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**THE HISTORY OF RECOVERED PEOPLE
AS WOUNDED HEALERS:
I. From Native America to the Rise of the Modern Alcoholism Movement**

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Abstract

This is the first of a two -part article that outlines the history of men and women who, having recovered from addiction to alcohol and/or other drugs, went on to devote their lives to helping others similarly afflicted. This paper will describe the roles recovered people played in: 1) late 18th and early 19th century Native American cultural revitalization movements; 2) the 19th century temperance movement; 3) 19th century inebriate homes, inebriate asylums and addiction cure institutes; 4) the urban mission movement; 5) the Emmanuel Movement; 6) early alcoholism-focused hospital units, farms and retreats; 7) the Minnesota Model of chemical dependency; and in 8) the birth of industrial alcoholism and halfway house programs.

Introduction

I must combat King alcohol, or else I may yet die a drunkard. George Dutcher, 19th Century Temperance Lecturer (Dutcher, 1872)

I can sympathize with and appreciate the condition of the poor inebriate. Have I not been one of their number? I now have an object in life—to reform men. Thomas Doutney, 19th Century Temperance Lecturer (Doutney, 1903)

The concept of the “wounded healer”—the notion that people who have faced and overcome adversity might have special sensitivities and skills in helping others experiencing the same adversity—has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements (Nouwen, 1972). This article traces the American origins of a special type of wounded healer: men and women who, having transcended their own addiction to alcohol and/or other drugs, went on to devote their lives to helping the still suffering addict.

The Question of Language

We must begin this exploration with a brief discussion of the rhetoric that has been used to designate those who once had, but no longer have, alcohol- and other drug-related problems.

Such terms include: *reclaimed, redeemed, reformed, reforming, arrested, dry* (drunkard), *cured, sobriate* (a sober inebriate), *recovered, recovering, ex-*(sot, drinker, drunkard, alcoholic, alcoholic, addict), and *former* or *post* (drinker, alcoholic, addict) (White, 1997). The debate over the most appropriate of such terms dates at least to Harrison's 1860 treatise on the Boston Washingtonian Home in which he makes a special point to refer to men in the Home as *reforming* rather than *reformed* (Harrison, 1860).

Most of the debate over these terms hinges on whether recovery is seen as an enduring process (the *"ing"* suffix) or a life event that can be mastered (the *"ex"* prefix and *"ed"* suffix). The former may have utility to the individual as a reminder that addiction recovery is a dynamic process that requires continued activity and vigilance, while the latter may be helpful in conveying to active alcoholics, their family members, and the public the very real potential for permanent recovery from addiction (Bissell, 1982; McInerney, 1973). The terms "recovering" and "recovered" may also be used to distinguish between those in early stages of recovery from addiction and those who have achieved stable recovery (Blume, 1977).

Both terms will be used in this study: *recovering* to indicate those in early periods of sobriety and *recovered* to indicate those who have achieved a measure of stable sobriety. This distinction is important in light of a history in which individuals with only a fragile hold on their own sobriety have been recruited to work as professional helpers (McGovern, 1992).

Historical Roots: Wounded Healers as Temperance Reformers

The advent of recovering and recovered alcoholics in America devoting themselves to carrying a message of "experience, strength, and hope" to those still addicted to alcohol can be traced to the late 18th and early 19th centuries. This practice was born within two separate cultural contexts: 1) the rise of alcohol-related problems among Native American tribes, and 2) the rise in alcohol-related problems in post-Revolutionary War America. Within both contexts, there emerged a conscious process of addiction recovery and efforts by those in recovery to spread the hope for recovery to others still afflicted.

Native American Temperance Reformers

As long as I live, as long as the number of my days is, I will never use it (alcohol) again. I now stop. Handsome Lake, 1800

The use of alcohol as a tool of economic, political and sexual exploitation of Native Peoples has been well-documented (Mancall, 1995; Unrau, 1996). Native American responses to increased alcohol-related problems included using Native healing practices to treat alcoholism, lobbying for a ban on the sale of alcohol, and organizing Native American Temperance societies. Tribal leaders, such as the Delaware Prophet and the Miami Chief Michikinikwa (Little Turtle), waged sustained campaigns against alcohol during the closing decades of the 18th century. It was within this broader pattern of resistance to growing alcohol problems that Native Americans who had themselves experienced such problems launched abstinence-based cultural revitalization movements.

A number of recovered Native American leaders played prominent roles in helping stem

alcohol-related problems within their tribes, and many went on to have significant intertribal influence on drinking problems. Samsom Occom, a Mohegan, wrote a widely distributed anti-alcohol pamphlet in 1772 entitled, "Mr. Occom's Address to His Indian Brethren," in which he graphically depicted the role alcohol was playing in the destruction of Native Peoples (Mancall, 1995). In 1800, a Seneca named Handsome Lake had a powerful vision experience that sparked his own recovery from alcoholism and his creation of a new nativist religion based on the practice of total abstinence. He spread his religion by establishing "circles" led by a "holder" who was responsible for teaching what came to be known as the "Code of Handsome Lake." These circles, which evolved into the Six Nations Temperance League, constitute one of the earliest geographically dispersed mutual support structures for alcoholism recovery in America (Cherrington, 1926).

Between 1805 and 1811, a Shawnee Indian named Tenskwatawa (originally Lalawethika, and widely known as "The Prophet") launched a highly effective spiritual revitalization movement. The Prophet assumed this role following a sustained death-like trance from which he awoke and told of his own death, resurrection and deliverance to carry a new religion to his people. Having been known as a notorious drunkard, he established complete rejection of the "White man's poison" and rejection of other trappings of European culture as a cardinal principle of his new religion. He preached that unrepentant drunkards would be forced in the hereafter to drink molten lead until fire poured from their mouths and nostrils. The Prophet's teachings were spread by the Indian political leader, Tecumseh, his brother, who had also been addicted to drink (Edmunds, 1983, 1984); Howard, 1981; Cherrington, 1926).

Another Native American messianic leader was the Kickapoo Prophet, Kenekuk, who in a drunken rage had killed his own uncle. Kenekuk, whose father had also suffered from alcoholism, launched an abstinence-based religious movement that had great influence between 1819 and 1831. This movement blended traditional Native customs and elements of Christianity and was founded on the belief that the very survival of Native Peoples was contingent upon their rejection of alcohol (Herring, 1998; Schultz, 1980).

William Apess was an Ojibway temperance reformer who regularly attacked alcohol in his writings and speeches. His 1829 book, *A Son of the Forest*, constitutes one of the first autobiographical accounts of alcoholism recovery in American literature. The 1847 autobiography of Kah-ge-ga-gah-bowh (George Copway), another Ojibway temperance reformer, detailed his own, and his father's, addiction to "the Devil's spittle" (alcohol) (Mancall, 1995; Cherrington, 1926).

These stories reflect an historically hidden picture of Native Americans recovering from alcoholism, and then using that recovery as a springboard to help other Native Peoples. Samsom Occom, Handsome Lake, Tenskwatawa, Kenekuk, William Apess, and Kah-ge-ga-gah-bowh all found a way to transcend their addiction to alcohol and turn their individual rebirth into broader movements of personal and cultural regeneration. Their individual stories share many common elements: debauchery, a spiritual crisis, vision experiences, a commitment to radical abstinence, a messianic desire to carry a message of hope to others, and the linkage of radical abstinence to a broader process of spiritual and cultural revitalization. The story of the first recovered alcoholics in America who sought to multiply their own recovery through the lives of others begins with these Native American figures. These traditions persist in the continuing history of addiction recovery within and across Native American tribes, from the Peyote Way through today's

culturally-nuanced approaches to addiction treatment and recovery (Abbott, 1998).

Alcoholics in the American Temperance Movement

They [reformed men] understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard's heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform..." from the Mercantile Journal, May 27, 1841 (Hawkins, 1859)

Alcohol-related problems in America grew between 1790 and 1830 in tandem with rapidly rising alcohol consumption. An awakening cultural consciousness of those problems triggered what Harry Levine has christened the "discovery of addition" and a century of first temperance and then prohibition movements (Levine, 1978).

There were two branches of thought within the 19th century temperance movement. The first branch, gospel temperance, contended that alcoholics were not redeemable and that the best strategy for addressing America's alcohol problems was to let the existing drunkards die off while preventing new drunkards from being formed. Methods to achieve the latter included temperance education, promotion of the temperance pledge, and the legal prohibition of the sale of alcohol. The second branch, therapeutic temperance, sought to rescue the drunkard and to use his experience as a powerful tool to reach still larger numbers of those in need of reformation. The vacillating opinions and blurred lines between these two branches led to large numbers of alcoholics in various stages of recovery working as temperance missionaries and lecturers during the 19th century.

Recovering and recovered alcoholics worked as solo reformers carrying their message of hope through their writings and public speeches, or they worked within organized temperance and mutual aid movements. As early as the 1830s, men like J.P. Coffin found sobriety within newly created temperance groups and then used the sharing of their own experiences from the lectern as a way to reach others in need of recovery (Steinsapir, 1983).

The Washingtonian Awakening of the early 1840s was the first time that larger numbers of working class alcoholics were drawn into leadership positions within a temperance organization. What these recovering men achieved was to shift the temperance format from one of debate, lectures and speeches to one of "experience sharing." They also recast the drunkard—historically an object of contempt and condemnation—as a person worthy of sympathy and support. The Washingtonian motto, "Let every man be present, and every man bring a man," embedded an evangelical service ethic within this new recovery movement. The Washingtonian Movement was based on premise that no previous temperance effort had gained access to the drunkard's mind and heart and that reformed men could "reach his sympathies, and bid him be a man" (A Member, 1842). Documents of the period suggest this new approach met with considerable success. An intoxicated George Haydock, who attended a Washingtonian meeting with the express purpose of making sport of the speakers, described his response to two Washingtonian speakers, J. F. Pollard and W.E. Wright:

...telling the drunkard that he was indeed a man among men, instead of despising

and denouncing him, appeared to me quite a new method of talking—and seemed to suit my feelings exactly. (Haydock, 1846)

The Washingtonian Movement generated specialists whose skills in organization and elocution evolved into professionalized roles. Men like John Hawkins and John Gough got sober in the Washingtonian movement and then spent the rest of their lives (1840-1858 and 1842-1886, respectively) working full time in the temperance cause. Hawkins, Gough and many less well-known recovered alcoholics organized local mutual aid societies, carried a message of unrelenting hope through their powerful speeches, maintained prolific correspondence with alcoholics and their families, and provided personal consultations—listening, encouraging, story sharing, and advice giving—to alcoholics and their families as they traveled around the country. Most temperance lecturers supported themselves on meager admission fees or collection plates. Others were provided set fees for their work—fees that while modest for most, eventually made men like Gough quite wealthy (Hawkins, 1859; Gough, 1870).

With the Washingtonian demise in the mid-1840s, many recovered alcoholics were drawn into newly forming fraternal temperance societies, some of which were organized exclusively for recovered alcoholics. Recovered alcoholics continued to reach out to the still-drinking alcoholic through service work within groups like the Sons of Temperance, the Independent Order of Good Templars, the Order of the Good Samaritans, and the Independent Order of Rechabites. The heyday of such groups spanned the years 1842-1880.

During the mid-19th century, we also see the first sustained effort to carry a temperance message to Americans of African descent. The problem of drunkenness among Blacks, which had not been a significant problem during slavery, did increase as first free Blacks and then former slaves (during Reconstruction) gained heightened access to alcohol (Franklin, 1974). Black temperance groups underwent considerable growth after 1830. Some members of groups like the Colored American Temperance Society and the African Temperance Society used these groups for personal recovery or as a means to prevent the risk of addiction to alcohol (James and Johnson, 1996). There are reports as early as 1833 of Blacks addicted to alcohol achieving permanent sobriety within local temperance organizations (Sigorny & Smith, 1833).

Many of the famed Black abolitionists were also involved in the temperance cause. Whether Frederick Douglass should be included among the recovered individuals discussed in this article is open to historical debate. We do know that Douglass bitterly condemned the way in which slave masters used alcohol as a ritualized tool of degradation during slave holidays. We know that he disclosed a period of intemperance in his own life, and that he referred to himself as an “old soker.” We know he took the pledge of abstinence in 1845. And we know that he was quite militant in his subsequent personal abstinence and his early support of the temperance cause (Douglass, 1855; Crowley, 1997). Douglass, like the Native American messianic leaders discussed earlier, placed alcohol abstinence within a framework of personal and cultural survival. By advocating abstinence within the historical framework of the drive to abolish slavery and the need to prepare Black people for full citizenship, he presaged modern Afrocentric models of addiction recovery (Williams, 1992).

A new sobriety-based support structure—the reform club—rose in the Northeast in the 1870s and then spread West and South across the United States. The first of such clubs was organized by J.K. Osgood in Gardiner, Maine in 1871 and was followed by Dr. Henry Reynolds'

Red Ribbon Reform Clubs, and Francis Murphy's Blue Ribbon Reform Clubs. The reform clubs were mutual aid societies organized by and for alcoholics who met weekly to share experiences and support their mutual recovery.

Reynolds and Murphy went on to full time roles organizing reform clubs and served as mentors to such famed reform club organizers as Lafayette Hughes, Milo Ward, Ed Shiel, Jack Warburton, and Mason Long. Some, like Hughes and Ward, traveled as teams speaking, teaching the ribbon songs, organizing clubs, opening temperance coffee houses, procuring local clubhouses, organizing local ribbon newspapers, and scouring the streets of each new city for drunkards whom-they would feed, cloth, challenge, and encourage. Many a sober, ribbon-adorned drunkard owed their reclamation to such men and the reform clubs they left behind them. The reform clubs embraced the drunkard within an uplifting recovering community whose total efforts were aimed at helping its members achieve an uncompromising goal: *To live and die sober* (Ferris, 1878; Vandersloot, 1878; Hiatt, 1878). Also interesting in light of their modern counterparts were a small number of "moderation societies" founded in the 1870s. These societies brought problem drinkers together for mutual support in their efforts to maintain mutually agreed upon limits as a control on their drinking (Cherrington, 1926).

Involvement in temperance work was not always an assurance of sobriety. The relapse of those with minimal sobriety was not unusual. Even some of the most famous reformed men in the temperance movement, such as Gough, experienced relapse during their careers. Recovering alcoholics who used the temperance lectern as a medium of self-cure often relapsed due to over-exertion and exhaustion. Edward Uniac ignored his friends pleas that he take a rest on the grounds that, "I feel safer from my old enemy when I am fighting in the field of active work." Plagued with continuing relapses, Uniac died in 1869 of an overdose of opium, bromides and whiskey while on a temperance lecture tour in Massachusetts (Berry, 1871, p. 137, 181). His was not an isolated case.

Thomas Doutney tried to engineer his own recovery in 1873 by taking to the temperance lecture circuit. He relapsed the day following his first speech, but then went on to a successful career within the temperance movement (Doutney, 1903). Claude Gunder and Luther Benson each shared their remarkable stories in autobiographies respectively entitled, *Saved by the Blood from a Drunkard's Hell* and *Fifteen Years in Hell*. Gunder's tale of his unrelenting and mostly unsuccessful efforts to get sober ends with his enrollment in a university to prepare himself for work as a temperance lecturer (Gunder, 1908). Benson's story of his drinking before, during, and after giving temperance lectures ends with a suicide attempt and his sequestration in a locked ward of the Indiana Asylum for the Insane (Benson, 1896).

Recovering and Recovered Alcoholics Employed by 19th Century Addiction Treatment Institutions

They [drunkards] fully understand each other's language, thoughts, feelings, sorrows, signs, grips, and passwords, therefore yield to the influence of their reformed brethren much sooner than to the theorists who speak in order that they may receive applause. – D. Banks McKenzie, Founder of the Appleton Temporary Home (McKenzie, 1875)

The therapeutic temperance movement birthed America's first addiction treatment institutions as well as her first alcoholic mutual aid societies. This new multi-branched field of addiction treatment included medically-oriented inebriate asylums such as the New York State Inebriate Asylum, religiously oriented inebriate homes such as the Washingtonian Homes in Boston and Chicago, nationally franchised private addiction cure institutes such as the Keeley, Gatlin, and Neal Institutes, and proprietary home cures such as Opacura, Antidote, and the White Star Secret Liquor Cure. Efforts by the inebriate asylums and inebriate homes to professionalize this newly emerging field culminated in the founding of the American Association for the Cure of Inebriety in 1870 and the publication of the first issue of *The Journal of Inebriety* in December, 1876 (White, 1998).

It was perhaps inevitable that recovering and recovered alcoholics would move from their roles in the wider temperance movement to seek employment within these new addiction treatment institutions as physicians, managers and attendants. Physicians in addiction recovery were hired to work in some of these new treatment institutions, particularly within the private addiction cure institutes. By 1900, more than 100 recovering physicians had been hired by The Keeley Institutes (White, 1998). Recovering inebriates also held positions as the managers of some inebriate homes. Most notable in this category was the work of D. Banks McKenzie who in 1872 founded the Appleton Temporary Home in Boston (McKenzie, 1875). Recovering inebriates worked as personal attendants to patients and in non-service roles ranging from accounting to facility and grounds maintenance. The branch of the field that offered proprietary home cures for sale through the mail also included those who claimed they had been cured by a particular remedy and were now offering it to the public (White, 1998).

The use of "reformed men" as managers, physicians and attendants was not without its controversies. The debate over this issue in the closing decades of the 19th century was one of the most contentious debates within the field. Few were more vociferous on this issue than Dr. T.D. Crothers, Editor, *Journal of Inebriety*. Crothers charged that personal experience of inebriety was not a credential for understanding inebriety and, in fact, precluded such understanding. Crothers claimed that physicians and others who entered into the direct care of inebriates following their own cure were "incompetent by reason of organic defects of the higher mentality" and that the direct care of inebriates rendered the recovering person vulnerable for relapse (Crothers, 1897, 1898, 1902).

Recent research on recovering physicians working in addiction medicine during the late 19th and early 20th centuries does confirm isolated problems of relapse among these physicians (Warsh, 1988; White, 1998). The practice of hiring recovering physicians and managers declined in the late 19th century as the addiction treatment field itself fell into a period of professional and public criticism and decline became the butt of considerable criticism. But the practice of encouraging some of the more stable patients to stay on at a modest salary to serve as cooks, accountants, electricians, carpenters, and grounds keepers within inebriate institutions continued well into the 20th century (Tracy, 1992).

"Reformed" People in the Urban Mission Movement

Religion has long been a framework for personal recovery from addiction in America. There were strong religious underpinnings to the temperance movement, and the scene of

alcoholics testifying at 19th century religious revivals that God had taken away their appetite for alcohol was not uncommon. But something special within this history unfolded in 1872 when two recovered alcoholics—Jerry and Marie McAuley—opened the doors of the Water Street Mission in New York City. Jerry and Marie were not likely candidates to lead a religious movement. Both had suffered from alcoholism, Marie had worked as a prostitute, and Jerry had been in prison for highway robbery. The mission was the product of a vision that Jerry McAuley experienced shortly after his religious conversion.

One Day I had a sort of trance or vision. I was singing at my work, and my mind became absorbed, and it seemed as if I was working for the Lord down in the Fourth Ward. I had a house, and people were coming in. There was a bath, and as they came in I washed and cleansed them outside, and the Lord cleansed them inside. They came at first by small numbers, then by hundreds, and afterwards by thousands. (Offord, 1885, p. 37)

The Water Street Mission founded by Jerry and Marie McAuley was the first of America's urban rescue missions that catered their services specifically to alcoholics. Many would follow, and the Salvation Army would, beginning in 1880, make special contributions within this new field of religious rescue work. The urban missions offered the alcoholic food, clothing, shelter, and an opportunity for religious conversion. In their view, recovery from alcoholism was not the primary goal but a secondary consequence of the process of religious rebirth. That message of hope was delivered within the missions by men like McAuley and Samuel Hadley who had themselves recovered from alcoholism through religious experience.

The Water Street Mission sparked the growth of religiously oriented institutions that truly welcomed alcoholics. The urban missions were organized by charismatic figures who, following their own rebirth, experienced a vision of carrying a message of deliverance to other alcoholics. This reformation of self turned to the reformation of others created an unending chain of service workers in this new American institution. As people got sober within the mission, they were recruited into evangelical roles within expanding mission programs. Many of the later religiously-based alcoholic mutual aid societies, from the United Order of Ex-Boozers (1914) to Alcoholics Victorious (1948), were birthed within the urban rescue mission (Bonner, 1967).

The Rescue Mission is the precursor to modern religiously-based treatment programs that continue to utilize a staff made up largely of recovered alcoholics and addicts. Pursuing religious service as avocation or vocation after one's own recovery from addiction has deep roots in America and constitutes a separate path from those recovered alcoholics who have carried out such service work within addiction treatment institutions.

The Lay Therapy Movement

A little knowledge is not a dangerous thing if it is known to be little. Dwight Anderson, on the importance of lay therapists knowing their limitations (Anderson, 1944, p. 264).

In 1906, the Emmanuel Church in Boston opened a clinic that for the following 23 years combined medicine, religion and psychology in the treatment of a wide spectrum of disorders. The Clinic developed a specialized treatment for alcoholism that involved medical assessment, psychological counseling, participation in a mutual support group (the Jacoby Club), and involvement in acts of service to other alcoholics. There are many elements within the Clinic's operation that left an enduring legacy on the treatment of alcoholism: the combination of individual therapy and educational classes, the use of mentors ("friendly visitors") that were in recovery from alcoholism, social activities, and social work services. The Clinic's founders viewed recovery from alcoholism as a process involving the alleviation of guilt (confession), the acquisition of religious faith, and the active management of emotions and thought through relaxation, suggestion (hypnosis), prayer, and daily self-talk. Most significant for our current exploration, the bulk of the counseling services provided by this Clinic were delivered by "lay therapists" who were former patients in recovery from alcoholism (McCarthy, 1984).

The story of lay therapy within the Emmanuel Clinic begins in 1911 when Courtenay Baylor sought help from the Clinic for his own problems with alcohol. Two years later, Baylor was hired at the clinic as perhaps America's first paid lay psychotherapist specializing in alcoholism. His understanding of alcoholism and the techniques he developed to treat it were set forth in his 1919 text, *Remaking A Man*. In 1922, Richard Peabody came to the Emmanuel Clinic seeking help for alcoholism and was treated by Baylor. Peabody went on to become a prominent lay therapist and wrote one of the most influential 20th century texts on alcoholism, *The Common Sense of Drinking* (1931). What Peabody provided was a remarkably detailed and prescriptive approach to the process of alcoholism counseling and alcoholism recovery. The techniques used by the lay therapists of the 1930s and 1940s were impressive even by today's standards. Lay therapy in the Peabody tradition included such elements as confirmation of resolution for permanent abstinence, medical detoxification where required, contracting mutual cooperation and mutual confidentiality, therapist self-disclosure, story elicitation, bibliotherapy, teaching interventions, construction of a daily schedule, prescriptions regarding daily habits (eating, sleep, exercise), formal relaxation techniques, hypnosis and suggestion, and programmed self-talk (Peabody, 1931; Anderson, 1944; Bishop 1945).

William Wister, Wilson McKay, Samuel Crocker, James Bellamy, and Francis Chambers all were treated by Peabody and went on to pursue careers as lay therapists (McCarthy, 1984). Most of the lay therapists operated private counseling practices in which clients (in the 1930s and 1940s) paid fees that ranged from \$10 to \$20 per session. Francis Chambers has a special role within this history in that he was the first lay therapist to work not in private practice but within a hospital-based multidisciplinary team. Chambers' clinical collaboration and written work with the psychiatrist Dr. Edward Strecker added considerably to the reputation of lay therapists in the treatment of alcoholism (Strecker and Chambers, 1938). Chamber's decision to work within a broader multidisciplinary team takes on added significance in light of charges that came from the psychiatric community that lay therapists were practicing medicine (psychotherapy) without a license.

Some recovered alcoholics practiced lay therapy as a part of their own self-cure. They pursued the work quite aggressively—some seeking out candidates for recovery in local bars—as an avocation, with all gratuities donated to local alcoholism councils (Parkhurst, 1941; Bishop, 1945). The lay therapists of the mid-20th century did not have access to their own sobriety

based support structures (most did not affiliate with A.A. when A.A. meetings became available) and, with the exception of Chambers, did not have access to regular clinical supervision. It seems that these men used the work itself as a vehicle for their own continued sobriety. But this method was not always a successful one. Several prominent lay therapists experienced relapses after they had entered the lay therapy field, and some left the field believing that the work was detrimental to their continued sobriety (McCarthy, 1984). But lay therapy remained popular into the 1940s. The biography of William Wister notes that fourteen recovered alcoholics visited him in the summer of 1941 seeking his advice and support for their entry into the field of lay therapy (Bishop, 1945).

The Emmanuel Clinic initiated a lay therapy tradition that exerted a profound influence on the future of alcoholism treatment. While recovering and recovered people had worked earlier within American addiction treatment institutions, they had done so in their roles as physicians, managers or attendants. The Emmanuel Clinic marks the beginning of people in alcoholism recovery who specialized in providing psychotherapy for the treatment of alcoholism. While there are earlier elements of alcoholism counseling, it is in the lay therapists of the Emmanuel Clinic that the multiple functions of alcoholism counseling came together within a clearly defined counseling role. Before Baylor and Peabody, the role of the recovered helper had primarily involved the elements of self-disclosure, story elicitation, encouragement and advice-giving. What Baylor and Peabody provided was a structure and a fully developed body of clinical technique for counseling the alcoholic.

Alcoholics Anonymous, Early A.A.-Treatment Linkages, and the Modern Alcoholism Movement

The founding of Alcoholics Anonymous (A.A.) in 1935 marked a turning point in the history of alcoholism and its treatment in America. A.A. provided a fully developed, geographically dispersed, long-term sobriety-based support structure to sustain the sobriety that could be initiated within the context of professionally-directed alcoholism treatment. To enhance the linkage and transition between primary treatment and A.A., treatment institutions began incorporating A.A. concepts and literature into their treatment protocol and eventually began to hire A.A. members as counselors.

The mutually ambivalent relationship between an evolving A.A. and fledgling alcoholism treatment institutions created a zone of ambiguity in which it was difficult to define and delineate A.A. and alcoholism treatment and the roles of A.A. members and alcoholism counselors. There are three key milestones that shaped the relationship between A.A. and alcoholism treatment institutions and established the structure within which A.A. members worked within alcoholism treatment institutions. The first milestone was Bill Wilson's decision in 1936, under pressure from A.A. members, to decline an offer to work as a lay therapist at the Charles B. Towns Hospital and pull A.A. within the umbrella of the hospital. By rejecting Charles Towns' proposal, A.A. avoided being simultaneously professionalized and commercialized (Alcoholics Anonymous, 1957).

The second milestone was the decision by A.A. not to directly own or manage hospitals, retreats, or farms whose purpose was the treatment of alcoholism. What emerged was a position that prohibited A.A. ownership or affiliation with treatment institutions, while allowing

cooperation with such institutions by local A.A. groups or individual A.A. members. This allowed A.A. to maintain a separate identity from the treatment institution with which it interacted. These positions were worked out through A.A.'s earliest experience with hospitals, private sanitariums, alcoholic "retreats" and "farms", psychiatric hospitals, and prisons. These first two milestones tempered A.A.'s, or more precisely Bill Wilson's, vision of carrying the A.A. program to the far corners of the globe through a network of A.A. missionaries and A.A. hospitals (Alcoholics Anonymous, 1981).

The third milestone was A.A.'s definition of the circumstances within which its members could work in paid roles in alcoholism treatment. This came in response to A.A. member-entrepreneurs founding facilities for the care of alcoholics and from A.A. members being recruited for employment in such facilities. There were many A.A. members who served as volunteers, aides and nurses on newly formed alcoholism units in Akron, Cleveland, New York City, and Philadelphia. Teddy R., a nurse recovering in A.A., describes her motivation for such work.

After a month of daily increasing happiness, I was struck with an overwhelming sense of gratitude....I felt I must do something in return. When I learned about the A.A. ward at Knickerbocker [hospital] I knew what that something would have to be....I can't convey how much it means to see the transformation in people....To know that I had some small part in this rebirth is a blessing far beyond what I deserve. (Anonymous, 1989)

Teddy R. went on to a long career working alongside Dr. William Silkworth treating thousands of alcoholics (White, 1998).

Controversies regarding whether A.A. members could work in paid roles in alcoholism treatment institutions were handled first on a case-by-case basis via consultation with Bill Wilson in New York and later were clarified within the framework of A.A.'s Twelve Traditions and specific guidelines issued by A.A. for members who worked within alcoholism treatment programs. The consultations, Traditions and guidelines focused on separating A.A. and its name from alcoholism treatment enterprises and distinguishing the Twelfth Step work performed as an A.A. member from the care that an A.A. member might provide someone as their nurse, social worker, or counselor. Bill Wilson explained this position in a June 2, 1959 letter to an A.A. member:

...Therefore the general principle seems to be this: so long as no general appearance of endorsement or alliance is created, there is no reason why an A.A. service person cannot participate in the general field of alcoholism. In short, I do not think there is any traditional reason why he could not do this. But practically speaking, in some circumstances, this may still be undesirable. If, in practical effect, the dual role does actually produce a lot of hostility and friction, then the usefulness of the individual in both roles is compromised. But these are questions of fact and degree—not of principle. This is a matter for estimate by the individual himself and by the groups that surround him.... (From General Service Office of Alcoholics Anonymous Archives)

What grew out of discussions of the role ambiguity and role conflict that could result from A.A. membership and alcoholism counseling was the need for A.A. members working in the alcoholism field to clearly delineate and articulate to their clients and their professional peers when they were speaking/acting as an A.A. member and when they were speaking/acting in their professional capacity. These guidelines paved the way for large numbers of A.A. members to pursue volunteer and paid roles within a growing network of alcoholism treatment programs (A.A. Guidelines).

While A.A. members began to extend their A.A. service work into the more formalized role of alcoholism counseling, a broader movement was underway that dramatically increased the availability of alcoholism treatment in America. Often referred to collectively as the “Modern Alcoholism Movement,” organizations such as the Research Council on Problems of Alcohol (1937), the Yale Center of Alcohol Studies (1943), and the National Committee for Education on Alcoholism (NCEA) (1944), worked in tandem in the 1940s to change America’s understanding of alcoholism and its response to the alcoholic. The creation of a national network of alcoholism treatment programs in the 1960s and 1970s marked the culmination of this Movement’s enduring efforts.

In keeping with the theme of this paper, it is important to note that recovered alcoholics played crucial roles in this Movement. Dwight Anderson outlined the basic elements of the campaign to destigmatize alcoholism (Anderson, 1942). Marty Mann’s sustained leadership of NCEA and her relentless travels throughout the United States place her among the most important public health reformers of the 20th century. (After helping create alcoholism treatment centers all over the country, she actually worked as an alcoholism counselor late in her life.) Ray McCarthy helped pioneer the Yale model of outpatient alcoholism clinics, the role of alcoholism counselor, and many counseling techniques used within those clinics. It was within the Yale clinics that staff in recovery from alcoholism were first referred to as “counselors” rather than “lay therapists” (Mann, 1973). And the philanthropy and leadership of R. Brinkley Smithers provided crucial support to this movement in the years preceding significant government support for alcoholism treatment.

An important milestone in the evolution of the modern alcoholism movement was the creation of a replicable model of alcoholism treatment and the creation of a replicable alcoholism counselor role. For that milestone, we must visit the State of Minnesota.

The Recovered Alcoholic within the “Minnesota Model”

A.A. membership grew in Minnesota during the 1940s, as it did in many states. That growth provided a medium for the emergence of a new approach to the treatment of alcoholism that came to be known as the Minnesota Model of Chemical Dependency Treatment. This model was the product of a synergy of innovations within and between three institutions: Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950). What emerged was the treatment of alcoholism as a primary disorder, the integration of A.A. concepts and practices within the treatment milieu, the utilization of a multidisciplinary team, the inclusion of recovered alcoholics as volunteers and full time paid staff within that team. While the Minnesota Model would go on to wide replication throughout the United States and beyond, the Model marked a

unique milestone in the history of recovered alcoholics working within treatment settings (Spicer, 1993).

While the names of Dr. Nelson Bradley, Dan Anderson, Jean Rossi, Rev. John Keller, and Rev. Gordon Grimm are justifiably linked to the birth of the Minnesota Model, recovered alcoholics such as Pat C., Lynn C., Otto Z., Lon J., Fred E., Mel B. and numerous others helped define this new model and this new alcoholism counseling specialty that was at its core (Richeson, 1978). In 1954, the State of Minnesota formalized this new role by creating a civil service classification entitled, "Counselor on Alcoholism." What is of note in this 1954 decision was not just the title, but that Minnesota had evolved a model that: 1) set minimal standards for this role (a high school education and two years of sobriety), 2) prepared and credentialed the recovered alcoholic to work in the treatment field, 3) paid this person on par with a starting social worker, 4) placed the recovered alcoholic as a legitimate member of a multidisciplinary team, and 5) clarified the boundaries between the recovered alcoholic's status and responsibilities as an A.A. member and as a paid counselor (White, 1998, p 204). The 1954 action drew laughter from some, outrage from others, and skepticism from many, but it was the beginning of the modern professionalization of alcoholism counseling.

The Wounded Healer in the Workplace

The 1940s and 1950s saw a surge in the roles recovered alcoholics were filling in a re-emerging alcoholism treatment field. In addition to serving in the previously discussed roles of lay therapist, retreat manager, and the newly christened role of counselor on alcoholism, recovered alcoholics were working in more varied settings and extending the reach of their professional service activities. Recovered alcoholics began working in psychiatric hospitals that had created "patient-counselor" positions through which selected alcoholics could move from the status of patient to staff member on an alcoholism ward. But these experiments paled compared to what was occurring in the workplace.

A.A. members in the workplace began suggesting to their companies that there were ways to effectively intervene with alcohol-impaired employees. These informal helping roles evolved into formal occupational alcoholism programs as recovered alcoholics like David M., Warren T., and Earl S. assumed full time positions in the early 1940s counseling alcoholics at Remington Arms, DuPont, Kaiser Shipyards, and North American Aviation. If there was a single person most responsible for selling occupational alcoholism programs during the 1940s and 1950s, it would undoubtedly be Lefty Henderson. Henderson, working first with NCEA and then with Yale, used his own recovery story and his remarkable communication skills to convince business leaders across the country that the alcoholic employee could be identified, rehabilitated, and restored to full productivity. The model of intervention advocated by Henderson involved the designation of a coordinator, generally a recovered alcoholic already working within the company, to create a company policy on alcoholism, orient supervisors and employees, and link impaired employees to alcoholism treatment and recovery resources (Henderson and Bacon, 1953).

As more alcoholics entered recovery without economic or family support, there emerged a need for a place where such men and women could live in a supportive environment until they could get back on their feet physically, emotionally and financially. This need birthed a new

institution, the halfway house, whose managers and staff were overwhelmingly drawn from those in personal recovery from alcoholism (Cahn, 1969; Barrows, 1979). The alcoholism halfway house movement of the 1950s was in many ways a formalization and extension of support that had been provided by A.A.'s co-founders, many A.A. sponsors, and by early A.A. clubhouses.

Preview

In the second half of this article, we will explore the roles recovered alcoholics and ex-addicts played within the rise and evolution of modern addiction treatment institutions. The article will conclude with a discussion of how the roles of recovered people as wounded healers have changed over the past 200 years.

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