

Dr. Silkworth in Action c. 1947: A Nurse's Eyewitness Account

The bizarre early theories of Charles B. Towns: no longer used by Dr. Silkworth

Preliminary note from Glenn F. Chesnut: The reader needs to be strongly warned that a good many of the statements in A.A. histories about the medical treatment which Bill W. was given when he was admitted to Towns Hospital are still based on what is known about the bizarre early theories held by Charles B. Towns, the man who had founded the hospital in 1901, along with journal articles written by Dr. Alexander Lambert in 1909 and 1912, a physician whom Towns brought in to give medical credence to his strange ideas. The original Towns-Lambert treatment was quite appalling: every hour, day and night, for fifty hours (that is, for a little over two days) the patient was given a mixture of belladonna, henbane, and prickly ash. Every twelve hours, the patient was given carthartics (medicines that accelerate defecation), and after abundant stools were being produced, castor oil was administered to completely clean out the intestinal tract. The doctor gave the patient very small amounts of the belladonna mixture until the first symptoms of belladonna poisoning began to appear, that is, "when the face becomes flushed, the throat dry, and the pupils of the eye dilated." The doctor then stopped the belladonna until the symptoms had disappeared, then began giving the belladonna again until the symptoms reappeared, in an endless cycle through the first fifty hours.

But Bill W.'s stay at Towns (when he had the vision of light) was 1934, a whole generation later. Towns' theories had now fallen out of popularity, Lambert had broken his association with Towns, and a totally new figure, Dr. William Duncan Silkworth, was now the hospital's medical director. We have two good descriptions of the kind of treatment that Silkworth started administering once he was in charge. The one which follows comes from a nurse who worked for him from 1947-1951. Then at the end of this article, we have put a summary of the doctor's own account of his method, given in William D. Silkworth, "Reclamation of the Alcoholic," *Medical Record* (April 21, 1937), available online at <http://www.aa-nia-dist11.org/Documents/silk.pdf>.

“I’m a Nurse in an Alcoholic Ward”

Anonymous

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AA History Lovers Message #938 (April 14, 2003)
from Jim Blair <jblair@videotron.ca>
<http://health.groups.yahoo.com/group/AAHistoryLovers/message/938>

The author—a onetime alcoholic—has nursed 5,000 drunks through the fading hours of their most spectacular sprees. Here is what she has faced in salvaging doctors, lawyers, ministers, priests, housewives and stenographers from drink and the devil.

A redheaded woman in a mess is really a mess, and five years ago I was just that. Like well over 100,000 others, I found my way to sobriety through Alcoholics Anonymous. AA says that if you want to stay sober you have to help somebody else get sober.

Since I was a nurse, it seemed logical that the best way to meet this requirement would be to find a job in an alcoholic ward.

That’s how it happens that during the past five years I’ve nursed more than 5000 alcoholics through the fading hours of their most spectacular sprees, in the AA ward of Knickerbocker Hospital in New York City. Helping other alcoholics to get well has become my life work

The origin of our ward is closely connected with the origin of AA itself. AA was founded in 1935. By 1939 it was evident that, though the movement was reaching a pitifully small percentage of the alcoholics who needed help, it was nevertheless achieving greater success than anything else ever had. Sufferers flocked to AA by the hundreds, many of them needing immediate medical treatment. The AA program of rehabilitation is based on understanding,

friendliness, honesty and faith--all things requiring maximum application of the mental and moral faculties. Many desperate drunks who wanted AA could never stay sober long enough to do the necessary clear thinking.

At this point a great team—the AA founders "Bill," a New York broker, and "Doctor Bob," an Akron physician—stepped forward with an idea. Why not a place where sick alcoholics could be sobered up under expert care and at the same time gain a foothold in AA? Private-hospital officials, conditioned to believe that drunks could mean only pandemonium, were chary. Then, in 1939, such a ward, of eight beds, was established at St. Thomas Hospital, in Akron. In 1945, Knickerbocker, a private general hospital with 200 beds and a forward-looking management, agreed to open its doors, and thus the first AA ward in the East was born. The third floor of one wing, with a capacity of nineteen beds, was given over to the experiment.

The ward's success surpassed its backers' hopes. AA volunteers are on round-the-clock duty, ready to discuss the temptations and techniques of the life of sobriety. Half our patients, we estimate, go out from Knickerbocker into immediately successful AA lives, and two thirds eventually find their way to recovery

I'll never forget my first day on duty. I spotted a wistful-looking little man with a red face and blue eyes waiting outside the ward. He was alone, and I knew that no patient could be admitted to this particular ward unless accompanied by a member of AA. Eager to demonstrate my efficiency, I said brightly, "Don't worry, we'll take care of you. Where's your sponsor?"

I took his bag and was about to remove his hat when he turned kindly old eyes up at me and said, quietly, "Relax, young lady; I'm Doctor Silkworth."

At that moment I wanted to sink through the three floors to the basement and on down into bedrock. Dr. W. D. Silkworth was widely known as one of AA's first medical advisers. Besides, he was the doctor in charge of the ward! Since then I've learned to tell the difference between doctor and patient, and possibly a few other

things. You can't work with a man like Doctor Silkworth—as I did until last year—when, at the age of seventy-eight, he died—without learning something

On entry, our patients are a beaten and penitent lot. They've been picked up by AA's wherever they happened to be when they called for help Nobody is ever brought to our ward against his will. Indeed, they're given to understand by their sponsors that they're lucky to get in. We have no repeaters—patients are admitted once, and only once. Sponsors deliver them, their suitcases and eighty-five dollars in cash in advance, then leave. Now begins the five-day course.

Once signed in, the patient's first two days are the most worrisome. It is in this period that deep depressions due to remorse are most likely to occur. The ward came near being discontinued during its first month, when a depressed patient found his way to an unbarred window and jumped three floors to his death. AA supporters quickly passed the hat, raising \$1000 for strong steel screens. We've never had another attempted suicide. No patient is admitted who shows signs of oncoming delirium tremens or convulsions—these are sent to a municipal hospital equipped to handle disturbed patients—but sometimes the doctors guess wrong. Last year, among 1000 patients, we were caught with two cases of convulsions and a dozen of DT's.

Delirium tremens must be sheer hell. Its onset is marked by acute nervousness. First come the auditory hallucinations; then, usually the visual. The patient hears his name being called, or a violent argument in progress, or non-existent loud music. Then he begins to see things. I've had patients ask me in all seriousness to watch where I stepped so I wouldn't squash the strawberries. One demanded to know how the geese got into his room. These visions are sometimes, but not always, frightening. The strawberry and goose people were quite calm about what they saw. Heaven knows what fiends and horrors they're seeing when they scream. The worst case I ever saw was a man who was convinced he was being run down by a train. Most patients, during DT's, have moments when they know that

what they're seeing is not real—and times when they're completely convinced of its reality.

No one condemns the alcoholic as he, when the remorse is on, condemns himself. We give them vitamins to re-establish nutritional balance, fruit juices to combat dehydration, and bromides and belladonna for jagged nerves. By the third day they're beginning to take an interest in the world again, and that's where Duffy's Tavern gets in its wonderful work. (Duffy's Tavern is a kind of clubroom in the men's division, where patients meet and talk.)

The five days are planned as a chain of healing that will lead back into a life of sober usefulness. The first couple of days there's nothing much to do but medicate and feed them and maintain an attitude of good-natured understanding

We also make a good sport of treatment with the B-complex needle. This is inserted in the part of the anatomy scientifically known as the gluteus maximus. When I come into Duffy's with the needles, calling, "All right, boys, bottoms up!" I can always count on an assortment of grunts, groans, grouses—and laughs.

On the third day, patients are encouraged to move around. In the women's ward, there's visiting from room to room and talks with AA's from the outside; and, for the men, socializing in Duffy's Tavern. The patient begins to realize he's not alone in his plight. If others can endure it, he guesses that he can too. The fog begins to clear, and memory, at least partly, returns

The fifth and final day of our treatment brings its own special hazards. The patient's head is clear, his strength has returned and he has found new and understanding friends. Now he must face the world outside, the mess he has himself created. He slept poorly the night before. This uneasiness is so common that we even have a fancy name for it—"predischARGE tension" Discharge day is the despair of many alcoholic wards. To many patients, the shambles outside seems beyond solution--they streak to the nearest bar, the deadly cycle begins all over again, and much good work is undone.

Our ward takes certain precautions. Nobody can be discharged unless he has been signed out, in person, by his sponsor and has

been safely conducted to his home. He's encouraged to attend the weekly meetings of his local AA group. There he learns that other men and women of his community—some of whom he knows and respects—have somehow found the courage to deal with situations at least as disastrous as his own. He digs in. In almost exactly half the cases, he's back in a few months as an AA volunteer, ready to help others back along the path to sobriety.

Dr. Silkworth's own account of his method as given in 1937

The following is a summary of the doctor's own account of his method, given in William D. Silkworth, "Reclamation of the Alcoholic," *Medical Record* (April 21, 1937), available online at <http://www.aa-nia-dist11.org/Documents/silk.pdf>.

The first phase of the Silkworth treatment was as follows, and even this was used only for those who were at an acute crisis stage where delirium tremens was imminent, and was used only for as long as long as the patient seemed to still be in danger:

1. About an ounce of alcohol every four hours, with an occasional ounce in between if symptoms are growing worse.
2. "To relieve the pressure in the brain and spinal cord (unless spinal puncture is contemplated), dehydration must be begun at once" by using a cathartic (a substance that accelerates defecation) and a purgative (a laxative to loosen the stool and ease defecation). If there is enlargement of the liver, high colonic irrigations of warm saline should be used instead. Dehydration is continued for from three to four days.
3. Sleep must be induced. Morphine should be avoided if at all possible. And what must be especially avoided is a combination of alcohol and sedative which results in a state of mental confusion leading to hallucinosis. Sedatives should be "given in moderation ... not enough to cause a sudden 'knock-out.'"
4. "On about the fourth day the alcohol can be entirely withdrawn, as by this time the crisis has been avoided or safely passed through and, hence, the patient is in the second phase of the treatment."

Silkworth did not say what kind of sedatives he used, except to note that he almost never used morphine, and that he administered only the minimum amount necessarily to calm the patient down and make the patient drowsy so he could gently drift off to sleep. You were not trying to knock the patient out, he warned, and you wanted to avoid anything that would produce mental confusion or hallucinations.

In my own reading of the literature from that period, the commonest sedatives used to calm down alcoholics were paraldehyde, barbiturates (colloquially called goofballs), bromides, chloral hydrate (colloquially called a Mickey or Mickey Finn), and codeine. Belladonna was normally spoken of as a “sedative” only in certain specialized cases (such as whooping cough and Parkinson’s disease). Nevertheless, at Knickerbocker Hospital in New York City (where Dr. Silkworth was also involved), even as late as 1952, we read of alcoholics who showed signs of going into delirium tremens being given “bromides and belladonna for [their] jagged nerves.”

But even if Dr. Silkworth was still giving some of his patients belladonna (those who showed symptoms of going into violent delirium tremens) the dosage could not have been very high. Belladonna was, quite literally, a standard ingredient in witch’s brews, and was not something that you gave people to make them gently and pleasantly drowsy, so they could drift off to sleep. Giving people belladonna could sometimes knock them out for a while, but the delirium it produced was even more apt to make them disruptive and uncontrollable. They would often compulsively repeat bizarre actions, and frequently could not even be made to sit still. This was what Dr. Silkworth was trying to prevent.

The object, as Silkworth explained in his 1937 article, was to *normalize* the alcoholics’ mind and mood.