

THE VITAMIN B-3 THERAPY:

A THIRD COMMUNICATION TO A.A.'s PHYSICIANS

EDITED BY BILL W.

January 1971

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An updating, progress report
and
Supplement to the 1968
(yellow cover) B-3 booklet

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PUBLICATION NOTE

Although the original 1965 B-3 booklet (green cover) from Bill W. had a very limited distribution, it initiated widespread trial of the megavitamin approach, as was subsequently reported in the 1968 B-3 report (yellow cover). Throughout 1970, there were many meetings, both at Bedford Hills and New York City, devoted to an updating of the booklet and during that time, there were many delays for a variety of reasons, including Bill's illness.

With the retirement of Bill's assistant, Helen W., in May, the B-3 office was transferred to Maggie H. and it was moved to its new address at P.O. Box 125, Oyster Bay, New York 11771.

Additional copies of this booklet are available at \$1.00 each.

Copies of the yellow covered 1968 booklet will continue to be available, but they are now \$2.00 each. The reason for the increase is not only increased costs, but the fact that the true cost of the booklets previously had been offset by sizeable contributions from personal friends of Bill's. The operation is now self-supporting and, therefore, the charge now covers the actual cost of printing, distribution and postage.

To The Reader:

The yellow B-3 booklet, since it was published in 1968, has been ordered by 30,000 people and hundreds more orders arrive every month. This updating supplement was edited by Bill W. and was put together to meet the thousands of requests for further, current information. As the attached letter from Lois explains, although Bill wanted this discovery to benefit the alcoholic, he kept this activity separate from AA and published the information as his own enterprise with contributions coming from a small number of grateful alcoholics.

Bill's first inspiration has had a profound impact throughout the world as evidenced not only by the growth of AA itself and its affect on the field of alcoholism, but also its impact on the field of mental health in general, with AA type group therapy having become the foremost successful treatment modality. Bill and those closest to him felt that he had a second inspiration when he recognized the importance of certain vitamins in returning the brain of some alcoholics to normal functioning. It was Bill who saw the far reaching implications of this discovery and brought it into awareness. This, again, is already having an impact on the entire field of mental health. The scientific importance of this discovery was recognized by the brilliant Nobel Prize Winning Professor, Linus Pauling, who termed this new development, Orthomolecular Psychiatry.

This, then, is the updated B-3 booklet supplement edited by Bill W. in the year prior to his passing, which so many have requested. The original B-3 booklet will also be kept in print and available to those who are interested in the original as well.

Very truly yours



Edwin Boyle, Jr., M.D.



David Hawkins, M.D.



Russell F. Smith, M.D.

MRS. WILLIAM G. WILSON
Stepping Stones
Bedford Hills, N. Y. 10507

Dear Dave, Ed and Russ:

When the matter of the AA Trustee's ratio was finally settled, Bill felt that he had finished his job and done all he could to help AA to build a lasting structure. Then, as rarely happens in life, he was given a second opportunity to aid the sick alcoholic.

Aldous Huxley, a great admirer of AA, introduced Bill to two psychiatrists who were researching the biochemistry of alcoholism as well as schizophrenia. Bill was convinced of the truth of their findings and realized he could again help his beloved alcoholics by telling them about this probable aid for the physical component of alcoholism. He recognized that this work must be kept separate and distinct from AA and wrote a letter to the AA Board so stating.

As you know, Bill's last years were mainly devoted to the spread of this information among alcoholics and other ill persons. With your help, he wrote and distributed to AA doctors a brochure which has twice been enlarged and brought up to date. Before he passed on, he dictated a letter stating his hopes that you three doctors who were interested in AA and had worked closely with him in the niacin field, would extend your endeavors along the latter lines.

I sincerely believe that you only want what is best for the sick alcoholic who, as yet, has not been able to join AA, and that you will continue to place the principles of AA first and researching second.

Bill's great hope was that continued research would find a means whereby those thousands of alcoholics who want to stop drinking but are too ill to grasp the AA program could be released from their bondage and enabled to join AA.

All good wishes.

Affectionately,



(Mrs. William G. Wilson)

MIAMI HEART INSTITUTE
4701 North Meridian Avenue, Miami Beach, Florida 33140
Phone: 532-8341

Research Division: Edwin Boyle, Jr., M.D., Research Director

Dear Bill:

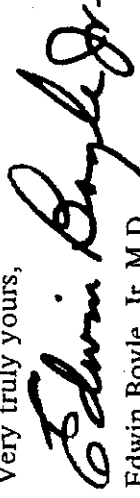
Niacin is one of the most promising drugs currently available to lower blood fats and cholesterol and help reduce death and disability from heart attacks. Heart attacks kill more alcoholics than any other cause. This unusual vitamin tends to "normalize" blood clotting and blood fats as well as help overcome certain nervous disorders. This vitamin is safe to take in large doses. The safety of niacin has been established over the many years since its discovery in 1867 and most states in the U.S. require by law that it be added to common foodstuffs to prevent overt pellagra — laws similar to those requiring the addition of iodine to table salt to prevent goiter.

The Federal Government is conducting a study known as the National Coronary Drug Project under the auspices of the National Heart and Lung Institute of the National Institutes of Health. Close cooperation is being provided by the American Heart Association with the Food and Drug Administration functioning in a monitoring capacity. This study involves testing four selected drugs with the most promise in reducing heart attacks and is being carried out in 53 research centers in the U.S., Puerto Rico, and Hawaii. Niacin is one of these four and was chosen because of its lowering effect on blood cholesterol and fat.

The Safety Monitoring Committee of the National Coronary Drug Project, after 3 years of careful observation, sees no cause for concern regarding human safety even when niacin is used at a dosage level of 3,000 mg. daily. This compares very favorably to acute and chronic toxicity data of commonly used agents such as table salt or aspirin. Nonetheless, it should be pointed out that patients with diabetes, peptic ulcer, or drug treated high blood pressure, should comply with the advice of their physicians when niacin usage is contemplated or undertaken.

My personal experience with large daily doses of niacin (3 to 4 grams) in patients with cardiovascular disease and high blood fat levels continues to be most encouraging. This experience extends back to 1956 and is particularly true when coupled with good general medical care, correct diet, and exercise programs.

Very truly yours,



Edwin Boyle, Jr. M.D.
Policy Board Member
National Coronary Drug Project

Research Director
Miami Heart Institute, Inc.
Miami Beach, Fla.

RUSSELL SMITH, M.D.
P.O. Box 518
Whitmore Lake, Michigan

Dear Bill:

The accompanying observations are intended to update our experiences with nicotinic acid in the Midwest. The invitation to set aside the strict criteria for scientific publication and to speculate freely on the possible, present and future implications of our findings should make this report all the more refreshing and stimulating. Although these comments represent projections and impressions, they are nonetheless based on fact.

You will recall we are now in the fourth of a five year longitudinal study of 500 alcoholics taking B-3. During this period we have added roughly another 5,000 alcoholics and several hundred adolescents to the number of persons taking nicotinic acid and at this point have accumulated approximately 4,500,000 patient days of clinical experience. The latter includes alcoholics during all stages of the disease and under a variety of circumstances, as well as adolescents with acute toxic and chronic organic brain syndromes. Observations based on such extensive experience can hardly be considered irresponsible.

We have nearly completed this year's survey of our hard core, treatment resistant, alcoholics. This group has diminished from 507 to 406 persons -- a loss of only 101 after nearly four years being impressive in itself. Our subjects have proven to be highly motivated and their geographic and vocational stability has defied initial predictions. The current tabulation of results is presented in the attached table.

A review of these figures indicates that the participants in our study are now stabilizing and show little tendency toward further change. It seems that the following preliminary conclusions will not require alteration.

1. Those who derive little benefit from B-3 eventually discontinue its use.
2. The motivation for continuing B-3 therapy in the absence of benefit may be based on a desire to please the therapist.
3. The hope of obtaining improvement comparable to that of others has prompted continuance of therapy despite modest results.
4. Benefits derived from B-3 may occur within weeks or perhaps take several years.
5. When B-3 therapy is interrupted, the resultant subjective change invariably prompts restarting the medication
6. One of four individuals started on B-3 derives no apparent benefit.
7. Failure may result from our lack of sophistication in the use of niacin and the measurement of its effects.
8. Three out of four persons derive benefit from B-3 therapy and demonstrate dramatic changes in their ability to abstain from alcohol.
9. Nicotinamide has demonstrated no beneficial effect in the pure alcoholic and those taking it have retired from the study.
10. Many of the effects seen in alcoholic subjects taking large doses of B-3 are demonstratable in nonalcoholic adolescents with chronic or acute toxic organic brain syndrome particularly caused by abuse of volatile inhalents or hallucinogens.
11. Benefits noted in those treated successfully include: an improved sleep pattern, a reduced anxiety level and mood stabilization, and increased ability to solve problems, absence of "dry drinks," reduced alcohol tolerance and reduced severity of withdrawal (where applicable), occasional

dramatic improvement in judgement and memory, protection against cardiac and cerebral vascular accidents, sustained job performance, improved family life and a better integration into Alcoholics Anonymous. In addition, it has been noted that niacin therapy reduces serum cholesterol and serum lipid levels as well as producing a lowering effect on blood pressure.

The foregoing observations apply equally well to the additional 5,000 alcoholics now taking nicotinic acid.

Response to B-3 is generally dose related but dosage adjustments should be made by the therapist not the subject. Some degree of favorable response is discernable early and often increases slowly with prolonged treatment. Interruption of therapy causes slow and predictable regression frequently requiring weeks to reach complete relapse. This represents an objective change which is dose and time related. The physiologic reaction to niacin serves as a model for what can and eventually should be accomplished by B-3 therapy. Those who respond best rapidly achieve a normal sleep pattern, freedom from uncomfortable extremes of mood, and elimination of the physical manifestations of the urge to drink. There is a marked reduction in alcohol tolerance with little tendency to risk exposure. All ancillary psychotropic medications become unnecessary and sustained alcohol abstinence is the rule. When a return to drinking is attempted, subjects find it very difficult to initiate or continue with a bout. Most impressive is the fact that these results are possible with B-3 alone and without the assistance of any other drugs.

Correcting what appears to be a biochemical lesion will do much to improve our traditional approach to the treatment of alcoholism. Certainly the problems leading to and stemming from alcoholism will always need attention. Nothing in our study to date indicates B-3 could ever restore the ability to return to controlled drinking. Therefore, the traditional forms of therapy (such as A.A.) remain necessary and desirable. However, relief from the physical problems of insomnia, mood swings, and "dry drunks," can make staying sober far easier, while reducing the need for other medications to accomplish these objectives will make the process much safer. In addition, when alcohol tolerance has decreased, a physiologic barrier against relapse is established providing a more humane deterrent than existing agents. Although sufficient motivation is necessary to continue nicotinic acid therapy, it seems possible in some alcoholics to remove the thought of gain from drinking. Thus we can discourage the use of alcohol in a positive way rather than by existing punitive, negative chemical restraints. Humphry Osmond was perhaps the first to recognize this possibility.

Even some of the unwanted effects of niacin may bring to light new insights into conditions other than alcoholism. Several years ago we began to encounter complaints of blurred vision. Initial examination failed to reveal anatomical or refractive errors, but later examinations indicated what we should have suspected initially, namely, that the difficulty stemmed from failure in convergence. Nystagmus and extraocular muscle difficulty are components of the alcohol withdrawal picture. We have also had difficulty maintaining glucose control in some diabetics. Much can and should be learned from these experiences.

I am convinced that nicotinic acid provides the opportunity of striking at the heart of the physiologic mechanisms underlying alcohol tolerance, withdrawal, and perhaps even the alcoholic disease process. Its apparent mode of action does not really fit the traditional concepts of a vitamin but rather that of a hormone. In any event, it seems to make a significant difference in the ability to obtain and maintain alcohol abstinence. This assistance has been denied a large segment of the alcohol population. Considerable experience has been amassed with nicotinic acid, including its effectiveness and a knowledge of its adverse reactions. With this information at hand it should be possible to measure risk versus effect.

At this point we have nearly completed the feasibility trials of niacin in an alcoholic population. It appears to be a most promising agent and we should enlist support from all sources. We must solicit financial support, advice, criticism, interest, and direction through the usual channels of scientific communication, governmental regulatory agencies, and the scientific community at large. Only

by following accepted procedures can we establish the use of B-3 as a useful adjunct in the treatment of alcoholism while ensuring that treatment costs will remain modest and within the reach of any individual who needs this form of therapy.

As ever,



Russell F. Smith

Attach.

* * *

October 10, 1970

	<u>Year</u>	<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>Excellent</u>	<u>TOTAL</u>
Outpatient Group	1967	18	70	109	42	239
	1968	3	42	126	62	233
	1969	0	20	125	69	214
	1970	0	0	124	70	194
Hospital Group	1967	40	19	111	46	216
	1968	26	21	87	57	191
	1969	0	20	91	63	174
	1970	0	0	101	63	164
Sanitarium Group	1967	8	9	20	16	52
	1968	3	5	23	19	50
	1969	0	3	25	21	49
	1970	0	2	25	21	48

Russell F. Amith

THE NORTH NASSAU MENTAL HEALTH CENTER
1691 Northern Boulevard,
Manhasset, L.I., N.Y. 11030
(516) MA 7-7535

Dear Bill:

Here are the updated results of our work at the North Nassau Mental Health Center with schizophrenics and alcoholics which were first reported in your 1968 brochure entitled "The Vitamin-B Therapy - A Communication to AA Physicians." This summary of our 1966-1971 activities makes a total of five years experience with the Megavitamin approach to these major illnesses.

My first report to you detailed the treatment effects on 315 schizophrenics, of whom 70 were schizophrenic-alcoholics. These were consecutive cases of patients admitted here during 1966-67. Then for the first time we used massive B-3, which has since become a crucial ingredient in our new treatment program. As a result of the success of this early pilot study our program has since greatly expanded.

In these five years we have treated over 4000 patients - of whom approximately 600 were alcoholics - with the megavitamin approach. The great majority of this large group have exhibited very marked improvement. Most of them could be called recovered; if we define "recovery" as the ability to function satisfactorily in the community with little or no professional help. The alcoholics of course must also be able to maintain their sobriety. Here at the North Nassau Mental Health Center these positive achievements have resulted in the evolution of what can be now seen as a Model Integrated Treatment System with the following ingredients:

1. An Outpatient Treatment Center that specializes in schizophrenia, alcoholism and other perceptual illnesses. Our Center is operated by a professional staff who are willing to use chemotherapy including the massive use of vitamins, notably B-3. Patients can be treated in all phases of the illness.
2. Hospital - A facility that accepts referrals with the understanding that our treatment methods will be used. In our case, this is a private institution which has become interested enough to conduct research programs of its own and publishes the results.
3. A Half-Way House for those who are recovering from the illness, or have no home to go to. The orientation of the House is one of rehabilitation in an overall patient regimen compatible with orthomolecular methods (megavitamins, diet, etc.)
4. A Day Care Center geared to rehabilitation with an Activities Program designed for vocation and social rehabilitation.
5. Patient Self-Help Groups including Alcoholics Anonymous and Schizophrenics Anonymous. These are often vital to aftercare in any overall recovery program.

6. Doctors in the community who are skilled in megavitamin therapy and administration of the H.O.D. Test; physicians who will not only treat patients, but will also be advisors and consultants to such groups as Schizophrenics Anonymous, where continual supervision of medication and diet are so essential.

7. A national organization like the American Schizophrenia Association devoted to research, education and the involvement of the patients' families and interested professionals. Here we have the Schizophrenia Association of Long Island which fosters education, family groups, research, fund raising and which backs the Half-Way House and Day Activities Centers.

On Long Island our model is attracting large numbers of schizophrenics and their families. Considerable public interest has also been aroused and press coverage has been widespread. Many requests for information are coming in, as well as professional visitors from the U.S., Canada and overseas.

The rapidly mounting demand for treatment is reflected in the expansion of our Center. Currently, our outpatient case load is 1500 patients. It is said that our operation has recently become one of the largest of its kind in the greater New York area.

Improved treatment methods have brought some valuable advantages. For examples: The need for hospitalization has been reduced 80%. Psychiatric treatment time (per patient) has dropped 80%. Out-patient shock treatment is no longer used. The need for extensive psychotherapy has been greatly reduced, and constructive family involvement has greatly increased.

Of course, the effect of these developments has been to drastically lower both diagnostic time and treatment costs. Let me illustrate:

At most clinics, the usual diagnostic procedure is for both family and patient to see a social worker for two separate interviews. This is followed by a diagnostic conference of psychiatrist, psychologist and social worker. The entire process may involve months, during which 12 to 15 hours of professional time has been consumed. This furnishes a diagnosis only; no formal treatment has meanwhile been possible.

By contrast, our current procedure requires the "HOD" test, a few biochemical tests, and a single interview with a psychiatrist. In 90% of our cases, this gives us a definitive diagnosis at a nominal cost. Because this can be done so quickly, we save both family and patient that endless waiting before treatment can start.

The total treatment time is also greatly reduced. We see the average patient 15 times the first year, and 4 to 6 times the second year. It should be borne in mind that in most cases we are treating severely ill people, many of them having multiple problems, as well as schizophrenia.

Our approach continues to move in the direction of searching for certain biochemical abnormalities in patients and correcting these first, before we commence to deal with any psychological

approaches to clinical problems. We have found that the great majority of our patients have biochemical and metabolic problems, conditions which have been extremely important in preventing any worthwhile recovery. In a very sizeable percentage of patients, once these abnormalities are corrected, rapid progress and recovery is the usual outcome.

Alterations of the molecular concentration of the substances normally present in the human body can greatly alter mental functioning. This important concept was convincingly presented by Nobel Prize Winner Dr. Linus Pauling in 1968, in an article entitled "Orthomolecular Psychiatry", Science, April 19, 1968. To many of us now working in this field, Dr. Pauling's concept very accurately describes the approach that we have been actually using for the past four years; an approach based on the extensive original work of Drs. Hoffer and Osmond that began in 1952.

Our clinic also treats alcoholic patients. Among them, three problems appeared over and over again which were either responsible for slips, or prevented full emotional recovery despite sustained sobriety. The first problem we check is the use of the hypnotics, barbiturates or the so-called minor tranquilizers. The effect of taking even small amounts of these substances seriously interfere with the patient's sobriety and brings about subtle alterations in his thinking and feeling, and sometimes outright slips. In every single case where these medications have been used, the effect was noticeably deleterious. (This has been reported by other doctors also in The Journal of the American Medical Association.)

Functional hypoglycemia (hyper-insulinism) or so-called low blood sugar, was another factor commonly present and previously undetected. This condition accounted for many failures to recover. Such alcoholic patients immediately felt better as soon as they were taken off sugar and sweets and placed on B-3 to elevate their blood sugar levels. We found this marked improvement to be as clinically conclusive as obtaining a six-hour glucose tolerance test in the laboratory.

Of the alcoholics who did get the six-hour glucose tolerance test, many reported that during the testing, they began to develop symptoms which they recognized they had often experienced periodically, and which often preceeded drinking. Quite a few patients who had been sober for considerable lengths of time reported periodic depressions, feelings of tension, anxiety and recurrent desires to drink. Correction of the hypoglycemia eliminated these symptoms in the great majority.

The third problem we discovered in alcoholics, which played a very important part in delaying or preventing recovery, was the presence of multiple perceptual distortions as revealed by administering the HOD Test.* This is a test for alterations of perceptions such as touch, taste, hearing, vision and perception of bodily parts with associated feelings. There are also alterations in the perception of time and space which show up on the "HOD". These malfunctions have a profound effect on mood, judgement and the ability to discriminate reality.

Most alcoholics who have just sobered up will show a high HOD score initially. But this rating rapidly returns to normal following continued sobriety. However, in many of the patients we see, who are unable to get sober, or who are sober but still miserable, an elevated HOD score persists. Such changes in perception are thought to be due to alterations in brain function on a chemical basis,

*See Bill W's 1968 Communication to AA Physicians - "The Hoffer-Osmond Diagnostic Test for Schizophrenia." (HOD Test equipment available at Bell Therapeutic Supplies, Inc., 382 Schenck Ave., Brooklyn, N.Y. 11207.)

due perhaps, to abnormalities of adrenalin metabolism as described by Drs. Hoffer, Osmond, and many others. In some patients, the HOD score was so high as to give the alcoholic symptoms of schizophrenia, so that it was difficult to say whether the patient had schizophrenia complicated by alcoholism, or alcoholism which had developed into schizophrenia. Though hallucinations are common during DTs, many such alcoholics continue to have hallucinations long after they have stopped drinking. The great majority of our group also had functional hypoglycemia, and they, too, were emotionally and mentally quite ill. Although these perceptual problems appear to occur more often in the younger alcoholics, we, nevertheless, screen every alcoholic patient with the HOD test.

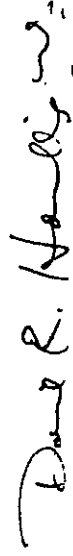
All these patients responded very well to a combination of Vitamin B-3 in doses of four grams or more per day; ascorbic acid four grams per day, with the additional of 50 mgs. a day of pyridoxine. In many cases, Vitamin E, 200 International Unit capsules, four times a day, were added. Many patients who are on niacin report a greatly diminished desire to drink as well as alleviation of other symptoms.

The theory behind the megavitamin approach is that the megavitamins correct the abnormal breakdown of the adrenalin into toxic byproducts which are the cause of the perceptual alterations and the elevated HOD score. Practically speaking, when we take patients off harmful drugs, correct their hypoglycemia and then place them on megavitamins, sometimes with the addition of one of the phenothiazine drugs, remarkable recoveries are often the result. It is clinical results rather than theory which concern us at the present time.

Within the last year, a new chapter of Schizophrenics Anonymous started on Long Island. Many AAs who have rather marked perceptual distortions identify with both SA and AA. In fact, many of the SA groups recently formed in the United States and Canada have been started by AAs who had perceptual problems. (The growth and success of these SA groups was reported in World Medical News in a special article on Schizophrenics Anonymous). Quite a few alcoholics have entered AA after SA had first helped them to correct their perceptual problems. Only then were they able to recognize and deal with their alcoholism.

The SA groups have all located doctors in their communities, knowledgeable about the megavitamin approach or who are truly interested in learning how to work with it. The number of doctors utilizing the megavitamin therapy is now proliferating at such a rate that the findings of suitable medical assistance should no longer be too difficult. There is now a National Medical Society devoted to the development of this new direction in psychiatry; the Academy of Orthomolecular Psychiatry, which has 100 founding members. The Academy will be publishing the Journal of Orthomolecular Psychiatry.

Very truly yours,



David Hawkins, M.D.
Director

DH:eg

*Dr. Hawkins is editing the first textbook on Orthomolecular Psychiatry which will be published in 1971 entitled Orthomolecular Psychiatry: Treatment of Schizophrenia. The book is co-edited by Prof. Linus Pauling and includes contributions by twenty-three different authors. A chapter on Schizophrenics Anonymous, describes the first sizeable patient group to make use of this new approach in helping to solve their problems. The book is being published by W. H. Freeman and Co., 660 Market St., San Francisco, California.

* * *

Case No. 1: We refer to this case as the "Lobotomy, Yes - Niacin, No!" case. This patient is a 33 year-old housewife and mother of four young children. She had been ill for an indefinite period but overtly and severely psychotic with schizophrenia for five years. The family had unlimited means and left no stone unturned in providing the best of professional help. She was in a number of hospitals and was treated by a number of highly qualified psychiatrists. In addition to this, she had all the psychotropic drugs in massive doses and in multiple combinations, as well as several courses of electroshock therapy. Despite all this, her condition became progressively worse. She was openly delusional, suicidal, out of contact and disturbed. Because of the hopelessness and severity of her condition, the physicians and hospital finally recommended a prefrontal lobotomy (in 1968 this was an almost unheard of procedure, as the results are often rather grave and irreversible which indicates the extraordinary severity of her condition.)

The patient was scheduled for the lobotomy and at the last minute, the family asked if she could be given a trial of megavitamin therapy before resorting to the drastic surgical procedure. At this point, the psychiatrist in charge of the case became infuriated at the family's temerity and exclaimed - "Lobotomy, yes - Niacin, no!" The family then had the patient transferred, against medical advice, out of the hospital and had her admitted to Brunswick Hospital in Amityville, Long Island. The patient was not at all happy about the transfer, did not like the new hospital, did not feel the new treatment would help her, did not like her new doctor, but did consent to take medications.

On a combination of megavitamins, thyroid, hypoglycemic diet and a small dose of tranquilizers she recovered in 10 weeks. She was discharged from the hospital 24 months ago and during the intervening time has returned to full normalcy, including taking care of her children, running her household, becoming active in PTA and other social activities and she is now working at a half-time job in addition. When interviewed currently, she gives no noticeable signs of ever having been ill and she is being seen for after-care for about twenty minutes every 12 weeks. She looks well, feels well and has no symptoms.

* * *

Case No. 2 - is a 45 year-old man who had been sick continually for 10 years and had been given up as hopeless after many hospitalizations, years of therapy, all the drugs, shock treatments, insulin coma therapy, etc. His diagnosis was that of chronic paranoid schizophrenia and the doctors had advised committing him for the rest of his life. The family, however, could not bear this prospect and so had kept him at home for several years where his condition was deplorable. He screamed

obscenities out the window at his hallucinated enemies, refused to shave, bathe, get a haircut, or change clothes and threw new clothing out the windows when it was offered. He refused to take any medication and eating was sporadic and bizarre. He was unable to speak a coherent sentence, much less able to give a relevant response. He was unable to function in any capacity, had no interest, even in TV. There was no way of reaching him and the family came to the Clinic on his behalf. The family refused recommitment, so that the only treatment approach feasible was to put the megavitamins surreptitiously in his food. Together we worked out a concoction of Niacin & Ascorbic Acid powder mixed with Bicarbonate of Soda, mixed with some chicory to cover the flavor in his coffee (he was a big coffee drinker). We saw the family every two to three months to check on his condition, and by the end of a year, he had made such progress that he was now a clothes dandy, ate normally, was able to remember, was no longer hallucinating, now watched TV, carried on a normal conversation, read a daily paper, was calm, and according to the family and neighbors, the extent of his recovery was unbelievable. He is currently looking for a job and to this day, because he still refuses to take any kind of a pill, he is unaware that he is getting large doses of megavitamins.

* * *

Case No. 3 concerns both schizophrenia of childhood onset, and severe drug involvement over a number of years. This 23-year-old young man was a behavior problem since early childhood and had been in continuous treatment since the 6th grade when he had become quite disturbed. The family had made considerable sacrifices and had him as well as themselves in treatment with some very famous and highly qualified psychiatrists. Despite this, the patient's condition worsened and he became heavily involved in the drug scene where he became addicted to barbiturates and amphetamines and in addition took LSD, STP, hashish, marijuana, demerol, dilaudid, opium, kief, hog, cocaine, mescaline, psilocybin, THC, Freon, amylnitrate, morphine, dexamy], carbona, etc. and heroin. He lived on the streets in New York City and his condition was dissheveled, malnourished and bizarre. He shot methedrine intravenously and had a \$140-a-day consumption of speed so that in addition, he also developed needle hepatitis. The family managed to bring him in just once for a diagnostic evaluation and, at that time, his HOD score was over 100. He then disappeared back into the City and showed up a number of months later in an acute drug crisis at Bellevue Hospital where he had been taken by the police (Speed plus STP).

He was transferred to the Brunswick Hospital in Amityville where his clinical course was extremely stormy. He was uncooperative, disturbed and hallucinating, and in addition, had generalized jaundice with markedly abnormal laboratory tests. With intensive treatment in the hospital, he was discharged in 8 weeks but still had an intense craving for methedrine. Although out of the hospital, he was unable to function in any way, was very regressed and did nothing but watch TV.

During the ensuing year, he has been on megavitamins, plus large doses of Vitamin B-3 and small doses of tranquilizers. It is now 14 months since he was discharged from the hospital and his HOD score is now 8, indicating the disappearance of any active schizophrenia. The craving for drugs has disappeared and he, in fact, now counsels young people who are currently in trouble with drugs. He is working full time, active in community affairs, is involved with a very normal young woman and is now moving on to a responsible job involving administrative responsibility in the counseling of young people who are still quite ill due to drugs plus schizophrenia.

Case No. 4 is a 28-year-old single, young man who had been ill for six years. He had been treated by all known methods, including drugs, electroshock therapy, etc. and had spent the last four years at one of the highest priced famous psychoanalytically oriented, private psychiatric hospitals, in the United States. While there, he received almost daily psychoanalytic sessions, but became worse and worse to the point that he had stopped eating and the family feared for his life. The Institution refused to use any drugs and instead, used wetpacks, restraints, seclusion. The Institution even refused to give him an injection so that he could be transferred, and instead, sent him up to Brunswick Hospital tied up in wet sheets and restraints. His arrival presented an almost unbelievable sight and the patient admitted frankly, he was committing suicide by starvation because he could not bear the agony of his illness any longer.

This patient was so ill that we had to institute electroshock therapy treatments but in 10 weeks he was discharged on a combination of megavitamins, plus phenothiazine drugs. He very shortly returned to work and during the last two years has done very well with an active social life as well as a responsible work record. We see him every 8 weeks for about 20 minutes to check on his medication and to see how he is doing. His family spent close to \$200,000 on his previous treatment up to the time that he arrived here in mummy fashion.

* * *

Case No. 5: This is a 34-year-old alcoholic and schizophrenic who had had a long, unsuccessful history of treatment with many hospitalizations, shock treatments, arrests and ultimate total rejection by his family. His alcoholism took a florid and bizarre trend. When drunk, he became assaultive, had blackouts, smashed up cars, got into violent fights and he was totally unemployable. In addition, he had delusions and hallucinations even when he was not drinking and felt so depressed that he had to return to drinking. He had tried AA but was too ill to comprehend the program.

He never dated and felt he was homosexual, as he had a number of homosexual experiences. In addition to all the other troubles he was addicted to a combination of Doriden, Librium, Valium and occasionally, amphetamines, which he took to keep from passing out from the combination of other drugs (he averaged over 40 pills a day). He was unsuccessful in getting off this combination of drugs because of either severe withdrawal or convulsions. We withdrew him from the addicting drugs as an out-patient and switched him to heavy doses of non-addictive phenothiazine tranquilizers. He was taken off sugar and sweets because of his Hypoglycemia and placed on heavy doses of megavitamins. In addition, he went to Schizophrenics Anonymous. Within several months, the schizophrenia symptoms abated, although the drinking continued. Finally, he became sufficiently rational to follow the suggestion that he give AA as well as Schizophrenics Anonymous a chance and his drinking stopped abruptly.

By the time he celebrated his first anniversary in AA he was working, was off Welfare, was going to dances and learning how to socialize. During the second year, he received a promotion, then went on to a better job, became engaged, and at the end of the second year, married a very nice girl. During the third year, they had the first baby whom they bring with them when they come to the Clinic which is now two or three times a year. He is still active in AA as well as SA and has helped a great many other ill people recover.

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1. The Annotated Bibliography of Alcoholics Anonymous 1939-89. by Charles Bishop, Jr., & Bill Pittman. Wheeling, WV, 1989. First Edition, signed by both authors. 284 pages. Contains over 1,400 listings of books, pamphlets, articles in popular magazines and scholarly journals, dissertations, etc. written by or about AA over the past 50 years. The essential reference work on the Fellowship for AA archivists, collectors, historians and professionals. \$12.
2. The WASHINGTONIANS and Alcoholics Anonymous. Wheeling, WV, 1992. First reprint in 150 years of the original 1842 Washingtonian book! Plus AA Trustee Milton Maxwell's 1950 essay comparing the two. Plus the extensive Blumberg bibliography. 128 pages. \$10.
3. Carrying the Message in the Comics 1949. Wheeling, WV, 1993. Reprint of the 35 comic strip panels from April 5 thru May 14, 1949, in WASH-TUBS by cartoonist Leslie Turner. The AA recovery story told in the comics and read by millions! Capt. Easy to the rescue! \$5.
4. Dr. Bob's Library. by Dick B. Wheeling, WV, 1992. First Edition, 116 pages. Here are the 100+ books the Co-Founder of AA had in his library and recommended to Fellowship members before the Big Book was published. The Bible, Oxford Group and other inspirational spiritual books are discussed. \$10.

5. AA Prospectus. 1991 reprint of the 1939 original offering AA members the chance to invest \$25. in a share of stock in Works Publishing Co. and print the Big Book and ... get rich on the profits. Bill & Hank really were promoters! 16 pages. one for \$1. dozen \$5.

6. The 1994 Sobriety Calendar. Wheeling, WV, 1994. The 5th annual wall calendar will be out around October. It's sold out for 4 straight years. Printed in 7 Solarbright colors, each month has a historic photo of AA or alcoholism in America. Each month has one of 12 Steps and a historic prayer. And... each day has a slogan, humor, or historic event in AA history or alcoholism in America. All new photos in 1994! No money now. Reserve your copies by writing now! one \$6. 10=\$40.

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