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## Can Recovering Drug Addicts Drink? A Historical Footnote

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In 2006, the author wrote an essay entitled “Alcohol, Tobacco and Other Drug Use by Addiction Professionals: Historical Reflections and Suggested Guidelines” that was widely circulated within the addictions field). The essay briefly noted a period in the history of therapeutic communities when clients (mostly recovering heroin addicts) could earn “drinking privileges” during the later stages of their treatment. The number of resulting emails regarding this practice and their pointed questions and animated comments suggested the need to elaborate on this fascinating chapter in the history of treatment. The twin purposes of this article are to recount the evolving policies toward alcohol within therapeutic communities and to offer reflections on the lessons that can be extracted from this interesting footnote in the history of addiction treatment and recovery in America.

### **Alcohol and the Early Therapeutic Community**

Most readers of *Counselor* know the highlights of the history of therapeutic communities (TC) for the treatment of

addiction. The TC movement began with the founding of Synanon in 1958, extended itself into the second generation therapeutic communities of the 1960s and 1970s, and was subsequently professionalized and modified for many institutional settings and special populations (DeLeon, 1984; White, 1998). Today, TCs constitute a primary and rigorously evaluated modality of addiction treatment that has exerted considerable influence on the larger arena of addiction treatment throughout the world (DeLeon, 2000).

The early policy of alcohol abstinence within Synanon was influenced by the history of its charismatic founder, Chuck Dederich. Dederich had used Alcoholics Anonymous (AA) to initiate his recovery from alcohol and Benzedrine addiction in the two years that preceded his split from AA and the creation of Synanon. Synanon maintained an alcohol abstinence policy until 1978, at which time alcohol was experimentally introduced first for board members and senior staff and then to others within the Synanon community. Alcohol problems grew within Synanon in the 1980s and contributed to Charles Dederich’s fall from grace and Synanon’s eventual

implosion as an organization (Mitchell, Mitchell, & Ofshe, 1980; Janzen, 2001).

The second generation TCs of the 1960s and early 1970s (e.g., Tuum Est, Amity, Daytop Village, Gateway, Phoenix House, Gaudenzia, Archway House, to name just a few) varied in their alcohol policies depending on when they were founded. Most emulated Synanon's early alcohol abstinence policy during their first years of operation, but as with Synanon, this changed over time. Part of the reason for this shift was the absence at that time of a well-articulated rationale for why a former heroin addict should abstain from alcohol.

During the 1960s and much of the 1970s, there was an "alcoholism field" and a "drug abuse" field—each operating in virtual isolation from one another. There were local drug programs and local alcoholism programs, with only a few brave programs experimenting with what was first called "combined treatment" (of alcoholics and addicts). TCs and Twelve Step programs constituted separate worlds, with TCs believing that they were different from and superior to anything that had come before. Within the larger fields, there were separate national institutes (that still remain), separate state agencies, separate professional associations, separate counselor training programs, separate counselor credentialing bodies, and separate local community advocacy groups—all split along the alcohol and drugs demarcation. Most importantly, there was no universally accepted concept of "addiction" or "chemical dependency" that provided a bridge in linking alcoholism to addiction to opiates and other traditionally defined "drugs". It is only in the context of such separation that the continuing history is understandable.

### **From Abstinence to Drinking Privileges**

The first change in alcohol policies within American TCs occurred in Daytop in New York City. In 1965, a party was held to celebrate members who had been drug free in Daytop for 1-2 years. Drinking was permitted at this celebration, and the event was completed without any incidents of

intoxication. In late 1966 and early 1967, the option of social drinking in certain circumstances was formally discussed in management meetings at Daytop. It was decided that social drinking (defined as drinking 1-2 drinks of alcohol in a social situation in the presence of more senior members of the community) would be permitted as an earned privilege for those approaching community reentry and by others (staff and graduates) in good standing within Daytop. At the "confirmation" signaling the end of phase one treatment, the client was taken out to dinner by senior TC staff. The client was expected to drink wine at dinner as a token of congratulations on his or her progress in treatment. The goal was also to provide a model for moderate drinking as part of one's community reentry experience.

Several things are noteworthy related to this practice. First, this was introduced into a community of recovering heroin addicts, many of whom had no prior history of drinking except to medicate the sickness of heroin withdrawal. Second, those with alcohol problems that preceded or co-existed with heroin addiction were given a clear message to avoid drinking. It was assumed by TC leaders at this time that the percentage of TC members vulnerable for alcoholism was about what it would be in the general population—estimated at that time to be about 6-10%. Third, this policy change did not constitute permission for intoxication. Intoxication was confronted and, if repeated, resulted in a loss of status in the TC. Fourth, problems related to this change in policy were not immediately evident (the supportive cocoon of the TC "family" may have prevented or slowed development of such problems). As a result, this relaxed policy on alcohol was transmitted to a large number of other second generation TCs through the influence of Daytop and then from second to third generation TCs. This evolution in TC alcohol policies unfolded within the larger drug treatment field (non-TC programs) that excluded alcohol from its stated goal of post-treatment abstinence.

The first signs of problems with the alcohol policy within Daytop and other TCs

followed a predictable two-stage pattern. The first stage was the appearance of drinking at social events within the TC community (e.g., staff parties) and at outside professional conferences that exceeded the bounds of social drinking and sparked other inappropriate behaviors. The second was the development of severe alcohol problems (or relapse back to heroin and other drugs while under the influence of alcohol) among some TC staff and graduates. The development of alcohol problems among those who left the TC for the community was not evident early on but became more visible over time and as follow-up became more routine and rigorous.

The alcohol-related problems of TC staff were significant enough that some TCs developed formal relationships with alcoholism treatment programs to which they could refer staff for treatment. In spite of these early alcohol-related casualties, the relaxed policies toward alcohol and the practice of “drinking privileges” continued in many TCs well into the early 1980s. A factor that slowed the recognition of the problem of alcohol was the presence of “ex-addicts” who were drinking socially and without any evident alcohol problems. These normal drinkers masked the reality of individuals who had significant leadership positions within various TCs who literally were drinking, and eventually drank, themselves to death. After alcohol policies changed, some staff who had resumed drinking under the earlier policies continued to drink in the following years. This created an uncontrolled experiment of social drinking among former heroin addicts whose outcome has never been formally investigated.

## **Changing Alcohol Policies**

As alcohol problems were emerging in many TCs, one individual, Michael Darcy, and one TC, Gateway Foundation, took the lead in calling upon the larger TC movement to rethink its policies on alcohol. Gateway is a second-generation TC (founded in 1968) that was heavily influenced by Daytop. Gateway emulated Daytop’s drinking policy, but began to reevaluate that policy after

eight of its first ten staff members developed alcohol problems after successfully recovering from addiction to heroin and other drugs. Gateway changed its alcohol policies through several steps over the course of 1973-1974. It began by introducing an alcohol abstinence philosophy and negotiating a formal arrangement with the Grant Hospital Alcoholism Treatment Unit to treat any Gateway staff experiencing alcohol-related problems. It then contracted with the Lutheran General Alcoholism Program to provide system-wide training within Gateway on alcoholism and its treatment, and began integrating Twelve Step philosophy into its existing TC philosophy.

There was considerable resistance early on within Gateway and the larger TC movement to the alcohol policy change. Early adoption of this policy change in other TCs began in the late 1970s and early 1980s and then spread slowly to most TCs by the mid-1990s. Several things helped consolidate this shift in TC philosophy. There was the pioneering work of early TCs that integrated the treatment of opiate addicts and alcoholics (Eagleview Hospital and the influence of Dr. Don Ottenberg is particularly noteworthy here). There was the eventual merger of the alcoholism and drug abuse fields and local alcoholism and addiction treatment programs. There was growing scientific evidence on the phenomenon of cross-addiction, including early studies noting alcohol problems among TC graduates in the US and Europe (Ogborne & Mellote, 1977).

## **Reflections**

So what does one take from this interesting historical footnote? History promises us important lessons if we sit at her feet and listen carefully to her stories. Answers to some of the questions posed by this historical account will likely be revealed in the science laboratory, but there are findings of cumulative experience that have important clinical implications.

Addiction to one drug may be shared by, and may even increase one’s

vulnerability for, addiction to other drugs. The roots of such broad-spectrum drug vulnerability and other excessive behaviors seem to be the engagement of a common neurological reward system. That broad spectrum of vulnerability should be a consistent message and warning to all individuals undergoing addiction treatment.

The prevalence of cross-addiction in the history of the TC is unknown. TC old-timer estimates of how many “ex-addicts” later got in trouble with alcohol range from the majority to less than 10%, but all of the TC elders interviewed for this article reported tragic stories of alcoholism-related deaths among early TC graduates.

Individuals recovering from drug dependencies (other than alcohol) who later develop problems with alcohol do so through a variety of patterns and across a continuum of severity and duration. The factors that differentially shape the trajectory and outcomes of such problems are unclear.

There are observed, but untested, predictors of those individuals recovering from drug dependence (other than alcohol) who are most likely to go on to develop the most severe and prolonged alcohol-related problems. When those with long histories within the TC movement are asked to recount such factors based on their observations over the past 40 years, they most often note the following risk factors: 1) a family history of alcohol problems, 2) a history of alcohol problems predating the emergence of another pattern of drug dependence, 3) co-addiction to alcohol and other drugs prior to entry into treatment, 4) the presence of a co-occurring psychiatric illness, 5) a history of childhood victimization, 6) later developmental trauma (e.g., loss via death or separation), and 7) enmeshment in a heavy drinking social network.

The dichotomy of “alcohol problems” and “drug problems” is breaking down as concurrent and sequential multiple drug use becomes the norm among persons entering addiction treatment. This trend is rendering clinically anachronistic such concepts as “drug choice”.

In spite of the quite different drug cultures that surround the use of particular drugs, at a neurological level, these substances share more commonalities than differences (Nature Neuroscience, 2005). While that potentially explains the propensity for cross-addiction, it leaves unanswered the question of how some individuals are able to recover from lives devastated by heroin addiction and then maintain non-problematic drinking while others achieve recovery from heroin addiction only to have their lives devastated by alcohol. This complex finding is one of the legacies of the TC movement’s experiment with drinking privileges. Perhaps many or most (a question the scientists need to answer for us) people entering addiction treatment possess a lifelong vulnerability for addiction to a broad spectrum of substances (and experiences), while in others that vulnerability is transient or restricted to a particular drug or class of drugs.

Until such questions can be answered scientifically, we have a clinical responsibility to share warnings related to the field’s experience with this issue. At the same time, we have the responsibility to honestly acknowledge that there is much we do not know about these varied patterns of vulnerability and resilience. Lacking science, we need to offer explanatory models that help each client make personalized, informed choices related to the whole spectrum of psychoactive drug use.

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