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Recovery Orientation in Addiction Counseling: A Brief History

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The profession of addiction counseling is historically rooted in the lived experience of recovery, but the degree of recovery orientation in addiction counseling has ebbed and flowed over the course of the field's history. Four overlapping eras illustrate the evolution in the field's recovery orientation—recovery orientation here defined as respect for recovery-based experiential knowledge, a focus on the facilitation of long-term personal/family recovery, adherence to recovery-linked and scientifically-grounded service practices, and emphasis on the role of community recovery capital in the initiation and maintenance of personal/family recovery.

Recovery Roots of Addiction Counseling

The birth of a specialized helping role to facilitate the resolution of alcohol and other drug problems can be traced to the first persons recovering from such problems who committed their lives to helping others similarly affected. In the United States, such roles included the leaders of 18th and 19th century Native American abstinence-based religious and cultural revitalization movements and the “reformed” temperance missionaries within the Washingtonian Temperance Society (1840s), recovery-focused fraternal temperance societies (1840s-1870s), the Ribbon Reform Clubs (1870s), and such local recovery mutual aid groups as the Drunkards Club in New York City (Coyhis & White, 2006; White, 2000a).

Collectively, these individuals shared their recovery stories in public and private meetings, penned recovery-focused pamphlets and autobiographies, conducted private consultations with individuals and families experiencing addiction-related problems, helped organize local recovery support groups, and maintained prolonged and prolific correspondence with those seeking recovery (White, 1998). The employment of such charismatic recovering figures within the rising network of mid-19th century inebriate homes, inebriate asylums, and private addiction cure institutes marked one of the first controversies and professional splits in the field of addiction treatment. Inebriate homes were often founded and directed by persons in recovery, maintained close links to local recovery mutual aid societies, and emphasized the importance of public commitment (signing the abstinence pledge), sober fellowship, service to others and the value of short voluntary stays to prime the recovery process. In contrast, inebriate asylums were physician-directed and emphasized physical methods of prolonged, legally mandated institutional treatment emphasizing medical treatments aimed at cure. Inebriate asylum directors attacked the hiring of “reformed men” on the grounds that:

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).

The tensions between the inebriate homes, asylums, and institutes; experiential knowledge versus professional knowledge; and recovery support versus medical cure were lost in the larger collapse of addiction treatment and recovery mutual aid groups in the opening decades of the 20th century.

The Addiction Counselor as Paraprofessional Recovery Specialist

The collapse of 19th century addiction treatment in the U.S. left those with the most severe alcohol and other drug problems abandoned to inebriate penal colonies, the back wards of aging state psychiatric asylums, or the “foul cells” of large public hospitals. Those conditions spawned new recovery support efforts, including clinics that trained people in recovery as “lay therapists.” Courtenay Baylor, Francis Bishop, and Richard Peabody were among the earliest and most distinguished of such lay therapists and might well be called the first addiction counselors in the United States. This lay therapy tradition was carried forward by Ray McCarthy and others within the Yale alcoholism clinics of the mid-20th century and the extension of Alcoholics Anonymous sponsors into what were first called “AA counselors.” IT was further extended with the hiring of “ex-addicts” in the growing network of therapeutic communities, methadone maintenance programs, and outpatient counseling clinics in the 1960s and early 1970s. This emerging “paraprofessional” counselor role incorporated multiple dimensions—the tradition of recovery storytelling (self-disclosure), mutual recovery support, counseling (new skills incorporated from the fields of psychiatry, psychology, and social work), and community recovery resource development and linkage (White, 1998, 1999). The paraprofessional era was marked by high recovery representation within the addiction treatment workforce, close linkages between treatment and local recovery communities (particularly AA), and an emphasis on experiential versus professional/scientific knowledge. The primary and sometimes exclusive credentials the paraprofessional addiction counselor brought to his or her role were personal recovery and a passion to help others recover (White, 1998, 2009b).

Professionalization of Addiction Counseling

The professionalization of addiction counseling unfolded within the emergence of a specialized, revitalized field of addiction treatment—the growth of local treatment programs; formally designated state and federal agencies responsible for planning, funding, and evaluating treatment programs; the extension of insurance coverage for the treatment of alcoholism and other addictions; the rise of hospital-based and private addiction treatment programs; and the emergence of addiction treatment program licensure and accreditation standards. To achieve public and professional credibility, this rebirthed field required an expanded and credentialed addiction counseling workforce.

Two milestones significantly shaped the addiction counselor role. First, addiction treatment migrated toward an acute care intervention (modeling itself on the hospital via early accreditation standards) rather than on the models of more extended recovery support that prevailed during the paraprofessional era. Second, the role of addiction counselor was modeled on clinical functions performed by psychiatrists, psychologists, and social workers. Notably, key

functions were lost in this transition, e.g., assertive outreach, community-based recovery resource development, linkage to indigenous recovery supports in the community. The core functions of the addiction counselor narrowed (screen, assess, diagnose, treat/counsel, document, discharge), and substantial state and federal resources were invested in skill development related to these core functions. The professionalization of addiction counseling was also marked by the rise of national and state associations for addiction counselors, the development of certification and licensing standards for addiction professionals (with increased educational requirements), the proliferation of preparatory addictions studies programs in colleges and universities, new resources for continuing education, and improved salaries and benefits for addiction counselors.

The 1970s and 1980s marked the transition of the addiction counselor from the status of paraprofessional to that of a clinical professional on par with other recognized helping roles. Rarely noticed during this period of explosive growth was the decline in recovery representation in the addiction treatment workforce and among executive leadership and governing boards, the erosion of once strong volunteer and alumni programs, weakened connections to local communities of recovery, and a shift in orientation from long-term recovery to ever-briefer periods of treatment. Cyclical episodes of biopsychosocial stabilization became the norm with a growing portion of persons entering treatment with multiple prior admissions. There was throughout the 1990s a sense of great pride in how far the field of addiction treatment had come in a few short decades, but there was also underlying unease that things of great value had been lost in the professionalization, industrialization, and commercialization of addiction treatment (White, 2000b).

The recovery advocates of the 1940s-1960s spent much of their lives advocating for the federal legislation that in the early 1970s established the foundation of modern addiction treatment. They did so in the belief that specialized addiction treatment could provide a portal of entry into recovery for people who could not otherwise initiate or sustain recovery. By the mid-1990s, there was a growing sense among a new generation of recovery advocates and many long-tenured addiction counselors that the multibillion dollar addiction treatment industry had become disconnected from the larger and more enduring process of addiction recovery and from the grassroots communities whose efforts had birthed the field (Else, 1999; Morgan, 1995; White, 2002, 2004).

Recovery Renewal

Several contextual conditions set the stage for calls to renew long-term recovery as the central mission of addiction treatment and addiction counseling: the growth and diversification of recovery mutual aid organizations, a new recovery advocacy movement that both supported addiction treatment and challenged its diminished recovery orientation, the emergence of new recovery support institutions as adjuncts and alternatives to addiction treatment, a growing body of research findings on the limitations of the acute care model of addiction treatment, the reconceptualization of addiction as a chronic disorder, and increasing calls to shift treatment of the most severe and complex AOD problems toward a model of sustained recovery management (Dennis & Scott, 2007; Kelly & White, 2011; McLellan, Lewis, O'Brien, & Kleber, 2000; White, 2005, 2008a,b,d; White, Kelly, & Roth, in press; White & McLellan, 2008). It was perhaps inevitable in the face of such changes that the field's organizing center began to slowly shift from its historical focus on addiction pathology and the mechanics of treatment to rising interest in the prevalence, pathways, and processes of long-term personal and family recovery.

Fulfilling the vision of recovery-focused addiction treatment and addiction counseling will require substantial changes in the field's infrastructure (McLellan, Carise, & Kleber, 2003), service practices (White, 2008c), and evaluation methodologies (McLellan, 2002):

- Recovery-oriented addiction treatment/counseling will require authentic and diverse personal/family recovery representation at all levels of decision-making within the addictions field.
- Major efforts at workforce stabilization and recovery-focused education and training of addiction professionals will need to be undertaken to ensure that each individual/family seeking help will have continuity of contact in a primary recovery support relationship over the course of long-term recovery.
- The diverse pathways and styles of long-term addiction recovery will need to be carefully mapped, and addiction professionals will need to be knowledgeable of the growing varieties of recovery experience and recovery cultures.
- Recovery-focused addiction counseling would extend the goal of acute biopsychosocial stabilization to encompass pre-treatment recovery priming (assertive outreach and engagement) and support for post-stabilization transitions to recovery maintenance, enhanced quality of life in long-term recovery, and family-centered interventions to break intergenerational cycles of problem transmission.
- Patients/families seeking addiction treatment would be routinely informed of independently verified, program and modality specific recovery outcomes (remission and survival rates) as well as the frequency of iatrogenic risks (harmful side-effects)—in the same way patients are today informed of such risks in life-invasive medical procedures for the treatment of cancer or heart disease.
- Recovery-focused assessment activities would move beyond assessment of individual addiction pathology as an intake activity to comprehensive (using global assessment instruments), strengths-based (focusing on the evaluation of personal, family, and community recovery capital) and continual assessment activities.
- Individuals and families once channeled into pre-packaged “programs” would have access to an ever-expanding menu of recovery-focused, science-grounded services/supports—including a broad spectrum of primary and behavioral health care services—that would be personally matched, combined, sequenced, and adequately dosed to maximize their effects on successful recovery initiation and long-term maintenance.
- Multi-disciplinary, multi-agency service models with inclusion of culturally indigenous institutions and healers would become the norm for treating the most severe substance use disorders.
- The service relationship would shift from an expert model toward a partnership model of long-term recovery support.
- The emphasis on professionally-directed treatment planning would be extended to person-directed recovery planning—both processes guided by personal/family choice (White, 2008e) with interim outcomes carefully monitored and communicated to inform continued treatment and recovery support decisions (McLellan, McKay, Forman, Cacciola, & Kemp, 2005).
- The locus of service delivery for addiction professionals would be extended far beyond specialty sector addiction treatment programs, with addiction professionals

working within a broad spectrum of healthcare, educational, business, military, religious, social service, sports, and media settings. Great emphasis would be placed on reaching and serving people within their natural environments using both face-to-face and technology-facilitated support.

- Aftercare as an afterthought in addiction treatment would give way to an emphasis on sustained post-treatment recovery checkups (for at least 5 years for everyone admitted to addiction treatment regardless of discharge status), stage-appropriate recovery education, assertive linkage to recovery mutual aid groups and other indigenous recovery support institutions, and if and when needed, early re-intervention (Dennis & Scott, 2012).
- The distinctive clinical orientation of addiction counselors would be expanded to cover community assessment and recovery resource development and mobilization (White, 2009a). Some addiction professionals would work in specialized roles aimed at the expansion of family and community recovery capital and building bridges of collaboration between professional addiction treatment organizations and the growing networks of recovery mutual aid organizations and other recovery support institutions.

Efforts to increase the recovery orientation of addiction treatment/counseling are underway across the United States under the conceptual rubrics of recovery management and recovery-oriented systems of care. The success or failure of these efforts will exert a powerful influence on the future of addiction recovery in America and the fate of specialty-sector addiction treatment as a cultural institution.

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