
Chapter 17, "Lackland: the Fully Developed Treatment Program," in William E. Swegan with Glenn F. Chesnut, Ph.D., *The Psychology of Alcoholism*, Hindsfoot Foundation Series on Alcoholics Anonymous History (Bloomington, Indiana: iUniverse, 2011).

Lackland: the Fully Developed Treatment Program

by William E. Swegan

When proposals are brought to Colonels and Generals to create fully developed alcoholism treatment programs on military bases, a very frequent response is to say that it would cost too much. But this is not true. A good rehabilitation system saves far more money than it costs to run it. With the aid of a cooperative psychiatrist (who was not an alcoholic himself) I put together a program at Lackland which saved the Air Force one million dollars with the first fifty patients alone. And we proved it, with data and controls far more rigid than the overwhelming majority of scientific papers written on alcoholism and its treatment. There was no “soft data” or subjectivism or use of fuzzy definitions of alcoholism and “success.” The results were published in the *American Journal of Psychiatry*, the article was reprinted and distributed by the National Council on Alcoholism in every major city, newspapers all over the United States picked it up and wrote articles about what we had accomplished, and our project was even mentioned in the yearbook of a national encyclopedia as one of the noteworthy achievements of that year.¹ Not only that, we worked out a combination of treatment techniques which achieved a fifty percent success rate, which in alcoholism treatment is a winning combination: alcoholism is the only disease where so many of your patients fight you to the bitter end to avoid getting well.

There in the summer of 1953 the Air Force had given me a choice of several places for setting up my second alcoholism treatment program. Lackland Air Force Base in San Antonio, Texas, seemed the obvious one to pick for a number of reasons. The base itself was huge, because every enlisted person in the Air Force went through basic training there, which in turn required an enormous support staff. This meant a large pool of military personnel, permanently assigned to the base, from which I could draw my patients. The 3700th USAF Hospital at Lackland was the largest Air Force hospital in the world, which meant I could count on medical support when necessary, particularly for detoxification and treatment of delirium tremens (the d.t.'s) and other purely physical issues during the first two to four days after the patient entered the program.

And I also hoped to expand my pool of candidates for the treatment program by bringing in personnel for treatment from the other bases which immediately surrounded the city—Randolph AFB, Kelly AFB, and Brooks AFB—plus the numerous other flying fields the Air Force had set up in nearby areas of Texas and New Mexico. There were an exceptional number of Air Force bases in that part of the United States. It was a good part of the country to train pilots, because you could count on blue skies and sunshine—perfect flying weather—most days of the year. I knew I could count on the fact that, with alcoholism affecting at least ten percent of the general American population, there would be a huge number of Air Force people in that general area who had serious drinking problems, and that a certain percentage of these would be at the point in their drinking careers where they would be willing to accept help.

San Antonio itself was a beautiful place. It was still a small, easy-going town back then. Palm trees grew everywhere, along with huge live oak trees with Spanish moss dangling from their enormous branches, which spread out horizontal to the ground and gave a welcome shade beneath them from the tropical sun. The old Spanish governor's palace and the venerable mission churches (including the

Alamo of course, where the Texas rebels made their famous last stand) gave you a feeling of a place with real history. The little parks and flower beds and pathways along the River Walk that wound through the downtown gave the city a kind of Old World charm.

Air Force personnel on leave would paddle rented canoes up and down the river, many of them drinking a bit too much, and occasionally falling out of their boats with shouts of terror, until they stood up and sheepishly discovered that the river was no more than waist deep. And they would dare one another to eat one of the rattlesnake sandwiches which vendors sold to the tourists, and try out the strange flavor of the spicy tequila which the Mexicans distilled from the juice of the Agave cactus. If you wanted to be fancy, you drank it from salt-rimmed glasses, with sweetened lime juice from the citrus groves down further south. Or you could do it the old-fashioned way, where you put a pinch of salt on the back of your hand, squirted some juice on it from a slice of lime, licked the back of your hand, and then downed a shot of the fiery liquid. Whichever way you did it, it was a very potent alcoholic beverage indeed, and you could get very drunk very quickly on a bottle of tequila. The parades and parties during Fiesta Week every April were not as well known as Mardi Gras in New Orleans, but the celebration was almost as big. The old Mexican grandees would still come out on parade back in those days, riding on magnificent horses with silver-mounted bridles and saddles glinting in the sun.

Not long after I got to Lackland Air Force Base, I met the man who was going to supply several of the crucial links necessary for setting up a fully functioning treatment program: Louis Jolyon West, M.D. He was around six years younger than I was, so since I was thirty-five he must have been only about twenty-nine years old. From his middle name, he had been nicknamed “Jolly,” and that was what everyone on the base called him, “Jolly West.” That was the way he signed his letters to me in later years. He had served as an infantryman for three and a half years in World War II and went to medical school after he got out of the service. He had just finished

his residency training in psychiatry, and now, in 1953, had just arrived at Lackland with a new set of major's oak leaves on his collar, to become Chief of Psychiatry at the huge base hospital there.

This was the beginning of an enormously successful career for him. By 1956, Dr. West was also Professor and Head of the Department of Psychiatry and Neurology at the University of Oklahoma School of Medicine, Oklahoma City. He also founded an alcoholism research and treatment facility there at that university, which was later named for him.

He eventually became Professor and Chairman of the Department of Psychiatry and Biobehavioral Sciences at the University of California, Los Angeles, at the UCLA School of Medicine, and was also Psychiatrist-in-Chief of the UCLA Hospital and Clinics and Director of the Neuropsychiatric Institute at the UCLA Center for the Health Sciences. He gave me the title of consultant there after he had taken up that position, so he and I could continue to be in contact with one another. He eventually authored seven books and more than 150 journal articles,² and became a major nationally recognized expert on alcoholism, serving at one point as a member of the National Advisory Committee on Alcoholism to the Secretary of Health, Education and Welfare, along with other national advisory bodies.

Dr. West was a brilliant psychiatrist at the theoretical level, but he was not just a “skull jockey.” He was a warm, caring, human being. I still treasure the friendship I enjoyed with him during those years. His commitment to establishing an alcoholism treatment program at Lackland came from the heart. He wrote a short piece for me in 1981, describing how we first got together at Lackland, where he talked about the horror he felt when he saw all the Air Force personnel on that base who were compulsively drinking themselves to death.³

A newly-minted major in the United States Air Force assigned to the Psychiatry Service at Lackland AFB Hospital near San Antonio, I realized that alcoholism was a far larger problem in the military service than I had ever imagined.

Certainly my years as an infantryman in World War II did not prepare me for what I began to see of the ravages of alcohol in my work as a psychiatrist at the Air Force's largest hospital. Nor did anything I had observed or read during my recently completed residency training in psychiatry provide any inkling of the scope and complexity of the problem of alcoholism among military personnel.

It is important to note that you do not need to be an alcoholic yourself in order to treat alcoholics effectively. Dr. West was one excellent example. The necessary thing to recognize, if you are a non-alcoholic who wishes to set up a treatment program which will obtain real success, is that you simply must team up with a recovered alcoholic who can serve as your A.A. liaison, and use that person continually for your "insider's knowledge" of the disease and how practicing alcoholics actually think and react. Treatment methods and theories which seem to make perfect logical sense to a non-alcoholic looking at the disease from the outside will often fail disastrously in practice. A fully recovered alcoholic who is active in Alcoholics Anonymous can tell you from actual experience how a man or woman who is still drinking destructively will feel emotionally and physically, and the strategies for denial and evasion which that drinker will use to attempt to manipulate you and undercut your efforts at therapy.

Even if you yourself are aware that the patient is using lies and devious underhanded strategies to block you, people who are alcoholics themselves can often confront the patient far more effectively. If you, as a non-alcoholic, tell the patient bluntly, "That's nonsense, what you're actually doing here is such-and-such," the drinker will simply be apt to use that as yet another excuse to fall into further righteous indignation and rebelliousness. A recovered alcoholic who has been active in A.A. knows how to say the same thing, often even more rudely and bluntly, but with an attitude of "Come off it now, I've been where you are, and I used that technique for years to con people. Sometimes I even believed

my own cock-and-bull stories myself, which was how I plunged down to the bottom. You can keep on lying to me—I don't care, it's your life, and it's not going to affect what I do, because I know all the tricks as well as you do—but if you want any kind of real help from me, you're going to have to at least start getting honest with yourself.”

Dr. Joseph J. Zuska (Capt. USN) was another well-known example of a non-alcoholic, a physician who became interested in setting up an alcoholism program at Long Beach Naval Station in the mid-1960's, and teamed up with retired Navy Commander Dick Jewell, an alcoholic who had recently gotten sober in A.A. Jewell worked at first as an unpaid co-worker while they set up their enormously effective treatment program there. This facility later became quite famous when President Ford's wife Betty Ford and President Carter's brother Billy Carter were sent there for treatment.⁴

When Sister Ignatia, who was of course not an alcoholic herself, first began trying to work with alcoholics at St. Thomas Hospital in Akron, Ohio, in 1928 she had good hospital facilities and eventually in 1934 gained the additional help of a competent non-alcoholic physician, but still had little long-term success during those early years.⁵ When she was finally able to team up with Dr. Bob and the other recovered alcoholics in the fledgling A.A. group in Akron in 1939, she used their additional knowledge and input to help her put her own considerable talents to work more effectively. As a result, she ended up saving thousands of human lives during the many years that followed, and if you wanted to see gratitude, you should have seen the scene on August 6, 1952, the evening before she finally left St. Thomas.

Literally thousands of grateful alcoholics and their families, now restored to good and useful lives, flooded in to say good-by and thank you, until their autos created enormous traffic jams on the streets around the hospital in all directions. Traffic came to a complete standstill on the old Akron viaduct which bridged the valley which lay on one side of the hospital, as drivers simply parked their cars wherever they could find a space, leaving their

headlights on, while the police looked on in silent acquiescence. You had to ignore the rules for a heroine of her stature. Parades of people filed down the streets and then stood in long lines at the hospital, just so they could shake Sister Ignatia's hand one last time.⁶

So if you are a nurse or physician, a psychotherapist, a social worker or a criminal justice system case worker, and you recognize that many of the other problems affecting your patients, clients, or inmates are insoluble until they first deal with their alcohol and drug abuse, please do not be afraid to start some sort of treatment program at the facility where you are employed. Just be sure to set up some kind of active linkage, whether official or unofficial, with the Alcoholics Anonymous program in your area, and listen to what they have learned from their own experience with the disease and their recovery from it. You will find them hardheaded and practical: they will understand the limitations of what you can and cannot do within your institutional setting, often because some of them have in fact been patients or inmates at similar institutions. But you will also find them willing to go to any lengths to aid you in any way they can, cheerfully and with contagious good humor.

Dr. West was young and just starting out his practice as a psychiatrist when I first met him there at Lackland. But he became enormously respected in his field during the years that followed. At one point he came within just a few votes of being elected president of the American Psychiatric Association. The reason he failed to win involved an unfortunate occurrence. He was asked to tranquilize an elephant, and prepared what he had calculated was a suitable dose of Thorazine to sedate the huge animal, based on its body weight. Either elephants are more susceptible to Thorazine—unlike white rats and monkeys, they are so big and require so much feed and care, that it goes without saying that they are not commonly used as test animals in experimental labs, so there is not a wealth of data on the drug responses of elephants—or this particular elephant was abnormally sensitive to that agent. At any rate, the poor creature died.

Dr. West had been assumed to be a shoo-in for election, but apparently some of the members of the American Psychiatric Association began to have anxiety attacks at that point over the possibility that some tabloid journalist might publish an article with a scandalous headline such as, “Does Your Psychiatrist Prescribe Enough Drugs to Kill an Elephant? The Head of the American Psychiatric Association Does.” I was saddened when I learned that he had fallen just short of gaining enough votes to receive the honor he so richly deserved.

Dr. West had come to Lackland in 1952, and had already been trying to devise some way of treating alcohol and drug abusers at Lackland even before I arrived, but had found barriers on every side. As he described his experiences:⁷

In those days official policy toward alcoholics and drug addicts in the military service was extremely punitive. It took me more than a year to figure out how to create a treatment program for patients whose illness officially was not allowed to exist. This peculiar situation obtained because the diagnosis of alcoholism immediately rendered the patient unacceptable for service, and required his immediate separation from the service (with an “undesirable” discharge).

Finally I obtained permission from the base commander and the hospital commander (with the informal approval of the Surgeon General’s office) to undertake an “experimental” program of evaluation and rehabilitation of persons who were incapacitated because of alcoholism, even though the official diagnosis was not inscribed upon their medical record.

But Dr. West could not find anyone in the psychiatry service there at the 3700th USAF hospital to help him. Everyone on staff was already overburdened with huge psychiatric caseloads of military men and women suffering from numerous kinds of problems, who had been sent from various U.S. bases and from Korea. The traumatic Korean war had begun on June 25, 1950, when North Korean forces invaded the south and quickly captured Seoul.

That was back when I was still at Mitchel AFB on Long Island. The Air Force was deeply involved of course in that bloody conflict, and fighting was still going on when I arrived at Lackland, because the armistice signed at Panmunjom did not come until six months after Dr. West and I had started our joint alcoholism treatment program.

But the problem ran deeper than just an overload of psychiatric cases suffering from acute posttraumatic stress disorder from their horrifying experiences in Korea. As Dr. West put it,

Even more important ... was the fact that among my medical colleagues there was nobody with any particular interest in alcoholism, and among the other health professionals in the hospital there was no expertise whatsoever.

That was the place where I came in. Dr. West kept on asking around the base, trying to find someone who had previous experience treating alcoholism.

I learned that a Master Sergeant William E. Swegan, who was at the time assigned to the Chaplain's Office on base, was working with alcoholics independently of any other program. Sergeant Swegan, with the concurrence of the Chief of Air Force Chaplains and the Surgeon General of the Air Force was assigned to Lackland AF Base to work specifically with alcoholics.

He also learned that I was experiencing the same kinds of frustrations that he was, and receiving little support in my efforts to make my own fledgling program a viable one.

I invited Sergeant Swegan to visit my office ... and made him an offer I reckoned he couldn't refuse: to become my partner in a venture to rehabilitate alcoholics. Naturally he responded to this proposition with enthusiasm. But even Bill Swegan as a canny sergeant who thought he had seen everything, was astonished when I looked him in the eye and said, "Sergeant, as of this moment you are a psychiatric social worker."

That supplied me with one of the most vital components I needed to make my program a success: the right kind of title. Psychiatric Social Worker made my help more acceptable to many who would have bluntly refused my assistance when I was defined as a Chaplain's Assistant. Alcoholics and drug addicts simply did not want to come to anyone associated with the Chaplain's Office, no matter how much I reassured them— if they did get pressured into visiting me—that I was not going to be scolding them or threatening them with going to hell or preaching religious doctrine and dogma at them. It is ironic, but as I mentioned earlier, most practicing alcoholics and drug addicts would far rather be regarded as mentally ill than as religious.

So I had a more effective title now—Psychiatric Social Worker—even though I had no letters like MSW or PhD to put after my name. Even years later, I still felt that I was being hampered at many points by my lack of any professional advanced degree in psychology or social work or medicine. But Dr. West was always far less concerned about that than I was. Thirty years later, after he had become Chairman and Director of the Neuropsychiatric Institute at the UCLA School of Medicine in Los Angeles, he wrote me a nice letter in which he told me,⁸

My own view is that anyone with sense will listen to you on the subject of alcoholism, and that fools won't pay attention no matter how many degrees you have. Many leaders in the field have no advanced degrees. Marty Mann comes to mind. Erik H. Erikson, one of the great contributors to contemporary psychiatry, had no college degree, much less a doctorate, and yet he may be the most influential psychiatric writer since Freud.

I know that what he said here is fully true—Marty, that wonderful woman, who knew so much about so many subjects, including literature and art, was entirely self-educated in terms of her advanced knowledge of alcoholism and its treatment⁹—but Dr. West's M.D. degree and gold major's oak leaves were also

necessary at that point to give us the kind of clout to get our program established in spite of the forces of opposition, apathy, and disinterest which opposed us.

We got our joint endeavor started, and within just three years had enough clinical data to start bragging publicly in national circles about what we had accomplished. As Dr. West summed up our success:¹⁰

For the next three years Sergeant Swegan and I worked together in a locally approved but officially non-existent program to identify, treat, rehabilitate, and if possible, retain for the Air Force a significant number of valuable military personnel. The results of this approach were finally published in 1956. Between us, Sergeant Swegan and I were saving the government approximately \$1 million a year in salvaged personnel. Unfortunately, it took another generation and another war [the Vietnam conflict c. 1963-75] before government policy sufficiently changed to make programs like ours official.

So in January 1953, our small experimental program was initiated at the 3700th USAF Hospital with the approval of the Hospital and Base Commanders and the Office of the Surgeon General. Treatment was offered to a selected group of alcoholics. They had to meet three essential criteria: (1) proved value to the Air Force through a record of achievement, (2) knowledge and approval of the patient's commander, and (3) the economy that could be effected through successful rehabilitation, without military risk.¹¹ Our official definition of chronic alcoholism was that used by a scholar named Diethelm in an article written in 1951, which had proven widely acceptable in professional circles and was extremely appropriate to the diagnostic standards we knew we could prove by military records:¹²

A patient suffers from chronic alcoholism if he uses alcohol to such an extent that it interferes with a successful life

(including physical, personality, and social aspects), and he is either not able to recognize this effect, or is not able to control his alcohol consumption although he knows its disastrous results.

Alcoholism is a complex illness which is usually the result of multiple causation. So our treatment plan for each patient attempted to take into account all the factors which might be involved in that particular person's case: genetic, hormonal, neurological, psychological, and social.

We employed both individual counseling and small group sessions. With my new title, I was now in a position where I could carry out a certain amount of deeper psychoanalysis on my patients when it was necessary, without being accused of overstepping my assignment. Some sort of marriage counseling was nearly always required: alcoholics— and the people who marry them as well— have difficulty setting up healthy relationships. Our job was to improve the quality of our patients' lives at every possible level, not only when they were carrying out their assigned duties on base, but also when they were at home. As the psychiatric social worker, I also investigated the administrative difficulties in which the patient was usually involved, and negotiated realistic solutions with the command structure.

A small percentage of the patients were able to benefit from more intensive individual psychotherapy. Most of these were individuals who were above average in intelligence and able to be effective in their jobs as long as they stayed sober, but oversensitive. In our sessions with them, we sought to strengthen the ego defenses they already had available. Our psychotherapeutic techniques varied from simple supportive methods to analysis and interpretation of previously unconscious material. In a few cases hypnotherapy was employed. Since alcoholism is such a complex disease and each individual alcoholic will be to some degree unique, we had to use a wide variety of different methods. There is no "one" treatment for alcoholics, and in spite of the fact that many books have been written claiming that there is one single, simple theory which will

account for alcoholism and enable it to be treated successfully, in practice these “single theory” approaches do not help most alcoholics at all.

We made use of the excellent hospital facilities to include in our treatment program, when appropriate, a high vitamin regime, adrenal cortical extract, chlorpromazine (Thorazine), and reserpine (Serpasil).¹³ Because that was almost fifty years ago, I should say that there are many other medications which have been developed over the intervening years which are sometimes safer or have fewer side-effects or are more specific in their application: serotonin reuptake inhibitors and other antidepressants that target specific areas of the brain chemistry, antipsychotics, lithium and other helpful medications for patients who are bipolar, specific medications for hyperactive attention deficit disorder, and so on.

Tetraethylthiuram disulfide (Antabuse) was administered to patients who requested it during their early period in the treatment program. Most individuals will have an extremely uncomfortable physical reaction if they try to drink alcohol as long as this is already in their system. The daily dose of Antabuse was discontinued if the patient requested it, if the physician judged it no longer useful, or if the A.A. worker indicated that the patient was now so deeply immersed in the A.A. program that he or she would no longer need this additional precaution.

I should say that Antabuse is no longer used in present day alcoholism treatment programs as frequently as we did back then, because too many of the alcoholics to whom it was administered assumed that taking this medication by itself provided a sufficient protective shield against any possible relapse. It became “the adhesive tape that held together a broken crutch.” They developed a false sense of security, and so had a greater tendency to dismiss the need for any significant change in their basic thinking and emotional approach to life. They wrongly assumed that they had been totally freed from any compulsive desire to drink, until some major catastrophe occurred in their lives. Then, when the chips were down, they discovered too late that they had developed very few tools for

coping with the stress caused by the emotional upheaval which was now overwhelming them. Some surreptitiously evaded taking their prescribed daily Antabuse dosage (sometimes even if administered by staff, because if the staff were not careful, patients would tuck the tablet under their tongues and spit it out later). Others would become so emotionally desperate that they would drink in spite of knowing what the Antabuse was going to do to them physically after it was combined with the alcohol. This reaction was not only extraordinarily distressing, but was dangerous enough that it could produce fatalities on occasion.

The absolutely vital and necessary component in the treatment program however, was to get the patient actively involved on a long term basis in attending Alcoholics Anonymous meetings conducted by civilians off of the military base. These were the people (all unpaid volunteers) whom we counted on to do the bulk of the therapeutic work. Some of our patients did not become involved in A.A. with any great fervor or commitment—they would go to the minimum number of A.A. meetings which they felt they could get away with, and would just sit passively in the meetings and refuse to become deeply or personally engaged with the twelve-step program or the other members of the A.A. group—but there were very few who failed to derive some definite and measurable benefit from attending these meetings even when they did so grudgingly.

Only about a third of our cases had to receive any individual psychotherapy at all after they had made the return to a more stable pattern of living. This is important to note: we were not asking the U.S. government to take on the enormous expense of creating a huge staff of psychiatrists and psychotherapists to carry on long term individual treatment of numerous military personnel.

The key factor in achieving success in this aspect of our treatment program was found to lie in the commitment and dedication of the military A.A. worker. This needed to be someone with long military experience who had gotten sober himself or herself in A.A. These sorts of individuals were found to be highly effective in dealing with

the majority of the patients involved. Their particular usefulness came from their availability and their familiarity with the peculiar stresses of military life, together with their ability to talk about their own life stories. When the patients wanted to talk about some particular anxiety-laden issue or circumstance in their own lives—overpowering resentments against other base personnel or family members, or perhaps circumstances in which they had been traumatically victimized or consistently made to feel inferior and inadequate, or sometimes degrading and humiliating experiences they had had while drunk (experiences which still haunted their memories)—the A.A. workers could respond by telling about similar experiences in their own past histories.

As was pointed out by Dr. Harry Tiebout, the first psychiatrist who became deeply involved in investigating A.A. methods, the therapeutic success of Alcoholics Anonymous is of particular interest in view of the large number of “rules” of psychotherapy which it breaks with impunity.¹⁴ My suggestion is that non-alcoholic mental health professionals simply take advantage of the help which A.A. meetings give their patients, without attempting to overanalyze why this help is working so effectively.

On the other hand, as the military A.A. worker in the Lackland treatment facility, I also found that my close association with a psychiatric unit definitely increased my own effectiveness. Many alcoholics have “problems other than alcohol,” as it is said in the A.A. program, and it can take considerable professional expertise to turn these individuals into happy and successful people who can enjoy life to the fullest.

The military A.A. worker was the one designated to carry out alcohol education on the base. In our case, I visited a large number of surrounding Air Force facilities in Texas and New Mexico as well. This work included giving both informal talks and regular formal lectures, showing films, distributing pamphlets and leaflets, and being available after presentations to give individual advice. The arrangements for these visits were made through training officers,

chaplains, line officers, traffic safety project officers and the like. The object was not only to talk about our treatment program to the ten percent or so of the military personnel in each group who were likely to be already well on their way to falling into serious trouble with their excessive drinking, but also to make noncommissioned officers and command staff more aware of the help we could give them if they had personnel under their command who was obviously producing more and more disciplinary and efficiency problems by their abuse of alcohol.

This was a time-consuming but vital and necessary part of the military A.A. worker's job. When I worked hard at setting up and making these outreach visits to various units and training groups, I found that referrals to our program shot up dramatically. Some military personnel would be referred to us by their commanders after I had made my presentation or distributed my materials, while others would come in as self-referrals. The core of the message which I delivered was adapted from the three basic principles which had been stressed so strongly by Mrs. Marty Mann all across the country in her role as head of the National Council on Alcoholism, which I have already referred to earlier in this book because of the importance of changing the public perception of this issue: "(1) Alcoholism is a disease and the alcoholic is a sick person. (2) The alcoholic can be helped and is worth helping. (3) This is a public health problem and is therefore a public responsibility." The only change I made was to make the third principle more specific. I stressed that alcoholism was also a basic problem in the U.S. military, and that the military itself therefore had to start taking effective responsibility for recognizing alcoholic personnel and providing the kind of treatment which would return them to full duty.

At least ten percent of the general American public is somewhere along the path in the progressive development of the disease called alcoholism. If the U.S. military attempts to deny that this problem exists, and attempts to brush it under the carpet, our armed forces

will pay an enormous price in dollars and cents, and an even greater cost in terms of human lives destroyed unnecessarily.

Our patients formed a quite heterogeneous population, with marked cultural and constitutional differences, and displaying a good deal of variability in terms of the relative influence of different psychodynamic factors. So some patients rejected A.A. but were helped by psychotherapy. Others responded poorly to one medication but were helped by another, or by the appropriate combination of medication and the right kind of talk therapy. Some were not helped by either medicine or psychiatry, but had their lives remade by becoming deeply involved in the spiritual aspects of the A.A. program.

All the cases who came into our program had this in common however, which became our “working definition” of alcoholism at the practical level: They had been experiencing a mounting *feeling* of discomfort and a need for alcohol to relieve this feeling. This need had become so strong that the knowledge of the inevitable negative consequences of drinking so much no longer sufficed as a deterrent. The overwhelming negative feeling itself might be anxiety, boredom, depression, tension, resentment, anger, or feeling used or victimized. There was often very little insight among these incoming patients regarding the real causes of these painful emotions. The precipitating factors which would plunge them back into this intolerable internal emotional state might originate in their family situation, on the job, or when certain memories or fantasies arose in their minds.

No single approach could therefore rationally be expected to meet the needs of every patient. “Single theory” alcoholism treatment programs do not ever achieve significant long term successful results when rigorous and objective follow-ups are carried out one year, two years, three years, and five years later. So Dr. West and I had to try out various treatment methods on each new patient until we found the ones that worked, although we did get much better, with experience, at noting increasingly reliable groups of indicators

which would allow us to prescribe a specific treatment program for a given individual without having to go through so much trial and error at the beginning.

I mentioned that our patients formed a heterogeneous population. This sometimes produced tensions, because in San Antonio at that period in our history (this was back in the 1950's we must remember) there was still great resistance toward any social mixing of different races and cultures. On several occasions early on, when I took minority personnel to A.A. meetings off of the base, it created some hostility, and I just had to ignore the negative responses to my breaking of their segregationist assumptions. I will say though, that as I continued to insist on bringing all of my people to the San Antonio meetings and defending them against any attacks, that some of the ones I sponsored ended up having a truly dynamic impact on the city's A.A. groups after they had gotten some sobriety under their belts.

The San Antonio A.A.'s actually held a vote on one occasion, when a local minority businessman with an alcohol problem came to them and sought assistance. Thank God the vote was positive, because among other things, this person not only became a very productive member of that city's A.A. program, but was personally responsible for many other people of minority backgrounds getting sober through the program later on. I wanted to insert these particular comments here in this chapter, because I feel so strongly that the principles I was fighting for back then were so important, and still are today: we practice tolerance, and we do not discriminate against people in A.A., regardless of race, sex, culture, educational level, religious background, or any of the other issues which can sometimes be so divisive outside of the program in the larger society. We must form the model for a new and higher level of human relationships, where those who have been made to feel "less than" and despised can learn to feel good about themselves and begin achieving their full potential as human beings.

But to return to our activities there on the base: what was truly amazing was the enormous success rate we achieved in our pilot program. We analyzed the first 50 consecutive cases who came into our treatment center, and found that a full 50% of these military personnel (25 cases) were much improved, with maintenance of total sobriety from the beginning, and continuously successful performance of their duties. This was a fully objective evaluation: we did not ask the personnel themselves in a telephone call whether they “thought their drinking had been brought back under control?” or “are you doing O.K. now?” There was one notorious report by a major research corporation in the 1970’s which based some highly controversial theories about the ability of alcoholics to successfully return to “controlled drinking” on this sort of subjective data. We were in contact with our patients’ commanders, looked at their official performance reports, watched out for any recurrence of disciplinary problems (including being sent for court martial for any kind of breach or being arrested by civilian police when off base), and we also conferred with the A.A. people who had worked with them most closely for their evaluation of how well these newly sober people were coping.

26% of these cases (13 of the 50) we considered as outright failures. Five of these never accepted themselves as alcoholics and refused to follow any advice that might lead to rehabilitation. Three of the ones whom we had listed as “failures” got into civilian A.A. programs after they had left the service, and were able at that point to get sober and adjust successfully to life, and obtain stable, long term employment. Those three reported to us that we had planted the seed. As their lives had continued to grow worse and worse, they had finally realized that we were telling them the truth about their condition and what they had to do to avoid death or prison or permanent incarceration in a mental institution.

14% (7 cases) we considered improved. When we did our evaluation, we found that they were doing much better at staying out of trouble, despite one or more episodes of drinking again after they had first entered our rehabilitation program.

We only had 10% (5 cases) whom we could not follow up on because of transfers overseas, so we felt that we had an unusually thorough system for looking at the vast majority of the patients whom we had worked with.

We calculated that we had saved the Air Force at least a million dollars by working with these first fifty patients. There was no question that nearly all of these personnel were on the verge of disaster in their military careers. Most of them would certainly have been lost to the service. We had chosen as our subjects, not raw new recruits, but seasoned veterans. The published figures in 1954 and 1955 for the price of replacing an individual with four years of service showed that this cost the Air Force a minimum of nearly \$15,000. For an enlisted person with advanced training, such as an electronics technician, the figure was \$75,000. That was what the government had to pay for the classes and course work which would be required to teach someone else to carry out that job. Officers were even more expensive to replace, and the training of a jet bomber pilot cost the Air Force half a million dollars.¹⁵ That was in 1950's prices. Now, half a century later, the lives of trained pilots are literally worth millions.

Is this a valid way to calculate the value of a successful alcohol and drug treatment program, in terms of personnel replacement costs? The present-day military devotes substantial amounts of money to efforts to encourage highly-trained personnel to reenlist, and the military's top financial planners not only insist that this is money well spent, but that the retention of trained and experienced personnel is vital to the maintenance of a topflight military. When a major conflict forces the U.S. military to flood its ranks with inexperienced people, everyone with military experience knows the kinds of difficulties this produces. If the military services are willing to spend enormous amounts of time and money encouraging good people to re-enlist, they ought to be willing to spend a few dollars making sure that some of their most competent people are in adequate physical and mental shape to continue their duties.

The conservative estimate we made of the cost of replacement of the individual patients in our successfully treated group averaged out to \$40,000 per person. Twenty-five times that figure comes out to \$1 million.

We did not even count in the cost to the Air Force of paying a full salary for personnel who were only doing half their job because of their heavy drinking when off duty, or the equipment damaged by men and women who were bleary-eyed, jittery, and unable to concentrate well because of the aftereffects of their binges. I could give a host of examples, like the Navy pilot I heard about later on, who admitted during treatment at a naval alcoholism rehabilitation center that he had crashed *three* high-performance military aircraft because of his alcohol abuse and its effects on his reflexes.

Nor did we count in the time we saved the command staff, who no longer had to waste hours dealing with the alcoholic escapades of these drinkers, or trying to help them sort out the difficulties they had gotten into in their home life because of their excessive drinking. A general court martial cost the Air Force \$4,320 to conduct back in those days. Confining alcoholics in the stockade cost a large amount of money. Hospitalizing people who had injured themselves while on binges cost the government many dollars. When Captain Joseph Zuska, the senior medical officer at the Naval Station at Long Beach, California, started the famous alcoholism treatment center there in 1965, his medical personnel noticed after a while that they were no longer treating so many broken jaws at the hospital.

And there were other positive effects of our program, due to the emphasis placed on alcohol education among all the base personnel. This was preventive psychiatry at its best. Dr. Zuska and his A.A. worker, retired Navy Commander Dick Jewell, noticed the same helpful consequences emerging due to their educational work at their Long Beach facility. From my links with the people in the Alcoholics Anonymous program in San Antonio, I discovered that, as a result of my educational presentations on base, greatly increased numbers of Air Force personnel were joining A.A. groups and

getting sober without going through the program on base which Dr. West and I were running. So our official figures said that we saved twenty-five people during the first two years we were operating our two-man program, but in fact during that period quite a few more personnel got sober as the indirect result of our efforts.

So we could have justifiably expanded our claims had we chosen to. We in fact saved more than twenty-five lives during that period, counting the indirect effects of our program, and we in fact saved the Air Force far more than a million dollars by our work over that short period.

We showed what could be done, and we demonstrated it resoundingly well. Our pilot program created a model of a truly successful alcoholism treatment program. In the years that followed, the Navy in particular showed how well this type of effort paid off. If you the reader are assigned to a military base, or are involved in any other kind of institution in which some of your people have gotten in trouble due to alcohol or drugs—including large commercial businesses as well as penal institutions and their associated rehabilitative centers—I hope you will look at this model and see how effective educational and treatment programs can be set up easily and economically. There is no excuse not to fix something which is undermining your operation.

Remember that ten percent of the American public is either in trouble with alcohol already or is well on the way, and that in the penal system (including the juvenile justice system) the majority of your inmates either had alcohol and/or drugs in their systems at the time they committed the offense for which they were incarcerated, or were imprisoned for illegal transactions involving these substances. This is everyone's problem in the long run. Dr. West and I showed a way to help solve that problem, and we showed that it worked.

NOTES

¹ Louis Jolyon West, M.D., and William H. [sic] Swegan, “An Approach to Alcoholism in the Military Service,” *American Journal of Psychiatry* 112, no. 12 (June 1956).

² See for example Louis Jolyon West, M.D., ed., *Alcoholism and Related Problems: Issues for the American Public*, Spectrum Books.

³ Louis Jolyon West, M.D., “I Couldn’t—We Did,” written to accompany an article written on military alcoholism treatment in that year: William E. Swegan, “Our Country’s Largest EAP: Military Alcoholism,” *Alcoholism* (July-August 1981), 36-39.

⁴ For the full story, see Nancy Olson, *With a Lot of Help from Our Friends*, ch. 16, “Twelfth Stepping the Military.”

⁵ She seems to have begun sneaking alcoholics who were in especially bad shape into isolated nooks and crannies of the hospital to sleep it off, not long after her arrival at St. Thomas on September 28, 1928. In 1934, she convinced an intern in the emergency room, Dr. Thomas P. Scuderi, to work with her on these unofficial alcoholic patients, giving them shots to calm them down and trying to keep them from going into convulsions. They worked together to treat an enormous number of alcoholics, beginning their project in fact before A.A. was born in 1935. August 16, 1939, was the date the first A.A.-sponsored patient was admitted to St. Thomas with her aid, not the beginning of Sister Ignatia’s work with alcoholics. See Mary C. Darrah, *Sister Ignatia*, 8-11 and 79-80. Mary Darrah interviewed Dr. Scuderi on September 26, 1985, to obtain some of the details of the earliest work at St. Thomas.

⁶ Mary C. Darrah, *Sister Ignatia*, end of chapter four, p. 150.

⁷ This and the following passages are excerpted from Louis Jolyon West, M.D., introduction to William E. Swegan, *From Intoxication to Emancipation*. This short account of his and Sgt. Bill’s work was originally written by Dr. West in April 1981, and later also distributed separately as a bifold leaflet.

⁸ Letter to William E. Swegan from Louis Jolyon West (signed “Jolly”), December 22, 1982.

⁹ Marty had of course gone to the best private schools when she was young, including the Chicago Latin School for Girls, Santa Barbara Girls' School, Montemare School in Lake Placid, New York, and a year at Miss Nixon's School in Florence, Italy, where she finished her studies the year she turned twenty-one. It was a superb education of the highest quality, but gave her no formal college degree where she could put a B.A. after her name. In 1944, the year she became a member of the Yale Center of Alcohol Studies, she spent six months living with the Jellinek's in New Haven, where "Bunky" (as the doctor was called by those close to him) became her close personal friend and mentor. She spent that time voraciously reading on her own every scholarly book and article he gave her on alcoholism, and turned herself into a nationally recognized expert on the subject. See Sally and David Brown, *Biography of Mrs. Marty Mann*, 22, 36-7, 50, 52-3, and 160.

¹⁰ West, introduction to *From Intoxication to Emancipation*.

¹¹ The account which follows is based upon the original one given in Louis Jolyon West, M.D., and William H. [sic] Swegan, "An Approach to Alcoholism in the Military Service," *American Journal of Psychiatry* 112, no. 12 (June 1956). Subsequently printed and distributed nationally under the imprint of the National Council on Alcoholism, 2 Park Avenue, New York, which was headed by my old friend and mentor, Mrs. Marty Mann.

¹² O. Diethelm, *Bulletin of the New York Academy of Medicine* 27 (April 1951): 232.

¹³ All patients were initially given high daily doses of basic vitamins. A number of them continued to receive those supplements because it was found that their cravings for alcohol returned when we stopped giving them the vitamins. Patients showing evidence of hypoadrenocorticism were treated with aqueous adrenal cortex extract (ACE), or in a few cases with Lipoadrenal Cortex. Chlorpromazine (Thorazine) proved to be very useful in treating the acute symptoms of newly-hospitalized patients. In some cases, it also helped them manage the tension-laden periods while they were in the process of reorganizing their way of life in the period immediately after they left the hospital. After a stable period back on the job, these patients were told to discontinue the regular dosage, but to keep a supply on hand. When they felt marked tension and anxiety as a result of

some stressful life situation, these patients were instructed to use the chlorpromazine until they were able to confer with the doctor or an A.A. worker, to diminish the risk of turning to alcohol. We were also able to use reserpine (Serpasil) with some benefit in the same fashion.

¹⁴ H. M. Tiebout, *Quart. J. Stud. Alcohol*. 12 (March 1951): 52.

¹⁵ H. E. Talbott, *Air Force Information Letters*, September 1954 and January 1955.