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A Lost World of Addiction Treatment

William L. White

This is the first of a series of articles in The Counselor that will explore the history of addiction treatment, counseling and recovery in America. The series will highlight some of the most important ideas, people and institutions that make up this history, and it will try to dig deep enough to find what lessons this history has to offer us today. When my research into this area began in 1976, I was stunned to discover just how little I knew about a field that I had then worked in for nine years. Perhaps you will share similar reactions as this series proceeds. What we are going to explore in this first article is an answer to the question: When did addiction treatment begin?

Dr. T.D. Crothers, in his 1893 text *The Diseases of Inebriety*, traced the earliest efforts to treat alcoholism to ancient Egypt, Greece and Rome. The early literature of each of these civilizations references the madness produced by wine, and Crothers traced the conceptualization of chronic alcohol inebriety as a disease to the first century writings of St. John Chrysostom. Early images of slaves attempting to treat the sufferings of their addicted masters with massage and various purgatives and potions suggest the presence of physical methods of treatment for alcoholism from the earliest periods of recorded history.

An American Binge

In America, the recognition of excessive drinking as an addiction emerged between 1790 and 1830. It was during this period that American tastes for alcohol shifted from cider, wine and beer to distilled spirits; annual per capita alcohol consumption increased from 22 gallons to 7 gallons; and the highly reputable colonial tavern gave way to the vice-ridden urban saloon. Heavy drinking was so pervasive that W.J. Rorabaugh entitled his book on this period *The Alcoholic Republic*. It took a century of religious, legal and medical experiments to overcome the consequences of this forty year binge that transformed America's drinking habits and drinking institutions into a major social and public health problem.

Early Addiction Medicine: The Inebriate Asylums

There were many types of institutions that shared responsibility for the care of the 19th century inebriate. Inebriates often found themselves in non-specialty

institutions that could do little for their condition—places like jails, county farms, almshouses, water cure institutions, and insane asylums. It was the failure of these institutions to adequately control or rehabilitate the inebriate that led to calls for new approaches. Addiction treatment arose amidst competing claims of ownership of the alcohol problem by medicine, religion, law and business— influences that continue today.

First, there was the rise of addiction medicine between 1780 and 1830. Medical leaders such as Dr. Benjamin Rush and Dr. Samuel Woodward began to conceptualize excessive drinking as an inherited or acquired disease. It was further declared that this newly conceptualized disease, christened *inebriety* (*alcoholism* wasn't coined until 1849), could and should be cured within special institutions set up for that purpose. From this new American view of chronic drunkenness grew research into the nature of inebriety and the establishment of medically-oriented inebriate asylums, beginning with the opening of the New York State Inebriate Asylum in 1864. Inebriate asylums emphasized physical causes of this disorder and utilized physical methods of treatment: drug therapies, aversion therapy, hydrotherapy, and electrical stimulation. Inebriates could be legally committed to such institutions for periods ranging from one year to “until the patient is cured.”

Temperance Reform: The Inebriate Homes

The second branch of 19th century addiction treatment grew out of efforts to reform inebriates by enlisting their involvement in the growing American temperance movement. Temperance reformers, many of them recovering alcoholics, founded mutual aid societies—Native American temperance societies, the Washingtonians, the recovery-focused fraternal temperance societies, and the reform clubs. Leaders within these societies were often the driving spirit behind the establishment of inebriate homes such as the Washingtonian Homes in Boston (1857) and Chicago (1863). Inebriate homes emphasized short voluntary stays and non-physical methods of treatment. Alcoholism recovery in most of these homes was viewed as a process of moral reformation.

Most of these inebriate homes and asylums focused on the treatment of alcohol inebriety but began to treat addiction to drugs other than alcohol in the decades following the Civil War. Homes such as the DeQuincey Home and the Brooklyn Home for Habitueés specialized in the treatment of narcotic addiction. In spite of significant differences in philosophy, the superintendents of the inebriate asylums and the managers of the inebriate homes came together in 1870 to found the American Association for the Cure of Inebriety and to establish the *Journal of Inebriety* (in 1876)—the first addiction-related professional association and first professional

addiction treatment journal.

The Urban Mission Movement

The religious influence on the history of alcoholism treatment increased when Jerry McAuley opened the Water Street Mission in 1872. McAuley and his wife Maria, both *redeemed* alcoholics, birthed an urban mission movement that brought safe shelter and a message of hope to the skid row alcoholic. The weekly newspaper advertisements for the Water Street Mission said it all: “Everyone welcome, especially drunkards.” McAuley and other alcoholic missionaries also played leadership roles in helping start some of the more religiously-oriented inebriate homes, most notably the New York Christian Home for Intemperate Men. McAuley’s missions were the forerunners of the Salvation Army and other urban mission programs that would come to serve the special needs of the Skid Row alcoholic. The missions and religiously-oriented treatment institutions viewed recovery from addiction as a process of religious conversion--a process of spiritual rebirth.

Addiction Treatment Franchises

The business branch of the 19th century treatment industry offered two types of proprietary treatment. First, there were the private for-profit sanatoria and addiction treatment institutes. Some of these, such as the Keeley Institutes, the Gatlin Institutes, the Neal Institutes, and the Oppenheimer Institutes, were franchised across the United States and made millionaires of their founders. There were many other local institutes that provided discrete detoxification and convalescence for affluent alcoholics and addicts. The home cures constituted the second type of proprietary treatment. A patent medicine industry that aggressively promoted alcohol-, opium- and cocaine-laced products, and that was responsible for the accidental addiction of many Americans, also began to offer its own bottled addiction cures in the second half of the 19th century. There were hangover cures and alcoholism cures--products like the Hay-Litchfield Antidote and Knights Tonic for Inebriates. There were even products like the White Star Secret Liquor Cure and The Boston Drug Cure for Drunkenness that were promoted to wives in the promise that the wives could cure their husbands’ alcoholism by secretly placing the advertised product in their husbands’ food or drinks. There were the various cures for the “drug habit” that could be purchased by mail order: the Richie Painless Cure, Morphina-Cure, Opacura, and Drug Crave Crusade. There were also home cures for *tobaccoism*: BACO-CURE, Nicotol, and Nix-O-Tine. The No-To-Bac company even claimed that their product could, at the same time it cured the tobacco habit, cure impotence. It seemed for a while that everyone was getting into the addiction cure business. Even Sears Roebuck &

Company offered a 50 cent cure for the liquor habit and 75 cent cure the for morphine habit in its late 19th century mail order catalogues.

The Collapse

In 1890, the future of addiction treatment in America could not have looked brighter. Progress was being made in medicalizing and destigmatizing addiction to alcohol and other drugs. The number of inebriate asylums and homes was rapidly growing. The proprietary franchises and home cures were undergoing explosive growth (and profit). The treatment/reformation of inebriates was emerging as a professional specialty within the fields of medicine and religion. But by the early 1920s, most 19th century addiction inebriate homes and asylums and addiction cure business enterprises were gone or on the verge of collapse. Only a handful of these institutions survived into the modern era, and it would take another fifty years to rebirth a national network of professionally-directed addiction treatment institutions.

In the next article, we will detail those factors that led to the fall of America's first system of addiction treatment. We will explore how the demise of this system was so complete that most of us entering the field during the past thirty years were not even aware of its existence. We will explore which, if any, of the factors that led to the demise of 19th century treatment are part of the current threats to the character and future of addiction treatment in America. (And we will find out what was really in those bottled addiction cures!)

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, from which this article is abstracted.

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A Cautionary Tale: The Fall of America's First Treatment Institutions William L. White

Many readers of *The Counselor* are likely aware that, in 1993, Parkside Medical Services Corporation ceased to exist as the largest national provider of addiction treatment services in the United States. The demise of Parkside and the demise or radical restructuring of many other addiction treatment providers was the consequence of an ideological and financial backlash that put the topic of managed care on the agenda of every addiction-related conference in the 1990s. What readers may not be aware of is that a similar collapse of addiction treatment occurred almost a century ago.

In the first article of this series, we explored the rise of an elaborate network of addiction treatment institutions in the 19th century: the medically-oriented inebriate asylums, the temperance-influenced inebriate homes, the religiously sponsored urban missions and recovery homes, and the proprietary addiction institutes and bottled home cures for addiction. Forces within and outside the field of addiction treatment led to the demise of most of America's first network of addiction treatment providers. Where there were hundreds of treatment institutions in 1895, only a handful existed in 1925. This is the story of what happened.

Internal Threats

There were many things that weakened the 19th century field of addiction treatment and rendered the field vulnerable to powerful threats that emerged unseen from the outside economic and political environment. Many of the first addiction programs in America imploded, unable to survive the excesses of their charismatic leaders. The field itself was fragmented into ideological camps that waged their battles not behind the closed doors of professional meetings but in the popular press. Inebriate asylums suffered from a long-term residential modality bias and were vulnerable to charges that their services were relevant to only the most severely afflicted. Addiction treatment methods were poorly developed and nearly all branches of the field eschewed the use of scientific methods to study the nature of inebriety and to evaluate treatment outcomes. As a result, some quite incisive ideas existed alongside some of the most harmful and ill-conceived--with

no agreed upon method to separate the former from the latter. When the field then reached a point of being put under a cultural microscope, it had no scientific data to justify its existence. In the end, there was not an agreed upon core knowledge or core technology of addiction treatment that could sustain the field.

Ethical Breaches

The field of addiction treatment came under increasing attack in the late 19th and early 20th centuries for breaches in ethical and professional conduct. There were highly publicized charges alleging medical incompetence, business fraud, misrepresentation of cure rates, excessive lengths of stay, aggressive solicitation of “refractory” (relapse) cases, patient abuses, and harmful treatments. Asylums and homes were charged with inadequate care. (A 1906 protest organized by patients of the Massachusetts Hospital for Dipsomaniacs and Inebriates ended with the criminal indictment of some of its staff.) The heads of the proprietary addiction cure institutes were bitterly attacked as financially motivated charlatans. In 1906, Samuel Hopkins Adams wrote an article in *Collier’s Magazine* entitled “The Scavengers” in which he published the results of his laboratory tests of the patent medicine home cures for the alcohol and drug habits. The laboratory findings confirmed that the cures for alcoholism contained exceptionally high proof alcohol or such substitutes as opium or cocaine and that the morphine addiction cures contained morphine, sometimes at higher doses than that which most addicts were accustomed. (Adams’ articles so outraged the public that Congress passed the 1906 Pure Food and Drug Act, the provisions of which put out of business the most fraudulent of the home cures for addiction.) Exposés of ethical abuses damaged the reputation of 19th century treatment institutions and eroded broad public support for their continued existence.

Economic Threats

Most of the 19th and early 20th century inebriate asylums and inebriate homes were supported financially by a combination of public funds (including some direct allocation of alcohol tax revenues), private philanthropy, and patient fees. Many programs closed during periods of economic depression when public funds were withdrawn and re-allocated to other areas, when philanthropic donations decreased, and when the admission of self-pay patients declined. These first treatment institutions were never able to establish a stable foundation of public or private funding to assure their existence through periods of widespread economic distress.

Political Threats

If there was a single factor that led to the demise of the inebriate asylums and inebriate homes it was the demedicalization and criminalization of alcoholism and other addictions. The inebriate came to be defined as depraved rather than diseased at the same time that the definition of America's alcohol problem began to shift from a focus on the alcoholic to a focus on alcohol. Alcohol and other drugs became defined as the source of great social evil. Between 1890 and 1920 a new public policy vision gained prominence: let the existing inebriates die off and prevent a new generation of inebriates from being created by banning alcohol and other addictive drugs. And perhaps one of the best kept secrets in American history is just how well these early prohibition laws worked in reducing alcohol and other drug-related problems. Inebriate homes, asylums and proprietary institutes closed their doors in great numbers as alcohol-related problems and admissions to inebriate homes and asylums plummeted in the early years of national prohibition. (By the late 1920s most alcohol-related problems were again on the rise.)

Leadership

In some ways the 19th century field of inebriety treatment simply died of old age. A group of physicians, clergy and reformed inebriates had birthed the field in the 1860s and 1870s and kept the field alive as they and it grew to maturity. Without any system of leadership development and any plan for leadership succession, there was simply not a body of men and women with the experience, the knowledge and the energy to face the threats posed to the field in the early 20th century. The field died in tandem with the death of its founding generation.

The Lessons of History

The relevance and implications of this history to our current circumstances would seem to be clear. We must get ourselves ethically and clinically re-centered. We must carefully define a core technology of addiction treatment and practice only within the boundaries of that technology. We must begin to address the problem of leadership development and leadership succession as growing numbers of our founding generation leave us. We must rigorously monitor the external political and economic environment for threats that could either destroy the accessibility of addiction treatment or corrupt its essential character. We must begin to rebuild the grass roots movement that birthed us and re-instill the cultural belief in the very real potential for permanent recovery from addiction. We must not lose sight of the singleness of purpose out of which we were born: the delivery

of a message of hope to suffering addicts and their families.

There is a transformative power that lies at the heart of this field--a power we have all witnessed but that sometimes is lost in the pomp, paper and procedures that fill our professional lives. If any part, or all, of our field ever collapses, it is that power that will be rediscovered in the future. And it is that power with which we must continually align ourselves.

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, from which this article is abstracted.

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White, W. L. (1999). First do no harm: Iatrogenic effects of early addiction treatment. *Counselor*, 17(4), 9-12.

**First Do No Harm:
Iatrogenic Effects of Early Addiction Treatment**
William L. White

Third in a series on the history of addiction treatment, counseling, and recovery in America.

Iatrogenic means physician-caused, or treatment-caused, harm—a reminder that well-intended helping interventions may have unforeseen and harmful consequences. The word is often used in the addictions literature to refer to drug addictions that grew out of the use of narcotics and other psychoactive drugs in the course of medical treatment. But there is another potential application of this term: the inadvertent harm that has been done to alcoholics and addicts in the name of helping them overcome their addictions. This article will explore some of the most invasive and harmful things that have been done to addicts in the name of treatment.

One is forced to pause in amazement when reflecting on the number and variety of “cures” for alcoholism and other addictions, ranging from the disgusting to the whimsical. Alcoholics have been forced to drink their own urine (or wine in which an eel had been suffocated) and surreptitiously dosed with everything from mole blood to sparrow dung, all in the name of treatment.

Alcoholics have been subjected to the “Swedish treatment,” in which everything they consumed and even their clothes and bedding were saturated with whiskey. Alcoholics have been put on every manner of dietary treatment, including the apple, salt, grape, banana, onion, and watermelon cures. And alcoholics have been asked to consume natural substances, from gold and iron to bark, that were thought capable of quelling their appetite for alcohol.

While the recounting of such treatments can elicit grimaces of disgust or smiles of wonder, there is a much more serious side to this story.

Harm in the Name of Good

Harm done in the name of good is an enduring theme in the history of addiction treatment. Even Dr. Benjamin Rush, who is deservedly called the father

of the American disease concept of alcoholism, treated alcoholism with methods that included blistering, bleeding, switching alcoholics from distilled spirits to wine and beer (or opium), and unknowingly poisoning alcoholics with prodigious quantities of the mercury-laden calomel.

Treatment practitioners of the 19th century regularly treated alcoholics and addicts by prescribing alcohol, narcotics, cannabis, sedatives, stimulants, and hallucinogens. Some of these practices are remarkable in light of subsequent knowledge. There was Dr. J.B. Bently, who in the 1870s and 1880s prescribed cocaine by the pound as a treatment for alcohol and morphine addiction and reported, as a testament to the cocaine's effectiveness, that his patients were requesting additional quantities of cocaine and that they had completely lost their appetite for alcohol and morphine.

There was Dr. J.R. Black who recommended in an 1889 medical journal article that alcoholics be medically addicted to morphine in the belief that morphine was cheaper and less physically devastating and rendered the alcoholic less socially obnoxious. There were "bromide sleep treatments" recommended in the treatment of narcotic withdrawal in spite of reports that 20% of patients died during the procedure. There was the physician who, noting that alcohol intake decreased among his patients suffering active stages of gonorrhea, recommended medically infecting alcoholics with gonorrhea as a way to save the expense of sanatorium treatment.

In the early 20th century alcoholics and addicts were included, along with the mentally ill and developmentally disabled, within mandatory sterilization laws. Sterilization was thought to not only prevent the breeding of degenerate alcoholic progeny but to also reduce the underlying physical causes of alcoholism. The coerced sterilization of alcoholics continued into the mid-20th century. Other early 20th century therapies prescribed for alcoholism and other addictions that proved ineffective or injurious included "serum therapies" that involved raising blisters on the addict's skin, withdrawing the serum from the blisters, and then repeatedly injecting this serum into the addict during withdrawal. There were also withdrawal therapies in the 1930s utilizing substances that could induce psychoses of up to two months duration.

For the first half of the 20th century, alcoholics and addicts were indiscriminately exposed to whatever was in vogue within the broader arenas of medicine or psychiatry. The 1940s and 1950s witnessed addiction treatments that included the use of electroconvulsive and insulin shock therapies as an aid to addict withdrawal and the experimental use of psychosurgery (the prefrontal

lobotomy) as a treatment for alcoholism and narcotic addiction. Some alcoholics commended the latter, reporting that, following the surgery, they could get twice as tight on half the liquor.

This same period also saw the use of apomorphine and socinylcholine to induce an aversion to narcotics. The latter, when paired with drinking, produced an aversion to alcohol by temporarily paralyzing the respiratory system and inducing the terror of suffocation. The 1950s also witnessed the use of methamphetamine as a medically prescribed substitute for alcohol and heroin. The latter substitution served as a petri dish for the subsequent growth of a methamphetamine injection subculture.

The Lessons of History

It is easy to look back with condescension insight at the practice of treating morphine addiction with cocaine or alcoholism with practically every other psychoactive drug. It is easy to look back with self-righteous outrage at the mandatory sterilization of alcoholics or their being blistered, bled, and subjected to invasive interventions from psychosurgery to shock therapies.

But what stands out for me is that the invasiveness and harmfulness of these interventions were not visible in their own time. History demands that we each ask how future specialists in addiction treatment will evaluate our own era. Who within our own period will future historians call the healers, and who will they castigate as the hustlers and charlatans?

What harm done in the name of good exists today in the field of addiction treatment? History tells us that, to differing degrees, we all suffer from temporal blindness. This history calls for clinical humility and a continual pledge to follow the first of all ethical mandates: First do no harm.

Next: America's first addiction counselors.

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America's First Addiction Counselors

William L. White

Fourth in a series on the history of addiction treatment, counseling, and recovery in America.

In the first three articles of this series, we explored the origins of addiction treatment in America; the rise and fall of 19th century inebriate homes, asylums and proprietary addiction cure institutes; and some of the unusual, often harmful things that have been done in the name of treating alcoholism and other addictions.

In this article, we will look at the beginning of addiction counseling in America, focusing not on the first use of the counselor title or first formalized role of addiction counselor but rather on when the core functions of addiction counseling began.

Native American Temperance Organizers

The first individuals in America who devoted themselves almost exclusively to carrying a message of hope for personal recovery from alcoholism were 18th and early 19th century Native Americans who led cultural revitalization movements following their own personal reformation.

Papoonan (Unami Delaware), Samson Occom (Mohegan), Kah-ge-ga-gah-bowh (Ojibway), Kenekuk (the Kickapoo Prophet), and Handsome Lake (Seneca) were among the Native American temperance leaders who, following their own near-death experiences with alcohol, brought a prophetic message about its role in the personal and cultural destruction of Native Peoples. They attacked alcohol as “fools water” or “the Devil’s spittle.”

Other Native leaders, such as the Delaware Prophet and the Miami chief, Little Turtle, launched total abstinence movements after experiencing visions that Native Peoples would be destroyed if they followed the White man’s drinking practices.

It is in Native America that we find one of the first anti-alcohol tracts aimed at drinkers (Samson Occom’s 1772 *Address to His Indian Brethren*, one of the earliest American accounts of personal recovery from alcoholism (William Apess’ 1829 *A Son of the Forest*), and the first individuals who devote themselves to

providing personal counsel on alcohol problems and organizing sobriety-based support structures (“circles”). These support meetings used speeches, walking, singing, chanting, dancing and cathartic weeping as rituals of recovery from alcoholism. Native leaders used their own recovery from alcoholism as a springboard to launch messianic cults founded on radical abstinence from alcohol and a return to Native traditions.

Temperance Missionaries

The increase in annual per capita alcohol consumption from 2½ gallons to 7 gallons between 1780 and 1830 produced a dramatic rise in alcoholism and a search for personal solutions to drinking problems. It was during this early period of the American temperance movement that temperance workers sought to counsel alcoholics to moderate their drinking by shifting from drinking distilled spirits to wine and beer.

These temperance workers were among the first to specialize in trying to use education and emotional appeal to influence the alcoholic’s drinking habits. Some of these workers were themselves recovering alcoholics who used their work in the temperance movement and face-to-face contact with other “hard cases” to strengthen their own recovery. The failure of many alcoholics to moderate their drinking, in spite of repeated pleas and the growing presence of recovering alcoholics in the temperance movement, helped shift the philosophy of this movement between 1825 and 1850 from that of a pledge of moderation (no distilled spirits) to one of total abstinence from all alcohol.

Between 1830 and 1890, a significant number of individuals turned their own experience of alcoholism and their story of recovery into a professional credential that qualified them to work as temperance organizers or speakers. They were paid either by local temperance societies or from collections taken from the audiences who heard them speak.

Local alcoholic mutual-aid societies sprang up in the 1830s, and men like J.P. Coffin took to the professional lecture circuit to reach other alcoholics. After 1840, these organizers and speakers were drawn primarily from the three dominant 19th century support structures organized by and for alcoholics: the Washingtonian societies, the fraternal temperance societies, and the reform clubs.

Battling Their Own Craving

John Hawkins and John Gough were among the most famous professionals who emerged from the Washingtonian Movement, J.K. Osgood, Dr. Henry Reynolds, and Francis Murphy were among the best known reform club

organizers. These individuals worked full time organizing support groups for alcoholics, used their gift for charismatic speech to motivate alcoholics to take the pledge, provided personal counsel to alcoholics and their family members as they moved from town to town, and used prolific correspondence to bolster alcoholics' resolve to sustain their sobriety.

Some of those recovering alcoholics who dedicated their lives to reforming other alcoholics they met on the temperance lecture circuit were not affiliated with the major mutual aid societies. There was a high casualty rate among solo practitioners like Luther Benson and Edward Uniac, who tried to use their speeches to other alcoholics while on the lecture circuit to quell their own unrelenting cravings for alcohol.

Uniac unsuccessfully battled his own raging appetite for alcohol while trying to carrying a message of hope to other alcoholics. He signed pledges after each drunken debauchery and used his own falls to illustrate the devilish power of alcohol. In 1870 at age 37, he died of an overdose of whiskey, sleeping powders, and opium in 1870 following what was considered a successful temperance lecture tour. In 1879, Luther Benson, who often drank before (and binged after) his famed temperance speeches, penned the history of his own repeated failures to sustain sobriety. His autobiography, *Fifteen Years in Hell*, was written from a locked ward of the Indiana Asylum for the Insane. The lives of Uniac and Benson affirmed what has been an enduring lesson within the profession of addiction counseling: Service work with other addicts cannot by itself ensure one's own recovery.

Use of Recovered Persons

Although there were not formal "counselor" roles in the 19th century inebriate homes and asylums, we find evidence of many counseling functions. The philosophy of "moral suasion" in the inebriate homes was to a great extent the use of a personal relationship to encourage, educate, and advise alcoholics and addicts on the process of recovery. The medium for this influence can be found in the use of formal lectures to residents and one-on-one meetings between residents and the superintendent or chaplain of the institution.

A point of major controversy in 19th century addiction treatment was the use of recovered alcoholics in institutions. Washingtonian-style inebriate homes often used recovered alcoholics as managers and aides, and some of the proprietary addiction treatment institutes (such as the Keeley Institutes) relied primarily on recovered alcoholics and recovered narcotic addicts to work as physicians and personal attendants.

Inebriate asylum leaders generally objected to such use on grounds that it would hinder mainstream acceptance of addiction treatment as a medical specialty. Other objections to this practice are reflected in the following excerpt from an 1897 editorial by Dr. T.D. Crothers published in *The Journal of Inebriety*:

Physicians and others who, after being cured, enter upon the work of curing others in asylums and homes, are found to be incompetent by reason of organic deficits of the higher mentality....The strain of treating persons who are afflicted with the same malady from which they formerly suffered is invariably followed by relapse, if they continue in the work any length of time.

This view was to change dramatically in the 20th century. The rise of the lay therapy movement of the early 20th century, the “AA Counselor” role of the 1940s, and the creation and evolution of the first fully professionalized alcoholism counselor roles in the 1950s and 1960s.

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, from which this article is abstracted.

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From Calling to Career: The Birth of Addiction Counseling as a Specialized Role

William L. White

Fifth in a series on the history of addiction treatment, counseling, and recovery in America.

In earlier articles we explored the rise and fall of 19th century addiction treatment in America and met some of the first people who first performed the core functions of addiction counseling as it is practiced today. What was absent in the 19th century was a fully developed role of addiction counselor. This role emerged from the ashes of a collapsing inebriate asylum movement.

In this article, we will trace the rise of lay therapy in the early 20th century, describe the evolution of this role within the mid-century alcoholism movement, and describe the formalization of this role in the 1950s in the “Minnesota Model” of chemical dependency treatment.

Lay Therapy Movement

Boston’s Emmanuel Church opened a clinic in 1906 that sought to integrate religion, psychology, and medicine in the treatment of various medical and nervous disorders. Over the following decade, the clinic developed special expertise in the treatment of alcoholism. It combined medical screening, individual and group counseling, classes, mutual support (the Jacoby Club), and special support provided by “friendly visitors” (recovered alcoholics). The latter element evolved into a system of “lay therapy” in which selected former patients in stable recovery received special training to provide the same therapy they had received.

The first seed of the lay therapy movement was sown by Courtenay Baylor, who was hired as a lay therapist at the Emmanuel Clinic in 1913 following his own treatment there by Dr. Elwood Worcester. Baylor is, to the best of this author’s researches, the first person without traditional professional credentials to be employed full-time as an addiction therapist. He treated many alcoholics and then recruited, trained, and supervised some of his most capable patients to be lay

therapists themselves. Some lay therapists trained at Emmanuel later provided therapy to alcoholics in what today would be called private practice.

A long line of noted lay therapists followed in the Baylor tradition, including Richard Peabody, Francis Chambers, William Wister, Samuel Crocker, Wilson McKay, and James Bellamy. Chambers deserves special mention; his enduring collaboration with the psychiatrist, Edward Strecker marks the first time that a lay therapist specializing in the treatment of alcoholism was integrated into a broader multi-disciplinary team within a traditional psychiatric hospital.

Through their various writings, Baylor, Peabody and Chambers formulated the core clinical technology of the practice of lay therapy in the treatment of alcoholism. The major elements arranging medical detoxification, eliciting a commitment to lifelong abstinence, negotiating a commitment to 60-100 hours of therapy, pledging mutual cooperation, contracting for mutual confidentiality, disclosing the therapist's personal story, eliciting the client's story, analyzing the inciting causes of the client's alcoholism, educating the client about alcoholism, giving the client reading assignments, creating a daily schedule for each client, training the client in relaxation techniques, utilizing hypnotic suggestion, and teaching each client how to reprogram his or her self-talk.

Works such as Baylor's *Remaking a Man* (1919) and Peabody's *The Common Sense of Drinking* (1933) were the first texts devoted to the structure and technique of alcoholism counseling. Peabody's book stands as one of the most influential 20th century books on alcoholism counseling.

Lay therapy in the Baylor-Peabody tradition continued into the early 1940s and helped legitimize alcoholism-focused therapy practices and the use of trained recovered people as "wounded healers." Most of the prominent lay therapists got sober before Alcoholics Anonymous was founded or got sober after 1935 without affiliation with A.A. Among those who got sober outside A.A. and who had traditional credentials within the helping professions, the most influential was Ray McCarthy, who pioneered many alcoholism therapy techniques in his work facilitating group therapy meetings at the Yale Clinics in the 1940s.

A.A. and Boundaries

As Alcoholics Anonymous entered a period of explosive growth in the early 1940s, it was faced with how to construct its relationship with a host of "drying out" sanatoria, public and private hospitals, state psychiatric hospitals, and newly emerging alcoholism treatment facilities. Some of the latter were launched by

A.A. members/entrepreneurs or A.A. clubhouses and were frequently referred to by such names as AA Farms, AA Retreats, and Twelfth Step Houses.

The interest that A.A. was sparking in the treatment of alcoholism led to A.A. members being asked to work in such facilities as managers, physicians, psychologists, social workers and aides. (The role of lay therapist was declining through the 1940s, so we have no clearly defined equivalent to the counselor role at this point for those without professional training.) All of this raised questions about the relationship between an A.A. member's activities in A.A. and the member's employment in these new institutions.

Forsaking its own early vision to operate alcoholism treatment hospitals, A.A., through its Twelve Traditions, forged a position of cooperation without endorsement or affiliation with such institutions and began to articulate principles through which A.A. members could separate their roles in A.A. from their paid roles in treatment institutions. Even though A.A.'s co-founder, Bill Wilson, had himself turned down an offer to work as a lay therapist at the Charles B. Towns Hospital for the Treatment of Drug and Alcoholic Addictions, he was generally supportive of A.A. members who sought his advice on whether to accept similar positions. Wilson's concern was that such employment not undermine the person's own recovery and that the member's actions in this paid role not injure A.A. as an organization.

What emerged were guidelines that prohibited the A.A. member working in the alcoholism field from speaking on behalf of A.A. and that required A.A. members to clearly delineate their A.A. activities from their paid activities as a social worker, psychologist, or lay therapist. With the clarification of such boundaries, Bill Wilson encouraged A.A. members to fill such roles. His support stemmed from his belief that it was important that alcoholics be able to find people in these new institutions who truly understood alcoholism and the process of recovery.

The boundaries between A.A. and treatment, and the differing roles of A.A. members and those employed in alcoholism treatment, were sorted out in the 1940s in older institutions that had begun cooperating with A.A. (e.g., Towns Hospital, the Chicago Washingtonian Home), in new alcoholism units (e.g., St. Thomas Hospital in Akron, Knickerbocker Hospital in New York), in new linkages being set up between A.A. and psychiatric hospitals (e.g., Rockland State Hospital, Manteno State Hospital), in new alcoholic "retreats" (e.g., High Watch, Alina Lodge), and in new facilities operated by members of A.A. clubhouses, (e.g., Twelfth Step House in New York, Friendly House in Los Angeles).

The conflicts that arose within High Watch and similar places helped distinguish the A.A. experience from what was coming to be called “treatment” and helped separate A.A. service activity from what was about to be christened “counseling.”

A Replicable Counseling Model

A synergy of innovation between three new A.A.-influenced treatment programs--Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950)--produced what came to be called the Minnesota Model of chemical dependency treatment. As it evolved in through the 1950s and 1960s, this approach solidified into a highly replicable model of treatment.

What is important about this innovation for our story is that the role of counselor was at the heart of this model. The Minnesota Civil Service Commission's creation of the Counselor on Alcoholism title in 1954 marks a significant milestone in the history of addiction counseling. With the fading of the lay therapist role, this decision marked the rebirth and reformulation of a specialized role (profession) for those caring for alcoholics.

But Minnesota did more than bless a new job title. In the face of considerable criticism, it created a means of preparing recovered alcoholics to work as counselors, 2) integrated the alcoholism counselor into a interdisciplinary team of psychiatrists, psychologists, social workers, and clergy, and 3) helped separate the status and responsibilities of the professional alcoholism counselor from the status and responsibilities as an A.A. member.

Early Minnesota pioneers like Pat C., Lynn C., Otto Z., Fred E. and Mel B. helped define this new role before its widespread replication throughout the United States in the 1970s and 1980s. As the Minnesota Model spread, it was adapted and refined. Foremost among these changes was the growing delineation between 12-step work within A.A. and the activities of professional counseling. As these roles became more clearly demarcated, people also began filling counseling roles who brought family recovery backgrounds. Later, counselors came without personal or family recovery experience. Still later, people entered the field who were in recovery from addiction to alcohol and other drugs but were not involved in 12-step recovery.

This brought counselors with a great diversity of personal, educational, and professional backgrounds to work in the arena of addiction treatment – and led to debates about who was qualified to treat alcoholics and addicts. There was a growing consensus that achieving the goal of specialized treatment resources for

addicts and their families was contingent on the full professionalization of the role of addiction counselor.

Next: Milestones in the professionalization of addiction counseling in the modern era.

William L. White is the Author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, from which this article is abstracted.

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Addiction Counseling The Birth and Maturation of a New Profession

William L. White

Sixth and final in a series on the history of addiction treatment, counseling, and recovery in America.

In the first five articles of this series, we have explored the deep historical roots that underlie the modern practice of addiction counseling. We have traced these roots from the leaders of 18th century Native American cultural revitalization movements through the 19th century temperance missionaries and to those who toiled in the inebriate homes and inebriate asylums. We have visited the Emmanuel Clinic and met many noted lay therapists of the early 20th century, and we noted the A.A.-influenced rise of the role of “counselor on alcoholism” within the Minnesota Model of the 1950s. We will pick up our story in the 1960s.

Treatment Models and Treatment Funding

Before a new profession of alcoholism or addiction counseling could fully emerge, there needed to be replicable models of treatment and an infrastructure to spread these models across the United States. Both of these requirements came together in the 1960s and early 1970s.

Replicable models of alcoholism treatment came from the residential model of alcoholism treatment birthed in Minnesota and from outpatient clinic models that had been developed in Connecticut and Georgia. Added to these was a new model of social setting detoxification pioneered in Canada as well as new designs for intervening with alcoholics in the workplace and in the criminal justice system (particularly for those arrested for impaired driving). There were three additional models that fully emerged in the 1960s to treat addiction to drugs other than alcohol: the therapeutic community first pioneered by Synanon, the development of methadone maintenance by Drs. Vincent Dole and Marie Nyswander, and a potpourri of individual, group and family therapies embraced under the rubric of “outpatient drug free counseling.” With models of intervention defined, what was

needed was a structure through which they could be widely disseminated to communities across America.

Early funding of services to treat those addicted to alcohol and other drugs came from multiple federal agencies and a smattering of states and municipalities. These coalesced in the early 1970s into a unique model of federal-state-local partnership, established initially by legislation pioneered by Senator Harold Hughes. This model that shaped addiction treatment for the next 30 years involved the flow of federal dollars from two institutes (the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse) to designated state alcohol and drug treatment authorities, who in turn worked with local communities to plan, build, operate, monitor and evaluate addiction treatment centers. Within a few short years, addiction treatment programs spouted up from one end of the country to the other. A controversy that quickly arose in this process involved the question of who was qualified to treat the alcoholics and addicts who would be served by these new facilities. The goals to accredit these programs at a national level and license these programs at the state level hinged on this question of who was competent to treat addiction.

Birthing a New Profession

Although the State of Minnesota created a civil service position entitled “counselor on alcoholism” in 1954, it would be many years before such a position would emerge as a recognized profession. It became quickly apparent to officials at NIAAA and NIDA that they were ready to do battle against alcohol and other drug addictions with no army to launch this effort. Because so many of the grass roots treatment models utilized people in recovery who often had more prior contact with penal institutions than educational institutions, the challenge was how to prepare and professionalize this indigenous workforce while blending it with a growing array of other professionals entering the field who also brought no specialized training in addiction treatment. The initial answer was to create two national training systems (one for alcoholism counselors, the other for drug abuse counselors) that would conduct training needs assessments, write training curricula, train trainers, deliver and evaluate training, and encourage states to begin the process of developing credentialing and certification systems to elevate this energetic but rather motley assortment of people into a professional workforce. Such milestone studies as the Littlejohn Report and the Birch and Davis Report laid the groundwork for the state and national alcoholism and drug abuse counselor certification efforts that would follow. The NIAAA- and NIDA-spawned training

systems helped prepare many people who had worked within earlier federally-supported alcoholism and drug abuse counseling programs, particularly those supported by the Organization for Economic Opportunity (OEO) and the National Institute on Mental Health (NIMH), as well as new generations of workers entering the field of addiction treatment. These top-down efforts were also accompanied by grass roots efforts to organize and train alcoholism and drug abuse counselors by state, regional and national counselor associations. Other elements of the field's professional infrastructure also began to emerge: academic and free-standing addiction counseling training programs, organizations that specialized in addiction research, and a growing body of addiction-related books, journals and newsletters.

Because so many of the early counselors were recovering and were working in roles that were ill-defined and for which they had been ill-prepared, a great deal of early focus in the 1970s was on mastering a basic level of knowledge about counseling, delineating one's role as a recovering person from one's role as an addictions counselor, and managing issues of self-care in an era when excessive hours was the norm. There were many counselors who had few qualifications other than their own sobriety, and, in some cases, this was fragile and of short duration. When isolated relapses did occur, they were wrenching experiences for not only those who relapsed but also for their fellow staff and clients who had to make their own painful sense of such episodes. In light of the lack of training, short lengths of sobriety, and minimal formal supports, it is amazing in retrospect just how few relapses there were and how many of these early pioneers in this "new profession" went on to make significant contributions to the field.

There were two debates that dominated the late 1960s and 1970s. The first was the question of who was qualified to treat alcoholics and addicts. This oft-heated debate pitted the recovered "paraprofessional" (or less pejoratively, "professional by experience") against the academically training and licensed psychiatrist, psychologist and social worker. A related and much more acrimonious debate involved the question of whether the treatment of alcoholism and other drug addictions should be brought under a single conceptual and administrative umbrella. This debate continued well into the 1980s before most treatment agencies, professional associations and credentialing/certification bodies in the field moved towards integrating these disorders under such rubrics as chemical dependency, substance abuse, or addiction.

One organization stood in the middle of all of these changes marking the birth of addiction counseling as a professional role.

NAADAC's Founding and Coming of Age

When Matt Rose, Robert Wayner, Jay Cross, W.W. Williams, Richard Kite, Fenton Moss, and James Towleron founded the National Association of Alcoholism Counselors and Trainers (NAACT) in Atlanta in 1972, it is doubtful that any of them could have envisioned their small group evolving into what NAADAC has become today. What NAADAC did through the leadership of people like Mel Schulstad and countless other individuals was forge an organization that could support addiction counselors across the country and provide a way for those counselors to speak with one voice on important public policy issues. NAADAC through the work of its members, its board, and its six executive directors (Matt Rose, Doug Harton, Ed Riordon, David Oughton, Steve Kreimer, and Linda Kaplan) helped build a new profession of addiction counseling and then bring credibility to that profession by defining ethical standards of practice, keeping its members professionally informed via its newsletter and journal, and by sustaining its training, credentialing, and advocacy activities. The work that NAADAC performed at a national level was mirrored in the development of state addiction counselor associations. Collectively, these associations oversaw the movement of addiction counselors from their status of “paraprofessional” pariahs to accepted members of multidisciplinary behavioral health teams.

Challenges

Addiction counseling is evolving dynamically within a turbulent cultural ecosystem that threatens to demedicalize and restigmatize addiction to alcohol and other drugs. Today’s addiction counselor is being asked to do a greater number of things within time frames that would have been incomprehensible only a decade ago. While fighting not to be drowned in paperwork, today’s counselor is faced with clients who are bringing multiple problems of great intensity and duration and significant personal and environmental obstacles to recovery. Today’s counselor is being asked to integrate into his or her practice new clinical breakthroughs (pharmacological adjuncts, manual-guided therapies, gender and cultural adaptations) that seem to be emerging with lightning speed. All of these demands are unfolding within agencies that are being caught up in a frenzy of mergers and service integration initiatives that threatens to dilute if not corrupt the core technology of addiction counseling. The central challenge is how addiction counselors can “keep their eyes on the prize” in the midst of such turbulence.

Looking Back and Forward

In looking back over the history we have shared in this series, it is perhaps appropriate to ask what the modern addiction counselor has provided that did not exist before. There are many potential answers to this question that would focus on the special knowledge and skills of the addiction counselor, but I would suggest an answer that lies in another arena. What addiction counselors brought to the alcoholic and addict that had not existed in any sustained way was a helping relationship that was free of contempt. Contempt, often mutual, had for well over a century marred the relationship between addicts and traditional professional helpers. What the new profession of addiction counseling brought to this relationship was not only specialized knowledge and skill but a relationship based on moral equality and emotional authenticity. The profession of addiction counseling and the larger treatment enterprises in which this profession is embedded face significant threats to their character and existence as we enter a new century and millennium. What must not be lost in the turbulent days ahead is the respect and mutual vulnerability that lies at the core of the relationship between addiction counselors and those they serve.

This last May at the NAADAC meeting in Philadelphia, I had the opportunity to present to the membership some of the lessons that I thought could be drawn from the history of addiction treatment and recovery in America. I close this series with my final remarks from that presentation.

I have spent more than thirty years with this imperfect instrument we call addiction treatment, but I reach this milestone more convinced than ever that, at its best, it can transform individuals, families and communities. The privilege of participating in this process of rebirth is the most sacred dimension of what we do. It is that power within which we must remain centered and, if the field should ever lose its way, that power that will have to be rediscovered in the future. I wish each of you and your organizations godspeed on your journey into that future.

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