ADDICTION TREATMENT HISTORY

The History of Addiction Treatment in America

William L. White — Selected Papers, Volume I

26 Papers

A comprehensive collection of William White's historical writings on addiction treatment in America — from 19th-century inebriate asylums through the modern treatment era.

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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Treatment Planning for Chronic Inhalers of Volatile Solvents

William L. White and Roger Krohe

This paper was prepared for and presented at the first South Dakota Solvent Abuse Conference sponsored by the Division of Drugs and Substances Control, South Dakota Department of Public Health, held September 20-21, 1977. William White is a Dangerous Drugs Specialist in the Planning, Research and Evaluation Section of the Illinois Dangerous Drugs Commission and Lecturer, Department of Psychology, Chicago State University. Roger Krohe is a family therapist at the Drug Dependence Program, Institute of Psychiatry, Northwestern Memorial Hospital, Chicago, IL. The material in this paper is based on the authors' clinical experiences from 1969 to 1977 with the Illinois Department of Mental Health and Developmental Disabilities, the McLean County Juvenile Probation Office, the McLean County Mental Health Center, and the McLean County Alcohol and Drug Assistance Unit, Inc.

Although there is early note of the inhalation of such substances as nitrous oxide, chloroform, ether and gasoline (Nunn et al. 1934, Nagel 1945, Nagle 1968) for purposes of mood alteration and intoxication, modern concern regarding this practice can be dated to reports in 1959 of adolescent glue sniffing in a number of western cities (Brecher, 1972). The reports which followed depicted a pattern of increased solvent inhalation primarily among pre-teen and teenage males in tandem with an increase in the number of substances inhaled (primarily plastic model cement, household cements, fingernail polish removers, various petroleum products such as gasoline, kerosene and lighter fluid, and a number of aerosols). A large body of literature has since described the manner of inhalant use and the serious and sometimes fatal medical consequences of such use. Readers interested in researching this background material are referred to The Deliberate Inhalation of Volatile Solvents (National Clearinghouse for Drug Abuse Information, Report Series 30, No. 1) which provides a concise bibliography of this literature up to 1974. While this body of growing knowledge about the effects of solvent abuse is invaluable, little has been reported which can aid the helping person as he or she intervenes in the life of the solvent user.

The use of solvents for a short period of time is not uncommon during pre-adolescence and adolescence. The majority of these users are not in need of treatment services and will cease use without any such intervention. The purpose of this paper is to share the authors' experience with those children and youth for whom solvent abuse becomes chronic and problematic. We will describe the following four sub-populations of users distinguished by the primary etiology of the use:

I. Peer-oriented solvent use;
II. Family-oriented solvent use;
III. Solvent use as a reflection of individual psychopathology; and
IV. Solvent use as part of a broader pattern of polydrug use.

Distinguishing characteristics, etiology, recommended methods of treatment and prognosis will be identified for each category and a representative case study will be provided. While such categorization of clients is always arbitrary and overlapping, the model may be useful as the most effective methods of intervention differ significantly for the respective populations.

An added introductory note is important as this paper will focus on non-medical intervention. Solvent use, like the excessive use of any psychoactive substance, carries with it inherent risks and consequences to health. A review of Bass' case reports on deaths following inhalation of solvents (Bass, 1970) and Glaser's work on the inhalation psychosis (Glaser, 1966) should sufficiently sensitize the reader to this issue.

I: Peer Oriented Solvent Abuse

A. This subgroup of solvent abusers is usually aged nine to fourteen, is almost completely male, and its members are generally white, Latino, and American Indian from low socio-economic neighborhoods of both urban and rural areas. Although solvents are the primary drug choice, alcohol is also used quite frequently and often in conjunction with the inhaled substance. These clients tend to come from large multiple problem families. Rarely are both natural parents in the home. Family members as a group, often going back a number of generations, have long histories of alcohol abuse and alcoholism, low educational achievement, divorces, desertions, separations, illegitimate births, and criminal activity. Children of these families usually fend for themselves with oldest brothers and sisters usually bearing the primary parental functions. Children often leave the family via pregnancy/marriage, arrest, institutionalization, or the gaining of marginal employment. The social and economic deprivation of these families leaves little family energy to assist one of the members who is in crisis.

The individual clients making up this group have often been involved in truancy, vandalism, curfew violations, gang activity, and petty crimes. They usually come to the attention of juvenile law enforcement authorities before they come to the attention of any social agency. Solvent use almost always occurs in a group setting, usually a delinquent or pre-delinquent group with a "macho" image. Vandalism and other property crimes may be committed by the group while members are intoxicated. Personal violence tends to be the exception unless the group leader brings a particular penchant for violence. These individuals also bring with them to treatment a high rate of educational failure. Many have specific undiagnosed learning disabilities which make adequate participation in school impossible without special services.

B. Etiology

The social and economic realities confronting these clients make chronic intoxication a seductive alternative to a world they experience with a sense of impending doom. Our work with these clients suggests a fourfold explanation for the choice of solvents as a drug of abuse.

1. Solvents are cheap and readily available.
2. The choice of solvents is in many ways seen as an anti-social choice by these clients. Both alcohol and solvents tend to be consistent with their "macho" images; whereas other polydrugs are seen as being for "hippies," which for them carries an effeminate connotation.
3. Nearly all of these clients have described their ability to control and shape the hallucinations (guided fantasies) produced by solvent intoxication. Most describe themselves as the central character of these hallucinations usually in roles of great importance. The rescue of women in danger, the performance of great feats which women

would admire and sexual encounters with women are also common themes in these hallucinations. The hallucinatory experience of success and recognition and the ability to control the hallucinatory content provide powerful reinforcement for solvent intoxication among these clients.

4. The high risks involved in solvent use (which all our clients were knowledgeable of) may in itself make solvents an attractive drug choice. The use of solvents is often only one of a large number of risk taking behaviors these clients are involved in. Such risk taking behaviors have important meanings within the peer group (such as symbols of status, manhood, and fearlessness.) The risk of the drug, separate from the drug's effect, produces its own sense of excitement. In listening to these youth, who have experienced little sense of personal importance or success, the choice of solvents (as a high risk drug) to experience themselves as worthwhile can easily be seen as an act of defiance and rage against the culture at large.

C. Treatment

Treatment approaches with this group must be seen in the social and economic context in which the abuse occurs. One is dealing primarily here with social pathology, not psychopathology. The initial task whether from the role of a community worker, probation officer, therapist, or teacher is to address some of the most immediate reality issues in the life of the client and his family. Developing the family as a resource in the treatment process is only possible to the extent that the worker can bring resources to assist the family with survival issues, thus freeing emotional energy to focus on the manner in which family members can support each other. Traditional treatment services may be offered but only after the therapist has established his or her usefulness on other grounds.

Since most of the solvent abuse of this group takes place in the context of an adolescent group, a detached worker or "streetwork" model has been utilized well as a method of intervention. The key to successful intervention here lies with the ability of the worker to form an alliance with the leader of the group, and through this relationship begin to shift the activity of the group away from anti-social behavior. Reviewing the outreach model for delinquency work (Carney, Mattic, Callaway, 1969) may be very helpful to anyone attempting this method of intervention.

Admission to residential therapeutic communities has not been extensively used with these clients as they are often precluded from admission due to their age and many programs cannot tolerate the degree of acting out these clients often bring to the treatment setting. Our experience has been that the most effective method of intervention initially involves the therapist in varying roles of advocate, big brother, and role model. This early stage focuses on linking the client with services that the client perceives he needs, i.e. medical services, jobs, housing, etc. The major focus in this period is establishing a relationship with the client and interacting in ways that enhance their self-esteem and sense of power. As the relationship develops, the client can be involved in more structured individual or group therapy even though in the majority of such cases the client agrees to these activities merely to please the therapist.

Treatment, whether individual or group, is effective to the extent that it teaches the client nonchemical methods of experiencing self-worth. Two methods are particularly useful here. The first involves the use of role playing, psychodrama, and guided fantasy exercises as a substitute for the positive feedback exercises and task assignments or contracts (i.e. "my contract for the week is to go to at least three job interviews and help Bob (a fellow group member) paint his mom's house.") Positive feedback exercises and group or individual task assignments are aimed at moving the client from experiencing self-esteem through fantasy to experiencing self-esteem through relationships and non-drug activities.

The most important long-term benefit from the treatment relationship rests on the therapist's ability to encourage and support the client in acquiring some marketable skill. Education and/or vocational training/placement are the primary determinants of future social

adjustment. The use of alternative schools special education programs should be considered as these clients find the structure and sense of failure they experience in most public schools almost intolerable.

D. Prognosis

If treatment success is measured by the cessation of solvent use, long term prognosis is good. Most of these clients will stop the abuse of solvents by age seventeen. Overall prognosis is very guarded due to the high probability of excessive alcohol use following the cessation of solvent use and limitations of these clients which have resulted from severe social and economic deprivation.

E. Case Study Number One

A 13 year old adolescent male, John B., was first contacted by one of the authors via "streetwork" with a delinquent drug abusing gang in 1971. John B. was the youngest child of seven (including step-brothers and sisters from previous marriages of the mother) in a family whose members had been notorious for anti-social and dysfunctional behavior for three generations in this community. No male member of this family has yet graduated from high school and most are unemployed or working in marginal and temporary jobs. There is a long history of psychiatric admissions, alcoholism, and incarcerations particularly among male family members. Significant losses include the father (desertion when client was 3), the next oldest brother (death at age 9 from a congenital heart defect), the oldest natural brother (incarceration for armed robbery), and at least three intimate peers (remanded to juvenile institutions for delinquent behavior.) The solvent abuse began at age 10 when the client first became involved in a pre-delinquent peer group, and also coincided with the incarceration of his oldest brother who he greatly admired. At age 12, John was declared in need of supervision for truancy and vandalism and was placed in the custody of the state child welfare agency, but was allowed to continue living at home.

The early contacts (first six months) with John, his family, and his peers included such things as: 1) getting increased financial assistance for the family; 2) arranging visitation privileges for John to see his brother at the state prison; 3) negotiating with the local school to get John and two of his peers transferred in a special remedial reading program; and 4) working to decrease the delinquent behavior of the gang John was involved with. Although John's delinquent behavior decreased significantly during this period the frequency of solvent intoxication was only minimally decreased. This period did facilitate the development of a relationship which brought John (and 4 of his peers) into outpatient treatment over the next 2 years.

Although John would utilize individual sessions only during periods of emotional crisis, he did utilize an on-going group experience. Solvent intoxication decreased to approximately one episode every three months for John during this period and primarily resulted from the group 1) providing an alternative to solvent intoxication to regulate his self-esteem; 2) providing a substitute family experience which was particularly enhanced by the use of male and female co-therapists; and 3) providing an alternative adult role/"career" model other than his incarcerated brother.

By age 16, John had ceased the use of solvents, although he continued to episodically abuse alcohol following experiences of failure. John did learn to read during this period, but dropped out of school at 16 to go to work in an auto-body shop. This client broke off contact at this time but contacted this worker two years later and reported that he was getting married, was employed in a low paying job, still was not using any "drugs," and that if his drinking did not slow down after the marriage he would call to "get dried out."

While it is doubtful there will be any return to solvent abuse, the probabilities are high that this client will encounter continued difficulties with his use of alcohol and that his overall social adjustment will be marginal at best.

II. Family Oriented Solvent Abuse

A. Population Characteristics

This subgroup of solvent users ranges in age from nine to sixteen with most thirteen or fourteen, are nearly all males, and are mostly white from working and middle class families. Females who are involved usually are inhaling solvents with a brother who is still in the home. These clients come from mostly intact families and are usually the middle or younger child. The families are marked by distant relations between father and children and mothers who tend to be excessively attached to the children. These adolescent clients usually have no history of pre-delinquent or delinquent behavior, are of average intelligence, and are average performers in school. They have rarely been described as problem children, and the solvent abuse at first impression seems to have emerged out of an otherwise normal development. The use of solvents occurs alone or occasionally with one other peer which may often be a brother or sister. Use quite frequently occurs in the home.

B. Etiology

The etiology of the solvent abuse for this group is twofold. First, the onset of solvent use for the majority of these clients coincides in time with the loss of a family member, most often an older brother or sister who had taken on a number of parental functions within the family and were highly idealized by the clients. Solvent abuse here is a response to an acute loss of self-esteem triggered by the loss of a significant family member. This loss most often occurred when the older brother or sister left home to marry or go to school. The client's response to this change in the family constellation could easily be described as a grief and mourning process. The drug becomes a substitute for the lost loved one. This lost person is nearly always thought about while intoxicated or is a central character in the hallucinatory experience.

The second dynamic often seen with these clients is the use of solvents to escape (through intoxication) an overly intrusive mother. This often occurs at the time of early adolescence when the client is trying to shift his primary interests, involvements, and attachments from the family to his peer group. Solvent abuse is often part of the client's anger toward the mother for trying to prevent him from making this separation.

C. Treatment

This group of clients can be effectively treated in individual, group, or family therapy. Rarely should residential placement be considered for this group as extrusion from the family to drug treatment may reinforce a deviant role for the client out of what was a short lasting transitional crisis of adolescence. The initial role of the therapist regardless of modality or philosophical orientation is to take the place of the lost family member. In this phase all solvent use stops after the first or second session and the client identifies with and idealizes the therapist. The client will take on mannerisms of the therapist, the language of the therapist, similar style of dress, smoke the therapist's brand of cigarettes, etc. It is crucial that the therapist allow this idealization to occur as it is an essential part of the treatment process. The other noteworthy part of the early treatment process is the client's almost constant presentation of grandiose fantasies. The client/therapist relationship and the client's flight to fantasy are the primary substitutes for the drug experience and cannot be removed until the self-esteem of the client is increased.

The second phase of treatment with these clients can be descriptively called a grief and mourning process. Grandiose fantasies subside and the client begins to share his feelings about the loss of the family member. This often coincides with the client showing his feelings about the unavailability of the father as an idealized model to the client. It is a short but important process for the client to share this sense of loss in the safety of the treatment relationship.

The third phase of treatment is much more active with the therapist's primary role being to guide the client in increasing peer relationships, increasing relationships with adult role models, re-establishing contact with the lost family member, (i.e., letters, visits, etc.) and attempting to establish closer contact with the father. It is during this phase that the therapist will

be most involved with the family unit. Either through family meetings (or in some cases meeting with father and son only), the therapist helps increase the bonds between father and son, and supports the mother in an effort to allow her to loosen the bonds between herself and the client. This is not usually a difficult process as such family restructuring has immediate payoffs for most family members and generally reflect changes the family wanted to make but was unsure of exactly how to change existing relationships.

The final or termination phase of treatment should focus on the separation between the client and therapist. This process should be done gradually over time with a clear message on the future availability of the therapist if needed by the client. We usually preferred to move from weekly, to every other week, to monthly, and then to meetings as needed by the client. It is not unusual for the client to have thoughts about getting high, or to get intoxicated during this period. It is the therapist's job here to support the client by pointing out what has been accomplished and to reinforce the strengths and self-esteem of the client that have developed during the treatment relationship. A recurrence of drug intoxication can usually be avoided here if the therapist allows the client to verbalize the sense of loss, downplay the importance of the relationship, and express anger toward the therapist. The previous loss of the family member gets replayed during this stage in metaphor.

D. Prognosis

The prognosis for this group is excellent and clearly the best of the four subgroups of solvent users described in this paper. These clients bring more personal and family strengths into the treatment process, have a much lower degree of overall risk taking behavior, and are not handicapped by economic factors. Most of these clients will cease solvent abuse, will not move to the abuse of a secondary substance, and will make an adequate long term social and vocational adjustment.

E. Case Study Number Two

A 15 year old young man, Paul R., was referred to one of the authors by the juvenile probation office after several recent episodes of glue-sniffing with the patient's former girlfriend in a city park. The middle child in a sibship of three, Paul lived with both parents and a younger brother in a comfortable middle-class suburban neighborhood. The older brother, whom the patient had emulated throughout his childhood, had entered college out of the state and Paul had broken up with his girlfriend, both only days before the first glue-sniffing incident. Although obvious marital conflict was not evidenced with the parents, Paul's mother had retained into his adolescence a high level of solicitous interest in all areas of his life, even compared to the two other brothers; his father, conversely, spent many additional hours at his work as a sales manager, having done so since Paul's early childhood. Paul had no prior juvenile record, nor any personal or family history of other chemical dependencies.

At the express request of his parents, the therapist first saw Paul, his younger brother, and Mr. and Mrs. R. together at their home during a school day evening. Paul requested outpatient office visits for himself alone, and was seen on a weekly basis for eight months, until the end of the school year provided a "natural" termination point. Both parents were interviewed conjointly twice and separately once each by the same therapist at the beginning of treatment; Paul and his father were seen twice together about two months prior to termination. The course of treatment was characterized by the patient's immediate cessation of solvent use (which did not reappear during the process) and a gradual concrete identification with the therapist, i.e. mannerisms, clothing. While a vast majority of Paul's individual sessions were spent in reviewing his weekly activities, he also initially worked rather extensively on his reactions to losing his brother and girlfriend. The sessions with both the patient and his father were at the father's request, and involved very simply working with them on some travel plans that involved just the two of them.

About two years after treatment terminated, Paul contacted his former therapist. At that time he was completing his senior high school year, having had no subsequent drug-related problems.

III. Solvent Abuse as a Reflection of Individual Psychopathology

A. Population Characteristics

Clients in this group are primarily white males between the ages of seventeen and thirty. They come from the same socio-economic background as the peer oriented solvent abuser, have minimal vocational and education skills, and although usually of average intelligence have very low aspirations. This group has had extensive contacts with law enforcement authorities usually for arrests for glue sniffing, for disorderly conduct, and for criminal damage to property (usually destroying property at the home of the parent while intoxicated.) Nearly all of these clients come from single parent families with family histories which include desertions, divorces, incarcerations for criminal activities, and alcoholism. The family characteristics which distinguish this group from the peer oriented user in a much higher incidence of psychiatric disorders (institutionalization for psychosis and suicide) and a much higher incidence of tragic deaths via auto and industrial accidents, death from diseases in childhood, etc. (most of these clients experienced at least one such loss between the ages of six and twelve.)

These clients have continued the abuse of solvents as the primary and in most cases the only drug of abuse since early adolescence. Solvent use usually occurs alone or with one other person. This group has made a career of solvent abuse. If allowed to, they can talk endlessly on the different intoxicating properties of various solvents, describe the various rituals used in inhaling the substances, and describe in animated detail the experience of solvent intoxication. Most will enter the treatment setting only under legal pressure and tend to mock the efforts of a large number of people aimed at getting them to stop “sniffing glue.”

In terms of psychopathology, most have either attempted suicide or report suicidal ideation. Symptoms of severe and chronic depression are clearly evident and the level of risk-taking behavior, separate from the issue of potential suicide, may at times be life-threatening. This point is illustrated by one 24-year old client who reported on a risk-taking assessment questionnaire the following:

11	Automobile accidents (9 single car accidents)
8	Motorcycle accidents
4	Falls of more than 15 feet
6	Broken bones resulting from various “accidents”
8	Hospital admissions
12	Emergency room visits

Hallucinations are sometimes reported during periods of non-intoxication and delusions of grandeur are not uncommon. The majority of these clients waking hours are spent either intoxicated or in fantasy. During periods of intense intoxication, it becomes difficult for the client to distinguish between what has been experienced in hallucinations while intoxicated and what has actually happened in reality. One such client reported having raped a woman while intoxicated. It was later confirmed that no such event occurred although the hallucinatory experience was interpreted by the client as “fact.”

B. Etiology

The etiology for this population of substance abusers is threefold. Solvents are the drug of choice not in spite of, but because of the high reported risks involved. Solvent abuse for this group of clients is part of a broad pattern of risk taking which is a response to chronic depression.

The onset of this depression usually followed the tragic loss of a significant family member and feelings of responsibility for the death on the part of the client.

The pleasure experienced from the intoxication and the ability to control the hallucinatory aspect of the drug experience, the content of which is similar to that described for population I, is a powerful reinforcement for use of the drug. In addition, the drug's short action makes it a convenient drug to use repeatedly during the course of a day.

Solvent abuse may also mask and in some ways medicate acute symptoms of psychosis. Hallucinatory experiences during periods of non-intoxication and bizarre ideation can be attributed by the client and others to peripheral effects of the drug. In short, the identification as a glue sniffer is less threatening to the client than to be considered "crazy."

C. Treatment

It should first be noted that verbal warnings to these clients about the risks to health from solvent abuse are not only ineffective, but counterproductive. Such warnings are by definition impotent to a client group to whom death is both attractive and at times seductive.

This group should whenever possible be treated in conjunction with a psychiatrist or with the benefit of psychiatric consultation. The first task with this group is to evaluate the immediate threat of suicide and to assess whether the current level of risk taking behavior is life threatening to the client. If it is the therapist's judgment that such risks are high, psychiatric hospitalization or placement in a controlled living situation, i.e., residential drug program should be the first step in the treatment process. The therapist should also be aware of the potential emergence of additional psychiatric symptoms following the cessation of solvent abuse.

Residential treatment with these clients is best done in programs which can provide a great deal of early attention and tolerate or reduce high levels of acting out in the early stages of the treatment process. There usually is not enough family members to effectively conduct a family oriented treatment regimen and the intense need for attention by these clients make their early participation in groups characterized by either disruption of the group or disengagement. We have seen most of these clients in weekly outpatient individual treatment or day activity programming plus weekly individual sessions.

Treatment of this group is at best difficult and long term. The therapist should proceed slowly in establishing the treatment relationship as these clients have great difficulty tolerating any intimate relationship. The therapist who moves too quickly will find that the client escalates the level of acting out in an effort to get the therapist to reject him. This inability to tolerate intimacy often comes from the client's irrational fear that anyone who gets close to him will die. This kind of magical ideation (if I care about you, you'll die and it will be my fault) usually began shortly after the death of a significant family member and reflects the client's sense of responsibility and guilt for this death.

The middle stages of treatment should focus on treatment of the depression, increasing the interpersonal skills of the client, remedial health care, and vocational training. Relapses to solvent intoxication are not unusual with this group at each new stage of the treatment process. Where possible the client should be given access to long term social (drop-in) and clinical contact with the program. We have had a number of these clients in treatment over five years who received services in small doses (1-2 times per month followed by no contact and then re-involvement.) It is important to let the client determine this pace, as we have found no methods that work for the majority of clients which can condense this process into a single intense treatment experience.

D. Prognosis

This is the most difficult group of all solvent-involved clients to work with. They have a high death rate and a high rate of institutionalization, both correctional and psychiatric. There is some evidence of a maturing out process occurring somewhere between twenty-two and thirty, with a subsequent high percentage moving to alcohol abuse. Maturing out does not seem to be

a function of treatment as much as the client tiring of repeated legal difficulties and incarcerations.

These are very marginally functioning individuals whose adjustment is tenuous with or without the abuse of solvents.

E. Case History Number Three

David W. was referred to one of the authors for a court ordered evaluation subsequent to his third arrest for glue sniffing at the age of 15. David was the oldest of five children in a low-income family. His father was “picked up by the police at the request of my beloved mother and taken to the funny farm” when the client was 10 years old. Although apparently quite psychotic, the father had related well to David and spent a great deal of time with him. The relationship with the mother deteriorated considerably following this incident and the first episodes of solvent abuse occurred within 6 months of the father’s admission to the state psychiatric hospital. The mother’s excessive drinking and frequent dating till late hours left the children to fend for themselves with David thrust into a parental surrogate role as the oldest child.

David’s solvent abuse increased both in frequency and severity of effects and he was involved in repeated automobile and motorcycle accidents, some requiring hospitalization. He was arrested repeatedly between the ages of 15 and 19 with most arrests precipated by “trashing” the home and threatening violence to his mother while intoxicated on solvents. These repeated legal involvements led to uneventful and short term involvement with four different social agencies, a number of short term incarcerations, and constant supervision by the juvenile and later adult probation offices. Solvents were the sole drug of abuse throughout this period.

When David was expelled from a residential program at the age of 19, his probation was revoked and he was remanded to a psychiatric ward of one of the state penal institutions. Up until this time, most of the psychiatric symptoms (occasional auditory hallucinations, suicidal thoughts while intoxicated with one attempt, and periods of severe withdrawal and isolation) had been seen by most of the social service workers as merely effects from the glue sniffing.

This worker again saw David four months after his release from prison. It was the first time the client had ever been to the agency voluntarily. David reported that he was only sniffing glue once a week but that he was staying intoxicated on alcohol almost daily. He had been sexually molested repeatedly while in prison by older inmates and reported that since his release he was not able to perform sexually with women, was having nightmares, was sure everyone around him “knew” about him, and was sure there were people trying to kill him. Arrangements were made for brief hospitalization in a psychiatric unit of a local hospital. David’s anxiety and paranoid thinking subsided with a low regular dose of anti-psychotic drugs and he was subsequently referred to a residential combined alcohol and drug program. David’s stay at this program was terminated due to his drinking behavior but he was later re-admitted to another residential program where he has currently been in treatment for 10 months. The program he is currently in is utilizing psychiatric consultation and allowing David to remain on medication to control the psychotic symptoms.

In retrospect, there is little doubt that solvents performed such multiple functions for David as: 1) an expression of his outrage at his mother’s commitment of the father and her “escapades” with men; 2) an escape from parental responsibilities thrust upon him at an early age; 3) chemical escape into fantasy to avoid the loss and subsequent depression following the father’s hospitalization; and 4) a masking and medication of non-drug induced psychotic symptoms experienced by the client since early adolescence. This latter function was particularly problematic. While solvent intoxication allowed the client to bring his hallucinatory experiences under control and escape much of the delusional thinking, it also lowered his inhibitions and impulse control resulting in expressed rage at his mother.

The prognosis of this client is still very guarded. Long term adjustment will highly depend on continued psychiatric help and the client's ability to refrain from all inhibition lowering intoxicants, particularly alcohol.

IV. Solvent Abuse as Part of a Broader Pattern of Polydrug Abuse

A. Population Characteristics

This group is similar in most characteristics to the last group described (and could be considered a sub-group) but abuse a large number of psychoactive substances, including volatile solvents. There are also a higher percentage of minority group members in this group than in population III. Although the overall risk taking in this group is somewhat less, the probability of death from an acute drug reaction is greater than in other clients due to the combinations and excessive dosages of ingested drugs. There is also high incidence of psychiatric disorders in this group. These clients should be evaluated regularly for suicidal risk. It is our impression that a number of accidental drug overdose fatalities among clients in this group are in fact suicides. This group may also be involved in more serious crime due to their poor impulse control and their tendency to be influenced easily by others.

B. Etiology

The etiology of abuse for this group is very similar to population III. The most impressive clinical feature of this group is the high rate of self-medication of psychiatric symptoms with illicit substances. These clients seek thru self-medication with a variety of psychoactive drugs to maintain some semblance of psychological homeostasis.

C. Treatment

All of the comments on treatment of population III are applicable here with the following additional emphasis. Medical and psychiatric evaluation and consultation are crucial to the treatment of this group of clients. The use of anti-psychotic, anti-mania, or anti-depressive drugs may be absolutely essential to eliminate the random and incompetent pattern of self-medication used by these clients in an attempt to stop bizarre and frightening thoughts and ameliorate emotional distress. While the use of such psychoactive drugs is often not permitted in many drug abuse programs, it is our feeling that a gross disservice is done to the client by such refusal when the client presents severe psychiatric symptoms in addition to the substance abuse. While the use of such medications should be highly controlled given the clients chemical abuse history, it may be the essential first step in involving the client in a long term rehabilitation process.

Therapists who are working with this group on an outpatient basis may also find the need to utilize short term psychiatric hospitalization particularly in the vent of acute psychotic episodes or at times of high suicidal risk.

D. Prognosis

The prognosis for these clients is usually very poor. Most of these clients will be in contact with helping agencies through most of their adult lives. A therapist's primary hope is to bring the client to maximum functioning and then plan for the need to intervene periodically during crisis periods to re-stabilize the client. The exception to this poor prognosis is a small number of these clients who utilize long term treatment in a therapeutic community to establish a relatively sound adjustment. This most successful group usually had psychiatric services provided prior to or during their stay in the residential treatment.

E. Case Study Number Four

Mark A. entered outpatient treatment with one of the authors over four years ago with a history of considerable drug usage. As the eldest child in a large low-income family, he had suffered continuous and massive disappointments from his alcoholic mother, who had been institutionalized during her own adolescence for unspecified behavioral and emotional problems. His father, though socially quite ineffectual and depressed during most of the patient's formative years, was highly regarded by Mark from his immediately preadolescent years on. Mark's parents were divorced during his 14th year, at which time Mark began solitary, regular inhaling

of glue; also at this point Mark lived variously with his maternal grandmother, his father and other relatives – a pattern that continued for three years until he dropped out of school to enter the Army. His drug use expanded during this later military service to hallucinogens and amphetamines with a short period of heroin use but discontinuance of solvents. This all eventuated in his dishonorable discharge and return to his hometown at which time the solvent abuse began again. Two brothers also began using solvents upon his return and were subsequently placed in residential treatment.

Just before the initial outpatient consultations, Mark had been discharged from a state hospital after a 60-day court-ordered stay that included daily transactional analysis-oriented group therapy meetings with other addicts. Although described as withdrawn, immature and bitter by an outreach worker who had contact with him just prior to the brief hospitalization, the patient had mad unusually sound use of his group experiences on those problem areas during that stay. His individual outpatient supportive psychotherapy was characterized by office contacts only once every one to three months. While these interviews were used quite productively by him for support in crisis situations, Mark could clearly tolerate the frightening, primitive feelings elicited by the treatment relationship only so long as the contacts were thusly spaced. More specifically and in retrospect, the peculiarly intense attachment to a relatively inexperienced therapist that, in turn, stimulated profound fears over engulfment and abandonment, presented the main difficulties in maintaining an uninterrupted treatment process. Although Mark never appeared grossly psychotic without the use of chemicals, his usage pattern strongly suggested a massive effort at self-medication (that quite often backfired.) The fact that he felt periods of severe personality fragmentation coming on, accompanied by suicidal thoughts, and his use of the therapist to recapture a sense of self-connectedness further confirm this impression.

Psychotherapy continued for just over two years. Two years after his unplanned termination of that process he was employed full-time, only minimally involved with street drugs, but remained marginally attached to his former drug-dependent peers; also, during that four year time period Mark had two drug crises that required brief emergency hospitalizations and began regular alcohol use. The fact that the patient was unable to develop any positive, sustainable relations and remained detached from his own family made the usual forms of family work impossible.

V. Summary and Conclusions

The majority of children and adolescents who use solvents stop the practice after a short period of experimentation and cease use without treatment intervention. Four groups of solvents abusers were described who continued this practice into adolescence and early adulthood. The four groups were identified by the primary etiology of the continuing abuse pattern.

The following conclusions are drawn from our clinical experience with these clients:

1. The choice of solvents as a primary drug of abuse indicates a higher degree of social dysfunction and a higher degree of psychiatric disturbance than most other drugs of abuse.
2. In three out of four of the groups studied, social and economic deprivation of the client and his family was central to the etiology of the abuse and a primary barrier to successful rehabilitation. Prevention and treatment programs which do not address this issue will only be remedial in nature.
3. Disturbances in regulating self-esteem were common to all the identified groups. The critical factor in the severity of solvent abuse was the amount of deprivation and the severity of losses (of persons who enhanced the self-esteem of the client) experienced.

4. The treatment of solvent abusers must address both the immediate issue of the chemical abuse and the broader pattern of risk taking, psychiatric disturbances, and problematic family relationships which coincide with such abuse.
5. The onset of solvent abuse occurred between the ages of 9 and 13 for the majority of clients, making this the target age group for any prevention or early intervention efforts.
6. Although information outlining the high risks involved in inhalation of solvents may deter pre-adolescent experimenters, it will not have a deterrent impact on the populations we studies and may increase the probability solvents will be chosen as a drug of abuse.
7. Cessation of solvent abuse always occurs in the context of a relationship. This relationship is not necessarily a formal treatment relationship and often simply involves a key adult relating to the client in a way that increases the client's self-esteem and provides a substitute for some of the significant persons lost to the client through death, desertion, separation, or divorce. This observation has obvious direct implication to the necessary central component of any prevention or treatment program.

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The Collapse of 19th Century Addiction Treatment: Could It Happen Again?

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For years I have been asking audiences of professional and lay people when treatment for addiction to alcohol and other drugs began in the United States. Their responses usually place such origins in the mid-20th century and note such milestones as the founding of Alcoholics Anonymous (1935), the opening of two federal Anarcotics "farms" in Lexington, Kentucky (1935) and Fort Worth, Texas (1938), the alcoholic halfway house movement (the 1950s), the founding of Synanon (1958), the introduction of methadone maintenance (1964), and the founding of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse (the early 1970s). Very few are able to report that addiction treatment in America began nearly a century before these admittedly important events. This article will briefly outline: 1) the rise and fall of 19th century addiction treatment in America, 2) identify those factors that led to the virtual demise of this network of treatment institutions, and 3) speculate on whether a similar collapse of treatment could occur again.

The Rise and Fall of 19th Century Addiction Treatment

A dramatic rise in alcohol consumption in the late 18th and early 19th centuries and the subsequent rise of addiction to opium, morphine, cocaine, bromides, chloroform, ether, chloral, and nicotine set the stage for what Harry Levine has christened the American "discovery of addiction." Recognition of this problem led to calls for, and the eventual (mid-19th century) creation of, specialty institutions whose sole purpose was to care for the addicted. This new field of addiction treatment had several branches. There were inebriate homes, like the Boston and Chicago Washingtonian Homes, that viewed recovery from alcoholism as a process of moral reformation. There were private physicians, such as Drs. J.B. Mattison and H.H. Kane, who treated alcoholics and addicts within their specialized addiction medicine practices. There were the medically-oriented inebriate asylums such as the New York State Inebriate Asylum. There were dozens of private, franchised

institutes and sanitaria such as the Keeley, Gatlin, and Neal Institutes and the Battle Creek Sanitarium. There were many proprietary, bottled home cures that sold under such trade names as Antidote and Opacura. And there were the urban rescue missions and rural religious colonies that viewed recovery from alcoholism as a byproduct of religious conversion. An unusual assortment of temperance missionaries, physician activists, business entrepreneurs, and religious evangelists had, in spite of their differing views about the nature of addiction and its treatment, birthed a new arena of professional endeavor during the second half of the 19th century.

The growing smorgasbord of services for addicts embraced hundreds of individual practitioners, institutions, and businesses. Some of the major institutional providers of treatment came together in 1870 to found the American Association for the Cure of Inebriety. In 1876, they established a central vehicle of communication—*The Journal of Inebriety*—to share the growing knowledge about treatment methods and the management of treatment institutions. Their advertisements filled the newspapers and journals of the dayBboldly proclaiming that drunkenness was a disease that could be cured. They lobbied state legislatures to provide financial support for treatment and to pass involuntary addict commitment laws. The cultural viability of some of these institutions is indicated by the hundreds of thousands of patients who were treated in ever-expanding franchises that spread across the country and made their founders wealthy. The future of addiction treatment as a professionally directed endeavor looked exceedingly bright in 1895, yet the field had virtually disappeared 25 years later. Only a few 19th century addiction treatment programs survived into the modern era, and none from that period exists today.

The Dynamics of Decline

Many factors led to the collapse of America's first network of addiction treatment providers. There were unanticipated economic depressions that undermined financial support for these enterprises, and there was a cultural shift away from view that alcohol- and other drug-related problems were treatable diseases. As the 19th century came to a close, the country moved toward a bold redefinition of, and solution to, her growing drug problems: let those currently addicted to alcohol and other drugs die off, and prevent the creation of new addicts through the vehicles of moral suasion and the legal prohibition of the non-medical use of psychoactive drugs. The shift from medical to moral/criminal models of viewing addiction and addicts undermined the foundation of the future of addiction treatment as America entered the 20th century.

A weakened field found itself unable to respond to these environmental threats. Several factors contributed to the field's professional and political impotence. The field's public reputation had been wounded by highly publicized breaches of ethical conduct. Newspaper exposés charged incompetence and fraud in the field's clinical and business practices. Allegations abounded of inadequate care, patient abuses, sleazy marketing practices, and the financial exploitation of patients and families. Muckraking investigations of the bottled addiction "cures" exposed products secretly loaded with alcohol, opium, morphine, and cocaine.

Because 19th century treatment institutions catered mostly to an affluent population, they had done little to ease the burden indigent alcoholics were placing on jails and community hospitals. Many institutions became viewed not as agencies that served their communities but as places where the rich went to dry out and escape the consequences of their drinking behavior. As a result, there were few community leaders who came to the defense of inebriate institutions during their time of most critical need.

There were also problems of scientific credibility that grew out of the field's modality bias (sustained residential sequestration), its poorly developed clinical technology, and its aversion to the use of scientific methods to study addiction and evaluate treatment

methods. Conflict within and between treatment institutions and between the addictions field and allied professions (particularly the emerging field of psychiatry) created a fragmented field that never was able to speak with one voice. And the failure to address problems of leadership succession had over the years left the field without competent and energetic leadership to respond to emerging threats to the future of the field. Unable to respond to such environmental and internal vulnerabilities, 19th century treatment institutions faded from existence in the opening decades of the 20th century, its leaders gone or too demoralized to even record the field's demise.

Back to the Future?

What relevance, if any, does this musty story have to the modern field of addiction treatment? Everywhere I travel within the world of addiction treatment today, I hear depictions of a field in crisis. That crisis is most often described in the same two categories that posed a threat to 19th century addiction treatment. The first category, that of external financial threat, is said to be posed by an aggressive scheme of managed care that is, as it moves from the private through the public sector, altering both the availability and character of addiction treatment in America. Remarkably, this threat has unfolded within the healthiest economy in American history.

The second category, the demedicalization and re-criminalization of addiction, is said to be evident from the widespread transfer of alcoholics and addicts from hospitals and other treatment agencies to the criminal justice system during the 1980s and 1990s. The public rational for addiction treatment today is rapidly shifting from a focus on personal and family recovery to a focus on social control: reducing the addict's threat to public safety (via crime, violence, and disease) and managing the addict's cost to society. The growth ring in addiction treatment is not at its core (which many believe is in a state of decline) but at the peripheryBthe extension of addiction treatment into the workplace, the schools, the criminal justice system, and the arenas of public health (HIV/AIDS) and child protection. Some of the external threats that mortally wounded the first generation of addiction treatment providers are clearly evident in today's environment.

And what of those internal vulnerabilities? Like our 19th century counterparts, we have been, and continue to be, prone to modality bias (first to a high dose inpatient/residential bias and now to a continually declining low dose outpatient bias). We have been, and continue to be, vulnerable to breaches in ethical conduct in the field's business and clinical practicesBbreaches that contributed directly to the emergence of the very system of managed care that now threatens the field. We have poorly developed ethical sensitivities, few organizational codes of professional practice, no universally accepted model of ethical-decision-making, and poorly defined and under-utilized ethics disciplinary procedures. We continue to have organizations prone to incestuous closure and the resulting problems of stagnation and implosion, or organizations with such weak leadership, poorly developed infrastructures, and porous organizational cultures that they are vulnerable for colonization by more powerful organizations within their operating environments. We continue to have weak relationships with allied fields in spite of all our rhetoric to the contrary. And we have done very little to stem the high turnover among front line treatment personnel or to prepare the field for the vacuum that will occur when a large portion of today's long-tenured leaders exit the field in mass.

These depictions of the field do nothing to detract from the fact that the field of addiction treatment today brings many strengths not present a century ago: most importantly, a federal, state, and local infrastructure responsible for the planning, construction, operation, monitoring, and evaluation of addiction treatment programs. While this larger and much more sophisticated field may not suffer the fate of its 19th century counterpart, there are quite clearly some of the same contextual and

internal factors that undermined the field's resiliency a century ago that are being replicated within the current period.

If the field of addiction treatment should face extinction again, it will likely not be from one but a combination of contextual and internal threats. The worst potential scenario would be a sudden and sustained downturn in the economy and a concurrent increase in social disorder. Such a combination would have public and private policy leaders making tough choices regarding the allocation of resources and doing so within a climate of fear that could shift the focus from one of treating addicts to one of sequestering and punishing addicts. The most likely scenario would be the destruction of addiction treatment as a categorically segregated enterprise, the widespread integration (merger) of addiction treatment into more powerful health and human service entities, and the illusion of continued service availability while large numbers of alcoholics and addicts are moved from the public health arena to the criminal justice arena. This scenario could happen only in the face of a weakened field of addiction treatmentBvulnerable in the marketplace of ideas about who should have cultural ownership of this problem, vulnerable in terms of the field's scientific and public credibility, vulnerable from the loss of the grass roots movement that birthed and sustained it, and vulnerable from the lack of statespeople to lead a response to such threats.

To prevent such a scenario, we must rebirth the grass roots movement that laid the cultural foundation for the rise of 20th century addiction medicine and the modern system of addiction treatment. We must both aggressively monitor the ecosystem within which we operate and take a more activist role within that ecosystem. We must get ourselves clinically and ethically re-centered. We must take a highly splintered field and find a way to speak with one voice. And we must rebirth a new generation of leaders who can carry our mission of serving the still suffering addict into the 21st century. If we fail to meet these challenges, we may be doomed to repeat an episode in history little known to today's providers of addiction treatment. And that lack of knowledge is perhaps itself a source of great vulnerability. As the great comedic scholar Lilly Tomlin once suggested, "Maybe if we listened, history wouldn't keep repeating itself."



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This is the first of a series of articles in The Counselor that will explore the history of addiction treatment, counseling and recovery in America. The series will highlight some of the most important ideas, people and institutions that make up this history, and it will try to dig deep enough to find what lessons this history has to offer us today. When my research into this area began in 1976, I was stunned to discover just how little I knew about a field that I had then worked in for nine years. Perhaps you will share similar reactions as this series proceeds. What we are going to explore in this first article is an answer to the question: When did addiction treatment begin?

Dr. T.D. Crothers, in his 1893 text *The Diseases of Inebriety*, traced the earliest efforts to treat alcoholism to ancient Egypt, Greece and Rome. The early literature of each of these civilizations references the madness produced by wine, and Crothers traced the conceptualization of chronic alcohol inebriety as a disease to the first century writings of St. John Chrysostom. Early images of slaves attempting to treat the sufferings of their addicted masters with massage and various purgatives and potions suggest the presence of physical methods of treatment for alcoholism from the earliest periods of recorded history.

An American Binge

In America, the recognition of excessive drinking as an addiction emerged between 1790 and 1830. It was during this period that American tastes for alcohol shifted from cider, wine and beer to distilled spirits; annual per capita alcohol consumption increased from 22 gallons to 7 gallons; and the highly reputable colonial tavern gave way to the vice-ridden urban saloon. Heavy drinking was so pervasive that W.J. Rorabaugh entitled his book on this period *The Alcoholic Republic*. It took a century of religious, legal and medical experiments to overcome the consequences of this forty-year binge that transformed America's drinking habits and drinking institutions into a major social and public health problem.

Early Addiction Medicine: The Inebriate Asylums

There were many types of institutions that shared responsibility for the care of the 19th century inebriate. Inebriates often found themselves in non-specialty institutions that could do little for their condition—places like jails, county farms, almshouses, water cure institutions, and insane asylums. The failure of these institutions to adequately control or rehabilitate the inebriate that led to calls for new approaches. Addiction treatment arose amidst competing claims of ownership of the alcohol problem by medicine, religion, law and business--influences that continue today.

First, there was the rise of addiction medicine between 1780 and 1830. Medical leaders such as Dr. Benjamin Rush and Dr. Samuel Woodward began to conceptualize excessive drinking as an inherited or acquired disease. It was further declared that this newly conceptualized disease, christened *inebriety* (*alcoholism* wasn't coined until 1849), could and should be cured within special institutions set up for that purpose. From this new American view of chronic drunkenness grew research into the nature of inebriety and the establishment of medically-oriented inebriate asylums, beginning with the opening of the New York State Inebriate Asylum in 1864. Inebriate asylums emphasized physical causes of this disorder and utilized physical methods of treatment: drug therapies, aversion therapy, hydrotherapy, and electrical stimulation. Inebriates could be legally committed to such institutions for periods ranging from one year to "until the patient is cured."

Temperance Reform: The Inebriate Homes

The second branch of 19th century addiction treatment grew out of efforts to reform inebriates by enlisting their involvement in the growing American temperance movement. Temperance reformers, many of them recovering alcoholics, founded mutual aid societies--Native American temperance societies, the Washingtonians, the recovery-focused fraternal temperance societies, and the reform clubs. Leaders within these societies were often the driving spirit behind the establishment of inebriate homes such as the Washingtonian Homes in Boston (1857) and Chicago (1863). Inebriate homes emphasized short voluntary stays and non-physical methods of treatment. Alcoholism recovery in most of these homes was viewed as a process of moral reformation.

Most of these inebriate homes and asylums focused on the treatment of alcohol inebriety but began to treat addiction to drugs other than alcohol in the decades following the Civil War. Homes such as the DeQuincey Home and the Brooklyn Home for Habitués specialized in the treatment of narcotic addiction. In spite of significant differences in philosophy, the superintendents of the inebriate asylums and the managers of the inebriate homes came together in 1870 to found the American Association for the Cure of Inebriety and to establish the *Journal of Inebriety* (in 1876)--the first addiction-related professional association and first professional addiction treatment journal.

The Urban Mission Movement

The religious influence on the history of alcoholism treatment increased when Jerry McAuley opened the Water Street Mission in 1872. McAuley and his wife Maria, both *redeemed* alcoholics, birthed an urban mission movement that brought safe shelter and a message of hope to the skid row alcoholic. The weekly newspaper advertisements for the Water Street Mission said it all: "Everyone welcome, especially drunkards." McAuley and other alcoholic missionaries also played leadership roles in helping start some of the more religiously-oriented inebriate homes, most notably the New York Christian Home for Intemperate Men. McAuley's missions were the forerunners of the Salvation Army and other urban mission programs that would come

to serve the special needs of the Skid Row alcoholic. The missions and religiously-oriented treatment institutions viewed recovery from addiction as a process of religious conversion--a process of spiritual rebirth.

Addiction Treatment Franchises

The business branch of the 19th century treatment industry offered two types of proprietary treatment. First, there were the private for-profit sanataria and addiction treatment institutes. Some of these, such as the Keeley Institutes, the Gatlin Institutes, the Neal Institutes, and the Oppenheimer Institutes, were franchised across the United States and made millionaires of their founders. There were many other local institutes that provided discrete detoxification and convalescence for affluent alcoholics and addicts. The home cures constituted the second type of proprietary treatment. A patent medicine industry that aggressively promoted alcohol-, opium- and cocaine-laced products, and that was responsible for the accidental addiction of many Americans, also began to offer its own bottled addiction cures in the second half of the 19th century. There were hangover cures and alcoholism cures--products like the Hay-Litchfield Antidote and Knights Tonic for Inebriates. There were even products like the White Star Secret Liquor Cure and The Boston Drug Cure for Drunkenness that were promoted to wives in the promise that the wives could cure their husbands' alcoholism by secretly placing the advertised product in their husbands' food or drinks. There were the various cures for the "drug habit" that could be purchased by mail order: the Richie Painless Cure, Morphina-Cure, Opacura, and Drug Crave Crusade. There were also home cures for *tobaccoism*: BACO-CURE, Nicotol, and Nix-O-Tine. The No-To-Bac company even claimed that their product could, at the same time it cured the tobacco habit, cure impotence. It seemed for a while that everyone was getting into the addiction cure business. Even Sears Roebuck & Company offered a 50 cent cure for the liquor habit and 75 cent cure the for morphine habit in its late 19th century mail order catalogues.

The Collapse

In 1890, the future of addiction treatment in America could not have looked brighter. Progress was being made in medicalizing and destigmatizing addiction to alcohol and other drugs. The number of inebriate asylums and homes was rapidly growing. The proprietary franchises and home cures were undergoing explosive growth (and profit). The treatment/reformation of inebriates was emerging as a professional specialty within the fields of medicine and religion. But by the early 1920s, most 19th century addiction inebriate homes and asylums and addiction cure business enterprises were gone or on the verge of collapse. Only a handful of these institutions survived into the modern era, and it would take another fifty years to rebirth a national network of professionally-directed addiction treatment institutions.

In the next article, we will detail those factors that led to the fall of America's first system of addiction treatment. We will explore how the demise of this system was so complete that most of us entering the field during the past thirty years were not even aware of its existence. We will explore which, if any, of the factors that led to the demise of 19th century treatment are part of the current threats to the character and future of addiction treatment in America. (And we will find out what was really in those bottled addiction cures!)

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America,* from which this article is abstracted.

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Many readers of *The Counselor* are likely aware that, in 1993, Parkside Medical Services Corporation ceased to exist as the largest national provider of addiction treatment services in the United States. The demise of Parkside and the demise or radical restructuring of many other addiction treatment providers was the consequence of an ideological and financial backlash that put the topic of managed care on the agenda of every addiction-related conference in the 1990s. What readers may not be aware of is that a similar collapse of addiction treatment occurred almost a century ago.

In the first article of this series, we explored the rise of an elaborate network of addiction treatment institutions in the 19th century: the medically-oriented inebriate asylums, the temperance-influenced inebriate homes, the religiously sponsored urban missions and recovery homes, and the proprietary addiction institutes and bottled home cures for addiction. Forces within and outside the field of addiction treatment led to the demise of most of America's first network of addiction treatment providers. Where there were hundreds of treatment institutions in 1895, only a handful existed in 1925. This is the story of what happened.

Internal Threats

There were many things that weakened the 19th century field of addiction treatment and rendered the field vulnerable to powerful threats that emerged unseen from the outside economic and political environment. Many of the first addiction programs in America imploded, unable to survive the excesses of their charismatic leaders. The field itself was fragmented into ideological camps that waged their battles not behind the closed doors of professional meetings but in the popular press. Inebriate asylums suffered from a long-term residential modality bias and were vulnerable to charges that their services were relevant to only the most severely afflicted. Addiction treatment methods were poorly developed and nearly all branches of the field eschewed the use of scientific methods to study the nature of inebriety and to evaluate treatment outcomes. As a result, some quite incisive ideas existed alongside some of the most harmful and ill-conceived--with no agreed upon method to separate the former from the latter. When the field then reached a point of being put under a cultural microscope, it had no scientific data to justify its existence. In the end, there was not an agreed upon core knowledge or core technology of addiction treatment that could sustain the field.

Ethical Breaches

The field of addiction treatment came under increasing attack in the late 19th and early 20th centuries for breaches in ethical and professional conduct. There were highly publicized charges alleging medical incompetence, business fraud, misrepresentation of cure rates, excessive lengths of stay, aggressive solicitation of "refractory" (relapse) cases, patient abuses, and harmful treatments. Asylums and homes were charged with inadequate care. (A 1906 protest organized by patients of the Massachusetts Hospital for Dipsomaniacs and Inebriates ended with the criminal indictment of some of its staff.) The heads of the proprietary addiction cure institutes were bitterly attacked as financially motivated charlatans. In 1906, Samuel Hopkins Adams wrote an article in *Collier's Magazine* entitled "The Scavengers" in which he published the results of his laboratory tests of the patent medicine home cures for the alcohol and drug habits. The laboratory findings confirmed that the cures for alcoholism contained exceptionally high proof alcohol or such substitutes as opium or cocaine and that the morphine

addiction cures contained morphine, sometimes at higher doses than that which most addicts were accustomed. (Adams' articles so outraged the public that Congress passed the 1906 Pure Food and Drug Act, the provisions of which put out of business the most fraudulent of the home cures for addiction.) Exposés of ethical abuses damaged the reputation of 19th century treatment institutions and eroded broad public support for their continued existence.

Economic Threats

Most of the 19th and early 20th century inebriate asylums and inebriate homes were supported financially by a combination of public funds (including some direct allocation of alcohol tax revenues), private philanthropy, and patient fees. Many programs closed during periods of economic depression when public funds were withdrawn and re-allocated to other areas, when philanthropic donations decreased, and when the admission of self-pay patients declined. These first treatment institutions were never able to establish a stable foundation of public or private funding to assure their existence through periods of widespread economic distress.

Political Threats

If there was a single factor that led to the demise of the inebriate asylums and inebriate homes it was the demedicalization and criminalization of alcoholism and other addictions. The inebriate came to be defined as depraved rather than diseased at the same time that the definition of America's alcohol problem began to shift from a focus on the alcoholic to a focus on alcohol. Alcohol and other drugs became defined as the source of great social evil. Between 1890 and 1920 a new public policy vision gained prominence: let the existing inebriates die off and prevent a new generation of inebriates from being created by banning alcohol and other addictive drugs. And perhaps one of the best kept secrets in American history is just how well these early prohibition laws worked in reducing alcohol and other drug-related problems. Inebriate homes, asylums and proprietary institutes closed their doors in great numbers as alcohol-related problems and admissions to inebriate homes and asylums plummeted in the early years of national prohibition. (By the late 1920s most alcohol-related problems were again on the rise.)

Leadership

In some ways the 19th century field of inebriety treatment simply died of old age. A group of physicians, clergy and reformed inebriates had birthed the field in the 1860s and 1870s and kept the field alive as they and it grew to maturity. Without any system of leadership development and any plan for leadership succession, there was simply not a body of men and women with the experience, the knowledge and the energy to face the threats posed to the field in the early 20th century. The field died in tandem with the death of its founding generation.

The Lessons of History

The relevance and implications of this history to our current circumstances would seem to be clear. We must get ourselves ethically and clinically re-centered. We must carefully define a core technology of addiction treatment and practice only within the boundaries of that technology. We must begin to address the problem of leadership development and leadership succession as growing numbers of our founding generation leave us. We must rigorously monitor the external political and economic environment for threats that could either destroy the accessibility of addiction treatment or corrupt its essential character. We must begin to rebuild the grass roots movement that birthed us and re-instill the cultural belief in the very real potential

for permanent recovery from addiction. We must not lose sight of the singleness of purpose out of which we were born: the delivery of a message of hope to suffering addicts and their families.

There is a transformative power that lies at the heart of this field--a power we have all witnessed but that sometimes is lost in the pomp, paper and procedures that fill our professional lives. If any part, or all, of our field ever collapses, it is that power that will be rediscovered in the future. And it is that power with which we must continually align ourselves.

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America,* from which this article is abstracted.

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William L. White

Third in a series on the history of addiction treatment, counseling, and recovery in America.

I*atrogenic* means physician-caused, or treatment-caused, harm□a reminder that well-intended helping interventions may have unforeseen and harmful consequences. The word is often used in the addictions literature to refer to drug addictions that grew out of the use of narcotics and other psychoactive drugs in the course of medical treatment. But there is another potential application of this term: the inadvertent harm that has been done to alcoholics and addicts in the name of helping them overcome their addictions. This article will explore some of the most invasive and harmful things that have been done to addicts in the name of treatment.

One is forced to pause in amazement when reflecting on the number and variety of "cures" for alcoholism and other addictions, ranging from the disgusting to the whimsical. Alcoholics have been forced to drink their own urine (or wine in which an eel had been suffocated) and surreptitiously dosed with everything from mole blood to sparrow dung, all in the name of treatment.

Alcoholics have been subjected to the "Swedish treatment," in which everything they consumed and even their clothes and bedding were saturated with whiskey. Alcoholics have been put on every manner of dietary treatment, including the apple, salt, grape, banana, onion, and watermelon cures. And alcoholics have been asked to consume natural substances, from gold and iron to bark, that were thought capable of quelling their appetite for alcohol.

While the recounting of such treatments can elicit grimaces of disgust or smiles of wonder, there is a much more serious side to this story.

Harm in the Name of Good

Harm done in the name of good is an enduring theme in the history of addiction treatment. Even Dr. Benjamin Rush, who is deservedly called the father of the American disease concept of alcoholism, treated alcoholism with methods that included blistering, bleeding, switching alcoholics from distilled spirits to wine and beer (or opium), and unknowingly poisoning alcoholics with prodigious quantities of the mercury-laden calomel.

Treatment practitioners of the 19th century regularly treated alcoholics and addicts by prescribing alcohol, narcotics, cannabis, sedatives, stimulants, and hallucinogens. Some of these practices are remarkable in light of subsequent knowledge. There was Dr. J.B. Bently, who in the 1870s and 1880s prescribed cocaine by the pound as a treatment for alcohol and morphine addiction and reported, as a testament to the cocaine's effectiveness, that his patients were requesting additional quantities of cocaine and that they had completely lost their appetite for alcohol and morphine.

There was Dr. J.R. Black who recommended in an 1889 medical journal article that alcoholics be medically addicted to morphine in the belief that morphine was cheaper and less physically devastating and rendered the alcoholic less socially obnoxious. There were "bromide sleep treatments" recommended in the treatment of narcotic withdrawal in spite of reports that 20% of patients died during the procedure. There was the physician who, noting that alcohol intake decreased among his patients suffering active stages of gonorrhea, recommended medically infecting alcoholics with gonorrhea as a way to save the expense of sanatarium treatment.

In the early 20th century alcoholics and addicts were included, along with the mentally ill and developmentally disabled, within mandatory sterilization laws. Sterilization was thought to

not only prevent the breeding of degenerate alcoholic progeny but to also reduce the underlying physical causes of alcoholism. The coerced sterilization of alcoholics continued into the mid-20th century. Other early 20th century therapies prescribed for alcoholism and other addictions that proved ineffective or injurious included "serum therapies" that involved raising blisters on the addict's skin, withdrawing the serum from the blisters, and then repeatedly injecting this serum into the addict during withdrawal. There were also withdrawal therapies in the 1930s utilizing substances that could induce psychoses of up to two months duration.

For the first half of the 20th century, alcoholics and addicts were indiscriminately exposed to whatever was in vogue within the broader arenas of medicine or psychiatry. The 1940s and 1950s witnessed addiction treatments that included the use of electroconvulsive and insulin shock therapies as an aid to addict withdrawal and the experimental use of psychosurgery (the prefrontal lobotomy) as a treatment for alcoholism and narcotic addiction. Some alcoholics commended the latter, reporting that, following the surgery, they could get twice as tight on half the liquor.

This same period also saw the use of apomorphine and socinylcholine to induce an aversion to narcotics. The latter, when paired with drinking, produced an aversion to alcohol by temporarily paralyzing the respiratory system and inducing the terror of suffocation. The 1950s also witnessed the use of methamphetamine as a medically prescribed substitute for alcohol and heroin. The latter substitution served as a petri dish for the subsequent growth of a methamphetamine injection subculture.

The Lessons of History

It is easy to look back with condescension insight at the practice of treating morphine addiction with cocaine or alcoholism with practically every other psychoactive drug. It is easy to look back with self-righteous outrage at the mandatory sterilization of alcoholics or their being blistered, bled, and subjected to invasive interventions from psychosurgery to shock therapies.

But what stands out for me is that the invasiveness and harmfulness of these interventions were not visible in their own time. History demands that we each ask how future specialists in addiction treatment will evaluate our own era. Who within our own period will future historians call the healers, and who will they castigate as the hustlers and charlatans?

What harm done in the name of good exists today in the field of addiction treatment? History tells us that, to differing degrees, we all suffer from temporal blindness. This history calls for clinical humility and a continual pledge to follow the first of all ethical mandates: First do no harm.

Next: America's first addiction counselors.

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America,* from which this article is abstracted.

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William L. White

Fourth in a series on the history of addiction treatment, counseling, and recovery in America.

In the first three articles of this series, we explored the origins of addiction treatment in America; the rise and fall of 19th century inebriate homes, asylums and proprietary addiction cure institutes; and some of the unusual, often harmful things that have been done in the name of treating alcoholism and other addictions.

In this article, we will look at the beginning of addiction counseling in America, focusing not on the first use of the counselor title or first formalized role of addiction counselor but rather on when the core functions of addiction counseling began.

Native American Temperance Organizers

The first individuals in America who devoted themselves almost exclusively to carrying a message of hope for personal recovery from alcoholism were 18th and early 19th century Native Americans who led cultural revitalization movements following their own personal reformation.

Papoonan (Unami Delaware), Samson Occom (Mohegan), Kah-ge-ga-gah-bowh (Ojibway), Kenekuk (the Kickapoo Prophet), and Handsome Lake (Seneca) were among the Native American temperance leaders who, following their own near-death experiences with alcohol, brought a prophetic message about its role in the personal and cultural destruction of Native Peoples. They attacked alcohol as "fools water" or "the Devil's spittle."

Other Native leaders, such as the Delaware Prophet and the Miami chief, Little Turtle, launched total abstinence movements after experiencing visions that Native Peoples would be destroyed if they followed the White man's drinking practices.

It is in Native America that we find one of the first anti-alcohol tracts aimed at drinkers (Samson Occom's 1772 *Address to His Indian Brethren)*, one of the earliest American accounts of personal recovery from alcoholism (William Apess' 1829 *A Son of the Forest*), and the first individuals who devote themselves to providing personal counsel on alcohol problems and organizing sobriety-based support structures ("circles"). These support meetings used speeches, walking, singing, chanting, dancing and cathartic weeping as rituals of recovery from alcoholism. Native leaders used their own recovery from alcoholism as a springboard to launch messianic cults founded on radical abstinence from alcohol and a return to Native traditions.

Temperance Missionaries

The increase in annual per capita alcohol consumption from 22 gallons to 7 gallons between 1780 and 1830 produced a dramatic rise in alcoholism and a search for personal solutions to drinking problems. It was during this early period of the American temperance movement that temperance workers sought to counsel alcoholics to moderate their drinking by shifting from drinking distilled spirits to wine and beer.

These temperance workers were among the first to specialize in trying to use education and emotional appeal to influence the alcoholic's drinking habits. Some of these workers were themselves recovering alcoholics who used their work in the temperance movement and face-to-face contact with other "hard cases" to strengthen their own recovery. The failure of many alcoholics to moderate their drinking, in spite of repeated pleas and the growing presence of recovering alcoholics in the temperance movement, helped shift the philosophy of this

movement between 1825 and 1850 from that of a pledge of moderation (no distilled spirits) to one of total abstinence from all alcohol.

Between 1830 and 1890, a significant number of individuals turned their own experience of alcoholism and their story of recovery into a professional credential that qualified them to work as temperance organizers or speakers. They were paid either by local temperance societies or from collections taken from the audiences who heard them speak.

Local alcoholic mutual-aid societies sprang up in the 1830s, and men like J.P. Coffin took to the professional lecture circuit to reach other alcoholics. After 1840, these organizers and speakers were drawn primarily from the three dominant 19th century support structures organized by and for alcoholics: the Washingtonian societies, the fraternal temperance societies, and the reform clubs.

Battling Their Own Craving

John Hawkins and John Gough were among the most famous professionals who emerged from the Washingtonian Movement, J.K. Osgood, Dr. Henry Reynolds, and Francis Murphy were among the best known reform club organizers. These individuals worked full time organizing support groups for alcoholics, used their gift for charismatic speech to motivate alcoholics to take the pledge, provided personal counsel to alcoholics and their family members as they moved from town to town, and used prolific correspondence to bolster alcoholics' resolve to sustain their sobriety.

Some of those recovering alcoholics who dedicated their lives to reforming other alcoholics they met on the temperance lecture circuit were not affiliated with the major mutual aid societies. There was a high casualty rate among solo practitioners like Luther Benson and Edward Uniac, who tried to use their speeches to other alcoholics while on the lecture circuit to quell their own unrelenting cravings for alcohol.

Uniac unsuccessfully battled his own raging appetite for alcohol while trying to carrying a message of hope to other alcoholics. He signed pledges after each drunken debauchery and used his own falls to illustrate the devilish power of alcohol. In 1870 at age 37, he died of an overdose of whiskey, sleeping powders, and opium in 1870 following what was considered a successful temperance lecture tour. In 1879, Luther Benson, who often drank before (and binged after) his famed temperance speeches, penned the history of his own repeated failures to sustain sobriety. His autobiography, *Fifteen Years in Hell*, was written from a locked ward of the Indiana Asylum for the Insane. The lives of Uniac and Benson affirmed what has been an enduring lesson within the profession of addiction counseling: Service work with other addicts cannot by itself ensure one's own recovery.

Use of Recovered Persons

Although there were not formal "counselor" roles in the 19th century inebriate homes and asylums, we find evidence of many counseling functions. The philosophy of "moral suasion" in the inebriate homes was to a great extent the use of a personal relationship to encourage, educate, and advise alcoholics and addicts on the process of recovery. The medium for this influence can be found in the use of formal lectures to residents and one-on-one meetings between residents and the superintendent or chaplain of the institution.

A point of major controversy in 19th century addiction treatment was the use of recovered alcoholics in institutions. Washingtonian-style inebriate homes often used recovered alcoholics as managers and aides, and some of the proprietary addiction treatment institutes (such as the Keeley Institutes) relied primarily on recovered alcoholics and recovered narcotic addicts to work as physicians and personal attendants.

Inebriate asylum leaders generally objected to such use on grounds that it would hinder mainstream acceptance of addiction treatment as a medical specialty. Other objections to this

practice are reflected in the following excerpt from an 1897 editorial by Dr. T.D. Crothers published in *The Journal of Inebriety*:

> *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.*

This view was to change dramatically in the 20th century. The rise of the lay therapy movement of the early 20th century, the "AA Counselor" role of the 1940s, and the creation and evolution of the first fully professionalized alcoholism counselor roles in the 1950s and 1960s.

William White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America,* from which this article is abstracted.

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William L. White

Fifth in a series on the history of addiction treatment, counseling, and recovery in America.

In earlier articles we explored the rise and fall of 19th century addiction treatment in America and met some of the first people who first performed the core functions of addiction counseling as it is practiced today. What was absent in the 19th century was a fully developed role of addiction counselor. This role emerged from the ashes of a collapsing inebriate asylum movement.

In this article, we will trace the rise of lay therapy in the early 20th century, describe the evolution of this role within the mid-century alcoholism movement, and describe the formalization of this role in the 1950s in the "Minnesota Model" of chemical dependency treatment.

Lay Therapy Movement

Boston's Emmanuel Church opened a clinic in 1906 that sought to integrate religion, psychology, and medicine in the treatment of various medical and nervous disorders. Over the following decade, the clinic developed special expertise in the treatment of alcoholism. It combined medical screening, individual and group counseling, classes, mutual support (the Jacoby Club), and special support provided by "friendly visitors" (recovered alcoholics). The latter element evolved into a system of "lay therapy" in which selected former patients in stable recovery received special training to provide the same therapy they had received.

The first seed of the lay therapy movement was sown by Courtenay Baylor, who was hired as a lay therapist at the Emmanuel Clinic in 1913 following his own treatment there by Dr. Elwood Worcester. Baylor is, to the best of this author's researches, the first person without traditional professional credentials to be employed full-time as an addiction therapist. He treated many alcoholics and then recruited, trained, and supervised some of his most capable patients to be lay therapists themselves. Some lay therapists trained at Emmanuel later provided therapy to alcoholics in what today would be called private practice.

A long line of noted lay therapists followed in the Baylor tradition, including Richard Peabody, Francis Chambers, William Wister, Samuel Crocker, Wilson McKay, and James Bellamy. Chambers deserves special mention; his enduring collaboration with the psychiatrist, Edward Strecker marks the first time that a lay therapist specializing in the treatment of alcoholism was integrated into a broader multi-disciplinary team within a traditional psychiatric hospital.

Through their various writings, Baylor, Peabody and Chambers formulated the core clinical technology of the practice of lay therapy in the treatment of alcoholism. The major elements arranging medical detoxification, eliciting a commitment to lifelong abstinence, negotiating a commitment to 60-100 hours of therapy, pledging mutual cooperation, contracting for mutual confidentiality, disclosing the therapist's personal 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 how to reprogram his or her self-talk.

Works such as Baylor's *Remaking a Man* (1919) and Peabody's *The Common Sense of Drinking* (1933) were the first texts devoted to the structure and technique of alcoholism counseling. Peabody's book stands as one of the most influential 20th century books on alcoholism counseling.

Lay therapy in the Baylor-Peabody tradition continued into the early 1940s and helped legitimize alcoholism-focused therapy practices and the use of trained recovered people as "wounded healers." Most of the prominent lay therapists got sober before Alcoholics Anonymous was founded or got sober after 1935 without affiliation with A.A. Among those who got sober outside A.A. and who had traditional credentials within the helping professions, the most influential was Ray McCarthy, who pioneered many alcoholism therapy techniques in his work facilitating group therapy meetings at the Yale Clinics in the 1940s.

A.A. and Boundaries

As Alcoholics Anonymous entered a period of explosive growth in the early 1940s, it was faced with how to construct its relationship with a host of "drying out" sanataria, public and private hospitals, state psychiatric hospitals, and newly emerging alcoholism treatment facilities. Some of the latter were launched by A.A. members/entrepreneurs or A.A. clubhouses and were frequently referred to by such names as AA Farms, AA Retreats, and Twelfth Step Houses.

The interest that A.A. was sparking in the treatment of alcoholism led to A.A. members being asked to work in such facilities as managers, physicians, psychologists, social workers and aides. (The role of lay therapist was declining through the 1940s, so we have no clearly defined equivalent to the counselor role at this point for those without professional training.) All of this raised questions about the relationship between an A.A. member's activities in A.A. and the member's employment in these new institutions.

Forsaking its own early vision to operate alcoholism treatment hospitals, A.A., through its Twelve Traditions, forged a position of cooperation without endorsement or affiliation with such institutions and began to articulate principles through which A.A. members could separate their roles in A.A. from their paid roles in treatment institutions. Even though A.A.'s co-founder, Bill Wilson, had himself turned down an offer to work as a lay therapist at the Charles B. Towns Hospital for the Treatment of Drug and Alcoholic Addictions, he was generally supportive of A.A. members who sought his advice on whether to except similar positions. Wilson's concern was that such employment not undermine the person's own recovery and that the member's actions in this paid role not injure A.A. as an organization.

What emerged were guidelines that prohibited the A.A. member working in the alcoholism field from speaking on behalf of A.A. and that required A.A. members to clearly delineate their A.A. activities from their paid activities as a social worker, psychologist, or lay therapist. With the clarification of such boundaries, Bill Wilson encouraged A.A. members to fill such roles. His support stemmed from his belief that it was important that alcoholics be able to find people in these new institutions who truly understood alcoholism and the process of recovery.

The boundaries between A.A. and treatment, and the differing roles of A.A. members and those employed in alcoholism treatment, were sorted out in the 1940s in older institutions that had begun cooperating with A.A. (e.g., Towns Hospital, the Chicago Washingtonian Home), in new alcoholism units (e.g., St. Thomas Hospital in Akron, Knickerbocker Hospital in New York), in new linkages being set up between A.A. and psychiatric hospitals (e.g., Rockland State Hospital, Manteno State Hospital), in new alcoholic "retreats" (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).

The conflicts that arose within High Watch and similar places helped distinguish the A.A. experience from what was coming to be called "treatment" and helped separate A.A. service activity from what was about to be christened "counseling."

A Replicable Counseling Model

A synergy of innovation between three new A.A.-influenced treatment programs--Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950)--produced what came to be

called the Minnesota Model of chemical dependency treatment. As it evolved in through the 1950s and 1960s, this approach solidified into a highly replicable model of treatment.

What is important about this innovation for our story is that the role of counselor was at the heart of this model. The Minnesota Civil Service Commission's creation of the Counselor on Alcoholism title in 1954 marks a significant milestone in the history of addiction counseling. With the fading of the lay therapist role, this decision marked the rebirth and reformulation of a specialized role (profession) for those caring for alcoholics.

But Minnesota did more than bless a new job title. In the face of considerable criticism, it created a means of preparing recovered alcoholics to work as counselors, 2) integrated the alcoholism counselor into a interdisciplinary team of psychiatrists, psychologists, social workers, and clergy, and 3) helped separate the status and responsibilities of the professional alcoholism counselor from the status and responsibilities as an A.A. member.

Early Minnesota pioneers like Pat C., Lynn C., Otto Z., Fred E. and Mel B. helped define this new role before its widespread replication throughout the United States in the 1970s and 1980s. As the Minnesota Model spread, it was adapted and refined. Foremost among these changes was the growing delineation between 12-step work within A.A. and the activities of professional counseling. As these roles became more clearly demarcated, people also began filling counseling roles who brought family recovery backgrounds. Later, counselors came without personal or family recovery experience. Still later, people entered the field who were in recovery from addiction to alcohol and other drugs but were not involved in 12-step recovery.

This brought counselors with a great diversity of personal, educational, and professional backgrounds to work in the arena of addiction treatment B and led to debates about who was qualified to treat alcoholics and addicts. There was a growing consensus that achieving the goal of specialized treatment resources for addicts and their families was contingent on the full professionalization of the role of addiction counselor.

Next: Milestones in the professionalization of addiction counseling in the modern era.

William L. White is the Author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, from which this article is abstracted.

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William L. White

Sixth and final in a series on the history of addiction treatment, counseling, and recovery in America.

In the first five articles of this series, we have explored the deep historical roots that underlie the modern practice of addiction counseling. We have traced these roots from the leaders of 18th century Native American cultural revitalization movements through the 19th century temperance missionaries and to those who toiled in the inebriate homes and inebriate asylums. We have visited the Emmanuel Clinic and met many noted lay therapists of the early 20th century, and we noted the A.A.-influenced rise of the role of "counselor on alcoholism" within the Minnesota Model of the 1950s. We will pick up our story in the 1960s.

Treatment Models and Treatment Funding

Before a new profession of alcoholism or addiction counseling could fully emerge, there needed to be replicable models of treatment and an infrastructure to spread these models across the United States. Both of these requirements came together in the 1960s and early 1970s.

Replicable models of alcoholism treatment came from the residential model of alcoholism treatment birthed in Minnesota and from outpatient clinic models that had been developed in Connecticut and Georgia. Added to these was a new model of social setting detoxification pioneered in Canada as well as new designs for intervening with alcoholics in the workplace and in the criminal justice system (particularly for those arrested for impaired driving). There were three additional models that fully emerged in the 1960s to treat addiction to drugs other than alcohol: the therapeutic community first pioneered by Synanon, the development of methadone maintenance by Drs. Vincent Dole and Marie Nyswander, and a potpourri of individual, group and family therapies embraced under the rubric of "outpatient drug free counseling." With models of intervention defined, what was needed was a structure through which they could be widely disseminated to communities across America.

Early funding of services to treat those addicted to alcohol and other drugs came from multiple federal agencies and a smattering of states and municipalities. These coalesced in the early 1970s into a unique model of federal-state-local partnership, established initially by legislation pioneered by Senator Harold Hughes. This model that shaped addiction treatment for the next 30 years involved the flow of federal dollars from two institutes (the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse) to designated state alcohol and drug treatment authorities, who in turn worked with local communities to plan, build, operate, monitor and evaluate addiction treatment centers. Within a few short years, addiction treatment programs spouted up from one end of the country to the other. A controversy that quickly arose in this process involved the question of who was qualified to treat the alcoholics and addicts who would be served by these new facilities. The goals to accredit these programs at a national level and license these programs at the state level hinged on this question of who was competent to treat addiction.

Birthing a New Profession

Although the State of Minnesota created a civil service position entitled "counselor on alcoholism" in 1954, it would be many years before such a position would emerge as a recognized profession. It became quickly apparent to officials at NIAAA and NIDA that they were ready to do battle against alcohol and other drug addictions with no army to launch this effort.

Because so many of the grass roots treatment models utilized people in recovery who often had more prior contact with penal institutions than educational institutions, the challenge was how to prepare and professionalize this indigenous workforce while blending it with a growing array of other professionals entering the field who also brought no specialized training in addiction treatment. The initial answer was to create two national training systems (one for alcoholism counselors, the other for drug abuse counselors) that would conduct training needs assessments, write training curricula, train trainers, deliver and evaluate training, and encourage states to begin the process of developing credentialing and certification systems to elevate this energetic but rather motley assortment of people into a professional workforce. Such milestone studies as the Littlejohn Report and the Birch and Davis Report laid the groundwork for the state and national alcoholism and drug abuse counselor certification efforts that would follow. The NIAAA- and NIDA-spawned training systems helped prepare many people who had worked within earlier federally-supported alcoholism and drug abuse counseling programs, particularly those supported by the Organization for Economic Opportunity (OEO) and the National Institute on Mental Health (NIMH), as well as new generations of workers entering the field of addiction treatment. These top-down efforts were also accompanied by grass roots efforts to organize and train alcoholism and drug abuse counselors by state, regional and national counselor associations. Other elements of the field's professional infrastructure also began to emerge: academic and free-standing addiction counseling training programs, organizations that specialized in addiction research, and a growing body of addiction-related books, journals and newsletters.

Because so many of the early counselors were recovering and were working in roles that were ill-defined and for which they had been ill-prepared, a great deal of early focus in the 1970s was on mastering a basic level of knowledge about counseling, delineating one's role as a recovering person from one's role as an addictions counselor, and managing issues of self-care in an era when excessive hours was the norm. There were many counselors who had few qualifications other than their own sobriety, and, in some cases, this was fragile and of short duration. When isolated relapses did occur, they were wrenching experiences for not only those who relapsed but also for their fellow staff and clients who had to make their own painful sense of such episodes. In light of the lack of training, short lengths of sobriety, and minimal formal supports, it is amazing in retrospect just how few relapses there were and how many of these early pioneers in this "new profession" went on to make significant contributions to the field.

There were two debates that dominated the late 1960s and 1970s. The first was the question of who was qualified to treat alcoholics and addicts. This oft-heated debate pitted the recovered "paraprofessional" (or less pejoratively, "professional by experience") against the academically training and licensed psychiatrist, psychologist and social worker. A related and much more acrimonious debate involved the question of whether the treatment of alcoholism and other drug addictions should be brought under a single conceptual and administrative umbrella. This debate continued well into the 1980s before most treatment agencies, professional associations and credentialing/certification bodies in the field moved towards integrating these disorders under such rubrics as chemical dependency, substance abuse, or addiction.

One organization stood in the middle of all of these changes marking the birth of addiction counseling as a professional role.

NAADAC's Founding and Coming of Age

When Matt Rose, Robert Wayner, Jay Cross, W.W. Williams, Richard Kite, Fenton Moss, and James Towlerton founded the National Association of Alcoholism Counselors and Trainers (NAACT) in Atlanta in 1972, it is doubtful that any of them could have envisioned their small group evolving into what NAADAC has become today. What NAADAC did through the leadership of people like Mel Schulstad and countless other individuals was forge an

organization that could support addiction counselors across the country and provide a way for those counselors to speak with one voice on important public policy issues. NAADAC through the work of its members, its board, and its six executive directors (Matt Rose, Doug Harton, Ed Riordon, David Oughton, Steve Kreimer, and Linda Kaplan) helped build a new profession of addiction counseling and then bring credibility to that profession by defining ethical standards of practice, keeping its members professionally informed via its newsletter and journal, and by sustaining its training, credentialing, and advocacy activities. The work that NAADAC performed at a national level was mirrored in the development of state addiction counselor associations. Collectively, these associations oversaw the movement of addiction counselors from their status of "paraprofessional" pariahs to accepted members of multidisciplinary behavioral health teams.

Challenges

Addiction counseling is evolving dynamically within a turbulent cultural ecosystem that threatens to demedicalize and restigmatize addiction to alcohol and other drugs. Today's addiction counselor is being asked to do a greater number of things within time frames that would have been incomprehensible only a decade ago. While fighting not to be drowned in paperwork, today's counselor is faced with clients who are bringing multiple problems of great intensity and duration and significant personal and environmental obstacles to recovery. Today's counselor is being asked to integrate into his or her practice new clinical breakthroughs (pharmacological adjuncts, manual-guided therapies, gender and cultural adaptations) that seem to be emerging with lightning speed. All of these demands are unfolding within agencies that are being caught up in a frenzy of mergers and service integration initiatives that threatens to dilute if not corrupt the core technology of addiction counseling. The central challenge is how addiction counselors can "keep their eyes on the prize" in the midst of such turbulence.

Looking Back and Forward

In looking back over the history we have shared in this series, it is perhaps appropriate to ask what the modern addiction counselor has provided that did not exist before. There are many potential answers to this question that would focus on the special knowledge and skills of the addiction counselor, but I would suggest an answer that lies in another arena. What addiction counselors brought to the alcoholic and addict that had not existed in any sustained way was a helping relationship that was free of contempt. Contempt, often mutual, had for well over a century marred the relationship between addicts and traditional professional helpers. What the new profession of addiction counseling brought to this relationship was not only specialized knowledge and skill but a relationship based on moral equality and emotional authenticity. The profession of addiction counseling and the larger treatment enterprises in which this profession is embedded face significant threats to their character and existence as we enter a new century and millennium. What must not be lost in the turbulent days ahead is the respect and mutual vulnerability that lies at the core of the relationship between addiction counselors and those they serve.

This last May at the NAADAC meeting in Philadelphia, I had the opportunity to present to the membership some of the lessons that I thought could be drawn from the history of addiction treatment and recovery in America. I close this series with my final remarks from that presentation.

> *I have spent more than thirty years with this imperfect instrument we call addiction treatment, but I reach this milestone more convinced than ever that, at its best, it can transform individuals, families and communities. The privilege of participating in this process of rebirth is the most sacred dimension of what we do. It is that power within which we must remain centered and, if the field should ever lose its*

way, that power that will have to be rediscovered in the future. I wish each of you and your organizations godspeed on your journey into that future.

***William L. White** is the author of Slaying the Dragon: The History of Addiction Treatment and Recovery in America, from which this article is abstracted.*

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The Role of Recovering Physicians in 19th Century Addiction Medicine: An Organizational Case Study[1]

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Abstract

An elaborate network of inebriate homes, inebriate asylums, nationally franchised private addiction treatment institutes, and proprietary home cures for addiction arose on the American landscape between 1850 and 1900. The pinnacle of the movement to professionalize America's first addiction treatment field was the founding of the American Association for the Cure of Inebriety in 1870 and its publication of the first issue of the Journal of Inebriety *in 1876. One of the most contentious issues among the various branches of this new professional field was the question of the use of "reformed men" as physicians, managers and attendants within treatment institutions. This article describes the employment of recovering physicians within one 19th century addiction treatment franchise—the Keeley Institutes—and documents the nature of the professional debate stirred by what was then a controversial practice.*

An elaborate network of inebriate homes, inebriate asylums, nationally franchised private addiction treatment institutes, and proprietary home cures for addiction arose on the American landscape between 1850 and 1900. The pinnacle of the movement to professionalize America's first addiction treatment field was the founding of the American

[1] The author wishes to acknowledge the late James Oughton, Jr., for providing the author permission to access confidential files housed within the Keeley Archives of the Illinois State Historical Society.

Association for the Cure of Inebriety in 1870 and its publication of the first issue of the *Journal of Inebriety* in 1876. One of the most contentious issues among the various branches of this new professional field was the question of the use of Areformed men@ as physicians, managers and attendants within treatment institutions. This article describes the employment of recovering physicians within one 19th century addiction treatment franchiseBthe Keeley InstitutesBand documents the nature of the professional debate stirred by what was then a controversial practice.

Recovering Addicts Working in 19th Century Addiction Treatment

The concept of the Awounded healer@Bthe idea that people who have experienced and overcome adversity might play a role in helping others similarly afflictedBcan be traced to early religious and moral reformation movements. “Reformed sinners” throughout history have used their own transformed lives as a springboard for evangelism and activism within personal and social reformation movements. This tradition set the stage for the important role “reformed inebriates” came to play in the 19th century temperance movement.

The first “wounded healers” in America were men like Samson Occom, Handsome Lake and The Prophet who used their own near-death experiences with alcohol as a springboard for their own personal reformation and their emergence as highly influential Native American Temperance Reformers in the late 18th and early 19th centuries. This role became fully developed following the Washingtonian Revival of the 1840s. John Gough, John Hawkins, Dr. Francis Reynolds, and Francis Murphy created professionalized roles that combined motivational speaking to large groups, personal consultations with inebriates and their families, and the organization of inebriates into local abstinence-based reform clubs.[1, 2, 3] The autobiographies of some 19th century temperance missionaries provide evidence that this work was not always successful in helping the reformer sustain their own sobriety.[4, 5, 6] Relapses of prominent reformers led to early controversies over the use of reformed men in this role and to arguments over whether such men should be referred to as “reformed” or “reforming”—a debate that has continued into the modern era in parallel arguments over the use of the terms “recovered” and “recovering.”[7, 8, 9, 10]

While recovering alcoholics had worked as temperance missionaries and as managers and attendants within some of the early inebriate homes,[11] the practice of hiring recovering people to work in direct service roles with other alcoholics became particularly associated with what were called “the gold cure empires” and other private addiction cure institutes. There were many late 19th and early 20th century addiction cure franchisesBthe Gatlin Institutes, Neal Institutes, Oppenheimer Institutes, Hagey Cure, and the Bartlet Cure, to name just a few. None of these franchised cures had more institutional sites, were more geographically dispersed, were more profitable, or were more controversial than the Keeley Institutes.

The Keeley Institutes

In 1879, Dr. Leslie E. Keeley of Dwight, Illinois publicly announced, ADrunkenness is a disease and I can cure it.@ By 1920, more than 500,000 people had taken the Keeley Cure in one of the 120 Keeley Institutes scattered across the United States, Canada and Europe. The Institutes spread rapidly behind a unique franchise arrangement that attracted many business entrepreneurs, an aggressive program of advertising that boasted Keeley's claim of a 95% cure rate, praiseful books written by former patients,[12, 13] and the highly publicized outcome of Dr. Keeley's challenge to Joseph Medill, Editor of the Chicago Tribune. Keeley challenged Medill that he would sober up any of the worst drunks of Chicago that Medill would send to Dwight. (Medill accepted this challenge and later acknowledged on the pages of the Tribune that the men he had sent to Dwight left Chicago as "sots" and had returned to Chicago as "gentlemen.")[14]

After a period of explosive growth in the 1890s, the Keeley Institutes went into a period of decline. Dr. Leslie Keeley and his treatment methods were bitterly attacked in both the professional and lay presses, and the Keeley empire eventually fell to many of the same forces that led to the virtual collapse of the entire network of 19th century addiction treatment programs. Only a few of the Keeley Institutes survived into the post-prohibition and modern periods of alcoholism treatment. The final blow to the surviving Keeley Institutes was the rise of state and federally funded community-based alcoholism treatment programs in the 1960s. The last Keeley Institute, the home Institute in Dwight, Illinois, closed its doors June 5, 1966, marking the end of 87 years of treating those addicted to alcohol and other drugs.

The original Keeley treatment consisted of both institutional and clinic treatment as well as bottled home remedies that could be ordered by mail by those who couldn't afford treatment at one of the Keeley facilities. The Keeley Institutes offered a four to six week treatment consisting of a banishment of tobacco, rest, exercise, good food, and warm fellowship via participation in Keeley League meetings—the Keeley patient mutual aid society.[15] While these aspects of treatment did not differ significantly from care in many of the inebriate homes or inebriate asylums, what made the Keeley Cure unique was the administration of a medicinal specific, the Double Chloride of Gold Remedy, that Dr. Keeley argued could unpoison the cells and cure those addicted to alcohol and other drugs of their morbid cravings. Each Keeley patient received four hypodermic injections a day plus oral tonics every two hours. While the contents of these injections and oral medications were closely guarded secrets and changed over time, Keeley's medicinal specific in the 1890s is thought to have contained individualized mixtures of strychnine, atropine, apomorphine, cinchona, aloin, and ammonium chloride. Keeley graduates were expected to publicly declare their newfound sobriety, continue participation in the Keeley Leagues, and boldly wear their Keeley League pin on their person as a daily affirmation of their cured status.[16]

The Keeley Physicians

To administer Keeley's elaborate medical protocol required physicians who were responsible for conducting physical examinations, supervising detoxification, treating

acute medical problems, administering the four shots per day to each Keeley patient, conducting patient education in the form of lectures, and maintaining written correspondence with would-be patients and family members. There is much that was controversial and noteworthy within the Keeley treatment method and the ways the Keeley Cure was promoted, but buried within this broader controversy was the fact that the Keeley Institutes hired more recovering physicians in professional treatment roles than any addiction treatment institution before or since.

There are two sources of information on the employment of recovering physicians within the Keeley Institutes. The first is Alfred Calhoun's 1892 book on the Keeley Cure which notes that there were than 100 former patient/physicians that were working as physicians within the chain of Keeley Institutes. The second, and more definitive source, is the *Leslie E. Keeley Company Physician's Record,* residing today in the Keeley Archives at the Illinois State Historical Society.

The *Physician's Record* provides a brief biographical account of each of the 418 physicians hired at the Keeley Institutes between 1891 and 1950, including notations of where and when they had completed their education, internships, and prior employments. There was also within each physician's resume a heading marked "Addiction." Following this heading were notes indicating whether each physician had a prior history of addiction and, if so, the nature of that addiction. The type of addiction was indicated by one or more letters: D for drunkenness, M for morphine, O for opium, and C for cocaine. Of the 418 physicians with resumes in the record, 131 were reported to have had a history of addiction, 226 were noted to have had no history of addiction, and the Addiction category was left blank for 61 of the physicians. For the 131 physicians with a noted history of addiction, there were additional notes indicating when and where the physician had been treated. All 131 of the recovering physicians hired by Dr. Keeley had been treated in one of the Keeley Institutes—some more than once.

The resume of each physician within the *Physician's Record* also indicated when each physician had come to Dwight, Illinois for his initial orientation and training by Dr. Keeley and his staff and when he had assumed his position within one of the Keeley Institutes. By comparing the treatment dates and these training and placement dates, an estimate of the maximum length of sobriety for each physician can be determined. Nearly all of the patient/physicians hired to work in the Keeley Institutes assumed these roles within one year of their own treatment and many did so within a few weeks or months. An extensive review of Dr. Leslie E. Keeley's correspondence did not provide an answer to the question of whether he and his staff directly recruited physicians and business entrepreneurs while they were in treatment, but the close proximity between the patient/physicians' treatment at a Keeley Institute and their recruitment to work as physicians within the growing chain of Keeley Institutes suggests the presence of some direct recruitment method.[17]

The Controversy

There were many sources of strain between the inebriate asylum institutions and such proprietary addiction cure purveyors as the Keeley Institutes. While both tended to conceptualize inebriety as a disease and call for its medical treatment, the treatment philosophies were quite different. The inebriate homes were allopathic in their medical orientation, while the addiction

cure institutes tended to be homeopathic, with many of the latter offering medicinal specifics that they claimed could cure addiction. The inebriate asylums called for involuntary and extended (1-4 year) institutional care; the addiction cure institutes offered brief (3-4 week), voluntary inpatient or clinic care in which each patient would visit the institute several times a day for the administration of medicines while living freely in local hotels or boarding houses. The inebriate homes and asylums viewed themselves as primarily public institutions and sought public (liquor tax revenue) funding to supplement their patient fees; the cure institutes were profit making ventures supported by investors who expected to make a profit from the fees patients paid for their cure.

The inebriate asylums and the cure institutes were competitors both in terms of their financial existence and in terms of their medical credibility. There were many broadside attacks on the cure institutes, but the Keeley Institutes, because of their national spread and their financial success were the subject of particularly bitter attacks.[18, 19, 20, 21, 22] It was within this broader context that the debate arose over who was qualified to treat the inebriate.

The intensity of this debate is revealed in an 1897 Editorial in the *Journal of Inebriety* by Dr. T.D. Crothers, the Superintendent of Walnut Lodge Hospital and long-time Editor of the *Journal*. Crothers' editorial was unequivocal about the inadvisability of hiring recovering people within addiction treatment institutions.

> *It is confidently asserted that a personal experience as an inebriate gives a special knowledge and fitness for the study and treatment of this malady. While a large number of inebriates who have been restored engage in the work of curing others suffering from the same trouble, no one ever succeeds for any length of time or attains any eminence.*[23]

Crothers' article provided two reasons why Areformed men@ should not assume professional roles in the treatment of inebriety. First, he contended that reformed inebriates failed the competency test.

> *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.*[24]

Second, he argued that work in the treatment business was a threat to the continued sobriety of the reformed inebriate.

> *The strain of treating persons afflicted with the same malady from which they formerly suffered is invariably followed by relapse....Usually they will break down and return to spirits or drugs after a time....In the history of the asylums in this country, no reformed man has ever continued long in the work, or succeeded as a manager and physician in the medical and personal cure of inebriates.*[25]

There were two major sources for Crothers' criticisms. The first was a desire by Crothers and others within the medically-oriented inebriate asylums to fully professionalize the practice of addiction treatment and achieve the recognition of addiction medicine as a legitimate medical specialty. It is quite clear that they saw the use of personnel with a history of personal impairment as a threat to this professionalization movement. Similar strains were evident when the modern addiction treatment field evolved from an essentially Aparaprofessional@ workforce to one that moved toward professionalization.[26]

The second source of Crothers' concernsBthat physicians whose addiction had left them with sustained impairments in professional functioning or left them vulnerable for continued relapseBseems to have had some validity. The literature of this periodBeven the *Leslie E. Keeley Company Physician's Record* itself offers evidence of this potential. Buried within the resumes of patient-physicians hired by the Keeley Company are such notes as, "gave up because of impaired memory," "suicided," "drinking heavily," and "relapsed, was rejected for treatment here, dead." Cheryl Krasnick Warsh found similar problems of physician relapse in her study of the Keeley Institute in New Brunswick, Canada. She noted one such physician who was declared insane in 1895 from "despondency and excessive use of cocaine."[27] Nearly a century later, similar concerns were expressed about the relapse of recovering people working in a reconstituted field of addiction treatment.[28, 29, 30, 31, 32]

It is somewhat surprising that Dr. Leslie Keeley, a prolific writer, did not formally respond to this issue in his many professional articles and books. Keeley, in addition to failing to defend this practice of hiring recovering physicians, actually seems to have changed this practice in response to professional criticism, an increasing supply of physician applicants, and a dramatic slowing of the demand for, and growth of, addiction treatment. The majority of recovering physicians were hired between 1891 and 1894 when the Keeley Institutes were experiencing explosive growth. Of the 131 recovering physicians hired to work within the Keeley Institutes, only 12 were hired after the year 1900, and only one between 1910 and 1950. The use of recovering physicians faded alongside the broader demise of addiction treatment in America between 1900 and 1920. It would take more than fifty years to rebirth a national system of addiction treatment in which physicians would again return in large numbers to care for alcoholics and addicts in specialized treatment settings.

Postscript

The use of recovering people to work with alcoholics rose again in the early 20th century under the influence of the lay therapists of the Emmanuel Movement, but there were few recovering physicians caring for alcoholics and addicts during this period.[33] When a fully developed and professionalized field of addiction medicine was reborn in the second half of the 20th century, recovered physicians again entered the field in significant numbersBmore than 200 by 1982.[34] While issues of technical competence and relapse continue to be of concern in isolated cases, recovered physicians in the modern era operate under quite different circumstances than their 19th century counterparts. Most enter the field having had their own addictions interrupted at a much earlier stage of physical and emotional deterioration. They begin work in addiction medicine with substantially longer periods of treatment and sobriety behind them. They have the benefit of both greater levels of professional training in addiction medicine prior to working in the field and superior models of clinical supervision. Today's recovered physicians are more likely to have their sobriety and their professional practice monitored by the larger medical community. They also have greater access to addiction recovery mutual aid societies, including groups specifically for recovered physicians.

A debate raged in the 19th century between those who believed that recovering addicts brought special knowledge and sensitivities that could enhance their work in addiction treatment, and those who believed that the recovering addict brought vulnerabilities that outweighed any such assets. On a clear day, the century long echo of this debate can still be heard.

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Addiction as a Disease: The Birth of a Concept

William L. White

First in a series on the history and future of the disease concept of addiction.

Are alcoholism and other addictions diseases? If so, what manner of diseases are they, and how can they best be treated? If not, then how else do we understand and respond to such conditions? Do we need more than one organizing concept to embrace the myriad patterns of harmful alcohol and other drug (AOD) use? What personal, professional and social consequences flow out of these different frameworks for viewing AOD-related problems?

Such questions have been the subject of heated debate in America for more than 200 years. The heightened crescendo of this debate leaves open the question of how this country and her citizens, and how we as addiction counselors, will understand and respond to AOD problems in the 21st century.

Ideas and Language: What is at stake here?

The ideas and words we use to frame AOD problems matter, and they matter at many levels.

At a personal level, such concepts can serve a preventative function, facilitate early self-recognition and self-correction of AOD problems, or provide a metaphor for transformative change for those in serious trouble in this person-drug relationship. When ill-chosen, these concepts can fail to perform these important functions.

At a community level, these concepts declare what people and institutions we want to have cultural ownership of AOD problems. Whether such ownership is in the hands of a priest, a police officer, a physician, a psychiatrist, a social worker, or a political activist affects the community as a whole, the fate of individual organizations and whole fields of professional endeavor, as well as innumerable careers. The debate over the disease concept and its alternatives cannot be easily separated from these broader interests.

For those who have been given ownership of AOD problems, these concepts, at their best, offer precision in problem diagnosis and the selection of effective interventions.

The nature of interventions into people's lives, for good or for bad, flows directly from these conceptual foundations.

The concepts we use to portray AOD problems also serve larger cultural, social, and economic agendas as they are differentially applied to people of different ages, races, genders, social classes and sexual orientations. It is only in viewing such contextual influences that we can understand how one drug-involved person is viewed as suffering from a disease and offered health care resources while another drug-involved person is viewed as a criminal and is incarcerated.

The debate over the disease concept of addiction is not a meaningless intellectual exercise. Any framework for understanding AOD problems will exert a profound influence on the lives of individuals, families, social institutions, and communities. The fact that these concepts must "work" at so many levels and the seeming intractability of AOD problems in the history of America have contributed to the conceptual instability of the AOD problem arena. No addiction model has ever fully replaced its competitors; radically different conceptualizations of AOD problems have always co-existed, and our citizenry has always been ambivalent about whichever model claimed temporary prominence.

Our task for the coming months will be to explore (in this continuing series of articles) the history and future of one such framework: the disease concept of addiction.

The Birth of the Disease Concept of Addiction

The conceptualization of chronic drunkenness as a disease did not originate in America. References to chronic drunkenness as a sickness of the body and soul and the presence of specialized roles to care for people suffering from "drink madness" can be found in the ancient civilizations of Greece and Egypt. Isolated and periodic references to chronic drunkenness as a disease, and even occasional calls for state-sponsored treatment, continued through the centuries before the first European migrations to America.

It took a lot to birth a disease concept of alcoholism in America. A breakdown of community norms that had long contained drunkenness in colonial America and a shift in consumption patterns from fermented beverages to distilled spirits led to a dramatic (nearly three-fold) increase in alcohol consumption between 1790 and 1830. In face of these changes, several prominent individuals "discovered" addiction and called for a new way of understanding and responding to the chronic drunkard.

Anthony Benezet In 1774, the philanthropist and social reformer Anthony Benezet expressed his alarm at changing drinking practices in colonial America. In the first American treatise written on alcoholism, Benezet challenged the prevailing view of alcohol as a gift from God. He christened alcohol a "bewitching poison," described "unhappy dram-drinkers bound in slavery," and noted the tendency for drunkenness to self-accelerate ("Drops beget drams, and drams beget more drams, till they become to be without weight or measure.").

Benjamin Rush Benezet's warning was followed in 1784 by Dr. Benjamin Rush's *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body.* Rush achieved five things with this highly influential pamphlet. 1) He medically catalogued the signs of

acute and chronic drunkenness. 2) He introduced a more medicalized language into the discussion of intemperance by describing "persons addicted to ardent spirits" and by declaring that chronic drunkenness was an "odious disease" and a "disease induced by a vice." 3) He medically confirmed Benezet's observation about the progressiveness of intemperance by noting that such episodes "gradually increase in their frequency." 4) He offered medical speculation about the causes of this disease. 5) He provided the first recommended treatments for chronic drunkenness based on a disease concept of addiction. Rush later used this embryonic disease concept to call for the creation of a special facility (a "Sober House") to care for the drunkard.

Lyman Beecher In the Reverend Lyman Beecher's *Six Sermons on the Nature, Occasions, Signs, Evils, and Remedy of Intemperance* delivered in 1825, we find a growing bridge between moral and medical views of drunkenness. Beecher declared that the intemperate are "addicted to the sin," referred to intemperance as an "evil habit" fueled by "an insatiable desire to drink," observed that intemperance can "hasten on to ruin with accelerated movement," and, then detailed the exact warning signs of this addiction to drink. Beecher concluded his sermons by declaring: "Intemperance is a disease as well as a crime, and were any other disease, as contagious, of as marked symptoms, and as mortal, to pervade the land, it would create universal consternation." Where Benezet and Rush had described the consequences of chronic drunkenness, Beecher described the process of becoming a drunkard and he did so by offering his listeners and readers a remarkably modern checklist of the warning signs that mark the loss of volitional control over alcohol consumption.

Samuel Woodward In the 1830s, the prominent physician Samuel Woodward, recommended the creation of special asylums for the treatment of the inebriate. Woodward described how intemperance was a "physical disease which preys upon his (the drunkard's) health and spirits... making him a willing slave to his appetite." Woodward aptly described the paradoxical entrapment of the drunkard whose source of woe and source of greatest comfort were both to be found in alcohol. He spoke of the role of heredity as a causative factor in chronic drunkenness, evoked powerful images of "the never-dying worm of intemperance...preying upon his [the drunkard's] vitals," and described the way in which the quantity of alcohol consumed by the intemperate must be ever increased to sustain its effect. Woodward believed that the drunkard should be taught the nature of his disease.

> *Show to him...the reason why the case is not controllable by the will, that it is a physical evil, a disease of the stomach and nervous system, and entirely incurable while the practice is followed*...

William Sweetser Dr. William Sweetser reflected a very modern understanding of disease and the complexities of viewing chronic drunkenness in this framework when he argued in 1829 that intemperance directly and indirectly created a "morbid alteration" in nearly all the major structures and functions of the human body. He believed many individuals "addicted to intemperance" were vulnerable to such alterations as a result of heredity or accidental circumstance. Sweetser viewed cycles of compulsive drinking for such individuals as the product of a devastating paradox: the poison--alcohol, was, itself,

its only antidote. Sweetser had great difficulty reconciling his emerging medical understanding of addictive disease with American ideas of free will and personal responsibility. His worries reflect tensions that will continue for nearly two centuries.

> *Now that it (intemperance) becomes a disease no one doubts, but then it is a disease produced and maintained by voluntary acts, which is a very different thing from a disease with which providence inflicts us....I feel convinced that should the opinion ever prevail that intemperance is a disease like fever, mania, &c., and no moral turpitude be affixed to it, drunkenness, if possible, will spread itself even to a more alarming extent than at present*.

Roots of Addiction Medicine We can see in these late 18th and early 19th century writings of Benezet, Rush, Woodward and Sweetser a cluster of ideas that will become the building blocks of an emerging disease concept of alcoholism: biological predisposition, drug toxicity, morbid appetite (craving), pharmacological tolerance, disease progression, inability to refrain from drinking, loss of volitional control over quantity of alcohol intake, and a detailed accounting of the biological, psychological, and social consequences of chronic drunkenness. We also see in these early writing the struggle to distinguish drunkenness as a vice from drunkenness caused by disease. Early disease concept advocates did not view intoxication itself as a disease, but as a potential symptom of disease. The disease itself was portrayed as: 1) the cluster of physical and social problems produced by chronic drunkenness, and 2) the "ungovernable appetite" that overwhelms willful choice and control of alcohol intake. We also see (in everyone following Rush) a clear opinion that the only hope for the diseased drunkard is complete and enduring abstinence from all forms of alcohol and other drugs—as Woodward would advise: "nothing stimulating, both now and forever."

These early writings stand out not because they represented the dominant view of their day, but because the then controversial ideas of these men marked the beginning of an experiment in conceptualizing drunkenness and the drunkard in a fundamentally new way. The gadfly call for a medicalized view of intemperance in the late 18th and early 19th centuries was bolstered by rapidly expanding knowledge about the physical effects of excessive alcohol consumption. This new knowledge, which ranged from the first studies of delirium tremens to the discovery of the toxic effects of alcohol on the stomach, blood, and nervous system, reached a pinnacle in 1849 in the work of the Swedish physician Magnus Huss. Huss's landmark study bolstered this emerging disease concept and gave the condition a new name: alcoholism. After detailing the multiple organ systems effected by chronic alcohol exposure, Huss noted:

> *These symptoms are formed in such a particular way that they form a disease group in themselves and thus merit being designated and described as a definite disease...It is this group of symptoms which I wish to designate by the name Alcoholismus chronicus.*

The works of Rush, Woodward, Sweetser and Huss called attention to chronic drunkenness as a problem that physicians should study and treat. As physicians took up

this challenge, the terms “drunkenness” and “intemperance” gave way to a more medicalized language that designated this newly formulated disease and the sufferer: *inebriety/inebriate*, *dipsomania/dipsomaniac*, and *alcoholism/alcoholic*. It was during this time that the term “disease” (of alcoholism) was used to designate a real thing that was believed to have a power and life of its own.

Next: the application of the disease concept to drugs other than alcohol and the role of the disease concept in America’s first mutual aid societies and treatment institutions.

William L. White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

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The Addiction-Disease Concept: Its Rise and Fall in the 19th Century

William L. White

Second in a series on the history and future of the disease concept of addiction.

In the last article, we explored the way in which new "disease" conceptions of addiction emerged and co-existed alongside the more popular perceptions of chronic intemperance as a product of sin, vice, indulgence, and habit. We noted how the speeches and publications of prominent social reformers, clergy, and physicians had birthed a disease concept of addiction, defined core elements of this concept, and catalogued the wide-ranging consequences of what Magnus Huss, in 1849, christened *chronic alcoholism.*

In this article we will describe the limited role the disease concept played in 19th century alcoholic mutual aid societies, the application of this concept to drugs other than alcohol, and the major role the disease concept played in 19th century addiction treatment. We will also hear from some of the earliest critics of the disease concept.

19th Century Mutual Aid Societies

There were many formally organized alcoholic mutual aid societies in the 19th century: The Washingtonians, the fraternal temperance societies, the reform clubs and such institutional aftercare associations as the Ollapod Club and the Godwin Association. None of these groups made the disease concept a centerpiece of their movements, but nearly all tended to see the roots of inebriety more in medical terms than in moral terms. From the Washingtonian literature of the 1840s we read, "He (the drunkard) knows and feels that drunkenness with him is rather a *disease* than a *vice,"* and we find a large gathering of Keeley League members sitting under a banner in 1892 that reads, "The Law Must Recognize a Leading Fact, Medical not Penal Treatment Reforms the Drunkard." But it should be emphasized that the disease concept was a peripheral concept for America's earliest alcoholic mutual aid societies.

What the 19th century alcoholic mutual aid societies did emphasize was the power of public commitment to total abstinence, alcoholic-to-alcoholic "experience sharing," sober fellowship, and service to other alcoholics. Little time was spent in these societies pondering how one became an alcoholic and none used the concept of "disease" as an organizing metaphor for personal sobriety.

"The Opium Disease"

As a medicalized concept of addiction rose on the American cultural landscape, a unique class of drugs sought the embrace of this concept. Epidemics of infectious disease and a spectrum of other painful medical disorders rendered 19th century Americans of all

ages in need of and vulnerable to the effects of narcotic drugs. The oft-times indiscriminate dissemination of opiate-laced medicines by physicians, the pervasive presence of a predatory patent medicine industry, and such technical developments as the isolation of morphine from opium and the introduction of a perfected hypodermic syringe all contributed to a rise in narcotic addiction. Whatever suffering medicine could not cure in the 19th century, morphine and the hypodermic syringe could alleviate.

The cultural perception of opiate addiction evolved over the 19th century from that of a misfortune, to that of a vice, to proposals that such dependence should be viewed as a disease. The latter view emerged in tandem with the growing awareness of the addictive properties of opium. By the 1850s, the power of opium over human will was increasingly illustrated by such aphorisms as: “It is not the man who eats Opium, but it is Opium that eats the man.”

While the dominant profile of the 19th century opiate addict was a white, middle-aged woman, opiate use was publicly linked to Chinese immigrants at a time (the 1870s) of heightened racial and class conflict surrounding the question of Asian immigration. The creation of America’s first ‘dope fiend’ caricature slowed the perception of opiate addiction as a medical disorder and injected the issue of racism into the public perception of opiate use. This was true even where the disease concept prevailed. Eating and injecting opiates—the pattern most prevalent among affluent whites—was referred to as a disease, while the smoking of opium—a pattern associated with the Chinese—was consistently labeled a vice.

In the face of America’s first anti-“drug” (opium) campaign, attacks on the disease concept of narcotic addiction increased, even from physicians. One of the most outspoken critics of the disease concept of opiate addiction was Dr. C.W. Earle of Chicago.

> *It is becoming altogether too customary in these days to speak of vice as disease...That the responsibility of taking the opium or whiskey...is to be excused and called a disease, I am not willing for one moment to admit, and I propose to fight this pernicious doctrine as long as is necessary.*

By the 1880s, addiction specialists were using terms such as “the drug vice” and “dreadful habit” to describe opiate addiction at the same time they described patients who “continued until the drug produced its *own disease.”* This mixture of moral and medical language was common in the addiction literature of the 19th century. The conceptualization of “morphinism” as “a disease of the body and mind,” while still poorly developed and quite controversial, began to slowly move into the mainstream medical literature. Simultaneously, addiction to alcohol and other drugs were embraced within a new term, *inebriety*, that captured a wide variety of drug choices, patterns of use, and types of resulting problems.

The Disease Concept of Inebriety

During the second half of the 19th century, a multi-branched profession emerged that specialized in treatment of alcohol, opium, morphine, cocaine, chloral, and ether inebriety. The story of specialized treatment institutions based on a disease concept of

inebriety begins with the opening of the New York State Inebriate Asylum in 1864, whose founder, Dr. Joseph Turner, had long advocated such a concept. In 1870, the superintendents of several inebriate asylums and homes established the American Association for the Cure of Inebriety (AACI). The first four founding principles of the AACI were the following.

1. *Intemperance is a disease.*
2. *It is curable in the same sense that other disease are.*
3. *Its primary cause is a constitutional susceptibility to the alcoholic impression.*
4. *This constitutional tendency may be either inherited or acquired.*

The AACI's *Journal of Inebriety* published hundreds of disease-themed papers that were joined by a growing number of medical texts on inebriety that advocated a disease concept of addiction. The flavor of these writings can be illustrated from the work of two of the most prominent leaders of the AACI.

Dr. Joseph Parrish, the founding spirit of the AACI, summarized his views on inebriety in 1888. He began by distinguishing between drunkenness as a vice and drunkenness as a disease, noting that the latter was fueled not by weakness of moral character but by a pathological and nearly irresistible appetite for alcohol.

> *It is the internal craving for alcoholic liquors, and for their intoxicating effect, that constitutes the disease, and not the fact of drunkenness.*

Parrish, like many 19th century inebriety specialists, didn't so much reject the view of drunkenness as vice as suggest that a line could be crossed where drunkenness evolves into a disease that is no longer under the conscious control of the drinker. He believed that there were multiple sources for this disease process but that the most significant of such sources were of biological origin. According to Parrish, heredity provided a "moral and physical predestination" that made a drunkard of one while protecting his neighbor from a similar fate.

Like Parrish, Dr. T.D. Crothers believed that the disease of inebriety had multiple causes (e.g., heredity, illness, emotional excitement, adversity), presented itself in quite varying patterns (e.g., chronic, intermittent), and required highly individualized treatments. What Crothers considered the "disease" was the "constitutional proclivity, or neurosis" which fueled excessive alcohol and other drug use. Crothers believed that such proclivity often had a physical source and manifested itself in a morbid appetite that ignited the manic pursuit of intoxication. Crothers had a special interest in how this concept could be reconciled with questions of human will and responsibility.

The disease concept of inebriety was the centerpiece of the work of Parrish, Crothers, and other leaders of the medical wing of the AACI. They saw this concept as the foundation of the movement to treat inebriety medically and scientifically and to garner support for specialized institutions where inebriates could be treated.

The proprietary addiction cure institutes of the 19th century also used the disease concept to buttress their marketing efforts. Franchised chains of addiction cure institutes, often bearing the names of their founders—Keeley, Gatlin, Neal, Oppenheimer—

advertised that inebriety was a disease that could be cured with the purchase of their injections or bottled cures. Later exposés related to the presence of alcohol, opiates and cocaine in such products helped undermine the credibility of the disease concept that was used to promote these alleged cures.

19th Century Disease Concept Critics

Support for a "disease concept" was by no means unanimous among those who cared for the inebriate. The most fully articulated opposition to the disease concept among the inebriate institutions came from the leaders of the Franklin Reformatory for Inebriates in Philadelphia. Dr. Robert Harris expressed the philosophy of this institution as early as 1874, when he declared the following:

> *As we do not, either in name or management, recognize drunkenness as the effect of a diseased impulse; but regard it as a habit, sin, and crime, we do not speak of cases being cured in a hospital, but "reformed."*

Leaders of the Franklin Reformatory attacked the disease theory as "a weak apology for the sin of drunkenness" and a "blasphemy against God." At the same time, they portrayed the inebriate as the victim of a society that through its promotion of drinking seduced the innocent into an unbreakable habit. We see in these views the struggle to reconcile the idea of free will with metaphors of slavery and entrapment that mark the growing emergence of the concept of addictionBa concept that was calling into question the limits of human will.

Some of the strongest attacks on the disease concept were rooted in an alternative view of chronic drunkenness proposed by evangelical Christians. This view, which found its practical application in religious revivals, the urban mission movement, and religiously sponsored inebriate colonies, viewed drunkenness as a sin against God that could only be cured by religious conversion. The tension surrounding the disease concept of inebriety reflected the different ways science and religion were defining the source and solution to the problem of intemperance. Many of those concerned about alcohol and other drug problems in the 19th century had difficulty defining the exact nature of these problems. Phrases like "addicted to sin," "moral disease," and "disease induced by a vice," and the interchangeable use of such terms as "habit," "indulgence," and "disease" represent the enduring confusion and ambivalence about the precise character of such problems. Many tried to reconcile these seemingly conflicting views by arguing that there existed a continuum of human will in which one could choose to begin drinking, choose to continue to drink, but at some point lose the power to not drink.

The Fate of the First Disease Concept

The disease concept of the 19th century competed against three alternative views of alcohol and other drug problems. One view, which we have highlighted, concurred that the source of the problem was in the person but defined the problem in terms of vice and sin. The second view portrayed the source of the problem not in the person but in the

product (alcohol, particularly distilled spirits, opium, and cocaine). A third view contended that America's drug problems were being caused by the aggressiveness with which alcohol and other drug use were being promoted by new distilleries and breweries, a new corruption-plagued institution (the saloon), and by physicians and pharmacists. Quite different proposals to solve America's alcohol and other drug problems emerged from each of these views. These contrasting views co-existed throughout the 19th century with each vying for prominence.

The disease concept as a purely medical concept fell out of favor at the end of the 19th century in tandem with the fall of the treatment institutions in which it had been imbedded. The demedicalization of addiction rose in the wake of alcohol and drug prohibitions movements that took their turn trying to resolve America's alcohol and other drug problems. Temporarily swept away was the language of "disease" and many elements of this embryonic concept: biological vulnerability (propensity), tissue tolerance, morbid appetite (craving), progression, obsession, and behavioral compulsion. We shall see in future articles how the core elements of the 19th century's disease concept of addiction will come to be rediscovered and how they will again stir new debates regarding their scientific validity and their moral consequences.

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The Rebirth of the Disease Concept of Alcoholism in the 20th Century

William L. White

Third in a series on the history and future of the disease concept of addiction.

The first article of this series described the rise of a disease concept of intemperance in the late 18th century, the extension of this concept to opiate and cocaine addiction, the prominent role of the disease concept in 19th century inebriate asylums and homes, and the diminishing popularity of the disease concept as the 20th century opened. This article will trace the addiction-disease concept through the 20th century, depicting its hibernation, re-emergence, and commercialization.

1900-1942: Dormancy

America's first addiction-disease concept was swept away in the transition between the 19th and 20th centuries. While individual physicians continued to advocate various disease concepts of addiction, the overall definition of alcohol and drug problems shifted from a focus on a vulnerable minority of users to a focus on the inherent "badness" of the drugs and the persons and institutions profiting from their sale. Cultural pessimism about the potential for permanent recovery, combined with exposés of fraudulent cures, contributed to a dramatic decline in addiction treatment and the rise of laws banning the non-medical use of alcohol, narcotics, and cocaine. Alcoholics and addicts, once "patients" worthy of sympathy, became "common drunkards" and "dope fiends" portrayed, at worst, as moral weaklings and criminals, and, at best, as dangerously insane.

This transition in attitude reflected and continued to fuel changes in state and federal laws. The Harrison Act of 1914 brought narcotics and cocaine under federal control by designating physicians as the gatekeepers for the legitimate distribution of these drugs. Subsequent Supreme Court decisions and law enforcement policies inadvertently shifted responsibility for the care of addicts from physicians to criminal syndicates. The voices of physicians who protested this change on the grounds that addiction was a treatable disease were silenced amid the larger cultural redefinition of the addict from that of a sick person worthy of sympathy and support to that of a psychopath deserving isolation and punishment.

Even when disease metaphors were used in the early 20th century, they were expressed in language that emphasized the danger the addict posed to the community. Winifred Black in her 1928 best seller, *Dope: The Story of the Living Dead*, depicted drug addiction as a "a wasting, loathsome, hideous, cruel disease" and portrayed the addict as a "carrier" of a disease "worse than smallpox, and more terrible than leprosy." The sequestration that Black and others called for was not in medically-directed specialty institutions but in federal penitentiaries.

The advent of Prohibition in 1919 similarly altered the country's perception of and response to the alcoholic. By the early 1920s, the bold 19th century proclamation that alcoholism was a disease had become a dying whisper that faded with the treatment institutions it had spawned. As the addiction disease concept fell from popularity and as specialty institutions closed, the care of alcoholics and addicts shifted to penal institutions (inebriate colonies and "drunk tanks") to the "foul wards" of large public hospitals and to the fledgling field of psychiatry. Most psychiatrists of this era framed excessive alcohol and other drug use not as a primary disease, but as a superficial symptom of underlying psychological disturbance. The important intervention, according to this theory, was treatment of the hidden, unconscious forces that drove excessive drug use.

Psychiatry's reluctant assumption of responsibility for the problems of alcoholism and narcotic addiction had two notable outcomes. First, it formed the theoretical foundation for what were quite humane efforts to find effective treatments. These included the Emmanuel Clinic model and its use of recovered alcoholics as lay therapists, the treatment of affluent alcoholics and addicts in private hospitals and sanatoria, and eventually new outpatient alcoholism clinic models in Connecticut and Georgia.

More ominously, this view subjected alcoholics and addicts to whatever psychiatric treatments were in vogue and to prevailing social policies toward the mentally ill. Thus, alcoholics and addicts were swept under the umbrella of mandatory sterilization and legal commitment laws in the early 20th century, and were subjected to often lethal withdrawal regimes, psychosurgery (prefrontal lobotomies), chemical and electroconvulsive therapies, and drug therapies that eventually included barbiturates, amphetamines, and LSD. Alcoholics and addicts, where they could be admitted, were subjected to the worst abuses of mental health institutions.

The importance of the early 20th century to our story is what it reveals about the consequences of abandoning a disease concept of addiction in the absence of an alternative concept that "works" at personal, professional, and cultural levels.

AA and the Disease Concept: A Complex Connection

It is difficult to pick up a book advocating or attacking the disease concept of alcoholism/addiction without having Alcoholics Anonymous credited as the source of the modern disease concept of alcoholism. Yet considerable evidence challenges this popular belief. When AA co-founder Bill Wilson was asked in 1960 about AA's position on the disease concept, he offered the following response:

> "We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore, we did not wish to get in wrong with the medical profession by pronouncing alcoholism a disease entity.

> Therefore, we always called it an illness, or a malady – a far safer term for us to use."

AA's use of medical terms reflects not an observation on the source or nature of alcoholism but its belief about the solution. When Wilson asked Dr. Bob Smith, AA's other co-founder, to comment on the accuracy of referring to alcoholism as disease or one of its synonyms, Smith scribbled in a large hand on a small sheet of his letterhead: "Have to use disease – sick – only way to get across ***hopelessness***." AA's use of medical metaphors served as a reminder of its belief that the alcoholic could never again safely drink alcohol.

In a paper that looks specifically at whether AA was the source of the disease concept, historian Ernest Kurtz, author of *Not God: A History of Alcoholics Anonymous*, summarizes his review of AA literature and practices:

> "On the basic question, the data are clear: Contrary to common opinion, Alcoholics Anonymous neither originated nor promulgated what has come to be called the disease concept of alcoholism. In the major texts of AA, there appear no discussions and bare mention of "disease," much less of the disease concept of alcoholism. Its paucity of mention in the officially published works suggests that this understanding is hardly central to the thought of Alcoholics Anonymous. Yet its members did have a large role in spreading and popularizing that understanding. Most AA members, in the year 2000 no less than in 1939, will tell an inquirer that their alcoholism has physical, mental, emotional, and spiritual dimensions. The contribution of Alcoholics Anonymous is not the idea of *disease* but of *threefold* disease – the realization that the alcoholic had problems in the physical, the mental, and the spiritual realms, the clear understanding that alcoholism is, as described on page 44 of *Alcoholics Anonymous*, 'an illness which only a spiritual experience will conquer.' Did AA's use the disease concept of alcoholism? Yes. Did AA's or AA originate or rediscover or dogmatically push the disease concept of alcoholism? Clearly, No."

What AA did contribute inadvertently to the disease concept – its goal was not to understand alcoholism but to help alcoholics–was its members' collective experience. This experience reflected:

- the reality that alcoholism had a physical, as well as a mental and a spiritual, component
- the potential helpfulness of medical metaphors ("illness," "allergy") in making sense of drinking experiences
- the portrayal of alcoholism as an accelerating process
- the importance of concentrating on drinking behavior rather than searching for underlying causes

- a belief that loss of control over alcohol could be contained only by complete abstinence from alcohol.

AA was not the source or promoter of the disease concept that emerged in the 1940s as a public policy slogan and an organizing construct for alcoholism treatment. AA's peripheral use of such medical metaphors was not a declaration of science but a simple statement of collective experience. ("It explains many things for which we cannot otherwise account." *Alcoholics Anonymous*, xxiv)

1942-1970: Modern Movement

The source of a rediscovered addiction disease concept in the mid-20th century begins with three organizations: the Research Council on Problems of Alcohol (founded in 1937), the Yale Center of Alcohol Studies (1943), and the National Committee for Education on Alcoholism (1944). RCPA, Yale, and NCEA collectively provided the driving force behind the "modern alcoholism movement" – a term intended to convey a focus on alcoholism, rather than on alcohol or the broad spectrum of alcohol-related problems. This movement met the cultural need to escape a century of polarized wet-dry debates and provided these organizations with hope for institutional funding of their research and educational agendas. The newly defined problem was the unique vulnerability of a small subpopulation of drinkers.

In 1942, Dwight Anderson of the RCPA published a seminal article in the Quarterly Journal of Studies on Alcohol in which he advocated a sustained public education campaign to reframe alcohol problems in terms of sickness rather than vice. Anderson proposed four "kinetic ideas" as the centerpiece of this campaign.

- The problem drinker is a sick man, exceptionally reactive to alcohol.
- He can be helped.
- He is worth helping.
- The problem is therefore a responsibility of the healing professions as well as health authorities and the public.

When Marty Mann founded NCEA in 1944, she integrated Anderson's ideas into her own proposed campaign, but she incorporated the words "alcoholism" and "alcoholic" into Anderson's kinetic ideas and added a fifth element, which she listed first:

- Alcoholism is a disease.

Mann spent the rest of her life leading the campaign to change America's conception of alcoholism and the alcoholic and to create local resources for alcoholism treatment and recovery.

The model of alcoholism treatment that most exemplified the disease concept subsequently emerged from the synergy of three programs in Minnesota: Pioneer

House (1948), Hazelden (1949), and Willmar State Hospital (1950). This model drew heavily on the experience of AA members in its conceptualization of alcoholism as a primary, progressive disorder whose management required sustained abstinence and an active, continuing program of recovery.

The story of the disease concept and the modern alcoholism movement would be incomplete without noting the influential work of E.M. Jellinek at the RCPA and Yale. Jellinek's *Disease Concept of Alcoholism* (1960) stands as the most widely cited (and least read) literary artifact of the modern alcoholism movement. In it, Jellinek noted the growing acceptance of the disease concept of alcoholism but expressed his reservations about this oversimplified understanding of the disorder.

He suggested that there were a variety of "alcoholisms," only two "species" of which he thought merited the designation of disease, and went on to criticize the tendency to characterize alcoholism as a single disorder. Jellinek's concern reflected that of other scientists who, even as the disease concept was being culturally embraced, feared a future day of reckoning for this simplistic portrayal of alcoholism. Among these scientists was Dr. Harry Tiebout, AA's first friend in the field of psychiatry and a leading supporter of the modern alcoholism movement, who as early as 1955 raised such fears:

> "[T]he idea that alcoholism as a disease was reached empirically by pure inference. It had never been really proved. ... I cannot help but feel that the whole field of alcoholism is way out on a limb which any minute will crack and drop us all in a frightful mess. To change the metaphor, we have stuck our necks out and not one of us knows if he will be stepped on individually or collectively. I sometimes tremble to think of how little we have to back up our claims. We're all skating on pretty thin ice."

Two new mid-century addiction treatment modalities influenced thinking about the application of the disease concept to drugs other than alcohol. First, the therapeutic community emerged as a treatment modality for drug addiction. Most early TCs rejected the disease concept, isolated themselves from AA and Narcotics Anonymous, and instead based their treatment on the process of character reconstruction.

Second, methadone maintenance became the major approach to the treatment of narcotic addiction. MM pioneers in both their theoretical orientations and their clinical procedures viewed opiate addiction as a metabolic disease.

1970-2000: Concept Extension and Backlash

By 1980, it appeared that many of the goals of the modern alcoholism movement were being achieved. The movement had extended its influence into major cultural institutions (media, law, medicine, religion, education, business and labor). There was growing professional and public acceptance of the proposition that alcoholism was a disease. The country had established national institutes that advocated medical

research on addiction and public health approaches to alcohol and other-drug related problems. People from all walks of life, including First Lady Betty Ford, were publicly declaring their recovery from alcoholism. The disease concept was being applied to a wide spectrum of other drugs and behaviors as recovery briefly became something of a cultural phenomenon. There was an explosive growth of treatment programs – particularly hospital-based and private programs – that used the disease concept.

The most widely replicated treatment approach in both private and public programs was the Minnesota Model, which perceived addiction as a primary disease. In short, the disease concept altered the public's conception of the alcoholic and challenged medical and public health authorities to take responsibility for the treatment of alcoholism – a significant achievement.

Every significant social movement has the potential to generate a counter-movement, and this happened with alcoholism movement. The backlash came in two forms. The first was a financial backlash against the business-practice excesses of the treatment industry. Aggressive programs of managed care that restricted treatment access and duration led to a plummeting daily census within, and the eventual closing of, many inpatient programs. Particularly impacted was the prototype 28-day inpatient treatment program that had most exemplified the disease concept. The second backlash was ideological and took the form of growing philosophical and scientific attacks on the disease concept and the treatment programs based on it.

The 20th century ended without popular or professional consensus on the nature of alcohol and other drug problems and the strategies that could best resolve these problems at a personal or cultural level. Scientific breakthroughs in genetics and neurobiology that promised to bolster the disease concept were offset by scientific findings that challenged some of the basic tenets of this concept. Such conceptual confusion left critics and advocates alike speculating about the fate of the addiction disease concept in the 21st century.

Next: Disease concept components, critics and criticisms.

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Addiction Disease Concept: Advocates and Critics

William L. White, M.A.

Editor's note: In the first articles of this series, William L. White traced the evolution of the disease concept of addiction from the 18th century to the dawn of the 21st century. He noted its early rise and subsequent fall from prominence, its resurrection in the mid-20th century, and the subsequent growing debate in the late 20th century regarding its scientific credibility and personal and social usefulness. In this article, he explores the typical arguments between critics and advocates of the disease concept of addiction.

For more than 200 years, America has vacillated over the question of whether excessive drug use is a disease, an illness, a sickness, a malady, an affliction, a condition, a behavior, a problem, a habit, a vice, a sin, a crime, or some combination of these. A new century opens with debate over this question raging ever more intensely.

Both advocates and critics of the addiction disease concept (DC) include recovering people, physicians, psychiatrists, addiction counselors, addiction researchers, alcohol/drug policy experts, and leaders in the arenas of business, law, theology, and education. The fact that neither group speaks with one voice demands considerable care in our synthesis of the prevailing themes within the pro-disease and anti-disease camps. (Where intra-group disagreement exists, the competing positions will be numbered.)

Rational arguments about the DC can mask other issues that fuel the intensity of this debate: 1) personal survival and recovery, 2) professional rivalries over alcohol/drug-problem ownership, 3) financial interests (both personal and institutional), and 4) broader social and political agendas. This is a debate not just about ideas, but about the future of personal and professional lives as well as institutions and communities. The harsh collision of these interests helps account for exchanges that often generate more heat than light. Linda Mercadante has aptly described the risks taken when one enters the heart of this debate.

> *Today, the assertion that alcoholism is a disease is "sacred." It has achieved a level equivalent, in theological terms, to dogma: a fundamental, non-negotiable, undergirding belief. Alcoholism as disease is so foundational that one cannot deny it without distancing oneself from the believing community.*

There are other circles within which the rejection of the disease concept constitutes an equally dogmatic litmus test of credibility and inclusion. This is all a way of saying that we are about to enter hazardous territory.

Our focus in this article will not be to take sides in this debate, but to synthesize as objectively as we can the propositions and counter-propositions that are at the center of this controversy.

Overview

DC Advocates: The addiction disease concept should be embraced for both its social and personal utilities. It conveys the seriousness of alcoholism/addiction to those suffering from it and to the public at large. It designates public health authorities as the agents responsible for the prevention and treatment of the condition and encourages the development of local facilities for the treatment of addiction. The DC replaces moral censure and criminal punishment of the alcoholic/addict with unprejudiced access to health care institutions. It relieves guilt and increases help-seeking behavior. The DC provides an organizing construct through which the addicted client, his or her care providers, and those in the wider family and social environment can understand the nature of his or her problem (disease), the manifestations of that problem (symptoms), the potential causes of that problem (etiology), the natural evolution of that problem (course), interventions that are available to diminish or eliminate this problem (treatment options), and the likely outcome of such interventions (prognosis). The addiction disease concept is true and it works as an organizing construct for both the individual and society.

DC Critics: The addiction disease concept has survived only because of its historically brief social utility and the interconnected organizational empire that continue to profit from it. It should be abandoned because it is scientifically indefensible, fails to provide an adequate framework for prevention, strips the alcoholic/addict of freedom and responsibility, and is misapplied to types of alcohol/drug problems for which it is ill-suited. Labeling alcohol/drug problems as incurable diseases is stigmatizing and dissuades many heavy drinkers from seeking help. By restricting its definition of vulnerability for alcohol problems to a small group of alcoholic drinkers, the disease concept has allowed the alcohol/drug industries to escape culpability for their product and promotional practices.

The DC has led to the misdirection of public resources in the areas of research, prevention and the management of alcohol/drug problems. The addiction disease concept is not true, does not work and is harmful to individuals and communities.

Nature and Etiology of Alcohol/Drug Problems

DC Advocates: Alcoholism/addiction is a chronic primary disease suffered by the biologically susceptible drinker. It is a unitary entity and not symptom of any other disorder. Addicts are different from non-addicts. One either has or does not have the biological risk for addiction. According to one prominent DC advocate, alcoholism is a true medical disease rooted in abnormalities in brain chemistry bio-chemical aberrations that are inherited by the majority of alcoholics and, in some cases, acquired through intense

and sustained exposure to alcohol and other drugs. Alcoholism and other addictions are comparable to such other chronic diseases as asthma, adult onset diabetes, and hypertensive disease.

DC Critics: 1. Sustained and excessive alcohol/drug consumption is not a physical disease but a symptom of an underlying emotional disorder or a failed attempt at self-cure of that disorder. 2. As unique clinical entities, alcoholism and addiction do not exist. These concepts are empty words used by well-intentioned but misguided people to medicalize socially deviant behavior. 3. Alcohol and other drug problems are a result of complex personal, interpersonal and environmental factors and are not the manifestation of a genetic disease. No such disease exists. What does exist is the *behavior* of excessive alcohol/drug use that can over time become a deeply ingrained *habit.* Alcoholics are not a distinct group, but exist on a continuum of drinking behavior and drinking consequences. All people who consume alcohol and other drugs are vulnerable for potential consequences related to such use, and these personal and social consequences are directly related to the frequency, intensity and duration of consumption. The focus should not be on the so-called *alcoholic* and this mythical disease *alcoholism*, but on how to alter drinking/drugging behavior that is personally and socially harmful.

Course and Natural Outcome

DC Advocates: Alcoholism is a progressive disease that with continued drinking self-accelerates toward insanity or death. While sustained symptom remission is possible, it is not curable/reversible. The symptoms and stages of this disorder are extremely consistent in their character and sequence, varying only by gender and drug of choice. Such consistency allows for clear diagnosis and the delineation of early, middle and late stages of the disorder.

DC Critics: There is considerable variability in the onset, course and outcome of alcohol and other drug problems and even variability in the same individual over time. Alcohol and drug problems are inherently self-limiting. As frequency and intensity (volume) of consumption increases in tandem with aging, the probability of deceleration or cessation of use increases. This is confirmed in studies of controlled drinking, spontaneous remission, natural recovery or maturing out.

Most individuals who experience alcohol problems eventually shed such problems either by moderating their drinking or stopping their drinking without the aid of professional treatment or support group involvement.

Craving and Loss of Control

DC Advocates: Addiction disease is defined by the presence of two conditions: 1) a morbid, uncontrollable physical craving that fuels preoccupation and drug seeking behavior, and 2) a loss of control over alcohol/drug consumption. Loss of control can take

two forms: the inability to consistently refrain from alcohol/drug use and the inability to consistently control the quantity or duration of use once drinking or drug use has started.

DC Critics: The concepts of craving and loss of control lack scientific credence. Craving is little more than memory, and loss of control as something that happens every time the alcoholic starts drinking is scientifically untenable. Alcohol and other drug intake is under the volitional control of the user. Loss of control is a learned (acquired) behavior that can be consciously unlearned (discarded).

What is called loss of control is a cognitively mediated behavior produced by the belief the "one drink, one drunk" dictum that prevents alcoholics/addicts from developing moderated patterns of use.

Treatment

DC Advocates: Medical expertise is often needed to resolve alcohol/drug-related problems, and alcoholics and addicts deserve access to treatment on par with persons suffering from other medical disorders. The only legitimate goal of treatment is sustained abstinence from alcohol and other mood-altering drugs. (Nicotine and caffeine historically excluded here.)

The most effective model for treating alcoholism is the Minnesota Model of chemical dependency treatment. Treatment works: It is clinically effective and cost effective. The remission rates following addiction treatment are comparable to those for other chronic diseases. Treatment outcomes for those externally coerced into treatment are comparable to those who enter treatment voluntarily.

DC Critics: 1. Treatment is a failed social experiment that has turned into a multibillion-dollar fraud. Most alcoholics recover not because of treatment but because they heal themselves. Public funds should not be used to support addiction treatment. 2. The most positively evaluated treatments (e.g., community reinforcement approach, cognitive-behavioral skills training, brief motivational interviewing) are not among the most frequently offered interventions for alcohol and other drug problems.

Mainstream approaches need to be expanded to include treatments that have greater scientific support. Abstinence as an exclusive treatment/recovery goal needs to be expanded to include the option of moderate drinking for some individuals. Coerced treatment is a violation of human rights and is not only ineffective but also harmful.

Mutual Aid Societies

DC Advocates: Life-long affiliation with Alcoholics Anonymous, Narcotics Anonymous or another 12-program is the most viable sobriety-based support structure for sustained addiction recovery. The best single predictor of long-term recovery can be found in the degree of sustained participation in AA/NA.

DC Critics: The majority of people who resolve alcohol/drug-related problems do so without affiliation with any mutual aid society. Enduring involvement in AA locks those with alcohol/drug problems into a closed social world inhabited only by others with such

problems. It simply replaces one form of unhealthy dependence with another. Emphasizing the usefulness of recovering addicts as lay and professional helpers identifies alcoholics/addicts as persons worthy of emulation while ignoring those who act responsibly to avoid such problems. Twelve-Step groups are little more than religious cults; coercing someone to AA/NA or 12-step-oriented treatment constitutes a violation of human rights and professional ethics.

Personal Culpability/Responsibility

DC Advocates: The alcoholic/addict is not responsible for his or her condition. People do not set out to willfully become addicted. The factors that separate the drinker who goes on to be an alcoholic and the non-problematic drinker are not factors over which the alcoholic has control.

Drinkers, and even heavy drinkers, drink by choice; alcoholics drink and get drunk in violation of their own intention not to and with full knowledge of the consequences and self-disgust that will follow.

Addiction is not a habit that can simply be consciously cast off, but a disease of the body and the will. Addiction is a no-fault disease. Once alcoholics/addicts are made aware of the nature of their condition and the steps that can be taken for its resolution, they become responsible for initiating and managing their own recovery.

DC Critics: The disease concept of addiction provides an excuse for past personally and socially destructive conduct as well as a rationale for continued drinking. Excessive drinking and/or drug use is not an addiction; it is a choice.

Alcoholics/addicts choose to become intoxicated, choose to continue to become intoxicated, and refuse to choose to be anything other than an addict. Such choice is driven not by disease but by weakness of character, “criminal self-indulgence,” or “love of degrading vice.”

The alcoholic/addict is responsible for when, where and how much they use as well as the consequences that accrue from such use. At worst, addiction is a habit under the control of the will (as demonstrated by those who quit smoking) that can be broken like any other habit. The disease concept has taken freedom and responsibility from the individual and replaced it with professional power and governmental coercion.

Stigma

DC Advocates: The moral and social stigma attached to alcoholism/addiction contributes to the minimization and denial of alcohol/drug-related problems, prevents or postpones help-seeking behavior, and contributes to the social isolation of the alcoholic/addict and his or her family. Stigma closes doors of service by rendering the alcoholic/addict less qualified for healthcare services than someone who suffers from a “real” sickness, e.g., an innocent who cannot be held morally responsible for their problems. The disease concept has played a major role in reducing such stigma and opening the doors to treatment and recovery.

DC Critics: Stigma helps reduce alcohol problems and helps the alcoholic. Any effort to reduce the stigma of addiction will do a disservice to the alcoholic by reducing pressures to moderate consumption and could have the additional unintended effect of increasing the prevalence of addiction. What is needed is not less but more stigma attached to personally destructive and antisocial patterns of alcohol and other drug consumption.

Rhetorical Extremes and Personal Animosities

The prior propositions and counter-propositions capture the views of the most prominent and perhaps fanatical disease concept advocates and critics. Such summaries provide only a glimmer of the extremes to which the arguments and tempers on both sides of this debate have reached.

Training events that touch on this debate have deteriorated into intense acrimony between participants wedded to extreme pro- and anti-disease positions, disease critics have been personally accused of killing people with their ideas, and each new article and book seems more strident than those that came before. (A just-released book by Jeffrey Schaler declares: “The idea that addiction is a disease is the greatest medical hoax since the idea that masturbation would make you go blind.”) In the face of such rhetorical excesses, one would be quite justified in expressing concern about the future of this debate and its implications for addicted individuals, families and communities, to say nothing of the field of addiction treatment,

It is this author’s view that the disease concept that emerged in the mid-20th century was a beautiful concept for its time. It “worked” in the truest sense and it worked at personal, professional and cultural levels. However, this concept enters the 21st century with: 1) a poor scientific foundation; 2) a narrowly defined clinical profile that does not reflect the diversity of individuals seeking help for alcohol- and other drug-related problems; and 3) a poorly defined boundary that leaves it open to continued corruption and commercial exploitation.

The future of the disease concept will hinge on the ability of the addiction field to redefine this concept in light of accumulated scientific research and accumulated clinical and recovery experience.

Next: Is there a way out of this polarized disease debate? A proposal for a disease concept for the 21st century.

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A Disease Concept for the 21st Century

William L. White

In the first three articles in this series, we reviewed the history of the disease concept of addiction in America from its birth in the 18th century through its collapse, rebirth and rising prominence in the 20th century. We also noted the emergence and growing stridency of an addiction disease debate and isolated the major points of contention between addiction disease advocates and critics. In this final article, I will cast aside the role of historian and offer my own conclusions and proposals regarding this concept and its future.

Toward a Better Disease Model

When Alcoholics Anonymous was first publicly criticized in a 1963 magazine article, A.A. cofounder Bill Wilson responded in the *A.A. Grapevine.* Rather than attacking the author or defending A.A., Wilson took the position that A.A. members should view critics as benefactors and that A.A. should use criticism lodged against it to self-assess and improve A.A. Those of us who have long-professed that addiction is a disease would be well-served by Wilson's example. Rather than defending an overly rigid concept, it would be better to acknowledge the weaknesses of the disease concept as historically constructed and to reformulate a disease concept that is more clinically and culturally dynamic and more scientifically defensible. Improving the addiction disease concept stands as a viable alternative to the critics' strident call for its abandonment.

William Miller warned in 1993 that the current disease model was inadequate to explain or resolve the wide spectrum of alcohol-related problems. This article builds on his proposal to construct a modernized disease concept within the rubric of a public health approach to disease prevention and intervention--an approach that provides a balanced focus on the agent (the drug), the vulnerability of the host (the drug consumer) and the (physical/cultural/legal) environment.

The Tower of Babel.

The new disease concept will forge consensus on a language that can be used to

differentiate types and intensities of alcohol- and other drug-related problems. Any conceptualization of such problems must contain a core set of words and ideas that can simultaneously: 1) help individuals construct or change their relationship with psychoactive drugs, 2) guide professional helpers in organizing and evaluating their interventions into drug-related problems, and 3) help communities and societies understand and manage these problems in the aggregate.

E.M. Jellinek, in his classic 1960 text, noted that the debate over the disease concept was plagued by too many definitions of alcoholism and too few definitions of disease. The continued proliferation of terms and their unclear meanings (alcohol/drug dependence/abuse/addiction/ problems, chemical dependency, substance abuse/misuse, disease, illness, sickness, malady, condition, habit) has created a virtual Tower of Babel within the on-going disease concept debate. To transcend the unproductive rhetorical excesses of this debate, a basic vocabulary of words and meanings must be forged.

One of the first definitions needed is that of *disease*. The addiction field must follow the rest of medicine in moving away from the depiction of disease as an entity to an understanding of disease as a metaphor. "Disease" is a *word* and an *idea* used to convey substantial, deteriorating changes in the structure and function of the human body and the accompanying deterioration in biopsychosocial functioning. To suggest that disease is a metaphor does not diminish the devastating reality that the term depicts, but it does suggest that this reality may constitute a process rather than a "thing."

Alcoholism to Addiction

The new disease concept will shift from an alcoholism model to a more encompassing addiction model. It will define the boundaries of its application to particular drugs, declaring the concept's relevance or misapplication to tobacco, opiates, cocaine and other stimulants, cannabis, and other licit and illicit psychoactive drugs. It will incorporate the latest advances in biomedicine to answer the question of whether personal vulnerability to addiction is drug-specific, drug-category specific, or expansive across a range of substances and experiences.

Boundary Integrity

The new disease concept will carefully map its conceptual boundaries, defining the conditions and circumstances to which it should and should not be applied. The concern here is that a concept can be diluted, distorted, over-extended, commercially exploited, and over-used to the point that its utility is destroyed. The history of the concept of "co-dependency" provides a vivid example of what can happen under such circumstances. If the concept of co-dependency taught us anything as a field it is that when a concept begins to be applied to everything, it ceases to have meaning applied to anything.

The area of greatest trouble is the application of the concept of *addiction* and *addictive disease* to include *process addictions*--harmful relationships with food,

relationships, sex, work, gambling, etc. It is the "etc." that is particularly problematic. Americans already speak of being "addicted" to everything from bowling to television shows, self-describe themselves as "chocaholics," "shopaholics" and every other kind of "aholic," and apply the term "disease" to everything from violence to the use of profanity. The new disease concept will carefully re-establish and then guard its boundaries to prevent its continued over-extension and financial exploitation. To draw this boundary will require nothing short of defining the very essence of addiction and its roots.

Addictions versus Problems

The new disease concept will place alcoholism/addiction within a larger umbrella of alcohol- and other drug-related problems. The consumption of alcohol and other drugs contributes to a large spectrum of personal and social problems: fetal drug exposure, drug-impaired driving, drug-influenced crime and violence, and underage and binge drinking, to name just a few. An undefined portion of these problems are not the product of alcoholism and other drug addictions, do not constitute "disease" states, and should not have a traditional disease model of intervention applied to them.

The new disease model will seek to delineate alcohol and other drug "problems" from alcohol and other drug "addictions" and distinguish the prevention and intervention strategies that should be applied to each. It will seek to clearly specify the conditions that must be present to declare the presence of "alcoholism" or "addiction" and further argue (in the tradition of E.M. Jellinek) that an AOD problem be declared a "disease" if, and only, if certain specified conditions are present.

The field of professionally directed addiction treatment cannot have it both ways. It cannot (without great harm to itself and its clients) continue to clinically define alcoholism and addiction in narrow terms and then, for reasons of professional and institutional gain, misapply this narrow model to an ever-expanding array of drug-related and non-drug-related problems. If the field continues to rely solely on a narrowly prescribed addiction intervention model, then ethically it must refuse to treat the wider pool of individuals with AOD problems for whom this model is inappropriate and potentially harmful. If the field embraces the larger spectrum of people with AOD (and other) problems within its purview (which it has), then it must significantly expand its potential treatment goals and intervention technologies (which it has not).

The new disease concept will acknowledge the differences in these populations and create a wider menu of treatment goals and technologies that can be selectively applied to these different but overlapping populations.

Disease Variability

The new disease concept will portray addiction as a cluster of disorders that spring from multiple, interacting etiological influences and that vary considerably in their onset, course, and outcome. This refined concept will incorporate rather than deny existing research on etiological factors, pattern variability and outcome variability.

The new disease concept will create taxonomies that delineate the clinical subpopulations that make up these divergent patterns and will move to a much more sophisticated approach to differential diagnosis and individualized treatment/recovery planning. To move the disease concept in this direction is not a call to break tradition but a call to return to earlier traditions, from the 19th century inebriety specialists understanding of "diseases of inebriety" to Jellinek's "alcoholisms."

The new disease concept will, for example, proclaim within its framework that:

- addiction is not caused solely by genetic or biological factors but by multiple interacting factors, a status that places it squarely within the rubric of other chronic diseases,
- not all addictions are progressive (accelerating), some remain stable but enduring while others decelerate, just like many other chronic diseases,
- patterns of spontaneous remission and maturing out exist in addiction just as they do with many other chronic diseases, and
- the movement from an AOD problem to a level of continued alcohol and drug use below the priming dose of problem activation is common in those with transient AOD problems but rare in those with patterns of severe and persistent addiction.

Determining just how common or how rare these variations are is an important question, one that needs to be moved from the arena of rhetorical debate to the arena of research. The "truth" on many of these contentious issues will be found in the space between the polarized positions of the most rabid disease advocates and critics.

Comorbidity

The new disease concept will define the complex inter-relationships between addiction and other acute and chronic disorders and champion integrated models of care for the multiple problem client/family. Alcoholism and other addictions can result from and contribute to other diseases. These comorbid conditions interact synergistically to debilitate, compromise recovery, and shorten lives. The longer addictive disease is active, the higher the risk for collateral disorders. A major challenge for the new disease concept will be to define the interaction between addiction and other disorders, discover strategies to prevent the onset and severity of comorbid conditions, and generate principles for the co-management of these conditions.

Multiple problem clients have become the norm in addiction treatment agencies across the country. These clients, many with long and complicated service histories, have not fared well in America's categorically segregated service system. They frequently report histories of service exclusion, service extrusion, premature service disengagement, repeated episodes of relapse and treatment re-engagement, and even treatment episodes that were more harmful than beneficial. The new disease concept will provide a framework through which the needs of these clients can be met by strategically

integrating the resources of multiple formal (professional) and indigenous helping institutions.

Role of Human Will

The new disease concept of alcoholism /addiction will define the role human will and personal responsibility play in the onset, course, and outcome of AOD problems and of alcoholism/addiction. Are alcoholics/addicts responsible moral agents who perpetrate acts of mayhem on themselves, their families and their communities, or are they victims of a disorder that undermines their values and best intentions? What is the effect of the answer to this question upon the individual alcoholic/addict and upon the society in which he or she resides?

The new disease concept will provide a more accurate and nuanced answer to this primary question, not in terms of whether addiction is or is not a choice, but by depicting how the freedom to use or not use varies across clinical populations and within the same individual across the stages of drug use, addiction, and recovery.

It will be helpful to plot the degree of freedom one has to use or not use across the stages of problem development and problem resolution. Alcohol/drug use, addiction and recovery are best portrayed not in terms of complete control and complete lack of control but in terms of degrees of diminishment or enhancement of voluntary control. Once educated, each person has a responsibility to:

- manage his or her own health,
- recognize his or her potential vulnerability for AOD disorders,
- act proactively to prevent the onset of such disorders,
- recognize the presence of such disorders, and
- act decisively to arrest and manage the disorder.

Most chronic diseases are characterized by risk/resiliency factors related to daily diet, work habits, exercise, sleep, stress management, psychoactive drug consumption, exposure to environmental toxins, specifically contraindicated (high-risk) behaviors, personal beliefs, and social support.

The new disease concept will emphasize the responsibility of the individual to actively manage these global health issues as an integral part of the daily process of long-term recovery.

The Variety of Recovery Experiences

The new disease concept will celebrate the variety of styles and pathways of long-term recovery management. Ernest Kurtz, the noted author of *Not-God: A History of Alcoholics Anonymous*, recently observed that if he were to write a follow-up to his original work, he would entitle it “Varieties of A.A. Experience.” What has become clear in recent decades is the enormous variety of ways that people are resolving AOD-related problems. This

reflects not only the growing varieties of 12-Step group experience that Kurtz suggests, but the equally significant proliferation in alternative support structures, alternative treatment approaches, and solo (without aid of treatment or mutual aid) recovery experiences.

What will flow out of the new disease concept is not “a program” that everyone goes through, but a menu of professionally-directed interventions, recovery support services, mutual aid groups, indigenous healers/institutions, and self-engineered (potentially manual-guided) programs of recovery that individuals can select for personal and cultural fit.

The challenge for the treatment professional will be to remain continually aware of the evolving choices on this menu and to help match menu items to the needs of their individual clients. Rather than be defensive about the fact that people are finding a variety of ways to resolve AOD problems, it is time we celebrated the growing diversity of the culture of recovery.

Recovery Management

The new disease concept will view addiction as a chronic rather than acute disorder and incorporate the principles of chronic disease management that are being used to understand and manage other chronic disorders. Alcoholism and other addictions have long been characterized as chronic diseases, but their treatment has been marked by what is essentially an acute care model of intervention.

All too often we respond to life-impairing and life-threatening episodes of chronic addiction disease with sequential episodes of brief, expensive, emergency-oriented interventions that do little to alter neither the overall course of addiction nor its personal and social costs.

The new disease concept will focus on interventions that strengthen and extend the length of remission periods, reduce the number of relapse events, reduce the intensity and duration of relapse episodes, and reduce the personal and social costs associated with such episodes.

It will achieve this by applying to the management of addiction recovery not just the new breakthroughs in addiction science, but also the new principles and techniques that are being successfully used to manage other chronic diseases.

Viewing recovery through this much longer time lens will require that the helper-client relationship move from a brief, expert-focused model of intervention to a partnership model of long-term disease/recovery management.

A Final Word

The addiction disease concept will continue to face two quite different litmus tests: 1) Is the disease concept true? 2) Does the disease concept work? Answering these will require achieving some degree of consensus as a professional field and as a society about how we know something is true and how we know whether something works, tasks

not as simple as they might seem. That the concept of “disease” has provided alcoholics an organizing metaphor for personal change and provided America a framework for organizing a response to her alcohol-related problems is undeniable.

However, there is still a question of whether additional or alternative metaphors would reach a larger number of those suffering from severe AOD-related problems and provide a more effective framework for organizing broad social responses to the prevention and management of AOD-related problems.

I believe that the disease concept of addiction has “worked” at personal, professional and community levels within particular historical periods and within particular cultural contexts. However, it is unlikely to survive as the dominant “governing image” for AOD problems unless it is able to continuously incorporate the following: 1) the new findings of addiction science, 2) major elements of the emerging public health model, and 3) the ever-accumulating lessons of clinical and recovery experience.

Nowhere is the gap between clinical research and clinical practice wider nor where there are more contradictions between treatment philosophies and treatment practices than in the application of the disease concept to the treatment of AOD problems. The fate of the disease concept rests in great part on closing these gaps and resolving these contradictions.

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The History of Addiction/Recovery-Related Periodicals in America: Literature as Cultural/Professional Artifact

Barbara Weiner and William White

Abstract

Can significant changes in the addictions field be identified by examining its specialized literature? Are political, economic, and cultural changes surrounding addiction and its treatment mirrored in its literature? In this paper an addictions historian/author (William White) and an addictions librarian/information professional (Barbara Weiner) examine the past 150 years of addiction/recovery history by analyzing the literature of the field. Over 250 American journal, magazine, and newsletter titles were examined for their focus, audience, and years of publication to identify important trends and cycles reflected in addiction/recovery-related periodical literature.

Key Words: *history, addiction literature, periodicals, journals, recovery publishing.*

I. Introduction

The story of a profession can be told through an exploration of its history, language, values, rituals, symbols, and literature. This paper combines the expertise of an addictions librarian and an addictions treatment/recovery historian to describe the evolution of addiction/recovery-related periodicals (ARPs) over the past 150 years. This paper explores what the periodic rise, changing character, and fall of ARPs reveal about the larger history of addiction treatment and recovery in America. The alcohol and other drug problems field is made up of diverse functions and institutions – formal prevention and treatment programs, informal mutual aid groups, scientific research institutes, personal growth movements, public policy bodies, education and advocacy agencies, and professional associations representing physicians, nurses, counselors, psychologists, and social workers. Addictions periodicals play an integral part in linking these various constituency groups. We will examine the history of the addictions

periodicals that have served to link these various constituency groups.

This is not the first effort to step back and examine ARPs. Andrews and Cohen (1979) and Boxenbaum and Jaffe (1982) provided independent reviews of the emergence of addiction-related periodicals that were birthed in the 1970s. These early review articles were followed by analyses of the evolving topical focus of articles in ARPs (Moll and Narin, 1977; Van Ruyven and Veenstra, 1993), analyses of the impact of particular ARPs via citation analysis within the broad arena of addiction literature (Jones, 1999), guides on where to publish addiction-related research manuscripts (Arciniega and Miller, 1997), and trend analyses of such issues as the rise of multiple authorship in ARPs (Jones, 1996; Howard, 1992; Howard and Walker, 1996).

This article is distinguished from these earlier efforts in three ways. First, it views this genre of literature within a much longer historical perspective. Second, it provides a widened perspective on ARPs by including--in addition to peer-reviewed journals-- professional trade journals, magazines, and newsletters for both professionals as well as general readers. Third, it suggests that trends in ARPs provide a subtle window of exploration into past and emerging trends in the alcohol and other drug problems arena.

II. Methodology

We began this study by attempting to assemble a listing or chronology of all American ARP literature for the past 150 years. Collections utilized included the Illinois Addiction Studies Archive housed at Chestnut Health Systems in Bloomington, IL (http://www.chestnut.org/), the Hazelden Library and Information Resources collection in Center City, MN (http://www.hazelden.org/library), and the online listing for the Alcohol and Drug Abuse Institute of Seattle, WA (http://depts.washington.edu/adai/). Also examined were *Ulrichs International Periodicals Directory* 2000, the *Serials Directory: An International Reference Book* 1999, the OCLC database, and serendipitous approaches such as word of mouth and advertisements. Our list of ARP titles continued to be added to and updated throughout the writing of this paper, until the paper became finalized in October 2001.

“ARP" was defined to include journals, newsletters, and government items--anything produced in serial and periodical form rather than monographic form. We defined “addiction/recovery-related” in the broadest sense, from publications that focused on the neurobiology of addiction to those that focused on treatment research and protocol to those written as mediums of personal support for persons in addiction recovery. When adding to the list, we focused on finding periodicals which were professional or non-professional in focus, regional or local or national in geographic scope, and published by any entity (private or public). The chronology of more than 200 collected titles was placed into a graph listing the title, publisher, date started, date ceased or still current (as appropriate), format, focus, and intended audience. The chart was manipulated to more easily analyze specific factors, such as date started, date ended, focus, or audience, and was then analyzed by various factors, looking for numbers, trends, and conclusions.

Several difficulties were immediately encountered when assembling this literature chart: inconsistencies, inaccuracies, lack of documentation (especially for regional or historical items), title changes, and title mergers. These difficulties are examined in detail in the discussion section of this paper

It is necessary to clearly detail the scope of what was and was not included in this chart, and thus the scope of this paper as well. First, titles were limited to American periodicals – those published in the United States. Rare exception was made for scientific journals published elsewhere, but whose existence exerted significant influence in America (e.g., *Addiction* and *Alcohol and Alcoholism*). Excluded were alcohol industry trade publications, consumer magazines (such as *Wine Spectator*), temperance and prohibition publications that were not serials, and the history of pro-drug periodicals, (e.g., *Marijuana Review*, *High Times*, and *High Society*). Our topical boundary for inclusion was that of addiction and the process of recovery from addiction and not the larger umbrella of alcohol consumption. For example, we did not include magazines such as *Wine Spectator.* Our focus was instead on those serial publications whose subject matter included the nature of addiction, its treatment, and the process of recovery. We did include periodicals such as those that addressed alcohol-impaired driving that often included articles on alcoholism and its assessment and treatment. Recognizing that there may exist a great many regional titles which did not surface during our searching, we listed as many of these titles as possible, and tried to have examples of those published by a variety of entities. Of the more than 260 titles examined, 25 were government publications, 33 were published by associations or societies, 14 originated from universities, 57 came from traditional publishing houses, 10 were the product of foundations, 121 came from other private sources, and 15 could not be categorized. Many of these titles were professional (39%) (written by or for professionals, some peer-reviewed), some were for a general (non-professional) audience (8%), others were clearly designed for both a professional and general audience (7%), and the rest could not be determined with precision. Finally, the complete title list we utilized represented 103 newsletters, 96 journals, 3 newspapers, 11 magazines, 7 others (annuals, serials, bulletins), and the format was uncertain for 58 of the titles.

Title names used in this paper are the most recent name in use, not necessarily the name used when the periodical was first started, e.g., *Alcohol Research and Health* rather than *Alcohol Health and Research World.*

III. The History of Addiction/Recovery-Related Publishing: A Brief Synopsis

The evolution of addiction/recovery-related publishing reflects, as it should, the evolution of the larger arena it represents. When the birth and death of addiction/recovery-related periodicals (ARPs) is charted by decade (see Table 1), four periods are evident:

1) Birth: the birth of ARPs in the 19th century and their subsequent demise in the early 20th century,
2) Rebirth: the rebirth of ARPs that accompanied the rise of the modern alcoholism movement in the 1940s and 1950s,
3) Explosion: the virtual explosion in ARPs between 1970 and 1990, and
4) Decline: the decline in the number of new ARPs and the demise of some existing ARPs between 1990 and 2001.

While Table 1 may seem to suggest that there was virtually no addictions publishing up to 1930, this is not necessarily the case. Temperance newsletters and other periodicals were published from the 1850s onward; however, most of these focused on alcohol rather than on alcoholism, treatment, or recovery. We included only those items that focused specifically on the "rescue of the drunkard". Our discussion of publishing within the Temperance era is provided in the narrative sections which follow.

An interesting extension regarding this chart would be to explore if the resulting pattern tells the story of the addictions field only, or is representative of the health care/human services field and related publishing enterprises as a whole. While this question was beyond the scope of our study, we would speculate that the chart reflects both field-specifc publishing trends as well as broader expansions and contractions in health-related publishing. Hughes and Oliveto (1990) examined this question and concluded that publications on alcohol-related problems had increased at or above the rate of growth of other science-and health-related publications.

The birth of a body of addiction literature accompanied what Harry Levine has christened America's "discovery of addiction" in the late 18th century (Levine, 1978). This discovery came at a time of dramatically rising alcohol consumption (Rorabaugh, 1979; Lender and Martin, 1982). This discovery generated early written tracts on alcohol and alcoholism, such as Anthony Benezet's *Mighty Destroyer Displayed* (1774) and Dr. Benjamin Rush's *Inquiry into the Effects of Ardent Spirits* (1785). Between 1830 and 1875, an assortment of moral and business entrepreneurs founded alcoholic mutual aid societies, inebriate homes, inebriate asylums, private addiction cure institutes, and bottled home cures for the "alcohol, tobacco, and drug habits". Individual tracts describing the nature of intemperance and the process of reform were written in this period, most in the growing body of temperance movement literature. One of the earliest tracts providing "reform" case studies was Sigourney and Smith's (1833) *The Intemperate and the Reformed.* The newsletters of the Washingtonians, an early alcoholism recovery mutual aid society that flourished between 1840-45, fraternal temperance societies, and early reform clubs mark the beginning of a specialized literature focusing on recovery. Most of these had a city, county, or regional readership, but some such as *The Organ of the Washington Temperance Benevolent Society and its Auxiliaries* (1841) did achieve widespread distribution (Blumberg and Pittman, 1991). There were also newsletters published by some of the earliest inebriate homes and asylums – such as *The Washingtonian* (Newsletter of the Chicago Washingtonian Home) (Blumberg, 1978).

Addiction/recovery-related periodicals increased in the closing decades of the 19th century. The periodicals of this era included institutional newsletters (such as the Keeley Institute's *The Banner of Gold* and *Golden News*) that served both as alumni/aftercare newsletters and marketing devices, institution-based professional journals such as Dr. Robert Parrish's *The Probe* (Pennsylvania Sanitarium for Inebriates), and Dr. H.H. Kane's *The American Journal of Stimulants and Narcotics* (De Quincey Home). There were also serialized marketing newsletters from such proprietary, bottled addiction cure purveyors as Dr. Haines Golden Specific and Knights' Tonic for Inebriates (White, 1998).

In 1870, a small group of the nation's first addiction medicine specialists founded the American Association for the Cure of Inebriety, later rechristened the American Association for the Study and Cure of Inebriety (AACI). Six years later, the AACI launched the most significant of the addiction journals of the 19th century: *The Quarterly Journal of Inebriety (JI)*. The AACI and its journal reflected a milestone in which heretofore independent institutions began to define themselves as a professional field. The first 5,000 copy issue of the *JI* released in December, 1876 was greeted by attacks from the religious press. Critics argued that the journal's portrayal of inebriety as a disease constituted an effort to "excuse crime and dignify vice" (Crothers, 1912). With the turn-of-the-century trend toward demedicalizing and criminalizing alcohol and other drug problems, the AACI and its journal struggled to define their niches within a rapidly changing

policy and professional environment.

There were a number of changes that signaled the struggles of the *JI* and its parent association. First there was a rise in competing organizations: the American Medical Temperance Association (1891) which published the *Bulletin of the American Medical Temperance Association,* and the Scientific Temperance Federation (1906) which published the *Scientific Temperance Journal*. *JI*'s new competition marked a cultural shift in focus from the vulnerability of the individual (alcoholism) to the pernicious power of the product (alcohol). Second, there were mergers that presaged the AACI's final collapse. The American Medical Temperance Association and the AACI merged in 1904 to create the American Medical Society for the Study of Alcohol and Other Narcotics. The *JI* continued under sponsorship of this merged organization (Blumberg, 1978). The *Journal of Inebriety,* which had been edited since its founding by Dr. T.D. Crothers, ceased publication in 1914. The collapse of the *Journal* signaled the approaching demise of the AACI in the early 1920s. The loss of addiction/recovery-related literature during this period reflected the larger collapse of an entire professional arena that would be reborn later in the 20th century (White, 1998).

Following Repeal of Prohibition, the founding of Alcoholics Anonymous and the rise of a "new science" approach to alcohol problems generated the "modern alcoholism movement" (Johnson, 1973; Roizen,1991) and a new generation of addiction/recovery-related periodicals. The 1940s and 1950s paralleled the earlier period in the types of literature: tracts (pamphlets), newsletters, and professional journals. The *Quarterly Journal of Studies on Alcohol (QJSA)* (1940) (later renamed the *Journal of Studies on Alcohol*) revived the likes of the *Journal of Inebriety*, with two important distinctions. First, the *QJSA* focused on alcohol rather than alcoholism, marking a shift from a clinical focus on alcoholism to a broader alcohol science focus. Second, the *QJSA* focused only on alcohol rather than the whole spectrum of psychoactive drugs that the JI had covered. This reflected the post-repeal split in social policies whereby the image of alcohol became culturally rehabilitated and celebrated while the opiates, cocaine, and cannabis were further stigmatized and criminalized.

The 1940s and 1950s also witnessed the spread of state and local alcoholism newsletters and journals aimed at both the general public and at special professional groups (particularly physicians and clergy). Some of the more noteworthy of these included:

- *Alcoholism: A Treatment Digest for Physicians* (New Jersey) (1940s)
- *The Connecticut Review on Alcoholism* (1940s)
- *The Louisiana Bulletin on Alcoholism* (1940s)
- *Utah Alcoholism Review* (1940s)
- *The Blue Book* (Annual Proceedings of the National Clergy Conference on Alcoholism) (1949)
- *Inventory: A Bimonthly Journal on Alcohol and Alcoholism* (North Carolina) (1951)
- *Challenge* (Alabama Commission on Alcoholism) (1959)
- *Lifelines* (South Carolina Commission on Alcoholism) (1959).

There were new institutional newsletters and recovery newsletters, reflecting the rebirth of both specialized treatment institutions and addiction mutual aid societies. During this period, most of the recovery-themed newsletters/magazines were published by mutual aid societies: *A.A. Grapevine* of Alcoholics Anonymous, *The Forum* of Al-Anon, and *The Key* of Narcotics Anonymous (which was followed by the *NA Newsletter*). It is worthy of note that, while there

were international journals (*British Journal of Addiction to Alcohol and other Drugs* and the *Bulletin on Narcotics*) that focused on addiction to drugs in addition to alcohol, there were few such journals in the U.S. during the 1940s and 1950s.

The quantity of literature generated by the 19th century inebriety movement (Birth) and the early (1940-1960) modern alcoholism movement (Rebirth) was minuscule compared to the virtual explosion in such literature between 1960 and the early 1990s. Of the 260 ARPs identified in our study, 202 began publication after 1960 (35 prior to 1960; 23 uncertain). This explosion in publishing activity resulted from two related phenomenon: (1) the massive infusion of federal, state, and private support for addiction treatment and (2) the emergence of "recovery" as a pop cultural phenomenon marked by an explosion in mutual aid groups and the application of the Twelve Steps of A.A. to a wide variety of human problems. The former created a mass professional appetite for addiction/treatment related literature and the latter created a mass market for recovery-themed periodicals. Accompanying the rapid proliferation of treatment centers was an equally dramatic growth (from less than five to more than 50) of American alcohol research centers between 1970 and 1990 (Babor 1993). The cumulative impact was an explosion of alcoholism-related scientific and clinical publications.

ARPs also became specialized in the closing decades of the 20th century. As the century ended, ARPs fell into the following categories:

Governmental Publications: The growing federal and state alcohol and other drug problems infrastructure generated an unprecedented level of publishing activity aimed both at professional and lay audiences. While state and regional level government publications began in the 1950s and 1960s, the number of these publications virtually exploded in the 1970s and 1980s. The more notable of the periodicals included *Alcohol Research and Health* (1972), *SAMHSA News* (1976), *NIDA Notes* (1985), *Alcohol Awareness* (1986), and *Alcohol Alert* (1988).

Peer-reviewed Research Journals: The growing professionalization within the alcohol and other drug problems arena was reflected in a dramatic increase in professional peer-reviewed journals. Some of the more notable additions to this body of literature include *Substance Use and Misuse* (1966), *Journal of Psychoactive Drugs* (1967), *Contemporary Drug Problems* (1971), *American Journal of Drug and Alcohol Abuse* (1974), *Drug and Alcohol Dependence* (1975), *Addictive Behaviors* (1976); *Alcoholism Clinical and Experimental Research* (1977), *Journal of Addictive Diseases* (1981), *Alcoholism Treatment Quarterly* (1984), *Journal of Substance Abuse Treatment* (1984), *Journal of Chemical Dependency Treatment* (1987), and the *American Journal on Addictions* (1992).

Professional Association and Trade Periodicals: There was a growing number of professional association newsletters and trade publications as the field of addiction treatment came of age. These fell generally into three categories. First, there were those aimed primarily at administrators and managers of substance abuse treatment facilities. These included such periodicals as *Journal of Alcohol Education* (1966-1971), *Washington Report* (1972), *NCADD Washington Report* (*Alcoholism Report*) (1972/1998), *NAATP Visions* (1975), *Monday Morning Report* (1977), *Of Substance* (1980*), Alcoholism and Drug Abuse Week* (1989), *Practical Communications: Accreditation and Certification* (1986), *NASADAD Alcohol and Drug Abuse Report : Monthly Report* (1987), *Drug Abuse Funding Monitor* (1991), *Treatment Today* (1993), and *Behavioral Health Management* (1980). There were also a genre of such newsletters that

were more clinically focused, such *as DATA (Digest of Alcoholism Theory and Application)* (1982), *ASAM News* (1985), and *Addiction Treatment Forum* (1992). A third genre of trade periodicals included those that were focused on getting information out to a larger community audience. These included periodicals concerned primarily with drug consumption trends such as *Drug Survival News* (1976), *Pharmalert* (1976), and *Street Pharmacologist* (1978) as well as those concerned with broader issues of alcohol and drug polices and recovery resources such as *Al-Anon Speaks Out* (1978) and *NCADD Amethyst* (1993).

Publications Focused on Specialized Populations or Specialized Roles: New ARPs published in the last three decades of the 20th century reflected the rebirth and coming of age of addiction treatment as well as its increasing specialization. There were new journals/newsletters aimed at special populations of clients such as the *Journal of Child and Adolescent Chemical Dependency* (1990); *Family Dynamics of Addiction Quarterly* (1991); *Alert: News of Alcoholism and Drug Addiction Services for Persons Who are Hard of Hearing* (1989); *Report on Alcohol, Drugs and Disability* (1992); *Drinking/Driving Law Letter* (1982); *Alcohol Drugs and Driving* (1985); *DWI Journal* (1986); and *California DUI Report* (1987). There were even specialized journals for those interested in drug policy (*Drug Policy Reports*, 1994), history (*Social History of Alcohol Review*, 1985) or literature (*Dionysos*, 1989).

There were new journals/newsletters aimed at the many professional roles that were becoming involved in addiction treatment. These included new periodicals for counselors (*The Counselor* and the *Professional Counselor*), psychologists (*The Addiction Newsletter* and the *Psychology of Addictive Behaviors*), physicians (*Journal of Addictive Diseases*), nurses (*Journal of Addictions Nursing*), clergy (*Journal of Ministry in Addiction and Recovery* and the *NCI Catalyst: Interfaith Action on Alcohol and Other Drug Problems*), and those working in the criminal justice system (*Journal of Addictions and Offender Counseling*), the workplace (*Employee Assistance Digest* and *Employee Assistance Quarterly*), and the schools (*Journal of Drug Education* and *Student Assistance Journal*).

There were even new journals that focused specifically on particular treatment modalities: *Journal of Maintenance in the Addictions* (1997), *TCA News* (Therapeutic Communities of America) (1989), and *National Drug Court Institute Review* (1998).

Institutional Newsletters Institutional newsletters such as *Findings* (Betty Ford Center, 1998), *Hazelden Voice* (1990), and *Sierra Quarterly* (1998) served, like their 19th century counterparts, as aftercare newsletters and marketing devices.

Recovery Newsletters/Periodicals During the 1980s, there was a significant increase in recovery-oriented publishing that began with small presses and expanded to the national publishing houses. By 1992, this new genre was being christened the “recovery boom”–a term that depicted the explosion in the publication of recovery-oriented literature and the emergence of addiction therapists as “new gurus” offering advice on a wide spectrum of human problems (Crichton, 1989; LeBlanc, 1991; Shore, 1991; Griffin, 1991; Dowd, 1992). But the peak of this publishing genre was short-lived. By 1994, *Publisher’s Weekly* declared that the recovery boom was over and was being replaced by a broader genre of literature focusing on spirituality (McCullough, 1994). Table 2 lists some of the more prominent recovery-themed journals and newsletters of this period.

In the late 1990s a new type of recovery-oriented periodical began to appear that was aimed not so much at personal recovery as recovery advocacy in the larger community and culture. These publications reflected the emergence of new grassroots advocacy organizations whose collective efforts came to be christened the New Recovery Advocacy Movement (White, 2000). Examples of new (1998-2001) publications reflecting this New Recovery Advocacy Movement and their sponsoring organizations include *The Voice of Recovery* (Recovery Communities United-Chicago), *FACTUALITY* (Friends of the Addicted for Comprehensive Treatment–New York City), *The Recovery Herald* of the Connecticut Community for Addiction Recovery, *Speak Out: Lesbian, Gay, Bisexual, and Transgender Voices for Recovery*--New York City, *The Ambassador* –Pennsylvania Recovery Organization, and the *Recovery Advocate* of the Substance Abuse and Addiction Recovery Alliance, Fairfax County, VA.

IV. Discussion

Table 3 presents a synopsis of our periodizing of the history of addiction/recovery related periodicals in the U.S. We found the following among the most important and interesting findings of our study.

Problems of Index Reliability.

- Inconsistencies and inaccuracies: Many inconsistencies and inaccuracies surfaced. SOBER TIMES, for example, is listed as current in OCLC and *Ulrichs*, suspended in 1995 in the *Serials Directory*, and considered ceased in 1995 in the Hazelden collection; the *Substance Abuse Lette*r is not found in OCLC or the Hazelden collection, shows a subtitle but no beginning date in *Ulrichs*, and includes a beginning date but no subtitle in the *Serials Directory*. Other titles, though, such as *Addictive Behaviors*, were found in all four of these sources, with matching information. Every effort was made to verify information from more than one source.

- Lack of documentation: Many titles, especially older, regional, government, or more unique items were not recorded into mainstream periodical reference books such as *Ulrichs*. No all-encompassing list of addictions/recovery periodical titles exists for either the historical or more current addictions literature. The existence of a comprehensive reference resource unique to addiction/recovery related literature would be an invaluable resource for researchers, historians, and others involved in the addictions field.

- Title changes and title mergers: When titles changed or merged, as was not uncommon, this produced great difficulties in recording and tracking. Should a title change become listed and counted as one periodical or two periodicals? Should mergers be listed by the current or previous title when all the titles are listed alphabetically?

- Many ARP titles are not found in mainstream reference or listing sources, include significant conflicting information where documentation does exist, and the frequent title changes and title mergers all created difficulty in tracking the life of ARP literature. Still, much useful and reliable information was assembled, verified by more than one source, and summarized into a literature chart that was as complete and accurate as we could construct.

Fugitive Literature. There is a large quantity of fugitive literature in the addiction field that escapes the notice of mainstream libraries as well as addictions libraries. For example, there

have been significant initiatives in the area of recovery advocacy (e.g., Society of Americans for Recovery) and new mutual aid groups (e.g., Secular Organization for Sobriety) whose histories are best reflected in newsletters that have not been included in the collection activities of most libraries. The archiving of such fugitive literature would constitute a significant contribution of the substance abuse librarian.

Durability. Of the titles evaluated, 174 are still in current publication, 53 did not present accurate start/stop dates, but the remaining 61 provided us with precise starting and ending dates. We evaluated the durability, or time in publication, for these 61 periodicals, divided into the four historical periods:

Birth	8 titles	averaged 20 years
Rebirth	8 titles	averaged 14 years
Explosion	35 titles	averaged 9 years
Decline	10 titles	averaged 3 years.

Titles from the Birth period had either very short or very lengthy durations; all titles from the Rebirth time had rather lengthy publishing lives; those in the Explosion period showed the greatest variability, from very short to much longer durations; and all the titles in the Decline period were in existence for a very short time frame. Thus for those periodicals which did cease publication over the past 150 years, there is a clear pattern of shortened life expectancy.

Frequency. Another factor in periodical growth is the change in frequency with which issues are published. Both *Alcohol and Alcoholism* and *Alcoholism Clinical and Experimental Research* changed from quarterly to bi-monthly production in the mid-1980s; the latter title also moved to nine issues a year in 1996, and then to a monthly in 1999. In the 1980s *Addiction* changed from a quarterly to a bi-monthly to a monthly by 1987. Such detail is not available for enough titles to present quantitative summaries, but the trend appears to be towards greater, rather than diminishing, frequency.

ARPs as Ephemera. The fact that we have continued to discover publications that do not appear in any of the traditional literature indexes suggests that short bursts of publishing activity could come and go without ever showing up on the radar screen of the addictions librarian. While much of the brief history of the Society of Americans for Recovery has already dissipated, issues of the *SOAR USA Bulletin* constitute important artifacts of this recovery advocacy organization. As another example, 19 new recovery advocacy organizations were funded by the Center for Substance Abuse Treatment in 1998 but less than half of these organizations received continuation funding in 2001. Some of these organizations may disappear even before their publications come to the attention of archivists and indexers. Under such a scenario, the only evidence of their existence 30 years from today could be the presence of a yellowed newsletter sitting on a table at a flea market or antique store. We believe that today's addiction/recovery-related ephemera is as important in documenting our current history as Temperance ephemera is to the reconstruction of the 19th century Temperance movement.

Artifacts of Ascension and Decline. Periodicals can be seen as artifacts that reflect the birth, evolving status, and death of particular institutions and professions. As might be expected, the number of journals and newsletters swells and shrinks as the fields they represent expand

and contract. As such, the birth of new journals/newsletters is an indicator of an emerging growth period of a field, and a decline in the number of journals/newsletters is one of the earliest signs of decline or demise of a field. Creation of the *Journal of Inebriety*, for example, reflected the professionalization of the field of inebriety treatment (Birth). It was through this act that the members of the American Association for Cure of Inebriety shift from seeing themselves as independent institutions to perceiving themselves as a new professional field. The demise of the *Journal of Inebriety* provided one of the earliest signals of what would be the eventual collapse of addiction treatment and the AACI as an organization. The sudden appearance of ten new journals/newsletters in the 1940s (Rebirth) signaled the rise of the modern alcoholism movement just as the continued rise of new journals/newsletters in the 1950s and 1960s reflected the further geographical extension of this movement. The publication of 27 new ARPs between 1970-1974 (and a total of 50 in the 1970s) (Explosion) marked the coming of age of this movement following passage of the Comprehensive Alcoholism Prevention and Treatment Act (commonly known as the Hughes Act) in 1970 that infused federal dollars into the development of local treatment programs. The 82 new ARPs that began being published in the 1980s (with only 10 ceasing publication) reflects the Camelot period for addiction/recovery publishing. This was followed by the 1990s with a period of contraction (Decline). In the 1990s there was a fall to only 58 new periodicals coming into existence, as well as an increase in titles ceasing publication (25 earlier ARPs ceased publication). The status of journals/newsletters mirrors the status of the organizational entities which they represent. Even subtle changes in journals/newsletters can, in retrospect, be read as indicating significant shifts in the character and health of an organization and a larger field of endeavor. The rise and fall of state, federal, or local government publications is frequent, and may indicate funding choices by new political officials. The fact that periodicals come and go may also reflect the temporary nature of some organizations rather than reflect the entire addictions field.

Subscription Levels. We suspect that the rise and fall of paid subscriptions to ARPs would provide an even more subtle indicator of the health of the addictions field if such data were accessible for analysis. In our search for year-by-year changes in subscription sales, we found such data to be withheld for proprietary reasons or sporadically reported. There are two hypotheses worthy of testing: 1) Subscription levels of existing ARPs rise and fall in tandem with the rise and demise of new ARPs, or 2) The subscription levels of existing ARPs decline in the face of new ARPs but will rise again as ARPs cease publication. Data for paid and/or requested copies of the *Journal of Studies on Alcohol (JSA)* (as reported in their annual year-end issues) would support the first of these contentions. *JSA* circulation rose in the 1970s, peaked in 1981-1982, remained relatively stable from 1982 to 1992, and was then marked by a progressive decline from 1993 to 2000. The data that we did find available in this area was plagued with erratic reporting over time and inconsistencies. For example, in seeking subscription data on the *Journal of Chemical Dependency Treatment*, the year 2000 circulation figure listed in the *Serials Directory* was 449 and the same figure listed in *Ulrichs* was 825. Financial troubles within the addictions field are quickly reflected in addiction library holdings. Library acquisitions may be particularly sensitive to the larger currents within the field as individual libraries reduce their number of subscription titles, forcing a decrease in publishers' subscriptions numbers.

Naming. The appearance of the (*Quarterly) Journal of Studies on Alcohol* in 1940 signaled by its title the "new science approach" to alcohol problems. The fact that it was labeled alcohol studies and not alcoholism studies or alcoholism treatment is significant in terms of the history of the movement of which it was a part–the strain between those wanting an alcohol

problems focus and those wanting an alcoholism focus, and the strain between academicians who wanted a research focus and clinicians and recovery advocates who wanted an activist (service) focus. The point is that the names of periodicals are significant and that the naming both reflects a field/organization at a point in time, but then continues to exert an influence on the identity of the field/organization (Stimmel, 1991).

Identity Confusion. When a field of endeavor is being birthed or re-birthed, the plethora of names reflected in the titles of its literature may reflect the struggle to shape and solidify the identity of the field. The wide disparity in language in the titles (alcohol, alcoholism, alcohol and drug problems, addictive diseases, drug dependence, drug abuse, chemical dependency, substance abuse) reflect a field struggling to define itself–a definitional challenge that has yet to be resolved.

Re-naming and Changing Identity. Changes in the names of periodicals reflect shifts in identity of professional fields. Changes in the name of a journal/newsletter can reflect 1) a clarified commitment to mission, 2) a struggle to find a field to represent, and/or 3) a diffusion and loss of mission. This instability of identity could reflect a field that is vulnerable for colonization by more powerful forces in its operating environment. If so, this would be reflected in the absorption of its periodicals within larger organizing umbrellas, e.g., the absorption of addiction periodicals into mental/behavioral health publications. In the addictions field we see several trends reflected in the renaming of ARPs:

- the movement of alcoholism and drug addiction from separate to integrated fields (the *Journal of Alcohol Education* is re-christened the *Journal of Alcohol and Drug Education* in 1972)
- the shift from a passing to a more enduring topical area (the *Journal of Psychedelic Drugs* is re-christened the *Journal of Psychoactive Drugs* in 1979)
- the separation of a specialty area of the addictions field into its own professional arena with diminished focus on alcohol and other drug issues (*Labor-Management Alcoholism Journal* becomes *Employee Assistance Quarterly*) or the integration of alcoholism and addiction into a larger behavioral health umbrella (the evolution of *Addiction and Recovery* and *Alcoholism and Addiction Magazine* into *Behavioral Health Management*).

Audience Extension and Specialization. Periodicals mirror a field's move via concentric circles toward audience expansion and specialization. This trend is evident in the addictions arena in the shift from generalist to specialist publications and the move beyond professional audiences to lay audiences. The former is evident in publications that focused on particular subpopulations or service contexts, and the latter is evident in the explosion of recovery oriented ARPs in the 1980s. Professional fields can become so extended that they birth new professional fields at the periphery. This was clearly the case with employee assistance and student assistance that started off within the addictions arena and then evolved into separate fields with their own specialty publications. The same process is unfolding in the study and treatment of such areas as eating disorders that started out enmeshed within the psychiatric and addictions fields/literature and have more recently pushed to create their own identity such as the publication of *Eating Behaviors: An International Journal*. An example of the boundary ambiguity of addiction/recovery related periodicals is the inclusion or exclusion of tobacco/nicotine addiction. Discussion and even full chapters (Crothers, 1893) on nicotine addiction were routinely included in nineteenth century addiction journals and texts, but became separated from

ARPs following the repeal of alcohol prohibition and state anti-tobacco laws in the 1930s. As a result, ARPs only recently began to take on the issue of nicotine addiction alongside discussions of alcoholism and other drug addictions. Future reviews of ARPs will likely need to include the wider span of literature on nicotine addiction and recovery.

Mergers. Mergers of two or more titles reflect a process of contraction that anticipates or mirrors a similar process of contraction within the larger professional arena. Several examples will illustrate this principle. The final demise of the *Journal of Inebriety* was preceded by mergers between the American Association for the Cure of Inebriety and other organizations and a merger of other journals with the *Journal of Inebriety*. The *Addiction Letter* merged with *Psychotherapy Letter* to become *Behavioral Health Treatment* only to cease publication in 1996. Most recently, *The Counselor* and *The Professional Counselor* merged in September 2000 to create *Counselor: The Magazine for Addiction Professionals*. This occurred following a six year erosion in the membership of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) (from 17,204 members in 1994 to 13,162 members in October, 2000), who had published *The Counselor* since its inception. All of this suggests the role of mergers in responding to either an over-saturation of ARPs or an overall contraction of the professional field that are the primary consumers of ARPs.

Recovery-oriented Periodicals. Several things are worthy of note within this genre of ARPs. First is the variety of formats such publications have taken over the past 150 years: pamphlets, circulars, newspapers, newsletters, journals, and magazines. The most enduring of the recovery-themed publications are the communication arms of mutual aid societies. The uninterrupted continuity of AA and Al-Anon newsletters are particularly noteworthy in light of the difficulty launching a national recovery magazine not linked to a particular recovery organization. In the failed efforts to establish a national addiction recovery magazine, there has been a shift toward periodicals focusing on the broader, ill-defined themes of spirituality and personal growth (Bearden, 1992).

Competition and Specialization. The dramatic expansion of ARPs in the 1970s and 1980s was spurred in part by the entrepreneurial competition within an emerging field and the resulting movement from generalist to specialists publications. The former can be seen from the dramatic growth of new ARPs between 1970 and 1985 with the 1990s evidencing a state of saturation and decline of new and existing ARPs. The latter were marked by a focus on particular types of client populations, particular types of professional roles, and particular types of service modalities. Prevention, treatment, and recovery publications all moved from the center of their identity toward more specialized definitions of AOD problems and their potential solution. Such specialization could constitute an inevitable stage of professionalization or a stage of dissipation marked by atrophy at the center, growth at the periphery, with a potential absorption of this problem area into more powerful institutions in the field's operating environment.

Impact of Technology. The authors had considerable discussion regarding changing technology and addictions/recovery periodical publishing. Internet publishing--and its resultant impact on the quantity of published material, distribution, cost, review, quality, archiving, and indexing--were all considered. We believe the current report on the status of addiction-related periodicals will constitute a helpful baseline from which to measure the enormous changes in publishing that will be created by this shift from paper to electronic publishing. The impact of the Internet on addiction/recovery related periodicals is a fertile area for future investigation.

The Addictions Librarian/Information Professional as a Trend Analyst

In closing this paper, we would like to acknowledge the invaluable role the addictions librarian/information professional plays in collecting and providing critical information resources to people working within the addictions, alcohol, and other drugs problem arena and to the larger public. Additionally, we would like to suggest that the addictions librarian/information specialist is also in a unique position to report on the meanings of this literature as cultural and professional artifacts. There are many potential indicators of the status of a particular societal problem and the status of the professional field that has been granted cultural ownership of that problem. We have suggested in this paper that a close analysis of the formal and folk literature of a field is one such indicator. The addictions librarian/information professional is in a unique position to monitor and report on what the changing status and character of addiction/recovery-related literature tells us about both subtle and dramatic changes that this field is undergoing.

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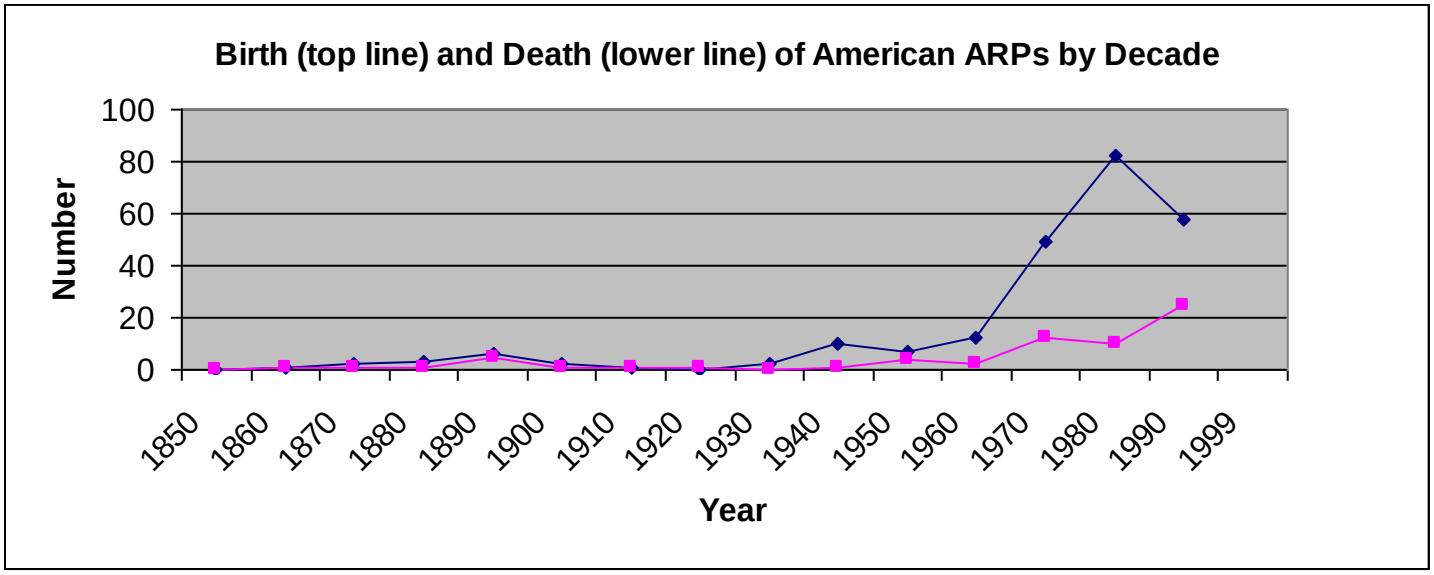


Table 1. Birth (top line) and death (lower line) of American addiction-related periodicals by decade

Table 2. Selected personal recovery periodicals, 1980s-1990s

Personal Recovery Periodicals
• *The Voice of NA* (later *The Voice*) (1968) • *Alateen Talk* (1969) • *Sobering Thoughts* (Women for Sobriety) (1976) • *Minnesota Recovery* (1976) • *NA Way* (Narcotics Anonymous) (1982) • *The Phoenix* • *JACS* (Jewish Alcoholics, Chemically Dependent Persons, and Significant Others) (1985) • *Changes: The Recovery Lifestyle* (1986) • *Sober Times: The Recovery Magazine* (1987) • *Recovering* (1987) • *Recovery Today* (1990) • *LA Steps* (CAL) • *Northeast Recovery Networker* (CT) • *SOAR USA Bulletin* (Society of Americans for Recovery) (1993) • *We in Recovery* (1995) • *SOS International Newsletter* (1988) • *Lifeline America!*

Table 3. A Synopsis of Addiction/Recovery-related Periodicals (ARPs)

Years	Social/Professional Context	Literature/Periodicals
BIRTH 1770- 1830	Per capita alcohol consumption triples. Rise of American Temperance movement.	Alcohol-themed tracts, pamphlets, medical dissertations.
1840- 1870	Washingtonians, fraternal temperance societies, reform clubs.	Early recovery-themed tracts and newsletters.
1870- 1900	Multi-branched field of addiction treatment. American Association for the Cure of Inebriety (AACI) founded. Dramatic growth of Addiction Treatment Institutions.	*Journal of Inebriety* (JI). Institutional newsletters and journals.
1900- 1935	Legal culmination of alcohol/drug prohibition movements. Collapse of addiction treatment and AACI in 1920s.	*JI* and specialty literature ceases publication.
REBIRTH 1935-1969	Multi-branched “modern alcoholism movement”. Alcoholics Anonymous founded.	*Quarterly Journal of Studies on Alcohol.* Rise in state/local ARPs.
EXPLOSION 1970- 1990	Proliferation and professionalization of addiction treatment.	Explosive growth in number / varieties of ARPs - “recovery rage” in publishing. Increasing specialization of ARPs. Reduction in new ARPs and

DECLINE 1990- 2000	Closure of many treatment programs. Shift away from service specialization/segregation. Extension of treatment into criminal justice, child welfare, public health arenas. New Recovery Advocacy Movement.	rise in death rate of existing ARPs. New recovery advocacy publications.



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Pre-A.A. Alcoholic Mutual Aid Societies

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Abstract

It would be hard to imagine picking up a late 20th century text on alcoholism that did not detail or debate the value of Alcoholics Anonymous (A.A.) as a framework for long term recovery from alcoholism. Based on its size, geographical dispersion and endurance, A.A. has rightfully earned its place as the standard by which all other sobriety-based support structures are judged. Given the more than 3,000 books and articles that have been written about A.A. (Bishop and Pittman, 1994), it is surprising that only scant attention has been paid to the American alcoholic mutual aid societies that preceded A.A. Modern understanding and even acknowledgment of these groups is quite rare. This paper seeks to stir interest in these lost chapters in the history of alcoholism recovery in America by:

- cataloguing and comparing pre-A.A. alcoholic mutual aid societies with A.A. and post-A.A. mutual aid groups,
- describing those characteristics that pre-A.A. alcoholic mutual aid societies shared in common,
- identifying the factors that led to the demise of pre-A.A. alcoholic mutual aid societies, and
- discussing what the collective histories of these groups reveal about the sources of A.A.'s resilience and the potential fate of post-A.A. alcoholic mutual aid societies.

The Boundaries of Mutual Aid

Alcoholics have a long history of reaching out to others for help, and they have for more than 200 years been involved in organizing support structures to help themselves and each other. To explore the latter, we must determine which efforts deserve inclusion in the present study. First, our discussion will focus on group-supported recovery rather than the many varieties

of “solo” recovery from alcoholism. Linda Kurtz has described such groups and classified them by their degree of focus on personal change, their degree of inclusion or exclusion of professionals, and their degree of organizational autonomy (L. Kurtz, 1997). For our discussion, we will operationally define “pre-A.A. alcoholic mutual aid societies” by limiting our scrutiny to groups that meet the following six criteria:

1. They were founded before 1935.
2. Alcoholics played leadership roles in their founding and/or operation.
3. Their goal, in whole or in part, focused on the resolution of drinking problems at a personal level.
4. They specifically (but not necessarily exclusively) recruited alcoholics as members,
5. They were member-directed as opposed to professionally-directed.
6. Their existence can be verified from multiple historical sources.

These criteria exclude from our discussion many 19th and early 20th century temperance and religious groups, including the Oxford Group, that were used by alcoholics as an aid to sobriety but were not organized by alcoholics and whose goals did not explicitly include the reclamation of the alcoholic. The requirement that groups be member-directed eliminates from our discussion the entire spectrum of 19th and early 20th century professionally-directed treatments for alcoholism. And by restricting ourselves to groups whose existence can be validated from multiple sources, we eliminate (at least pending further historical investigation) groups such as the Harlem Club of Former Alcoholic Degenerates whose fictional depictions may or may not have had a real counterpart (Cullen, 1899). At the same time, the above criteria include several Native American cultural revitalization movements and 19th century urban missions even though these groups had goals that included, but transcended, recovery from alcoholism. These criteria also embrace the mid-19th century moderation societies organized by and for those with drinking problems but whose goal was not total abstinence.

Having set the boundaries for our discussion, we will introduce the pre-A.A. alcoholic mutual aid societies in the order in which they appeared.

Native American Temperance Societies

The first abstinence-based mutual aid societies in America were organized by Native Americans whose own sobriety often followed near-death experiences with alcohol. The vision experiences of these messianic leaders vividly revealed the role alcohol (the “Water of Death”) was playing in the destruction of Native Peoples. As early as the 1750s–nearly a century before the Washingtonian Revival–Wagomend, an Assinsink Munsee, and Papoonan, a Unami Delaware, exhorted their tribes to denounce rum and return to their cultural traditions. Wagomend hosted quarterly meetings where walking, singing, dancing and cathartic weeping were used to support the personal and cultural rejection of alcohol (Francis, 1996, P. 121).

In the late 18th and early 19th centuries, Samsom Occom, Handsome Lake, Tenskwatawa (The Prophet), The Kickapoo Prophet Kenekuk, Kah-ge-ga-gah-bowh (George Copway), and William Apess turned their own rebirths into broader temperance and cultural revitalization movements. The local “circles” organized by Handsome Lake were led by a “holder” who served as a teacher of the “Code of Handsome Lake,” the first principle of which was complete rejection of alcohol. To the best of this author’s researches, these circles constitute the first geographically de-centralized alcoholism recovery framework in America (Cherrington, 1926; Mancall, 1995; Edmunds, 1983, 1984; Schultz, 1980; Apess, 1992; White, 1999).

The personal recoveries of these Native American leaders generated the first alcoholic confessional literature in America, the first anti-alcohol tracts written by and for alcoholics, and the first group experiences whose goals included personal and cultural sobriety. The extent and nature of Native American alcohol problems have often been misportrayed in the form of what

Leland has christened “firewater myths” (See MacAndrew and Edgerton, 1969, and Leland, 1976), just as the contributions of Native Americans within the history of alcoholism recovery in America have been almost universally ignored. These contributions constitute an area of much needed study.

Of particular historical importance is the way in which the earliest Native American abstinence-based movements viewed personal recovery from alcoholism as inseparable from the physical survival and the economic, political and cultural revitalization of Native American tribal life. As we shall see, the degree to which alcoholic mutual aid societies address broader political, economic and social concerns will vary widely and constitute a subject of considerable on-going controversy.

The Washingtonians

Recovered alcoholics served as temperance missionaries in the 1830s, but it was not until April 2, 1840, that a mutual aid society was organized by and for Euro-American alcoholics. The Washingtonian Temperance Society was birthed out of the failure of the existing temperance movement to focus any significant and sustained energy on the reclamation of the drunkard. It was only a matter of time before a group of “sots” would organize their own temperance group–one whose membership would invite others like themselves into sober fellowship. The Washingtonians grew to a collective membership of more than 500,000 within three years, distinguishing it as one of the fastest growing social movements in American history. Their membership, which at first was made up almost exclusively of “hard cases,” grew in the face of its public recognition to include members who had not suffered from alcoholism. In most places, the latter quickly outnumbered the former.

The Washingtonians pioneered a program of alcoholism recovery based on: 1) a public commitment to total abstinence (signing the pledge), 2) public confession, 3) continued participation in weekly “experience sharing” meetings, 4) service work (“Let every man be present, and every man bring a man.”), 5) mentorship (older members visiting newer members), 6) personal assistance (provision of food, clothing, shelter, work), and 7) sober fellowship (social activities). The Washingtonians also created special support branches for women, young people, and “free colored” (Anonymous, 1842; Baker, 1844; Maxwell, 1950; Blumberg and Pittman, 1991; Alexander, 1988). The Washingtonians are the most widely known of pre-A.A. alcoholic mutual aid societies. They were the only alcoholic mutual aid society before A.A. to achieve that unique and often fatal American phenomenon, “super-success.”

The Fraternal Temperance Societies

A new sobriety-based support structure–the fraternal temperance society–rose from the ashes of the collapsing Washingtonian groups in the mid-1940s. These societies–groups like the Sons of Temperance, Order of Good Templars, Order of Good Samaritans, and Order of Rechabites, to name just a few–used group cohesion, mutual surveillance, financial assistance, and elaborate meeting rituals to bolster one’s pledge of abstinence. The centerpiece of the recovery approach of the fraternal temperance society was regular sober fellowship. The transition from the Washingtonians to the fraternal temperance societies was marked by a shift in emphasis from signing the pledge (initiating sobriety) to developing a new sobriety-based lifestyle (sustaining sobriety). This shift was also marked by a movement from a highly public to a more private (“secret”) venue of alcoholism recovery–a venue within which one’s identity as a former drunkard could be protected (Temple, 1886).

Fraternal temperance societies grew prolifically in the middle decades of the 19th century. Membership in the Sons of Temperance grew to more than 250,000, and membership in the Good Templars exceeded 2.9 million. Since the membership of most of these societies was not exclusively alcoholics, the number of alcoholics using these societies as frameworks for personal

recovery is not precisely known, but some indication is the estimate that 400,000 of the 2.9 million Good Templars were former drunkards. Smaller groups, such as the Independent Order of Good Samaritans, were organized by alcoholics and sustained an exclusive membership of those seeking recovery. Amidst great controversy, some of the fraternal temperance societies included women and African Americans (Fahey, 1996, p. 20). While some of these local fraternal temperance societies meet our criteria of being organized by and for alcoholics, this focus was often lost over time.

The Reform Clubs

As fraternal temperance societies became less focused on the reclamation of the drunkard, reform clubs emerged as a new sobriety-based support structure in America. The roots of the whole movement can be traced to events in Maine during the early 1870s. It was here that newly recovering alcoholics J.K. Osgood, Dr. Henry Reynolds, and Francis Murphy organized their Royal Purple Reform Clubs, Red Ribbon Reform Clubs, and Blue Ribbon Reform Clubs. The "ribbon" in the reform club names reflected the practice of reform club members wearing a colored ribbon as a public sign of membership and as a personal reminder of their commitment to total abstinence. The reform club movement spread throughout the East and Midwest in the closing decades of the 19th century. Because of its highly de-centralized structure, the total membership in the reform clubs is unknown, but the state membership of some reform clubs in the 1870s exceeded 40,000 (Ferris, 1878; Hiatt, 1878).

The recovery framework of the reform clubs consisted of public commitment (pledge signing and carrying a signed pledge card), weekly experience sharing meetings in the Washingtonian tradition, active recruitment of new members, and regular sober fellowship. The reforms clubs were more religious in their orientation than the Washingtonians or fraternal temperance societies, but strictly prohibited political discussions within their meetings. Most of the reform clubs were organized geographically, but some were organized within particular professional groups, e.g., railroad employees and police and fire department employees (Vandersloot, 1878).

The Moderation Societies

Not all of the 19th century alcoholic mutual aid societies were founded upon the principle of abstinence. Early 19th century temperance workers had tried (unsuccessfully) to coach alcoholics to moderate their drinking, but it wasn't until the second half of the 19th century that moderation-based mutual aid societies were organized. One of the better-known of these groups was the Business Men's Moderation Society founded in 1879. The moderation societies relied on a unique type of pledge and mutual support to ameliorate their drinking-related problems. They pledged not abstinence, but that they would not drink during working hours, would not participate in "treating," and would limit the amount they drank to certain predetermined levels (Cherrington, 1926).

Institutional Aftercare Associations

Between 1860 and the early 1900s, an elaborate network of inebriate asylums, inebriate homes, and addiction cures institutes appeared on the American landscape. Some of these institutions grew out of alcoholic mutual aid societies. The Washingtonian Home in Boston grew out of the Boston Washingtonian Temperance Society while the San Francisco Home for the Cure of the Inebriate was founded by the Dashaway Association, a mutual aid group originally formed for alcoholic firemen (Baumohl, 1986).

Some mutual aid societies were birthed within pre-existing alcoholism treatment institutions. The first of these–the Ollapod Club–appeared in the 1860s within the New York

State Inebriate Asylum (Parton, 1868). Over time, these groups designed to support alcoholics while they were undergoing treatment were extended beyond the walls of treatment facilities to also support alcoholics after they had left treatment. These usually took the form of local alcoholic temperance societies such as the one organized for current and former residents of the Appleton Temporary Home in Boston. It was a powerful experience for a man who had just entered such a home to sit between men who had themselves entered that home months or years earlier but today were sober, productive and respected (McKenzie, 1874).

In 1872, "inmates" of the Franklin Reformatory Home for Inebriates in Philadelphia organized a "practical, mutual-benefit association" that was named after its first president, Samuel P. Godwin. The Godwin Association conducted weekly support meetings, sought out delinquent members, served as an "ambulance corps" to find and bring the intemperate to the Home, and provided financial support to care for the indigent at the Home. The Association also held special meetings and dinners on election nights, the Fourth of July, Thanksgiving, Christmas Eve, and other "days of general excitement, when temptations incident to them are better guarded against" (*Twelfth Annual Report..., 1884).* The meetings themselves were very much in the experience sharing style of the earlier Washingtonian meetings. The presentations at the Tuesday night Total Abstinence Conversational Meetings were described as follows:

> *These brief addresses, free from display and personal vanity, but teaching a manly, self-reliant spirit, chastened and controlled by a humble trust in God, make their impress upon the heart and soul, so recently prey to all anguish of remorse and despair. (Twelfth Annual Report..., 1884)*

The most highly organized and geographically dispersed of all the mutual aid societies linked to treatment institutions were the Keeley Leagues. The first Keeley League was founded on April 8, 1891 at the original Keeley Institute in Dwight, Illinois. (The Keeley Institute was the largest and best known of the private addiction cure institutes.) The Keeley Leagues grew in tandem with the expanding Keeley Institute franchises. The 370 Keeley League chapters embraced a membership of more than 30,000 former Keeley patients by the mid-1890s. Keeley League meetings were held daily at the Keeley Institutes, run by officers who were continually replaced from the arriving pools of new patients. Keeley meetings were then held back in local communities where former Keeley patients met for support and fellowship. Keeley League meetings were a mix of welcome to new patients, speeches from departing patients, reading communications from former patients bearing news and encouragement, and social and religious activities. Keeley League members were expected to prominently display their club pin on their person, write their local newspapers proclaiming their cure, and contribute financial support to subsidize the treatment of indigent alcoholics within the Keeley Institutes (Barclay, 1964).

The Mission Support Groups

When Jerry McAuley opened the doors of the Water Street Mission in October of 1872, he birthed the urban mission that would open its door and its heart to the indigent alcoholics. McAuley also marked the beginning of the leadership role that the recovered, or in their language, *redeemed*, alcoholic came to play within such institutions (Offord, 1885; Bonner, 1967). McAuley's work was replicated within independent urban missions throughout the country, the best known of which would be the Salvation Army service centers. What is noteworthy for us in this current study is the fact that the daily meetings at urban missions served as alcoholic mutual aid structures and birthed even more formal mutual aid societies. Among the latter was the United Order of Ex-Boozers founded in 1914 as a "fraternal group devoted to the reclamation of other drunkards." Such groups hosted gospel meetings, planned or participated

in “Boozer’s parades,” and provided personal testimony within the urban missions (White, 1998, p. 74).

The Emmanuel Movement and the Jacoby Club

In 1906, two clergy, Elwood Worcester and Samuel McComb, and a physician, Isador Coriat, created a clinic within the Emmanuel Church of Boston that for several decades integrated religion, medicine, and psychology in the treatment of disorders ranging from tuberculosis to alcoholism. The clinic’s work with alcoholics birthed a “lay therapy” movement that exerted a profound influence on the treatment of alcoholism in the 20th century (McCarthy, 1984). It is noted here because of a unique adjunct to the Emmanuel Clinic: the Jacoby Club.

The Jacoby Club was started by Ernest Jacoby in 1910 to provide a place for fellowship and support for those undergoing treatment for alcoholism at the Emmanuel Clinic. Although Ernest Jacoby was not an alcoholic, the Jacoby Club is included here because its mission so specifically focused on support for the newly recovering alcoholic. It functioned much like the earlier noted Appleton Temperance Society, Godwin Association, or Keeley Leagues. Its motto was “A club for men to help themselves by helping others.” Sometimes referred to as a “Drunkard’s Club,” the Jacoby Club blended sober fellowship, recreation, and service to “men and women who are struggling to escape the slavery of drunkenness,” all within an informal atmosphere of “sympathy and encouragement” (Purrington, 1909; Dubiel, 1999). Also interesting was the expectation that “every man who is cured shall undertake the reformation of one other person.” This other person was known in the language of the Jacoby Club as a “Special Brother.” Ernest Jacoby referred to the process of how men changed in the Jacoby Club as one of “regeneration” (Dubiel, 1999).

Early Counterparts to Later Groups

Before closing this review of pre-A.A. mutual aid societies, it is appropriate to pause and place such groups within the context of subsequent developments. There are historical counterparts to many of the alcoholic mutual aid societies that emerged as adjuncts and alternatives to A.A. following its founding in 1935. Alcoholics Victorious, which was founded in 1948 to provide an explicitly Christian framework of alcoholism recovery has its counterparts in groups such as the United Order of Ex-Boozers that rose within the late 19th and early 20th century urban mission movement in the U.S. Women for Sobriety, founded in 1975 by Dr. Jean Kirkpatrick (1978, 1986) to provide an alcoholic mutual aid society organized by and for alcoholic women, mirrors concerns about the special needs of inebriate women that were present in the 19th century and that led to the founding of the Martha Washington Society and the Keeley Leagues for Women.

While the Washingtonian Society is often referred to as A.A.’s predecessor, it might be more aptly described as the predecessor of Secular Organization for Sobriety founded by James Christopher in 1985 and Rational Recovery founded by Jack Trimpey in 1986 (Christopher, 1988; Trimpey, 1989). While there are similarities between A.A. and the Washingtonians, the Washingtonians were so distinctly non-religious and non-spiritual in orientation that they were charged by their religious critics with the heresy of humanism (placing their own power above the power of God) (Blumberg and Pittman, 1991, p. 152). Contemporary groups like Moderation Management, DrinkWise and Drink Watchers similarly have their counterparts in such 19th century groups as the Business Man’s Moderation Society.

America has also witnessed the emergence of Afrocentric mutual support models for addiction recovery in the late 20th century (Williams, 1992). This author has been unable to discover mutual aid societies of the 19th century organized exclusively by and for African American alcoholics, but the earliest efforts to frame sobriety within an African American cultural

context can be traced to the 19th century writings of Frederick Douglas and the practices of groups like the Black Templars (Douglas, 1855, pp. 252-256; Crowley, 1997, p. 126-128).

II

Before exploring what influence, if any, these early alcoholic mutual aid societies had on the history and structure of A.A., we will examine what these societies shared in common as well as their collective fate.

Shared Characteristics

There are several similarities in the history and structure of the groups reviewed in this paper. Most were founded by and primarily for white, adult, working class men. They emerged during or immediately following a period of economic depression or cultural crisis, and most emerged out of the messianic vision of a charismatic leader who was himself in the earliest days or months of his own recovery from alcoholism. Most of these leaders had achieved sobriety in the wake of a profound experience akin to religious conversion. The organizational life of these groups tended to be dominated by these charismatic leaders.

Most of the groups profiled in this paper share what Linda Kurtz has described as the "self-help ethos": a set of core values that place a high premium on the personal, the democratic, and on experiential as opposed to expert knowledge. They also relied on the mechanisms of change that Linda Kurtz notes as typical in self-help groups: *identity transformation, empowerment, insight, reframing, and the formation of a new way of life* (Kurtz, 1997). Most of the pre-A.A. societies relied on a public commitment to abstinence (pledge signing), emphasized the importance of experience sharing, relished symbols and rituals, and immersed their members in sober fellowship and rescue work with the intemperate.

Pre-A.A. alcoholic mutual aid societies managed the "spoiled identity" of their members through a mechanism that Blumberg and Pittman have christened "status reversal." These groups turned the social stigma of the drunkard on its head by creating a milieu within which "having been a drunkard brought high prestige and not having been a drunkard led to low prestige" (Blumberg and Pittman, 1991, p. 148). Group members qualified themselves through the vehicle of an almost archetypal three-part story style: the extent and general consequences of their drinking, the specific events and experiences that led to their sobriety decision, and what their life was like after they signed and kept the pledge. Identity reconstruction through the ritual of storytelling was the centerpiece of recovery within these mutual aid societies.

The Fate of the Pre-A.A. Societies

The influence of most of the abstinence-based cultural revitalization movements faded under the continued physical and cultural assault on Native American tribes, but their shadow extends to later movements such as the "Peyote Way" of the Native American Church (Albaugh and Anderson, 1974) and even to contemporary abstinence-based intertribal support structures, e.g., the Red Road, Circles of Recovery, and Firestarters (Bordewich, 1996; A Report..., 1998).

While the explosive growth of the Washingtonian Movement breathed new life into a waning temperance movement in 1840-1842, most of the Washingtonian groups had disbanded by the mid-1840s. The demise of the Washingtonian Societies has been attributed to many factors: conflict with mainstream religious and temperance groups, controversies surrounding religious and political issues, lack of a defined program of long term recovery, a lost focus on the personal recovery of the alcoholic, professionalization (leaders seeking careers as temperance lecturers), the relapse of prominent leaders and members, and a weak organizational structure that left the Washingtonians vulnerable for co-optation by mainstream temperance organizations (White, 1998).

The fraternal temperance societies that evolved out of the collapse of the Washingtonians declined and became less hospitable to alcoholics as they developed restrictive membership criteria, got caught up in the political debates surrounding the drive for legal prohibition of alcohol, or fell victim to authoritarian leadership. These organizations, many founded for the specific purpose of providing safe haven for reforming men, became more and more focused on the personal, social and political agendas of their leaders. As this occurred, recruitment and service to alcoholics precipitously declined.

The fate of the reform clubs in the 1870s and 1880s was often tied to the fate of their charismatic founders. Many of these groups faded into oblivion when their leaders died or otherwise disengaged from their positions. The reform clubs never rose above their local level of organization, and never established a collective identity that linked local groups into a strong national organization. They also lacked a formal program of recovery, believing that religious faith, experienced sharing, and sober fellowship were sufficient to sustain sobriety.

We know very little about the fate of the 19th century moderation societies other than the attacks upon them by temperance advocates who charged that these groups ceased to exist because their members died of drunkenness. While some of these groups were the subject of attack and ridicule for pledges that allowed as much as 14 glasses of wine per day, the more responsible of such groups provided a medium of moderation for excessive, but non-addicted, drinkers (Dorchester, 1884).

The fate of mutual aid societies tied to treatment institutions was, not unsurprisingly, closely tied to the fate of these institutions. The Dashaway Association disappeared by 1890 and the San Francisco Home for the Cure of the Inebriate with which it was so closely linked was turned into a “private prison.” The collapse occurred amidst growing conflict between the Association and the Home–conflict that sparked charges of patient maltreatment, financial improprieties, and even murder and suicide attempts by key figures in the dispute (Baumohl, 1986). The Keeley Leagues similarly fell into decline in the late 1890s. A major factor in this demise was the growing conflict between League officers and Dr. Leslie Keeley. The officers charged that Dr. Keeley was trying to transform the Leagues from a vehicle of mutual support into a “great advertising medium” for the Keeley Institutes. There were also charges of financial impropriety in the operation of some of the Leagues. The last Keeley League National Convention was held in 1897 (Account of...., ND; Barclay, 1964).

Mutual aid societies born within the religious missions rarely sustained themselves. This was due to both the difficulty creating and sustaining an identity and autonomy separate from the authority of the missions in which they were born and the fact that the strongest of the indigenous leadership either took full time positions in the mission or returned to sober productivity far from the physical and social world of Skid Row.

The Jacoby Club eventually split from the Emmanuel Church and broadened its mission beyond that of serving alcoholics to the broader goal of helping the “down and out.” There was considerable conflict during this transition over the question of whether the Club should keep its mission focused on service to the alcoholic. In the end, that mission was lost, but in an interesting touch of historical continuity, an A.A. group in Boston used the facilities of the waning Jacoby Club to hold its regular meetings.

What this review reveals is the large number of factors that can contribute to the demise of an alcoholic mutual aid society. Some of these movements were enmeshed within larger movements and collapsed in tandem with the demise of the larger movement or were smothered within this larger movement. This might well have been the fate of A.A. if its earliest members had remained within the Oxford Group.

Mutual aid societies are vulnerable for cult-like isolation and implosion if they are too closed but are also vulnerable for co-optation by more powerful organizations within their environment if they become too involved in outside interactions. The former typified many of the local reform clubs while the latter process clearly contributed to the demise of the Washingtonian Society.

Mutual aid societies are at risk of being hijacked from within for personal or financial gain, and are at risk of being exploited or consumed by more powerful organizations. Alcoholic mutual aid societies are at risk with both weak leadership and charismatic leadership, and they are at risk when their program of recovery is either ill-defined or too rigidly defined. Mutual aid societies, like any social institution, are vulnerable for dissipation in the face of competition from more viable structures. This may have occurred in Boston as the Jacoby Club's mission of serving alcoholics weakened in tandem with A.A.'s growth in Boston.

Mutual aid societies are vulnerable to lose the evangelical zeal that marks their founding and developmental years. When this zeal is lost, the organization is vulnerable for distractions, diversions, and even a fundamental redefinition of its mission. This seems to have happened with many of the fraternal temperance societies, where the focus shifted more from reaching the still suffering alcoholic to providing comfortable social fellowship for those who were already members while supporting the political agenda of alcohol prohibition.

III

A.A. and the Lessons of History

Having briefly catalogued the history of the major pre-A.A. alcoholic mutual aid societies, we are left with the question of how A.A. differed from these earlier mutual aid efforts and with the question of what lessons might be drawn from this history that could benefit current and future alcoholic mutual aid societies. These questions take on added significance in light of:

- the continued growth of A.A.,
- the emergence of what E. Kurtz (1999) has called the "varieties of the Alcoholics Anonymous experience,"
- the virtual explosion in other Twelve Step programs,
- the recent intensification of criticisms of A.A., and
- the proliferation of organizational alternatives to A.A.

There are many unique elements within the history, structure, and processes of A.A. that have been the basis of both praise and criticism. The focus of the present discussion will be primarily upon those aspects of A.A. that have contributed to its survival, the integrity of its mission, and its growth.

A.A. did not draw upon the experience of earlier alcoholic mutual aid societies when its program of recovery (the Twelve Steps) was retrospectively formulated in 1938. A.A.'s co-founders weren't even aware of the existence of such groups until a July 1945 *A.A. Grapevine* article brought the history of the Washingtonians to Bill Wilson's attention, and there is no awareness reflected in A.A. literature (even today) of pre-A.A. groups other than the Washingtonians (Wilson, 1945). But discovery of the Washingtonians may have played another significant role in A.A.'s history.

Wilson's new knowledge of the Washingtonians occurred in the middle of a decade in which A.A. was undergoing experiences–growth, conflict–not unlike those that had unfolded a century earlier. Wilson's discovery of the dramatic rise and then rapid dissipation of the Washingtonians must have sparked serious reflection regarding A.A.'s future. It may be more than coincidence that within a year of learning of the Washingtonians, Wilson formulated, published, and began promoting what became the Twelve Traditions of A.A.

The Twelve Traditions, whose purpose was to guide A.A.'s organizational life in the same way that the Twelve Steps guided the personal recovery of A.A. members, provided unique answers to the most critical problems that had mortally wounded the alcoholic mutual aid societies that preceded A.A. Whether one looks at A.A. through the eyes of a grateful and

adoring member or through the eyes of the most rabid A.A. critic, one fact is unarguable: Alcoholics Anonymous is the only widely available alcoholic mutual aid society in American history that has outlived its founding generation.

When we examine A.A.'s resilience in light of the demise of its predecessors, eight distinguishing characteristics stand out.

1. *Program Codification*. In contrast to the Washingtonians and other early mutual aid societies, A.A. refined its program through the trials and errors of its early members and then described its program of recovery in writing before experiencing the trials of public acclamation and rapid growth. This minimized dilution and distortion of the Twelve Steps and the group rituals that surrounded them during A.A.'s explosive growth in the early 1940s. That A.A. was able to capture its program in writing within its basic text was as important to A.A.'s early survival as what was included in that text.

2. *Program Content.* There are many elements of what came to be incorporated into A.A. experience that are mirrored in its predecessors: sober fellowship, alcoholic-to-alcoholic experience sharing, acts of service to other alcoholics. A.A. was unique in redefining sobriety from the status of a single "decision" to that of "working a program" and in defining sobriety as something qualitatively different than not drinking. The "program" that A.A. "suggested" as a framework for recovery (the Twelve Steps) involved nothing less than a change in one's philosophy of living, a reconstruction of one's identity and character, and a reformulation of one's interpersonal relationships. The language used to depict these Steps achieved a fine balance. The Twelve Steps offered enough specificity to guide the newcomer while offering sufficient ambiguity to allow stable members to continually re-interpret the Steps through the various developmental stages of their recovery processes. This onion-like layering of meaning within the Steps contributed to the longevity of A.A. member involvement and to the unending adaptation of the Steps to other problems.

3. *Organizational Autonomy and Singleness of Purpose*. A.A. did not tie its fate to any other organization and took the quite opposite stance of separating from its parent organization (the Oxford Group) and subsequently refusing to align itself with any other organizations. In contrast to nearly all of its predecessors, A.A. maintained a "singleness of purpose" behind its painful discovery of the potential disruptiveness of outside diversions. This emerging value prevented A.A. and its mission from being hijacked. Without this emerging value, at least three early episodes in A.A. history might have fundamentally altered A.A.'s identity and mission: 1) the offer to Bill Wilson to work as a lay therapist and to bring A.A. under the organizational umbrella of Towns Hospital, 2) A.A.'s plans to operate hospitals for the treatment of alcoholism, and 3) Bill Wilson and Dr. Robert Smith's early involvement in the National Committee for Education on Alcoholism. Each of these episodes might have led A.A. down a path of shared fate with the Washingtonians or the institutional aftercare groups (See E. Kurtz, 1979; White, 1998).

4. *De-decentralization of leadership*. By pledging itself to a system of rotating leadership and a minimalist approach to organizational structure, A.A. limited the ability of leaders to manipulate an A.A. group or exploit their membership for financial or political gain. By eliminating permanent leadership positions and pledging itself to corporate poverty, A.A. eliminated the booty over which members of earlier groups had fought. A.A. enhanced its resiliency by defining the source of its strength in a Higher Power expressed in the form of "group conscience" rather than by relying on the knowledge and skills of a charismatic leader. The open acknowledgment of the imperfection and strength of all A.A. members and the stance of "principles before personalities" created organizational units whose fates were not tied to the fates of any single person.

5. *Cell Structure*. The codification of the A.A. program, the de-centralization of leadership, and the minimalist approach to organizational structure and membership requirements enabled A.A. to evolve what Mäkelä (1996) has described as a highly de-centralized cell structure. The centerpiece of the A.A. experience became not listening to the charismatic speaker at the large

temperance meeting house or marching with thousands in a Boozer's Day Parade, but in sharing experience, strength and hope within a small group of one's peers. The ease with which cell division could occur through growth, conflict, or unmet needs contributed to A.A.'s viability and spread.

This cell structure was also particularly adept at meeting the needs of special populations of alcoholics. Sobriety based support structures for young people, for example, have always been inherently unstable because virtually all the members mature out of eligibility for membership. The cell structure of A.A. allowed young people to have their own meetings while providing a structure that could simultaneously nourish such groups and provide a larger framework of support into which members could graduate. A.A.'s cell structure contributed in a similar way to a wide range of alcoholics who naturally cluster around their shared characteristics, experiences and needs.

6. *Alcoholic-to-Alcoholic Identification and Mentorship*. A.A. assured that the almost archetypal image of one alcoholic sitting across the table from another sharing their experience, strength and hope would be protected by refusing to compromise its closed meeting structure and by evolving the practice of sponsorship. A.A. narrowly escaped developing the exclusive class structure that plagued the fraternal temperance societies when A.A. rejected early group membership criteria that excluded "beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women" in favor of one criteria: "a desire to stop drinking" (Twelve Steps and Twelve Traditions, p. 139-140). A.A. assured that no member could claim moral superiority over another and eliminated the potential for non-alcoholic members to manipulate A.A. to serve other needs and interests.

7. *Anonymity.* A.A.'s predecessors had been wounded by leaders and members who either used visibility as a springboard for financial profit or whose public downfall brought discredit to the organization. A.A. avoided both of these pitfalls by declaring that no one with a name (at least a full name) could speak for A.A. Anonymity, while practiced as a spiritual exercise, also protected A.A. as an organization and brought many individuals into recovery who saw in anonymity a shroud of protection from the injury that can result from one's being linked to a socially stigmatized condition.

8. *Duration of Participation*. A.A. also established an expectation for continued participation in A.A. long after sobriety was achieved. While this may have reduced the risk of relapse, it provided two equally important organizational functions: assuring organizational continuity and assuring the availability of members with stable sobriety and knowledge of the A.A. program when the next suffering alcoholic reached out for help.

The creation of a sustainable alcoholic mutual aid society takes more than a workable framework of personal recovery. As the history of the pre-A.A. mutual aid societies teaches us, such groups must also position themselves within the larger culture, create their niche within the broader alcohol problems arena, construct viable operating structures and procedures, and, perhaps most importantly, find ways to transcend and manage the foibles of their leaders and members. A.A. discovered and then institutionalized via its Twelve Traditions strategies to manage the forces that posed the greatest threat to their existence and character: conflicts about purpose, position, property, politics, personalities, and, of course, money.

The future of the post-A.A. alcoholic mutual aid societies may have very little to do with their philosophy of alcoholism or the effectiveness of their framework for personal recovery. For example, the expectation of several such societies that members need only attend until they have established stable sobriety may prove quite adequate to meet the needs of many of their current generation of members but may simultaneously doom the future of these organizations. Without building a stable group of members out of which indigenous leaders can be developed, it is unlikely that many of the local cells of these groups will survive over time.

Summary

Alcoholic mutual aid societies have for more than 200 years emerged from a vacuum of unmet need. The shared elements of these societies are not derivative; most did not have detailed knowledge of their predecessors. Instead, they are the product of a common process of experimentation and discovery of what works to help move alcoholics into stable recovery. And yet, even as they found things that helped particular individuals, these same societies encountered forces that threatened and ended their organizational lives. A.A.'s endurance in the face of the demise of all its predecessors is an anomaly worthy of serious investigation.

Alcoholics are not a homogenous group and no alcoholic mutual aid society, including A.A., has been able to reach more than a fraction of the men and women who suffer from alcoholism. A.A. stands out in this history for having reached more alcoholics in more places and over a longer period of time than any alcoholic mutual aid society that came before or after. It may take a large menu of support structures to expand the entryway to recovery for the mass of alcoholics. As these groups emerge to seek their own niche in a growing multi-branched culture of recovery, they would do well to study the keys to A.A.'s resilience–keys that have as much or more to do with A.A.'s Twelve Traditions than A.A.'s Twelve Steps.

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A Photographic Essay
Addiction Treatment in the United States: Early Pioneers and Institutions

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Between 1780 and 1830, a near-tripling of annual per capita alcohol consumption and a related rise in alcohol problems in America (Rorabaugh, 1979) led to what Levine (1978) has christened the "discovery of addiction." The speeches and tracts of early American social activists, physicians, and clergy, (Benezet, 1774; Rush, 1784; Beecher, 1828) mark the crystallization of a shift from exclusively moral to medical conceptualizations of habitual drunkenness.

It is in the writings of these reformers that one finds the emerging elements of the about-to-be-christened disease, *inebriety*: genetic and biological predisposition, pharmacological tolerance and toxicity, symptom progression, and the erosion of human will (compulsion). These sources chronicled the medical, psychological and social effects of habitual drunkenness, and were followed by works depicting the chronic effects of opium, morphine, cocaine, chloral and ether as variants of this same disease. Dr. Benjamin Rush (1810) (Plate One) and Dr. Samuel Woodward (1838) pushed this medicalization of alcohol- and drug-related problems to its logical conclusion by calling for the creation of specialized institutions for the care of the inebriate.

Concerns about alcohol problems and the elevation of sobriety as a social value spawned sobriety-based mutual aid societies and a multi-branched field of addiction treatment. The former included Native American religious and cultural revitalization movements, the Washingtonians, the fraternal temperance societies, the ribbon reform clubs, and early moderation societies (White, 2001). Treatment was provided in inebriate homes, inebriate asylums, addiction cure institutes, and in the private practices of the nation's first addiction medicine specialists. There were also bottled home cures for the "alcohol, tobacco, and drug habits" that were aggressively promoted by a flourishing patent medicine industry (Baumohl and Room, 1987).

Early inebriate homes, such as the Washingtonian Homes in Boston (1857) and Chicago (1863) (Plate Two) and Chester Crest in New York (Plate Three), viewed moral/religious reformation combined with mutual surveillance and support as the best antidote to drunkenness. These homes provided brief, voluntary stays that mixed non-

medical detoxification, isolation from drinking subcultures, moral suasion, and enmeshment in new sobriety-based social fellowships. In the 1870s and 1880s, urban missions and rural inebriate colonies provided more explicitly religious pathways of alcoholism recovery.

The first medically oriented inebriate asylums were modeled after state-operated insane asylums. They differed from inebriate homes in their emphasis upon legal restraint, prolonged institutionalization (1-3 years), and more physical methods of treatment. The first of these institutions, the New York State Inebriate Asylum (Plate Four) opened in 1864 under the leadership of Dr. James Edward Turner (Plate Five). Other facilities like Walnut Lodge Hospital for Inebriates (1880) (Plate Six) followed that were run as private hospitals.

The inebriate homes and asylums received financial support from state legislatures, liquor license revenues, religious and temperance organizations, private philanthropists and from patient fees.

The leaders of the inebriate homes and asylums came together in 1870 under the leadership of Dr. Joseph Parrish and founded the American Association for the Cure of Inebriates (AACI). The AACI's founding principles declared:

1. Intemperance is a disease.

2. It is curable in the same sense that other diseases are.

3. Its primary cause is a constitutional susceptibility to the alcoholic impression.

4. This constitutional tendency may be either inherited or acquired.

The principles went on to call for the legal recognition of intemperance as a disease and the creation of inebriate homes and asylums throughout the country (Proceedings, 1870).

In 1876, the AACI began publishing the *Journal of Inebriety* (Plate Seven) under the editorship of Dr. T.D. Crothers (Plate Eight). The conceptualization of addiction as a treatable disease during the late nineteenth century pervaded such addiction medicine texts as Albert Day's *Methomania* (1867), Robert Parrish's *Alcoholic Inebriety* (1883), and T.D. Crothers' *The Disease of Inebriety from Alcohol, Opium and other Narcotics* (1893).

The pages of the *Journal of Inebriety* reveal sustained controversies about the nature of inebriety, the value of liberty versus restraint in its treatment, the merits of rapid versus gradual withdrawal, and the best methods of managing the asylum (Crothers, 1912). There were even controversies over who could best provide services to the inebriate. In 1897, T.D. Crothers castigated those who advocated for the use of "reformed men" as asylum managers on the grounds that such men were "incompetent by reason of organic defects" and would likely relapse if they chose to work with inebriates.

The most controversial branch of nineteenth century addiction treatment in America encompassed the proprietary addiction cure institutes and proprietary home cures. The best known of these institutes was founded in 1879 by Dr. Leslie Keeley (Plate Nine), who went on to franchise more than 120 Keeley Institutes in North America and Europe. Dr. Keeley also sold the bottled Double Chloride of Gold Cures for drunkenness, opium addiction and the tobacco habit by mail order. The for-profit addiction treatment franchises–the Keeley, Gatlin, Neal, Empire, Oppenheimer, Key Institutes, among the most prominent–claimed they could cure addiction faster, cheaper and more successfully than the inebriate homes and asylums. These widely advertised institutes (Plate Ten) often recruited their patients through the promise of a medicinal specific that could quickly destroy all craving for alcohol, morphine or cocaine. The institutes often combined hypodermic injections (Plate Eleven), oral tonics, and participation in patient-run support societies such as the Keeley Leagues (Plate Twelve) (White, 1998, 2001).

Inebriate homes and asylums, and proprietary addiction cure institutes, briefly flourished in America in the 1880s and early 1890s, but were never able to garner sustained public support or scientific credibility. Inadequate clinical technologies, exposès of ethical abuses in the field's clinical and business practices, economic depressions, and the larger stigmatization, demedicalization and criminalization of alcohol and other drug

problems led to the virtual collapse of America's first era of addiction treatment. Of the hundreds of nineteenth century treatment institutions, few survived the first two decades of the twentieth century. *The Journal of Inebriety* ceased publication in 1914 and its parent organization disbanded without notice in the early 1920s (White, 1998). When recovery mutual aid societies and new treatment programs were re-birthed in America during the middle decades of the 20th century, its leaders new little of this earlier era. It is only in recent years that the historical reconstruction of this lost period has begun.

America was not alone in its discovery of addiction and some have argued that she was not the first to discovery this phenomenon (Porter, 1985; Warner, 1994). The medicalization of alcohol and other drug problems gained similar prominence in Europe in the nineteenth century. There were more than sixty European facilities specializing in the treatment of addiction founded in the late nineteenth century, and such institutions also operated in Australia, China, India and Africa. Professional societies for the study and treatment of addiction were established in England, France, Switzerland, Germany and Sweden, and the first International Congress of these societies was held in London in 1887 (Crothers, 1893). In future photo essays, we will attempt to visually portray this global story of the rise of addiction and its treatment.

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Adolescent Treatment: Its History and Current Renaissance

By William L. White, M.A., Michael Dennis, Ph.D., & Frank M. Tims, Ph.D.

The United States experienced a number of troubling drug trends during the past decade. Most prominent among these trends was a surge in youthful polydrug (cannabis, stimulant, hallucinogen, sedative) use, a rise in juvenile opiate addiction, and changing patterns of youthful binge drinking. The 1990s witnessed shifts in drug tastes and availability that brought old and new drugs onto the psychoactive drug menu: LSD, methamphetamine, "club drugs" (MDMA/ "ecstacy", GHB, rohypnol), and dissociative anesthetics (PCP, ketamine). Respondents in the latest national school survey reported particularly high rates of binge drinking (consuming five or more drinks in a row in the past thirty days): 15% of 10th graders, 26 percent of 10th graders, and 31% of 12th graders (www.MonitoringTheFuture.org). The most disturbing and historically significant of these trends was the lowered age of regular onset of alcohol and other drug use.

Shifting patterns of youthful drug consumption were evident in a number of data sources: alcohol- and drug-related deaths, emergency room admissions, arrest and incarceration rates and treatment admissions. Particularly important for the addiction counselor was the fact that, between 1994 and 1999, the number of persons aged 12 to 17 admitted to addiction treatment in the U.S. increased 20%. (SAMHSA, Treatment Episode Data Set Report). Today's addiction counselor is more likely to see adolescents within his or her caseload and see adults whose relationship with alcohol and other drugs began before or during early adolescence. The resurgence in adolescent illicit drug use and binge drinking has sparked renewed calls for evidence-based intervention programs for substance-involved youth and their families. This article reviews the history and future of such interventions.

Drunkard children (1780-1900)

Children regularly consumed (diluted) alcohol in Colonial America, and youth in some Native American tribes experienced shaman-guided, drug-facilitated rights of passage into adulthood. What did not occur in the seventeenth and eighteenth centuries was widespread misuse of alcohol or other drugs by young people. As per capita alcohol consumption skyrocketed among all Americans between 1780 and 1820, concern

grew about youthful alcohol misuse, particularly among orphaned children. An emerging temperance movement responded by:

- lobbying for minimum drinking age and temperance education laws,
- publishing youth temperance literature,
- including young people in temperance society activities, and
- suppressing drinking on college campuses (Mosher, 1980).

Nineteenth century recovery-support societies sponsored “cadet” branches for young inebriates and launched “youth rescue” crusades. Many of the recovered alcoholics who led these efforts had themselves started their downfall as youth. One even became known on the temperance lecture circuit as the “saved drunkard boy” (Foltz, 1891). Young people were also included within America’s first addiction treatment institutions. Alcoholics between the ages of 15-20 constituted nearly ten percent of admissions to nineteenth century inebriate homes and inebriate asylums. By the 1890s, patients as young as 12 were being admitted for hospital detoxification even as adolescent alcohol use was dramatically declining (White, 1998). By the end of the 19th century, most American youth were protected from significant exposure to alcohol and other drugs, and youth in large numbers were enlisted in the movement to legally prohibit alcohol and other drugs.

Treating juvenile narcotic addiction (1910-1950)

Two trends sparked interest in the treatment of drug- and alcohol-involved youth in the early 20th century. The first was the advent of opiate use among disaffiliated urban youth (Musto, 1974). This trend spurred rising juvenile arrests and the rejection in thousands of World War I draftees due to heroin addiction (Terry & Pellens, 1921). The second trend was the reversal of the decline of alcohol consumption among children and adolescents. Prohibition (1920-1933) produced a decrease in most alcohol-related problems through the mid-1920s, but generated an unintended interest in alcohol among young people. By the end of the 1920s, drinking and smoking had become symbols of youthful liberation and rebelliousness.

Efforts to treat adolescent addicts occurred in several settings. Juveniles were represented among the clientele of the morphine maintenance clinics that operated in the U.S. between 1919 and 1924. Of the more than 7,500 addicts registered at the Worth Street Clinic in New York City, 743 were under the age of 19 (Hubbard, 1920). New York City also established Riverside Hospital as a specialized facility for treating narcotic addiction, but it was closed after it was discovered that most addicts quickly relapsed following their release (Copeland, 1920).

By the mid-1920s, most juvenile addicts were “treated” in municipal correctional institutions, their incarceration a testament to the growing belief in the incurability of addiction. By the time two “narcotic hospitals” were opened in Lexington, Kentucky (1935) and Fort Worth, Texas (1938), the earlier epidemic of juvenile narcotic addiction had abated.

What occurred between 1900 and 1950 was first the inclusion of adolescents within new approaches to the treatment of narcotic addiction and then the collapse of nearly all such treatment. From the closing of Riverside Hospital to the channeling of most addicts to the two federal prison-hospitals, adolescent addicts entering treatment were viewed as miniature versions of adult addicts and were mainstreamed via the indiscriminate application of adult

treatment methods.

Early community-based adolescent treatment (1950-1990)

Following two decades of abeyance, juvenile narcotic addiction rose dramatically in the early 1950s, particularly within urban African-American and Puerto Rican neighborhoods. Admissions of persons under age 21 to the two U.S. Public Health Hospitals rose from 22 in 1947 to 440 in 1950. Juveniles were seeking help at local hospitals in many communities, particularly in New York City, where two city hospitals admitted 340 teenage narcotic users between January and October, 1951 (Conferences, 1953). The lack of community resources to help young addicts spurred the opening of addiction wards within some urban hospitals. Churches also became involved in youth addiction ministries during the 1950s, creating such programs as St. Mark's Clinic in Chicago, the Addicts Rehabilitation Center in Manhattan, the Astoria Consultation Service in Queens, and Exodus House in East Harlem. These were followed by other religiously affiliated programs like Teen Challenge and the Samaritan Halfway House Society in the early 1960s (White, 1998).

Most of the treatment programs of the 1950s mixed juveniles with adults. The exception to this rule — the re-opening of Riverside Hospital in July 1952 as a treatment facility exclusively for juvenile addicts — marks the birth of specialized adolescent treatment. This 140-bed facility and its multidisciplinary staff offered detoxification; psychiatric and medical evaluations; psychological testing; individualized programs of therapeutic, educational, vocational and recreational activities; and outpatient follow-up via community clinics following three-to-six months of inpatient treatment. In spite of its "state-of-the-art" status, Riverside was closed in 1961 after a follow-up study of 247 former patients documented that 97 percent of the juveniles treated at Riverside returned to heroin use following their discharge (Gamso & Mason, 1958).

Other mid-century events that influenced the future evolution of adolescent treatment included the development of "young peoples' meetings" within Alcoholics Anonymous and Narcotics Anonymous, the development of modified therapeutic communities for adolescents, and the appearance of adolescent chemical dependency programs based on the "Minnesota Model."

Through the 1960s, 70s and 80s, the treatment of adolescent substance use disorders continued to be provided primarily in adult substance use units using adult models. These programs were often developmentally inappropriate and were not adapted to adolescent patterns of substance use, particularly the high rates of co-occurring problems. Not surprisingly, treatment outcomes for adolescents revealed less success than those achieved by adults (Craddock, Bray & Hubbard, 1985; Dennis, Dwaud-Noursi, Muck & McDermeit, in press; OAS, 1995; Sells & Simpson, 1979).

The Modern Era

Starting slowly in the 1980s and early 1990s, several scattered groups of clinical programs, state funding agencies and addiction researchers started modifying treatment models to be more developmentally appropriate for adolescents by:

- using youth-oriented, multi-dimensional assessment instruments
- developing youth-focused family and group treatment modalities
- using younger and more educated staff
- dealing more flexibly with rule violations
- shifting from confrontation to motivation/engagement
- coordinating care with schools and

the juvenile justice systems
- defining clinical subpopulations requiring special approaches of engagement and treatment (e.g., ethnic minorities, runaways, and adolescents with conduct disorder, ADHD, depression, HIV/AIDS and other co-occurring disorders), and
- refining the use of pharmacological adjuncts in the treatment of co-morbid conditions.

The Center for Substance Abuse Treatment (CSAT) sought to spread these innovations through a series of widely distributed Treatment Improvement Protocols. The rate of clinical and research advances in the field of adolescent treatment accelerated rapidly at the end of the 20th century. Of the 36 empirical studies of adolescent treatment published by the end of 2001, 22 were published after 1997. The total number of such studies will be more than double in the next few years. Table 1 projects the release of the major findings and treatment manuals, and other materials from the studies currently underway.

Table 1. Timeline for Releasing Adolescent Study Results

Year	Study
2001	The National Institute on Drug Abuse (NIDA) started releasing the results of its Drug Abuse Treatment Outcome Study of Adolescents (DATOS-A) longitudinal study of 1,785 adolescents treated in outpatient, short- term residential and long-term residential treatment programs (Grella et al., 2001; Hser et al., 2001). DATOS-A is also the focus of a special issue of the *Journal of Adolescent Treatment Research* and has an online bibliography of findings at www.datos.org
2001	The Center for Substance Abuse Treatment (CSAT) started releasing the results of its Cannabis Youth Treatment (CYT) multi-site experiment of 600 adolescents from four sites randomly assigned to five types of outpatient treatment (Dennis, Titus et al., in press). CSAT has released the CYT treatment manuals through the National Clearinghouse on Alcohol and Drug Information (1-800-729-6686 or www.health.org) and CYT has an online bibliography of findings at www.chestnut.org/li/cyt.
2002	CSAT will start releasing the results of its 10 Adolescent Treatment Model (ATM; Stevens & Morral, in press) grants to manualize outpatient, short-term residential and therapeutic community programs and evaluate their effectiveness with over 1800 adolescents. The individual grantees will be responsible for distributing their own model. A list of current publications can be obtained from Randy Muck (rmuch@samsha.gov)
2002	CSAT will start releasing the results of its Persistent Effects of Treatment Study of Adolescents (PETSA) with 1200 adolescents from CYT outpatient programs and ATM residential programs followed up at 24, 30 and 42 months. Some of the early results will appear in a special issue of Evaluation in Program Planning due out in late 2002, and PETSA maintains an on-line bibliography at www.samhsa.gov/centers/csat/csat.html (then select PETS from program resources)
2002	The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and CSAT

	have collaborated to fund over a dozen independent grants to develop and evaluate new approaches to adolescent treatment that are expected to start publishing their findings in 2002.

The Emerging Renaissance of Adolescent Treatment

This emerging renaissance of adolescent treatment promises to continue for many years. In addition to the studies already in the field, there are several major initiatives just getting underway. CSAT is funding several five-year studies to develop and evaluate community-based efforts to create continuum of care models for adolescents that include linkage to schools and juvenile justice agencies. CSAT and NIDA are collaborating on studies of continuing care after adolescent residential treatment. The Robert Wood Johnson Foundation is funding a guide to adolescent treatment and several demonstrations linking treatment with the juvenile justice system. NIDA and NIAAA are also continuing to fund several individual grants related to individual aftercare. Within the next five years, we expect the development of several dozen, evidence. It is expected that elements of the infrastructure of such studies will also be increasingly mainstreamed, e.g., standardized assessment, competency-based training, treatment manuals, and model fidelity instruments/procedures, and rigorous clinical supervision.

In addition, it is anticipated that adolescent treatment in the coming decades will make major advances in such areas as early intervention strategies, clinical engagement and retention techniques, and the ability to match particular interventions to particular subpopulations of clients. Perhaps most significantly, we anticipate that the treatment of adolescent substance use disorders will shift (for those adolescents presenting patterns of high problem severity and complexity) from sequential, self-encapsulated episodes of acute care (assess, admit, treat, discharge) to a more time-sustained, community support model of recovery management. This will integrate existing clinical approaches within a deeper understanding of the social and cultural ecology of adolescent recovery. The treatment of adolescent substance use disorders is moving from the status of a folk art to that of a science-guided endeavor.

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Shifting patterns of youthful drug consumption were evident in a number of data sources: alcohol- and drug-related deaths, emergency room admissions, arrest and incarceration rates and treatment admissions. Particularly important for the addiction counselor was the fact that, between 1994 and 1999, the number of persons aged 12 to 17 admitted to addiction treatment in the U.S. increased 20%. (SAMHSA, Treatment Episode Data Set Report). Today's addiction counselor is more likely to see adolescents within his or her caseload and see adults whose relationship with alcohol and other drugs began before or during early adolescence. The resurgence in adolescent illicit drug use and binge drinking has sparked renewed calls for evidence-based intervention programs for substance-involved youth and their families. This article reviews the history and future of such interventions.

Drunkard children (1780-1900)

Children regularly consumed (diluted) alcohol in Colonial America, and youth in some Native American tribes experienced shaman-guided, drug-facilitated rights of passage into adulthood. What did not occur in the seventeenth and eighteenth centuries was widespread misuse of alcohol or other drugs by young people. As per capita alcohol consumption skyrocketed among all Americans between 1780 and 1820, concern

grew about youthful alcohol misuse, particularly among orphaned children. An emerging temperance movement responded by:

- lobbying for minimum drinking age and temperance education laws,
- publishing youth temperance literature,
- including young people in temperance society activities, and
- suppressing drinking on college campuses (Mosher, 1980).

Nineteenth century recovery-support societies sponsored “cadet” branches for young inebriates and launched “youth rescue” crusades. Many of the recovered alcoholics who led these efforts had themselves started their downfall as youth. One even became known on the temperance lecture circuit as the “saved drunkard boy” (Foltz, 1891). Young people were also included within America’s first addiction treatment institutions. Alcoholics between the ages of 15-20 constituted nearly ten percent of admissions to nineteenth century inebriate homes and inebriate asylums. By the 1890s, patients as young as 12 were being admitted for hospital detoxification even as adolescent alcohol use was dramatically declining (White, 1998). By the end of the 19th century, most American youth were protected from significant exposure to alcohol and other drugs, and youth in large numbers were enlisted in the movement to legally prohibit alcohol and other drugs.

Treating juvenile narcotic addiction (1910-1950)

Two trends sparked interest in the treatment of drug- and alcohol-involved youth in the early 20th century. The first was the advent of opiate use among disaffiliated urban youth (Musto, 1974). This trend spurred rising juvenile arrests and the rejection in thousands of World War I draftees due to heroin addiction (Terry & Pellens, 1921). The second trend was the reversal of the decline of alcohol consumption among children and adolescents. Prohibition (1920-1933) produced a decrease in most alcohol-related problems through the mid-1920s, but generated an unintended interest in alcohol among young people. By the end of the 1920s, drinking and smoking had become symbols of youthful liberation and rebelliousness.

Efforts to treat adolescent addicts occurred in several settings. Juveniles were represented among the clientele of the morphine maintenance clinics that operated in the U.S. between 1919 and 1924. Of the more than 7,500 addicts registered at the Worth Street Clinic in New York City, 743 were under the age of 19 (Hubbard, 1920). New York City also established Riverside Hospital as a specialized facility for treating narcotic addiction, but it was closed after it was discovered that most addicts quickly relapsed following their release (Copeland, 1920).

By the mid-1920s, most juvenile addicts were “treated” in municipal correctional institutions, their incarceration a testament to the growing belief in the incurability of addiction. By the time two “narcotic hospitals” were opened in Lexington, Kentucky (1935) and Fort Worth, Texas (1938), the earlier epidemic of juvenile narcotic addiction had abated.

What occurred between 1900 and 1950 was first the inclusion of adolescents within new approaches to the treatment of narcotic addiction and then the collapse of nearly all such treatment. From the closing of Riverside Hospital to the channeling of most addicts to the two federal prison-hospitals, adolescent addicts entering treatment were viewed as miniature versions of adult addicts and were mainstreamed via the indiscriminate application of adult

treatment methods.

Early community-based adolescent treatment (1950-1990)

Following two decades of abeyance, juvenile narcotic addiction rose dramatically in the early 1950s, particularly within urban African-American and Puerto Rican neighborhoods. Admissions of persons under age 21 to the two U.S. Public Health Hospitals rose from 22 in 1947 to 440 in 1950. Juveniles were seeking help at local hospitals in many communities, particularly in New York City, where two city hospitals admitted 340 teenage narcotic users between January and October, 1951 (Conferences, 1953). The lack of community resources to help young addicts spurred the opening of addiction wards within some urban hospitals. Churches also became involved in youth addiction ministries during the 1950s, creating such programs as St. Mark's Clinic in Chicago, the Addicts Rehabilitation Center in Manhattan, the Astoria Consultation Service in Queens, and Exodus House in East Harlem. These were followed by other religiously affiliated programs like Teen Challenge and the Samaritan Halfway House Society in the early 1960s (White, 1998).

Most of the treatment programs of the 1950s mixed juveniles with adults. The exception to this rule — the re-opening of Riverside Hospital in July 1952 as a treatment facility exclusively for juvenile addicts — marks the birth of specialized adolescent treatment. This 140-bed facility and its multidisciplinary staff offered detoxification; psychiatric and medical evaluations; psychological testing; individualized programs of therapeutic, educational, vocational and recreational activities; and outpatient follow-up via community clinics following three-to-six months of inpatient treatment. In spite of its "state-of-the-art" status, Riverside was closed in 1961 after a follow-up study of 247 former patients documented that 97 percent of the juveniles treated at Riverside returned to heroin use following their discharge (Gamso & Mason, 1958).

Other mid-century events that influenced the future evolution of adolescent treatment included the development of "young peoples' meetings" within Alcoholics Anonymous and Narcotics Anonymous, the development of modified therapeutic communities for adolescents, and the appearance of adolescent chemical dependency programs based on the "Minnesota Model."

Through the 1960s, 70s and 80s, the treatment of adolescent substance use disorders continued to be provided primarily in adult substance use units using adult models. These programs were often developmentally inappropriate and were not adapted to adolescent patterns of substance use, particularly the high rates of co-occurring problems. Not surprisingly, treatment outcomes for adolescents revealed less success than those achieved by adults (Craddock, Bray & Hubbard, 1985; Dennis, Dwaud-Noursi, Muck & McDermeit, in press; OAS, 1995; Sells & Simpson, 1979).

The Modern Era

Starting slowly in the 1980s and early 1990s, several scattered groups of clinical programs, state funding agencies and addiction researchers started modifying treatment models to be more developmentally appropriate for adolescents by:

- using youth-oriented, multi-dimensional assessment instruments
- developing youth-focused family and group treatment modalities
- using younger and more educated staff
- dealing more flexibly with rule violations
- shifting from confrontation to motivation/engagement
- coordinating care with schools and

the juvenile justice systems
- defining clinical subpopulations requiring special approaches of engagement and treatment (e.g., ethnic minorities, runaways, and adolescents with conduct disorder, ADHD, depression, HIV/AIDS and other co-occurring disorders), and
- refining the use of pharmacological adjuncts in the treatment of co-morbid conditions.

The Center for Substance Abuse Treatment (CSAT) sought to spread these innovations through a series of widely distributed Treatment Improvement Protocols. The rate of clinical and research advances in the field of adolescent treatment accelerated rapidly at the end of the 20th century. Of the 36 empirical studies of adolescent treatment published by the end of 2001, 22 were published after 1997. The total number of such studies will be more than double in the next few years. Table 1 projects the release of the major findings and treatment manuals, and other materials from the studies currently underway.

Table 1. Timeline for Releasing Adolescent Study Results

Year	Study
2001	The National Institute on Drug Abuse (NIDA) started releasing the results of its Drug Abuse Treatment Outcome Study of Adolescents (DATOS-A) longitudinal study of 1,785 adolescents treated in outpatient, short- term residential and long-term residential treatment programs (Grella et al., 2001; Hser et al., 2001). DATOS-A is also the focus of a special issue of the *Journal of Adolescent Treatment Research* and has an online bibliography of findings at www.datos.org
2001	The Center for Substance Abuse Treatment (CSAT) started releasing the results of its Cannabis Youth Treatment (CYT) multi-site experiment of 600 adolescents from four sites randomly assigned to five types of outpatient treatment (Dennis, Titus et al., in press). CSAT has released the CYT treatment manuals through the National Clearinghouse on Alcohol and Drug Information (1-800-729-6686 or www.health.org) and CYT has an online bibliography of findings at www.chestnut.org/li/cyt.
2002	CSAT will start releasing the results of its 10 Adolescent Treatment Model (ATM; Stevens & Morral, in press) grants to manualize outpatient, short-term residential and therapeutic community programs and evaluate their effectiveness with over 1800 adolescents. The individual grantees will be responsible for distributing their own model. A list of current publications can be obtained from Randy Muck (rmuch@samsha.gov)
2002	CSAT will start releasing the results of its Persistent Effects of Treatment Study of Adolescents (PETSA) with 1200 adolescents from CYT outpatient programs and ATM residential programs followed up at 24, 30 and 42 months. Some of the early results will appear in a special issue of Evaluation in Program Planning due out in late 2002, and PETSA maintains an on-line bibliography at www.samhsa.gov/centers/csat/csat.html (then select PETS from program resources)
2002	The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and CSAT

	have collaborated to fund over a dozen independent grants to develop and evaluate new approaches to adolescent treatment that are expected to start publishing their findings in 2002.

The Emerging Renaissance of Adolescent Treatment

This emerging renaissance of adolescent treatment promises to continue for many years. In addition to the studies already in the field, there are several major initiatives just getting underway. CSAT is funding several five-year studies to develop and evaluate community-based efforts to create continuum of care models for adolescents that include linkage to schools and juvenile justice agencies. CSAT and NIDA are collaborating on studies of continuing care after adolescent residential treatment. The Robert Wood Johnson Foundation is funding a guide to adolescent treatment and several demonstrations linking treatment with the juvenile justice system. NIDA and NIAAA are also continuing to fund several individual grants related to individual aftercare. Within the next five years, we expect the development of several dozen, evidence. It is expected that elements of the infrastructure of such studies will also be increasingly mainstreamed, e.g., standardized assessment, competency-based training, treatment manuals, and model fidelity instruments/procedures, and rigorous clinical supervision.

In addition, it is anticipated that adolescent treatment in the coming decades will make major advances in such areas as early intervention strategies, clinical engagement and retention techniques, and the ability to match particular interventions to particular subpopulations of clients. Perhaps most significantly, we anticipate that the treatment of adolescent substance use disorders will shift (for those adolescents presenting patterns of high problem severity and complexity) from sequential, self-encapsulated episodes of acute care (assess, admit, treat, discharge) to a more time-sustained, community support model of recovery management. This will integrate existing clinical approaches within a deeper understanding of the social and cultural ecology of adolescent recovery. The treatment of adolescent substance use disorders is moving from the status of a folk art to that of a science-guided endeavor.

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Addiction and Recovery among African Americans before 1900

William L. White and Mark Sanders

There are many themes imbedded within the early history of alcohol and other drug use among African Americans that can heighten the sensitivities of today's addiction counselor.

Africa: Cultural Cohesion and Control of Intoxicants

Most African people brought to America as slaves came from West African cultures in which beer and wine had been blended into the economic, social, and religious customs since antiquity. Within non-Islamic African cultures, highly defined drinking rituals encouraged moderate drinking and stigmatized drunkenness as a threat to the order and safety of the tribe. Alcohol problems rose in tandem with the colonization and deculturation of African tribes—a process strikingly similar to the rise of these same problems within many Native American tribes (Pan, 1975).

Alcohol and Slavery

The African slaves' access to alcohol in America was governed by the Slave Codes. These codes governed all aspects of slave life, prohibiting living by oneself, traveling without a pass, gathering in groups, and owning a weapon. Buying or drinking alcohol was prohibited except under conditions defined by the slave's owner (Larkins, 1965). The restrictions on drinking were spawned by two concerns. First, slave owners were worried about alcohol-related damage to their property, e.g., the financial loss incurred if a slave was injured or killed while drinking. Second, slave owners feared slave insurrections after the slave revolts led by Gabriel Prosser (1800), Denmark Vesey (1822), and Nat Turner (1831), and believed that alcohol could spark such rebellions (Katz, 1990).

Freed Blacks often chose not to use alcohol, seeing sobriety as a prerequisite to personal safety and citizenship. Where Black people had access to alcohol, they were so moderate in their drinking habits that the medical community described them as racially immune to the influence of alcohol (Herd, 1985). There was one major exception to this pattern of abstinence and moderation among the slaves.

Alcohol as a Weapon of Degradation and Exploitation

Intoxication of slaves was promoted during harvest and holidays through the provision of large quantities of cheap, concentrated alcohol. Drunkenness was assured via the sponsorship of drinking

contests among the slaves. In his autobiography, Frederick Douglass described the role that such ritual intoxication played in the institution of slavery.

> *These holidays serve as conductors, or safety valves, to carry off the rebellious spirit of enslaved humanity….When a slave was drunk, the slave holder had no fear that he would plan an insurrection; no fear that he would escape to the north. It was the sober, thinking slave who was dangerous, and needed the vigilance of his master to keep him a slave.* (Douglass, 1855, p. 256)

In spite of the efforts of Douglass, drinking and intoxication among Black people increased following emancipation, with White's continuing to control, and profit from, the infusion of alcohol into the Black community (Christmon, 1995).

Alcohol also played a role in the violent victimization of Black people. In spite of White fears of alcohol-inspired violence, the reality was quite the opposite. The earliest and most significant alcohol problem for Black people in America—in the North and the South, both slave and free—was the risk of what could happen to them when White people became intoxicated (Blassingame, 1972).

Early African American Recovery

While alcoholism as it is clinically defined today was rare among African Americans before and after the Civil War, there are isolated accounts of African Americans being treated for alcoholism. One of the earliest reported "cures" of an African American is in Dr. Benjamin Rush's 1874 treatise on alcoholism. Accounts of recovery activism among African Americans increased through the nineteenth century. According to the research of Crowley (1997), Frederick Douglass may be the most prominent of early African Americans in recovery. Douglass openly talked about a period of intemperance in his life, signed a pledge of abstinence in 1845, maintaining sobriety the rest of his life, and worked to promote Black temperance groups.

Douglass saw sobriety as a prerequisite to liberation and full citizenship. Through his encouragement and example, nineteenth century African Americans generated their own temperance and mutual aid societies, e.g., the Black Templars. These societies and their pledges framed sobriety within the historical and cultural context of the post-Civil War years:

> *Being mercifully redeemed from human slavery, we do pledge ourselves never to be brought into slavery of the bottle, therefore we will not drink the drunkard's drink: whiskey, gin, beer, nor rum, nor anything that makes drunk come.* (Temperance Tract for Freedman) (Cheagle, 1969, p. 29)

Back to the Future: Race and Cocaine

American slaves had only limited contact with drugs other than alcohol, and this limited exposure continued after emancipation. This lack of significant exposure is contradicted by late nineteenth century media reports of the "Negro cocaine fiend." These reports charged that cocaine incited Black men to sexually assault White women and that spreading cocaine use among Blacks could spark an uprising against White society. Typical of such reports is a 1914 article by Dr. Edward Huntington Williams in *The Medical Record* describing how the sexual desires of the Negro Cocaine user were "increased and perverted" to such an extent that he was a "constant menace to his community until he is eliminated "(p. 247). The image of the "cocaine fiend" constructed in the medical and popular press was that of a Black man whose "immunity to shock, together with the fearlessness, hallucinations, and homicidal tendencies" made him an "object of special dread" to the White race (Williams, 1914, p. 248).

What is remarkable about these accounts is the complete lack of data to

support the claim of widespread cocaine use among African Americans during this period of history. Historians who have investigated this question report no evidence of widespread cocaine use among Black people or that any such use was linked to violence or sexual assault (Courtwright, 1983; Spillane, 1994). At a time when cocaine use was an overwhelmingly White problem, the public image of the cocaine user was overwhelmingly Black—a phenomenon repeated a century later.

Some Brief Reflections

What can be learned from these brief historical vignettes? Several lessons seem clear. The first, drawn from pre-colonial Africa, is that strong communities and indigenous institutions constitute one of the most powerful forces for the prevention of alcohol- and other drug-related problems. Conversely, the weakening of cultural institutions dramatically heightens community and personal vulnerability for such problems. This suggests that, for a besieged people, personal recovery is inseparable from the health of the larger community.

The second lesson is the sustained influence of racism upon the public portrayal (misrepresentation) of alcohol and other drug use in the African American community. Such misrepresentation undergirded the birth of slave codes, drove the spread of anti-alcohol and anti-cocaine laws in the South in the late nineteenth century, and fueled the anti-cocaine laws and racial patterns of enforcement in the late twentieth century that injected the criminal justice and child protection systems as colonizing and occupying institutions within poor African American communities. While African Americans currently represent 15% of illicit drug consumers (NIDA Household Survey), African Americans constitute 60% of those incarcerated in state prisons on felony drug charges (U.S. Dept. of Justice, Bureau of Justice Statistics). While illicit drug use during pregnancy is equal for White and African American women, the latter are ten times more likely to be reported for prenatal drug use (Chasnoff, et al, 1990).

Third, alcohol and other drugs have long been used as tools of exploitation and pacification of the African American community. This trend can be seen from the ritualized intoxication of the slave, to the early control of alcohol and drug markets by people outside the African American community, to the modern targeting of African Americans by the alcohol, tobacco and illicit drug industries.

Fourth, there is an enduring African American tradition of using indigenous religious and cultural institutions as frameworks for the personal resolution of alcohol and other drug problems. From the Black Templars to the Black Nation of Islam, from the integration of A.A. and N.A. in the mid-twentieth century to the rise of Afro-centric models of prevention and treatment in the late twentieth century, African Americans have found resources within their communities to resolve alcohol and other drug problems (Williams, 1992; Sanders, in press).

The history we are reviewing is important to the addictions counselor because it is a living history. When a White counselor and an African -American client sit in a room together, the ghosts of slave and slave master shimmer in the air until that history is buried in each developmental stage of the helping relationship. When an African-American coerced to treatment first encounters an African-American counselor, the ghosts of the house slave and field slave are there with them until an authentic, present-oriented relationship is developed. The emotional memory of this history lives even where the detailed knowledge of the history is unknown to both client and counselor. Buried within this history are demons of rage, fear, and guilt that must be exorcized if we are to avoid replicating the worst of this history in our service relationships (Bell, 1992; Green, 1995).

The history we are reviewing reminds us that what is commonly called psychopathology can also be understood in terms of toxic social processes–an

understanding that calls for the healing of communities and cultures as well as individuals. That same history also reveals styles of collective resistance and survival that can be tapped to ignite and enrich the process of addiction recovery.

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Trick or Treat?
A Century of American Responses to Heroin Addiction

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When Congress passed the 1972 Drug Abuse Treatment Act, it forged a federal-state-local partnership that called for shared responsibility in the design, implementation, operation, monitoring, and evaluation of community-based, multi-modality narcotic addiction treatment programs across the United States. This paper reviews the evolution of American approaches to the treatment of narcotic addiction from the first professionalization of addiction treatment in the 1870s to the rise of these modern multi-modality treatment systems in the late 1960s and early 1970s. Changing treatment technologies will be outlined within five overlapping periods that collectively laid the foundation for the current system for treating heroin addicts in America. Particular note will be made of the vacillating views on the etiology and nature of heroin addiction, the ambiguous claims of institutional ownership of the heroin problem, the shift in the goal of treatment from that of personal recovery to one of containment of social costs, and America's enduring ambivalence (if not open hostility) toward narcotic maintenance.

I. The Pre-heroin World of Addiction Treatment: 1830-1898

America's earliest narcotic addiction problems were iatrogenic in nature. They were spawned by the isolation of morphine and codeine, the introduction of the hypodermic syringe, the widespread distribution of opiate drugs by physicians, and the aggressive marketing of opiate-laced medicines by a multi-million dollar patent medicine industry. Narcotic addiction rose in a 19th century America that had few non-narcotic alternatives for the management of acute and chronic disease or trauma (Musto, 1985; Courtwright, 1982).

Nineteenth century narcotic addicts, like many of their 20th century counterparts, were likely to find themselves in generalist systems of care that lacked any special knowledge of or specialized approach to the treatment of narcotic addiction. Many addicts sought help from private physiciansBsometimes the same physicians that were the source of their introduction to opiates. Others sought discrete detoxification in such non-specialty institutions as water cure

establishments or private rest homes. Still others found themselves coerced into private hospitals or legally committed by family members to state insane asylums.

Growing concerns about alcoholism, narcotic addiction, and addiction to non-narcotic drugs such as cocaine and bromides during the second half of the 19th century and the growing perception that existing institutions were not adequately responding to these problems birthed the first specialized addiction treatment institutions in America. There were five overlapping branches of this emerging field of addiction treatment. There were inebriate homes like the Washingtonian Home of Chicago that were sponsored by religious or temperance organizations. These homes viewed addiction recovery as a process of moral reformation. There were the more medically oriented private or state-sponsored inebriate asylums, such as the New York State Inebriate Asylum. The inebriate homes and asylums were linked organizationally with the founding of the American Association for the Study and Cure of Inebriety in 1870 and through Association's central organ, *The Journal of Inebriety*. These institutions embraced all addictive disorders within the umbrella concept of Ainebriety@ and viewed inebriety as a "disease" that could be either inherited or acquired and that could be cured with appropriate treatment (Proceedings, 1981). In addition to the inebriate homes and asylums, there were also private proprietary institutes and sanataria, some of which, like the Keeley Institutes, Neal Institutes and Gatlin Institutes, operated as for-profit addiction cure franchises with branches all over the country. Such institutes catered to affluent narcotic addicts, including many physicians and others from the professional classes. Most of those admitted to inebriate homes, inebriate asylums, and proprietary institutes were there for the treatment of alcoholism, but these institutions did admit narcotic addicts, and there were also private institutions in the 19th century that specialized in the treatment of narcotic addiction. These latter included the DeQuincey Home operated by Dr. H.H. Kane and the Brooklyn Home for Habitués operated by Dr. J. B. Mattison. Finally, there were bottled home cures for narcotic addiction promoted by the same patent medicine industry that was spewing opiate-laced home remedies across the land. These medicinal specifics that claimed to cure narcotic additionBproducts such names as Denarco, Opacura, and Antidote--almost all contained high dosages of morphine and provided little more than disguised drug maintenance.

Nineteenth century treatment methods for narcotic addiction focused almost exclusively on withdrawal and brief physical convalescence. There were three general approaches: 1) abrupt withdrawal over 24-36 hours, 2) rapid withdrawal over four to ten days, and 3) gradual withdrawal over a period of weeks or months. A wide variety of pharmacological adjuncts were utilized to facilitate withdrawal: narcotic substitutes such as codeine, non-narcotic substitutes such as cannabis or cocaine, tonics such as whiskey or strychnine, sedatives such as chloral hydrate, purgatives that were thought to speed the elimination of narcotic poisons, and belladonna derivatives such as hyoscine and scopolamine whose induced delirium, confusion and forgetfulness tended to prevent the addict's flight from care. Agents used toward the goal of reducing the enduring craving for morphine included aversive agents like tartar emetic and plants such as Avena sativa. (White, 1998) The choice of some of these pharmacological treatments is surprising by today's standards. American physicians as early as 1880 were prescribing cocaine (by the pound) as a treatment for morphine addiction and reporting, as a testament to the cocaine's effectiveness, that their patient' s were requesting additional quantities of cocaine and that they had completely lost their appetite for morphine (Bentley, 1880). Withdrawal and post-withdrawal convalescence were also aided by such treatment adjuncts as hydrotherapy, massage, specialized diets, electrical stimulation, and special exercise regimens.

Autobiographical accounts of 19th century narcotic addicts describe such treatments as excruciating and uniformly ineffective (Day, 1868; Cobbe, 1895). Relapse rates were exceptionally high but publicly shrouded behind the advertised cure rates of addiction treatment institutesBclaims that usually exceeded 95% and were based on either a patient' s status at discharge or the percentage of patients that did not call for re-admission.

As we move into the twentieth century, there are two things that rendered this makeshift system of 19th century narcotic addiction treatment inappropriate for the new problem of heroin addiction. First, much of this system collapsed in the first two decades of the 20th century. A decline in morphine addiction produced by new prescription laws and improved physician education, ethical breaches and public exposés of both institutional treatment and the patent medicine cures, economic depressions, and state and then national alcohol prohibition laws all worked to decrease demand for addiction treatment institutions and withdraw financial resources that supported such institutions (White, 1998). Second, the early 20th century heroin addict could not have been more different from their 19th century, morphine-addicted counterparts. Heroin addicts were male rather than female, young rather than middle aged, more likely to live in urban cities of the North than the rural South, more likely to be children of immigrants than the native-born, used narcotics for pleasure rather than for relief of pain, and were more likely to be viewed as incorrigible than sick. They also had neither the social standing nor the financial resources to gain access to the remnants of what was in essence a private treatment system (Terry and Pellens, 1928). As heroin addiction spread in the 20th century, what was needed was not a refinement of 19th century treatment methods but a newly configured approach to treatment based on an understanding of heroin and the characteristics of those who were being drawn to it.

II. The Clinic and Community Hospital Period: 1898-1924

Three public policy milestones marked the shift in the treatment of narcotic addiction in the United States during the first two decades of the 20th century: 1) the passage of the Harrison Tax Act in 1914, 2) the 1919 *Webb. v. the United States* Supreme Court decision, and 3) the failure of the France Bill to pass Congress in 1919. The first two produced the de-facto criminalization of the status of addiction in the United States. The Narcotics Division of the Department of Treasury took the position that addicts should not be maintained on narcotics when acceptable cures were available. Physicians who maintained addicts on their usual and customary doses of narcotics were considered to not be practicing in good faith as defined in the Harrison Act and were subject to criminal arrest. More than 25,000 physicians were indicted under the Harrison Act between 1919 and 1935 and 2,500 were sentenced to prison (Williams, 1935, 1938). The France Bill provided a unique window of opportunity to alter the early course of American narcotics control policy. The Bill would have provided federal funds for local communities to establish addiction treatment programs and to utilize the services of the U.S. Public Health Service hospitals as backup for these community-based services. The failure of this Bill to even come to vote shifted responsibility for the care of addicts squarely on the shoulders of local communities.

Many communities responded by establishing local narcotics clinics to care for addicts. These clinics maintained incurable and infirm addicts on stable doses of narcotics while encouraging more able-bodied addicts to undergo detoxification via gradual outpatient withdrawal or rapid withdrawal in local hospitals. The goals of the clinics were twofold: 1) to provide consistent medical management of narcotic addicts, and 2) to suppress the illicit drug traffic by keeping addicts from falling prey to drug peddlers. The clinics varied greatly in their operation. Clinics like those operated by the State Board of Public Health in Shreveport, Louisiana or the police department in New Haven, Connecticut were highly regarded, while others such as the Worth Street Clinic in New York City were castigated for their disorganization and ineffectiveness. Neither the Worth Street Clinic nor Riverside Hospital where addicts were encouraged to complete final detoxification produced any notable cures among the thousands of addicts they admitted (Graham-Mulhall, 1921). What was christened “ambulatory treatment” came under bitter attack from law enforcement authorities and from the national medical establishment. (Bureau of Narcotics, 1955; Council on Mental Health--AMA, 1966) During the early 1920s, all of the clinics closed under threat of indictment. America’ s brief experiment with

morphine and heroin maintenance had been declared a failure by administrative fiat of the Narcotics Division of the Department of Treasury.

The fledgling specialty of addiction medicine was all but obliterated between 1914 and 1924. Physicians who continued to treat narcotics outside of Lexington and Forth Worth did so at great peril to their professional reputations and licenses—risks that for most were just too great. It would be more than 50 years before significant numbers of physicians re-involved themselves in the on-going care of heroin addicts. With the closing of the last clinic, responsibility for the care of addicts was removed from physicians and turned over to criminal syndicates.

III. The Vacuum: 1924-1935

Isolated voices of protest of the de-medicalization and criminalization of addiction did not alter the reality that, between 1924 and 1935, there were almost no resources available for the treatment of narcotic addicts. While affluent, middle-aged addicts sought discrete detoxification in a new generation of private hospitals--such as the Charles B. Towns Hospital for Drug and Alcoholic Addictions in New York City, a growing number of young heroin addicts were more likely to undergo withdrawal in a jail cell than in a hospital bed. When state-supported inebriate asylums closed, states did loosen commitment laws to allow for the admission of addicts into state psychiatric hospitals, but few of these facilities providing any specialized approach to the treatment of addiction. An exception to this rule was the California State Narcotics Hospital at Spadra that provided institutional treatment for addicts from 1928 to 1941 (Joyce, 1929).

Physicians within private and community hospitals continued to focus on the problem of narcotic withdrawal. Withdrawal regimes going by such names as the Towns-Lambert Treatment, the Pettey Method, the Nellens and Masse Method, and Narcosan vied for prominence as a means of quickly detoxifying addicts. But there was growing agreement that most of these methods produced few enduring cures. The vision of a medicinal specific that could cure narcotic addiction gave way to therapeutic pessimism in the late 1920s (Musto, 1973). The shift from viewing addicts as diseased to viewing addicts as depraved marked a new era of coercive and invasive methods of suppressing and managing addiction. Addicts denied access to hospitals entered the criminal justice system in ever-increasing numbers. A Eugenics Movement that attributed America' s social problems to bad breeding successfully lobbied for inclusion of addicts in state mandatory sterilization laws. Inebriate commitment laws were expanded to provide for the involuntary commitment of narcotic addicts to state insane asylums. As heroin use became increasingly associated with young male criminals, it was proposed that addicts be indefinitely quarantined in inebriate colonies so that addiction could be prevented from spreading to the larger community. It is perhaps not surprising in this context that perceptions of the causes of addiction shifted from discussions of the addict' s diseased cells to the addict' s psychopathic character (Compare: Crothers, 1902, Bishop, 1912 or Pettey,1913, with Kolb, 1925). Perhaps this growing climate of contempt for the addict can help us understand the introduction of brutally invasive cures during the opening decades of the twentieth century. There were the so-called Aserum therapies@ that involved raising blisters on the addict' s abdomen and thighs, withdrawing the fluid from the blisters, and then re-injecting it into the addict over several days of withdrawal (Radddish, 1931). There were the "blood therapies" that involved withdrawing blood from the addict and then re-injecting it over the course of heroin withdrawal. There were sodium thiocyanate-based withdrawal therapies that could induce psychoses for up to two months duration (Bancroft and Rutzler, 1931). But even these treatments paled next to Abromide sleep treatments@ that continued to be recommended as a withdrawal strategy in spite of early reports of a twenty percent death rate (Church, 1900).

IV. The Narcotic Farm Era: 1935-1965

Calls for the creation of specialized hospitals for the treatment of narcotic addicts increased during the 1920s from such influential persons as Dr. Lawrence Kolb of the U.S. Public Health Service. These calls became more strident when, by 1928, more than two-thirds of federal inmates were addicts. Overcrowding produced by the growing numbers of addicts entering federal prisons and the lack of any systematic approach to the care of addicts led congressional passage of the Porter Act in 1929. This act called for the creation of two "narcotics farms" to be operated by the U.S. Public Health Service. The first of these farms-hospitals-prisons opened in Lexington, Kentucky in 1935 and the second opened in Fort Worth, Texas in 1938. These institutions were to treat addict prisoners and addicts voluntarily seeking treatment. All addicts east of the Mississippi River were treated at Lexington; those west of the Mississippi River were treated at Fort Worth. Lexington could accommodate 1,400 inmates at a time and Forth Worth could accommodate 1,000.

Between 1935 and the late 1950s, the Lexington and Forth Worth facilities constituted the primary source of addiction treatment in the United States. Treatment at the U.S. Public Health Hospitals was divided into three phases: withdrawal, convalescence, and rehabilitation. The evolving character of the illicit drug culture is revealed in the changing profile of the addicts admitted to Lexington and Fort Worth. The self-medicating aged and infirm addict continued to give way to the young addict, morphine continued to give way to heroin as the addict' s drug of choice, and non-white admissions increasing from 12% in 1936 to 56% in 1966.

Treatment was administered by interdisciplinary teams of physicians, psychiatrists, nurses, social workers, chaplains, and recreational therapists. Following drug-aided withdrawal, inmates were moved to wards where they spent most of their time working in such institutional industries as farming, landscaping, and construction labor for which they were reimbursed with cigarettes. The length of stay was variable and problematic. Involuntary patients stayed to long (because of the length of their sentences) while voluntary patients often decided to leave before staff felt they were stable enough to avoid relapse. Evaluations of discharged patients from Lexington and Fort Worth consistently concluded that 90-95% of those discharged returned to the use of narcotics (Maddux, 1978). The Lexington and Forth Worth facilities were sustained until their function began to be taken over by the rise of local community-based addiction treatment. The Fort Worth facility was closed in 1971 and the Lexington facility was closed in 1974. The responsibility for the treatment of addicts with these closures officially shifted from the federal government to the states and local communities.

Those addicts not treated at Lexington and Forth Worth could, with sufficient resources, still be cared for by private physicians, be cared for in private settings such as the Towns Hospital, or be cared for in a growing number of local treatment experiments that began in the 1950s. Most were likely to find themselves treated within a psychiatric institution. Whether at a private hospital such as the Menninger Foundation in Topeka, Kansas or one of many large and overcrowded state psychiatric hospitals, addicts were subjected to whatever was currently in vogue in psychiatric care. Private treatment was heavily influenced by psychoanalytic thinking that portrayed addiction as sexually-derived character disturbance in the same category as kleptomania, Don Juanism, and gambling. Treatment, in this view, involved a several month sanitarium stay that consisted primarily of rest and individual psychoanalysis (Knight and Prout, 1951). While the use of methadone as a highly effective aid to withdrawal began at the U.S. Public Health Hospitals as early as 1948, withdrawal treatments outside these settings remained quite primitive. The range of experimental treatments that addicts were subjected to in psychiatric institutions, prison hospitals, and in community care settings is astounding. The earlier noted serum (blister) cures continued to be practiced in the 1930s in settings like the Colorado State Penitentiary. The 1940s and 1950s witnessed treatments that included the use of electroconvulsive therapy (ECT) and insulin shock therapy as an aid to addict withdrawal, the use of hibernation therapy (withdrawal aided by sodium pentothal narcosis), the use of

apomorphine and socinyl choline to induce an aversion to narcotics, the experimental use of psychosurgery (the prefrontal lobotomy) as an addiction treatment, the use of LSD as an adjunct in psychotherapy with addicts, the use of anti-psychotic drugs (phenothiazines) in narcotic withdrawal, and the use of methamphetamine as a medically prescribed substitute for heroin (Kleber and Riordan, 1982).

As a response to such ineffective and invasive treatments, it should not be surprising that the first American mutual aid society for narcotic addicts was birthed in this period. The roots of Narcotics Anonymous (N.A.) can be traced to "Addicts Anonymous" meetings at the U.S. Public Health Hospital in Lexington in 1947 which were organized by Houston S., a member of Alcoholics Anonymous. N.A.'s program of mutual support mirrored A.A.'s Twelve Steps and Twelve Traditions. N.A. struggled to survive in the 1940s and 1950s but eventually grew to a membership of more than 250,000 active members in the 1990s (Stone, 1997). Many treatment programs would eventually establish linkages with NA similarly to those they had earlier developed with Alcoholics Anonymous.

V. The Rise of Community-based Treatment

Two inter-related events set the stage for the rise of local experiments in the treatment of narcotic addiction. The first was a dramatic rise in juvenile narcotic addiction in the early 1950s and the second was the passage of laws in 1952 (The Boggs Act) and 1956 (The Narcotic Control Act) that dramatically increased penalties for possession and sale of narcotics—including the first potential for life imprisonment and the death penalty. These draconian measures spurred many groups to re-examine narcotics policy. Studies that began to portray addiction as a product of poverty and social deprivation, joint committee reports of the American Bar Association and the American Medical Association, and recommendations of the Presidential Advisory Commission on Narcotics and Drug Abuse all provided momentum for increased experimentation with more effective responses to the problem of drug addiction, as did a 1962 Supreme Court decision declaring that narcotic addiction was a disease.. A few states experimented with state-operated addiction treatment hospitals: Blue Hills Hospital in Connecticut and Avon Park in Florida. Local experiments spawned in this climate included a variety of church-sponsored addiction ministries in places such as Chicago and New York City. There were addict wards established in some community hospitals (Manhattan General Hospital.) and a special institution (Riverside Hospital) was opened in New York City specifically for the treatment of juvenile narcotic addiction.

Communities across the United States needed a means of responding to rising rates of addiction. What was required to fill this need were replicable models of addiction treatment. Two approaches to the treatment of heroin addiction emerged: the therapeutic community (TC) and methadone maintenance (MM).

TCs for the treatment of drug addiction were born in 1958 when Charles Dederich began an experimental mutual aid community called Synanon. While Synanon would not sustain its focus on addict rehabilitation, its early years set the model for TCs all over the United States. The model called for an addicts sustained (1-2 years) enmeshment in a confrontive, caring community of recovering addicts—a community that provided an authoritarian surrogate family in which the addict was regressed, re-socialized and then given progressively greater responsibility and contact with the outside community. The etiology of addiction was defined characterologically and recovery was defined as a process of emotional maturation. By 1975, there were more than 500 TCs in the U.S. modeled after Synanon (Yablonsky, 1965, Mitchell, Mitchell, & Ofshe,1980).

MM was pioneered in 1964 by Drs. Marie Nyswander and Vincent Dole who conceptualized heroin addiction as a metabolic disease and introduced the daily oral administration of methadone as means of stabilizing the addict' s disordered metabolism so that full rehabilitation could be possible (Dole, 1997). With appropriate doses of methadone, addict' s discovered a

zone of stable functioning that prevented acute intoxication on the one hand and narcotic withdrawal on the other. Following positive evaluations of the pilot sites, MM programs were established in urban areas across the U.S. By 1973, more than 80,000 heroin addicts were being maintained on methadone in licensed treatment programs scattered across the American urban landscape.

Other methods of treating heroin addiction in the 1960s and 1970s included renewed experiments with civil commitment programs, the use of narcotic antagonists as a treatment adjunct, alternative maintenance agents, new withdrawal adjuncts (acupuncture), and the introduction of new treatment monitoring tools—drug testing and aggressive case management. All of these approaches were integrated within a growing network of federal- and state-funded treatment programs. In Connecticut, Illinois and New York, methadone detoxification and maintenance (both residential and outpatient), residential therapeutic communities, outpatient drug-free programs and a number of new special populations programs began to be integrated within multi-modality treatment systems. By 1975, there were more than 1,800 local drug treatment programs in the country supported by a newly forged federal and state partnership. The modern era of addiction treatment had begun.

VI. Themes and Closing Observations

I would offer the following observations regarding the evolution of the treatment of heroin addiction in America.

Trends The story of heroin addiction in America is a story of changing heroin potency, changing methods of heroin administration, changing motivations for heroin use, changing characteristics of heroin users, and the changing nature of the illicit drug culture in America. Views of heroin addiction and its treatment at any point in time must be defined within the context of these elements.

Problem Perception Perceptions of the etiology of heroin addiction have placed the locus of vulnerability within the biology of the addict ("disease" conceptualizations), the moral or emotional architecture of the addict (characterological explanations), and the social environment of the addict (sociological explanations). Early treatment reflected a single pathway model that posited singular causative agent and a singularly narrow approach to treatment. Later multiple pathway (ecological) models have posited varied etiological pathways, multiple clinical subpopulations, and the need for highly individualized approaches to treatment. These latter models have emphasized the important of understanding initiating and sustaining (consolidating) factors in heroin addiction and the interaction of biological, psychosocial and spiritual dimensions to addiction and recovery.

Role of the Physician Supervision of the heroin addict was removed from physicians in the early 20th century and turned over to criminal syndicates and the criminal justice system. The major story of the last half of the 20th century is the rebirth of addiction medicine and the rising responsibility of the physician in the treatment of heroin addiction. Only time will tell whether this involvement is sustainable.

Treatment Environment There are cyclical and co-existing trends of isolation and integration that mark the treatment of heroin addiction in the U.S. During periods in which the addict is demonized and addiction is portrayed as contagious, addicts are socially extruded (quarantined) in the name of treatment. The sequestration of incurable addicts was effected in a most unusual way in the United States. By criminalizing addiction, the American prison system, without acknowledgment, absorbed the functions set

forth in early proposals for the establishment of addict colonies. During periods of greater social stability and less fear, efforts are made to localize the treatment of addicts within non-institutional models of care.

Treatment Specifics Since the mid-1800s, narcotic addiction specialists have sought a "specific" a pharmacological intervention that could restore the addict's cells and psyche to their pre-addiction state. To date, that search has failed. It is unlikely that any specific, by itself, will ever be capable of severing the addict's relationship with a drug and a drug culture that have become the center of his or her existence.

Treatment Methods The major achievement in the treatment of heroin addiction in the 20th century is the recognition that narcotic withdrawal does not in and of itself constitute treatment. All our advancements have grown out of this shift from the preoccupation with the mechanics of withdrawal to the more difficult issues of managing drug craving and chronic drug-seeking behavior.

New Treatments New breakthroughs announced in the treatment of heroin addiction are notoriously unreliable. Claims ranging from the grandiose to the optimistic often break down when tested by controlled studies and cumulative clinical experience.

Treatment Replication Treatment innovations have often been corrupted during their widespread replication. Such replications are marked by a loss of the core technology as well as by a shift in focus from one of personal recovery for the addict to social control of the addict. Such problems were encountered in the replication of both therapeutic communities and methadone maintenance.

> "The stupidity of thinking that just giving methadone will solve a complicated social problem seems to me beyond comprehension."
> --Dr. Vincent Dole, Co-developer of Methadone Maintenance (Courtwright, et.al., 1989)

Treatment Intensity What modern models of narcotic addiction from the original designs of the therapeutic community and methadone maintenance shared in common was a belief that treatment for narcotic addiction needed to be characterized by high intensity and long duration. In short, there was a belief that positive treatment outcomes were related to treatment dose both qualitatively and quantitatively. This premise is being challenged by a system of behavioral health care that is using an acute care model of low intensity, brief interventions in both the public and private sector. This shift could pose the greatest threat to the future of treatment for heroin addiction.

Drug Maintenance The consistently positive evaluation of narcotic maintenance (in spite of model diversion and erosion) has done very little to alter this country's continued feelings (ranging from ambivalence to open hostility) about this modality.

Addict Vulnerability Addicts and their families are exceptionally vulnerable for exploitation. The social demonization of the addict, the political manipulation of the resulting fear of the addict, capitalization on the issue of addiction for personal and bureaucratic gain, and the continued presence of fraudulent cures are enduring themes in the history of heroin addiction in the 20th century.

Treatment Harm

In discussions of heroin, the term "Aiatrogenic@ has been used to denote addiction that grew out of the use of heroin as a medical treatment—a phenomena, as David Courtwright has documented in this volume that was not a widespread problem. But there is another more relevant use of the term iatrogenic in this arena and that regards the injury that has been caused to addicts under the auspices of care. When one considers a history of addiction Atreatments@ that include agonizing withdrawal regimes, multi-year legal commitments, psychosurgery, electroconvulsive therapy, serum therapy, and the administration of a wide spectrum of toxic and aversive drugs, it is clear that harm done in the name of good is an enduring thread within the history of addiction treatment in America.

The Lack of Voice

The voices of American narcotic addicts, in contrast to addicts in some European countries or American alcoholics, have rarely been heard on questions of social policy or treatment. There has been no indigenous modern narcotic addiction movement mirroring the achievements of the "modern alcoholism movement." No grassroots consumer movement has impacted narcotic addiction treatment in America.

Mutual Aid

A major factor in alcoholism recovery in America has been the rise of Alcoholics Anonymous and other alcoholic mutual aid societies and the local linkages established between these groups and alcoholism treatment agencies. In contrast, linkages between agencies treating heroin addiction and Narcotics Anonymous have not reached the same level, either quantitatively or qualitatively. NA remains one of the most potentially beneficial but underutilized resources in the treatment of heroin addiction.

Addiction as Chronic Disease

A quite useful emerging model of narcotic addiction treatment views such addiction for a significant percentage of addicts as a chronic disease characterized by periods of remission and relapse. Such a view suggests that addicts may need different types of treatment and support services at different points in their addiction/recovery careers. In terms of treatment matching, this paradigm suggests not just that different treatments need to be carefully matched to particular addicts but that the same addict may require different treatments at different points in time. This model further posits that treatment episodes need to be evaluated not in terms of their event effect but in terms of their cumulative effect.

Natural Resources

There has been a growing recognition through studies of what is being variously christened as maturing out, spontaneous remission, and natural recovery that there are sources of resiliency within the addict and the addict's natural environment that can aid addiction recovery (Winick, 1962; Biernacki, 1986). The most successful treatments of the future will find ways to align themselves with these natural forces.

Problem Ownership

Heroin addiction constitutes one of the intractable problems of the 20th century. The ownership of such intractable problems is inherently unstable. (Room, 1978) America' s ambivalence about a drug that promises not only relief from pain but pleasure and escape; disregard for people associated with the drug' s use; and fear that those close to us are, or could be, within this drug' s reach have kept

ownership of this problem forever shifting across the boundaries of religion, law and medicine. Which arena, and where within each arena, an addict was likely to be involved during any decade of this century was influenced primarily by issues of age, gender, race, social class, and geography.

Vulnerability of Treatment Systems

Systems of addiction treatment--the 19th century network of inebriate homes and asylums, the early 19th century maintenance clinics, the federal narcotics hospitals—are prone to collapse in the face of any or all of the following conditions: highly publicized ethical abuses, economic depressions that erode their financial viability, a public image of treatment as a place where the rich or the bad are coddled and protected from the consequences of their behavior, a shift from medical to criminal models of viewing addiction (usually during periods of heightened social disorder), failure to develop a credible treatment technology, and the failure to address problems of leadership development/succession (White, 1998).

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The Treatment Renewal Movement

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Two emerging movements, a new grassroots recovery advocacy movement and a treatment renewal movement will, through their success or failure, reshape the character of addiction treatment and recovery in America in the early twenty-first century. This second article of a two-part series describes the latter of these movements.

The Context for Renewal

There are several forces from outside the field of addiction treatment that are challenging the field's cultural ownership of alcohol and other drug problems. The restigmatization, demedicalization and recriminalization of these problems in the 1980s and 1990s undermined the perceived legitimacy of addiction treatment as a cultural institution and moved a growing number of people with alcohol and other drug problems from systems of professional care to systems of punishment and control. During this same period, a loosely organized backlash movement challenged the conceptual foundations of modern addiction treatment. This movement's core texts, celebrity speakers and internet web sites argued that:

- Alcoholism/addiction is a myth–that no such self-contained clinical entity exists (Davies, 1992, 1997).
- Excessive alcohol and other drug use is not a disease; it is a choice (Fingarette, 1989; Schaler, 2000).
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The field of addiction treatment also faced technical and ethical challenges in the 1980s and 1990s that tarnished its image and contributed to rising therapeutic pessimism about the prospects for permanent recovery from addiction. The technical deficiency involved using an acute model of intervention and then overselling the ability of a single, brief treatment episode to bring severe alcohol and other drug problems into sustained remission. Subsequent serial episodes of acute treatment for large numbers of clients left communities concluding that 1) individuals who return to alcohol/drug use following

treatment are failures and untreatable, 2) the local program is not a "good" program, or that 3) the condition itself is untreatable and should be managed in other ways. The public image of treatment institutions was also injured by exposés of exploitation within such arenas as marketing, fee-setting/collection, and financially-motivated admission, discharge, re-admission, and length of stay decisions. These exposés portrayed treatment practitioners more as hustlers than healers. As the public perception of the value of addiction treatment changed, the treatment field was forced to take a serious look at itself.

II. State of the Field

Most professional fields and the organizations that make up such fields go through cycles of renewal and decline. Periodically replenishing a field from within is as essential as renewing its relationship with the culture and communities within which it is nested. There were a number of critical signs in the 1990s suggesting the need for such a renewal process in the field of addiction treatment.

Decay was evident in the declining membership of key organizations. The number of affiliates of the National Council on Alcohol and Drug Dependence declined from a peak of more than 240 in the early 1980s to less than 90 by the late 1990s. Membership in the National Association of Addiction Treatment Providers fell from its peak of 800 in the late 1980s to 96 in 1996, before beginning to rise again to its current membership of 182. NAATP membership attrition reflected the dramatic decline in hospital-based and private treatment programs in the 1990s. Similarly, membership in NAADAC declined from 17,204 in 1994 to 13,162 in 2000. All of these declining numbers were accompanied by something of an identity crisis as many addiction treatment programs (and their funding authorities) were merged within larger mental health or public health entities. By 2000, the field was growing at its periphery (e.g., into the criminal justice and child welfare systems) at the same time its historical core appeared to be shrinking. Old-timers began to lament the potential death of the field by diffusion and absorption–a loss of the field's core values and service technologies amidst the illusion of the field's continued existence.

Another sign of concern at the close of the century was the pattern of tenure and turnover in the field. Senior administrative and clinical positions in many agencies were filled by persons who had long served in these roles, while surveys revealed a 30-40% annual turnover rate for front line service positions. The field now faces significant morale problems among its front line practitioners at the same time its elders are set to exit the field in mass in the next decade taking much of the oral history and experience from this modern era with them. When long time addiction counselors are asked to critique the state of the field, they often depict a field whose institutions have lost touch with their historical roots and founding missions and who have become isolated from the very communities out of which they were born. Many depict institutions more preoccupied with financial self-maintenance than clinical outcomes–seemingly more concerned with the presence of a progress note than the progress of a client. Others contend that addiction treatment has become detached from the larger and more enduring process of recovery and divorced from the major findings of addiction science. Collectively, they suggest that it is time the field conducted a searching and fearless self-inventory and got itself ethically and clinically re-centered.

The Treatment Renewal Movement

The signs of a treatment renewal movement can be seen across the country. It can be seen in professional meetings of addiction counselors where one hears repeated calls for a new wave of activism aimed at getting the field refocused on the long term recovery of clients and families. It can be seen in the reflections of the field's long-tenured leaders who at the sunset of their careers are seeking to solidify their

legacies. It can be seen in the coalitions with other agencies and indigenous institutions that are forging new models of serving multiple problem clients and families. It can be seen in the growing dialogue between researchers and front line counselors. It can be seen in the way that treatment agencies are working with new recovery advocacy organizations to enhance local community recovery resources. The three emerging goals of this treatment renewal movement are to:

- Refocus and refine the historical missions, core values and ethical standards of professional practice of addiction treatment agencies,
- Forge a meaningful integration of two ways of "knowing": the knowledge of science and the knowledge of cumulative clinical and recovery experience, and
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Keeping Our Eyes on the Prize An increasing number of treatment agencies are holding agency retreats to self-assess themselves as organizations and to get themselves reconnected with their past and repositioned for the future. Flowing from these meetings are re-commitments to service, refined mission and vision statements and new or updated codes of professional practice. These same processes are evident as agency leaders come together within their state, regional and national organizations. It is in these latter sessions that one finds broader discussions about extending this refocusing effort into the arena of policy advocacy. Also evident in such settings is a growing awareness of the coming leadership crisis and many emerging proposals for leadership development, leadership succession and increased staff support. This element of the renewal movement is strengthening the organizational infrastructures and service cultures of addiction treatment agencies.

Clinical Research and Clinical Practice The significant federal investment in addiction research is now paying dividends. Such dividends span new discoveries about neurobiological roots of addiction through the development of new evidence-based treatments. The list of potential applications of this research is a long one but particularly striking are:

- the conceptualization of addiction as a "brain disease" and the elucidation of the mechanisms of this disease process;
- new breakthroughs in the understanding of the role of trauma as an initiating and sustaining force in addiction and potential barrier to treatment and recovery;
- new developmental models of recovery with stage-appropriate engagement and intervention techniques;
- new pharmacological adjuncts; and
- the refinement of addiction treatment protocol for particular clinical subpopulations.

Also of note is the potential mainstreaming of clinical trials technology emerging from such studies as Project MATCH and the Cannabis Youth Treatment Study. The goal of such mainstreaming is not just to move evidence-based therapies into the front lines of addiction treatment but to also transfer the clinical infrastructure within which treatments are tested within multi-site randomized clinical trials (Carroll, 1997). This clinical infrastructure is itself part of the emerging technology of addiction treatment and includes such elements as:

- Defining, proceduralizing and manualizing the active ingredients of a particular treatment approach,
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instruments and procedures,
- individualizing treatment within the framework of clinical supervision, and
- applying principles of chronic disease management to the treatment of severe and persistent alcohol and other drug problems.

These research advances are propelling many agencies to shift from offering a "program" to offering "treatment and recovery support service menus" from which unique service ingredients, service combinations, and service sequences are being matched to the needs of particular clients/families.

Treatment, Recovery, Community

The board and staff of Dawn Farm (until recently a traditional therapeutic community in Ann Arbor, Michigan) invited a large number of stakeholders (funding agencies, current/former clients, allied agencies, mutual aid leaders, clergy, and local officials) to a community meeting. At the meeting, Jim Balmer, Dawn Farm's director, reviewed the organization's history and then acknowledged that Dawn Farm had evolved a variety of policies and procedures over the years that in their cumulative effect had made it harder for people to enter and successfully complete treatment. He concluded by offering an apology to the community and asking those present to enter into partnership with Dawn Farm to help the board and staff reshape Dawn Farm's relationship with, and responsiveness to, the local community. That renewed community partnership has led to a change in Dawn Farm's service philosophies and its involvement in such new ventures as street and jail outreach, sober housing and participation in multi-agency service models for clients with special needs. Dawn Farm is among a vanguard of addiction treatment programs who are redefining the relationship between treatment, recovery and community.

Understanding this power of the community to harm and heal is at the heart of efforts to move the locus of treatment and recovery from the hospital, residential program, or clinic into the natural settings in which AOD problems are initiated and sustained. This approach does not deny the role of biological or psychological variables in the onset of AOD problems, but it does force us to recognize that the long term course of these problems are influenced by the relative strength and pervasiveness of local cultures of addiction and cultures of recovery (White, 1996). Both barriers to and incentives for recovery exist in the community space surrounding our clients and it is into that space that addiction treatment professionals are beginning to carry their service interventions.

Treatment organizations that redefined themselves as businesses in the 1980s are now recapturing their lost identities as community service agencies. They are recapturing such lost functions as community education, community resource development, community organization, and public policy advocacy. They are moving into the very heart of their communities and, like Dawn Farm, inviting greater community and recovery constituency participation within their organizations. Treatment agencies are rejoining their communities and rediscovering the natural healing powers that lie within these communities. When universities became too isolated from their local communities, there were calls for these institutions to move back into the life of their communities–to become "universities without walls." What is emerging in this treatment renewal movement is advocacy for an analogous process of treatment and recovery without walls.

A Window of Opportunity

Very few professionals have an opportunity during their lifetime to shape the ultimate destiny of their chosen fields. That opportunity is at hand for addiction professionals. Leadership vacuums are emerging that must be filled.

As a field, we have too often played the role of the chameleon, reflecting not character but context, constantly changing color with the latest funding demand or

regulatory site visit. All too often we have let forces other than the needs of our consumers dictate who we treated; what, how and by whom treatment was provided; and when and how long treatment was provided. It is time the field broke the chains of its passivity and once again advocated, not for itself, but for the needs of those it is pledged to serve.

If there is anything addiction counselors know it is that there are brief developmental windows of opportunities that when capitalized upon can forever alter the trajectory of one's life. The same is true for cultures, communities, and professional fields. That window of opportunity exists today, but it is narrowing. The future of this field and the future of recovery in America will be shaped by our silence or our voice. Speak out about our need to remain client-centered. Become a serious student of addiction research. Lead the movement back into our communities. Where you see evidence of this treatment renewal movement, support it. Where this movement lies dormant, help incite it. We must speak boldly and act with courage while that window of opportunity is still open.

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The Treatment Renewal Movement

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The History and Future of "Aftercare"

William L. White, MA and Mark D. Godley, PhD
Chestnut Health Systems

At its best, modern state-of-the-art addiction treatment involves a sequenced process of screening, assessment, therapeutic intervention (often involving multiple levels of "stepped down" care), and relatively brief "aftercare" services that often include referral to mutual support groups. This model of care is successful for many clients, but a substantial percentage of clients, following only one or two levels of care, experience relapse and repeated admissions to acute treatment. This acute model of intervention and brief aftercare is being challenged by findings from the literature on chronic disease management as well as by a group of addiction treatment researchers who are advocating new models of sustained recovery management. In this article, we will review the history of aftercare, highlight lessons from recent continuing care research, and offer our vision of the future of continuing care as a concept and a clinical activity.

Aftercare: A Brief History

America's first addiction treatment programs—the nineteenth century inebriate homes, inebriate asylums and the for-profit cure institutes—were spawned by, or themselves spawned, recovery mutual aid societies, e.g., Washingtonian Temperance Society, Ollapod Club, Godwin Association, Ribbon Reform Clubs, and the Keeley Leagues. As inebriety specialists came to recognize the high rate of post-institutional relapse, they intensified linkages to these societies and began to organize their own systems of patient follow-up. Many medical superintendents maintained a prolific correspondence with former patients that evolved into the first institutional alumni newsletters.

Efforts to provide extended professional support following treatment remained weak until the Massachusetts Hospital for Dipsomaniacs and Inebriates established 29 outpatient clinics in 1906. These clinics marked the beginning use of outpatient treatment as a transition between institutional sequestration and re-entry into community life. The outpatient clinic model was further developed when the Emmanuel Clinic (Boston) started a social fellowship (the Jacoby Club) to support alcoholics during and after their treatment. Following its founding in 1935, Alcoholics Anonymous increasingly served as an after-treatment support structure for the early hospitals with which it collaborated. Recovering

entrepreneurs began to organize AA Farms and AA Retreats that evolved into private treatment centers and halfway houses.

Mid-twentieth century follow-up studies of narcotic addicts treated at the two federal narcotics hospitals revealed post-treatment relapse rates of more than 90 percent. This led to a call first for aftercare clinics that would follow-up such patients, and then to a call for the development of local, community-based treatment programs. Civil commitment programs in California, New York and Illinois also suffered from high post-treatment relapse rates during their heyday in the 1960s. Again, the absence of effective post-treatment aftercare services was sited as a primary causes of their failure.

The need for post-treatment support services was also recognized within the residential model of alcoholism treatment that emerged in Minnesota in the late 1940s and 1950s. It became clear that there were many clients treated at Pioneer House, Hazelden and Willmar State Hospital who needed much more support than A.A. alone could provide. This triggered the growth of halfway houses linked to these treatment facilities and new systems of post-institutional follow-up such as the first full-time traveling aftercare workers.

All of these events created a clearer vision of the need for post-treatment support services and assured that aftercare would be a point of discussion in the design of local programs of the 1960s and 1970s. Two additional influences on this continuing history were the subsequent development of a "step down" approach to treatment reflected in the placement criteria of the American Society of Addiction Medicine, and the first rigorous research on the effects of post-treatment support services (reviewed by Donovan, 1998). The former shifted the addiction field's thinking from "aftercare" to "levels of care" and "continuing care," and the latter underscored the importance, timing and ideal nature of post-treatment support services.

Seven Lessons from Continuing Care Research

Several conclusions can be drawn from recent research studies on continuing care services.

1. Addiction treatment is marked by a high post-discharge relapse and readmission rates. Of people admitted to public treatment in the U.S., 60% have been in treatment before (including 23% 1 time, 13% 2 times, 7% 3 times, 4% 4 times, and 13% 5 or more times) (OAS, 2000). The future window of opportunity lies in monitoring client progress and intervening in the time between these treatment admissions.
2. Most people completing addiction treatment are precariously balanced between continued recovery and re-activation of addiction. Short-term abstinence is not predictive of long-term abstinence; recovery from addiction is not stabilized (point at which risk of relapse dramatically declines) until four to five years of symptom remission (Jin, et al., 1998). This suggests the need for monitoring and sustained recovery support services during the early years of recovery.
3. Post-treatment utilization of continuing care services is low, with studies showing that as few as 20% of clients attend two or more continuing care groups in the month following their discharge (Donovan, 1998).
4. The window of greatest vulnerability for relapse for most clients is the first 30 days following discharge from primary treatment. In Project MATCH, 50% of the clients in the outpatient study arm had their first relapse within 30 days after discharge from treatment (Babor, et al., in press). In a randomized study of adolescent continuing care services, 52% of the "usual continuing care" group relapsed compared to only 31% in the "assertive continuing care" group in the 30 day window following discharge from residential treatment (Godley, et al., 2002). Taken together with Donovan's findings that relatively few clients have a significant aftercare experience, these studies suggest

the need for more effective linkages to continuing care services immediately following discharge from primary treatment.

5. Continuing care services vary widely across treatment programs. Among the most typical of such services are step-down to lower levels of care, continuing care-orientation groups, brief or extended professionally-directed continuing care groups, passive or active referral to mutual aid groups, peer-based recovery support services (e.g., alumni activities), and linkage to recovery homes (or other transitional living environments) (Donovan, 1998).

6. Active participation in mutual aid groups such as Alcoholics Anonymous are associated with decreased substance use and increased emotional health (Montgomery, et al., 1997), but these potential benefits are limited by low rates of post-treatment mutual aid affiliation and high rates of attrition following initial mutual aid exposure.

7. While controlled studies have produced mixed findings on the efficacy of continuing care services (McKay, 2001), more intensive approaches can increase post-treatment continuing care participation and improve clinical outcomes (Godley, et al., 2002). Such assertive approaches shift the responsibility for continued contact from the client to the counselor and involve extended telephone follow-up and home visits for monitoring, support, and early re-intervention (Stout, et al., 1999; Godley, et al., 2002; Dennis, Scott, & Funk, in press). Continuing care interventions using behavioral (contingency) contracting, family involvement, case management, couples relapse prevention groups, and the community reinforcement approach also show promise (Donovan, 1998; Godley, et al., 2002).

The Future of Continuing Care

Addiction has been treated in America for more than 200 years with the expectation that a brief intervention combined with brief “follow-up” or “aftercare” could generate sustained recovery. There is growing recognition that this model is insufficient for many clients, particularly those who present with high problem severity and chronicity, high rates of co-occurring problems, and low family and social supports (McLellan, et al., 2000). What is being advocated for such clients is an alternative model of sustained recovery management (White, Boyle, & Loveland, in press; Stout, et al., 1999) that wraps acute interventions within a larger and more sustained continuum of pre-treatment, in-treatment and post-treatment recovery support services. The recovery management model provides acute detoxification and stabilization but places its greatest emphasis on sustained and assertive monitoring and feedback; peer-delivered recovery education and coaching (support and problem-solving), ongoing linkage to indigenous systems of support, enrichment of the post-treatment recovery environment (family, social network, school/workplace, and community), and, when necessary, early re-intervention to minimize the harm from relapse and to re-initiate the recovery process (See www.bhrm.org for details).

This emerging model of recovery support services will need to be rigorously evaluated to determine what unique combinations and sequences of services generate the best long-term recovery outcomes. Recovery management calls not for larger doses of traditional services but earlier intervention and more sustained intervention using assertive outreach methods to keep clients engaged. In particular, the model extends the duration of post-treatment support services, intensifies those services during windows of initial and subsequent vulnerability, and moves the locus of recovery support from the treatment environment to the natural environment of the client. The management of all chronic disorders is expensive, but advocates of recovery management suggest that sustained support may provide a less expensive and a more clinically effective alternative to recycling people through multiple episodes of acute treatment. Future research will determine if this new vision of continuing care and these new experiments in recovery management are capable of

producing improved clinical outcomes and a better stewardship of community resources.

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Treatment Institutions

Jim Baumohl and William L. White

This article reviews the history of institutions established to "redeem," "reform," "rehabilitate" or "treat" individuals who experience problems in their relationship with alcohol and/or other drugs. Historically, the combined use of alcohol and other drugs has been very common, and institutions established to treat obsessive drinkers rapidly found themselves dealing with habitués of opium, morphine, heroin, cocaine, and in later years, a variety of more exotic substances.

Therapeutic Temperance

Pleas from physicians and social reformers for the creation of specialized institutions for the care and control of habitual drunkards came on the heels of a tripling of annual per capita alcohol consumption in the decades following American independence. It was in this context of widespread heavy drinking and related problems that medical leaders like Dr. Benjamin Rush and Dr. Samuel Woodward conceptualized chronic drunkenness as a disease and called for its treatment.

The first such institutions were established by temperance organizations shortly before and after the Civil War. Although the temperance movement would become increasingly associated with the goal of alcohol prohibition, groups like the Women's Christian Temperance Union, founded in 1874, typically supported efforts to sober and rehabilitate obsessive drinkers. Most temperance leaders believed that while prohibition would prevent the creation of drunkards and make treatment measures unnecessary at some point, in the meantime, treatment was an important element in the battle against Demon Rum.

The temperance movement's most important contribution to the history of treatment was a fellowship-based approach, drawn from Protestant religious practices (most notably early Methodism). Put simply, "therapeutic temperance" as practiced by the Washingtonians, fraternal temperance societies and reform clubs, relied on collective measures to exhort drunkards to pledge their abstinence and keep their pledges. Sobriety was to be achieved within a network of likeminded others who provided support and maintained surveillance. Usually, this process was undertaken without the use of any segregation in a formal treatment facility. The affected individuals, typically men, attended

temperance meetings and other "elevating" activities held in local temperance halls and tried to limit their social partners to others pledged to abstinence. Visiting committees looked in on recovering people and their families. However, some temperance groups established formal residences for recovering people. Often, these were called "homes" to convey their simultaneously supportive and controlling character.

The first "inebriate homes" based on these principles were established in Boston (1857), San Francisco (1859), and Chicago (1863), with many others following their lead. These homes shared several important characteristics: Their residents were present on a legally voluntary basis rather than treated by force of law; they were private organizations (although some received public funds); they employed recovering people as staff; they were relatively small, housing fewer than fifty residents at a time; and they were located in cities so that family, friends, and the members of temperance fellowships would be available to each resident. Finally, they relied on a very short term of residence, usually just long enough for residents to get through withdrawal symptoms and be restored to reasonable health. The real work of achieving sobriety was to be accomplished in fellowship outside of the institution.

It is impossible to know how effectively such institutions and their related fellowships restored alcoholics to sobriety. For every testimonial to their success there is a condemnation of their methods. The homes' critics focused mainly on the voluntary nature of the treatment and its short duration. They developed an alternate view of treatment derived from institutions for the treatment of people with mental illness. In time, the asylum model prevailed, but inebriate homes never disappeared entirely. Though transformed in significant ways, the philosophy of therapeutic temperance remains influential, as we discuss further on in this entry.

Nineteenth-Century Inebriate Asylums

In some part, the conflict between the supporters and critics of inebriate homes was about understandings of human nature. While many supporters of inebriate homes were physicians, and while most used the language of disease to characterize habitual drunkenness, they emphatically denied that inebriety could be reduced to an involuntary state created by changes in the brain or nervous system. Their logic was religious: Human beings had immortal souls that represented the spirit of God; thus, habitual drunkards had a residual self-control that could never be entirely extinguished. While treating the physiological symptoms of inebriety, the homes' methods spoke to matters of human purpose and community in ways that were often frankly spiritual.

Their critics tended to be younger, trained more rigorously in scientific medicine, and enormously influenced by the neurological research emerging from Europe. They took a decidedly material approach to inebriety: It was a disease of the brain and nervous system, often incurable, and always requiring lengthy treatment in settings distinctly segregated from insalubrious influences, including those of friends and family. Asylum enthusiasts had little regard for the methods of therapeutic temperance, and to achieve treatment of the sort they admired, they turned to the model of the insane asylum.

Important reasons quite apart from therapeutic ideology inclined these men to admire the asylum. In the late 19th century, public insane asylums – or mental hospitals as they would begin to be called early in the 20th century – represented the single largest annual expenditure of American states. They were grand, castellated affairs and their superintendents were men of great professional and political power. The Association of Medical Superintendents of American Institutions for the Insane (AMSAII), the forerunner of the American Psychiatric Association, was the model for any professional group seeking power and influence. The promoters of inebriate

asylums were attempting to create a new medical specialty and the AMSAII's success was not lost on them. A specialty needed an institutional base. The American Association for the Cure of Inebriates (AACI) was formed in 1870 to do for medical specialists in inebriety what AMSAII had done for "alienists," physicians now known as psychiatrists.

In addition to the prestige and power associated with the control of public institutions, the inebriety doctors sought financial stability. The cyclical depressions that followed the Civil War caused many inebriate homes to fold, especially those that depended on payments from patients. Early in its career, the AACI took up the cause of creating public inebriate asylums on substantially the same political and financial footing as asylums for the insane.

The asylum model offered another advantage that was both therapeutic and political: The force of legal commitment could be brought to bear most easily on the patients of public institutions designed to provide some measure of secure custody. Legal commitment would permit the lengthy detention of patients, thus allowing the AACI to portray the inebriate asylum as a potential solution to the endemic homelessness of the late 19th and early 20th centuries. Just as the insane asylum had to some extent allowed local poorhouses to transfer the care of the insane to state institutions, inebriate asylum promoters envisioned a similar transfer of tramps and habitual drunkards who turned up in local police courts over and over again. Indeed, as the inebriate asylum idea was elaborated over time, it became two institutions in one: A treatment facility for "recent and hopeful cases," as the asylum rhetoric often put it, and a custodial facility for the castoffs of poorhouses and jails.

The strategy failed. Very few public inebriate asylums were ever opened, and even the best run and most long-lived example, in Foxborough, Massachusetts, closed with the advent of Prohibition after only twenty-seven years (1893-1920). Ironically, the seed of the public inebriate asylum movement's failure was contained in its therapeutic approach. While the methods of therapeutic temperance were derided as sentimental and unscientific in an era increasingly enamored of hard-headedness, therapeutic temperance at least had methods appropriate to its philosophy. The asylum approach, on the other hand, had no therapeutic methods consistent with its claims about the nature of inebriety. Simple custody, healthy diet, exercise, the routine of institutional work – these were not medical interventions. Moreover, such methods were the stock in trade of a variety of institutions that managed inebriates at far less cost. In the end, the inebriate asylum was perceived in most jurisdictions as a costly and redundant enterprise. In Toronto, Ontario, the only North American jurisdiction in which public support for an inebriate asylum was put to a vote (in 1889), it failed in every ward, usually by a wide margin.

Other responses to the treatment of inebriety in the nineteenth century included private, for profit addiction cure institutes, bottled home cures offered by the same patent medicine industry that was distributing alcohol-, morphine- and cocaine-laced patent medicines, and religiously-oriented urban rescue missions and rural inebriate colonies. The most culturally visible and controversial of the nineteenth-century treatments promised brief, low-cost treatment usually involving some medicinal specific that was promised to destroy all craving for one's pet poison. Most of these cures bore the names of their founding entrepreneurs: Keeley, Neal, Gatlin, Key, and Oppenheimer, among the most prominent.

The Influence of the Mental Hygiene Movement

In 1875 the AMSAII grudgingly approved the creation of public inebriate asylums. The superintendents were reluctant to create political competitors, but this was outweighed by their intense desire to rid their institutions of patients whom they bluntly characterized as "nuisances." Indeed, by the 1870s many well-established

private mental hospitals had banned the admission of inebriates. Others hoped for the day when their finances would permit them to do the same. But as the years went by and few inebriate asylums materialized, state hospitals remained the principal sites of public treatment. In large states with several hospitals, it was common for one to be designated mainly for inebriates. From the superintendents' point of view, this concentrated the evil in one location.

In the decade before World War I, however, what we now call "deinstitutionalization" began to take hold in several states under the influence of what is customarily called the mental hygiene movement. Mental hospitals were scandalously crowded and their therapeutic intent had been, in most places, reduced to professional pieties. Involuntary commitment resulted in many infamous abuses of civil liberties. At the same time, office practice had become a more common method among psychiatrists and neurologists, who devoted themselves increasingly to the treatment of mental distress that fell short of psychosis. In this context, the treatment of what was by now frequently called "alcoholism" was recast, particularly if the patient was employed or had a family to support. In Massachusetts, the Foxborough State Hospital was reorganized in 1908 to emphasize brief, voluntary inpatient treatment combined with systematic aftercare in local outpatient clinics. Here, the older methods of therapeutic temperance were reworked in the service of building a coherent system for the treatment of inebriates that linked hospitals and community care. Although the "deinstitutionalization" of inebriates would not occur until the 1960s and 1970s, the methods employed by Foxborough during its last decade were a striking anticipation of treatment as it developed after World War II as the result of community psychiatry and the rapid growth of Alcoholics Anonymous.

Early and Mid-Twentieth Century Treatment

The number of inebriate homes, inebriate asylums and private addiction cure institutes diminished dramatically during the first two decades of the twentieth century as America sought to resolve problems related to alcohol and other drug use mainly by prohibiting or aggressively controlling the manufacture and distribution of these drugs.

Four different types of institutions filled the continuing need for treatment: 1) outpatient clinics that utilized recovered alcoholics as lay psychotherapists, 2) private sanatoria and hospitals, such as the Towns Hospital in New York City that provided discrete detoxification for the affluent, 3) public hospitals that treated narcotic addiction (Riverside Hospital in New York City), and 4) outpatient narcotic maintenance clinics, most of which operated only briefly between 1919 and 1924. The brunt of care for the impoverished inebriate fell upon the large public hospitals, the "drunk tanks" of city jails, county work farms – many of which functioned as inebriate colonies -- and state psychiatric hospitals.

Beyond private hospitals and sanatoria, there was very little specialized institutional treatment for alcohol and drug addiction during the 1920s and early 1930s. Only California funded a specialized facility (the State Narcotic Hospital at Spadra, 1929-1941) for the treatment of narcotic addiction, and few state-funded alcoholism treatment units existed. This began to change in 1935, with the opening of the first of two U.S. Public Health Hospitals for the treatment of narcotic addiction and the founding of Alcoholics Anonymous (A.A.).

Through much of the 1930s and 1940s, the only addiction treatment facilities were these federal hospitals in Lexington, Kentucky and Forth Worth, Texas. During this period a growing number of hospitals did begin to collaborate with A.A. The first were Rockland State Hospital, a psychiatric facility in Orangeburg, New York, and Blythewood Sanitarium in Greenwich, Connecticut. To detoxify and stabilize the large number of

"late-stage" alcoholics entering the A.A. fellowship, members pioneered a model of brief detoxification and treatment at St. Thomas Hospital in Akron, Ohio, St. Vincent's Hospital in Cleveland, Ohio, and at Knickerbocker Hospital in New York City. So-called "A.A. wards" spread across the United States in tandem with A.A.'s growth. A.A. "retreats," "farms" and "rest homes" were also started by A.A. members to meet the post-hospitalization needs of alcoholics. Many of these small institutions, such as Alina Lodge (Kenvil, NJ), High Watch Farm (Kent, CT) , and Beech Hill Farm (Dublin, NH), later evolved into formal alcoholism treatment programs. In 1939, having worked with alcoholics along the lines of therapeutic temperance since the 1880s, the Salvation Army opened its first alcoholism treatment facility. The Army subsequently became one of the largest providers of alcoholism treatment services in the United States.

During the 1940s, several new models of alcoholism treatment gained prominence. First, an inpatient psychiatric model of addiction treatment was promoted by private psychiatric hospitals like the Menninger Clinic in Topeka, Kansas. This approach provided medical detoxification and treatment of the primary psychiatric illnesses of which alcoholism was thought to be a symptom.

The second approach was an outpatient clinic model pioneered at the Georgian Clinic and Rehabilitation Center for Alcoholics (Atlanta, GA), the Yale Plan Clinics (New Haven and Hartford, CT), the Institute of the Pennsylvania Hospital (Philadelphia, PA), and Johns Hopkins Hospital (Baltimore, MD). These clinics viewed alcoholism psychodynamically as an escape from life's travails and, like the Menninger Clinic, sought to resolve underlying problems.

The third approach was a residential model of alcoholism treatment developed within three Minnesota institutions: Pioneer House, Willmar State Hospital and Hazelden. The major components of the "Minnesota model" were the conceptualization of alcoholism as a progressive, primary disease (not as merely symptomatic of other disorder); the use of a multidisciplinary treatment team that incorporated recovered alcoholics as primary counselors (a practice that recalled the era of therapeutic temperance); the infusion of A.A. philosophy and A.A. "step work;" the focus on abstinence from all mood altering drugs; and reliance on continued support from A.A. following treatment. This approach became closely aligned with a "halfway house" movement in the 1950s that provided a structured transition from institutional treatment to a sustained recovery lifestyle in the community.

While there were other residential models of alcoholism treatment during this period (Bridge House in New York City, Portal House in Chicago, Brighton Hospital for Alcoholism in Brighton, Michigan), the Minnesota model evolved into the dominant approach in the second half of the twentieth century. A rise in juvenile narcotic addiction led to the re-opening of New York City's Riverside Hospital as a juvenile treatment facility and the creation of addiction wards in such hospitals as the Detroit Receiving Hospital, Chicago's Bridewell Hospital, and Bellevue, Kings County, Manhattan General, and Metropolitan hospitals in New York City. Local religious organizations also sponsored new counseling agencies aimed at juvenile addiction. Some of the more notable were St. Mark's Clinic in Chicago, the Addict's Rehabilitation Center in Manhattan, and Exodus House in East Harlem. During this period, many states organized alcoholism treatment units within their state psychiatric hospitals, and a few states organized hospitals that specialized in alcoholism treatment (Blue Hills Hospital in Connecticut and Avon Park in Florida).

Treatment Comes of Age

. The National Council on Alcoholism and a joint committee of the American Medical Association and the American Bar Association were at the forefront of advocacy for the expansion of treatment for alcoholism and "drug abuse" during the

1950s and 1960s. To be successful, this movement needed models of addiction treatment that could be widely replicated. Added to the outpatient clinic, detoxification, and residential treatment and halfway house models were three new approaches to narcotic addiction and "polydrug abuse."

Ex-addict-directed therapeutic communities (TCs), representing a long-term, residential model for the treatment of drug addiction, began with the opening of Synanon in 1958. TCs viewed drug addiction as a problem of immaturity and poor socialization that required a reconstruction of personality and character. By 1975, there were more than 500 TCs in the U.S. modeled after Synanon. In 1964, Drs. Vincent Dole and Marie Nyswander conceptualized heroin addiction as a metabolic disease and introduced the daily oral administration of methadone as a means of stabilizing the addict's disordered metabolism so that social rehabilitation could begin. By 1973, more than 80,000 heroin addicts were maintained on methadone in licensed treatment programs in the United States. Growing concerns about youthful alcohol and polydrug use during this same period generated an outpatient clinic model that provided individual, group and family counseling for young people experiencing problems with drugs other than narcotics. Outpatient drug-free treatment quickly became the most frequently utilized treatment modality in the United States.

Federal support for community-based treatment of alcoholism and other drug addiction increased through the 1960s and culminated in the passage of landmark legislation in the early 1970s. The Comprehensive Alcoholism Prevention and Treatment Act (Hughes Act) of 1970 and the Drug Abuse Treatment Act of 1972 created a federal, state, and local partnership to treat alcoholism, drug addiction and drug abuse. The major elements of this partnership were two federal institutes (The National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse), designated treatment planning authorities within each U.S. state and territory, and community-based treatment agencies. Together, these partners planned, built, staffed, operated, and evaluated treatment programs across the United States. The remote federal narcotic hospitals and alcoholism wards in state psychiatric hospitals gave way to community-based treatment agencies.

The emerging field of addiction treatment was marked by expansion (from less than 200 programs in the 1960s to more than 500 in 1973, 2,400 by 1977, and 6,800 by 1987), increased regulation (development of accreditation and program licensure standards), and professionalization (preparatory training and worker certification/licensure). The field also reorganized itself from what had essentially been two separate fields (one treating alcohol problems, the other treating "drug" problems) to a single field that addressed all alcohol- and other drug-related problems within an integrated framework. This very contentious integration process was nearly complete at the state and local levels by the mid-1980s, leaving in its wake new language such as "chemical dependency" and "substance abuse."

The 1980s witnessed significant growth in for-profit and hospital-based addiction treatment programs and an expansion of programs for special populations of clients: adolescents, women, ethnic and cultural minorities, and those with co-occurring psychiatric illness. The service missions of many treatment institutions also expanded to include early intervention with alcohol and other drug-impaired employees, students, and drivers.

The growth of residential treatment programs was reversed in the 1990s when ethical concerns about the field's business and clinical practices led to an aggressive scheme of managed behavioral health care that significantly reduced inpatient treatment admissions and lengths of stays. This led to the closure of many for-profit and hospital-based treatment programs and in all programs, a greater emphasis on outpatient, brief therapies..

The Current Status of Addiction Treatment Institutions

Some 15,239 institutions participated in the latest (1999-2000) national survey of alcoholism/addiction treatment facilities in the United States, 45 percent of which were concentrated in eight states. This national network of facilities is made up of private non-profit agencies (60 percent), private for-profit organizations (26 percent), and state/local government-operated facilities (11 percent). In sixty-five percent of these facilities, treating addiction was the primary organizational mission. Ninety-six percent of the facilities treat both alcohol and other drug-related problems. Types of care provided by these agencies include outpatient rehabilitation services (82 percent of facilities), residential rehabilitation services (25 percent), partial hospitalization (19 percent), outpatient counseling (13 percent) and residential detoxification (5 percent).

Seventy percent of all clients admitted to American treatment institutions are men. The racial/ethnic composition of these clients is 60 percent non-Hispanic white, 25 percent non-Hispanic black, 10 percent Hispanic, and five percent other. The primary drug choices of clients being admitted to these facilities are alcohol only (26 percent), alcohol with a secondary drug (20 percent), opiates (16 percent), cocaine (14 percent), marijuana (14 percent) and other stimulants (5 percent). More than 1,200 facilities (8 percent of all facilities) dispense methadone or LAAM (levo-alpha-acetylmethadol) for the treatment of narcotic addiction. Two -thirds of the facilities provided both treatment and prevention services.

Addiction treatment programs in the United States are today funded by a combination of federal, state, and local grants and contracts; public (Medicare and Medicaid) and private health insurance; and by client self-payment. Costs of treatment vary widely by modality and by type of provider organization (public versus private). Most programs meet the accreditation standards of the Joint Commission for the Accreditation of Healthcare Organizations or the Council on Accreditation of Rehabilitation Facilities and/or state program licensure standards. The programs are staffed by interdisciplinary teams of physicians, nurses, social workers, counselors, counselor assistants, and outreach workers.

Individuals with alcohol and other drug problems get to these programs by self-referral or referrals from physicians, community service agencies, the courts, employee assistance programs, schools, alumni and members of recovery support groups like A.A. and Narcotics Anonymous. Most treatment consists of a combination of one or more of the following: outreach/engagement services, detoxification; individual, group, and family counseling; pharmacotherapy (e.g., methadone, LAAM, antabuse, naltrexone); relapse prevention training; linkage to community mutual aid groups; and a structured program of follow-up counseling. Nearly all addiction treatment programs in the United States provide treatment that is based on the goal of complete abstinence and the majority provided treatment based on A.A.'s Twelve Steps.

The United States spends more than $3.1 billion federal dollars per year on addiction treatment and treatment-related research, and more than one and one half million people each year are admitted to the nation's treatment institutions. Today's field of addiction treatment has achieved partial ownership of the nation's alcohol and other drug problems. The field has attained a high level of professional organization. It is supported by multiple federal and state, addiction-focused agencies. Its interests are promoted by public advocacy organizations (National Council on Alcoholism and Drug Dependence) and numerous trade organizations (American Society of Addiction Medicine, National Association of Addiction Treatment Providers, the National Association Addiction Treatment Professionals). And the field's development is being supported by major philanthropic

foundations (the Smithers Foundation, the Robert Wood Johnson Foundation).

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A photographic essay: The history of "medicinal specifics" as addiction cures in the United States

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I know of no class of people who have been so victimized by the quack as the inebriate. (Rogers, 1913)

Drugs have served as adjuncts in the treatment of alcohol and other drug problems in the United States since such treatment began, but the promotion of various drugs as complete curative agents marks a special thread in the history of addiction treatment. Nineteenth and early twentieth century inebriate homes and asylums found themselves competing for clients and cultural attention with a rapidly growing proprietary drug industry that promised cures for "alcohol, tobacco and drug habits" that were faster, cheaper, less personally disruptive and more discrete than institutional treatment (White, 1998). This essay briefly reviews the long history of such bottled and boxed home cures for addiction in the United States.

American medicine was at a primitive state of development in the nineteenth century. The title "doctor" was as likely to be adopted as earned, and trained physicians competed with midwives, folk healers and traveling medicine shows. It was in this context that a patent medicine industry emerged to offer quick panaceas for the treatment of trauma and disease. While its aggressively promoted alcohol-, opiate- and cocaine-laced products cured nothing, they provided symptomatic relief for almost everything. Heightened drug potency (the isolation of morphine and cocaine and the introduction of the hypodermic syringe), high availability (non-existent or weak prescription laws), the absence of product labeling, and public naiveté about the chronic effects of drug consumption all set the stage for the addiction of a growing number of American citizens ((Musto, 1973; Morgan, 1981). That stage became quickly filled with a long and ever-changing list of mood-altering products.

Opiate-based medicines were aggressively promoted to women (Godfrey's Cordial, McMunn's Elixar) and children (Mrs. Winslow's Soothing Syrup and Mother Bailey's Quieting Syrup) (Plate One). By the close of the nineteenth century, heroin was

publicly promoted alongside aspirin (Plate Two). There were cocaine-laced products (Wine of Coca, Coca Cigarettes, and Dr. Birney's Catarrh Powder) that promised cure for everything from consumption to dandruff (Plates Three and Four). And there were a large number of alcohol-laced "medicines" (Dr. Kilmer's Swamp Root, Paine's Celery Compound, and Hostetter's Stomach Bitters) (Plate Five), some of which were promoted as temperance remedies, in spite of alcohol content as high as 45 percent by volume.

The growing problems of addiction and the heightened social value of sobriety generated by the American temperance movement opened the market for medicinal specifics that claimed to destroy the appetite for alcohol, tobacco and other drugs. These bottled and boxed cures were distributed by drug companies, private physicians, addiction cure institutes, and by individual entrepreneurs. Reports on hundreds of these products fill the American Medical Association's Historical Health Fraud and Alternative Medicine Collection.

Products that claimed to cure alcohol-related problems came in two forms: hangover remedies and alcoholism cures. The former, which peaked in popularity by the 1930s, included products like Alka-Nox, Sobrosal, Sober-Up, and Mrs. Moffat's Shoo Fly Powders. Early products claiming to cure alcoholism included the Hay-Litchfield Antidote, Knight's Tonic, White Star Secret Liquor Cure, Alcoban, Alcola, Mickey Finn Powders, and Dr. Haines Golden Specific (Plate Six). There were also a large number of products promising to cure addiction to tobacco (BACO-CURE, Nicotol, Nix-O-Tine, Tobacco Redeemer, and No-To-Bac)(Plate Seven) and addiction to opiates (Antidote, Starnes' Drug Habit Cure, and Narcoti-Cure)(Plates Eight). The opiate cures often came in number-sequenced bottles that constituted gradual withdrawal for some and extended maintenance for others.

The purveyors of addiction cure specifics aggressively marketed their products through health-related books and magazines as well as through newspapers, flyers, and billboards. There were particular appeals to family members that claimed the alcoholic or addict could be cured secretly through the surreptitious spiking of food and drink with the miracle product (Plate Nine). The alcohol, tobacco and drug cures were marketing directly to physicians and some of the companies paid physicians to provide lists of addicted patients who would then be contacted via unrelenting direct mail solicitation. Prominent celebrity endorsements, extolling secret formulas, and promises of complete comfort ("no substitutes" "no vomiting" "no injections") were the norm in the promotion of these products, as were promises of secrecy and exaggerated claims of cure. Dr. Collin's Painless Opium Antidote promised "never a failure in a single case" The advertisements often claimed added health benefits as a side-effect of their product. The most frequent of such promises were new found energy (e.g., Oxien "cures drunkards and makes weak women walk) and heightened sexual performance (e.g., "No-To-Bac cures impotency and is used with magical effect by men in advanced years") (Helfand, 1996).

Attempts to expose the fraudulent practices of the addiction cure entrepreneurs began with the Medical Society of New York in 1827 and continued throughout the nineteenth and early twentieth centuries. The 1880s witnessed an expose of fraudulent opium antidotes published in the Journal of the American Medical Association and separate investigations launched by the Massachusetts State Board of Health and the American Association for the Study and Cure of Inebriety (Bradner, 1890; Crothers, 1892; Kerr, 1892). While these studies revealed that most of the cures contained alcohol or opium and sold at higher prices than the drugs themselves, public attention was not galvanized until a 1905 exposé by Samuel Hopkins Adams in *Collier's* magazine (Plate Ten) spurred passage of the 1906 Pure Food and Drug Act. In response to Hopkin's exposure of the hidden presence of alcohol and opiates in many medicines and in the addiction cures (Plate Eleven), this Act required the accurate labeling of the presence of alcohol, opiates, and cocaine in medicines.

Unfortunately, the story of fraudulent addiction cure specifics does not end in 1906. The American Medical Association detailed new generations of such frauds (e.g., Antialkolin, Coho Drink Cure, St. Anne's Morphine Cure, Tucker's Drug-Habit Cure) in their serialized publication Nostrums and Quackery, and the National Better Business Bureau issued warnings in 1929 regarding such cures. Typical of this later generation of cures was Thirty-Two (See Plate Twelve), a leather-encased series of 32 vials (price $32) that were to be consumed over 48 days as a "complete course of treatment for alcoholism."

An interesting product introduced in the 1930s was an alleged non-intoxicating substitute for alcohol sold under such names as Prescription Brand Whiskey and RMS Private Formula (Masters, 1931). A 1939 article in the Journal of the American Medical Association attacked the advertising claims that the use of these products could turn the chronic alcoholic into a "moderate and sane drinker" (RX Medicinal..., 1939). Bottled cures for alcoholism continued into the 1940s with products like Alcoban and Alconox promising to cure drunkards in twenty-four hours. As late as the 1960s, the Federal Trade Commission was taking legal action to ban the advertising of products like Soberin as a cure for alcoholism.

It can be seen from this brief review that fraud and exploitation are a continuing theme in the design and marketing of alcohol-, opiate- and cocaine-laced products and medicinal specifics claiming to cure addiction. It is in this context that the term iatrogenic takes on two meanings: the development of addiction secondary to self-care or medical treatment, and the harm done in the name of help that constitutes a long thread in the history of addiction treatment.

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Acknowledgment: Products and their advertising slogans referenced in this article were identified through the following collections: The American Medical Association's Historical Health Fraud and Alternative Medicine Collection, the Hazelden Archive, the Illinois Addiction Studies Archive, and the private collection of William Helfand.

Plate One: Mrs. Winslow's Soothing Syrup (Strong Museum)
Plate Two: Heroin Add (Bettman Archives)
Plate Three: Cocaine Toothache Advertisement (IASA)
Plate Four: Cocaine Dandruff Advertisement (IASA)
Plate Five: Hostetter's Bitters (Strong Museum)
Plate Six: Haines Golden Specific (Hefand Collection)
Plate Seven: No-To-Bac (Helfand Collection)
Plate Eight: Narcoti-Cure (Strong Museum)
Plate Nine: Drunkards Saved Secretly (AMA)
Plate Ten: Colliers Cover (IASA)
Plate Eleven: Narcotic Cures and their Hidden Contents (IASA)
Plate Twelve: Twenty-Four (AMA)



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The National Council on Alcoholism and Drug Dependence

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For more than fifty years, the National Council on Alcoholism and Drug Dependence has served as the leading voluntary public policy advocacy group in the United States on alcoholism-related issues. In 1942, Dwight Anderson, representing the Research Council on Problems of Alcohol, called for a "new public health movement" to change the way America perceived alcoholism and the alcoholic. That movement began two years later, when Mrs. Marty Mann founded the National Committee for Education on Alcoholism (NCEA). Mann drew her inspiration for NCEA from the success of other public health organizations that had been formed to support education, research and treatment for tuberculosis, cancer and heart disease.

Mann was aided in her initial efforts to organize NCEA by E.M. Jellinek of Yale University, Ruth Bangs of the New York Herald Tribune, Austin McCormick of the Osborne Association, Dwight Anderson of the New York State Medical Society, and Dr. Ruth Fox, a psychiatrist specializing in alcoholism. E.M. Jellinek was so taken by Mann's vision that he offered the Yale Center of Alcohol Study's sponsorship of NCEA. The new organization began operations in April, 1944, with an annual budget of $13,000.

Mann established local NCEA branches around the country in order to pursue NCEA's five-point program: 1) educate local communities about alcoholism, 2) establish local alcohol information and referral centers, 3) enlist the aid of local hospitals in detoxifying alcoholics, 4) establish clinics for the diagnosis and treatment of alcoholism, and to 5) establish "rest centers" for the long-term care of alcoholics. These local chapters were staffed by volunteers of recovered alcoholics and their family members, as well as physicians, clergy, and others concerned about the problem of alcoholism.

The primary means of changing public attitudes and public policies was through instilling in the American culture a set of "kinetic" ideas formulated by Anderson and refined by Mann. The five ideas that

were at the heart of NCEA's educational campaigns were:

1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.
4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility.

NCEA, along with the Research Council of Problems of Alcohol, Alcoholics Anonymous, and the Yale Center of Alcohol Studies, forged a "modern alcoholism movement" that affirmed hope for recovery from alcoholism, called for a new scientific approach to the study and resolution of alcohol problems, and laid the foundation for a national network of community-based alcoholism prevention and treatment programs.

Coming of Age (1950-1980)

In 1950, NCEA separated from Yale to become an independent organization. This separation was facilitated by the financial support of philanthropist R. Brinkely Smithers and the Christopher D. Smithers Foundation. Signaling this new independent status was the board decision to change the name of the organization to the National Committee on Alcoholism (1950) and later to the National Council on Alcoholism (NCA) (1956). Through Mann's visits to communities across the country, the number of local NCEA/NCA affiliates grew from fourteen in 1946 to fifty-three in 1956.

Through the 1950s and 1960s, NCA focused on educating the public through its publishing activities and its influence upon the press, radio, television and motion pictures. Major initiatives included lobbying to change policy positions on alcoholism by major medical and public health organizations, hosting alcoholism-themed conferences for helping professionals, and lobbying for federal legislation for funding to support local alcoholism education and treatment efforts. As the number of local NCA affiliates reached 80, NCA successfully pushed the passage of landmark federal legislation (the 1970 "Hughes Act") that provided federal funding for local alcoholism treatment programs.

During the 1970s, NCA helped expand alcoholism treatment and occupational alcoholism programs and provided organizational sponsorship of the American Society of Addiction Medicine. NCA also intensified its educational campaigns to destigmatize alcoholism through its media blitzes, seeding television shows such as "Maude" and "All in the Family" with information on alcoholism, and by hosting professional education and training events. The boldest of such activities was its 1976 "Operation Understanding." In this highly publicized event, fifty-two prominent Americans proclaimed their recovery from alcoholism.

Another significant change within NCA in the 1970s was the decision to no longer have alcohol industry representatives on the NCA board.

Retrenchment and Renewal (1980-2002)

Marty Mann died 22 July 1980. She had served as NCA's Director for twenty-four years and had continued to influence NCA's advocacy vision until her death. Her speaking and writing exerted a profound influence on American attitudes toward alcoholism, and her political savvy and spellbinding oratory coaxed many state and federal legislators into formulating public-health responses to the problem of alcoholism. Following Mann's death, NCA experienced a period of financial struggle. The Smithers Foundation provided crucial financial support to NCADD during this period.

In 1990, NCA changed its name to the National Council on Alcoholism and Drug Dependence (NCADD), bowing to the growing integration of the alcoholism and drug addiction fields. The debate over the name change signaled a larger uncertainty regarding NCA's future direction as an organization. Many local NCADD affiliates

had taken on the responsibility of providing local treatment services—services that progressively dwarfed their public education and public policy activities. As a result of these changes, relationships between NCADD and its affiliates weakened. By 2000, the number of local NCADD affiliates, which had peaked at more than 230 affiliates in the early 1980s, dropped to below ninety.

Today, NCADD is undergoing a renewal process. The board has recommitted NCADD to its historical public education and public policy mission and to rebuilding the grass roots affiliate relationships that have contributed to the organization's greatest successes. NCADD continues its media campaigns, taking leadership roles in Alcohol Awareness Month and National Recovery Month activities. It reaches Americans through cable television programs, its newsletters and publications, and through the more than 10,000 visits per month to its web site. NCADD also continues its public policy advocacy activities by supporting parity in insurance for addiction treatment and in serving as a watchdog over the marketing practices of the alcohol industry.

Perhaps the best measure of NCADD's effect on American perceptions about alcoholism is its successful inculcation of its core ideas. In 1943, the year before NCADD's founding, only six percent of Americans surveyed believed alcoholism was a disease. Fifty years later, eighty-seven percent of Americans believed alcoholism was a disease.

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Christopher D. Smithers Foundation

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The Christopher D. Smithers Foundation has for fifty years promoted the understanding, prevention and treatment of alcoholism. The Foundation funds alcoholism-related projects, disseminates alcoholism-related information through the print and electronic media, and participates in alcoholism-related public policy forums.

Christopher Duncan Smithers was one of the founders and major stockholders of IBM. His son, R. Brinkley Smithers, was born 30 July 1907, in Glen Cove, New York. The young Smithers was painfully shy during his developmental years, but discovered the liberating effects of alcohol while studying medicine at John Hopkins University. When it was evident that Brinkley's love of alcohol far exceeded devotion to his studies, his father withdrew him from the University. Brinkley then worked as an investment banker through the Wall Street crash of 1929 and went on to work as a salesman at IBM. His business success was accompanied by an escalation in drinking that led to Brinkely's decision to retire at the age of 30. The retired life proved very conducive to his advancing alcoholism, which continued through his service in World War II. Following his discharge from military service, Brinkley operated a successful auto franchise, but was admitted more than fifty times for discrete detoxification at the Charles B. Towns Hospital in New York City.

In 1952, Brinkley created a philanthropic foundation to honor his father, who had died earlier that year. Originally chartered to support a wide variety of charitable activities, the mission of the Christopher D. Smithers Foundation was changed following R. Brinkley Smithers' recovery from alcoholism in 1954 and his attendance at the 1956 Yale School of Alcohol Studies. Ironically, it was through an employee he had once fired for drinking and who later found sobriety, that Brinkley was linked to Yev Gardner and to the beginning of his own recovery from alcoholism. Gardner was a recovered alcoholic who was, at the time he met Brinkley, working as Marty Mann's assistant at the fledgling National Committee for Education on Alcoholism. It was an auspicious meeting for both Brinkley

Smithers and the alcoholism field. The new mission of the Foundation was to address alcoholism as a public health problem Over the next half-century, the Smithers Foundation would provide more than $13 million to alcoholism-related projects, with more than double that amount contributed to such projects by members of the Smithers family.

The role of the Smithers family and the Smithers Foundation in the history of alcoholism treatment and recovery in America is difficult to depict because of the length and breadth of its scope. This support included enhancing the development of nearly every area of the alcoholism field from support in building its organizational infrastructure, to support for public and professional education, policy advocacy, research, treatment, and prevention.

The Smithers Foundation provided crucial financial support to the National Council on Alcoholism and Drug Dependence (NCADD), both in terms of the operations of the national office and in providing seed grants to nurture the development of more than fifty local NCADD affiliates. It also provided financial support to such key institutions as the Center of Alcohol Studies (in its transition from Yale to Rutgers), the North American Association for Alcoholism Programs, the North Conway Institute, and the American Society of Addiction Medicine.

Smithers' actively supported the spread of occupational alcoholism programs within business and industry and provided a $6.7 million gift to Cornell and Rutgers Universities to establish the R. Brinkley Smithers Institute for Alcoholism Prevention and Workplace Problems. The Smithers Foundation also supported the development of many prominent treatment institutions including Hazelden Foundation and Chit Chat Foundation. In the early 1970s, Brinkely Smithers provided a personal gift of $10 million to Roosevelt Hospital in New York City to open the Smithers Alcoholism Treatment and Training Center.

In addition to financially supporting journals (such as the *Quarterly Journal of Studies on Alcohol*) and seminal books in the field (such as E.M. Jellinek's *The Disease Concept of Alcoholism*), the Smithers Foundation published and distributed its public information and professional education materials on alcoholism. Particularly significant was its support in getting alcoholism books, pamphlets and treatment resource guides into the nation=s libraries.

R. Brinkley Smithers' legacy transcends the financial resources that he infused into the alcoholism field and crucial points in its modern history. From the early days of his recovery from alcoholism, R. Brinkley Smithers remained personally involved in leadership roles with NCADD and the larger alcoholism field. In addition to serving as chairman and president of the NCADD board, he founded the Long Island Council on Alcoholism and was co-founder of the Alcoholism Council of New York. He personally involved himself at critical times in the field=s history. For example, when the most critical piece of legislation in the history of modern alcoholism treatment in the United States (the 1970 Hughes Act) had passed by both houses of Congress, but was not supported by the president, it was R. Brinkley Smithers who rallied the political forces that reached President Richard Nixon on 31 December, and persuaded him to sign the act into law only hours before it would have died by pocket veto.

R. Brinkley Smithers died at the age of 86 on 11 January 1994. He dedicated his life and financial resources to the proposition that alcoholism was a treatable disease. That legacy continues today through the ongoing work of the Christopher D. Smithers Foundation under the leadership of Brinkley's wife, Adele C. Smithers-Fornaci, who at the time of this writing serves as president of the Smithers Foundation and the chair of the board of the National Council on Alcoholism and Drug Dependence.

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The Road Not Taken: The Lost Roots of Addiction Counseling

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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 outreacher, 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.

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HISTORY CORNER
Intervention Keeley Style

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The most famous and controversial treatment for addiction in the 19th century was Dr. Leslie Keeley's Bichloride of Gold Cure. Dr. Keeley franchised his cure procedures through more than 120 Keeley Institutes scattered across North American and Europe. These Institutes became the preferred drying out institutions for the rich and famous in the 1890s. But the problem then (as today) was this: Even where there are financial resources to pay for such treatment, how can the afflicted person be convinced to enter such a treatment institution?

There were four general resolutions of this dilemma: self-motivation resulting from the accumulated pain of addiction, company pressure upon an alcohol/drug-impaired employee, pressure from families and legal commitment of the inebriate (for as long as four years). Family pressure to enter treatment sometimes involved processes similar to what today would be called "intervention," but these processes did not always go as planned, as is revealed in the following account from Alfred Calhoun's 1892 book, Is It a Modern Miracle? A Careful Investigation of the Keeley Gold Cure for Drunkenness and the Opium Habit.

As this story unfolds, a family at its wit's end responds to the chronic drunkenness of one of its members by hosting a meeting of all concerned. The upshot of this meeting is that the young man in question, who we shall call Robert, was to be sent to the Keeley Institute headquarters in Dwight, Illinois, to undergo the Keeley Cure. Seriously doubting Robert's ability to make this trip on his own, the family enlisted the aid of his uncle to accompany him during the travel to Dwight.

On the following day, Robert and his uncle set off for the long trip to Dwight. Robert pleaded with his uncle to stop periodically for alcoholic refreshment on the grounds that this was the only way to stave off the onset of "DTs." The uncle agreed to such stops, willing to humor his young nephew in any manner that would keep them moving toward Dwight. But the additional catch was that Robert refused to drink such medicinal libation unless his uncle would join him. Although quite an abstemious person, the uncle agreed to imbibe with his nephew

as long as they could keep proceeding to Dwight.

So at each stop, which seem to increase in frequency as the pair neared Dwight, both Robert and his uncle downed various alcoholic concoctions. By the time the now well-oiled pair reached Dwight, both were in a state of considerable intoxication, although they looked quite different. Robert, whose alcohol tolerance was massive, didn't look too worse for the wear. His uncle, however, whose alcohol tolerance was virtually non-existent, was nearly unconscious by the time they entered the doors of the Keeley Institute.

Upon their arrival, Robert admitted his uncle to the Keeley Institute and absconded with his uncle's prized car. It took several days to get the uncle sobered up and the nephew located, returned to Dwight, and admitted to treatment. Getting someone in treatment then, as now, was not always easy. But some of the 19th century treatment centers did find ways to keep people in treatment once they were finally admitted: At admission, they took all of their clothes and all of their money!



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Commentary
Fallen Giants:
The Loss of Addiction Treatment and Recovery Pioneers in the United States

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If I have seen further it is by standing on the shoulders of giants.
--Isaac Newton, 1675

The recent death of Griffith Edwards, MD (1928-2012), psychiatrist, addiction specialist, and long-standing editor of *Addiction*, forced me to pause to reflect on the many modern pioneers of addiction treatment who have died over the span of my career. Based in the UK, Griffith Edwards made innumerable contributions to the study of addiction. His conceptualization of alcohol dependence exerted a profound influence on modern diagnostic schemas for substance use disorders and he was a commanding presence on the international drug policy front for more than four decades. But equally important was the mentoring that he offered to many addiction specialists throughout the world, including this author. He and other giants of the addiction field are deeply missed.

The rise of addiction as a modern specialty field of knowledge and practice over the course of the past half century was forged through intersecting social and professional movements. These movements were led by pioneers in the arenas of mutual aid, public education and advocacy, social policy, scientific research, primary and secondary prevention, clinical practice, professional education, and program management and administration. It is fitting that we pause as a field and acknowledge the contributions of such pioneers. This short essay will focus on a few such pioneers from the United States.

Anyone with substantial tenure in the modern addictions field has witnessed the passing of leaders whose lives exerted an enormous influence on the evolution of addiction treatment and recovery in the U.S. We have seen the passing of leaders from major addiction recovery mutual aid societies, including Alcoholics Anonymous

co-founder Bill Wilson, 1895-1971, Al-Anon co-founder Lois Wilson, 1891-1988, Narcotics Anonymous co-founder Jimmy Kinnon, 1911-1985, and Women for Sobriety founder Jean Kirkpatrick, 1923-2000. There are the prominent celebrities, such as Lillian Roth, 1910-1980, and Jason Robards, 1922-2000, who challenged prevailing stereotypes about addiction and addiction recovery through public disclosure of their own recovery stories. There are the policy advocates who politically nurtured the birth and evolution of modern addiction treatment (e.g., Marty Mann, 1904-1980, Senator Harold Hughes, 1922-1996, Senator Paul Wellstone, 1944-2002). There are those whose philanthropy supported the drive for such policy changes (e.g., Brinkley Smithers, 1907-1994; Joan Kroc, 1928-2003).

Those with long tenure in the field have witnessed the passing of early pioneers of occupational alcoholism programming (Dr. John Norris, 1900-1985; Dr. Luther Cloud, 1921-1991), those who contributed to our understanding of the sociology of addiction (e.g., Dr. Selden Bacon, 1908-1992; Dr. Alfred Lindesmith, 1905-1991; Don Cahalan, 1912-1992; Dr. David Pittman, 1928-2002), and perhaps the first modern addiction information specialist (Mark Keller, 1907-1995). We have seen the passing of early addiction medicine specialists (e.g., Dr. Ruth Fox, 1896-1989; Dr. Marvin Block, 1903-1989; Dr. Frank Seixas, 1920-1992) and addiction psychiatrists (e.g., Dr. Harry Tiebout, 1896-1966; Dr. Norman Zinberg, 1922-1989). We have lost the early generation of alcoholism educators (e.g., Raymond McCarthy, 1901-1964; Father James Royce, S.J. 1915-1996; Reverend Joseph Kellerman, 1910-1933). We have witnessed the passing of leaders who championed new intervention techniques (e.g., Reverend Vernon Johnson, 1920-1999) and led the development and evolution of new treatment models, (e.g., Dr. Dan Anderson, 1921-2003; Dr. Nelson Bradley, 1917-1983; Richard Caron, 1914-1975; Charles Dederich, 1913-1997; Geraldine Delaney, 1907-1998; Sister Mary Ignatia Gavin, 1889-1966; and Dr. Marie Nyswander, 1919-1986). The field has also witnessed the loss of modern addiction research pioneers (e.g., Dr. Sidney Cohen, 1911-1987; E.M. Jellinek, 1890-1963; Dr. Lawrence Kolb, 1881-1972). And we have witnessed the passing of iconic drug enforcement figures (i.e., Harry Anslinger, 1892-1975).

The pace at which we are losing the modern pioneers of addiction treatment and recovery in the U.S. has quickened in recent years, particularly the leaders who shaped the field's coming of age in the 1960s and 1970s and went on to devote their lives to this field. Here are brief profiles of some of the distinguished leaders we have lost in the past decade.

Nathan Azrin, PhD (1931-2013), conducted landmark studies on the application of behavior principles to the treatment of alcoholism following his training at Harvard under the tutelage of B.F. Skinner. His studies at Anna State Hospital in Illinois led to the development of the community reinforcement approach (CRA) to the treatment of addiction.

LeClair Bissell, MD (1928-2008), was an influential leader in the rebirth of addiction medicine in the United States. She was an early advocate of specialized treatment for women, conducted pioneering studies on alcoholism among professionals, and co-authored the groundbreaking *Ethics for Addiction Professionals*. For decades, she was a leading voice on alcoholism treatment policies and practices.

Alex Brumbaugh (1942-2013), was director of Project Recovery and a prominent recovery advocate. His recovery advocacy activities included participation in the history making 2001 Recovery Summit that launched the new addiction recovery advocacy movement and authoring two notable books—*Transformation and Recovery* and his about-to-be-released *Praxis of Recovery*.

Morris Chafetz, MD (1924-2011), was a vocal advocate in the late 1960s for creating the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and served as NIAAA's first Director. He was

responsible for forging the federal-state-local partnership through which local alcoholism programs rose across the American landscape. Under his leadership, federal resources devoted to alcoholism treatment grew exponentially, and the foundation was laid for the modern era of alcoholism research. Dr. Chafetz authored more than 200 articles and 14 books on alcoholism, including *The Alcoholic Patient: Diagnosis and Management*.

John Chappel, MD (1931-2011), was a notable figure within modern addiction medicine. He crossed ideological divides within the field by simultaneously championing methadone maintenance treatment and the role of spirituality and 12-Step participation in long-term addiction recovery. He was a strong advocate of addiction training for physicians and in the early 1980s led development of the first certification exam for addiction medicine specialists.

Herman Diesenhaus, PhD (1938-2006), is best known for his role as a senior public health analyst at the Center for Substance Abuse Treatment. While serving as the Associate Director of the Institute for Medicine, Dr. Diesenhaus helped draft and edit the highly influential report, *Broadening the Base of Treatment for Alcohol Problems*.

Vincent Dole, MD (1913-2006), in collaboration with Drs. Marie Nyswander and Mary Jeanne Kreek, pioneered the use of methadone maintenance in the treatment of opioid addiction. He also served as a non-alcoholic trustee on the General Service Board of Alcoholics Anonymous. Throughout his distinguished career, Dr. Dole advocated treating addiction on par with diabetes, heart disease, and other chronic medical disorders.

Kaye Middleton Fillmore, PhD (1941-2013), conducted landmark studies on changes in drinking patterns over the life course that added important new insights into the natural remission of alcohol problems. Her longitudinal studies of drinking practices conducted through the Alcohol Research Group, the University of California at San Francisco, and the Institute for Scientific Analysis exerted significant and sustained influences on the international field of alcohol research.

Mrs. Betty Ford (1918-2011) and former President Gerald Ford announced to the nation in April 1978 that Mrs. Ford had been treated and was recovering from addiction to alcohol and other drugs. Four years later, the Betty Ford Center opened and went on to become an American cultural institution—a symbol of hope and healing for those seeking recovery from addiction. Mrs. Ford's openness about her addiction exerted a profound influence on the history of recovery in the U.S., particularly the public perception of women in recovery.

Avram Goldstein, MD (1919-2012), through his work at Stanford University and the Addiction Research Foundation, conducted pioneering work on the neurobiology of addiction. His research included collaborations that led to the discovery of endogenous opioid peptides and opioid receptor sites. He was an early advocate of addiction as a brain disease that merited and warranted competent and compassionate treatment rather than punishment. His landmark works include *Addiction: From Biology to Drug Policy.*

Bill Iron Moccasin, Lakota (1921-2004), served as an honored member of the Council of Elders that guided the birth and development of the modern Native American Wellbriety Movement. His sage advice and teachings helped lay the foundation of a vibrant movement that continues to promote and celebrate sobriety, health, wholeness, and cultural revitalization within Indian communities.

James Kemper, Jr. (1914-2002) served as chief executive and chairman of Kemper Insurance Companies between 1969 and 1979. He used his own recovery from alcoholism as a platform for pioneering an employee assistance program and a framework for insurance coverage for the treatment of alcoholism that became national models.

Allen "Skip" Land (1942-2012) was the Chief Operating Officer of Chicago's A Safe Haven and Cofounder of the Illinois Association of Extended Care. His greatest passions were housing and recovery support

services for addicted persons who were homeless or re-entering the community from prison. His advocacy for people seeking recovery in the Midwest and nationally was so effective, he was often introduced with warm affection as “Mr. Recovery.”

Charles Lieber, MD (1931-2009), conducted landmark studies on the metabolism of alcohol and the biological aspects of alcoholism, including the first studies confirming alcohol as a liver toxin. He published more than 900 papers and 15 books over the course of his career and was the driving force behind the creation of one the leading addiction journals, *Alcoholism: Clinical and Experimental Research*.

George Mann, MD (1923-2012), was founder, Executive Director, and Medical Director of St. Mary’s Hospital Chemical Dependency Program and founder of The Retreat. He was an influential figure in the evolution of the Minnesota Model of treatment and a beloved teacher at Rutgers Summer School of Alcohol Studies and at the University of Minnesota.

Ira Marion (1945-2013) was a methadone maintenance patient who went on to administer Albert Einstein College of Medicine’s methadone maintenance program. He was a tireless advocate for patient-centered medication-assisted treatment of opioid addiction. Long known as a leading advocate of methadone patient rights, he served on the board of NAMA-Recovery and supported the development of the Medication Assisted Recovery Support (MARS) project—a collaborative effort between NAMA-Recovery and Albert Einstein College of Medicine.

Alan Marlatt, PhD (1941-2011), conducted pioneering research on the use of cognitive-behavioral therapy in the treatment of addiction. His classic works spanned the arenas of relapse prevention, moderation goals, and self-control skills for non-dependent drinkers, harm reduction strategies for people who choose to continue alcohol and other drug use, and mindfulness meditation as a tool in the prevention and treatment of substance use disorders.

Father Joseph C. Martin (1924-2009), following his own treatment for alcoholism at Guest House in 1958, became an indefatigable speaker on alcoholism. He is perhaps best known for his “Chalk Talk on Alcoholism,” which when released in 1972, went on to become perhaps the most widely viewed film ever produced on alcoholism. Father Martin was a central figure in the rise of modern alcoholism treatment and later, with Mrs. Mae Abraham, founded Father Martin’s Ashley, a non-profit addiction treatment program in Havre de Grace, Maryland.

Mercedes McCambridge (1916-2004) used her status as an award-winning actress and recovering alcoholic to advocate for the treatment of alcoholism as a medical condition. Her public story of recovery inspired many women to seek help for alcoholism. She offered influential Senate testimony in 1969 in support of legislation that a year later laid the foundation for modern community-based alcoholism treatment.

Monsignor Ignatius McDermott (1909-2004), known affectionately as “Father Mac” and the “Skid Row Priest,” co-founded Haymarket Center—the first social setting detoxification program in Illinois that later evolved into a comprehensive addiction treatment program. Father Mac regularly drew inspiration from and often recited in his speeches the words of St. Vincent DePaul: “When you no longer burn with love, others will die of the cold.”

Jack Mendelson, MD (1929-2007), played a significant role in the rise of modern addiction treatment as an administrator (Chief, National Center for Prevention and Control of Alcoholism; Director, McLean Hospital’s Clinical Research on Substance Abuse), educator (Harvard University Department of Psychiatry), and research scientist (e.g., early investigations into the effects of buprenorphine on heroin self-administration). Dr. Mendelson championed the study and treatment of alcoholism and other addictions as a medical disorder.

Lonnie Mitchell, PhD (1927-1997), led the efforts of the newly created National Institute on Drug Abuse to recruit and prepare the nation’s addiction treatment workforce. He and his state and local

partners forged a system of education, training, and credentialing of what was at the time a primarily "paraprofessional ex-addict" workforce while at the same time recruiting and training physicians, nurses, psychologists, and social workers to collaborate with the "new profession" of addiction counseling in newly created addiction treatment programs.

Harold (Hal) Mulford, Jr, PhD (1922-2012), was an iconoclastic sociologist from the University of Iowa's Department of Psychiatry who conducted early studies on public attitudes toward alcoholism. He went on to pioneer a unique community response to alcohol problems that relied on community alcoholism consultants who worked to enhance natural recovery. This model served as an early alternative to the disease model of alcoholism treatment).

David Musto, MD (1936-2010), served for most of his career as professor of the history of medicine at Yale School of Medicine. He also served as a drug policy advisor under Presidents Nixon and Carter. Dr. Musto published his classic text, *The American Disease: Origins of Narcotic Control*, in 1983 and went on to become the most renowned scholar on American drug policy. His sophisticated scholarship and his gracious personality made him one of the few people widely respected from all corners of the often highly vitriolic debates about U.S. drug policy. *The American Disease* remains must reading for anyone working in the addictions field.

Nancy Moyer Olson, (1930-2005), served as the legislative aide to Senator Harold Hughes and played a key role in drafting the legislation that established the National Institute on Alcohol Abuse and Alcoholism. Her experiences during this critical turning point in the history of alcoholism treatment in the U.S. are recounted in her book, *With a Lot of Help from our Friends: The Politics of Alcoholism*.

Don Ottenberg, MD (1919-2004), through his prolonged leadership at Eagleville Hospital, was a pioneer in the integrated treatment of alcoholism and drug addiction at a time these were isolated and competing fields. He was an influential figure in the early therapeutic community movement and the larger arena of residential addiction treatment. Following his retirement from Eagleville, Dr. Ottenberg and his wife Martha trained addiction counselors in Europe and Africa.

Riley Regan (1935-2012) embodied numerous aspects of the modern alcoholism movement by comfortably wearing his recovery status and serving as the founding director of the New Jersey Division of Alcoholism and in his subsequent positions as long-time faculty member at the Rutgers Center for Alcohol Studies, Director of the Maryland Alcoholism Control Administration, Deputy Director of the National Center for Alcohol Education, and five-year member of the National Advisory Council of NIAAA.

Ann Richards (1933-2006), best known as the outspoken Governor of Texas, championed numerous causes during her long political career all the while living openly as a person in long-term recovery from alcoholism—26 years of sobriety at the time of her death. Her candor about her recovery challenged the prolonged stigma attached to women and alcoholism. While Governor, she visited the prison- and community-based treatment programs she had politically supported and simply introduced herself as, "My name is Ann, and I'm an alcoholic."

Lee Robins, PhD (1922-2010), led the Epidemiologic Catchment Area studies that laid the foundation for modern longitudinal studies of the prevalence of substance use disorders. Her classic study of Vietnam veterans returning home after having been addicted to narcotics during their military service sparked growing interest in the phenomena of "natural recovery"—the resolution of addiction without professional treatment.

Bruce Rounsaville, MD (1949-2011), served as Professor of Psychiatry and Director of Research—Substance Abuse Division at the Yale School of Medicine, Director of the VA Mental Illness Research Education and Clinical Center at the VA Connecticut Healthcare System, and Director of the Psychotherapy Development Research Center and Clinical Scientist

Training Program in Substance Abuse. His most widely recognized contributions were reflected in the publication of more than 350 papers/chapters and six books, including *Diagnostic Source Book on Drug Abuse Research and Treatment.*

Mel Schulstad (1918-2012), following his retirement from the U.S. Air Force and the beginning of his own recovery from alcoholism, became a central figure in the professionalization of addiction counseling in the United States. He was the founding president of NAADAC: The Association for Addiction Professionals and worked tirelessly into his 90s to elevate the quality of addiction treatment. One of his final contributions to the field was co-authorship of *Beyond the Influence: Understanding and Defeating Alcoholism*. At the time of his death, he had 46 years of continuous sobriety.

Charles Robert Schuster, PhD (1930-2011), was a pioneer in the field of behavioral pharmacology. He held academic positions at the University of Michigan, the University of Maryland, the University of Chicago, Wayne State University, and Loyola University. He served as Director of the National Institute on Drug Abuse (NIDA) from 1986-1992. His work on the underlying principles that governed addictive behavior set the stage for later work on addiction as a brain disease and for non-punitive responses to drug addiction.

Harold "Harry" Swift, MSW (1937-2013), joined the staff of Hazelden in 1966 and became a leading advocate for family programming within addiction treatment. After his appointment as CEO in 1986, he led numerous Hazelden expansion efforts.

Lisa Mojer Torres, JD (1957-2011), was a methadone maintenance patient who became a civil rights lawyer and unrelenting patient advocate through her role as Consumer and Recovery Advocate for the New Jersey Division of Addiction Services. Widely viewed as the "Rosa Parks of medication-assisted treatment," she served on numerous national drug policy advisory committees and was the founding President of the Board of Faces and Voices of Recovery—the leading recovery advocacy organization in the United States. She co-authored the monograph *Recovery-Oriented Methadone Maintenance*.

James West, MD (1914-2012), was co-founder of Haymarket Center in Chicago and the first Medical Director of the Betty Ford Center. He was one of the modern pioneers of addiction medicine. Quite open about his own recovery from alcoholism, he went on to create clinical breakthroughs in alcoholism detoxification and treatment. His most noted publication, *The Betty Ford Center Book of Answers*, grew out of a regular question and answer column, Sober Days, written for the *Desert Sun Newspaper* in Palm Springs, CA. He remained active in the field until his death at age 98.

Several things distinguish the individuals profiled in this article: a willingness to question prevailing beliefs and practices; the ability to articulate seminal and profoundly influential ideas via publications and presentations; a passion for integrating the worlds of scientific research, clinical practice, and recovery support; a deep interest in and willingness to support the work of others; a high level of personal integrity and ethical sensitivity; and a level of humility that belies their enormous accomplishments. To these pioneers who have passed, we pause to acknowledge again: Your commitment and competence helped shape the future of addiction treatment and recovery in America. A grateful field and those it is dedicated to serve thank you for your service. We who have been blessed by your presence in the world must now carry forward your legacies.



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Further Reflections on the Loss of Addiction Libraries and Databases

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Through their missive on the global downsizing and closing of addiction libraries and bibliographic databases, Mitchell and colleagues [1], like the proverbial canary in the mine, have sounded a warning to the alcohol and other drug problems arena. They caution that a critical component of the field's infrastructure is collapsing with little notice from the field's leaders. Research I conducted between 1978 and 1998 on the history of addiction treatment and recovery in the United States [2] was made possible by access to an extensive network of addiction libraries and databases in the United States. In my current work to update this history, several recent trends noted by Mitchell et al. are evident First, many of the addiction libraries that I relied upon in my earlier research no longer exist, including the Library of the National Institute on Drug Abuse. Many rare historical documents are passing into the hands of private collectors and are no longer available to researchers. To a historian, it feels like the field has died and its most valuable possessions are being auctioned via an eBay estate sale. Second, key bibliographic databases that once served as a pipeline to addiction science journals and to unpublished reports no longer exist, including ETOH—the exceptional bibliographic database maintained by the National Institute on Alcohol Abuse and Alcoholism until its defunding in 2003. A significant portion of the addiction field's specialty journals are not indexed by remaining bibliographic databases as they were in ETOH and other addiction-specialty databases. Third, even when located, access to articles has become prohibitively expensive to researchers who do not have access to library support (and even more so to members of the general public). Fourth, much of the field's "grey literature" no longer resides in libraries and has only an ephemeral existence on the Internet. The disappearance of cited internet documents between submission and publication of articles in professional journals is becoming commonplace. The loss of these documents, in the absence

of addiction libraries, will constitute a significant loss of the field's history.

What we are seeing is an unplanned and minimally acknowledged dismantling of the field's information infrastructure and the resulting loss or privatization/commercialization of the field's history, science, policy, and practice documents. Mitchell et al. outline viable options to forge a response to this crisis. Bold proposals are needed to sustain the field's information collection, preservation, and support activities. Perhaps it is time for a consensus conference through which the field's international leaders can review these recent trends and explore how to best support the field's present and future information infrastructure needs.

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NAADAC and the History of Addiction Counseling: An Interview with William White

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For some years, NAADAC has been laying the foundation for the development of a book on the history of addiction counseling. That project is now underway with the assistance of William White, author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. We recently caught up with Bill to give us a progress report on the new book.

NAADAC: Bill, what or who is the inspiration behind the new book on the history of addiction counseling?

Bill White*:* This book was Mel Schulstad's vision. Mel was a co-founder and first president of NAADAC, and believed that no profession has come of age that lacks a history of its own development. Mel began promoting development of a history of addiction counseling by NAADAC as early as the late 1980s and began laying the foundation for our current project. Mel and I had conversations with Cynthia Moreno Tuohy, NAADAC's Executive Director, about this project for years, and as NAADAC celebrates its 40th anniversary, it just seemed like the time to do it. Cynthia pushed this book to the top of the NAADAC agenda in hopes we could finish and launch the book at NAADAC's Annual Conference and 40th Anniversary Celebration in Seattle this fall.

NAADAC: What preliminary work was done over the years to prepare for this project?

Bill White: This work began with the NAADAC Foundation National Archive Advisory Council, under the leadership of Mel, co-founder Marcia Lawton, Bill Butynski, Walter Kloetzli, and others. Creation of the NAADAC Archives was an essential step in providing the archival documents that could be drawn upon to research and write the history. I had also created a section on addiction counseling within the Illinois Addiction Studies Archives in anticipation of this project and began collecting the papers of some of the addiction counseling pioneers, including all of the early NAADAC newsletters and all of the issues of *The Counselor* and *Addiction Professional* during the years these magazines served as the communication arms of NAADAC. More recently, Jay Lewis reviewed all of the issues of *The Alcoholism*

Report and created a chronology of the early professionalization of addiction counseling.

NAADAC: How are you approaching your work on this project?

Bill White: My first step was to pull together all of the key archival documents and create a chronology that will serve as the skeleton of the book. That work is all but completed, with a few rare documents remaining that we are trying to locate. The second step was to obtain the interviews completed over the years in anticipation of this project and get them transcribed. Most of that work is completed. The third step involved surveying some of the key leaders within NAADAC over these past decades about the evolution of addiction counseling and NAADAC. The final research step will be locating photographs that will help us tell this story visually. Then comes the really fun part—locking myself up, making sense of all we've collected and writing like a mad man for a few months.

NAADAC: How will this book be different than *Slaying the Dragon*?

Bill White: *Slaying the Dragon* tells the larger story of the evolution of addiction treatment in the United States. While there are sections that detail some aspects of addiction counseling, it is not a definitive history of the evolution of the addiction counselor role. I have always wanted to do a more detailed history focusing on addiction counseling and I'm delighted to now be working on this.

NAADAC: What are you most excited about with this project?

Bill White: Working on this book has given me an opportunity to hear the experiences and insights from some of the leading addiction professionals in the country. Their words are so powerful. To the greatest extent possible, we want the voices from the field to resonate within this book. I'm also excited to be able to give to the field a book that I wish someone could have placed in my hands some 45 years ago as I entered full-time work in the field. I see this book as one of my final contributions to the field and it is such an honor for me to have been selected to lead this project.

NAADAC: Will there be an opportunity for people in the field to review drafts of the book?

Bill White: Only to a limited extent because of the timeline of finishing the book before the 2014 NAADAC Annual Conference, but we will be sending out chapters as they are completed to key informants. We do anticipate future editions of the book so we are viewing the first printing as a starting point in formalizing a history of addiction counseling. My hope is that feedback on this first edition will enrich subsequent additions. No one will be happier than me if we discover missing chapters within this history through feedback we receive from our readers.

NAADAC: Why should addiction counselors be interested in this history?

Bill White: I can promise that this is going to be a very inspirational history from the quality of the interviews to date, but there is a much deeper reason addiction counselors will want to read this book. Put simply, history can serve as the ultimate experience of supervision. Where else can you get the accumulating wisdom and advice of people who have pursued this calling across multiple eras and across diverse cultural and clinical contexts? I'm not interested in history for the sake of history. I want to mine history for the lessons she can offer us to guide professional and institutional decision-making. I think the new book will provide a helpful guide to do just that.

NAADAC: You speak with a sense of urgency about this project.

Bill White: I do feel that sense of urgency. We are losing the pioneers who laid the foundation for our field. We need to capture their wisdom and their voices for future generations. If we do not do that now, their legacies and what they can continue to offer to us through their vision and their experience will be forever lost.



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Addiction Medicine in America: Its Birth and Early History (1750-1935) with a Modern Postscript.

The recent recognition of addiction medicine as a medical specialty obscures the fact that American physicians have been involved in the treatment of severe and persistent alcohol- and other drug-related problems for more than two centuries.

THE BIRTH OF ADDICTION MEDICINE

The roots of addiction medicine began not in a young America but in the ancient civilizations of Africa and Europe. The earliest American medical responses to alcoholism emerged within the systems of medicine practiced by Native-American tribes. In colonial America, there was pervasive consumption of alcoholic beverages but no recognition of excessive drinking as a distinct medical problem. This changed in response to increased alcohol consumption between 1780 and 1830, a shift in preference from fermented to distilled alcohol, and the emergence of socially disruptive binge drinking. Signaling alarm was Dr. Benjamin Rush (1746–1813), whose 1784 pamphlet, *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body,* stands as the first American medical treatise on alcoholism. Rush was the first prominent physician to claim that many confirmed drunkards could be restored to full health and responsible citizenship through proper medical treatment and to call for the creation of a special facility to care for the drunkard.

Between 1774 and 1829, physicians proposed that chronic drunkenness was a diseased state characterized by biologic predisposition, drug toxicity, pharmacologic tolerance, disease progression, morbid appetite (craving), loss of volitional control of alcohol/drug intake, and the pathophysiologic consequences of sustained alcohol and opiate ingestion. Treatment methods of this era included purging, blistering, bleeding, and the use of highly toxic medicines. Concern grew among physicians about addiction to drugs other than alcohol, prompted by the isolation of morphine from opium and cocaine from coca, the introduction of the hypodermic syringe, and the widespread distribution of opiate- and cocaine-based medicines by a rapidly growing patent drug industry.

Early Professionalization and Medical Advancements (1830–1900)

In 1828, Dr. Eli Todd, superintendent of the Hartford Retreat for the Insane, called for the creation of a physician-directed inebriate asylum. Under his influence, the Connecticut State Medical Society passed a

resolution supporting this idea in 1830. A year later, Dr. Samuel Woodward, superintendent at the Hospital for the Insane at Worcester, Massachusetts, wrote a series of influential essays echoing the Connecticut recommendations. In 1849, Magnus Huss published *Chronic Alcoholism,* the landmark addiction medicine text of the mid-19th century.

A multibranched treatment field emerged in the mid-19th century that included inebriate homes and medically-directed inebriate asylums, the first of which was the New York State Inebriate Asylum chartered in 1857 and opened in 1864, under the leadership of Dr. Joseph Turner. There were also privately franchised, for-profit addiction cure institutions (e.g., Keeley Institutes) and bottled patent medicine addiction cures (most containing alcohol, opium, morphine, or cocaine). By the late 1870s, large urban hospitals, such as Bellevue Hospital in New York City, also opened inebriate wards.

In 1870, Dr. Joseph Parrish led the creation of the American Association for the Cure of Inebriety (AACI), which brought together the heads of America's most prominent inebriate homes and asylums. The AACI by-laws posited that: *1. Intemperance is a disease. 2. It is curable in the same sense that other diseases are. 3. Its primary cause is a constitutional susceptibility to the alcoholic impression. 4. This constitutional tendency may be either inherited or acquired*. The AACI held regular meetings and published the first specialized medical journal on addiction—the *Journal of Inebriety* which was edited by Dr. T. D. Crothers from 1876–1914.

Demedicalization and the Collapse of Addiction Treatment (1900–1935)

Between 1900 and 1920, addiction treatment institutions closed in great numbers in the wake of a weakened infrastructure of the field, rising therapeutic pessimism, economic depression, and a major shift in national policy. The country turned its gaze to state and national prohibition laws as the solution to alcohol and other drug-related problems.

As inebriate homes and asylums and the private addiction cure institutes closed in tandem with the spread of local and state prohibition laws, persons suffering from alcohol and other drug dependencies were relegated to the "foul wards" of large city hospitals, the back wards of aging state psychiatric asylums, and the local psychopathic hospital, all of which did everything possible to discourage their admission. Those who were wealthy sought discrete detoxification in newly opened private hospitals or sanitaria established for this purpose. There were also brief efforts to integrate medicine, religion, and psychology in the treatment of alcoholism, most notably within the Emmanuel Clinics in New England. For all but the most affluent, the management of the alcoholic shifted from a strategy of treatment to a strategy of control and punishment via inebriate penal colonies. The large public hospitals also bore much of the responsibility for the medical care of the chronic alcoholic.

Addiction medicine organizations struggled in this shifting cultural climate. The AMTA and the American Association for the Study and Cure of Inebriety merged in 1904 to create the American Medical Society for the Study of Alcohol and Other Narcotics. The last issue of the *Journal of Inebriety* was published in 1914, and the American Association for the Study and Cure of Inebriety collapsed in the early 1920s after passage of the Volstead Act and the subsequent sharp decline in demand for treatment.

The medical treatment of narcotic addicts was dramatically altered by passage of the Harrison Anti-Narcotic Act of 1914. This federal act designated physicians and pharmacists as the gatekeepers for the distribution of opiates and cocaine. Although this law was not presented as a prohibition law, a series of Supreme Court interpretations of the Harrison Act (particularly the 1919 *Webb vs. the United States* case) declared that for a physician to maintain an addict on his or her customary

dose is not in "good faith" medical practice under the Harrison Act and therefore an indictable offense. Physicians in 44 communities operated morphine maintenance clinics between 1919 and 1924 that were eventually closed under threat of federal indictment. The influence of psychiatry on the characterization and treatment of addiction increased in tandem with the decline of a specialized field of addiction medicine. Karl Abraham's 1908 essay, *The Psychological Relations between Sexuality and Alcoholism*, marked the shift from seeing alcoholism as a primary medical disorder to seeing the condition as a symptom of underlying psychiatric disturbance. In the mid-1920s, Public Health Service psychiatrist, Dr. Lawrence Kolb, published a series of articles portraying addiction as a product of defects in personality—a characterization that reflected the growing portrayal of addicts as psychopathic and constitutionally inferior. The first American Standard Classified Nomenclature of Disease (1933) included the diagnoses of "alcohol addiction," "alcoholism without psychosis," and "drug addiction" and classified these conditions as personality disorders.

Few institutional resources existed for the treatment of alcoholism and narcotic addiction during the 1920s and early 1930s, but the growing visibility of these problems began to generate new proposals for their management. The opening of the California Narcotics Hospital at Spadra in 1928 marked the beginning of state support for addiction treatment. Physicians working within the federal prison system raised concern about growing population of incarcerated addicts and advocated more specialized addiction treatment. In the community, medical treatments for narcotic addiction in the first three decades of the 20th century continued to focus on managing the mechanics of narcotic withdrawal. The first decades of the 20th century were marked by a profound therapeutic pessimism regarding treatment of alcoholism and narcotic addiction. Biological views of addiction fell out of favor and were replaced by psychiatric and criminal models that placed the source of addiction within the addict's character and argued for the control and sequestration of the addict.

The Rebirth of Addiction Treatment (1935–1970)

Addiction medicine was revived within the context of two larger movements. The "modern alcoholism movement" was ignited by the founding of Alcoholics Anonymous (1935), a new scientific approach to alcohol problems in post-Repeal America led by the Research Council on Problems of Alcohol (1937) and the Yale Center of Alcohol Studies (1943) and by a national recovery advocacy effort led by the National Committee for Education on Alcoholism (1944). Two goals of this movement were to encourage local hospitals to detoxify alcoholics and to encourage local communities to establish post-hospitalization alcoholism rehabilitation centers. This movement spawned new institutional resources for the treatment of alcoholism from the mid-1940s through the 1960s, including "AA wards" in local hospitals, model outpatient alcoholism clinics developed in Connecticut and Georgia, and a model community-based residential model pioneered by three alcoholism programs in Minnesota: Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950). Dr. Nelson Bradley, who led the developments at Willmar, later adapted the Minnesota Model for delivery within a community hospital. That adapted model was franchised throughout the United States in the 1980s via Parkside Medical Services and was replicated by innumerable hospital-based treatment programs.

The spread of these models nationally was aided by efforts to legitimize the work of physicians in the treatment of alcoholism. Early milestones in this movement included landmark resolutions on alcoholism passed by the AMA (1952, 1956, 1967) and the American Hospital Association (1944, 1951, 1957) that paved the way for hospital-based treatment of

alcoholism. The former were championed by Dr. Marvin Block, chairman of the AMA's first Committee on Alcoholism. Mid-century alcoholism treatments included nutritional therapies, brief experiments with chemical and electroconvulsive therapies, psychosurgery and new drug therapies, including the use of disulfiram (Antabuse), stimulants, sedatives, tranquilizers, and LSD.

A mid-20th-century reform movement advocating medical rather than penal treatment of the opiate addict also helped spawn the rebirth of addiction medicine. This began with the founding of state-sponsored addiction treatment hospitals (e.g., Spadra Hospital in California) and led to the creation of two U.S. Public Health Hospitals within the Bureau of Prisons—one in Lexington, Kentucky (1935), the other in Fort Worth, Texas (1938). Many of the pioneers of modern addiction medicine and addiction research—Drs. Marie Nyswander, Jerry Jaffe, George Vaillant, Patrick Hughes—received their initial training at these facilities. The documentation of relapse rates after community reentry from Lexington and Forth Worth confirmed the need for community-based treatment. Three replicable models of treatment emerged: ex-addict directed therapeutic communities, methadone maintenance pioneered by Drs. Vincent Dole and Marie Nyswander, and outpatient drug-free counseling.

State and federal funding for alcoholism and addiction treatment slowly increased from the late 1940s through the 1960s and was followed by landmark legislation in the early 1970s that created the National Institute on Alcohol Abuse and Alcholism (NIAAA) and the National Institute on Drug Abuse (NIDA)—the beginning of the federal, state, and local community partnership that has been the foundation of modern addiction treatment. The growing sophistication of addiction science was aided by the College of Problems of Drug Dependence, and the Research Society on Alcoholism.

Addiction Medicine Comes of Age (1970–2013)

The reemergence of addiction as a clinical specialty of medical practice has been significantly advanced by two professional associations: the American Society of Addiction Medicine (ASAM) and the American Academy of Addiction Psychiatry (AAAP).

The ASAM can trace its roots to the establishment of the creation of a New York City Medical Committee on Alcoholism in 1951 by the National Council on Alcoholism, the 1954 founding of the New York State Medical Society on Alcoholism under the leadership of Dr. Ruth Fox, and the movement of this group in 1967 to establish itself as a national organization—the American Medical Society on Alcoholism (AMSA). AMSA was later evolved into the American Medical Society on Alcoholism and Other Drug Dependencies and then into the ASAM.

ASAM's achievements include 1) gaining ASAM membership in the American Medical Association House of Delegates, as a national medical specialty society (achieved in June 1988), 2) advocating the AMA's addition of addiction medicine to its list of designated specialties (achieved in June 1990), 3) offering a certification and recertification process for addiction medicine specialists based on the early work of the California Society of Addiction Medicine, 4) hosting its Annual Medical-Scientific Conference, and 5) publishing its widely utilized ASAM Patient Placement Criteria , *Principles of Addiction Medicine and* the *Journal of Addiction Medicine.*

The AAAP (formerly the American Academy of Psychiatrists in Alcoholism and the Addictions) was established in 1985 with the goal of elevating the quality of clinical practice in addiction psychiatry. The AAAP's contributions include successfully advocating that the American Board of Psychiatry and Neurology grant addiction psychiatry subspecialty status (1991), administering an addiction psychiatry certification and recertification process,

hosting an annual conference on addiction psychiatry, publishing the *American Journal on Addictions*, and promoting fellowships in addiction psychiatry.

Several additional initiatives have advanced addiction-related medical education. The NIAAA and the NIDA created the Career Teacher Program (1971–1981) that developed addiction-related curricula for the training of physicians in 59 U.S. medical schools. In 1976, Career Teachers and others involved in addiction-related medical education and research established the Association of Medical Education and Research in Substance Abuse (AMERSA). AMERSA draws its members primarily from American medical school faculty, hosts an annual meeting, and publishes the journal *Substance Abuse*. In 1980, the Consortium for Medical Fellowships in Alcoholism and Drug Abuse was established to promote addiction-focused research and teaching specialists.

The American Board of Addiction Medicine (ABAM), and The ABAM Foundation (2008 - 2012)

The American Board of Addiction Medicine (ABAM), and The ABAM Foundation were incorporated in 2007, with ASAM's "encouragement and assistance," to certify physicians in addiction medicine, and develop and accredit addiction medicine residencies, thus expanding the pool of physicians who can provide specialty care to patients with addiction problems. The goals for achieving this are to gain certification of physicians who practice addiction medicine by one or more member boards of the American Board of Medical Specialties (ABMS), and gain accreditation of addiction medicine residencies by the Accreditation Council for Graduate Medical Education (ACGME). This will make ABMS board certification in addiction medicine available to physicians of all specialties, complementing the certification of psychiatrists in addiction psychiatry approved by the ABMS in 1991, and offered through the American Board of Psychiatry and Neurology since 1993.

Certification: ASAM transferred the Examination to ABAM in 2009, and the *ABAM Credentials Committee* renewed the eligibility criteria to have them comply with ABMS's licensure and other requirements. The 5 ½-hour written examination is developed and continuously updated by a collaboration of the National Board of Medical Examiners (NBME) and the *ABAM Examination Committee*. There are 3,148 physicians certified in addiction medicine by ABAM: 2,060 of the ASAM certified physicians were granted ABAM certification, having met ABAM grandfathering requirements, and 1,088 were certified by the 2010 and 2012 ABAM Examinations. An additional 1,985 physicians hold a time-unlimited certificate from ASAM. The American Board of Psychiatry and Neurology has issued 2,206 certificates in the subspecialty of addiction psychiatry.

Maintenance of Certification (MOC): To assure that ABAM diplomates are current with the developments in the field of addiction medicine, the *ABAM Maintenance of Certification (MOC) Committee* launched the MOC Program in 2009. All diplomates must enroll in Part I to annually validate their licenses, and diplomates with a time-limited certificate are required to enroll in Parts II (Life-long Learning), III (recertification examination every 10 years), and IV (Practice Performance Assessment). Diplomates with time-unlimited certificates are invited to voluntarily participate in the four-part MOC Program.

Defining the field: In July 2010 The ABAM Foundation identified the core documents that define addiction medicine and its training programs. The documents included *Addiction Medicine Scope of Practice: Version 4* (September 13, 2012); *Addiction Medicine Core Content: Version 2* (March 11, 2010); *Core Competencies for Addiction Medicine: Version 2* (March 6, 2012); *Compendium of Educational Objectives for Addiction Medicine Residency*

Training (March 25, 2011); *Program Requirements for Graduate Medical Education in Addiction Medicine* (September 13, 2012), and the *Program Accreditation Application Form (PAAF)* (2013 cycle).

Accredited addiction medicine residencies: The *ABAM Foundation Training and Accreditation Committee* fostered the development of the nation's first addiction medicine residency programs. The first seven addiction medicine residents graduated in 2012. Nineteen (19) programs are accredited as of December, 2013.

Key Points

- Addiction medicine rose in the United States in the mid-19th century, collapsed in the opening decades of the 20th century, but reemerged and became increasingly professionalized in the late 20th and early 21st centuries.
- Early pioneers of addiction medicine in American during the 19th century include Drs. Benjamin Rush, Eli Todd, Samuel Woorward, Joseph Turner, Joseph Parrish and T.D. Crothers.
- Ninetenth century addiction treatment spanned private specaitly medical practices, inebriate homes, inebriate asylums, private for-profit addiction cure institutes and bottled home cures for addiction.
- Following the collapse of addiction treatment in the early twentieth century, addiction treatment was reborn as a professional field in the mid-twentieth century as a product of both alcohol and drug policy reform movements.
- The progressive professionalization of addiction medicine in the modern era has been led by the American Society of Addiction Medicine, the American Academy of Psychiatrists in Alcoholism and the Addictions, and the American Board of Addiction Medicine Foundation.

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The Three Missing Elements in the Treatment of Substance Use Disorders: Lessons from the Physician Health Programs

Abstract

To make recovery, and not relapse, the expected outcome of the treatment of moderate to severe substance use disorders (SUDs), three currently missing elements would need to be emphasized: 1) the definition of long-term recovery as the goal of all treatment and post-treatment interventions; 2) the provision of sustained post-treatment monitoring and professional and peer support, including drug testing; and 3) the insistence by others around the patients on sustained abstinence as crucial for those suffering from moderate to severe and prolonged SUDs. Each of these three elements is central to the distinctive care management system of the state physician health programs (PHPs). This approach to the long-term management of SUDs fits with the new direction of healthcare for serious, chronic diseases – away from isolated, and expensive acute care episodes and toward sustained chronic disease management with long-term monitoring, support, and early re-intervention if and when needed.