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Before NAADAC: The Pre-professional History of Addiction Counseling

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As NAADAC celebrates its 35 anniversary as an organization, it is a fitting time to look back over the history of addiction counseling. There is a growing body of literature on the history of addiction treatment, but the history of NAADAC and a definitive history of addiction counseling as a profession have yet to be written. This article will offer a few snippets related to the origin of addiction counseling and discuss the state of the field at the time NAADAC came into being. This article is a way to honor generations of men and women who spent their lives laying the foundation for what would become the profession of addiction counseling. We can still draw upon their lives and their stories for wisdom and inspiration.

Before There Were Addiction Counselors

There was no formal role of addiction counselor in the eighteenth and nineteenth centuries, but there were those who reached out to those with alcohol and other drug problems through activities that would later be integrated into this role. Those activities could be found in two settings: the earliest addiction recovery mutual aid societies and within America's first inebriate homes, inebriate asylums, private addiction cure institutes and faith-based recovery ministries.

Early addiction recovery support groups included Native American recovery circles, the Washingtonians, recovery-based fraternal temperance societies, the Ribbon Reform Clubs, the Drunkard's Club and the United Order of Ex-Boozers (Coyhis & White, 2006; Ferris, 1878; White, 1998). The reformed drunkard turned temperance missionary became a prominent figure in the American temperance movement. Individuals such as John Gough and John Hawkins used their charismatic speeches detailing their fall and redemption to call others into recovery (Gough, 1870; Hawkins, 1859). They also provided personal consultations with alcoholics and their families, helped organize local recovery support groups, and maintained a prolific correspondence with individuals and families in recovery.

The therapeutic branch of the American temperance movement became involved in “rescue work” with confirmed drunkards, and these efforts spawned calls for specialized treatment institutions. What followed in the mid-nineteenth century was an ever-expanding network of inebriate homes, medically-directed inebriate asylums, private for-profit addiction cure institutes and urban rescue missions catering to late stage alcoholics. As “reformed men” sought service roles in these institutions, controversies raged about who was best equipped to do this work. The relapse of some prominent recovering temperance lecturers added to this debate (Benson, 1879; Berry, 1871). Dr. T.D. Crothers, a prominent leader in the American Association for the Study and Cure of Inebriety—the first professional association of addiction treatment providers--adamantly opposed the hiring of persons in recovery.

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 (Crothers, 1897).

This debate died in the larger collapse of addiction treatment in the opening decades of the twentieth century—a collapse resulting from a perfect storm of intrafield factors (e.g., ideological schisms within the field, ethical abuses, aging leadership) and contextual factors (economic depressions, lost cultural faith in the prospects of long-term addiction recovery, and the advent of national alcohol and drug prohibition laws). In spite of the collapse of addiction treatment as a field, key functions performed by those in recovery carried into the twentieth century: self-disclosing, educating (including providing lectures during residential treatment), advising, encouraging, modeling, and linking individuals to sources of long-term sober fellowship. These functions mark a thread of historical continuity that influenced the later rise of addiction counseling.

The Lay Therapy Movement

Between 1900 and 1920, local efforts to treat alcoholism continued in spite of the larger national collapse of addiction treatment as a field. In 1906, the Emmanuel Church of Boston established a clinic that integrated religion, psychology, and medicine in the treatment of alcoholism. The clinic provided medical evaluation, educational classes, individual and group counseling, mutual

support (the Jacoby Club), and personal support of “friendly visitors” (recovered alcoholics). Within a few years, the latter evolved into a formal system of *lay therapy*. Selected patients who had been successfully treated at the Emmanuel Clinic were trained to provide the same type of counseling they had received (Anderson, 1944).

Courtenay Baylor was hired as a lay therapist at the Emmanuel Clinic in 1913 following his own treatment there by Dr. Elwood Worcester. Baylor was the first person without traditional medical or psychological training to be employed full-time as a therapist specializing in the treatment of addiction. He was followed by other noted lay therapists, including Richard Peabody, Francis Chambers, William Wister, Samuel Crocker, Wilson McKay, and James Bellamy. Francis Chambers worked with noted psychiatrist Edward Strecker and is the first lay alcoholism therapist to work as a fully accepted member of the multidisciplinary team within a major psychiatric hospital (Strecker & Chambers, 1938).

The essential approach of the lay therapists included negotiating a treatment goal of lifelong abstinence, eliciting a commitment for 60-100 hours of outpatient therapy, negotiating a contract for mutual confidentiality, sharing the therapist’s personal addiction/recovery 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 positive self-talk (McCarthy, 1984). Baylor’s *Remaking a Man* (1919) and Peabody’s *The Common Sense of Drinking* (1933) stand as the first texts devoted to the structure and techniques of alcoholism counseling.

The lay therapy movement exerted great influence on the re-emergence of alcoholism treatment, but these therapists worked in isolation, maintained only informal contact with one another, and did not constitute an organized field of addiction counseling. The isolation within which they worked may have contributed to the relapse of some prominent lay therapists. If there is a single person who forms a human bridge between the early lay therapy movement and the rise of new outpatient alcoholism counseling clinics in the 1940s, it would be Ray McCarthy who pioneered many alcoholism counseling techniques at the clinics established by the Yale Center of Alcohol Studies in the 1940s.

AA and the Alcoholism Counselor

Alcoholics Anonymous experienced explosive growth in the early 1940s, and this growth and the efforts of the newly created National Committee for Education on Alcoholism (Precursor to today’s NCADD) spawned a parallel

growth in alcoholism treatment facilities. AA members, continuing a long “wounded healer” tradition, began working in various service roles within new alcoholism units in community hospitals (e.g., St. Thomas Hospital in Akron, Knickerbocker Hospital in New York), alcoholism units in psychiatric hospitals (e.g., Rockland State Hospital, Manteno State Hospital), alcoholic “retreats” and “farms” (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). What emerged were guidelines that helped AA members clearly delineate their A.A. activities from their paid activities as nurses, social workers, psychologists, and lay therapists.

The road from lay therapy to modern addiction counseling wound through the state of Minnesota in the late 1940s and 1950s. It was there that three abstinence-based, AA-oriented alcoholism programs—Pioneer House, Hazelden and Willmar State Hospital—birthed what came to be called the Minnesota Model of chemical dependency treatment. For purposes of our discussion this model had two very important influences. First, it birthed the role of the alcoholism counselor at the center of a multidisciplinary alcoholism treatment team—even getting the State of Minnesota Civil Service Commission to establish the civil service position of “Counselor on Alcoholism” in 1954. (The position required two years of sobriety and a high school education.) Second, the model was widely replicated across the United States. That replication sparked the rise of the new specialty role of alcoholism counselor in communities across the country (White, 1998).

That therapy for the alcoholic would be relegated to the lay alcoholism psychotherapist was not without its challenges. Alcoholics regularly found themselves in services setting with physicians, nurses, psychologists, social workers and pastoral counselors and many of these traditional service professions were employed to work in specialized alcoholism treatment setting. A central debate of the 1960s was, “Who is qualified to treat the alcoholic?” (Krystal & Moore, 1963).

The Ex-Addict Counselor

In 1958 Charles Dederich founded Synanon—the first ex-addict directed therapeutic community (TC) for the treatment of drug addiction. Six years later, Drs. Marie Nyswander and Vincent Dole introduced methadone maintenance treatment (MMT) in the United States. As TC’s and MMT spread in communities across the U.S., the “drug abuse counselor” role emerged as a central service role within each modality. The polydrug epidemic of the 1960s generated new mainstream and countercultural service institutions (e.g., free clinics, crisis lines,

drop-in centers, “acid rescue”). Many of these institutions morphed into “outpatient drug free” counseling clinics in the 1960s and early 1970s. The primary service role within these clinics was also that of the drug abuse counselor. Added across these setting was a mix of traditionally trained nurses, psychologists, social workers and clergy drawn to service with this particular client population and the frontier nature of the field, or drawn to the field to work out their own troublesome relationships with alcohol and other drugs.

The first national meetings that brought what were then christened “para-professional counselors” together from these diverse service settings were something to behold. Meetings were loud and boisterous as treatment philosophies (more like religions then) and personal values and lifestyles collided. Such differences were further amplified in the first meetings that brought the alcoholism treatment workforce together with the drug abuse treatment workforce. That a professional field emerged from these building blocks is something of a miracle—a miracle of leadership in which NAADAC played a significant role.

Closing Reflection

As we celebrate this historical milestone for NAADAC, we should pause to consider the state of the field when NAADAC was founded. In 1972, the federal, state and local partnership that has been the hallmark of modern addiction treatment was just being formed with no promise that it could sustain itself. The field at all levels was really two fields—an *alcoholism field* and a *drug abuse field*—fields that viewed each other with mutual hostility and distrust. It took more than a decade and much heated debate to forge an integrated field of addiction treatment that could distinguish itself from the broader arenas of health and human services. In 1972, few treatment programs rested on a solid financial infrastructure. Programs lived from single grant to single grant, staff were paid a pittance, and at the end of each funding year, counselors often left work on a Friday not knowing if their organization or their jobs would exist on the following Monday. In 1972, there was no defined core of knowledge and skills for addiction counseling, no formal addiction counselor training programs nor any advanced degrees in addiction studies. There were no national established standards of practice for programs or individual practitioners. There were no universally accepted code of ethical conduct in the practice of addiction counseling and not a single book available on that subject.

In 1972, the field utilized a predominately recovering workforce whose members brought little if any formal training prior to their entry into the field, and yet few guidelines existed on the screening, hiring, orientation, training and on-

going supervision of these early addiction counselors. The field's workforce was dominated by white men, and it took more than twenty years to significantly increase the numbers of women and people of color working as addiction counselors. That we have come so far in my professional life span is itself a tribute to NAADAC's sustained presence as a force of influence within the larger field of addiction treatment.

Happy Birthday NAADAC. You nurtured the field of addiction counseling through a turbulent birth and adolescence. You lit our pathway from par-professional to professional status. You have been there to guide us into maturity. Some would say we are now facing a mid-life crisis in which we need to redefine the very essence of who and what we are as a profession. The threats to, and opportunities for, the profession of addiction counseling have never been greater. Today, we need NAADAC's leadership more than ever.

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