David A. Deitch, Ph.D.

Few people more personally embody the modern therapeutic community movement than David Deitch. Following his early experience in Synanon, David co-founded Daytop Village, Inc., served as an indefatigable consultant to therapeutic communities all over the world, and most recently served as Senior Vice President and Chief Clinical Officer for Phoenix House's Foundation. He has served in numerous academic positions including Professor of Clinical Psychiatry at the University of California, San Diego, and appointments at Temple University, the University of Chicago, and the University of California at San Francisco. I have greatly valued David's friendship over the years and his candor in responding to my many questions about the history and current state of the field.

Much has been written about the role of the recovering alcoholism counselor within the modern treatment system, but much less has been written on the role of the ex-addict in the early history of therapeutic communities, methadone maintenance clinics and early polydrug counseling clinics. In the article below, David Deitch offers a set of insightful and prophetic reflections about the status and fate of the ex-addict counselor within the history of modern addiction treatment. It is an article that captures both David's wisdom and his passion for the field.

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The End of the Beginning: Dilemmas of the Paraprofessional in Current Drug Abuse Treatment

David A. Deitch

I. The emergence of the paraprofessional

IN THE BEGINNING THERE WAS failure and everybody bemoaned it. Bureaucrats and congressmen, judges, hacks, social workers and psychiatrists scratched their heads and had a variety of knee jerk responses under lengthy conference tables, and suggested answers. These answers depended on the amount of cigar smoke filling the rooms, and of course the alcohol preceding the meetings. They ranged from the Palovian response of "give em dope" to the threatened one of "lock em up" to the religious one of "help them find God". And, in the beginning, there was frustration.

However, in every era of social dilemma a prophet appears. These prophets, by

necessity, are charismatic, disconfirm the answers of old, and use the failures of the past to gain the opportunity to try out new solutions. They generate new hope, and above all, new faith. This more or less is the background for the emergence of the paraprofessional in the field of narcotic addiction.

During the early 1960's, self-help communities emerged and were felt by some to be the most promising solution to the ever increasing problems of drug abuse. In these communities, former addicts assumed the roles ordinarily held by professionals, from the top of the hierarchy on down. The self-help Synanon and Daytop prototypes had a number of things going for them: a strong belief that only people with similar experiences were able to break through the drug and character encapsulation of most addicts, and that this had to occur in a residential setting, 24-hours a day, highly structured, "most function" environment. The clients were there because they chose to be, and entry could only occur through confession - in this instance, the admission of the sin of being irresponsible and stupid and the need to grow up.

In the beginning, there seemed to be little need to understand intrapsychic process or interpersonal dynamics. The group and peer confrontation, and an internal value system with little ambiguity were the modus operandi of the conversion-faith system that did, in fact, generate behavioral change for those clients who remained. Admittedly, not many remained of those who applied. But for those who did, the behavior shaping techniques utilized by this faith system did, in fact, produce characterological change. However, much of this change was only sustained by a conformity to and an ongoing affiliation with the faith system. It is with this background, and from these sources, that most of the paraprofessionals and paraprofessional urban drug treatment systems existing in this country had their origins.

Excitement attracts media, and because the new modalities were exciting and different, and because other more traditional methods were failing, media entered the scene and bestowed their mixed blessings. With the interest of media, and immense exposure, great success was attributed to therapeutic communities long before they had demonstrated this success. It is at this point, as a result of grass roots public concern about the spread of addiction, that money became available for extended treatment responses of new and differing kinds. And, as happened often in the past, those who were formerly disinclined to become involved in social psychological treatment issues had their interest whetted when money became plentiful. Thus, many couch-type entrepreneurial psychiatrists and others were recruited back into the business of treating narcotic addiction. Most of these quite naturally occupied managerial positions. And in smoky rooms all over the country, many of the new managers from the ranks of entrepreneurial psychiatry and psychology were busy having meetings with the zealous leaders of the new faith systems. The results of these discussions ranged from total rejection of the other, with the insistence that neither knew his business, or fledgling cooperation, prompted by the cured ex-addicts from the faith system gaining increasing media exposure, and the funding possibilities in the hands of the new managers. I do not mean to suggest that there was no concern for impact on or helping the consumer of these services, but rather like other historical union issues, personal gains had first to be worked out before effective cooperation could occur.

For the paraprofessional one of three things occurred when he left home base:

1. The paraprofessional was able to regenerate a treatment system along the same lines,

with minor modifications of his former treatment experience. He was incorporated as a whole, with major responsibility.

2. He attempted movement into another bureaucratic system, without the supports of the familiar faith system, and failed to surmount his re-entry crisis. He had to face ambiguity; unique identity issues; etc. and then, more hazardous, a return to drugs.

3. Those who moved into a similar situation but through personal resiliency, circumstances, and the potential of upward mobility as a gratifying chance at social definition, survived and tried to bring to their new work situations the systems that they believed in, i.e. the ones that worked for me. Again in this latter instance, the individual, knowing what worked (for him, brought great conviction and certainty that this was the answer for others.

Those paraprofessionals who left these systems to start others which were similar, generally, were able to offset the re-entry crisis which deals with the individual's unique identity instead of his communal identity, the capacity to deal with ambiguity, and the torture of identity crisis resulting from changing social roles and status. They were able to handle their re-entry crisis by movement into treatment roles where they could essentially bring the former faith system as a method of treatment with minor personal innovations. They were generally intuitive, innately skilled, and had leadership capabilities. They also had a critical substitute for more complicated training, zealousness. If one accepts the notion that the essential healing process in any therapeutic transaction is the amount of faith, conviction, and energy the therapist has in his system and can transmit to the client, it is not surprising that there are generally positive results, especially in a situation where nothing else seems to be available to offer hope. However, even acknowledging the contribution of this ingredient the difficulty is that for many a particular brand of zealousness may be toxic or simply not helpful. These difficulties did not go unnoticed by the paraprofessionals themselves.

The next landmark was the appearance of methadone, which also had a great deal of controversy, and consequently, media exposure. The use of methadone was generally negatively critiqued, especially by those in paraprofessional roles at that time. However, the arguments wore thin as many from the methadone ranks began to demonstrate the capacity to remain free from illegal drugs and survive without other social failure. In addition, with the availability of a new modality now being supported by government and promulgated as having promise, many addicts who either disliked or could not respond to the former faith system modalities, or who essentially preferred methadone to other forms of treatment, made this preference known by increased enrollment in methadone programs. Many of the treatment managers of methadone programs and others of course, understood in short order, that methadone was not a panacea, and found that their usual attempts at generating social control, getting responsiveness from the clients, and general community agreement were insufficient. They looked to the magic that had been generated about the ex-addict, and began to both hire and use him in front lines work to create a sense of identification with the narcotic using methadone patient, and handle those tricky, potentially explosive situations in methadone clinics that they felt both inept to handle and wished to avoid. Who else then, but the ex-addict paraprofessional, who himself felt he had all the answers, whom media suggested had the answers, and was enjoying the magical status of savior.

However, many of these treatment managers quickly saw that many of their

methadone clients were unwilling to behave as change agents to implement the value code held by the managers, the culture, and government. Those ex-addicts treated in the faith system, therapeutic community, arenas emerged with a value code similar to that of the prevailing culture. In addition, it appeared that those ex-addicts generally, because of their lengthy residential nature, had developed experience in administrative tasks, group process, and a rigorous approach to deviance. Consequently, these were looked for and hired to fill counselor roles at the front lines and to assist in training of the methadone patients for similar roles.

Of course, as funding became increasingly available, more and more academically trained professionals saw for themselves a legitimate role and social opportunity in joining the war on addiction. As such, they brought with them acceptable academic training and limited clinical experience in this field. Initially, they usually occupied the writing, medicine dispensing and management roles. In most instances, when they first arrived, the paraprofessionals had been there before, were usually still there, and were most predominantly occupying the front lines. Inasmuch as the notion of the magical ex-addict curer has preceded them in media propaganda, and certainly because they felt initially tentative or uncertain about their role and how best to implement it, the professional who generally had little extensive exposure and experience in dealing with the addict, was inclined to seek out the paraprofessional and ask of him advice, tactics, his thinking, and hopefully his impressions so that they could help translate this information into treatment plans. Consequently, as new programs get funded, the ex-addict is sought out, his advice and information requested, listened to for a while and then, as the professional gains experience and competence, his attitude shifts to one of condescension when the paraprofessional attempts to make clinical input.

This is not always done out of disregard or malice. Often, it is due to the fact that the paraprofessionals know little academic, psychodynamic nomenclature or personality theory with which to stimulate his input. Consequently, he often retreated into silence. The professionals then wonder why the paraprofessional sometimes becomes angry and uncooperative.

II. *Dilemmas of the Paraprofessional*

A. *In Residential treatment settings:*

In the residential therapeutic community, paraprofessionals have had the comfort of a faith system which dictated in some detail how problem situations were to be handled, and hence zealousness could substitute for clinical skills. This zealousness, and the value system found in most therapeutic community's have been adequate as a behavior shaping technique at least for those who could accept this kind of faith system. Inasmuch as it is a controlled and structured environment, many of the crises that frequently occur in outpatient clinics are first mitigated against by social controls within the environment (peer pressures), and the religious belief that a demonstration of any behavior that violates the norms of that treatment community is the equivalent of not wanting help ("wishes to remain a sinner") and little concern or appreciation for the intrapsychic and situational process motivating this behavior is considered relevant.

Two major factors have occurred in the last five years which complicate the righteous response mechanisms found in most therapeutic communities. As I currently perceive the issues, they are: (i) a depletion in the rapid funding which permitted expansion in the therapeutic community. They resulted in the freezing of the lines of mobility within the structure which in the past were a seduction for clients to remain in treatment with these positions filled with careerists an important source of motivation for the client was lost. (ii) a major shift in the values of those entering the treatment situations, whereby many of the clients are less receptive to the method and its payoffs as a reason for staying in treatment. The faith system as treatment mechanism has been weakened, and the paraprofessional is left without the comfort of a model which dictates the handling of the problems which confront him. If there is no longer any one "right way", the paraprofessional may find himself in a situation where more complex assessment and intervention skills are required than he feels he possesses.

The paraprofessional working in the residential therapeutic community, conforming to the former faith conversion system method, frequently did an excellent job of behavior shaping, especially with the older addict imprinted with the value system of the 1940's. However, the classic problem was and remains, re-entry, when the individual, faced with trying to determine his unique vs. communal identity, faced with the development of a new social definition (especially now that career ladders are filled) remains the source of greatest failure and difficulty. It is regarding this issue that most paraprofessionals with whom I am in contact, and agencies with whom I currently consult, exhibit their greatest frustration, fear, demoralization, and manifest the need for knowing something else. The above is also generally true for paraprofessional staff in those agencies dealing with the new adolescent. It is at this point that true appreciation of fears, conflicts, etc., and how they influence behavior are needed. One can argue that professional psychological training is unnecessary other than for situational crises (like psychotic states), and in the first phase of residential treatment may not be required. However, if the paraprofessional wishes to remain alive in the field, mobile, competent and increasing his skills, he needs additional clinical training and with such can probably do a far better job than others less experienced.

B. *In Outpatient treatment settings:*

Those former addicts who generally demonstrate the capacity to function responsibly, are cooperative with management, generally identify with the treatment goals for the using addict, and who also see the opportunity of new social definition and mobility as treater, are the prime candidates for jobs in the new outpatient agencies. New treatment programs see him as a critical representative from the community in which the program exists, and view his identification and relationship with using addicts on the street as a valuable asset. After being hired, this paraprofessional is usually in the front lines and has primary contact with that uncertain, unpredictable client, and they must deal with this client without the benefit of the supportive controls of a structured residential environment. In addition, we ask this paraprofessional to give up those survival skills acquired in the turf (e.g. "if a guy sells me a wolf ticket I send him a gorilla ticket back") and in some magical way expect him to have other survival skills without the benefit of good clinical training. As a result, many paraprofessionals working with angry, violent

prone, frustrated clients are asked to put their feelings aside, are not given new tools with which to respond, and bum out ... "After all, they are expendable and can't be totally trusted anyway". Why waste the time or the money on providing them with more substantive training to replace their street survival skills which we have so lightly asked them to give up. With this magical expectation on the ex-addict's innate resources, we frequently see in his front line activity the fact that if someone threatens to hit him as counselor and new professional, he is not supposed to behave in kind. That behavior is unprofessional. However, what skills and clinical training have we offered him to assess the potential for violence, to offset situational conflicts that might result in violence? Have we equipped him to be discerning about what might be borderline or pre-psychotic states with the potential for unpredictable regression? Have we assisted him to assess danger signals manifested symptomatically or interpersonally? Have we supported his hunger to be more adept at his job? Or have we fed into the temporary delusion that being an ex-addict makes him have the answers? Perhaps some of the things that made him well are not always appropriate to every other client. Thus he remains vulnerable to unending front line activity and protects us from the mess we tacitly choose to avoid.

It is also frequently true that this paraprofessional engages in conduct which is anathema to our professional ethics. After all, he often comes in late, sometimes he fails to appear at all, and of course occasionally he has sexual contact with clients. However, we overlook that we have often tacitly requested (relying on his commitment to help addicts) that he work far more hours than that which is generally expected of his other professional colleagues... Is not some form of blackmail a legitimate expectation? Have we bothered to train him adequately so that he knows the danger and potential consequences of acting out transference situations? And, of course, after a while, we really fail to listen to him at all, and suspect that we are now trapped by the fact that we hired him on contract for the initial reasons listed above, and he, in fact, cannot behave and conduct himself as a good case load counselor should, and wonder how we can terminate him without creating community explosions.

Let us, for a moment, take a look at what is often considered his counseling role. "Kindly inform the clients to give up their urine . . . monitor this process . . . fill out the tag for the urine sample . . . insist that the client fill out his weekly activities sheet ... by all means assist the nurse in getting rid of an alcohol intoxicated client, and, of course, any fights in the clinic". These, and other forms of social control, are the essential requisites of his role. Of course, he is frequently criticized if he is spending too much time talking to the clients - after all, he has another sixty urines to collect - and then, of course, he is criticized by management representatives for obviously doing a bad job because many of the clients are using heroin. Such are the difficulties that surround and confuse the arguments over his effectiveness. The fact that he fails to have many of the clients heroin free probably clouds our conscience and obscures the fact that we have asked him to occupy the front lines for a long time now, with little, if any, appreciable training either to make him increasingly effective or to provide mobility out of the trenches.

III. *Conclusion*

While it is true that there are many paraprofessionals throughout the United States who gained access to management and significant treatment roles because of a vacuum in

the field, and the erroneous notion that ex-addicts have the answers, it is no longer true. Those who remain in upper level positions are presently there because they have demonstrated significant gifts of administrative ability, intuitive clinical skills. They have capitalized on their experience with professionals and others. They remain adept, innovative, professional, and capable of delivering service in this complicated business. However, there are many others who, once capitalizing on their know-it-all ex-addict role, have had this concept exploited by others. In addition, there are the vast array of other ex-addict professionals who do not think they know it all, but who currently feel that their only role in life is to occupy the front lines and who are indeed battle weary. Those who deserve and desire additional training must be provided the opportunity. The vast numbers who have had the experience of chronically using illegal narcotics, and the more complicated experience of their personal treatment and the new experience of helping others with the same problems are without question a remarkable and fertile ground. However, this fertile ground can only see a greater impact on the addiction problem with the provision of rich training and the opportunity for mobility. There is no question that we are at the end of the beginning. Nor is there a question that, without adequate training, many of those who participated in making the beginning, will fade away in the end.

Note from David Deitch…

In January of 1973 I met with a colleague - a young black paraprofessional who had for 9 years served as best he could - with unbelievable dedication, commitment and time, the addicts he cared so much to help. Our conversation went something like this: "David, I am scared, I know I don't know it all, I am confused and frightened I need more training, just some time out of the trenches. I've gone to those training centers, they ain't giving up anything that I don't already have. I can't ask for supervision in my own turf - that'll blow my image and I am afraid might even cost me my job, which I am burnt out doing, especially the way I am doing it, but I know I can't get nothing outside of the field and no where else to go, at least without losing some of the material pleasures we come to enjoy". He was obviously tired, overworked, depressed and frightened.

In January of 1974 he died in the trenches - "alcohol suicide". His name was Kenny Williams - this paper is dedicated to him.

Note from William White: Readers may also be interested in the following article:

Deitch, D., & Casriel, D. (1967). The role of the ex-addict in the treatment of addiction. *Federal Probation*, *31*, 45-47.