally if it is true that a great many people are worried and unhappy more or less because of the depression, why is it that alcoholism has not increased by leaps and bounds? The answer is that the average man, while he may be unhappy, while he may be none too strong of will, and while he certainly knows the temporary soothing effects of a drink, simply does not choose this way out of his troubles. He instinctively knows that it will not work, and furthermore that, except for a brief period, it will make matters much worse. It is not a question of will power so much as a lack of desire. In this he is fortunately diametrically opposed to the person whose nerves have become poisoned by alcohol.

I don't want to weaken the truth of my statements by being misunderstood and hence considered fanatical. Any sound theory can be made ridiculous by carrying it to an absurd degree. Plenty of normal drinkers do seek a party with their friends because they are "fed up," but they do not make a habit of it because they know from experience that it will work satisfactorily only once in a while. They go to the great majority of their parties because their friends are going also, and not because they are unhappy or worried.

This brings us to the third point in our consideration of what signs indicate that the danger line of drinking has been or is about to be passed. Is the monthly or yearly dosage being steadily increased even if slowly? Most men's habits, certainly their drinking habits, have more or less crystallized by thirty. So if a man's drinking increases after that he may easily be concerned without being accused of morbid introspection. A man who is steadily drinking more at thirty-five than he was at thirty, and more at forty than he was at thirty-five, has cause for worry, unless of course drinking has always been a matter of negligible importance in his life. This increase is often subtle,
and it is generally accompanied by a series of plausible excuses. But the fact remains that the normal man tends to do most of his drinking when he is young, and his nerves and body can stand it. As he advances in age, and responsibilities develop, he drinks less. In other words he restricts his consumption of alcohol to that amount which does not injure his health, his reputation, or his efficiency. Still another danger signal to bear in mind is how much more, as time goes on, a person depends on alcohol for enjoyment. Has he the same enthusiasm (with due regard for advancing age) as he had five or ten years ago, or is he leaning more and more on alcohol in his attempt to get happiness out of life? I do not mean he is depending on it in the same quantity, to enjoy those social functions where it is habitually used, but is his drinking slowly becoming a necessary accompaniment in the gaining of pleasure from those things which used to be spontaneous hobbies and which should be still? Has the "nineteenth hole" become the most interesting one to the golfer, and is the flask as important to the fisherman as his bait? If so, be careful.

As a final symptom to be watched we will add insane conduct, that is, behavior extremes beyond the point of drunkenness. Most men who drink to excess at all do something sooner or later which causes them much chagrin, but the man who frequently and without cause fights, insults ladies, or in any way conducts himself in a dangerous, crazy, or indecent manner, shows an abnormal mental deterioration. I am not concerned here with the moral or esthetic effects of alcohol, but such behavior as has been mentioned denotes mental sickness, and thus it is a danger signal of serious trouble ahead.

Just as we have qualified our statements in the direction of leniency toward drinking—that is breaking rules without danger—so in the other direction too much should not be made of technicalities to bolster up oneself in the belief that one is indulging in a safe and sane manner. For instance, the man who waits until lunch time to begin drinking, but who from that time
habitually keeps on for the rest of the day, need not pride himself that his use of alcohol is safe and sane. He may have one of those *very rare* old-fashioned nervous systems, but the chances are that unless his consumption and his reactions to it have become fixed for a considerable period of time he is a semi-alcoholic in process of becoming a full-fledged one.

To sum the matter up, we may say that the danger line of drink has been reached under the following conditions:

1. Drinking to get over effects of previous drinking, particularly when it is done in the morning.
2. Using alcohol as a means of escape from a disagreeable reality.
3. Slowly but surely increasing the monthly or yearly dosage.
4. Depending more on alcohol for enjoyment, particularly in connection with those things to which it is not a normal accompaniment.
5. Extreme conduct while under the influence of drink, that can only be described as "crazy."
A PSYCHOLOGICAL APPROACH IN CERTAIN CASES
OF ALCOHOLISM

Francis T. Chambers, Jr.

Mental Hygiene, 21:67-78, 1937

I realize that it would be impossible in the short space available to describe the various subdivisions of the psychotherapeutic treatment advocated by the late Richard Peabody, which I am using in treating abnormal drinkers; at best, I could leave only a vague impression of the treatment as a whole. Therefore, I will limit this paper to the approach that may lead up to a successful termination of a very common and destructive addiction.

My work with abnormal drinkers has been made possible by the generous help and cooperation of the psychiatric group and the general practitioners in Philadelphia and its vicinity, as my layman status makes it impossible for me to treat the condition in any but a non-medical field. This has a psychological advantage in that those who consult me, with the approval of a physician, come with a beginning already made.

First, they have admitted that they are abnormal drinkers, an essential admission before treatment can be given.

Second, the suggestion has been given by a physician whom they respect that there is a way to overcome alcoholism for a group of addicts, who are not psychopathic, but who have sprung from a vast legion of psychoneurotics, those so-called nervous individuals who have found that a perverted indulgence of the intoxication impulse may serve as a temporary compensation for a maladjustment of personality. This type of neurotic alcoholic is unwilling to be considered either insane or stupid; for this reason the best approach to a specialized treatment can be made by the physician, who is usually present at the psychological moment when the patient cries for help.
Once a patient has sought aid, the clinical picture of alcoholism permits little opportunity for a misdiagnosis. You distinguish the neurotic from the normal, though perhaps heavy drinker by his inability to control his drinking and the stupidity of his sacrifice of the most valuable things in life for the state of mind produced by his alcoholic indulgence. Usually we find an uncontrolled drinker utilizing self-deception, one phase of which is his forever blaming his addiction on the conditions of his environment. In so doing he is only following in an exaggerated way the same procedure practiced by his controlled-drinking brothers, whose nervous systems are resistant to alcohol.

The controlled drinker usually wishes to have an excuse for indulging himself. He drinks because it is hot, or because it is cold: he drinks to prolong a pleasant occasion, and he cheers himself up with a drink when he is unhappy. In fact, to him alcohol is a sort of psychic Aladdin's lamp, which he uses to alter mentality. There is a vast difference between this type and the uncontrolled drinker. The line separating abnormal drinking from social drinking is a matter of the degree to which the drinker is psychologically dependent on the drink. This in itself is a fairly accurate indication whether the personality has or has not made a good adjustment to reality. We find well-adjusted people using alcohol in its accepted legitimate field, and though they may be far more addicted to it than they wish to admit, they are able to limit their indulgence in it to given occasions, because, having made good adjustments to reality, reality is acceptable to them. They may for a little while put on the mask and costume of a psychic harlequin, but after an hour or two they are quite ready to get back into their own more sober psychic garments, even though they know that this change may be accompanied by headache and frazzled nerves. On the other hand, the alcoholic, with his psychoneurotic maladjustment, is searching for the psycho-medicinal properties of alcohol rather than the pleasurable intoxicating effects.
Physicians who are familiar with the anaesthetics, ether and chloroform (the medicinally used narcotic intoxicants), have ample opportunity to observe, in the operating room, the exciting phase followed by complete anaesthesia. At cocktail hour in any hotel or club bar, you will see the social use of narcotic intoxicants by an earnest group who are searching for and finding the exciting phase and the relaxing phase in a narcotic intoxicant disguised as a highball or a cocktail, and having found this pleasurable phase, they are satisfied. The abnormal drinker in the same situation is getting drunk quickly because he is searching for the anaesthetic properties or deeper narcotizing effects of alcohol. Hence we observe him hurrying through the exciting pleasurable and relaxing phase brought about by drinking in much the manner of one anaesthetizing himself. When you question the abnormal drinker about this peculiarity, he assures you that he did not mean to get drunk, nor did he want to get drunk; and I believe that consciously he means what he says, not recognizing the fact that unconsciously there is a demand for the oblivion of drunkenness, once the higher nerve centers have been affected by alcohol.

The other day one of my friends who was consulting me about his abnormal drinking said, "If you would only say that you could teach the abnormal drinker how to drink in moderation, you would have thousands flocking to your door." This is undoubtedly true, but if I made any such claims, I should be the most unmitigated liar, and those who consulted me would be doing so with no chance of success, for the simple reason that normal intoxication is not what the alcoholic is after, nor is he ever satisfied with it. The proof of this statement is obvious. No one makes these people seek drunkenness, and yet that is the state in which they inevitably arrive, if they use alcohol in any form whatsoever.

It is difficult to give a textbook definition of the underlying neurotic condition that makes alcoholism possible in certain individuals. It is perhaps most nearly covered by the
definition of "compulsion neurosis" as given by Professor Horace B. English:

"Group of mental disorders characterized by an irresistible impulse to perform some apparently unreasonable act or to cherish an unreasonable idea or emotion. Generally the patient is not deluded and frankly admits the unreasonableness of his attitude."

This definition would, of course, apply to the alcoholic only when he has been sobered up, as the effects of alcohol may create a delusional state.

The causes of an alcoholic compulsion neurosis are soon apparent in a cooperative patient anxious to aid therapy by unburdening himself of his innermost thoughts and reaction. Usually we find a marked lack of mental hygiene in the early parental environment. Often one or both parents have failed to make adequate adjustments to reality and they pass on to their offspring, by suggestion and tactless handling, a predisposition to maladjustment in maturity.

Citing from cases which I believe I have analyzed correctly, I find overprotection in childhood is often projected into adolescense and maturity as an abnormal dependence on the state of mind produced by alcohol. For instance a mother consulted me about her grown son. She was active in the prohibition movement and a strict disciplinarian in the home, over which she domineered in a tyrannical manner, utilizing her fanatical interpretation of right and wrong to justify her every intolerant attitude. At thirty-one, her son was ruled by, and depended on, his forceful mother. He was still waiting for her to manipulate the puppet strings. At the same time he resented this forced dependence, and so he rebelled and hurt her in her tender spot - prohibition - by seeking escape in chronic alcoholism, ironically enough still depending on her in a way that she decidedly did not like.

Not infrequently the overprotection resulting from inherited wealth seems to turn out ill-equipped personalities that find an
escape solution in alcohol. Man rich men, free from the necessity of earning their bread in a business or a profession, seek to suppress their creative urge by substituting alcoholic phantasies. Such men find in alcohol a synthetic existence which apes the give and take of normal life (emphasis always being on the take). This type might be described as perpetual euphoria seekers. They usually must endure a severe alcoholic breakdown before they learn the primary equation of life - that "you can't get something for nothing."

Among the neurotics who become alcoholic we occasionally find an initial adjustment to a smooth, uneventful environment, with no abnormal dependence on alcohol until an emotional shock is experienced. Then they start searching for a stabilizer and often find it and utilize it with little realization that they have developed a psychopathological addiction. War experiences and business failures have produced a group of these men who might under other circumstances have gone through life as normal drinkers. Occasionally a gonorrhoea infection and the mental reaction to it have seemed to herald an abnormal addiction to alcohol. One man traced his narcotic use of alcohol to the fact that, after a severe infection, the doctor who was treating him said that if he started to drink and there was no return of his symptoms, it would be a proof that the condition was cured. He went on a drinking spree and though he had been a controlled drinker up to the time of this incident, he found, after his humiliating experience, that alcohol offered him a solace for the shame and feelings of inferiority which the disease had caused. From this time on, he said, he used alcohol more and more as a psychic cure-all.

Marital discord is often used as a reason for drinking, but this is usually a cart-before-the-horse explanation whose falsity is evident as soon as the patient gains real insight into his personality maladjustment. The truth is that marriage enlarges the field of reality and increases responsibility, the very thing the alcoholic was seeking to avoid by his narcotic use of
alcohol. Hence the conspicuous failures of those women who marry in order to reform their inebriate lovers.

An arrested psychological sexual development is sometimes found at the bottom of discord between wife and alcoholic husband. The husband blames his drinking on his wife's lack of affection. The wife, on the other hand, is sexually and growing more so because of the impotency of her husband, which is exaggerated by alcohol. Such a circle becomes ever more vicious, the husband's sense of inferiority being increased by his wife's attitude, which further inhibits the possibility of a normal sexual adjustment. To add to the confusion, the husband considers alcohol as an aphrodisiac, not realizing that the drug that narcotizes his inhibitions is equally narcotizing his sexual power, so that metaphorically he is using gasoline to put out a fire. I have recently had the pleasure of seeing a case of this sort gradually work out into a normal adjustment. The insight gained and the readjustment of the personality after reeducation, which was undertaken to overcome the alcoholism, automatically took care of the sexual immaturity. This adjustment could never have been made on any but a non-alcoholic basis.

The double standard of drinking which came about during prohibition has increased the number of feminine inebriates. I have found this condition harder to treat in the limited number of women who consult me. They seem to find it more difficult to be absolutely frank about themselves. However, where they can see the necessity of strict truthfulness and are sincere in their desire to overcome abnormal drinking, they respond to therapy in much the same manner as men. The underlying cause in women and in men is the same - i.e., emotional immaturity, which renders their personalities unequal to the task of facing reality. In their narcotic use of alcohol they find the answer at least temporarily, and to the emotionally immature the temporary solution is sufficient. This temporary escape from reality is soon extended into days and weeks.
Most of those who wish to take formal steps to overcome their alcoholism are between the ages of thirty and fifty. This is perhaps a psychological time, because under thirty the driving force of youth and a nervous system that can withstand repeated alcohol shocks are reasons for not taking the alcohol problem seriously. After thirty the abnormal drinker gradually becomes aware that his drinking is forcing him to pay an exaggerated price mentally, morally, and physically, and his inability to limit his drinking to even the dissipated variety of indulgence is brought home to him by repeated unsuccessful attempts. By this time the penalty that one must pay for breaking any law of nature has become an obvious fact, no longer to be dismissed with a shrug and a smile as it was in young manhood. In the last analysis, I should say that the instinct of self-preservation is aroused only when the situation is so bad that it cannot fail to cause the gravest apprehension and alarm.

Having experienced fifteen years as a chronic alcoholic, I doubt whether any of us in the alcoholic brotherhood want to get well without reservations. Alcohol means too much to the man who is using it psycho-medicinally for him to want to give it up in its entirety. The best that can be hoped for is that he shall want to get well. Such a state of mind is sufficient at least to get him to consult some one who can show him how to help himself. Whether or not he will undergo treatment is another matter, but usually if he gets as far as this, he is on his way to a more mature handling of his problem. Bringing himself to this point amounts to a formal admission on his part that something definite must be done.

In the first interview with the patient I explain that I have been alcoholic and that I understand and sympathize with what he is going through: after which I ask him to describe his own case in his own way. I take down the history of his case as he gives it. I ask him to state when he realized that his drinking was abnormal. I ask him his reasons for consulting me and get him to describe his early environment and his present
environment. This may take several interviews during which I do not commit myself as to whether or not I think he is a fit subject for this type of work. I give him a copy of Richard Peabody's book, The Common Sense of Drinking, and ask him to mark any passages in it that he thinks are applicable to his case. Though I find that many of these men have read Peabody's book, they have little more than a superficial understanding of their own problems, probably because, at the time they read it, they were unwilling to project themselves into the position of one in need of treatment. This marking of the book and the subsequent discussions of it put psychotherapeutic treatment on a sound basis from the start. The patient has shouldered the full responsibility of the admission that he is one of those with a nervous system non-resistant to alcohol. It is a form of self-analysis, and the patient usually appreciates, and is impressed by, the fact that, he is believed in and to a certain extent is allowed to act as his own analyst.

It has been my experience in this type of treatment that it is best never to attempt to convince a man that he is an abnormal drinker; rather I put it to him that he must convince me, and incidentally himself, that he is in need of instruction in methods of helping himself. I take my cue from Peabody with this approach, and I remember my own shocked amazement in one of our early talks when he said somewhat as follows: "If you have any idea that you can still drink in moderation, there is absolutely no use in your consulting me. If you really believe that you can drink in a controlled manner despite what you have been through, the best thing for you to do is to go out and try. Then if you fail, come back to me and I will be glad to go into the matter further." This approach is a shock to most men who have spent many years as abnormal drinkers. Heretofore they have been surfeited with advice as to what they can and what they cannot do. They have been told that they must never have liquor in the house, they must avoid associating with their friends who drink, their wives must under no consideration take anything to drink. Very often they have been advised to leave their environment and
attempt to make a new start in a community in which there is no drinking. In the first place, I don't know of any such community, and in the second place, such advice amounts to telling a man that he is a weakling and advising him to escape reality, which is the very thing he has been attempting to do by his abnormal use of alcohol. The psychological approach which I have found effective is that of accepting the prospective patient as an individual who is perfectly able to stand on his own two feet, provided he will apply himself to the work that is outlined for him in a conscientious manner. It is up to him to prove whether or not he is in need of hospitalization. Many men come to me in bad shape nervously, despite which they say that they can pull themselves up in their own homes. My reply to this is, "Fine. I hope you can. But if you find you cannot, it is then up to you to admit it, and we will make arrangements for you to go somewhere and get physically and nervously in shape."

The purpose of this is twofold - to get the patient to act entirely on his own, and to allow him to determine his own degree of stability or instability. The man who can not pull himself out of an alcoholic rut in his own environment, and who admits it, is in a position to benefit by institutional treatment without the resentment that usually results when outsiders frighten or overpersuade one to go to an institution.

As I wish to keep my contact with the patient on a basis of friendship and mutual trust, I try to be entirely frank and honest in my approach. For instance, I tell him that I am going to instruct his wife, with his full consent, to let me know if he has a relapse. I explain to him that this is not done because I feel that he will not be perfectly honest with me, but because a man who has started to drink and is in the throes of an alcoholic breakdown is not capable of acting in a mature or reasoning manner. I always try to keep the patient informed of the reasons for everything that has to do with treatment. In fact, I consider him more of a student than a patient - a student who has failed to pass the final entrance examination into a mature existence. It is up to him to gain insight as to why he failed and how he
can succeed. There is only one thing that will prevent his passing this examination, and that is retaining the state of mind that sought an escape from reality in the use of alcohol. This is the reason why this psychotherapy has been an effective treatment in a great many cases of chronic alcoholism. It is well called reeducation, which is a word implying the possibility of a new and successful adaptation to life. For this reason, the insane and the imbecile must be excluded from the group who may be said to have a favorable prognosis.

If we accept alcoholism as a compulsion neurosis, psychotherapeutic measures at once suggest themselves, and we see that insight, reeducation, and readaptation of the personality must be brought about before the condition can be cleared up. This, I think, is the correct approach and one more hopeful and helpful than the defeatist stand so often taken, or the limited objective of keeping a man sober by any means that occur to an adroit mind.

The following quotation from Dr. Abraham Myerson, in his book, The Psychology of Mental Disorders is of interest. He says: "The alcoholic's mental disease disappears with abstinence and there is nothing to distinguish him from other people except his reaction to alcohol." I beg to disagree. There are many things, besides his reaction to alcohol, by which he may be distinguished from other people. That reaction is definitely and recognizably abnormal, but so is the state of mind back of that reaction. Peabody referred to the alcoholic's conflict in sobriety and pointed out that until this conflict - whether or not to drink again - is settled on a lasting basis, nothing of a permanent curative nature has taken place. Settling this conflict once and for all time is not the simple proposition that many non-addicted seem to think. The man who has not experienced the state of mind of alcoholism usually has little realization of the bombardment of alcoholic impulses that besiege such a mind in periods of sobriety. Nearly every association of life has an alcoholic tie-up. Without alcohol the mental process is a painful one which the
addict knows can be temporarily relieved by a reversion to his habit. The state of mind denied alcohol could be compared to a dull perpetual ache rather than an agony. I asked one man who had been off alcohol for three weeks before he consulted me how often the thought of drinking came up in his mind. "It is much less now," he said, "I only average an alcoholic thought about every fifteen minutes."

The gesture of making a formal effort to give up alcohol creates an added mental conflict. Baudouin, in describing the difficulties of a patient overcoming a neurosis, used a very apt simile which I think is particularly applicable to the man undertaking treatment for alcoholism. He compared the neurotic to one who is learning to ride a bicycle. Ahead of him looms a large dangerous rock and, despite himself, he seems drawn towards it and usually comes a cropper on it. Probably we have all experience this in learning to ride a bicycle, and we know that confidence and technique soon enable us to avoid the rock. To the alcoholic the rock signifies drinking. He wishes to avoid it, yet seems irresistibly drawn toward it. Psychologically the job is to teach him how to ride the bicycle and to show him how to avoid the rock, so that with a new technique he may learn to travel the pleasant road of reality that lies on the farther side.

To sum up the psychological approach to certain cases of alcoholism, the following methods of treating these cases have been of the greatest help to me:

1. Letting the patient convince me, and incidentally himself, that he is an abnormal drinker.


3. Always taking the scientific psychological approach to the problem, which is usually welcomed as a relief from admonitions and emotional approaches.

4. Helping him to gain a psychological insight into his alcoholic problem and discussing his other problems with him during frequent appointments.
5. Instructing him how to relax physically and mentally and following this with suggestion while he is in a relaxed state.

6. Discussing alcoholic dreams. It is significant that every cooperative patient who has worked with me has, after a period of abstinence, experienced dreams of an alcoholic wishfulfillment nature.

7. Giving the patient for exhaustive study some 80 notes by Richard Peabody which he kindly allowed to use in my work. These notes are of particular interest in that they cover and redirect certain trends of mind that inevitably occur to the man undergoing treatment. The vivid imagination of some of my patients has enabled me to add to these notes from time to time.

8. Mapping out a course of outside study so that it is interesting to the individual case.

9. Systematizing a daily routine which includes the keeping of a schedule, exercise, recreation, study, business, and hobbies.

The length of time necessary for adequate treatment is usually from 80 to 100 hours over a period of a year. With the beginning of treatment, two or three hourly appointments a week are necessary. Where patients are in hospital, daily appointments for several weeks, in conjunction with medical care, physio- and occupational therapy, and a scheduled existence, constitute an ideal beginning for treatment.

The major advantage of this form of therapy, however, is that it is carried on after the patient has returned to his environment. Here he has a chance to apply his newly learned psychological reapproach on the actual battle front, where the real test must take place. It is the adjustment in his environment with a sympathetic instructor that is the most important phase of readjusting the point of view of the chronic alcoholic. The battle front is life, his life, with its sorrows and joys, perhaps complicated by a nagging or flirtatious wife, or domineering parents, a vicious business partner, or personal
failures and successes, or just monotony and boredom. These are the offensive and defensive engagements that the partially rehabilitated personality must face. It seems reasonable that this best be done with some one who understands the condition and who can discuss the problems of adjustments as they occur, in conjunction with the opening of the mind and reeducation along modern scientific methods.

The successful patient is one who realizes that alcohol is a mental poison for him, and who has learned, by repeated actual experiments over a long period of time, that the technique of facing reality is a far more pleasant and dividend-paying proposition than finding a miserable escape in alcohol.
ANALYSIS AND COMPARISON OF THREE TREATMENT MEASURES FOR ALCOHOLISM: ANTABUSE, THE ALCOHOLICS ANONYMOUS APPROACH, AND PSYCHOTHERAPY*

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In 1935 I joined the staff of the Institute of the Pennsylvania Hospital, and with the generous support of the senior staff members endeavoured to work out a treatment plan to be available for those seeking help for acute problems. This plan had the then unique characteristic of being a positive, rather than a negative approach. By and large, at this period, most treatment consisted of the facilities offered by rest homes and "cures", where the whole emphasis was placed on sobering a man up. Temporary sobriety having been achieved, he was then discharged with little or no understanding of himself or his problem.

Dr. Edward A. Strecker, who held the Chair of Psychiatry at the University of Pennsylvania, collaborated with me in writing ALCOHOL: One Man's Meat, published in 1938. This book, because it presented a positive treatment plan, had the effect of stimulating a more optimistic approach toward the problem, and we were deluged by requests for help. We did not have the necessary staff, facilities, nor the economic support that would have made help available for all. Fortunately, the Alcoholics Anonymous movement became active at about this time, and has contributed a great deal of help for many alcoholic addicts who could not have received it in any other way.

* Read before the Society for the Study of Addiction at the rooms of the Medical Society of London, 11 Chandos Street, W.1., on Tuesday, 26 August, 1952, the President, Dr. G. W. Smith, being in the Chair.
In 1949, Antabuse was introduced in our country for controlled study, and in 1951 it was released to the medical profession. This release was introduced in part by the following paragraph:

"Antabuse, the drug that builds a 'chemical fence' around the alcoholic, is now available for general prescription use in the fight against the Nation's number one emotional disease."

In sequence, then, we see three positive approaches, each of which was met by great optimism on the part of the public. This optimism has been tempered by the sobering fact that each one of these approaches had, along with successes, many failures, and did not live up to the hope engendered by wishful thinking. This does not mean that Antabuse should be discarded as a treatment measure because there are failures, and sometimes fatal failures; nor does it mean that those who fail to respond to the Alcoholics Anonymous group movement indicate that the A.A. is not a helpful measure; nor again does it mean that psychotherapy should be discarded because it, too, has failures. There is in the United States a number of treatments other than those we are discussing. Dr. Abraham Myerson points out: "The treatment of the individual case has at this time some twenty varieties, ranging from Alcoholics Anonymous and frank religious exhortation to spinal fluid drainage, benzedrine sulfate and the conditioned reflex, not forgetting psychonalysis, psychotherapeutics, and shock therapy." Add to this the many advertised cures in sanitariums and health farms, and one sees how bewildering the burden of choice can be to the patient or his family seeking help.

Let us first analyze Antabuse as a treatment measure. Bear in mind that it was introduced as "the drug that builds 'chemical fence' around the alcoholic." We must first ask ourselves: what about the individuals who do not wish a fence built around them, and is it always wise to do so? In reference to the first group, who do not wish to be protected, there is in the United States not a legal statute to enforce this means toward total abstinence.
In connection with this point whether or not it is always wise to build a chemical fence around the alcoholic, my associates, Dr. Edward A. Strecker and Dr. Vincent T. Lathbury, have discussed two patients in whom the experimental use of Antabuse was followed by a psychotic reaction. A like reaction was discussed by Dr. O. Martensen-Larsen, and more serious effects by Dr. Erik Jacobsen of Denmark.

Dr. Jacobsen says, in part, that the "effective deprivation of alcohol without adequate psychotherapy can be just as dangerous as the untoward effects of disulfiram." In the same article, Dr. Jacobsen reports that there were 17 fatal cases following treatment with Antabuse among 10,000 patients. Of this total, he cites five cases of death were due to sudden, unexplained causes. Deaths following the administration of Antabuse are cited by R. O. Jones, M. C. Becker and G. Sugarman, and D. M. Spain, V.A. Bradess and A.A. Eggston. I am quoting only in part from the available literature dealing with such unfavorable reactions.

Briefly, then, we have three contraindications to the use of Antabuse. First, there are those who refuse this treatment; second, those who may develop a psychotic reaction following the treatment: and third, those to whom the treatment may be fatal. Let me add a fourth risk, perhaps the most important; namely that the indiscriminate use of Antabuse on a group of patients most apt to respond to psychotherapy might interfere with or even block their potential accessibility to psychotherapy. Experience with patients who have had previous treatment with Antabuse shows that they have often resented this treatment and discontinued it. As one of them expressed his attitude to me, "I found that my reaction to alcohol after the Antabuse treatment was terrifying. Therefore I was pretty sure to take no more Antabuse." Several patients have told me that while taking Antabuse they found that a very little alcohol plus the Antabuse reaction gave them a desirable result of intoxication.
On the other hand, medical literature is full of successful results obtained by the administration of Antabuse. One patient of mine, a woman of 65, asked for the Antabuse treatment two years ago. My associates, Dr. Kenneth Appel and Dr. Alexander Vujan, after careful tests, administered Antabuse, and this woman has since then made a much better adjustment. We recommended follow-up psychotherapy, which was not accepted. Without such follow-up therapy, we can only guess as to why the Antabuse worked. This woman was highly intelligent, with a strong indication of psychoneurotic nucleus. She came from a protected walk of life. Later on she encountered more than her share of tragedy. The death of two husbands during her young womanhood probably augmented an already established unconscious feeling of rejection. The insidious sway of her addiction held fast through middle life. Now her grown children were repeating the pattern of rejection because of her addiction problem. At this psychologically important moment we supplied, via the Antabuse treatment, a way to make alcohol actually reject her even more severely than did reality from her neurotic viewpoint.

In 1939, the Alcoholics Anonymous group movement published their book Alcoholics Anonymous. It received a tremendous amount of publicity because of the enthusiasm of its members, plus the fact that it had a very understandable popular appeal. In the forward of this book the writers remark that they wish to show other alcoholics "precisely how we have recovered," and they state. "We are not an organization in the conventional sense of the word. There are no fees nor dues whatsoever. The only requirement for membership is an honest desire to stop drinking. We are not allied with any particular faith, sect, or denomination, nor do we oppose anyone. We simply wish to be helpful to those who are afflicted."

Since this book was written, groups of Alcoholics Anonymous have formed in all the large cities of the United States, and in many of the smaller towns. As a movement it has a strong similarity to religious conversion. They state in their book;
"The great fact is just this, and nothing less: that we have had deep and effective spiritual experiences, which have revolutionized our whole attitude toward life, toward our fellows, and toward God's universe. The central fact of our lives to-day is the absolute certainty that our Creator has entered into our hearts and lives in a way which is indeed miraculous. He has commenced to accomplish those things for us which we could never do by ourselves."

I have gathered from talks with many of the group that the spiritual experience does not always take place, but that even without this experience some are successful in refraining from drinking. With or without the religious experience, members have a very deep sense of Cause, and each becomes an Apostle for this Cause. They insist that members attend weekly or bi-weekly meetings, at which meeting novices hear ex-alcoholics recount the misery of their drinking history, and how they had hurt all their loved ones, but how, now, with the help of the Alcoholics Anonymous group they are no longer hurting those they love, and are happy and successful without alcohol. They recommend twelve steps in their program to recovery:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual experience as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."

I understand that you have similar groups in Great Britain. I believe that they work with the same principles as Alcoholics Anonymous in the U.S.A. In the States some of its appeal is because of the 'go-getter attitude contained in its emotional approach. It savors of the credo of the American success story, and it is colored by the aggressive streamlined glamorization so woven into American custom. My experience with members of this group has been that the successful men and women are those who have made A.A. the most important thing in their lives. They devote a tremendous amount of time to discussion of Alcoholics Anonymous work, they attend meetings regularly, and are willing, at great inconvenience to themselves, to be called out to administer to one of their group who has fallen, or to call on some drunkard in order to persuade him to seek their help. Let me briefly try to analyze some of the aspects of what they have to offer.

Most of those who become members have gone downhill quite far. In fact, many A.A. members say you have to "hit bottom" before you are accessible to their movement. These men and women, due to their abnormal drinking lives, have by and large lost their normal friends and their contact with society. They are lonely, isolated by their addiction problem. To be welcomed again in an uncritical group, where their past alcoholic history can be worn as a badge of honor, provided they recover, must give them a tremendous emotional lift in re-establishing contact with other human beings.
All of us who are interested in the vast problem of mental hygiene owe a debt of deep gratitude to the circumstances that presented this movement at this time. The group is keeping many men and women sober, who otherwise would be cluttering up our jails and our mental hospitals. They are relieving psychiatrists of an already intolerable load, and most important, this approach is keeping many men and women from destroying themselves and crippling their families irretrievably.

With all due credit for A.A.'s valuable work, some of the more fanatical members bring to mind a sketch written by the American humorist, James Thurber, entitled, The Bear Who Let It Alone.

"In the woods of the Far West there once lived a brown bear who could take it or leave it alone. He would go into a bar where they sold mead, a fermented drink made of honey, and he would have just two drinks. Then he would put some money on the bar and say, 'See what the bears in the back room will have,' and he would go home. But finally he took to drinking by himself most of the day. He would reel home at night, kick over the umbrella stand, knock down the bridge lamps, and ram his elbows through the windows. Then he would collapse on the floor and lie there until he went to sleep. His wife was greatly distressed and his children were very frightened.

"At length the bear saw the error of his ways and began to reform. In the end he became a famous teetotaller and a persistent temperance lecturer. He would tell everybody who came to his house about the awful effects of drink, and he would boast about how strong and well he had become since he gave up touching the stuff. To demonstrate this, he would stand on his head and on his hands and he would turn cartwheels in the house, kicking over the umbrella stand, knocking down the bridge lamps, and ramming his elbows through the windows. Then he would lie down on the floor, tired by his healthful exercise, and go to sleep. His wife was greatly distressed and his children were very frightened."
About ten years ago, I was asked to read a short paper, "Emotional Immaturity in Alcoholics," at the Philadelphia General Hospital. This was followed by a talk given by one of the key men in Alcoholics Anonymous. He began his talk by saying that he agreed with me that all alcoholics were emotionally immature: hence they needed Alcoholics Anonymous to compensate for the deficiency of emotional maturity. This pointed out to me the outstanding difference between their approach and a psychotherapeutic approach: namely, that they accept the emotional immaturity, and supplied a crutch for it, where psychotherapy attempts to supply insight into the emotional immaturity, and helps the patient toward emotional growth and maturity as a necessary adjunct to abstinence.

One of the earliest papers on the subject of alcoholism that I have come upon was by Dr. Benjamin Rush, written in the early eighteen hundreds. He cites religious conversion as the only effective means of bringing about abstinence among his alcoholic patients. This phenomenon, I think, is explained in part by the extraordinary egocentricity we find in alcoholics, and this in turn leads us to uncover the omnipotent infant hidden behind the iron curtain of the unconscious, who is still dictating the personality, policy, and behavior of the patient. We see that these patients are in a way playing God. This highly disguised phenomenon was beautifully revealed in the William Saroyan play, The Time of Your Life. In religious conversion, one admits to an all-powerful God. Therefore the convert is forced to abdicate the throne, but in turn becomes God's lieutenant. This is an emotional growth step not always possible, not always wise, but where it works effectively and suffices to give a fractional degree of stability to the addicted personality, we should thank God for its occurrence wherever we encounter it.

Psychotherapy may include a great many different approaches and various disciplines and techniques. Alcoholics Anonymous might be described as a simple form of psychotherapy. Freudian psychoanalysis is considered by some as the only thorough
approach to a non-addicted readjustment. This could be described as a very complicated and time-consuming psychotherapy. Because of the variant concepts of psychotherapy, I would like to outline briefly the type that we have found practical and effective with a certain group of patients.

"The first and often neglected step in the treatment of pathological drinking is a personality diagnosis. This diagnosis should be avoided during the intoxication symptoms and withdrawal symptoms. Even after a state of sobriety has been reached, the physician should delay opinion as to the best method of treatment until he has had ample opportunity to study the personality of his patient.

"The following classification can be employed advantageously in the clinic devoted to abnormal drinking if it is used in the spirit that Thompson suggests when he says: 'We have revised this classification to some extent, but we have altered still more extensively our application of it. Many individuals who are examined in this clinic we now regard as normal or average individuals with an exaggeration of some particular personality characteristic, rather than as psychopathic personalities or deviates.' Even a glance at this classification makes clear how wide is the range of alcoholism. The classification is as follows:

A. Psychosis.
B. Borderline psychosis.
C. Mental deficiency.
D. Psychopathic personalities.
E. Neurosis.
F. Normal individuals with predominant personality characteristics:
   Agressive type.
   Unstable type.
   Swindler (hysterical type)
   Unethical, sly, wily type professional gambler or 'con man'; professional criminal of the planning, careful
type. I think you have a slang word "Spiv" that describes the type.
Shrewd type.
Adolescent type.
(a) Adolescent immature type,
(b) Adolescent adventurous type.
Adult immature type.
Egocentric and selfish type.
Shiftless, lazy, uninhibited, pleasure-loving type.
Suggestible type.
Adynamic, dull type.
Nomadic type.
Primitive type.
Adjusted to lower economic level.
Personality adjusted to ordinary, average life."

We have found that the germ of alcoholism reaches far back into childhood and that most patients are suffering from unconscious feeling of guilt and rejection coming, usually, from these childhood experiences. We are beginning to see more clearly that drinking alcohol in itself did not create their problem. Rather it was their neurotic insecurity which created their addiction. We see in the paranoid patient a tendency to project his personality discomfort outward, in the psycho-neurotic a tendency to project personality discomfort inward, and in the alcoholic a tendency to reach for a drug to anesthetize his personality discomfort.

We have found in the study of the personalities of those who consulted us that emotional immaturity manifests itself prior to drinking, and certainly we have found that emotional immaturity is ever-present in the emotional life of the abnormal drinker. "Man is but a child-born," and I doubt that in our civilization emotional maturity is a completely obtainable goal. When we talk of maturity, we talk of degree. In the abnormal drinker, emotional immaturity plus the addiction problem precludes
emotional growth. We see a like reaction in the psychoneurotic, and we see, perhaps, in the psychotic a terrifying regression to the infantile level. Maturity, if we must attempt to analyze it, could be described as an individual's ability to deal with, compromise with, and sublimate the primitive infantile tendencies that exist in all of us. The alcoholic, when intoxicated, is on an infantile level. When sober, he is a very uncomfortable child in an adult body in an adult world.

I think we often see in the abnormal drinker an actor living a role of pretence that is fooling him far more than the audience. This actor has a complete misconception of the reality of himself. All he knows is that this reality is painful. He does not see that reality is painful because of his maladjustment to it. Having found that alcohol will induce a brief pleasurable fantasy of self, the abnormal drinker seeks more and more the escape mechanism of alcohol. Because such a patient appears to be normal to his family and the public when he is not drinking, the degree of his emotional maladjustment is not recognized by society, nor is it recognized by the patient. In the mind of the public and the patient the problem seems simple, i.e., if alcohol is destroying this man or woman's potentiality to live a normal, constructive life, then the answer is to give up alcohol. I think we can say that the majority of non-deteriorated and non-psychotic alcoholics want to get well. Despite the contradiction of oft repeated drunken behaviour, there is little doubt that somewhere within the mental recesses of the abnormal drinker there lies the desire to rid himself of his addiction. He wants to be normal, but he does not know how to start. To bridge the gap of understanding between the patient and those who want to help him we must first recognize and understand his conception of what constitutes normality. What does he mean when he says: "I want to get well?"

Mental exploration uncovers an apparent contradiction of sane thinking: i.e., normality is synonymous in the mind of the alcoholic with only one thing - drinking normally. He really
believes he wants to drink in a normal way. Most patients give a history of repeated determination to drink in moderation, which attempt eventually ends in acute alcoholic episodes. This self deception on the patient's part, of wanting to be temperate in the use of alcohol, should be discarded with the insight gained in psychotherapy. It is not easy for the patient to see that the one or two cocktails he thinks would suffice actually would be as unsatisfactory to him as one or two aspirin tablets would be to the morphinist awaiting his customary dose of morphine.

Therefore, in dealing with patients, we must realize that a mental condition exists which renders a normal response impossible. We do not tell our patients that they are normal and that all that is wrong with them is that they drink too much. If this were only true, everything would be so beautifully simple. We would only have to say, "Please stop drinking, and everything will be all right." Obviously if they stop drinking they will be more acceptable to society, but otherwise nothing has been accomplished toward curing the state of mind that originally sought escape from their personality discomfort by blunting this discomfort with alcohol. When the stream of alcohol is dammed but nothing else is done then there is merely produced a condition of suppressed alcoholism that could be rightly described as an alcoholic complex, or a partially repressed but imperative urge, that becomes endowed with a super-emotional content. In all probability this is the condition of many successful non-drinking alcoholics, wherein hate and fear have supplanted the love of and depending on alcohol. The partially repressed but imperative urge becomes endowed with a superemotional redirection. The truth is that abstinence frequently means the discarding of an all-important crutch by a sick personality. This may be the right moment for psychotherapy to be substituted for the crutch, not as something to lean on, but as a means of gaining insight into the little boy or girl who never grew up emotionally.

It is obvious to anyone who ever studied the problem of addiction that the abnormal drinker is playing a very passive
role no matter how well he may disguise it by over-compensating action. The very role of drinking is passive. Without being conscious of it, he is asking a drug to change his ways of thinking and being and feeling. The addict carries the passive role to its extreme in deep intoxication. He is helpless.

With this hidden passivity in mind I endeavor to lead a patient into an active role toward treatment. I ask him to read and analyze the book, Alcohol: One Man's Meat,, underscoring any passages that he thinks might give us insight into his own problem. By the very act of doing this he is taking an active rather than a passive role toward his recovery.

I inform the patient at the first contact that he and he alone will effect his recovery, that I can only help him to gain understanding of himself and his problem. If a good rapport is established I find it is helpful to anticipate with the patient the emotional growing pains that he will encounter during the beginning of his non-alcoholic readjustment. The patient puts much emphasis on the immediate withdrawl symptoms from alcohol. He has experienced these and knows how dreadful they are. He has no understanding of or preparation for the secondary emotional withdrawal symptoms that he will encounter during the first year or two of abstinence. These secondary withdrawal symptoms seem to take place in insidiously disguised protests against reality and in bombardments of rationalization urging him to return to alcohol. The late Richard Peabody contributed great insight into this phase of readjustment. In his book, The Common Sense of Drinking, he supplies this insight to the patient, as well as forearming him against the extraordinary rationalizing technique that he will uncover from time to time during his struggle to make readjustment without alcohol.

We encounter in alcoholism an age-old phenomenon of politics: the political psychology of the dictator. Dictator ideology survives only by creating and then enlarging the enemy without, in order to take the focus off the real enemy within - i.e., the dictator. With this technique whole populations are
seduced into relinquishing their freedom. They become willing slaves to their State, hypnotized through propaganda by the imagined enemy without. In the addicted personality, alcohol is the dictator and here, too, the enemy without is created and becomes part of the rationalizing process of alcoholism. The typical alcoholic drinks because his wife nags him, or because he does not get the promotion he thinks he deserves, or because his friends let him down or shun him. In effect each aspect of reality soon becomes the threatening enemy without and the patient relinquishes his freedom to the alcoholic dictator in order to save himself from his own misconception of a hostile reality. There is always a paranoid-like rationalizing system in alcoholism. Understanding the abnormal psychology of addiction, one sees that rationalization is a necessary support to the alcoholic disease that has taken over the personality. Outside of delirium tremens, alcoholic psychosis and the occasional psychotic reactions following the administration of Antabuse, it does not reveal itself overtly, but it is there nonetheless, and it is very important that the patient gain insight into its abnormal mechanisms.

During therapy the patient will under our guidance gain insight into his unconscious feelings of rejection and guilt. If he is successful he learns to deal with these feelings instead of running away from them, and if acquired his insight into their source may help to allay a great deal of his personality discomfort.

I hope it will be seen from my very brief description of a treatment approach that I attempt to deal with a patient's personality problem as well as his alcoholic problem. Personality problems presented by patients vary enormously, as do the underlying causes for their addiction. They have, however, an extraordinarily similar system of irrational thoughts about drinking which will apply to all of them. Just as the understanding of the warped thought process in the paranoid schizophrenic will help to make the diagnosis and indicate the
type of treatment, so also will the understanding of the warped thought process in the alcoholic help us to treat him.

A criticism of this type of psychotherapy is that it is limited to a group who can afford the expense involved in such a treatment. Many of our patients are out-patients, and do well on an out-patient status. In this way, the expense can be kept down so that it is within the reach of nearly everyone. However, many of our patients need psychotherapy and would not respond to it without an initial and sometimes prolonged hospital stay, and this is, of course, expensive.

In order to make a treatment plan available to a greater number of people it has been suggested that group therapy might be instigated. Unhappily group treatment precludes the rapport which has been shown to be so necessary. It has been tried by some of my associates, but the results have not been favorable.

In my attempt to analyze and compare three treatment measures, I have clarified for myself, and I hope for you, the fallacy of finding the treatment for alcoholics. Far better, and much more rewarding in results, is to find the form of treatment best suited to each type of personality afflicted with alcoholism.

Note: Francis T. Chambers, Jr. was a lay-therapist and was trained by Richard R. Peabody.
REMAKING A MAN

ONE SUCCESSFUL METHOD OF MENTAL REFITTING

BY

COURTENAY BAYLOR

OF THE

EMMANUEL MOVEMENT, BOSTON

1919
In order to understand the aim of the methods employed by Courtney Baylor as described in detail in his book REMAKING A MAN, it is necessary to understand the fit of The Emmanuel Movement as undertaken in the Emmanuel Church, Boston, as a precursor to Alcoholics Anonymous.

The Emmanuel Movement had a major influence on lay therapist's involvement in treating alcoholism and on the principles of Alcoholics Anonymous.

The Emmanuel Movement

The period between 1900 and 1908 in the United States was considered the beginning of the era of Progressive Reform. The Evangelical Protestant Churches, industry and labor began to take an active part in encouraging temperance. These years saw the beginning of a movement in Boston that would have a definite influence on the future of the treatment of alcoholism.

The individuals involved in this work in 1908 were Rev. Elwood Worcester, Rev. Samuel McComb and Isador H. Coriat, M.D. The precursors that had influenced this group were the rise of psychiatry in Europe, the doctrines of Christian Science, the anthropologic work of Darwin, and the American psychologist William James.

The application of psychological principles in the field of religion and health was explored intensively in Boston. The clergymen, in collaboration with a physician, established a clinic where physical medicine, psychological suggestion, and the resources of religion were integrated. These men stressed the interrelatedness of mind, spirit, and body. Scientific procedures were employed in diagnosis, case records were kept, and specialists in physical medicine were employed where indicated.
The clinic included, among the patients, a certain number of "drunkards" and many of them responded favorably. After a physical checkup, a system of relaxation and of suggestion was initiated, and in many cases, hypnosis was incorporated. A group process, the Jacoby Club was organized for men who were recovering from alcoholism, and through total abstinence, group support, mutual help, and spiritual inspiration, many recoveries were achieved.

Along with the scientific side of their work, an equal emphasis was placed on Christian characteristics. The return to the Gospels of Christ and the acceptance of His words in a more literal sense were the aims of the Emmanuel Movement, for a return to first century Christianity would be more helpful to people than the dogmatic ceremonies then found in most churches. This emphasis on the spiritual saw the conversion of many thousands of people in Boston. This interpretation of Christianity was later to be employed in a yet unfounded movement to be named the Oxford Group.

The Emmanuel Movement, also called the "God With Us" movement, was inspired on its manward side by psychology or "Wilt thou be made whole?" William James had given his approval to the movement.

The methods of "cure" used by the movement were as follows;

The first method of cure was "confession", wherein the patient unburdened himself of his worries, confessed his follies and indulgences that went back for years, perhaps, holding him to his present diseased condition. In the Emmanuel Movement, Dr. Worcester had claimed there were large benefits to the sufferer in this opportunity to free his mind to a sympathetic listener. it also opened avenues for insight into the nature of the person's malady, so that curative suggestion could be applied easier.
What may be termed a second method of remedy was the imparting of religious faith. To all persons whose personalities were submerged in immorality, unbelief or the cold empty realization of the senses and were therefore depressed and inert, comes the message of hope and faith in God. He was proclaimed as a present, near-by strength, ready to put His infinite power under that life if the person would ask for His help. Christ was represented as the giver of rest and peace. The afflicted soul received the hopefulness offered and for the first time was able to rest and sleep in the new assurances that all was well.

The third method of remedy was in remoralizing the life. The emotions had a very apparent and violent influence upon the nervous system, the digestive organs, and the action of the heart. If the emotions of fear and worry filled the life, physical derangement inevitably resulted. "How necessary then to banish fear, worry and grief and install in their stead the pleasing, cheerful, and joyous emotions, for we will someday learn, God grant soon, that if love and peace pervade the soul, the entire body responds to these health - restorers and a normal state of our functional life results."

The fourth remedial agency then was the application of "suggestion." The patient was put into a relaxed, quiet state. The will relaxed its striving, mind and body sank down into rest. Complete surrender of the individual to the universal life was realized. The depths of the subconscious universal life was realized. The depths of the subconscious self were laid bare, and into these depths, where evil habit was rooted, were put suggestions of health and strength and victory. This technique of suggestion was realized through the use of hypnosis and autosuggestion.

The patient, having been guided through the four phases, emphasis was placed on individual responsibility and daily prayer to maintain abstinence.
The term "lay therapy," literally means treatment by laymen. In the field of alcoholism, it is a term which usually means a particular method of treating alcoholics.

Before psychiatrists began to consider that alcoholism fell within their province and while doctors as a whole were usually leaving excessive drinkers to the churches, a layman—a "dry drunkard" who had no psychiatric training and no degree but who had a remarkable insight into the state of the mind of the alcoholic began to treat alcoholics professionally and to attain measurable results. The man was Courtenay Baylor who in 1912 began to work with Dr. Elwood Worcester.

The Emmanuel Movement's principles, applied specifically to alcoholics, were presented by Courtenay Baylor in the book, REMAKING A MAN. It is this writer's opinion that Baylor was the first recovering alcoholic to present a workable, concise treatment for alcoholics. This opinion is supported by Marty Mann in her book, PRIMER ON ALCOHOLISM, although popular belief usually places the first professional use of recovering alcoholics in the treatment of alcoholism in the Yale Plan Clinics at New Haven and Hartford, Connecticut during the early 1940s.

Baylor began his work with alcoholics with the assumption that for people who were suffering from an alcoholic neurosis, the condition to be treated was the same regardless of whether it was the cause or the outcome of drinking.

He believed that the craving for drink was the result of a state of mental tension that was akin to physical tension. His first concern was to teach his patients how to relax temporarily: then he would show them how to prevent the states of tension from recurring. To make this state of relaxation permanent (and by relaxation Mr. Baylor meant not a state of limpness but "a combination of suppleness, vitality, strength
and force—a certain definite intentional-elasticity"), an alcoholic must re-outfit his life and acquire a new sense of values.

In Courtenay Balyors book he writes extensively of the following points ---

- Alcoholism is characterized always by the existence of a secondary and false philosophy.
- As alcoholism progresses the false philosophy of excuse becomes more persistent.
- In many cases the alcoholic patient does not really want to get entirely well.
- The patient must eventually be re-educated in his whole mental process so as to know how to recognize and to dissolve certain tendencies at their very inception.

  Temporary relaxation is necessary before attempting psychological work.
- through trust the instructor has the power of "suggestion" to implant ideas in the mind of the patient.
- The patient often has a feeling of self-censure because he is not doing what he knows he should do.
- The aim of treatment is to help the patient to help himself.
- The patients and instructors minds must be working at the same speed.

Courtenay Baylor's method of treating alcoholism was used extensively by others during the 1920s. Naturally he had followers both among the individuals he had helped to restore and among others who were drawn to his work. The best known of these individuals was Richard R. Peabody, also a Bostonian, who was treated and trained by Baylor who encouraged him to write The Common Sense Of Drinking (which Peabody dedicated to Baylor) before he began to extensively treat patients.
In this book, which became a source book for both alcoholics and therapists, Peabody gave greater form and detailed development to Courtenay Baylor's method.

Further knowledge of the Emmanuel Movement may be gained by reading the following books:

RELIGION and MEDICINE: The moral control of nervous disorders.  
Worchester, E., McComb, S., Coriat, I.  

MIND, RELIGION and HEALTH.  
MacDonald, R.,  

THE COMMON SENSE of DRINKING  
Peabody, R.R.  

BODY, MIND and SPIRIT.  
TO THE READER

As a student of the history of Alcoholics Anonymous and the precursors to Alcoholics Anonymous I had come across the names of the Emmanuel Movement and Courtneay Baylor a few times.

In searching for the book REMAKING A MAN by Courtneay Baylor, the only copy found was in Dartmouth College and a friend borrowed it and reproduced it. As the copy quality was poor, I decided to retype the book with the sole intention of making it available to other students of Alcoholics Anonymous and its precursors.

I hope that you enjoy the retyped copy of the original and I am sure you will gain a greater understanding of the evolution of the program of Alcoholics Anonymous.
FORWARD

The writer's one object in his psychological work has been to obtain results. He has therefore explained his ideas to his patients in the language each individual would understand. Since his experience has been that of a layman talking entirely to laymen, he has not acquired a technical vocabulary. This he regrets as he is perfectly conscious of the value of technical terminology in arriving at an exact expression of one's ideas when addressing scientific men. He asks, therefore, that those readers to whom his terminology may seem crude will criticise his methods and results rather than the terms he uses to describe them in this paper.
Whatever progress medicine may make as a science, the treatment of the sick, as Dr. Weir Mitchell maintained, will always be an art. It is from this point of view that Mr. Baylor's treatise should be judged. It describes as simply and truthfully as words can describe a method of moral treatment of certain selected cases which has been productive of good results. For years I have sat in my study in Emmanuel Church, and I have seen Mr. Baylor's patients come and go. Many have come to the Church, broken and ruined men. They came to us because life itself had cast them off and they knew not whither else to go, nor how to escape from the vices and miseries which were destroying them. Many of them have gone forth new men, having undergone a change in character, in physical and moral health and in facial expression little short, of miraculous. These men, I should state, were not recruited from any single rank in life. They represented almost all types of education and social environment from the lowest to the highest. While many presented definite problems of alcoholism, morphinism or sexual abnormality, many others have sought relief from the ordinary neuroses and psychoses—depression, fear, weakness of will, painful thoughts, insomnia, evil temper, lack of mental concentration, with the resultant tale of failure, impoverishment and discouragement.

In talking with many of these men I am have been impressed by the extent to which they had been able to accept and appropriate Mr. Baylor's philosophy and by the use they were able to make of it. It would be strictly true to say that this teaching has changed life for hundreds of men and for the families of such men. I know alas! only too well how far the written word fails to express the whole personality of a man.
INTRODUCTORY STATEMENT CONT.

Yet I hope that this little book, conceived in charity and illumined in every page by vital experience, may produce upon its readers some portion of the effect which the same thoughts have created when informally uttered.

EDWARD WORCESTER.

Emmanuel Church
There are three reasons why this paper is written at this time. First the writer wishes to establish if possible his claim that it is logical, legitimate, ethical, and safe for one who has no medical or surgical knowledge and who has no psychological degrees to do a certain type of psychological work in conjunction with skilled physicians, provided such a person has demonstrated by a long period of results that he is competent to handle certain types of neuroses. Just as officers who have gained their military knowledge in the practical school have a place with those who have had theoretical training, so he feels that the man who has acquired a knowledge of psychology in a practical way has a proper place in the field of psychological work. He hopes to justify his own claim to a legitimate place in this field by the following account of his methods and of results he has obtained through them. He also wishes so to present his ideas that this paper may be of value to any one who is interested in the practical application of these methods, either for the purpose of helping others or possibly for his own relief; and finally he wishes to suggest to the physicians in authority the practicability of this method for use in the treatment of returned soldiers suffering from the neurotic conditions known as "shell-shock" and from other emotional results of war-strain.

He has been working for some seven years under the guidance of Dr. Elwood Worcester of the Emmanuel Movement in Boston. During this time he has handled personally some thousand cases of which fully two-thirds have resulted successfully. He first applied himself to the refitting of mental processes by psychological methods in work with alcoholics—those who obviously and avowedly wished to give up drink entirely but who, owing to a condition of mental conflict, were unable to do so.
From this experience with alcoholism he has worked out an analysis of what he believes to be the condition and the underlying cause in alcoholic neurosis, and one method of permanently removing this cause.

But, though he has worked primarily with alcoholic conditions, his whole experience has necessarily led him into dealing with many other neurotic conditions. Every case of alcoholism has behind it what might be called an alcoholic or neurotic atmosphere. We can hardly expect a patient to become or to stay cured if he must remain in an environment which has in all probability contributed to his own abnormal nervous condition. This environment must in its turn be "cured." The writer has therefore, when he has been working directly with the alcoholic patient, dealt also personally with the individuals involved in the background of each case.

It is upon this experience that he bases his confidence in the value of his methods as an aid to handling the neurotic conditions among returned soldiers. So often he has found, in the families of alcoholic patients, persons in whom exactly the same abnormal condition has obtained, although they have never taken alcohol. They have presented symptoms corresponding or similar to those of an alcoholic neurosis; they have shown a mental state answering to the same analysis; and they have yielded to the same treatment. For it is evident, the writer feels, that after all—whatever its cause, whether it be the result of a long or a short period of sorrow or care or horror, or merely a precipitation of an existing neuritic tendency, and whatever the manifestations characterizing the individual case—there is a particular neurosis which is fundamentally the same condition always, and which therefore responds always to the same method of treatment. He believes that this neurosis is, in many instances, characteristic of "shell-shock" and of war-strain; and he feels confident that any methods which have already proved successful in its relief elsewhere will also prove valuable for the relief of war-strained men in whom physicians find it to exist.
In working with patients who presented themselves for relief from alcoholism I found that they fell naturally into three classes: those with an alcoholic neurosis; those who, while they appeared at first to have simply a neurosis, proved upon further acquaintance to be suffering from a definite psychosis or from actual insanity; and a few individuals who, while they were neither insane nor psychopathic, seemed incapable of responding to any method of treatment. For these last two groups I do not pretend that any permanent reconstruction can be brought about by this treatment: but for the alcoholic neurosis I have worked out one method of obtaining permanent relief which has proved successful in many instances.

It seemed to me that the condition in this trouble was essentially the same whether the use of alcohol had been the original cause or was the outcome and expression of an-existing neurotic tendency: the same analysis seemed to apply to any alcoholic neurosis. I recognized that the taking of the tabooed drink was the physical expression of a certain temporary but recurrent mental condition which appeared to be a combination of wrong impulses and a wholly false, though plausible, philosophy. Further, I believed that these strange periods were due to a condition of the brain which seemed akin to physical tension and which set up in the mental process a peculiar shifting and distorting and imagining of values: and I have found that with the release of this "tenseness" a normal coordination does come about, bringing proper impulses and rational thinking.

Alcoholism is characterized always by the existence of a secondary and false philosophy. In some cases this abnormal point of view replaces the man's normal philosophy to such an extent that he is conscious of the one attitude only—the false.
In the majority of cases however, the normal and the abnormal are revealed to him as existing together and conflicting more or less noticeably. But in any phase of the trouble and whether the conflict is revealed or not, it is the existence of the two different attitudes which characterizes the mental state in alcoholic neurosis.

Take the man who drinks moderately. It is safe to say that in the great majority of cases a man who takes a drink does so with a mental reservation that it is because the weather is hot or cold, or he is wet or fatigued or depressed or excited, or his football team has won, or for the sake of sociability, or because someone has died. It is almost never that he realizes and frankly states that he wants a drink because it is a drink and that drinking has such a hold on him that he cannot get along without it. He assumes the nonchalent air that drink in itself is really immaterial to him—that he only drinks on occasions as above.

But as a matter of fact even the most moderate drinker—the man who may go through life without drinking to so-called excess—has an alcoholic neurosis, and therefore this secondary philosophy, to just the extent of his drinking. He may have no scruples about the use of alcohol, and therefore he may not be conscious of any difference in his philosophy at the moment when he wants a drink and at any other time. Let him for any reason attempt to give up drinking entirely however, and he will discover his inability to do so without a struggle. He will, each time he wants a drink, offer himself some good reason for this particular lapse; and the point of view which he holds at that moment will be to him apparently true and conscientious.

With the acknowledged victim of alcoholism this philosophy of excuse becomes more and more persistent; either it becomes a perpetual state, or it breaks intermittently—allowing a consciously different point of view for some time, only to have the excuse return with full persuasiveness. In the first case
with the excessive drinker, the normal mental attitude has been so completely replaced by the alcoholic philosophy that there is no consciousness of any conflicting ideas. In the latter case with the periodical drinker, the two attitudes exist side by side for a time and their conflict is revealed. This last is the condition of the moderate or occasional drinker intensified. Then the man has not yet identified his drinking philosophy as anything apart from a normal point of view; but with the periodical drinker the drinking has reached a point where it is its own indictment. Here the man himself recognizes as false the philosophy which justifies it, and the two points of view are therefore revealed to him in opposition.

The same dual condition is found in the non-alcoholic neuroses of this type. There is a conflict of impulses, an instability of thought, a kaleidoscopic change of values, and with these the lack of power in the sick person to truly analyze his attitude and actions. He rarely realizes that business, family, friends, and politics seem all wrong largely because of his own fear, depression, irritability, or distorted imagination. He conscientiously believes that he is fearful, depressed, or irritable entirely because of negative circumstances or because of the attitude of other people. Even the difference between his normal and abnormal periods he usually explains away, if he recognizes it at all, by attributing it to a change in something outside of himself. Thus, while the conflicting philosophies of the non-alcoholic conditions are perhaps less conspicuous than the two points of view in alcoholism, they are nevertheless two distinct mental attitudes—the one neurotic and the other normal, and they have been an important feature of this particular neurosis in each phase with which I have come in contact.

In the abnormal periods the mental state is literally a circle of wrong impulses and false philosophy—each a cause and the result of the other. It seems logical in an alcoholic
condition to think of the impulse as starting the philosophy—that is, a man wants a drink and then thinks up a justification for taking it; but on the other hand, the neurotic condition which follows from that drink brings distorted values and as a result false reasoning and wrong impulses. In non-alcoholic phases of the trouble a person becomes neurotic and proceeds to apply his neurotic reasoning to everything—the conduct of his business, his relations with the members of his family and with friends—in short, to whatever may hold his attention at the moment. That is, the impulse to fear or depression or irritability, which is itself the result of a neurotic condition, arouses in him an attitude of mind which, as soon as it becomes apparent—in his conduct—and it is inevitably translated into conduct—creates in reality the condition which he first imagined in his fear. This new and real condition now gives him a logical reason to continue and increase his fear tendency; and so, he goes around the circle again with ever increasing momentum—fear creating conditions and conditions creating new fears.

Underlying and apparently causing this mental state, I have always found the brain condition which suggests actual physical tenseness. In this condition the brain never senses things as they really are. As the tenseness develops, new and imaginary values arise and existing values change their relative positions of importance and become illogical and irrational. Ideas at other times unnoticed or even scorned become, under tenseness, so insistent that they are converted into controlling impulses. False values and false thinking run side by side with the normal philosophy for a time; and then with the increasing tenseness the abnormal attitude gradually replaces the normal in control. This is true whether the particular question be one
of drinking or of giving way to some other impulse; the same indecision, changeability, inconsistency, and lack of resistance mark the mental process. In fact a person will behave like one or the other of two different individuals as he is or is not mentally tense.

For instance, on Monday when he is normal and values appear to him in their right proportion, a man honestly feels he will never take nor want another drop of liquor. By normal I mean that he is coordinating physically, mentally, and psychologically, and is free from fear, depression or exaltation, irritability, or any of the other children of the tense mental condition. Yet the same man, on Thursday, when he has developed the tenseness which prevents perfect coordination and when again as a consequence the mental confusion and distorted values have returned,—may be debating with a sort of second self and finally deciding he needs just one drink. He has been fully conscious of both lines of reasoning at first, and he has known perfectly well the train of events which is bound to follow the "just one drink"; yet as the tense condition increases, he yields to the alcoholic philosophy.

Take the man who does not drink. He has, we will say, worked up to a very good position: he is too old to secure any different kind of work; and it is therefore essential that he retain his present place. Further, because of long years of companionship and real love, his wife is necessary to his happiness and it would seem to his very existence: and his love for his children and their love for him is a condition he would give his life to protect. These he knows are the true values; but what do we find when this man's brain becomes tense? He will endanger his wife's affection by scolding and finding fault with trivial things which at other times he would ignore. He will risk losing his children's love and respect by unjustly punishing and impulsively and irrationally criticising them.
Even here he will shift from day to day as to the things which he chooses for his fault finding. His position in business he will endanger by impertinence to his employers and a grouchy lack of cooperation with his associates. In the background running parallel with all this for a time is the consciousness that he must retain his position and that he loves his wife and children dearly and wants and needs their love in return: but, as the mental tenseness increases and so long as it holds, it is the false values which control his conduct.

In normal sleep we are conscious only of dream-life or of nothing at all; in the normal waking condition the whole brain is awake and capable of carrying on its real work of all 'round balanced thinking based on true values; in the neurosis which I am describing it seems as if a part of the brain were awake while the other part were dreaming, and the result is a mental state of uncertainty and conflict. This seems to be true whatever the extent of the trouble; the dream condition may become perpetual or it may be broken or very slight in proportion to the mental tenseness; but always with this tenseness, come the dream values and the irrational impulses and their consequent philosophy and behavior.

Take our illustration of the non-alcoholic man who has become mentally tense. His brain is in the condition of one waking from a nightmare in which some horror is chasing him and in which he is unable to make his legs run him away, while at the same time the thought goes through his mind, "I know this is only a dream, and yet I must wake up before this thing catches me." With the part of his brain which is awake he recognizes the unreality of the values upon which he is acting; but the tense dreaming part seems to have control of the situation. Take also the man who reverts to drinking again on Thursdays after having been so very far from even the thought of such a thing on Monday. He is sufficiently conscious of his real philosophy to
debate the question with himself at first; and yet, as the tenseness gradually gains control of his brain, he surrenders to the dream values and to the action which they justify.

One important characteristic not to be overlooked in this neurotic condition is the absence of any real desire—if not the presence of actual reluctance—on the part of the patient to reach a point of complete normality. It is hard to realize that a person suffering from alcoholism or from fear, melancholy, trembling limbs, or any other symptom of this neurotic state should not want to get entirely well; but such is the fact in a great many cases. The patient wishes to have the symptoms allayed, but there is an unconscious tendency to secretly hold on to his difficulties while making believe that he is trying to surmount them. This point is elusive. It is so hidden by the surface symptoms of the trouble at first that the patient is honestly unconscious of it and the instructor is aware of its presence only because experience has taught him to look for it. It reveals itself beyond question, however, as soon as the acute difficulties have been cleared up. Then once the patient recognizes and understands this tendency to hide behind his illness and acknowledge its existence, his recovery can become rapid; but until this can be accomplished he will unconsciously prevent his own return to complete normality.

The neurotic patient's attitude is like that of a person who, in a happy convalescence from physical illness, dreads getting back into the vigorous responsibility of life. He realizes that in his neurotic condition that he is not competent to meet the problems of life as a normal man would, and he assumes that this is not expected of him. The fact that he is considered a sick person is a relief, since it implies that he is to be looked out for in some degree. He feels that, while he is sick, either his problems will be met for him or he will have an excuse for going down before them. He has not sufficient imagination to realize that those things which seem to be problems to him in his illness will cease to be anything more
than mere incidents of life when he is well. From his present point of view they will always be problems. He feels that he will go down before them without a doubt and if he is considered well there will be no excuse other than mental incompetency. That he is mentally incompetent he fears and admits to himself; but he does not wish to share his secret. He may talk loudly about being competent; but in reality he does not believe in his own returning capabilities; and he dreads to put them to the test.
If I am right in my contention that "mental tenseness" is the underlying cause of this neurotic condition, we must, to relieve the neurosis, permanently remove this cause. That is, we must induce as permanent the mental state which exists in the absence of tenseness.

Freedom from tenseness in my opinion is merely a normal state in which the entire brain is awake and the man coordinates simply and naturally with his surroundings and within himself. I like to describe it by the word "relaxed"; and when I use this term, while I do mean to indicate the opposite of tense, I mean also something far more than a state of mere limpness. Relaxation to me suggests a combination of suppleness, vitality, strength, and force—a certain definite intentional elasticity. It is always the condition behind good work, physical or mental. The athlete, the musician, the writer, the teacher, the businessman, all do their best work when they are relaxed and running free. Then they coordinate all their powers without tension; then they do not rigidly charge their problems, but blend and work with and direct them.

To induce this relaxed state permanently, the tenseness must first be released temporarily by some means; the patient must then be taught to prevent its recurrence; and in order to make these measures lasting and effective, he must be provided with the inspiration of an entirely new outlook on life—"a new scale of values."

The patient must eventually be re-educated in his whole mental process so as to know how to recognize and to dissolve certain tendencies at their very inception and before they get under way, for it is only by doing this that he can prevent the recurrence of his tenseness.
Irritability, dread of making a contact, procrastination, depression, self-pity, a general feeling of fear—all of these and more—should be labeled as danger signals and eliminated while they are still tendencies. This re-educational work is done through logical analysis and explanation and definite instruction, which are combined, if the patient can cooperate in relaxation, with direct relaxing exercises.

But the temporary relaxation, direct or indirect, is, I feel, an essential preliminary at each interview. Since tenseness in the brain causes destructive, negative, and irrational thinking and prevents the normal action of the mind, whatever tenseness exists must be released before any attempt is made to re-educate that mind. It is of little avail to feed logic to a tense mind, for such a mind cannot digest it. But a brain relaxed and cleared from tenseness and free from that dream-condition spoken of works normally. Not that it is necessarily filled with knowledge; but it is in a receptive and responsive state in which values can more readily appear in their right proportion and constructive and consistent impulses arise. Thus the instructor should always be sure that the patient is relaxed and in harmony before he attempts any psychological work.

What might be called the inspirational phase of the treatment is practically bound up in the two phases which I have just outlined. Every person suffering from any form of this neurosis needs a new point of attention, a new philosophy of life, and new courage with which to face life. The method in itself thoroughly understood meets these needs. It supplies the patient with a new interest and a new point of view so big and so different that they occupy the present moment fully and at the same time make all life seem worth while to him. It gives him something new to live for, and with this new purpose, a new consciousness of power within himself; and so eventually it arouses and develops his nature to its full capacity.
He need rely no longer upon the functions and senses which have failed him so often. He has through this method discovered another, hitherto unrecognized, 'sense or function or power upon which he has learned to draw at will and which enables him to meet the problems of life with joy and to master them. He knows now how to release the tension in himself and in persons and conditions surrounding him. More than this, he has learned how to cultivate right impulses and constructive thinking and so create within himself and thus in his surroundings better and stronger and happier conditions: and according to his new philosophy he realizes that the whole secret of life lies in creating these right impulses and conditions rather than in resisting wrong and harmful influences.

To bring about a psychological change which shall straighten out a chaotic mind into permanent normality is more than a science; it is also an art. The physician, surgeon, psychologist, or layman who has this art may by practice develop various degrees of technique with corresponding results. But in my opinion the knowledge of medicine, surgery, or psychology alone, without the art factor, does not produce concrete results along these lines.

The instructors aim is to bring about in a sick mind permanent relaxation and re-education. To do this he must develop intuition and resourcefulness. To teach a man to relax his body is one thing; to teach him to relax his mind is a much more difficult problem. The first is necessary to the second, and there are many ways of attaining both. There are also many and various temperaments each of which calls in the refitting process for a different handling as to details of approach and treatment.

In order to accomplish anything by any method, the instructor must first gain the confidence and cooperation of the sick man's mind. To insure these conditions he should remember
that the obtaining of the patient's confidence does not depend upon what the instructor thinks of him but upon what he thinks of the instructor. Thus, while obviously he will hold a position of dignity in every interview, the instructor must eliminate at the outset all possibility of any real or imaginary point of cleavage between the patient and himself—such as might appear between a man "who knows it all" and a "poor fool who knows nothing." If such a feeling of cleavage does appear, it cannot be eliminated by patronage or make-believe intrest. The instructor must make sure he is honestly intrested in the patient's welfare, and with this basic truth planted his honesty of purpose will be revealed to the patient as the interviews progress.

Further, it is not what the instructor says but what the patient actually believes which will determine the latter's impulses and actions. There may be some types of mind which will accept and believe dogmatic statements rigidly expressed; but I am sure that the average person combats this method. He will, however, cooperate quickly if ideas are offered for his acceptance or rejection—as they may or may not appeal to him—rather than handed to him as something which we have already accepted for him. The instructor must therefore sense the mental process of each patient and adjust his manner of conversation and instruction always to the type of mind with which he is dealing.

The instructor must also keep in mind constantly how large a part indirect methods play in the successful handling of any patient. When he remembers that all personal interviews are one hundred per cent "suggestion," direct or indirect, and it is watchful and skillful he may so arrange his contact with the patient that everything which is said and done—the entire atmosphere—shall contribute to the latter's recovery. Every quiet conversation and every moment of interest in anything
outside himself and his own affairs is in itself just so much gained towards the patient's relaxation and re-education in any case; and when the points of interest and the activities offered are deliberately chosen by the instructor they can be made to carry a "suggestion" tending very definitely toward reconstruction.

We hear the terms "suggestion" and "auto-suggestion" used as if they implied something uncanny and unnatural, weird and oriental, when in reality they refer simply to the reaction of thought to something seen or heard or felt and to the natural expression of that thought in some physical or mental action—an obvious and familiar process. The salesman meets the customer: there is the attitude on the salesman's part of cheerfulness; this has a definite effect upon the customer. The orator comes upon the platform; there are certain things about him which arouse in the individual members of the audience a positive or a negative reaction: as he speaks, the words he says start trains of thought in the minds of his hearers; the audience in its applause or quietness sends back a definite impression to the orator. A mother kisses a baby's bump and makes it well; she raises her eyebrows with a look of surprise and the child draws its hand away from the sugar bowl. In all these there is the play of "suggestion".

We use and respond to "suggestion" so continuously and unconsciously that it has very little interest for most people. It has a new interest however, when we consider it as it is applied in this treatment, when we realize that a person can "suggest" to himself and bring about a desired condition—that he can tell himself to be free from nervousness the following day, for instance, and find next day that this "suggestion" is carried out. "Suggestion," then, as the term is used in this discussion, refers merely to this everyday process
deliberately applied to the reconstruction of a sick mind.

The direct work—the detailed explanation—which is necessary for permanent reconstruction should, of course, be begun as soon as possible: but some temperaments and conditions react unfavorably to a direct approach. The patients are embarrassed or frightened or antagonized, and their mental tenseness is increased, by direct instructions or even by comments bearing frankly upon their own treatment. In such cases the instructor should blend, as soon as he perceives this disturbance, into indirect methods only and should use them exclusively until he has brought the patient through to a point where he is ready for the usual treatment and willing to accept it.

For instance he may tell a patient how he wishes him to practice definite relaxation by himself latter in the day describing here step by step what he wants him to do later on. This postponing of the time of action relieves the patient of embarrassment by allowing him to do the exercise by himself, and it takes out of the situation any possible appearance of insistence, which is so petrifying to the neurotic. Or if the patient is annoyed by this discussion of relaxation as such, the instructor may talk more or less impersonally about some other phase of his treatment. The tone of voice and the speed of the conversation will have a relaxing effect upon the patient, and the result will be some release of his bodily and mental tenseness for he will unconsciously let go to a certain extent as he listens.

Or if a patient cannot bear at first even a direct reference to his condition or to any part of the process which is to relieve it, the instructor may introduce some topic apparently wholly unrelated to the subject of "treatment," trusting to the momentary self-forgetfulness and unconscious relaxation which usually follows the patient's interest in that topic to pave the way for a change of attitude.
My reply to a patient who had reached the point of herself asking me what was "indirect suggestion" will illustrate my meaning. I answered her:

"I avowedly want to get you quiet—your mind at ease and into a habit of thinking of other things than those about which you have been thinking—to the end that you may relax and coordinate properly and use all of your functions in a normal way so that you may walk—for there is no physical reason why you should not walk. I want you to get into a habit of a hopeful and happy frame of mind. I want you to become a natural optimist so that you will begin to have a feeling of surety that sooner or later you are going to walk. I therefore have come to see you quite frequently, told you funny stories to make you laugh, presented you with a ukelele that you might become interested in playing it and in singing, and in other ways have buoyed you up.

"I have never once directly urged you to walk or cut down on your sleeping powders. I recognized that to speak of walking fretted you, and to speak of sleeping powders fretted you, and to the extent that you fretted you became tense, and to that extent we were going backwards. All of our work is for the purpose of getting you well; this is perfectly obvious to you and does not have to be spoken of. Your intelligent mind realizes that natural sleep is necessary for recovery from any nervous trouble; and natural sleep means breaking away from powders for one thing. Therefore, indirectly, the mere fact of my continuing to come here suggests those things which we wish to bring about—walking and the cutting out of sleeping powders. There is nothing underhand about this indirect suggestion; we both of us know it is going on: we both of us know what I am here for; and I shall continue this method as long as it seems best."

By the time a person is recognized and classified as a "patient" he is often in such a condition of mind that he is
unable to make a consistent and persistent effort in any one direction. His own conscience and often the attitude of his friends have urged him to continued attempts at activity; he has been striving to concentrate on some definite line of work without success; until through discouragement he has finally settled back into an attitude of laziness. The fact that he is physically doing nothing brings him no real rest, however, for while he may defend his conduct to his friends and to himself— he is haunted, nevertheless, by a feeling of unhappy guilt because he realizes that he is not doing what he should.

This feeling is an important contributing factor in his general nervousness and disturbed psychic condition, and it must be eliminated before he can yield himself fully to the treatment. It is my custom, in a condition of this kind, to tell the patient that he must do absolutely nothing for a week (or whatever period of time I think wise) and to insist upon this in spite of his declarations that we must work—that he must be active.

Inasmuch as he has been accomplishing nothing anyway there is no harm in his continuing his inactivity a little longer; and there is a great mental and moral relief to him in the fact that he is told definitely that he must not even try to do anything. Now, for the first time since his illness, he is making his body and his mind do what he tells them to do. He is definitely and successfully doing something, although that "something" consists of doing nothing; and since he is doing it under instructions it is the thing to do, and his self-censure passes away. This interval of rest also gives an opportunity for necessary psychological and possibly medical work so that, after it, the patient can be brought gradually from definite inactivity into definite activity until his tendencies to lack of concentration and action have disappeared entirely.
As I always explain to the patient, I want him to learn and to accept for himself and to be able to apply to himself all that this treatment teaches. I can help him while he is with me, but I can only see him in half-hour periods for a limited number of meetings. He is with himself twenty-four hours a day, and my aim is to help him to help himself that his reconstruction will be permanent.

A certain type of mind will cooperate more or less blindly—that is with perfect confidence and willingness but with very little **comprehension** of what I am really doing: and this type very often shows a temporary response, sometimes covering a considerable period of time. But I have found that it is the intelligent cooperation which comes from a real grasp of the method that makes for permanent independence. The patient's ability to grasp and apply the new ideas depends largely upon his thorough understanding step by step of all that is done and said. Furthermore, points which he does not fully understand will inevitably disturb him; he will be sure to combat them—openly or silently—and in either case he will be hampered until the question in his mind is answered. It is important therefore in order to get the most complete response from the average person, that he have a full and careful explanation of each phase of his treatment as soon as possible, and that the instructor keep his explanations and **exercises** well within the patient's mental capacity, and that he guage and keep pace with the speed of his understanding.

One point especially may cause trouble until the patient understands the situation fully. This is the necessity of working primarily, not upon the surface difficulty, but upon the condition behind it and upon the cause underlying this condition. I discovered in working with alcoholics that I was getting my best results when I frankly devoted all my
explanations and comments to the condition behind the physical act of taking a drink and spoke of alcohol only enough to indicate that I had an intelligent idea of its effect. In non-alcoholic neuroses I adopt the same method. I touch upon the things uppermost in the patient's mind only enough to satisfy him that I do not belittle his difficulty, and then I work upon the general condition behind that difficulty. But this procedure I always explain clearly to the patient: for unless I do he may feel that I have failed to grasp and am not going to get at his particular trouble. Once the situation is clear to him, however, he will usually cooperate with me and will set his symptom aside for the moment and help me to analyze and remedy the underlying cause.

Take, for instance, a definite "fear." This is in reality, I believe, a general fear condition revealing itself in this particular way. Suppose that a person is at some time extremely nervous and, although perhaps not conscious of it, is already in a condition of timidity. At this time he walks through an open space and the recognition of this feeling of timidity comes to him, either because it is ripe to come or because it is precipitated by some catastrophe that occurs before his eyes—a shooting affair or the breaking up of a mob, for instance. From this time on, this person is always conscious of having, as he thinks, a definite "fear" of an open space, when it is really merely one revelation of a general fear-feeling which has become associated with open spaces.

Now if we work to eliminate the space-fear alone, we may remedy that particular out-cropping; but the underlying condition will still be there to crop out in some other way. My point is that, by working to eliminate the general fear rather than the specific manifestation, we do away with the whole condition so that there is no fear to be focussed on open spaces, tunnels, audiences, or any thing else.
It often happens, however, that the thought that he must do any work himself is terrifying to the patient at first. In such cases I drop for the moment the idea of explanation and assure him that, until he feels like it, he need do nothing for himself—that I will do it all; and I follow out for an interview or two the method of using dogmatic statements without explanation. Then as he improves I explain more fully and lead the patient into doing his part; and when he is strong enough, I call his attention to the fact that for some time he has really been doing the work. I show him then that, after all, complete recovery must be brought about by himself; but I assure him again that I will stand by until such recovery is accomplished. In this way the patient arrives just as surely at permanent reconstruction and independence, but he is saved the unnecessary tenseness from real terror or resentment at having too much expected of him.
IV

With the foregoing general points in mind to guide him in possible modifications of the treatment for each patient, the instructor begins the process of systematic mental refitting. This work usually falls, I have found, into definite psychological steps; but the varying circumstances, temperaments, and conditions of each individual must be dealt with here also. The treatment is a series of progressive interviews, each meeting growing out of the preceding meeting; but any arbitrary plan for fitting certain points into certain interviews or even any fixed rule for the order in which these points shall be attempted is quite impossible. With some persons one point can be made at each meeting; with others it may be necessary to devote several interviews to the taking of one step; with still others one interview may cover several steps. I have in some instances even seen the complete change wrought by one long session into which the whole process of instruction was crowded.

The patient's attention must first be caught temporarily and his thoughts diverted from their habitual channels. Then a certain amount of interest and curiosity can be aroused by means of the new ideas which the instructor offers him. This interest and curiosity must then, in turn, be deepened into a desire on the patient's part to try out these new ideas and to prove them true; and the natural evolution of this desire will be his complete cooperation with the instructor.

But if he hopes ever to get the kind of attention which will lead to reconstruction, the instructor must arouse on the part of the patient a sub-conscious, or conscious, reaction which is favorable to him personally; and the moment to establish such a reaction is when he makes his first contact with the patient. This is the time, more than any other perhaps, when the latter should be convinced of the instructor's personal interest in his welfare. To this end I endeavor to make my reception cordial, unhurried, strong, and keenly interested.
It is, I feel, important that the instructor should so cultivate the habit of thinking only of the person before him that each patient will feel a perfect confidence in his undivided attention and interest.

Furthermore, the instructor should acquire the patient's inner and deeper attention at this first meeting. So often we think, because a person is physically present, gazing at us and listening to us or even answering questions, that we have his attention, when subsequent events show quite the contrary. It is the mental and not the physical attention that we want, for it is only through this that any active and permanent interest can be aroused.

An unexpected manner of approach does much to secure this kind of attention at the outset. Take, for instance, a person accustomed to harsh treatment and harrangue and criticism who is unconsciously expecting censure from me. To this man I show a quality of personal kindness and attention such as he has never thought of; and I explain to him how natural it was that he should have acquired the particular habits that are causing his trouble, I try to make him feel an understanding and a sincere sympathy on my part. On the other hand, with the successful man who is accustomed to dominate his office, his home, and his associates and who because of his position expects servility and soft words, I deal roughly. I analyze this man point by point, showing him exactly what are his shortcomings and why they are largely his own fault and how, in his present attitude of mind, he is a useless member of society.

With either type this approach so surprises the patient that for the moment it disconnects his thoughts from whatever subjects have been obsessing them; and in this way we get an effective hold on his attention. At the same time it tends to establish a footing of confidence between patient and instructor. In one case the unaccustomed kindness and sympathy create this feeling at once; even though it arouses the
patient's anger at first, commands a respect on his part for the instructor's honesty of purpose and so contributes to the same end.

The patient will very likely show at the outset a tendency to take the situation and run away with it; but of course he must never be allowed to do this. On the other hand, he must not feel that the instructor is doing it either, for if he gets this latter feeling he combats every suggestion—even the most obvious truth—or he readjusts his mental process to what he thinks the instructor would like it to be. Any of these attitudes is false and does not create the proper appetite in the sick man's mind for a true analysis of his trouble. Therefore, in spite of the fact that we want the patient to recognize his right to think for himself and his obligation eventually to conduct his life according to his own ideas, it is better if he can be brought to have a mental leaning towards the instructor during the treatment so that he will have the tendency to accept his leadership regarding matters in which he needs guidance.

It may seem best to have the patient begin talking at once; but usually I find that, just as a host or hostess puts a guest at ease on his entrance into the room, so the instructor should put his patient at ease by beginning the conversation. In this way he can also establish the tone of this and future interviews and begin at once to make headway towards readjustment.

For instance, after an exchange of a few commonplace remarks I usually begin somewhat as follows:

"You are not feeling very well, are you? (Let the patient answer.) You have made a good many explanations to yourself and have had a good many made to you as to what may be the matter with you. But what you want to know is what really is the
matter, don't you? ( Let the patient answer ) It is up to you and me to find that out. We, you and I have got to analize you. I do not mean criticize; I meam analyze you-dissect you-so that we may get at the exact truth. You will act in a double capacity; you are to be patient and physician at the same time. What you and I want is to get you well. If we can get you free from fear, nervousness, depression, tenseness, ( name other negatives, including his well known symptoms ), we can give you peace of mind-and peace of mind will do wonders.

I purposely ask an occaisional question to make sure that the patient is blending with and following my line of thought. It is necessary, moreover, in order to establish his confidence in the instructor's understanding of hisb difficulty, to let him rehearse his own idea of his condition quite fully. I avoid here expressing anything in the nature of a definite diagnosis, for in my opinion a psychological diagnosis at this period is a pure guess and if subsequent events prove one's guess to have been wrong the patient's faith is shattered irrevocably. It is well however to tell the patient at this time that, whatever may be his particular trouble, he may reasonably expect to get well, and then to explain to him how he and yhe instructor are to study out certain fundamental psychological laws, the knowledge of which will enable them to get to the bottom of that trouble.

When once he sees he has the patient's real confidence, the instructor, may begin the questioning which is necessary for an intelligent analysis of the difficulty. This point of confidence may be reached in the first interview, or it may be necessary to wait for several meetings; but the instructor must be perfectly sure of this feeling on the part of the patient before he begins to question him, for without it the patient is going to answer to satisfy his ideas of expediency and not his idea of truth.
When I feel sure that we are ready, I begin with something on this order:

"We have all heard of mind reading. I do not know of anyone who can use it; at all events I cannot. But I must know what is going through your mind and what is going through in order to help you. If I were a mind reader I would not bother you; as it is, I must rely on you to tell me what I cannot read. There is plenty of time and I will help you at first with questions. Remember these interviews are confidential and mutually so. Before we get through I shall have to reveal as much about myself as you do about yourself. Now tell me, for instance, what you are thinking of at this moment."

It usually takes some time to get the patient to state exactly what he is thinking of at that given moment. But after he has acquired the ability to so focus and express in words his present thoughts, I lead him through the same mental exercise to his thoughts of a few hours before, then to a few days before, then back a few weeks, then a few months, then a few years, and so back to his earliest memories.

This exercise tends to train the patient's mind to respond to questioning and to cooperate in the method. It develops a flexibility and a certain facility of memory which enable him to think back more clearly and to remember more easily the happenings and mental conflicts of childhood so that in this way he can do his part in his own analysis. Also it contributes effectively to attracting and holding his attention. He concentrates upon his own thoughts from a new angle; he watches his own mental process impersonally, for perhaps the first time; and quite unconsciously he is interested, for the moment at least, in this rather than in the thoughts he has been dwelling on.

Now before patient and instructor can work together at all effectively the patient must be somewhat relaxed physically and mentally, and their two minds must be working at the same speed. The patient's thoughts will probably at first be either racing
or lagging. As he has the sick mind he cannot be expected to take the initiative in making an adjustment to the instructors speed, so the instructor must be the mental acrobat and do the adjusting. If the patient's mind is working slowly, he must adapt his own mental pace to the sick mind until he can bring that up to normal. Or in the opposite case, he must catch the speed of the patient's mind and slowly bring it down and direct it in its course as a mounted police might seize and direct and bring to a quiet walk a runaway horse.

When I find the racing mind, I use the following exercise to relieve it. I begin in a conversational manner, as I do every interview, asking questions and receiving answers for the purpose of reviving the atmosphere and attitude which have been gained in our previous meetings. Then I lead the conversation naturally into something like this:

"Before we take up any new matters, let us see if we cannot get your thoughts quiet. Let that brain work a little slower—rest your head against the back of the chair—and close your eyes. Now put out of your mind all thoughts of anything outside of this room for two minutes by the watch. I will keep time. You cannot make any real plans in two minutes. You cannot get out of trouble or into trouble in here in two minutes. Nothing will happen to you in these two minutes but rest. So just stop thinking of anything outside this room, and get your thoughts down between you and me. (slight pause) I will tell you when the two minutes begin and end. (pause) To stop your brain racing we shall handle it as we would any rapidly moving object, starting with it at the speed it is going and gradually pulling it down slower and slower. Now we will start the two minute period, and for our rapidly moving object we will think of a boat.

"Get a picture in your mind of sailing rapidly down a harbor on a beautiful summer day, with a stiff breeze. We are going towards an island in the distance—an island with a hill
and trees. We are flying over the waves—the spray is dashing over the bow—the boat keeling to the wind. Now we overtake the boat ahead—Now we are passing it—leaving it astern. We are still going towards the island—the spray dashing over the bow. Now we overtaking the next boat—now passing it—now leaving it astern. Now there are no boats between us and the island, and we are still going on towards that island faster and faster and faster.

"Now we are comming around a point of land under the lee, where the wind is less, and the waves are less, and the boat is going less rapidly—less rapidly—and less rapidly; and the farther and farther and farther under the lee we go, the less rapidly and less rapidly the boat is moving. Now we are comming around another point of land into a miniature harbor that is protected by the hill and trees, and there is no wind, and there are no waves. We lower the sail, and the boat is comming slowly in under its own momentum—slower—and slower—and slower—and now—it—is—barely—moving. We throw over the anchor—the boat slowly comes about, and we are at anchor—and at rest—and at peace—and—we—take—a—long—sigh—of—mental—contentment. (PAUSE)

"We get out of the big boat into the little boat—and skull ashore—and pull the little boat up behind us on the beach—and go over under the shadow of the trees—and lie down upon the soft ground beneath. There you rest—completely relaxed—shoulders and spine and all—and quietly watch the birds in the nest above you and the clouds in the sky beyond."

If this exercise is sucessful the patient is fairly quiet, and I explain that I wish him to use the same picture between now and our next interview whenever his mind shows a tendency to race. Now I explain that I do not ask him to believe in this method of treatment, but I do ask him to be sure that he does not disbelieve, and I want him to note the coincidence that to some degree—even after this short exercise—there is less
nervousness, and fear and depression are less acute. I explain further that after all I am simply carrying out with adults the method which all mothers intuitively use with their frightened babies. A mother puts her child's body at rest by taking it in her arms; she quiets its mind by saying "csh-csh-csh-csh"; and when the child is fairly quiet, she changes its point of attention by supplying a new interest in, for instance, the birds building their nest outside the window. In our exercise the body is at rest in the chair; the picture of the boat journey takes the place of the "csh"; and the island ahead where we eventually arrive and rest changes and holds the patient's point of attention by furnishing for the time being a new interest.

Any story such as this boat story is in itself one effective method of indirectly relaxing the patient. The man with racing thoughts is not usually ready for a direct relaxing exercise; but in listening to the instructor's voice and in following the description he is giving the patient forgets himself to some extent and accordingly lets go his tenseness to that extent. Also the fact that his racing thoughts can be quieted and the simple explanation of how this is done are of distinct interest to him.

Discussions on matters the patient has been mulling over do not have any real interest for him. They hold his attention, and he will talk or think of them incessantly; but no deep interest sufficient to change his quality of thought can be aroused by any angle given to these old ideas. So the instructor, while he speaks of them sufficiently to satisfy the patient that he knows what the latter is worrying about, must lead him away as dexterously as is possible from this "vicious circle of neurasthenia." He must frankly change the patient's point of attention and then illuminate the new point which he offers him so that it becomes a matter of pertinent and absorbing interest.
The direct relaxing exercise is a method which I have found successful in accomplishing just this purpose. The experience of relaxing constitutes in itself a telling factor of the new interest; the new ideas which the patient is given during this exercise fill his thought for the moment; and together they render his mind receptive to further illumination.

For this exercise I proceed practically as follows;

"Now a little later I am going to take up with you more fully these matters that you are speaking of (calling them by name); but for the moment I want to speak of other matters, which may seem to you irrelevant but which, later on, you will find do in reality cross-section your difficulties.

"You know I can go to sleep to-night at ten o'clock and wake up to-morrow morning at half-past four, or half-past five, or a quarter past six, just as I wish. If you cannot do this yourself, you have known someone who could. Now what does this mean? It meant that six and a half hours or seven and a quarter hours after we have told our body to do a certain thing, that body, without any conscious volition on our part, will proceed to carry out the instructions given, it some hours before.

"We have applied these principle to what we call WAKING UP. If it will act in waking up it is reasonable to suppose that the same quality of mental attitude which will make the body open its eyes may create some other involuntary reaction, and if it will do this we are perhaps working with a definite function which we have never considered before, and it may be of great value to develop such a power to a point of practical application.

"We know that swimming is all in the head. That is to say, when a man thinks he can swim, he swims, and when he thinks he cannot, he sinks. By a certain quality of thought, therefore, he starts some causation which either floats or sinks his own weight. We know, too, that a certain kind of thought will chase
the blood to the face and another kind of thought will take the blood out of the face. Or let one be as hungry as may be and let a sudden, shocking, disagreeable thought come into his mind, and his appetite immediately vanishes and a condition of nervousness is noticed. This nervousness, therefore, has been induced by a certain quality of thought. If a certain quality of thought will induce nervousness, it is reasonable to assume that a certain quality of thought will reduce nervousness; and if these and other phenomena can happen unintentionally, it is also reasonable to experiment to see if they can be deliberately induced. This from now on, is what we want to practice doing.

"Now clinch your fist. (Pause) You realize that it is clinched because you thought it clinched. Now think your arm straightened out and rigid; now think your fist-your wrist relaxed-and your arm relaxed. Were you not conscious, as you changed from the tense to the relaxed muscles, of a different feeling in your mind also-a different quality of thought? Now think your shoulders tense; now think them relaxed; now think your spine tense; now think it relaxed all the way down. It is no more of a phenomenon for your spine to relax all the way down in response to thought than it is for your arm to stiffen in response to thought.

"I was talking to a friend of mine some time ago. He lives in Tacoma, Washington; is forty-three years old; has a wife and three children. He has always been liked by every one; all the people in the neighborhood have gone to him for advice; he will put himself out for any one, is generous to a fault, and is always cheerful and confident although he was in debt for years. For the last five years, however, he has made good in business; he has paid off his indebtedness and now has money in the bank, owns property, has an automobile, and is able to give his family all they need. People still turn to him for advice, and he is able to help them more than ever. Every one wants him around; he is a good singer, a good mixer, and a generally good fellow.
"You have a pretty good idea of what kind of fellow this is, haven't you? (Yes, is usually the answer.) Yet you have not thought whether he is tall or thin, bald or with flowing hair, has blue eyes or brown—in fact, you have not thought of the physical man at all, have you? (The patient invariably answers; "No.") Still you have a definite idea of the man? (Yes I am giving this example to illustrate to you how, when we think of a person who is described to us, we just naturally think of something else besides the chemicals of flesh and blood called body.

"It is this other thing—different from the body—which is sick with you, and it makes the body sick. This thing which I have in mind—this life force—or psychic force—or personality—or whatever name you may wish to give it—is the you by which right of eminent domain should control your body and your mind but which, for causes we are trying to locate, has lost its position of control in your life.

"To restore this condition we want to induce a condition of physical and mental relaxation. Under this relaxation, physical conditions will be relegated automatically to the outer rim of your consciousness so that the realization of your personality may take the center and you may again direct your body and your mind normally and effectively.

"Now do not forget that this power we are after is you. It is you who makes the arm move in the air. It is you who makes the body sit up and sit down. It is you who makes the feet walk. It is you who makes the thoughts go to the floor, the ceiling, or the window. It is you who control the body and the mind, for the moment at least; and if you can do this for the moment, you can cultivate this momentary power so that it will become permanent and automatic. Now your body and mind are all tied up in a knot, and we want them to be untied; so I am going to show you how to untie or relax them. We will take a little exercise in relaxing now.
"Rest where you are and close your eyes so that you can quietly hold your thoughts on what we are going to do. Now just think your shoulders relaxed—don't think then stiffened—think them relaxed; and your responsibility is over when you have thought of your shoulders as relaxed. Now think of your spine as relaxed—from the back of your neck all the way down—think of it as being relaxed. Think of the muscles of the back and of the chest and of the abdomen—as being relaxed—and the legs all the way down—relaxed—and the ankles, and the feet, and the toes, even—move the toes and feel that they are relaxed. Now think of the arms—all the way down—as relaxed—and the wrists and hands and fingers— and now the cords of the back of the neck and the throat—the jaw muscles—(don't clinch the teeth)—the face—and the forehead—and the mind. Just let the thoughts drop as if they were feathers floating down-down-down. (Pause) Just let the chair (or bed) hold you up (Pause) and now (Pause) rest."

When I am sure that the patient is really quiet, I explain the effect of relaxation to him in this way:

"Your nervousness is less just to the extent that you are now relaxed, and the same is true of your fear and depression. It is not that you think these feelings are less or that you are credulous and believe they are less because I say so. Under this relaxation you are functioning more normally in every way, and the more normal you get the more nervousness and fear and worry and irritability pass away. You do not just think that you slept last night; you did sleep last night. Sleep is a phenomenon that follows a certain attitude of mind and body, and so it is with the phenomenon following an attitude of relaxation. As relaxation progresses, tenseness is released and nervousness and fear and worry begin to pass away."

Following this explanation, I instruct the patient to carry out this simple method of relaxation when he goes to sleep
at night and when he awakens in the morning and at times during the day if he feels tense and nervous. I warn him not to overdo this exercise however, for I have found from experience that patients sometimes become so interested at first that they work the exercises over-time with the natural reaction of soon becoming bored.

As soon as possible, sometimes at the beginning of the treatment, I begin to combine with the personal interviews a line of simple reading which is so chosen that the "man of the street" may understand it and benifit by it. I use also the method of having the patient write down, for five minutes at a given hour each day, his exact thoughts. I explain to him that he is not to write what he thinks I would like to have but what he is really thinking of at that time—whether it be of drink or sex or music or murder. I feel that it is important, in order to get at just what is in his mind, that he should be assured that his daily writing will be destroyed immediately after the instructor has read it. This diary method enables the instructor to become familiar with the patient's mental process—with the reasons prompting his philosophy, and it often brings out many hidden and important thoughts. It also enables him to learn the patient's mental language, as it were, so that he can make himself better understood.
When we have brought the patient to the point where he really wants to get well, there is usually such a blending and understanding between him and the instructor that they are working as one. The patient is not only interested and willing to cooperate; he is eager to learn and to practice more of this method in the hope of securing permanent results. He believes now, because of the actual results of the meetings so far, that he will entirely recover his health and normality; and this confidence has diffused his whole mind with hope—has colored every thought with new light. His values on life are beginning to be readjusted; new desires are coming into play; and he is changing from a pessimist to an optimist.

Subsequent interviews are for the purpose of deepening and extending and making permanent these changes; and they should cover a period of a year—the interval between them being extended as time goes on.

An important indication of the patient's recovery, which is revealed in his daily notes and in his conversation as these interviews progress, is the improvement in his thinking process. He comes gradually to distinguish almost unconsciously between true and false thinking, until he learns to recognize any reasoning which does not ring true so promptly that his old "false philosophy" is in evidence less and less frequently.

Gradually he learns his true relation to the forces of life, and so he comes to realize that now he can become in reality whatever he has hoped in the most idealistic moments of his youth. He knows that he is in fact "the captain of his soul" and in a new self-confidence—in the glorious certainty that he need never fail again—he finds perfect freedom and happiness.
ILLUSTRATIVE CASES
ILLUSTRATIVE CASES

COMMENT

In the previous pages I have discussed my observations and methods from the angle of successful reactions only, because it is almost entirely upon these that my ideas are based. Unsuccessful cases, of which there have been nearly one-third, are purposely dismissed with the following recognition and classification.

In my experience the educational value of failures has been almost nil. Very little reliable information can be gleaned from the unsuccessful case. He is seen only when he comes back at periods of remorse or depression; and practically all our knowledge of his reactions must come from his own statements, which may or may not be true.

It is easy to see in medicine or surgery how much constructive knowledge can be gained through mistakes; but in this work we are dealing with a much more elusive proposition, and I have found that a method which fails with one patient is not at all sure to fail with the next. Because one man does not respond to a given procedure in this work is no sign that that procedure may not be worth trying with the next man. On the other hand, certain methods have always been found to bring
favorable results; and every favorable reaction is worth noting, because any method which has worked successfully with one individual has a chance of proving effective with another.

The reason for failure is in every case the same. I fail when I am unable to get a man's attention sufficiently to impress upon him the need for prompt relaxation and for the immediate elimination of wrong tendencies at their very inception. No one can help himself to complete a permanent recovery until he realizes that his waves of drinking or depression or irritation, or whatever the condition may be, begin with and grow out of a barely perceptible tenseness and its resulting tendency to a negative condition and that these waves can be avoided only through promptly relaxing that tenseness and dispelling that tendency.

I fail to get this necessary attention either because the patient has an innate lack of desire to change his life and ideas and no spiritual element out of which to build such a desire, or because he has an actual mental defect, or because his illness is so deep-seated and his spiritual side so buried that the stimulus dynamic enough to reach and arouse him or the time and personal attention necessary to get through to him have been lacking.

The first classes I have found hopeless. The last-the hard shelled type-has suggested no practical constructive method. The possibility of success through the described method would call for such constant personal attention and authority that it would become impractical if one considered taking any other patient.

The successful case, however, is under close observation, and his mental process and reactions can be watched first hand. Thus it has been through successful cases that I have learned most, and it is in these only that the working of the treatment
are really demonstrated. Therefore in the following report, which is intended to illustrate the application of the method in individual cases of different types, I have described successful cases only.
THE CASE OF A

The A's, a man, wife, and two children, had been sustained for several years by a wellknown relief organization which, because of the native intelligence of the man and the brave struggle of the wife, had made vigorous though futile attempts to put him on his feet and prevent the breaking up of the family.

A, had seen actual service in the Spanish War and had been wounded in action. He returned a hero and became the center of attraction to many of his friends who gathered about him at the bar and at the table to hear his experiences and to show their appreciation by treating him. For two years or more this idle drinking life continued, leaving A an alcoholic and his family a burden, first on the battery to which he belonged, next on his friends and acquaintances, and finally upon charity.

The long suffering Relief Organization at last decided that the situation was no longer tenable; but before taking definite action to arrange the final break, asked me if I would disregard my rule and call upon A., as he could not be induced to come to me.

We met on neutral ground at a settlement house. He told me that his only reason for coming was to give me "a strong touch" for twenty dollars.

When we were alone, I said to him; "You know what this meeting is for, and I suppose that you expect me to ask you to give up your drinking, to sign a pledge, or something of that sort. I may discuss drinking with you some time, but not to-night. What I want to call to your attention 
tonight is that you are tied up in a knot-physically and mentally. You are worried; you cannot sleep, cannot concentrate, could not hold a job if you had one, and for that reason really do not want one. You are sore with yourself and with the world; you have lost confidence with in yourself and therefore you have lost confidence in humanity; and there are a lot of other things the matter with you that you do not know about.

"If you were going to teach a child to swim, you would not, if you were wise, continue while the child was rigid from fear or from any kind of protest. In my opinion it is just as unwise to try to teach an adult who is physically rigid from fear or protest to swim or to do anything else.

Every one is a potential teacher. Your little boy could teach me where you live. You could teach me about the conditions among soldiers under fire. You could teach me a good many interesting ways of the East Side—about the dangerous dives and about the sporty places. I don't imagine there is much about the East Side that you do not know. You can teach me these things, and still you do not pretend to know it all; and so I have a few things I can teach you, but I do not pretend to know it all.

"What I wish to teach you is how to let go of your tense physical, mental, and nervous conditions—how to let these conditions pass away from you that your efficiency may increase and logical success and happiness follow. I want to show you how to relax without becoming limp. You may think you know how to relax; but you probably do not. There is not one person who knows anything about it until he is shown.

"Do not be afraid that this relaxing exercise will take us away from your difficulties. We shall reach them, but not merely for the purpose of helping them temporarily. We are going to dispel them forever; and we shall not be in a position to carry this out until you have learned what relaxing is. Do you care to
try this relaxing? You need not unless you wish to."

The reply was, "Yes."

"All right. Get into an easy position with both feet on the floor. Let your arms rest on the arms of the chair and rest your head back. Close your eyes so that your thoughts will not wander and put out of your mind all thoughts of anything outside of this room. (Pause)

"Now bear in mind that your arms and legs and body move in response to thought. You think of your arms as stiffened and it stiffens. Your body gets up and sits down according to your thought. If you tell your feet to walk, they do so. If you tell your thoughts to go to the floor or the ceiling or the window, they do so. If you tell your shoulders to become rigid, they do so; and if you tell your spine to become relaxed, it obeys you. It is no more of a phenomenon for your spine to relax all the way down in response to a thought than it is for your arm to stiffen all the way down.

"Now think of your shoulders as stiffened, for instance; now think of them as relaxed. Now think of your spine as relaxed all the way down - the muscles of the back relaxed. Now think of the muscles of the chest and of the abdomen as being relaxed - and the legs all the way down - and the ankles - relaxed - and the feet - relaxed. Think of the arms all the way down - the wrists - the hands - and fingers relaxed - just as the cells of the body were opening out. Think of the cords in the back of the neck as relaxed. Your responsibility is over when you think of them as relaxed.

"You of course will not suddenly relax the first time, but you will get some effect. Now think of the throat as relaxed - and the jaw muscles - and the face and the forehead - relaxed. Don't clinch the teeth - let the tongue lie quietly on the floor of the mouth. Now let the thoughts just drop as if they were grain falling down through a hopper (pause) and now rest - and listen to me.
"If your thoughts wander off from what I am saying, bring them back quietly to the main road as you would bring back sheep you were driving if they wandered from the path. You would not violently rush them back. So with your thoughts - don't bother if they seem to wander a little - simply guide them quietly back.

"Before you get through this evening, your nervousness and depression will be a great deal less and you will have learned of new laws which will certainly arouse your interest - laws which may be of practical use this very night. We shall deliberately work with the power which enables a person by assuming a certain mental attitude to dictate to his body that it shall wake at a given time the following morning and causes the body to obey directions later without any conscious volition on the part of the person. I can wake any time I wish by arranging for it in my mind the night before. If you cannot awaken in this manner, you know other people who can and therefore know it to be a fact that this can be done.

"Now if the body will respond to the instruction of "waking up" as we call it, it is reasonable to believe that if the same mental attitude is assumed it will respond to other instructions. If this proves to be the case, it is also reasonable to believe that we may possibly be working with a function which we have not consciously recognized before. We all know that by assuming a certain mental attitude we are able to swim. The man weighing two hundred pounds thinks he can swim, and he swims; he thinks he will sink and he sinks. Two hundred pounds is floated or sunk by a certain quality of thought. This is a point that we will take up at some future time and investigate.

"What I want to demonstrate to you tonight is this - that by thought you have relaxed your body and mind. You have relaxed your shoulders, your legs, ankles, feet - your arms and wrists, hands and fingers - the cords in your neck and
throat, your jaw muscles, your face, and forehead — and your thoughts. Just let go. Now you have relaxed or let go your physical and mental self with the result that your tenseness is less; and to the extent that you have released that tenseness, to that extent you are coordinating more normally. Your blood is circulating more freely; your brain is working more normally; fear and depression, irritability, and nervousness in general are passing away.

"It is not that you think that these feelings are passing away; they are passing. It is the phenomenon that follows relaxation just as the phenomenon of sleep follows a certain attitude of mind and body. It is not that you think that you slept last night; you did sleep last night; and it is equally true that your nervousness is actually passing away. To whatever extent you are now relaxed, to the same extent nervousness is passing away. It is not that you are credulous and that I am making an arbitrary statement which you accept. Results will show that you are less nervous and that the brood of troubles from nervousness will be distinctly less.

"I want you to note as a coincidence that tonight you will sleep better than you have been sleeping and that tomorrow you will be more hopeful and freer from all these negatives. I am calling your attention to these things that you may note the coincidence of their coming true. They would be true whether I called your attention to them or not; but the calling of your attention to them is for the purpose of giving you confidence in this method, that we may proceed to further steps to the end that not only will all desire for drink pass away but you will have found a new method of conducting life's battle.

"Because you have recognized a new function, or another sense perhaps, you will have a hope that you can handle life instead of having life handle you. If you sense this idea yourself — and you will if you are sure you are getting the results I predict from this method — then you are going to
have a new confidence in yourself; and that very confidence is going to build efficiency; efficiency is going to build success; and success is going to result in happiness enveloping you. For one never obtains happiness by going after it; happiness comes to us - envelops us. Happiness is a state of mind.

"To exercise this method properly we must change your point of attention from those things on which it has been riveted to this newly discovered function. What we wish to induce is a craving on your part to work, a craving to be sober, a craving to live a respectable, successful, and happy life. This craving must be as definite as thirst.

"You are at present expressing your impulses; and we wish you to continue to do so. We are not seeking supression but expression; for it is only through expression that a man can be free and can develop his efficiency and his life. There are impulses that a man obviously should not continue to express; but to concentrate upon those impulses for the purpose of supressing them only increases their activity. Surely the thing to do is to fill the mind with thoughts that can be expressed without calamity.

"One of the children in our family was sitting in front of the open fire in his nightgown just before going to bed. He murmured, starting in a low voice, "My knees are hot - my knees are hot - my knees are hot." Each time he said this more quickly and louder until his voice had reached a shriek and the tears were rolling down his face. Even the other children were impressed with his folly in not changing the condition which was causing his distress instead of holding his position and trying to supress the reaction. Now that in a sense is the matter with you. Your knees are hot, and you are still sitting up against the fire.
"I do not wish to impress you with a desire to stop anything; but I do wish to see you build up and bring about in yourself a new set of impulses, which will keep you so active in another direction and make you so successful that your present impulses will seem like counterfeit money. Then when the counterfeit impulses have been revealed to you as such, they will take their proper place and drop away out of your life. There will be no fighting temptation. No man ever fought temptation and won; the only way to win is to have no temptation, and the way to have no temptation is to "resist not evil." Don't waste time resisting; use your energies along new lines of thinking. Your old philosophy and wisdom have proved a failure.

"Now rest for a few moments in silence. Let yourself relax once more - from the top of the head right down all over the body - and realize that it is you who control the body and control the thoughts; for the body gets up and sits down and the arms and legs move at your bidding, and the thoughts go to the floor or the ceiling or the window at your bidding. You control the body and you control the thoughts for the moment, and if this control can exist for the moment it can be made to become perpetual.

"If so far these things interest you, think of tomorrow as a beginning - the first day of a new study, which, if this new study proves to be what I say it is, will be the first day of a new life. (Pause) Now rest."

Here I allowed two minutes of silence, and after the silent period I said to him:

"If you have gotten anything out of this interview we will not weaken it by talking it over now. I will go with you so that I may know where you live and call at your own house tomorrow night."
On the way home we said very little. I instructed him not to talk much to the family but to go right to bed.

At the second interview, on the following night, I called upon him in his three rooms back in the sixth story of an East Side tenement. He reported that he had gone to sleep the night before in a remarkably short time and he had had the best night's sleep for years; that he was so much calmer through the day and so much freer from irritability that he could hardly attribute the condition to coincidence; and that he had no desire for drink - which might be a coincidence, as he had not felt like going out but had stayed in the house all day and had done a lot of thinking.

After some talk I decided to have him go to bed and repeat the exercise of the previous night in bed. While A. was preparing for bed I talked with the wife, who of course was dumbly discouraged, had no confidence in his ability or desire to reform, no confidence in my method - which I outlined quickly - and no confidence in me.

I explained to her how the Chinese had plays that ran for days at a time and drew a picture of the actors practically living their assumed characters during the entire period. I asked her - as things could not be worse - if she would make believe for two weeks that we were in a play and that she was an actress. In the play the husband had been sick; the delirium of sickness had passed away; and he was now convalescing. He was supposed not to remember any of the events of the past and therefore was not to be censured for the past nor urged to take actions for the future. (I wished his actions to come quietly from himself, and hope to avoid friction which would throw the mind back into chaos.)

She thought all this sounded very silly and very foolish. She did not see why a man should be let off for his misdeeds without having a good talking to and be petted just because he
was a loafers and a drunkard. Besides, there had been a number of other people who had "prayed" with him and tried to reform him in this same way. She thought if he could be sent away and made to work good and hard and the money sent to her it would be better. What he really needed was somebody to come along and give him a good licking.

However, I finally induced her to be the leading lady in my play. And I want to say here she was a success; in fact, she filled the role to perfection and has from that day to this - six years and more.

After a little further talk with A., in which it was revealed that on the following day the landlord was to make vigorous demands and present just ultimatums, I repeated the exercises of the night before. After getting him to relax and summing up the points that had been made, I showed him how it was possible not only to relax the body and the mind but also to relax a tense situation.

The landlord would come the following day with a tone and manner supposed to be a sure receipt for getting blood out of a stone. A. was not to listen in detail to what he would say, but was to think back to the night before and the effect of relaxing upon his (A's) body and mind. This would give him a memory of relaxation if not the actual feeling; and if only the memory, the effect upon him would be one of calmness. This would allow him to reply to the landlord calmly, which in turn would have a calming effect on the latter. Passion and tenseness would be eliminated from the situation. The subject under discussion would then be whether the landlord felt there was a possibility of A's getting work and paying the overdue rent. There would be no conflict.

The following night I called again. The result with the landlord was what had been predicted. At first the calmness made him madder than ever; he took it for insolence. But A.
had himself in an attitude of real and not assumed calmness and therefore did not consider it beneath him to explain that he had started on a campaign of calmness, giving his reasons why and what he expected the result to be. The landlords reaction was all that was looked for; an extension of time was granted, and a friendly hope of success was expressed.

This third interview was a summing up of the two previous ones. We went over the difficulties in the situation, bringing out psychological points that had developed. We frankly accepted the fact that these points might very possibly be coincidences; but we noted however that there had been good sleep, a reviving appetite, practically no nervousness, no irritability, and still no desire for drink, and that there was a dawning feeling that it was possible for one to have a quiet, hopeful, and even happy mind in the face of unhappy conditions, and that this attitude of mind seemed to bring about a vision of ways and means of eliminating such negative conditions.

"If all this is really true," queried A.,"why won't it go further, and not only energize a man so that he will unearth a job but build up in him qualities that will create efficiency to hold and improve the job? But one thing," he said, "I am sure of. I shall never take another drink, for I shall never want to. Discouragement, depression, unhappiness, and all the former things I took a drink for, I can eliminate with this new idea."

The six years that have passed have proved that he was right.

It was very interesting to see how he used this new idea in his work. This was Thursday night; on Monday A. had a job at twelve dollars a week. At half-past three that afternoon he realized with a shock that he had been looking at the clock for half an hour wondering if the time to close would never come. This involuntary attitude on his part he recognized as a familiar one and realized that it must be eliminated. That night he relaxed and "suggested" to himself that on the
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following day he would have an actual craving for his work; and the result, or coincidence, was that this habit of watching the clock disappeared never to return. As he expressed it, As he expressed it, it was like putting a pin into a toy balloon.

The next step was the overcoming of irritability. His employer, who was himself irritable, would arouse A.'s anger, and while he never answered back, it was by a mighty effort. The blood was in his head; the bitterness of thought had an actually sickening reaction; and he realized that this was suppression. By the now familiar method he pursued this condition and almost immediately acquired the ability to relax to the situation when the employer began his tirades. He had the satisfaction before the end of the week of having the employer say, "You are doing your work well; don't take my gruff way too seriously; my bark is worse than my bite," and of finding in his pay-envelope on Saturday fifteen dollars instead of twelve.

A. is still working out this method. He is now at the head of an accounting department for a very large organization. He is receiving a salary of over four thousand a year. There have been some sickness, surgical operations, and other difficulties of life to meet; but they have all been met calmly and strongly. The whole family are now living in proper quarters and environment and are healthy and happy.
THE CASES OF B. AND C.

B. was thirty-eight years old, married, no children, an architect. He had been drinking since he was seventeen or eighteen. As usual, he first took beer to see what it tasted like; then took enough to get a "whiz"; then, at about twenty, increased the "whiz" by whisky. The "whizzes" themselves multiplied on ever increasing occasions, such as Saturday nights and celebrating the getting of good jobs, the winning of bets, and so forth, - until now he was intoxicated practically all the time.

His wife succeeded in having him sober up sufficiently to come and see me. His attitude was very friendly; he was frank about his drinking and also about his bewilderment at the results. This bewilderment proved to me that it was impossible for him to give up drinking without help, for while he had always felt that he could stop whenever he wished, actual results were proving that notwithstanding a deep desire on his part he was unable to do so.

My method with this man was psychologically the same as with A., and his reaction was somewhat similar, although a lack of fine mental caliber in the man made it impossible for him to achieve the same striking material success as A.

This case was interesting, however, because of certain physical symptoms which entirely disappeared under this method of treatment. The man was obviously very tense. He talked in a short, quick, snappy, metallic manner, bringing out each word
separately, so that his speech always reminded me of a chain of separate links. The movement of his arms was quick and mechanical, and he had a jerky, spasmodic, undirected way of using the left leg which gave him a limping walk. After the first relaxation and interview - which took about an hour and a half - he was much impressed when he noticed in walking out of the room that the limp had almost entirely disappeared. After the fourth meeting it had gone. By this time also the movement of the arms was natural, and the separate links of his speech had become like a connected chain. His whole being, in fact, seemed to co-ordinate and blend; and under this normal coordination the desire for drink passed away.

C. was fifty-one years old, a widower with three sons who had turned him out because of his drinking. A man who I had helped brought him to me one evening. He was sober but utterly discouraged and remorseful.

I asked my friend to stay outside while I had my preliminary talk with C. It was night and he was so very tired that he responded easily to relaxation which followed. It was probably the first time he had been thoroughly relaxed since he was a baby, and the result was that he went into a natural and restful sleep. I timed him and found that he slept for seven minutes.

He opened his eyes, gaped and stretched, and then looked at his left arm - which was still outstretched - with an expression of amazement. He then jumped from his chair; moved the arm up and down; open and shut the hand; took off his coat and put it on; called to his friend, who came in, and said, "look at this!"; and took off his coat and put it on again.

The friend, also with an expression of amazement, said, "What in the world has happened?"

C. answered, "This man has performed a miracle."
I had purposely said nothing up to this time as I wished the situation to develop under perfect freedom, but I now asked them to explain what had happened for I was in the dark. It seemed that the left arm had been partially paralyzed according to various diagnoses, and that C. had not only been unable to use it, but had always had to be assisted in dressing.

I explained to them that obviously this was not a case of true paralysis and gave them my theory of the condition being one of a purely functional nature which had disappeared under the treatment used.

Prompted by experience with other patients, I asked C. if the room we were in seemed to bbe the same one he had come into; and he replied, "Yes, but it looks different." I then explained that perhaps everything around him seemed clearer because his mind had become clearer, and asked him if he did not notice that the pictures showed more sharply against the wall and that the angles of the window frames and the piano were sharper and more distinct.

"Yes," he said eagerly, "that is true, and my whole body feels different and my limbs are freer."

I also suggested to him that on the following day he would notice the sky - line of the building where he had not noticed it before; that the branches of the trees would stand out clearly; and that upon a familiar walk he would see objects which he had never noticed before. On our next interview two days later he told me that these predictions had come true.

I kept track of this man for three years, and during that time the condition of the arm never returned.

It was this case which suggested to me an especial value, with patients who have any purely functional physical symptoms, in obtaining complete relaxation at the outset. At that time, had I known about the arm condition and had it been diagnosed as functional, I should have discussed the matter
with the patient before proceeding to any relaxation and have attempted to give him a rational explanation of how it would be possible for him to recover the use of his arm. But in this case nothing was said by either of us in regard to this condition, and the relief came without even the knowledge on my part that any such symptom had existed. Complete relaxation alone brought about the result which I had formerly thought could be induced only through psycho-analysis or suggestion. Since this experience I have worked upon the theory of inducing complete relaxation immediately whenever possible so as to eliminate any functional symptoms at the outset and leave a clear field for the psychological and re-educational work.

I offer this case, and the case of B. preceding, as suggestive of the peculiar value of this method in the treatment of war-strained men in whom physical conditions which are purely functional may exist. While only a small portion of my patients have shown conditions of this kind, my experience with these has been such that I am convinced of the practicability of using the same methods for the relief of corresponding conditions in war-strain.
THE CASE OF MRS. D.

Mrs. D. was fifty-three years old, an intelligent, talented woman, who had formerly been a singer in a high class opera troupe. Her husband had deserted her, and she had suffered much adversity, finally becoming confined to the house for two years by reason of her fear of going out. She was nervous and irritable to the last degree, could not sleep well, and had no appetite, suffered from pains in various parts of her body, and had always thought she had heart trouble, though her physician could find no organic difficulty of any kind.

She was prevailed upon one day to take a taxi and come to our rooms. Upon arriving in the hall where I came through to meet her, she wheeled on her heel and fell in what appeared to be an honest unconsciousness. After she revived we walked to my room, but she trembled and was so very unsteady that I thought she might fall again at any moment. She sank into a chair and was evidently in much fear and real pain. She held on to her side breathing short laboring breaths, and her face was pallid and distorted.

She kept her eyes closed and maintained a silence through the whole interview, but I learned from the woman who was present with her and from the physican's message that she suffered a great deal of pain and was in constant fear. Her companion explained that for years she had been afraid of open spaces, tunnels, elevated trains, crowded streets, railroad trains, and so forth, and that this had finally reached a point where she would not leave the house. These were the more definite points, but it was evident that she was in this condition of fear over anything upon which her mind was focussed.
She of course heard her own symptoms described by her companion on this first interview so that, although she had not spoken to me personally, she felt when I talked about her condition that I had at least an understanding of what she was going through. Nevertheless, I realized that she was very combative, and it did not take highly developed intuition to discover that her attitude was extremely disagreeable.

I held her attention by moving slowly about the room, opening a window, fixing the open fire, and doing a number of different, definite things, and occasionally speaking quietly to her. The result was that she relaxed somewhat under this indirect method and the general atmosphere of calm.

Then I said to her:

"Mrs. D., I am not going to tell you it is foolish for you to have these fears. The fact remains that you have them, and my purpose is to help you to get rid of them. Logically you know as well as I that nothing is going to hurt you in an open space such as the Common or the Public Garden; and you would so advise any other person suffering from the same fear. Notwithstanding this, you do fear, and this condition of fear is psychological and is just as much to be considered as though there were a logical reason for it.

"One cause for this mental reaction is the tenseness not only of your body but of your brain. You are all tied in a knot and you would feel much easier if you would let your shoulders lower. Don't keep them hunched up to your ears—just let them drop. That's it. Let your arms and wrists relax too, while I am talking to you. That's it; take it easy. I also wish you would not clinch the teeth. It keeps the muscles of the jaw and of the face tense; it affects the forehead and the mind itself. If you will just let those jaw muscles relax and let the forehead and the face relax, the blood will go out of the head to some extent, and you will find that your thoughts are quieter and slower."
"also to help the situation a little, won't you please take two or three deep breaths. If you have ever done any singing you will know what I mean - inhale through the nostrils a deep breath and exhale through the mouth. This deep breathing will help your nervousness; in fact, you will notice that the more nervous you get the shorter are your breaths and when you are in a panicky condition you are breathing way up in the throat - panting. Now once more take a deep breath and deliberately let yourself relax all over."

Here I repeated the relaxing treatment as with A. so far as the psychological steps went, and explained after she was somewhat relaxed and free from twitching:

"We have found in a great many cases that this relaxation brings about a certain coordination which reduces nervousness. The blood seems to circulate more normally; the mind seems to do less racing; and following this condition fears become somewhat less, and a great many times a new hope springs up that possibly one has found a method by which she can get some relief. As I say, this proves to be the case with many people who come here. It is possible that even this little relaxation may be of assistance to you - not just at this moment necessarily - but you may this evening feel a little calmer than you have been. Of course, you may be one of the people this method does not help; but I see no reason why you should not be one of the fortunate. So if you feel encouraged to do so I shall be very glad to have you come tomorrow morning, and we will try to get this relaxation down a little finer.

"There is one point that I want to advise you about. Do not try to overcome this fear by common-sense; you are going to get rid of it, but it is going to fade away; so if you feel like having a fear, go ahead and have it."

"Mrs. D. appeared the next morning; she did not faint but seemed to be just as trembling in her walk. She would answer occasionally in monosyllables, which was an improvement over
over the day before. To my question she gave me to understand very curtly that there had been no benefit whatever from yesterday's interview and that her coming to-day indicated neither hope in the method nor confidence in me personally. I explained to her that it would be a paradox if she were in her present condition and had confidence in anything or anybody. I had better results in relaxation at this interview; and she thought upon leaving that she might as well come every day for a while as long as she had started with the idea.

We kept to the relaxing and philosophizing for four more treatments. by this time she was coming to church on her bicycle. Curiously enough, she derived some confidence and courage from wheeling along the sidewalk this bicycle, which after a time she was able to ride. This was her own idea; and it was encouraging to me as it indicated that, notwithstanding her surface attitude of indifference, she was in reality making an effort.

On the fifth call I got her to walk out on the street with me a little way. On the sixth I went with her to the entrance of the Public Garden which was near the church. This nearly caused her collapse; but I assured her that she need never go in until she was willing and that she would never have to go any further than she wished, for it would do no good to walk through it a thousand times physically if she were not at ease mentally. We went to the entrance a number of times after this. By this time she was relaxing physically and mentally very well, she was sleeping better, was less irritable, and in many ways showed a distinct improvement. However, her face still had a peculiar pallor, and there was as yet no color in her lips.

My training at this point was that she might relax to her fears; and one day when we were talking about her theatrical experiences, we walked to the Public Garden again and
continued on through. When we had come out on the other side, I said, "You realize what you have done, do you?" She nodded and answered that she had not had any fear or panic while going through. I explained to her that I believed that this was due to the transfer of her point of attention to something so interesting that it was of much more value to her momentarily than the fear which she had been cultivating, and that I thought if she would directly or indirectly build up some interest to which she could shift her attention at will she would find it a great aid in relaxing mentally and in evaporating that fear which had so persistently clouded her mind.

From now on we tried the Garden walk, lengthening it each time. Occasionally it was unsuccessful, but on the whole we obtained better and better results, going further downtown until we arrived at the shopping district. There we would look at the shop windows or sometimes, while I stood at a given place in a store, Mrs. D. would go to some counter out of sight and make a purchase, coming back to find me.

Then one day when she was with me I remembered that I had an appointment to speak, and asked her to go with me. She accepted my invitation, but her courage failed when we got to the entrance of the elevated. However, she knew that I was late and that I could not leave her to go home alone, and upon being encouraged to relax in this situation she did so and rode in an elevated train for the first time in twelve years.

After this experience she developed very rapidly. There were certain definite streets which she dreaded, but upon one visit to these with me the complex disappeared. The hot weather began at this time. Formerly this had been a period of the most intense nervousness and fear; but now, while she felt the heat tremendously, she exercised the methods she had been practicing and the fear feeling was practically nil.
In the fall there was a change in her family arrangements, and it became necessary for her to conduct her own affairs—that is to keep the house, rent the rooms, and so forth, without any assistance from her family. She took this up quite naturally, and from that time on has improved in every way.

The pallor is gone from her cheeks and lips, and she looks years younger. She is apparently singularly free from fears and apprehensions for she has much that would worry the average person. Her attitude of chronic pessimism and antagonism has entirely disappeared. She now firmly believes that whatever she makes up her mind to will come about and that, this being the case, she can make for herself a life full of richness and happiness.
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