

Don Ottenberg, M.D.

Dr. Donald J. Ottenberg was a pioneer of modern addiction treatment and a particularly influential figure in the worldwide therapeutic community movement. I first met Don when at national addiction conferences in the early 1970s and was drawn by his magnetic personality and his capacity for penetrating truth-telling about what was occurring within the turbulent environment in which addiction treatment was becoming rapidly professionalized. I owe Don a great deal of gratitude for his warm mentorship and his invitations to speak at his well-know Eagleville Conferences. After a distinguished career and rich life, Don died of cancer at his home in Philadelphia, Pennsylvania on August 20, 2004. For an informative and beautifully written tribute to Don written by Eric Broekaert, Stijn Vandavelde and Rowdy Yates, see <http://www.eftc-europe.com/Resources/Papers/don.pdf>

At the dawn of the twenty-first century recovering people are re-entering the world of addiction treatment in large numbers in refined and new roles. And perhaps inevitably, discussions have begun anew within the field about the relative value of those credentialed by education and those credentialed by experience. Few people have written with more clarity on this issue than Don Ottenberg. Below is a paper Don shared with me that he presented at the Seventh Eagleville Conference and that was later published in revised form in *The Addiction Therapist* (1977, Volume 2, Number 1, pages 56-63). It is one of Don's many classic papers and one of my favorites.

TRADITIONAL AND NONTRADITIONAL CREDENTIALS IN ADDICTIVE PROBLEMS—A DISPATCH FROM THE BATTLEFIELD¹

*Donald J. Ottenberg, M.D.
Eagleville, Pennsylvania*

I remember reading somewhere a study showing that test subjects scored as more intelligent when the temperature of the environment was cool rather than warm; and I can confirm the correlation from recent experience, at least to the extent of observing that around the issue of professional and so-called paraprofessional staff in the addictive problems field the heat of controversy certainty has been making some intelligent people sound foolish. Many complaints, charges and claims have been made on grounds that at best must be considered shaky. A lot of assumptions need testing. If found valid, they could be used to bring about necessary changes in attitudes and policies; if invalid, they should be recanted and put to rest.

To continue to do battle in a controversy full of noisy emotional outbursts launched from shaky premises on both sides is wasteful in time and energy, not to mention what it costs in dignity and mutual respect. As one small step, hopefully constructive, I'd like to examine some of the assumptions that need to be shaken down.

The first assumption is that having been an addict or alcoholic necessarily equips

¹ A paper presented at The Seventh Eagleville Conference, June 7, 1974.

one to be an effective counselor or therapist in this field. I think that most experienced workers, including recovered alcoholics and addicts, probably would agree that some people aren't suited to this type of work, even though they have had the experience of personal recovery from addiction. And yet, very little has been said about how to select candidates appropriate for work in this field.

All too frequently, it is a matter of self-determination. As a recovered addict, I want to help other addicts so I apply for a job as a counselor. Or I may simply continue my own process of recovery by working with others who have a problem similar to my own. Rarely is a testing procedure used to help determine whether the field of work is appropriate for me and I for it.

Another assumption is that having an earned degree, say a master's degree in psychology or a master's in social work, necessarily qualifies a person to work with addicts or alcoholics. Here, a tricky word, "qualifies," can have two meanings. My degree may satisfy a bureaucratic office, perhaps the State Civil Service system, that I am qualified to be a counselor or therapist, but, looked at carefully, the academic degree is no more certain proof of my ability to work effectively with addicted people than was the mere fact of being a recovered addict or alcoholic. In both cases a true test of my competence in the field of work has not been applied.

One might argue that some degrees, such as doctor of medicine, carry with them reasonable assurance of functional competence in the specified field of work by virtue of the type of training provided in the regular curriculum. But even here, as physicians working in the addictive problems field know all too well, simply having an M.D. or D.O. after one's name does not signify competence to work effectively with addicted persons. The usual training of physicians has not included sufficient education for this type of work, and many physicians seem attitudinally unsuited. The same might be said regarding many who hold advanced degrees in psychology, social work, and rehabilitation counseling. Nor does the inclusion of an internship or field placement in the curriculum necessarily assure the kind of clinical skill needed. Many of these practicums are so specialized and so far removed from the world of addictions and addicted people as to provide little that can be learned in one sphere and used effectively in the other.

This questioning of competence in one's work role applies equally to traditionally trained and nontraditionally trained professionals or, to put it in the language of the debate going on in many programs and at various conventions and meetings where workers of both types gather, the so-called paraprofessionals or nondegreed professionals - most of them recovered addicts or alcoholics - are saying, "If there is need for a means of 'credentialing' or 'licensing' us nondegreed folk, there is a similar need for testing and credentialing people with traditional degrees." This is the kind of statement coming from one quarter. I don't know if those who have undertaken the task of devising credentialing systems for the noncredentialed and non¹degreed are hearing what is being said; and, if they do hear, I don't know what credence is being given this positron.

Yet another assumption is that recovered alcoholics and addicts working in this field have more to learn from psychiatrists than psychiatrists can learn from them. One could substitute social workers, psychologists and physicians; the point applies to traditionally degreed professionals in general.

On this issue I have heard the complaint several times from recovered staff members. It goes something like this: "I'm a recovered narcotic addict who spent a year in the rehabilitation program and have worked for several months at low level jobs around here and now I am a therapist in training, and you've assigned me to work in a group therapy setting with Dr. so-and-so, a psychiatrist. We have been working together now for a few months, and although I don't deny that I am learning some things from him, I think he is learning more from me. He learns about life on the street and what it was like to be a member of a street gang; what black family life in the ghetto is like; about the various kinds of hustle on the street; about prison and what goes on there. I don't begrudge him the opportunity to learn these things from me, but I do question why you say that he is training me, when I am training him just as much, if not more."

It isn't so easy to contradict a statement like that, because it contains much that is true. We may have to revise our concept of what goes on in so-called training relationships. Perhaps, for a long time, teachers have been getting as good or better than they give, and we have failed to appreciate that our designation of one person as teacher and the other as student is a distorted (and insensitive) labelling of what is really happening. As radical as the idea may seem, perhaps some kinds of training must always be a two directional interaction, with both participants understanding from the outset that both are trainers and both trainees.

If this idea has merit, I merely ask the question: In the revised relationship where both parties train and both are trained, will they be paid equally?

This carries us to another assumption demanding careful, yet courageous, examination. It has to do with money, in many places spelled e g o, so we know in advance we will have difficulty with it.

The assumption is that staff members doing what, to all intents and purposes, looks like the same work should be paid the same salary. To put a specific example before us: two staff members are supervising groups of patients; each runs a therapy group with a dozen patients, does some one-to-one counseling, confers to some extent with other staff, and is responsible for some recording and participation on task forces and committees within the program. One staff member is a recovered alcoholic who was addicted for about ten years and has been sober for five, the last two of which he has put in as a therapist here. The other staff member is a master's level psychologist with five years experience, the last two of which have been here in his current job as a therapist.

The recovered, nondegreed therapist says, "We do the same work, we should get the same pay. His psychology degree is something special so-and-so brings to his work, but It is no more important than my direct experience with alcoholism, my own recovery and my knowledge of street culture, which are some special assets I bring to my work. If there are things he knows that I don't know, there are just as many things I know that he doesn't know.

The psychologist says, "It is nonsense to think a recovered person with no degree and no formal education beyond high school is going to receive the same salary as a psychologist with a master's degree. I put time, money and a lot of effort into going to school with the intention of equipping myself for my work. I also did it for the very reason that I knew I could earn more money if I had an advanced degree. Now you are asking me to cancel out the value of the degrees I've earned. What I learned and what I know as a result of my formal education is a valuable asset that improves the quality of my work with patients. I'm a better therapist as a result of my training. It is worth something and I want the value of it reflected in my paycheck. Why should a recovered person receive the same compensation without facing the time-consuming, costly and difficult challenge of obtaining a higher education?"

The program director, already caught between the demand and the complaint, has other concerns neither disputant has even thought about. For example, the fact that there is a market value placed on each type of professional talent and experience, just as there is on any commodity or service in a free economy. If the program is supported by state or county funds, it may not be possible to pay a nondegreed person the same salary as a degreed person even if they are doing the same work. In some places it just cannot be done under current civil service definitions and regulations. Furthermore, the master psychologist was earning a salary at the going rate when he joined the staff. He had established his market value. The recovered alcoholic, on the other hand, when he arrived, was earning much less.

Some might say our problem is that the psychologist is over-qualified for the job he is doing, that we should use only nondegreed persons in this particular job category. But we as a program want this kind of variety in our counselors and therapists. We feel it blocks mobility and opportunity of nondegreed staff to keep all of them in a certain layer of the program hierarchy. Also, we think it is true that the psychologist does bring something different to this particular job, and we consider it a source of additional strength in our overall program. We want to be a truly interdisciplinary program, and keeping all recovered nondegreed staff at the same level and degreed staff at other levels tend to perpetuate elitism based on academic credentials which is the very inequity we are trying to escape from.

Along with the continuing dispute over the relative competence, status and value of recovered persons and traditional professionals goes an intensifying challenge of the claimed assets brought to the work situation by both sides. Many characteristics seen as advantages by each side are now denigrated as disadvantages by the other side. A look at some of these claims and counter-claims gives an idea of the weaponry currently

in use.

Among the attributes of recovered staff members generally thought to make them valuable members of a treatment program is their ability to identify with addictive persons and to have such persons identify with them. Recovered staff are also strongly committed to the work and have a great deal to contribute out of their own addiction experience. Almost always they exhibit a highly developed sensitivity to the feelings, thinking patterns, deceptions and defenses of addicted people, and they are frequently able to neutralize self-defeating behavior by effectively challenging it out of their own experience. Recovered addicts and alcoholics are not encumbered by the need to make observed behavior and characteristics fit into predetermined theoretical models. As a consequence, they have a more generous view of what may be possible and worth attempting with various patients. They are not caught in conflict between professional jargon and ordinary language, which makes it a lot easier for them to establish channels of direct communication with patients. Neither are they hampered or stifled by the “medical model” which says that first one must establish a diagnosis, then determine the cause, and then treat to remove or obliterate the cause and thereby effect a cure. Nontraditional recovered staff are quite willing to wade in and attack the drinking or the drug taking directly without too much concern that this may represent an attack on symptoms of some underlying problem that they are not addressing themselves to. Recovered addicts and alcoholics are not seduced by their own professional image. They have no need to play the role of “doctor” or “nurse” or “social worker,” nor are they as susceptible to elitist attitudes toward patients. They don't sit on a professional perch from which it is impossible to see patients as on the same human level as themselves.

These attributes of recovered staff, if they do in fact exist, are not accepted as necessarily useful or desirable by traditional professional staff. The highly developed empathy is seen more as overidentification with the patient and a tendency to project one's own needs onto the patient. In the same way the recovered alcoholic's and addict's deep commitment to the job and to the patients is sometimes questioned as being an excessive degree of dedication that expresses the therapist's own dependency needs and which functions as part of his system of “salvation.” While it is true that the nondegreed recovered staff member is not encumbered by theoretical models, is this simply a reflection of the lack of formal training needed to conceptualize observations and put data and therapeutic information into a systematic frame, and is such a deficiency of education necessarily an asset? If the recovered alcoholic or addict who has no formal training is not inhibited by diagnostic labels, even those such as schizophrenic or psychopathic personality, and is willing to take on almost anyone, the traditional professional asks if this is simply being uninformed and thereby unable to make a diagnosis, and whether the willingness to attempt to treat any case manifests a mixture of omnipotence and naiveté.

The fact that the recovered alcoholic or addict staff member is unhampered by the “medical model” and is willing to attack the addiction directly is seen as a failure to understand the disease concept of alcoholism and as a confusion of symptoms with the underlying pathologic process that causes the symptoms. That the recovered staff

member is less susceptible to playing the “doctor role” or “nurse role” is put down as sour grapes. Furthermore, the nonprofessional image problem is seen as just as bad when expressed in terms such as “only an alcoholic can help an alcoholic” or “it takes one to know one.” The almost unlimited willingness of the recovered staff member to become involved with patients, to enter into the patient's life and use his own life situation and emotion as a therapeutic implement may be seen by the traditional professional as acting out in response to the therapist's own unconscious needs. The recovered staff member is seen as unable to maintain the distance necessary in a good therapeutic relationship, and this is considered risky behavior which may result in the therapist being pulled into unhealthy emotional entanglement with patients.

The recovered staff member is also viewed as being omnipotent and too possessive of patients, with resulting difficulty letting go of patients and making appropriate referral of patients to other staff members, other elements of the program, or other agencies. Undue involvement in the patient's life is also criticized as being too manipulative to be helpful. It has been suggested that the recovered therapist's ego is fed more by feeling that he is stronger than most patients he works with than by any satisfaction he feels when patients succeed. An alleged narrowness of approach is explained as the recovered therapist's failure to incorporate experience beyond his own, with the consequence that every patient is expected to follow a pathway of recovery similar to the therapist's. The traditional professional attributes to the noncredentialed recovered therapist the position: “This is the way I did it, and if you want to recover this is how you have to do it.”

Not all the arrows are flying in one direction, however, and I think that to physicians, nurses, social workers, psychologists, psychiatrists, and the like, who earn the status of “professional” at considerable cost of money and hard work, it has come as a rude awakening to learn that “professional” in the minds of some is a term of derision. Instead of conveying the idea of respectability, dependability, and competence, “professional” may be seen as insensitive and distant, behaving in a contrived, somewhat unnatural manner behind a mask of assumed dignity and self assurance; and performing in a way that is not so much incompetent as irrelevant. While the professional would wish to have that word almost synonymous with trustworthiness and reliability, the connotation in some minds is with self-serving inaccessibility. That which the professional presents as neutral objectivity, these critics perceive as indifference or fear of close human contact. Hiding or withholding information or knowledge in the name of confidentiality or professionalism may be perceived as a maneuver designed to veil the esoteric healing art and sustain an air of mystery around professional practice.

The professional's judicious distance in the therapeutic relationship is seen as a partial cop-out by the nonprofessional, a way of keeping the commitment to the patient limited. This serves to protect the therapist from being forced to put into the therapeutic relationship more time, effort and personal involvement than he wishes to. Unwillingness to meet the patient directly in a here and now confrontation is interpreted at times as a lack of courage. Traditional professionals are perceived as

relying more on tests, formulations and intermediate information than on direct and immediate experience of the patient. This may be related to a need to have everything broken down into formulations and conceptualizations that fit into a scheme that enables the professional to “understand” what is happening to the patient and what he is doing in his therapeutic intervention. At times the concern of the professional appears to be more related to questions of his own potential professional liability than to the patient's actual disability.

When professionals talk in technical language and medical jargon, they are suspected of covering up ignorance or uncertainty. The nontraditionally trained recovered staff member operated on the assumption that what is understood can usually be discussed in everyday language. Preoccupation of the professional with diagnosis and the affixing of diagnostic labels to patients and their symptoms is seen to interfere with a therapeutic relationship, especially if the professional has a fixed viewpoint that certain diagnostic categories are either inappropriate for treatment or beyond the reach of effective treatment. To the noncredentialed recovered staff member, the professional's use of psychoanalytic jargon suggests that he is either covering a retreat from a shaky position or he is using language as a weapon. The professional's preoccupation with confidentiality is not always accepted at face value as a deep concern with the rights and welfare of the patient so much as it is perceived as a means of avoiding scrutiny and the need to share responsibility; confidentiality then becomes one more way of keeping people in the dark about what goes on in the therapeutic interaction.

This view of the professional as someone not too likely to be helpful, on whom one ought to keep a suspicious eye may be unknown to some professionals, even though they work side by side with people who hold the view. And when psychiatrists call absurd the notion that the more sobriety one has obtained, the more expert one becomes, recovered staff counter that it is just as absurd to believe that only a psychiatrist can direct a mental health or addiction program. The multiple-point indictment of professionals by some recovered staff members seems to parallel the rabid brand of anti-professionalism exhibited by some reactionary elements in AA. This is the counterpart of reactionary elements among professionals who always have acted as though it were impossible for someone without a degree to know anything of importance or to be of any real value in a therapeutic relationship. Some nondegreed staff reduce the charge to a single word: professionals are snobs.

Of course what is expressed publicly and what is said privately may be quite different. Publicly I have heard the nontraditionally qualified recovered staff attack professionals, attack treatment programs, attack the establishment, and generally exhibit contempt for training by professionals, credentialing by licensing schemes that would apply to nondegreed staff and not to traditionally degreed staff, and to academic degree programs. I have heard an almost paranoid reaction of some staff who seem to be saying, "I'll be damned if after all these years you're going to force me to go to school." Suspiciousness of any educational requirement has at times degenerated into contempt for education itself. One hears statements that come perilously close to “all you need is

time on the streets.”

When the just claims of nondegreed and noncredentialed staff are perverted into an attack on intellect and formal education, we have reached the level of absurdity. Then we witness the sad spectacle of intelligent men and women trying to convince themselves and others that it is somehow a better experience to have been an addict on the street than to have completed successfully a well-rounded educational program leading to an advanced degree. Then ability to outcon the addict is equated with competence as a therapist, and the only qualification for therapists needed is the naive, narrow, subjective feeling that “when it comes to addiction, I know where it's at.”

When things come to this pass, it is no surprise to see nondegreed workers acting publicly as if there were no programs responsive to their needs, no professionals sensitive or appreciative of the special and invaluable contribution they make and to the problems they face, no facilities going out of their way to remove inequities, no real effort to find solutions in the treatment bureaucracy that would remove some of the disqualifying restrictive policy and red tape, no searching for educational policies that would credit realistically the competence they have or educational forms that would be appropriate to their wishes and needs.

And yet, privately, one can observe that many nondegreed recovered staff devour any useful and appropriately designed training opportunity. Many of them try to improve their basic skills, even such elementary skills as reading and writing. In the privacy of a friendly conversation, many will admit feelings of inadequacy, narrowness, relative ignorance of the field as a whole. They express their feelings of self-doubt and uncertainty based on what they see as a very modest degree of success in their work with patients. They also indicate that they know that some traditionally qualified professionals are just as in tune to the needs and mechanisms of addicted people as they are and they are well aware that some professionals and some establishment programs are their best allies.

And some traditional professionals in private among themselves have been saying that so-called paraprofessionals are over-invested, narrow in outlook, uncritical, impaled on the program that happened to work for them, demanding, falsely confident, and victimized by a delusion of competence far beyond what they may have achieved.

But in public, at least in my view at recent gatherings, traditional professionals have failed to answer even unreasonable attacks from the nontraditionally qualified workers. Such inappropriate and excessive attacks, very much like some of what has been detailed above, were largely unanswered at recent meetings such as the Fifth National Methadone Conference in Washington last year, the National Drug Abuse Conference in Chicago this year, and the National Drug Abuse Training Conference in Washington this year. I don't know why degreed professionals have backed away from a confrontation with nondegreed protagonists. It could be fear, guilt, or failure to understand and accept their own deep feelings about the issues raised. I've seen some professionals acting very much like white "liberals" who are incapable of disliking a black person or exhibiting

toward a black person any behavior that is angry, challenging, contradicting or rejecting.

So far I have heard a good deal of rhetoric and many angry charges based on stereotyped accusations. We still await a reasonable statement that begins to address in an honest and courageous fashion the true advantages, disadvantages, potentialities and limitations of both degreed and nondegreed professionals and which begins to work out mechanisms for assessing competence and assigning value to competence without regard to the way in which the competence was achieved.

Although it is hard to hear the truth when people are wildly shouting, anyone familiar with the arguments on both sides may believe, as I do, that there is some truth in what is being said in both camps. It may be that both nondegreed recovered professionals and traditionally credentialed professionals suffer from disabilities such as insensitivity, narrowness of viewpoint, inability to extend beyond one's own peculiar training and experience. It is simply that the disability is different for each type of professional. Clearly this is an opportunity as well as a difficulty, for it certainly seems likely that people of goodwill could help one another to extend their understanding and capability, if the spirit was right. More than equity in the job situation is being demanded, and I think we must understand this. These are questions of dignity and status. It is a matter of self respect not to accept less compensation for one's work than what another person equally capable and working at the same job receives. The fact that these are difficult problems cannot allow us to evade them. At the root, the issue is economic as well as personal and emotional. We must come up with answers that are as fair as we can make them and that express equity economically as well as in status and prestige.

I look to this conference to begin the necessary and difficult task of understanding one another and then moving toward policies, procedures and standards that are proper and fair to all.

We can agree, I would hope, that neither side has a monopoly on knowledge and wisdom, however obtained, and neither on sensitivity, empathy, compassion, or the necessary generosity and courage to make these commendable human traits useful to other people.

Can we also agree that it is foolish to think that people learn nothing in schools - or to take the corollary, that the only way to become educated is on the street?

Perhaps we need to pause and examine our terms. I think we all have a fair notion of what a school is but I wonder if we could all agree about what the street is. I want to introduce the view that all of us are born and raised on some street. It is not only those from economically limited and socially oppressed backgrounds who know the street; they know a particular street. What I am driving at is that we all derive knowledge and understanding of life and human experience from our particular individual, family, neighborhood, and societal experiences. If you believe that people who come from similar backgrounds and who have known similar experiences can be helpful to one another, I share your view. But I reject as over-simplified any idea that whites know

nothing and have experienced nothing and are capable of offering nothing that can be useful to blacks; or that people from middle class backgrounds can in no way be helpful to those who grew up in poverty; or that someone who has never been addicted to any substance has nothing to offer persons struggling to free themselves of dependency on chemicals, such as alcoholism or narcotic addiction.

Would it strike you as too radical for me to suggest that we all have experienced addiction - or helpless dependency - in our lives; that all of us know something subjectively about the nature of irresistible impulses and needs?

I also have very personal reasons for challenging the mindless idea that all the suffering in the world is in ghettos and slums. There is more anguish and agony than I care to contemplate in middleclass homes, and the worst emotional wastelands may be the prettiest, tree-lined streets. You don't have to be poor, black, or addicted to be hurt by life. And if winning free from the lonely despair and anguish of emotional disability is a tempering process that turns out helpful character, I can only report that many people who would never be thought of as socially or economically deprived have that dubious opportunity. Our society at all levels seems to provide an abundant variety of oppressions, any of which in the overcoming can test and strengthen sensitivity, empathy, perceptiveness, forgiveness, generosity and many other useful qualities of personality and character.

It is just these traits that training schools have not been capable of developing, and it is their lack in many traditional professionals that has led to cries of protest from persons who must look to these professionals for help of some kind.

But I contend that it is utterly foolish and self-deluding to think that everyone who survived poverty or a socially oppressed background has these traits - or that everyone who achieved sobriety after being addicted has them. What determines the development of the traits that make a good person - or a good therapist - is a complex affair not to be reduced to the single variable of the neighborhood or the family one happened to be born in.

My plea is for a reasonable, rational and generous approach to understanding and alleviating a difficult and painful issue. I hope we can begin today.