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The Road Not Taken: The Lost Roots of Addiction Counseling

William L. White, MA

There are growing calls to rebuild the connecting tissue between treatment and recovery and to rebuild the relationship between treatment agencies and the local communities out of which they were born (White, 2002). There are also concerns that the role of the addiction counselor is being corrupted by an inordinate preoccupation with regulatory compliance and financial profit (and the resulting paper processing) rather than on transforming lives. This perceived detachment from our communities and our clients is being countered in some quarters by adding what are lauded as new roles to the interdisciplinary addiction treatment team: outreach workers, recovery support specialists/coaches/mentors and peer counselors. The focus of these roles is to personally engage and motivate clients and to link them to the recovery community. Ironically, these are the very functions (and the traits of assertiveness, persistence, and hopefulness) that first distinguished the role of the addiction counselor. This article describes a brief period (before and during our transition in status from “paraprofessional” to professional) when treatment and recovery were inextricably linked, when the addiction counselor was an outreach worker and a community organizer, and when the community was both the “client” and the treatment program.

New professions are often birthed out of a cauldron of competing ideas—each of which seeks to shape the emerging profession in its own image. As the winners of such processes quickly consolidate their gains, many valuable competing ideas are often lost. (The winners write the history!) Between 1960 and 1970, two quite different models vied for prominence as the best approach for intervening with America’s growing alcohol and other drug problems. The eventual winner utilized a clinical model of intervention that defined the sources and solutions to these problems as residing inside the individual. This approach emphasized case-finding, clinical screening and assessment, medically modeled treatment of the individual, and brief aftercare services--all provided by clinically trained professionals. This model was integrated within the federal-state partnership of the 1970s that spread alcoholism and addiction treatment agencies across the American landscape. The model became the foundation for program

accreditation standards, counselor certification and licensure standards, addiction counselor training programs and guidelines for treatment funding. The model became so dominant that there is only a rapidly fading memory of its alternative.

Lost Roots

During the 1960s and early 1970s, there existed an alternative to the medical model of alcoholism intervention. That model was promulgated within several states and through the alcoholism programs funded by the Office of Economic Opportunity (OEO) under the leadership of Matt Rose. Rose is most known today for having brought together the leaders of these local alcoholism programs in 1972 to found the National Association of Alcoholism Counselors and Trainers, the earliest precursor to NAADAC: The Association of Addiction Professionals. But Rose also warrants recognition for having helped pioneer a unique model of alcoholism intervention.

The model pioneered within OEO and in states like Iowa focused attention on building capacity to address alcohol problems not within a treatment center but within the larger community. Robert Waymer, describes the early focus of this model:

Our original idea was to have counselors train people in communities to deal with the growing alcoholism problem. The training we taught was not based on clinical skills; it was based on a community development model with emphasis on AA. (NAADAC..., 1992)

OEO's focus on empowering members of poor communities gave these early alcoholism programs more the feel of a grassroots, activist-led movement than a clinical service agency. What was most distinctive was the belief that alcoholism programs had to be built on the needs of, and be ultimately controlled by, the alcoholics and their families" (Renaud, 1982). Within the OEO programs and in selected states, these community-focused alcoholism programs sought to do two things: 1) undermine the forces in the community that promoted or contributed to alcohol and other drug problems, and 2) create space within the community where recovery could flourish. The intervention was focused as much on the community as it was on the individual alcoholic.

Harold Mulford extensively documented the philosophy of this early model in Iowa. The role that was at the center of the Iowa model was not a counselor, but a "Community Alcoholism Agent" (CAA). Mulford described the CAA as follows:

The CAA functioned as an outreach, motivator, advisor, empathic friend, confidant, and “follow-upper” providing a long-term continuum of emotional support and common sense advice, all tailored to the individual case. As a catalyst for the larger community process, he is an educator, mobilizer, coordinator and motivator for anyone and everyone he can get involved in the individual’s recovery process. To maximize community involvement, the catalyst does nothing for the alcoholic he can get someone else in the community to do. He acts as a “shoehorn” helping the alcoholic fit himself back into community life through job, family, church, AA, etc., getting as many other people involved in the alcoholic’s recovery as possible (Mulford, 1976).

The Iowa model focused on organizing and mobilizing natural resources within the community that could aid the recovery process, and on linking the alcoholic to these resources. The Iowa model also emphasized—years before the introduction of motivational interviewing—that the job of the “counselor/consultant” was to “motivate and accelerate progress toward recovery” even when the alcoholic was not yet ready for help (Mulford, 1976). So what happened to this community-based, recovery focused (rather than treatment-focused) model of intervention? This model, which relied to a great extent on volunteer support, fell out of favor in the 1970s amidst calls to address alcohol problems with greater organization, skill, and financial resources. In that rising tide of professionalization and industrialization, voluntarism within the addiction problem arena slowly declined and was replaced by an ever-growing class of paid helpers. Mulford charged that the alcoholism field “sold out” in its search for federal and state funding: “To the extent that the centers turned to face the State Capital, they turned their backs on the alcoholics and the communities they had been serving” (Mulford, 1978).

This was not the first time a professional field had been so accused. There was a similar shift in the history of social work from community-oriented casework to psychotherapy. This shift marked a relocation of service delivery—from the community to the consulting room—and a shift in the target of such services from the environment of the client to the unique developmental history and mental/emotional processes of the client. In its search for professional status, the field of social work shifted its emphasis from social and political action to the mastery of clinical technique—a shift that brought greater status and higher salaries (Specht & Courtney, 2002).

Back to the Future

The goal of this brief historical review is not to call for the complete abandonment of clinical models of intervention into serious alcohol and other drug problems. Nor is it to disparage those like myself who have spent their lives trying to professionalize the role of the addiction counselor. But I do want to suggest that something got lost along the road to professionalization. What got lost was a relationship between two people that transcended the roles of counselor and client. What got lost was our deep involvement in the community and in local communities of recovery. What got lost was our recognition of the power of community to heal and sustain people. John McKnight in his recent book, *The Careless Society: Community and Its Counterfeits*, argues that compassion shifted from a cultural value to a job description as paid helping roles replaced functions of families, extended families, neighbors, co-workers and friends. He argues that we don't need more agencies or larger agencies, but that we desperately need more community. In medicalizing alcohol and other drug problems in hopes we could escape its social stigma and moral censure, we turned our backs on the power of community and created an ever-growing distance between ourselves and those we are pledged to serve. Perhaps it is time we went back and discovered what was of value along that road we didn't take.

William L. White is a Senior Research Consultant at Chestnut Health Systems and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

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