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**THE HISTORY OF RECOVERED PEOPLE
AS WOUNDED HEALERS:
II. The Era of Professionalization and Specialization**

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Abstract

Part I of this article traced the history of recovered alcoholics as wounded healers from their roles in late 18th century Native American cultural revitalization movements and the American temperance movement through their work as lay therapists and counselors within outpatient counseling clinics, Minnesota Model inpatient programs, industrial alcoholism programs and halfway houses. This article will focus on how the roles of the “paraprofessional” recovered alcoholic and ex-addict evolved into the professionalized role of the modern addiction counselor.

The Ex-Addicts

The history of the wounded healer in the addiction recovery arena was until the mid-twentieth century a story almost exclusively about those recovering from alcoholism. Three events between 1947 and 1965 brought people in recovery from addiction to drugs other than alcohol into paid helping roles within an emerging national network of addiction treatment programs. The first event was the emergence of Narcotics Anonymous (N.A.) between 1947 and 1953. N.A. provided a counterpart to A.A. for those addicted to drugs other than alcohol and created a pool of recovered addicts from which addiction treatment agencies could recruit staff.

The second event was the founding of Synanon by Charles Dederich in 1958. This milestone marked the birth of therapeutic communities (TCs) for the treatment of drug addiction. In its early years, this model was exclusively staffed

by “ex-addicts” drawn from the growing pool of rehabilitated clients. The dramatic spread of TCs created a large market for the newly created role of professional ex-addict.

The third milestone was the emergence of methadone detoxification and maintenance in 1964-1965. This new treatment modality also incorporated a large number of ex-addicts to work as counselors. Expanding treatment modalities--organized into ideological camps openly hostile to one another--were eventually integrated into large multi-modality treatment systems. Ex-addict staff, in addition to performing key clinical functions and serving as role models for their clients, provided a cultural bridge between the addicted clients and the professional staff (Senay, 1981; Senay, 1989).

This first generation of professional ex-addicts were strongly linked to the institutions within which they had been treated, but were rarely linked to such long term mutual aid societies such as A.A. or N.A.

Growing Federal Involvement

With replicable alcoholism and other drug addiction treatment modalities available, the challenge was to replicate and refine these programs in communities across the country. Alcoholism programs spread through the support of funds from multiple federal agencies. The Organization for Economic Opportunity (OEO) established alcoholism services within more than 200 local anti-poverty programs. The OEO programs relied almost exclusively on recovered alcoholics to help alcoholics and their families gain access to needed medical and rehabilitation services. The National Institute on Mental Health incorporated alcoholism services within the newly funded comprehensive community mental health centers where recovered alcoholics were hired as counselors to work alongside psychiatrists, psychologists and social workers. The Law Enforcement Assistance Administration funded social setting detoxification and other criminal justice diversion programs. The social setting detox programs became ports of entry for large numbers of recovering people wishing to work in the alcoholism treatment field. Recovered alcoholics such as Congressman C. Elliot Hagan and Matt Rose (at OEO) played important legislative and administrative roles in creating such programs and blessing the incorporation of recovered alcoholics into key staff positions within these new treatment initiatives.

The renewed practice of using recovered alcoholics as professional helpers, as in earlier periods, stirred considerable controversy. The flavor of this controversy was revealed in a 1963 debate between two Michigan psychiatrists,

Dr. Henry Krystal and Dr. Robert Moore, over the question of who was qualified to treat the alcoholic. Dr. Krystal opposed the use of recovered alcoholics as treatment specialists on the grounds that they had often not worked through their own emotional problems and that they were not equipped to deal with the clinical complexities that alcoholism presented. Dr. Moore countered that traditional helpers, particularly psychiatrists, had not been particularly effectively in treating alcoholics and that many institutions were successfully incorporating recovered alcoholics into their alcoholism treatment teams (Krystal and Moore, 1963).

One factor that tipped the scales toward the use of recovered alcoholics as counselors was the existence of contemporaneous movements to use trained lay workers in related fields--mental health, child welfare, criminal justice, education and community action (anti-poverty programs) (Grosser, et.al., 1969; Rosenberg, 1982; Reiff & Reissman, 1964; Briggs, 1963). The beginning of what came to be referred to as a “paraprofessional movement” was launched in a 1959 report of the Joint Commission for Mental Health and Illness that called for a broadening of the mental health delivery team to include the use of indigenous community volunteers as paid service providers (Pattison, 1973). The subsequent studies of Carkhuff and his colleagues confirmed that paraprofessionals could be trained to provide effective counseling services related to a wide spectrum of personal problems (Carkhuff and Truax, 1965; Carkhuff, 1969, 1971). This broad paraprofessional movement providing a legitimizing context to the reborn contention that recovered alcoholics could play valuable service roles in the treatment of alcoholism.

The growing practice of hiring A.A. members to work in various roles in alcoholism treatment programs continued to stir controversies in some local A.A. groups. Re-emphasizing the importance of the separation between A.A. and treatment programs and between Twelfth Step work and alcoholism counseling, the General Service Conference of A.A. went on record as opposing what was becoming the frequent use of the title, “A.A. Counselor,” and rejected use of the term, “two-hatter” for the preferred, “A.A. member employed in the field of alcoholism” (Alcoholics Anonymous, 1970; Alcoholics Anonymous, 1975). The intensity of these debates subsided as clear guidelines emerged within A.A. about how A.A. members could work in the alcoholism field while clearly delineating their paid activities from their A.A. service activities. Independently sponsored national conferences, beginning in 1977, also helped recovered alcoholics and “co-alcoholics” explore the problems and opportunities of working in the alcoholism field (The Fifth “Two Hatter”..., 1981).

Growing public concern with youthful polydrug abuse spurred additional federal, state and local funding to new youth-oriented services: street drug testing

services, outreach (“streetwork”) programs, emergency services (crisis lines and “acid rescue”), school-based early intervention programs, outpatient drug free counseling centers, and short term residential centers. These new modalities incorporated a growing number of recovering polydrug addicts in staff positions. The recovering polydrug users who filled such roles often existed in limbo within the broader field of addiction treatment and within the broader recovery community. At a professional level, they didn’t identify with those working in alcoholism treatment programs, the TCs or the methadone programs, and, at a personal level, they often felt little identification with A.A. or with N.A. (which at this time was dominated by recovering heroin addicts).

Toward a Treatment System

In the early 1970s, the federal government acted to both expand and organize alcoholism and addiction treatment services. The plan called for a partnership between newly created federal agencies--the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA)--and designated alcoholism and drug abuse treatment authorities within each state and territory. Recovered alcoholics and recovered addicts from across the country played pivotal roles in the drive to create the enabling legislation that supported this new structure to plan, build, staff, operate, and evaluate alcoholism and drug abuse treatment programs in local communities across the country. In the case of the 1970 Comprehensive Alcoholism Prevention and Control Act, a recovered alcoholic (Senator Harold Hughes) introduced the funding Bill. Recovered alcoholics, (from Bill Wilson to noted Actress Mercedes McCambridge to Marty Mann), testified at the hearings regarding the legislation, and politically influential recovered alcoholics (particularly R. Brinkley Smithers) played a critical role in preventing a planned presidential veto of the legislation.

During this same era, two other formal branches of the nation=s treatment system emerged. The growing trend by insurance companies to reimburse treatment for alcoholism led to the rapid growth of hospital-based and private for-profit addiction treatment units. Growing concerns about alcohol and other drug problems in the military also led to an expansion and formalization of treatment services within the U.S. military and within the Veterans Hospitals and local service centers. Paralleling what was occurring in civilian communities, recovered alcoholics played seminal roles in birthing alcoholism intervention and treatment services in the U.S. military.

Looked at as a whole, it appeared that the nation was declaring war on

alcohol and other drug problems in the 1970s, but the nation had no troops prepared to wage this war. It was in this vacuum that a “new profession” was born. New agencies and a new profession to treat alcoholics and addicts emerged to fill a void created by the contempt with which alcoholics and addicts were regarded by traditional helping professionals. Recovered people shaped the new role of specialized work with alcoholics and addicts because psychiatrists, psychologists, and social workers had consistently made clear that they did not want such a role (Pattison, 1973).

The Beginnings of a “New Profession”

Between 1965 and 1975, virtually thousands of recovered alcoholics and addicts were enlisted in a wide variety of helping roles within newly emerging alcoholism and drug abuse treatment programs. They were often recruited directly out of treatment or out of local mutual aid societies. They worked as counselors, aides, psychiatric technicians, and house managers. Recovering and recovered people who were physicians, nurses, psychologists and social workers were also drawn to the field at this point.

Mel Schulstad, who played a pioneering role in the professionalization of the alcoholism counselor, describes what it was like for those without degrees in this pre-professionalization stage of the field.

We were regarded as something of an oddity. Some of the professionals worried that they were going to have to clean us up and that we might get drunk a week after we were hired. They didn't know what to expect. The only way an alcoholism counselor could get some kind of credibility was to venture up to Rutgers Summer School of Alcohol Studies, go to school for a few weeks, and come home with a piece of paper that you could hang on the wall. Graduate of Rutgers was about the highest qualification you could get. This new profession had no standing whatsoever with the older professions which based their credibility on academics. Their attitude was, “Who the hell are you to tell us anything?” And yet these were the very people who had failed miserably in their efforts to help the alcoholic. Slowly they began to see what we could do and even began to approach us to help members of their own families who were struggling with alcoholism. (Schulstad, 1998)

Some new members of this field entered recovery through the auspices of addiction training, perhaps drawn to the field like many before them in hopes of working out their own problematic relationship with alcohol or other drugs. For example, of the 475 physicians who participated in addiction training at the Long Beach Naval Regional Center between 1974 and 1978, 44 signed themselves into treatment before pursuing continued work in addiction medicine as recovering physicians. By 1982, more than 200 recovered physicians had entered the re-emerging field of addiction medicine (Of the 475..., 1978; Bissell, 1982).

As a whole, the roles of those recovered people working in alcoholism and drug abuse counseling were ill-defined. They carried individual caseloads as high as 50 clients (Senay, 1989). They worked an unconscionable number of hours per week at rates of pay that would be incomprehensible by today's standards. But they laid the foundation of a new field with their passion, their commitment, and their instincts about what was needed to incite the process of addiction recovery.

A rarely told story of this period was the casualties that were part of the process of building this foundation, and many of those casualties involved episodes of relapse by those working in helping roles in the earliest days of many modern treatment programs. While such relapses were nearly always attributed to factors within the individual, recovering people working within addiction treatment settings in the early to mid-1970s often did so under conditions that inadvertently undermined their continued recovery (White, 1979). Dr. John Norris, the Nonalcoholic Chairmen of A.A.'s General Service Board, noted during this period that many A.A. groups were making significant contributions to the alcoholism field. But he went on to warn that A.A. members invited to work as alcoholism counselors with no qualifications for counseling other than their A.A. membership often discovered that they were unable to cope with the demands and stresses of a job for which they were ill-prepared (Norris, 1970).

What is perhaps surprising in retrospect, is not that there were relapses, but that there were so few relapses in the days before all of the modern supports of preparation, screening, orientation, supervision, and dual relationship discussions were in place.

“Combined Treatment” and the Recovered Counselor

The recovered alcoholics working in alcoholism programs and the ex-addicts working in drug treatment programs operated in separate worlds through much of the 1960s and 1970s. Recovering alcoholics were known to dabble with prescription (and sometimes illicit) drugs, all the while proclaiming their continued sobriety. Many ex-addicts, some treated in programs where they had earned the right to drink as a privilege, went on to develop serious problems in their relationship with alcohol. And both groups were notorious chain-smokers. It was only a matter of time before the contradictions created by such categorical thinking came to a head.

The call to integrate alcoholism and drug abuse treatment within a single conceptual umbrella emerged as the most wrenching professional issue within the alcoholism and drug abuse fields from the early 1970s to the early 1980s. The person most responsible for clinically bridging the chasm separating these two fields was Dr. Donald Ottenberg of Eagleville Hospital and Rehabilitation Center in Pennsylvania. While proposals to integrate local and state treatment agencies, professional associations, and counselor credentialing bodies stirred debates of unprecedented intensity, nearly all of these debates eventually gave way to the forces of integration.

The movement to integrate the alcoholism and drug abuse treatment fields exerted a profound influence on the role of recovered people working in these two fields. For years the recovered alcoholic's most essential qualification had been defined as his or her capacity for alcoholic-to-alcoholic identification. When suddenly those addicted to drugs other than alcohol were assigned to this recovered alcoholic counselor, the source of that identification--the essence of his or her perceived credibility--was compromised. This process forced many recovered alcoholics and ex-addicts to redefine the assets they brought to the helping process. It also spurred the need for new knowledge and skill development for counselors who quickly realized that they needed much more than their personal story of recovery to operate effectively as an addictions counselor.

Professionalization, Privatization, and Specialization

The 1970s and 1980s witnessed three trends that exerted a profound influence on recovered people working in addiction treatment settings. The first of these trends—professionalization--was marked by two major milestones. The first milestone was the establishment of training programs for those working in alcoholism and drug abuse treatment programs. Early (1966-1972), training initiatives were developed by the Office of Economic Opportunity, the Department of Labor, and the National Institute on Mental Health. These were then followed by NIAAA and NIDA's development of formal addiction counselor training systems between 1973 and 1979. NIAAA and NIDA created national, regional and state training programs that conducted training needs assessments, created training curricula, trained trainers, and delivered and evaluated training. They also encouraged the development of external degree programs and graduate programs to enhance the credibility of a large portion of the treatment workforce that lacked academic credentials. The focus of these initiatives was to turn a large (some 45,000 workers) and largely untrained "paraprofessional" workforce that lacked credibility into a professional workforce that could take its place alongside more traditional helping disciplines (Over 200..., 1972; Davis and Ford, 1980). There was a debate during this period regarding whether alcoholism and drug abuse counselors should become a "new profession" or whether they should be trained as specialists within such existing professional disciplines as psychology, social work, and counseling. Strong advocacy for the former eventually tipped the scales toward creating a new professional specialty of addiction counseling. Implicit within this transition was the decision that addiction counselors would no longer remain "paraprofessionals" working under the supervision of "professionals" but would instead seek to emerge as professionals in their own right (Valle, 1979).

The second milestone of professionalization involved the development of professional associations and credentialing processes for addiction counselors. These activities occurred at both state and national levels. National addiction counselor associations can be traced to the founding of the National Association of Alcoholism Counselors and Trainers (1972) which evolved into the National Association of Alcoholism Counselors (1972) and, subsequently (1982), became today's National Association of Alcoholism and Drug Abuse Counselors (NAADAC). State credentialing and certification systems for alcoholism and drug abuse counselors spread in the 1970s, with addiction counselor credentialing mechanisms in place in 23 states by 1979 (Camp and Kurtz, 1982). Competing national addiction counseling credentials were offered by the American Academy

of Health Care Providers in Addictive Disorders, the National Certification Reciprocity Consortium, and NAADAC. The foundation of these credentialing efforts was laid by a series of technical reports--the Roy Littlejohn Report (1974), the University Research Corporation and the Medical College of Pennsylvania's reports on drug abuse counselor functions (1975-1977), the Finger Panel Report (1977), and the Birch and Davis Report (1983)--that collectively tried to move addiction counseling from a folk art to a professional discipline by defining the knowledge and skill components of addiction counseling and recommending approaches to the training and credentialing of addiction counselors. What emerged was a patchwork system of competing national and state certification bodies, registries, civil service classifications, and licensure movements (Mitchell, 1981). Debate continues on relative value of these various approaches to credentialing and whether such systems have improved the quality of treatment and effectively protected the public from harm by incompetent practitioners.

The advent of addiction counselor training programs and the advent of counselor certification and licensure created a situation where recovered staff without degrees either obtained degrees or alternative credentials (certification) or drifted out of the field. This trend toward professionalization was particularly difficult for those who lacked a high school education, lacked full literacy, lacked prior experience with job interviewing and testing and, not uncommonly, had prior criminal records. Many such workers were filtered out of the system during this move toward professionalization.

The major transition in this period was from a situation where recovered people began working as counselors and then obtained training, to a situation where people obtained training *before* they begin working in the field. There were also growing numbers of other professionals entering the addictions field who did not bring backgrounds of personal recovery.

A second trend, that of privatization of addiction treatment, was influenced by the development in the early 1970s of accreditation standards for alcoholism treatment programs and a shift by the insurance industry to reimburse costs for alcoholism treatment. These changes spawned a rapid proliferation of hospital-based and private, freestanding alcoholism treatment programs that catered to a more affluent class of clients. This trend further exerted pressure to elevate the knowledge, skills, appearance and interpersonal skills of those working as addiction counselors. One dimension of the trend toward privatization was the opening of a market for private addiction counseling. With the availability of third party reimbursement for such services, credentialed people in recovery worked within solo or group private counseling practices for the first time since the early

20th century lay therapists (Schmidt, 1993).

As the field became professionalized and more privatized, a third trend—specialization--emerged. Recovered people could not only acquire professional credentials, they could also specialize in work in particular settings (hospitals, schools, military, workplace, criminal justice system, or child welfare system). They could specialize in working with clients with particular drug choices. And they could specialize in work with particular types of clients (women, adolescents, the elderly, clients of color, gays and lesbians, the deaf, the dually diagnosed, or other special needs groups). Recovering people pushed treatment institutions and mutual aid societies toward greater responsiveness to the needs of special groups and created new intervention choices. Two examples are particularly noteworthy. Dr. Vernon Johnson used his own recovery experience and his frustration with the traditional position that alcoholics couldn't be helped until they had hit bottom to pioneer new techniques of family intervention that brought thousands of alcoholics into treatment. Dr. Jean Kirkpatrick, reacting to her own struggles getting sober within A.A., formulated a sobriety-based support group based exclusively on the experiences and needs of addicted women. The resulting group--Women for Sobriety--provided an alternative or adjunct to A.A. for many recovering women. The rise of groups like Women for Sobriety (1975), Secular Organization for Sobriety (1985), and Rational Recovery (1986) brought recovered people into professional helping roles in addiction treatment who did not come from a traditional Twelve Step recovery background. There were also a growing number of recovered people carrying a message of hope to addicts through cultural and religious frameworks of recovery. Recovered people working in the field of addiction treatment moved from a homogenous group to one that reflected many diverse styles of personal recovery.

The Family Recovery Movement

Parents, partners, and children of alcoholics have been involved in service roles in the addiction arena for more than two centuries. Several Native American temperance reformers were children of alcoholics as was Dr. Benjamin Rush--the godfather of American addiction medicine--and large numbers of wives and children of alcoholics sought support and service roles with the 19th century temperance movement. From the Washington Movement through A.A., wives similarly played crucial roles in the history of these mutual aid societies. But it wasn't until the 1970s and 1980s that their presence within American treatment institutions become visible and legitimized. Prior to that period, family members

were viewed as a contributing factor in the etiology of addiction, a potential source of sabotage during treatment, or, at the very best, an instrument of support for the alcoholic in treatment (White, 1998).

A whole movement emerged in the 1980s around the ideas that: 1) family members of alcoholics and addicts experienced distortions in their thinking, emotions, and behavior as adaptations to addiction within the family, 2) family members of alcoholics deserved treatment and support for their own recovery, and 3) the movement through the developmental stages of recovery for family members and the family as a whole could be facilitated by mutual sharing and support with others who were in a similar process of recovery. Champions of early family perspectives on addiction (Joan Jackson) gave way to new pioneers (Claudia Black and Sharon Wegscheider-Cruse) and a new genre of family-oriented confessional, self-help and treatment literature.

During the 1980s, the percentage of recovered alcoholics filling direct care roles in addiction treatment programs decreased as the number of recovering family members increased and as the number of academically trained professionals without recovery backgrounds increased. Recovering family members were especially drawn to work within newly created “family programs”--specialized tracks of family education and treatment that were incorporated into increasing numbers of addiction treatment agencies. By the late 1980s, these tracks evolved into formalized programs for children and adult children of alcoholics which evolved into “codependency” treatment programs. One of the by-products of these transitions was a growing number of women and men working in the field who brought both personal and/or family recovery perspectives to their professional service activities, and affiliation with such groups as Al-Anon and Adult Children of Alcoholics. After more than 150 years as a primarily male field of endeavor, the profession of addiction treatment finally began a process of feminization.

Discussion

To conclude this historical review, we will briefly review: 1) how the status of wounded healers has evolved within the larger history of addiction-related mutual aid and addiction treatment in America, 2) the current status of recovered people working in addiction treatment, and 3) the special assets and vulnerabilities of the wounded healer.

The Evolving Role of the Wounded Healer

There are several major themes within the history we have explored.

From Cultural Reform to Personal Reform It could be argued that the abstinence-based, Native American cultural revitalization movements led by recovered alcoholics do not constitute threads within the tradition of recovered alcoholics working within addiction treatment on the grounds that these groups did not have a singular focus on the problem of alcoholism. It seems likely, however, that the leaders of these movements understood that these structures would have had little relevance if they had been so narrowly defined. Recovery movements that arise within a people under physical and cultural assault must address personal recovery within its most pressing political, economic, and cultural contexts. While the earliest roots of professional helping by recovered people were by necessity enmeshed within broader acts of political advocacy and political/cultural renewal, there is an enduring strain between the impulse to rally against environmental conditions that contribute to excessive drug use, and the impulse to focus on the personal reformation of those who are casualties of that excess.

From Avocation to Vocation Wounded healers have long experienced a strain between an avocation (calling) to work with the addicted and the more formal demands of vocation--the use of one's addiction and recovery experience as a credential for professional employment.

From the Spiritual to the Secular The stories of many of the most noted wounded healers--Handsome Lake, John Gough, John Hawkins, Jerry McAuley, Bill Wilson, Malcolm X--are remarkable, in part, for their dramatic conversion experiences and the messianic visions that drove their subsequent service activities. Emerging movements to help those addicted to alcohol and other drugs often begin in the spiritual arena and then migrate to a secular arena. This can be seen in the movement from Courtenay Baylor's religious approach of lay therapy at the Emmanuel Clinic to the emergence of Richard Peabody's technical approach to lay therapy that was privatized and stripped of its religious and spiritual dimensions. In these transitions, we see a shift from doing things with and for the alcoholic (housing, feeding, listening, sharing, praying) in the context of an equal relationship, to doing things to the alcoholic ("treating") in the context of an unequal, fiduciary relationship. The modern credentialing movement similarly shifted the focus of the helping process from one that was essentially a spiritual process to one that was rooted in the disciplines of physiology, pharmacology, psychology, and social casework.

From the Personal to the Professional/Technical Throughout the 19th century, recovered alcoholics pursued highly personal activities for the benefit of themselves and others similarly afflicted. The essence of this service to self and

others was the sharing of experience, strength and hope through persuasive speaking, personal correspondence, face-to-face consultations with alcoholics and their families, and through telling one's story in books, pamphlets, and such specialized newspapers as *The Reformed Drunkard*. There has been an enduring strain between whether recovered alcoholics should continue to perform these functions or whether they should instead be performing more technical and less personal services. The modern debate about counselor self-disclosure suggests a movement from the personal to the professional/technical.

It is in the lay therapy movement of the Emmanuel Movement that we see the emergence of a defined structure, process, and body of clinical technique that constitutes a specialized psychotherapy for alcoholism. This is the first time we see the recovered alcoholic taking on primary responsibility for the "treatment" of other alcoholics. It is here that we see the functions of the recovered professional helper expand beyond his own storytelling, advice-giving and encouragement. We find here a well-developed theory of the etiology of alcoholism, criteria for the selection of those candidates most likely to be helped, the use of informed consent and confidentiality negotiations, a multi-staged counseling process, well-defined and codified counseling techniques, and literature assigned to the client as an adjunct to the counseling process. It is in the early Peabody-trained lay therapists that we first get the feeling that there is much more involved in counseling an alcoholic than passing along what one learned in the mastery of one's own personal recovery. It is here that we see how the legitimacy of the recovered professional helper evolved from the credential of internally acquired knowledge to a credential of externally mastered knowledge and skill.

From the Public to the Private There are repeated cycles of moving the helping process by recovered people from one wrapped within a larger institutional setting that has broad public support to an activity that is done in isolation and for personal profit. This trend spans the movement of Washingtonian leaders into the professional lecture circuit to the movement of modern addiction counseling into private practice. A hallmark of professionalization--the ability to practice independently--seems to work against the enduring calls for multidisciplinary models for the care of the addicted.

Cyclical Presence The use of recovered people as professional helpers has been continually rediscovered over the past two centuries. The ascension of this practice has often involved recovered people filling a void within a stigmatized arena that attracted only a small number of professionals. The decline in this practice is less clear. We know very little about why inebriate homes and addiction cure institutes moved away from the practice of hiring recovered inebriates just as

we know very little about the mid-20th century decline of the lay therapy movement. But three hypotheses are worthy of testing: 1) Problems of sustaining levels of commitment and competence arise as the use of recovered people moves from its pilot (social movement) stage to its replication (professionalization, institutionalization) stage. 2) Recovered people can claim ownership of the addiction problem only when that problem is perceived to have no value to mainstream helping professionals. 3) When the medicalization of addiction enhances the prestige and profitability of those laying claim to this problem, recovered people without traditional academic credentials diminish in number and visibility.

Changing Roles There is a cyclical aspect to the role changes of recovered people. The emergence of recovered people in A.A. working within the early farms, retreats, and eventually within the newly emerging Minnesota Model constitute a reversion to the style of the 19th century temperance reformer. The influence of the lay therapy movement was to a great extent lost as A.A. members working in the alcoholism field essentially reverted to the functions of sharing their own story, offering encouragement, and offering advice drawn from A.A.'s basic texts. The later strain to professionalize the Minnesota Model resulted in re-integrating many of the lay therapy elements back into the role of alcoholism counselor.

The Modern Transition What alcoholism counselors had in the social movement phase of treatment was a deep, experiential understanding of the stakes involved in addiction treatment. Counselors understood that there was a life or death quality to their work. They saw the whole alcoholic and the entire outcome of treatment--at its best and its worst. In what has become a much more fragmented and clinically antiseptic field, today's counselors work with addicts that somebody else sobered up, and they work with them for a narrow slice of time, knowing little of what came before or what follows. Many (if not most) of today's counselors have never seen Delirium Tremens (DTs), never seen heroin withdrawal face-to-face, never held the hand of an addict dying from addiction-related diseases, never stood beside family members over the graves of alcoholics and addicts who didn't make it. The knowledge base of counseling has moved from an emphasis on an experiential understanding of the process of addiction and recovery--its physiology, its psychology, its spirituality, its geography and sociology--to an emphasis on what is for many of today's addiction counselors essentially hearsay knowledge. Those systems that have helped recovered addicts acquire education and professional credentials have sustained a valuable blend of firsthand and secondhand knowledge.

From Community to Career Addiction counselors of yesteryear had a sense that they and their clients were part of a larger family or community. The relationships between counselors and their clients have become much more professionally encapsulated and more emotionally detached. Viewed nationally, the relationships between counselors and the recovering community have evaporated. Counselors of yesteryear, like their clients, had an umbilical cord attached to the recovery community that linked them, fed them, nurtured them. The number of today's counselors who have never been (or not been in years) to an A.A., Al-Anon, NA, CA, WFS, SOS, RR, or MM meeting or who do not see themselves as being part of this larger community would be incomprehensible by the standards of yesteryear. In the face of such disconnection, today's counselors must seek other sources of strength from which they can convey a hope to the alcoholics and addicts sitting across from them. Where such sources are not found or consistently tapped, hope may be a diminishing element within a treatment milieu.

Support Then and Now The conditions under which recovered people have pursued their service roles have changed significantly. Recovered people today enter the enterprise of addiction treatment having often had their own addiction careers interrupted at earlier stages. They bring longer periods of sobriety before entering the work and greater access to sobriety-based support groups to sustain their own recovery process. They have received considerable education and training before they begin counseling others. They are more likely, than their 19th and early 20th century counterparts, to be imbedded within a large interdisciplinary team and have greater access to clinical supervision. These conditions provide a greater level of preparation and support than has been available during any earlier period of American history.

Lost Dimensions In reviewing the evolution of this wounded healer role, it is perhaps appropriate to ask whether anything of value has been lost within the many transitions in this role. If addiction counseling were represented metaphorically as an onion, we have added layer upon layer to this role while some believe that we have come to neglect the core. There is almost universal concern that, in our preoccupation with documentation, billing, scheduling, and all of the other mechanisms that surround the counseling process, we have forgotten the empathic relationship that is the core of this process. It is the recovered person who has most consistently brought this capacity for empathy to the engagement of addicts and their families. Their professionalization and declining numbers might reflect a diminishing emphasis in modern treatment on this most fundamental foundation of addiction counseling.

The medically and psychologically derived therapeutic models in which

recovered alcoholics and addicts are trained as part of their transition into the profession of addiction counseling has limitations as well as value. By over-identifying with this new body of knowledge, the recovered person may refute the value and legitimacy of their own experience in ways that diminish their empathy and connectedness to the still suffering alcoholics/addicts who seek their services (Kite and Keyes, 1973, p. 79-80). Emotional detachment in the name of professionalism may neutralize the most important assets the recovered person brings to the field of addiction treatment. When this happens on a large scale, then the question of the future of recovered people working in the field will have been rendered irrelevant because all clinically important differences between counselors with and without recovery backgrounds will have dissipated.

Current Status of Recovered Professionals

Studies of the addiction treatment workforce have found different percentages of direct care staff in recovery at different times and within different treatment modalities. The percentage of those with a recovery background who work as addiction counselors has been reported as low as 7% in community mental health centers and 14% in inpatient VA programs; as ranging from 35-40% in methadone and outpatient drug free programs; and as high as 70-75% in private inpatient programs, detoxification programs, and halfway houses (Humphreys, Noke and Moose, 1996; Aiken, et.al., 1985; Mulligan, et.al., 1989). Over half of certified addictions counselors surveyed nationally acknowledge recovery status (Birch and Davis, 1983, 57%; McGovern, 1987, 70%; NAADAC, 1993, 63%; NAADAC, 1995, 58%; Roman and Blum, 1997, 62%).

These studies suggest that the percentage of recovered people working in the field peaked at between 70-80% between 1985-1990 and then slowly declined to the 50-60% range in the 1990s. Given the lower use of recovered people in community mental health centers and independent health care systems like the VA, this percentage will likely continue to decline if the treatment of addiction to alcohol and other drugs continues to move from a segregated system to integration within broader behavioral health service systems.

Assets and Vulnerabilities of Wounded Healers

Several efforts have been made to delineate the characteristics of those with and without recovery backgrounds who work in the addictions treatment field (Anderson, 1944, 1950; Blume, 1977; Bissell, 1982; McGovern and Armstrong, 1987; White, 1979, 1998). These collective observations suggest eight assets that recovered people have brought to their roles in addiction treatment institutions in America: 1) a knowledge of the physiology, psychology, and culture of addiction that is derived from direct experience; 2) a capacity for, and openness to, emotional identification (kinship) with the addict; 3) an absence of condescension and contempt derived from an equality of shared experience and vulnerability; 4) a zeal (calling) to heal others that flows out of a deep sense of personal gratitude for their own recovery; 5) the ability to use their own stories to incite hope in the potential for recovery; 6) a willingness to be more directive (than traditionally trained helping professionals) when counseling alcoholics in the earliest stages of recovery; 7) the capacity to serve as a role model for the client and to coach the client on day-to-day issues faced in early recovery; and 8) the ability to provide clients with a detailed and personal orientation to A.A. and other mutual aid societies.

At the same time, the professional helper in personal recovery may be prone to: 1) experience interprofessional conflicts arising from differing views about the nature of addiction and recovery as well as from their own unresolved feelings about past maltreatment by professionals, 2) overextend themselves to compensate for their self-perceived lack of credentials, 3) experience special problems of countertransference with clients, e.g., trying to program a client's recovery within the framework of his or her own recovery, 4) develop a dependency upon the social and emotional intensity of the work milieu to meet unmet social and intimacy needs, 6) experience role confusion and role conflict between mutual support group activities and professional counseling activities, and 7) to experience a rare, but quite real, vulnerability for relapse.

There are two points that should be made regarding this catalogue of assets and vulnerabilities of professional helpers in personal recovery. The first is that assets and vulnerabilities are often closely linked regardless of one's recovery status. The recovered person's capacity for identification has a shadow side (the vulnerability for over-identification), just as the objectivity and clear professional boundaries that are the alleged hallmark of the academically-trained professional helper can evolve into emotional detachment and clinical abandonment. Every experience or trait that can add to the helping process, when pushed to excess, reveals a shadow side (Ottenberg, 1977). A second point is that assets and

vulnerabilities applied to such categories as “recovered” or “non-recovered” may not hold up under the scrutiny of science. For example, the idea that recovered staff as a group hold either certain beliefs or rigid beliefs about addiction, treatment and recovery has been challenged in research comparing staff with and without recovery backgrounds. For example, recovered staff in one major study were less likely than other staff to see alcoholics as an homogenous group whose needs could be met within a single approach to treatment (Humphreys, Noke and Moose, 1996).

Personal Recovery as a Professional Credential

A personal history of recovery from addiction does not, *in and of itself*, qualify or disqualify one as an effective facilitator of recovery for others. Modern studies have confirmed that the presence or lack of personal recovery are not predictors of counseling effectiveness or ineffectiveness (Covner, 1969; Rosenberg, et.al., 1976; Allison and Hubbard, 1985). Only one study noted superior treatment outcomes for patients assigned recovered counselors and that gain was only for younger (under age 35) patients (Argeriou and Manohar, 1978). Individual counselor beliefs and practices often thought to be defined by recovery or non-recovery status often are frequently found in research studies to be shaped instead by such factors as age, years of education, or treatment setting (Berger-Gross and Lisman, 1979; Shipko and Stout, 1992).

In recounting the power of the wounded healer in the history of addiction treatment, one must be careful not to romanticize the pain of addiction. Such pain is more naturally debasing than ennobling. There is nothing in the addict’s injured and fouled body, oft-profane tongue, or emotional/physical cruelties that stands as a qualification to help others. The personal experience of addiction takes on value only in the context of recovery. For every wounded healer carrying a message of hope today, there are a thousand addicts whose wounds were mortal. The lessons to be learned from the wounding become available to others only within the context of enduring recovery. And yet, even the most remarkable recovery from addiction may not, by itself, render one capable of working effectively as an addictions counselor. The best addiction counselors are often described by a constellation of traits--compassion, empathy, respect, genuineness, emotional courage--that cannot be easily reduced to categories of life experience or formal education.

A Closing Reflection

There are many things in this history worthy of emulation. If we look at the

most notable of the recovered people within this history, we find a sense of personal calling and a vision of how that calling can unfold within a particular historical context. We find a profound belief that working with addicts and their families is a worthy and noble way to spend one's life. We find a purity and singleness of purpose. We find in this story people who enter relationships with alcoholics and addicts from a position of moral equality, lacking the contempt and condescension that has long marred the relationship between addicts and their would-be professional helpers. We find a style of influence that is based more on life experience couched in story than in theory or rational argument. There is perhaps most of all an authenticity of emotional contact--an empathic understanding of the deforming powers of addiction and a passionate belief in the healing power of recovery. Recovered people, with all their assets and vulnerabilities, enter relationships with their clients with an unshakable belief that there is hope for permanent recovery from addiction, the best evidence of which lies within their own transformed lives.

So how does one emulate such qualities? If we look at those without personal addiction recovery experience who have been universally acknowledged for their special skills in working with alcoholics and addicts, we do find that they are individuals who have, like the alcoholic and addict, faced their own stark limitations, emptied themselves out, and experienced their own rebirth (Kurtz, 1996/1999). Concepts like "wounded healer" and "kinship of common suffering" transcend such labels as alcoholic and non-alcoholic. While the mechanism of addict-addict identification has long been a dimension of recovery for many people, what may be most important in the professional arena, is this authenticity of emotional contact that provides the context for the technical skills one offers as a professional helper. Such empathy and authenticity transcend the issue of one's recovery status.

A final lesson that can be drawn from those in recovery is the personal vulnerability that is inherent within the process of relating out of such emotional authenticity. Some of the most notable figures in this history--from John Gough to Jerry McAuley to Marty Mann, experienced brief relapses during their service careers while others had their careers (and their lives) destroyed by such falls from grace. Recognizing the kinds of daily activities that have long helped recovered people sustain their recoveries and their health working in this field can offer guidance for us all. Those activities include: 1) centering rituals that provide an opportunity for self-reflection and re-focus, 2) mirroring rituals that bring us together with kindred spirits for refreshment and re-commitment, 3) acts of self-responsibility and self-repair that allow us to make sure that our own home is not

left in darkness while we carry light to others, and 4) private, unpaid acts of service that serve to rekindle the values and commitments that first drew us to this work.

Historically, recovered and recovering people brought great passion and energy to the treatment milieu. They brought a focus on direct service to the still suffering addict and a deep faith in the potential for recovery derived from their own transformed lives and their participation in a community of recovered and recovering people. It is that contagious spirit of hope that must not be lost as this field enters a new century.

References

- Aiken, L., LoSciuto, L. and Ausetts, M. (1985). Who is Serving Drug Abuse Clients. In: Ashery, R. Ed., *Progress in the development of Cost-effective Treatment for Drug Abusers*. Rockville, MD: NIDA (NIDA Research Monograph 58).
- Alcoholics Anonymous (1970). *Final Report, Twentieth Annual Meeting of the General Service Conference of Alcoholics Anonymous*. New York: General Service Office of Alcoholics Anonymous.
- Alcoholics Anonymous (1975). *Final Report, Twenty-Fifth Annual Meeting of the General Service Conference of Alcoholics Anonymous*. New York: General Service Office of Alcoholics Anonymous.
- Anderson, B. and Blankman, B. (1986). Impaired Counselors: A National Survey. *The Counselor*, 4(5):18-19.
- Anderson, D. (1944). The Place of the Lay Therapist in the Treatment of Alcoholics. *Quarterly Journal of Studies on Alcohol*, (September), pp. 257-266.
- Allison, M. And Hubbard, R. (1985). Drug Abuse Treatment Process: A Review of the Literature. *International Journal of the Addictions*, 20: 1321-1345.
- Argeriou, M. and Monohar, V. (1978) Relative Effectiveness of Non-alcoholics and Recovered Alcoholics as Counselors. *Journal of Studies on Alcohol* 39:793-700.
- Berger-Gross, V., and Lisman, S. (1979) Attitudes of Paraprofessionals toward Alcoholism: Settings Effects. *Journal of Study on Alcohol* 40:514-517.
- Birch & Davis Associates (1983). *Development of Model Professional Standards for Counselor Credentialing*. Rockville, MD: NIAAA.
- Bissell, L. (1982). Recovered Alcoholic Counselors. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism*. New York: Gardner Press, pp. 810-817.

- Blume, S. (1977). Role of the Recovered Alcoholic in the Treatment of Alcoholism. In: Kissin, B. and Beglieter, H. Eds. *The Biology of Alcoholism, Vol. 5, Treatment and Rehabilitation of the Chronic Alcoholic*. New York: Plenum Press, pp. 545-565.
- Briggs, D. (1963) Convicted Felons as Social Therapists. *Correctional Psychiatry and Journal of Social Therapy* 9:122-126.
- Camp, J. and Kurtz, N. (1982) Redirecting Manpower for Alcoholism Treatment. In: Prevention, Intervention and Treatment: Concerns and Models. Alcohol and Health Monograph, No. 3, pp. 371-397. (DHHS Publication No. ADM 82-1192) Washington, D.C.: U.S. Government Printing.
- Carkhuff, R. and Truax, C. (1965) Lay Mental Health Counseling: The Effects of Lay Group Counseling. *Journal of Counseling Psychology* 29:426-431.
- Carkhuff, R. (1969) *Helping and Human Relationships: A Primer for Lay and Professional Helpers*. New York: Rinehart & Winston.
- Carkhuff, R. (1971) *The Development of Human Resources: Education, Psychology, and Social Change*. New York: Holt and Rinehart.
- Covner, B. (1969) Screening Volunteer Alcoholism Counselors. *Quarterly Journal of Studies on Alcohol* 30:420-425.
- Davis, C. and Ford, C. (1980). *Preparing a Drug Abuse Workforce: A National Training System*. Washington, C.C.: Career Development Center.
- The Fifth ATwo Hatter@... (1981) *Alcoholism Report*, February 27, 1981, p. 7.
- Grosser, C., Henry, W., and Kelley, J. (1969) *Nonprofessionals in the Human Services*. San Francisco: Josey-Bass.
- Humphreys, K., Noke, J., and Moos, R. (1996). Recovering Substance Abuse Staff Members= Beliefs About Addiction. *Journal of Substance Abuse Treatment* 13(1):75-78.
- Kinney, J. (1983). Relapse Among Alcoholics Who Are Alcoholism Counselors. *Journal of Studies on Alcohol*, 44(4): 744-748.
- Kite, R. and Keyes, R. (1973). The Para-Professional in the Poverty Community. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: Illinois: Charles C. Thomas Publisher, pp.78-84.
- Kolpack, R. (1992) Credentialing Alcoholism Counselors. *Alcoholism Treatment Quarterly* 9:97-112.
- Krystal, H. and Moore, R. (1963). Who is Qualified to Treat the Alcoholic? *Quarterly Journal of Studies on Alcohol*, 27:449-59.
- Kurtz, E. (1996). Spirituality and the Secular Quest: Twelve Step Programs. In: *World Spirituality Encyclopedic History of the Religious Quest*, Vol 22, Ed. Peter Can Ness, NY: Crossroad. (Also in Kurtz, E. (1999) *The Collected*

- Ernie Kurtz*. Wheeling, West Virginia: The Bishop of Books, pp.145-176).
- Lisnow, F. (1989). Is Impairment a Current Issue Facing Alcoholism and Drug Abuse Counselors? *The Counselor* 7(4):18-19, 42.
- McGovern, T. (1986). Our Professional Identity, Birth, Infancy, and Adolescence of our Profession. *The Counselor*, 4(4), 7-9, 30.
- McGovern, T. and Armstrong, D. (1987). Comparison of Recovering and Non-Alcoholic Counselors: A Survey. *Alcoholism Treatment Quarterly*, 4(1):43-60.
- McGovern, T. (1992). Alcoholism and Drug Abuse Counseling: A Personal Reflection. *The Counselor*, 10(3):38-46.
- McInerney, J. (1973). Alcoholics Anonymous Members as Alcoholism Counselors. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: Illinois: Charles C. Thomas Publisher, pp. 91-105.
- Mitchell, L. (1981). Credentialing and Certification of Drug Abuse Workers: A Review and State of the Art Report. In: Lowinson, J. and Ruiz, P. *Substance Abuse: Clinical Problems and Perspectives*. Baltimore: Williams & Wilkins, pp. 830-839.
- Mulligan, D., McCarty, D., Potter, S., and Krakow, M. (1989). Counselors in Public and Private Alcoholism and Drug Abuse Treatment Programs. *Alcoholism Treatment Quarterly* 6(3/4):75-89.
- NAADAC Education and Research Foundation (1993). *Salary and Compensation study of Alcoholism and Drug Abuse Professionals*. Arlington, VA.
- NAADAC Education and Research Foundation (1995). *Salary and Compensation study of Alcoholism and Drug Abuse Professionals*. Arlington, VA.
- Norris, J. (1970). The Hazards of A.A.'s Counseling for Pay. *A.A. Grapevine*, October, pp. 2-3.
- Of the 475 physicians... (1978). *Alcoholism Report* 6(15):8.
- Ottenberg, D. (1977) Traditional and Nontraditional Credentials in Addictive Problems: A Dispatch from the Battlefield. *The Addiction Therapist* 2(1)(Winter):56-63.
- Over 200...Community Action Poverty Programs (1972). *The Alcoholism Report*. 1(2):6, November 10.
- Pattison, E. (1973). A Differential View of Manpower Resources. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: Illinois: Charles C. Thomas Publisher, pp. 9-31.
- Reiff, R. and Reissman, F. (1970) The Indigenous Nonprofessional. *Community Mental Health Journal*. Monograph No. 1.
- Roman, P. and Blum, T. (1997). *National Treatment Center Study: Summary*

- Report*. Athens, GA: Institute for Behavioral Health.
- Rosenberg, C., Gerrein, J, Manohar, V., and Liftik, J. (1976) Evaluation of Training of Alcoholism Counselors. *Journal of Studies on Alcohol* 37:1236-1246.
- Rosenberg, C. (1982). The Para-professional in Alcoholism Treatment. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism*. New York: Gardner Press, pp. 802-809.
- Roy Littlejohn Associates, Inc. (1974) *Competencies of an Alcoholism Counselor: Proposed National Standards for Alcoholism Counselors. Final Report*. National Institute on Alcohol Abuse and Alcoholism.
- Schmidt, L. (1993). Private Practice: Wave of the Future? *The Counselor* Sep/Oct, pp. 25-29.
- Schulstad, M. (1998). Transcribed Personal Interviews, July 2 and July 17.
- Senay, E. (1981). Multi-modality Programming in Illinois: Evolution of a Public Health Concept. In: Lowinson, J. and Ruiz, P. (Eds.). *Substance Abuse: Clinical Problems and Perspectives* Baltimore, Maryland: Williams & Wilkins, pp. 396-402.
- Senay, E. (1989). Drug Abuse treatment in Illinois, 1966-1984. In: Arif, A. and Westermeyer, J. Eds. *Methadone in the Maintenance of Opioid Dependence: Programs and Policies Around the World*. New York: Praeger, 216-226.
- Shipko, J. and Stout, C. (1992) A Comparison of the Personality Characteristics Between the Recovering Alcoholic and non-alcoholic counselor. *Alcoholism Treatment Quarterly* 9:207-214.
- Spicer, J. (1993). *The Minnesota Model: The Evolution of the Interdisciplinary Approach to Addiction Recovery*. Center City, Minnesota: Hazelden Educational Materials.
- Valle, S. (1979). *Alcoholism Counseling: Issues for an Emerging Profession* Springfield, IL: Charles C. Thomas.
- Valle, S. (1983) Alcohol/Drug Counselor Credentialing Movement Changing the Profile of Health Care Delivery. *The U.S. Journal of Drug and Alcohol Dependence*. 7(2):1-4.
- White, W. (1979). *Relapse as a Phenomenon of Staff Burnout in Recovering Substance Abusers Working as Counselors*. Rockville, MD: HCS, Inc.
- White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.
- Wilson, D. (1984). Impaired Counselor: The Ignored Problem of the New Profession. *The Counselor*, July/August, p. 5.