I'LL QUIT TOMORROW

A practical guide to the alcoholism treatment which has worked for seven out of ten exposed to the Johnson Institute approach

Vernon E. Johnson

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Acknowledgments

Mark Twain is reported to have originated the observation "Adam had all the best of it. When *he* said something he *knew* no one had ever said it before!" One has to wonder if Twain really thought of *that* first. In any case, it is an apt phrase to describe the quandary of this writer in making acknowledgments regarding sources and resources for the thoughts on the following pages. No claim to originality can be made. Nor is it made. One only wishes one could remember each source. Proper credit would gladly and gratefully be made.

From unnumbered sick individuals, Alcoholics Anonymous members, physicians, clergymen, other professionals, has come information and insight. This effort has been simply to synthesize and give order to their contributions.

Three special groups must be given my thanks: first, the hospitals, their patients, their forward-looking boards, and administrative and medical staffs (pioneers in spirit, every one of them); second, the people at Hazelden, Center City, Minnesota, under the guidance of Dr. Dan Anderson, and third, those of the board of the Institute itself. "May they live long on the land and prosper!"

Over the years, associates in the work have been many—over fifty, in fact. If mentioned by name surely I will overlook some. I know they will understand if I say to them simply, "Thank you. I feel much more like I do now than I did when we started!"

Nevertheless, individual thanks must go to Barbara Heines, secretary, confidante, and friend, whose struggles through hen scratches brought it all to the publisher.

Finally, there is Mary Ann, whose long suffering permitted absences frequently, tardiness often, and whose compassion still answers the constantly jangling home telephone with patience with patients. This book is dedicated to the most "normal" person I know—my wife.

Contents

Introduction 1

1. A Drinking Culture 7
2. The Rising Cost of Dependency 14
3. Rational Defenses and Projection 24
4. Blackouts, Repression, and Euphoric Recall 32
5. The Dynamics of Intervention 43
6. The Cry for Help and the Use of Crisis 56
7. Treatment of the Acute Phase 60
8. Characterological Conflict 74
9. The Stages of Recovery 79
10. Rehabilitation 84
11. Counseling Alcoholics 92
12. The Dynamics of Forgiveness 99

Appendixes: 111

- A Patients' Handbook 113
- B Group Therapy Handbook 118
- C Patient's Self-Evaluation 124
- D Counselor's Initial Interview 130
- E Meaningful Person Evaluation Form 133
- F First Step Preparation 142
- G Outpatient's Handbook 143
- H Hospital Personnel Training Handbook 150
- I Clergyman's Handbook 161

Introduction

Alcoholism is a fatal disease, 100 percent fatal. Nobody survives alcoholism that remains unchecked. We would estimate that 10 percent of the drinkers in America will become alcoholic, and that these people will not be able to stop drinking by themselves. It is a myth that alcoholics have some spontaneous insight and then seek treatment. Victims of this disease do not submit to treatment out of spontaneous insight—typically, in our experience they come to their recognition scenes through a buildup of crises that crash through their almost impenetrable defense systems. They are forced to seek help; and when they don't, they perish miserably.

This disease involves the whole man: physically, mentally, psychologically, and spiritually. The most significant characteristics of the disease are that it is primary, progressive, chronic, and fatal. But it can be arrested. The progress of alcoholism can be stopped, and the patient can be recovered. Not cured, but recovered. This is a hard-headed, pragmatic statement of fact which has visible proof in the recovery of thousands of alcoholics who are well today. They are alive, and they bring alive hope for countless others. Their return gives the lie to the notion that this illness is too complex and too individual by nature even to tackle.

At the Johnson Institute in Minneapolis, Minnesota, we have had the privilege of assisting in the development of three such treatment programs in private general hospitals in Minnesota and Nebraska. The oldest is in its fifth year in St. Mary's Hospital in Minneapolis, where a 52-bed unit is available for treatment of this disease. The programs in these three hospitals have recovered thousands who were desperately sick. These people have returned to happy and productive lives—not the bleak, unrewarding, abstinent existence that is associated with arrested alcoholism.

Very simply, the treatment involves a therapy designed to bring the patient back to reality. The course of treatment consists of an average

of four weeks of intensive inpatient care of the acute symptoms in the hospital, and up to two years of aftercare as an outpatient.

Annual studies of St. Mary's former patients have consistently indicated that 52 percent of the patients never drink again after completing the program. The other 48 percent relapse and experiment with alcohol. About half of these dropouts return and complete the outpatient program successfully, and remain abstinent. This means that in the end three out of four of St. Mary's patients successfully recover from alcoholism. Continuing studies of the patients at the other two hospitals have indicated almost exactly parallel results.

The myths and old wives' tales around alcoholism are legion. When you demythologize it, you find that this disease is an entity as distinct as measles. Alcoholism has a describable, predictable pattern of pathology. It is primary in the sense that it effectively blocks any care or treatment we might want to deliver to any other problem; if an alcoholic has a diseased liver, which he frequently does, the doctor cannot do anything about the liver until the alcoholism is brought under control. Our observation of the illness leads us to believe that it is always progressive. It never plateaus. It always worsens.*

Who contracts this illness? What sort of personality becomes alcoholic? The answer seems to be that, mysteriously, all sorts of personalities become alcoholic. The fact is that the cause of alcoholism is unknown. The difficult question, in fact, is why some people cannot become alcoholic no matter how hard they try. A drinker has to be able to develop a tolerance for ethyl alcohol or he can't make it. If alcohol makes him sick and he throws up, he is immune. Drinking is not enough—you have to get drunk to become alcoholic, but even the definition of drunkenness can cause endless debate.

Our most startling observation has been that alcoholism cannot exist unless there is a conflict between the values and the behavior of the drinker.

People of every stripe of character and morality become alcoholics, but ultimately the disease causes all its victims to behave in a destructive and antisocial way. In searching for common denominators, we have observed that the alcoholic is likely to be an achiever in his peer group. Interestingly, people who appear entirely phlegmatic seem less likely to become addicted to alcohol or other mood-changing chemi-

*We mention on p. 84 a plateau which may occur during recovery. This never happens in the illness itself.

cals. They just live along, and the frustrations of life don't seem to get to them—neither does alcohol. Another way of avoiding this conflict is not to care. Sociopaths appear to lack the values or conscience essential to the conflict we observe in alcoholics. They *actually* feel no guilt or shame.

Since it is not known why people become alcoholic, the Johnson Institute began to inquire into other areas. Why do people who have the disease wait so long to get treatment? Why do they suffer so long? To accept the necessity of such extreme suffering and such damage seemed unconscionable. Since alcoholism is progressive and fatal, it was evident that the most urgent need was to stop the process of the disease as early as possible. We were very much concerned about the popular conviction that you could not do anything with an alcoholic until he hit some ultimate bottom. A first effort of the Institute was to study 200 recovered alcoholics. Our questions were designed to find out why they suffered so long and what kept them from getting help. Our goal was to discover how they came to treatment.

Well, it turned out that we were asking the wrong questions in the wrong way. We repeatedly got reports from recovered alcoholics that they had simply seen the light, that a spontaneous insight had brought them to treatment. By redesigning the questions we came up with the information—and the truth: all these people had suffered a buildup of crises that brought them to a recognition of their condition. The crises themselves were usually fortuitously grouped together so that they broke through the almost impenetrable defenses of the victims of the disease, which were organized into highly efficient "denial systems."

It became clear to us that it was not only pointless but dangerous to wait until the alcoholic hit bottom. The crises everybody was trying to help him avoid could actually be employed to break through his defenses, by an act of intervention that could stop the downward spiral toward death. We came to understand that crises could be used creatively to bring about intervention. Because, in fact, in all the lives we studied it was only through crisis that intervention had occurred. This led to experimentation with useful methods of employing crisis at earlier stages of the disease.

For ten years now, people have charged the Institute with inventing a system of treatment based on creating crises. And our response is that we do not invent crisis, that it is not necessary to invent it. Every alcoholic is already surrounded by crises, no one of which is being

used. All we have to do is to make those around him knowledgeable enough so that they can start using the crises. This makes it possible for them to move sooner, and to limit the very real damage to themselves that comes from living with a worsening situation. In a later chapter we will explain how crises can be employed to set up confrontations which can lead to successful treatment.

A misconception about alcoholism causes people to be fearful to confront alcoholics. We are told that the alcoholism may be a cover for some more serious emotional disorder, and that alcoholics can be shattered if they are cornered. Another misconception is that since he behaves the way he does, the alcoholic is heedless and does not care what damage his behavior causes. This leads to the erroneous assumption that he will be unresponsive to any attempts to help him. Because of his wide mood swings, the alcoholic is a formidable person to confront, and it is true that he is able skillfully to rationalize his own behavior. But in this book we will share our observations that the alcoholic does not smash so easily, and that there is an explanation for his careless behavior. Actually he is loaded with self-hatred which is repressed and unconscious, and he projects this onto the persons around him.

The people around an alcoholic do not realize how little he knows of himself and of his own behavior. He is *not* confronted by his own actions; many of them he is not even aware of, although those around him assume that he is. They believe that he sees himself as they see him. In point of fact, as the disease runs its course, he is increasingly deluded. He lives with increasing impairment of his judgment, and eventually loses touch with his emotions entirely. He has conscious and unconscious ways of forgetting painful experiences. It is a matter of self-survival. If a person is alcoholic, by definition he is unable to recognize the fact. Any attempt to interrupt his drinking or change his life-style he views as meddling.

Since the alcoholic is not going to have any spontaneous insight, and since his disease makes it so difficult to approach him, it is crucial that the persons close to him understand the nature of his problem. For they must take the initiative if the illness is to be arrested. One of the chief goals of this book is to explain why this is so and how to do it.

Very different sorts of people become alcoholic, but all alcoholics are ultimately alike. The disease itself swallows up all differences and creates a *universal alcoholic profile.* The personality changes that go

with the illness are predictable and inevitable, with of course some individual adaptation. When we describe the behavior of a victim of this disease, there is always instant recognition by members of the family. The classic description fits almost any individual alcoholic to a startling degree.

It is our observation that the symptoms we find are present in victims addicted to other chemicals. In observing the effects of alcohol we have inevitably been forced to evaluate the effects of mood-changing chemicals such as the amphetamines, the barbiturates, and the minor tranquilizers. Persons dependent on these chemicals go through the same disintegration as the alcoholic. And they can be recovered by the same treatment that is proving so successful with alcoholics. Nowadays, a majority of alcoholics are simultaneously involved with other mood-changing chemicals. Our treatment was developed in the light of this reality, and is effective with multiple-chemical use.

The experimental programs in the field of alcoholism that led to the founding of the Johnson Institute began in 1962. The early studies were conducted within the framework of the parish of St. Martin's-by-the-Lake, an Episcopal church in Minneapolis which volunteered itself as a working laboratory. A four-man staff of clergymen devoted themselves to solving certain major problems in the community, one of which was alcoholism. Community leaders who saw the value of continuing work in this field then organized the Johnson Institute in 1966 as a non-profit foundation. Two basic goals were set up: to design specific programs for alcoholics through applied research, and to educate the public in methods of intervention. In pursuing these goals the foundation discovered that it was necessary to use a multidiscipline approach which would include the fields of medicine, psychology, sociology, theology, and practical drug experience.

We soon realized that we could not have an effective working laboratory unless we were directly involved in treating alcoholics. And treating alcoholics led us to the obvious conclusion that alcoholics should be treated where other sick people were treated—that is, in our general hospitals. So we were very fortunate when St. Mary's General Hospital approached us in 1966 about opening its doors to these patients. We started with 16 beds in a 600-bed hospital. They filled immediately, and we had a waiting list. The unit at St. Mary's grew from 16 to 25 beds, then 36, then 42, and eventually to 52 beds, or a full floor in the modern section of the hospital. From the first we

designed the unit as simply another service for the medical staff. The admitting physician in this design is the attending physician. Some 200 doctors have used the service for their patients. The result has been the creation of a great medical resource for alcoholics.

Since the opening of the alcoholic unit at St. Mary's, our Institute has started programs in other hospitals, among the first of which were Miller Dwan General Hospital in Duluth, Minnesota, and Lincoln General Hospital in Lincoln, Nebraska. We are getting reinforcing statistics from these hospitals. This total experience supports our conviction that alcoholism can be effectively treated and that a large majority of alcoholics can be saved from an ignominious death.

In the next chapters we will describe our observations of the process by which the social drinker develops a chemical dependency and becomes alcoholic. This mood-changing drug can precipitate the onset of a disease with a predictable, inexorable course. It can ultimately destroy the physical, emotional, spiritual, and mental life of the victim. The disease is typified by a progressive "mental mismanagement" and an increasing emotional distress which can reach suicidal proportions. There is a developing spiritual impoverishment that makes the destruction complete. Because this pattern can now be specifically described, a specific form of treatment can be employed with predictable and significant recovery rates.

People who get sick with this disease can and do get well.

1.

A Drinking Culture

Let me get you a little dividend

As we begin to deal in detail with the progressive emotional distress of alcoholism, the fact that we can now be specific is worth noting. There has been very little precise information on the course of the disease. Virtually all of us in our society have been exposed to alcoholism in some form or other, and it has caused us great consternation and confusion. We have had no handle or method for approaching it which was specific enough so that we could take directions and set goals. Alcoholism has been as a health problem both too complex and too idiosyncratic to handle within the framework of conventional medical care.

Our approach at the Institute has been strictly pragmatic. We have not been out to prove any theory. We were simply given the opportunity to observe literally thousands of alcoholics, their families, and the other people surrounding them. All our trained and experienced personnel shared their observations, and we came up with the discovery that alcoholics showed certain specific conditions with a remarkable consistency. Such applied research then led to the development of experimental programs designed to try to meet these conditions and cope with them. As the years passed, we continued to use and refine the programs that worked in practice. A decade of such efforts is reported in this book.

First we noted that physical addiction with its withdrawal problems could be quite safely handled in a qualified medical setting. The process of detoxification is essentially the substitution of some other chemical for alcohol while the toxic effects of the alcohol subside. This process is generally completed within a few days. We can take care of the physical addiction with relative ease; the burden of the harmful

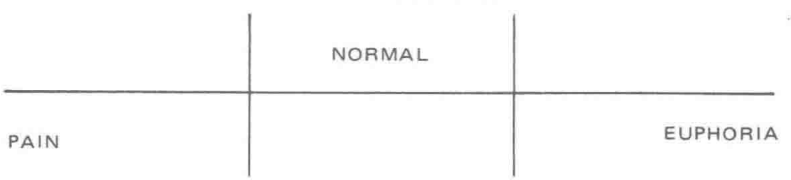
dependency is psychological. Breaking through the psychological addiction is a much more complex and difficult problem.

Nevertheless, our continuing experience with increasing numbers of cases suggested that this condition could be accurately described in terms of a special kind of emotional distress found to be present in all of them. In order to illustrate this universal emotional pattern of alcoholism we used the Feeling Chart. This is essentially a straight-line graph where all human emotions can be represented. The mood swings which are the emotional symptoms of alcoholism are shown on successive graphs as we trace the inevitable deterioration of the self-image of the suffering alcoholic.

In Figure I below, human feelings are registered graphically from left to right. The most painful feelings at the far left merge into less painful ones, which shade into normal feelings and ultimately build to ecstatic emotions or the euphoria depicted at the far right of the graph. Thus the feelings range from suicidal despair to ecstasy. Theoretically, everybody is somewhere on this graph at any given moment. Since we all have mood swings, in a lifetime any of us would move over a large part of this spectrum. According to the law of averages, most of us would occupy the center of the graph during most of the days and years of our lives.

Figure I

THE FEELING CHART



We have arbitrarily divided all human emotion into three feeling areas. We are not suggesting that the population is divided in this way. We do not know exactly how many human beings would fall into each category. But for the purpose of illustrating the dynamics of alcoholism or mood swings, the chart can be useful to us as a tool. Moods range from "I'm no damn good" up through "I'm okay," to "I'm blissful." We can assume that the great majority of persons are emo-

tionally more or less comfortable and therefore in the middle of the chart. A significant fraction of the population live in chronic emotional pain and need help. While there are fewer profoundly or ecstatically happy people, at any one time they do exist. The question of how many there are in each category is not important. Inexplicably, alcoholism seems to hit approximately 10 percent of each of these groups as we roughly define them in considering our patients' earlier histories—the desolate and the joyful alike. One might think that people in chronic emotional pain would become alcoholic in disproportionate numbers, and on the other hand, that productive, well-adjusted individuals with integrated personalities would have a powerful immunity. On the basis of the thousands of alcoholics we have observed, this is not true of the conditions that precede their active alcoholism.

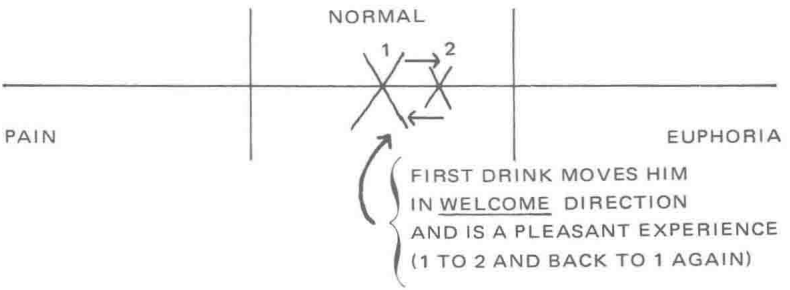
Joe loses his wife, becomes distraught with grief and starts drinking heavily. He does become helplessly alcoholic as a result. But Harry and Tom, who are also inconsolable with grief and who also try to drown their sorrows, do not become alcoholic. Since we cannot anticipate who will take the downward, disastrous path, the only productive way to study the disease is to consider thousands who already have a harmful dependency and retrace their progress into alcoholism. Before the onset of the disease, their emotional backgrounds are different. After they have contracted the illness, however, it becomes more and more apparent that the pattern of emotional distress is universal, and that chemically dependent people not only show the same pathology, but respond to the same treatment. We use the Feeling Chart to record the drinking experience of the alcoholic from the first phase, or introduction to ethyl alcohol, to the first instance of *emotional cost* which signals the onset of the disease, and finally to the last, fatal stage which may be either slow or rapid suicide.

The first two phases on the Feeling Chart, discovering or learning the mood swing and seeking the mood swing, are entirely pleasant and benign. They describe the experiences of all drinkers, not just alcoholics. The individual is introduced to some beverage containing ethyl alcohol (wine, beer, or distilled spirits), and in our culture this will likely be very early in life. It may be beer or liquor from the parents' supply. It may or may not taste good, but it is a significant discovery as a new feeling, and in no time most young drinkers get accustomed to the taste. In terms of the Feeling Chart, that first drinking experience is a mood swinger in a postive direction—it gives the drinker a

warm, good feeling, may even make him giddy, depending upon the amount. And when the effects of the alcohol wear off, the drinker returns to normal (see Figure II). There is no damage, there is no emotional cost. On the chart he goes from 1 to 2, then swings back to 1 again when the effect disappears.

Figure II

PHASE ONE: LEARNS MOOD SWING



The initiation has been interesting and pleasant, and the only aftereffect is the exhilaration of a new experience. The new drinker is onto a good thing. The fact that he can make himself feel better is a real discovery. He can turn it on and he can turn it off. There are three steps in this learning experience. Alcohol always moves him in the right direction. He can control the degree of the mood swing by the amount. And it works every time. If one drink will do this, two or three will do *that.* It does not take very long to learn that he can set the amount and select the mood. He swings up into a relaxing mood, then swings back to home base. So, on the chart, it is 1 to 3 and then back to 1 again (see Figure III).

Notice, too, *how* he is learning. It is not from a lecture or a printed page—that is, didactically or intellectually. He is learning experientially, by doing it. And he is learning by feeling it, or emotionally, which is the very best way to absorb anything. This is the difference between learning to drive a car from behind the wheel—with the surge of power under your foot as you depress the accelerator and the landscape whipping by until you brake and grind to a stop—and a purely classroom type of experience with a good book on *How to Drive an Automobile.* There is no comparison between these learning processes.