Many of us [corporate staff] *who disagreed strongly with these decisions (especially during 1989-1991) could not do so publicly, and maybe we appeared to be supportive....I discovered when talking with LGH leadership in 1993 that many of us were seen by them as supporting a business plan and philosophy that we strongly disagreed with.*

A Lasting Legacy

There are many ways in which the fall of Parkside could be told. Parkside could be depicted as an innocent victim of shifting markets. Parkside could be depicted as a victim of poor business decisions by its leaders. Or the story of Parkside's fall could be told—as former staff tended to tell it—in terms of character defects that emerged in its own organizational culture. Some of the themes we have touched on in this are not unique to Parkside. They can be traced from the rise of the earliest treatment institutions into the present. Lutheran General/Parkside provided a rich vein of knowledge and experience that continues to be felt in many areas of the field today. As one former employee noted:

The company may be gone, but the best of that system—the core of its treatment—is not gone. Our people are everywhere, taking the best of what was Parkside to the far corners of the treatment industry. In spite of what happened to Parkside as a company, the simple message of Twelve-Step recovery continues to live among the former Parkside clients and staff.

As I constructed the dramatic growth of Parkside in the 1980s and the crises of the 1990s, it was impossible not to think of A.A. in the 1940s and the crises that sprang from a similar period of explosive growth. There was a recognition in the 1940s that issues of money, property, and personality could destroy A.A., and the Twelve Traditions were created as a means of ensuring the future of the fellowship. These traditions articulated a set of values and principles that came to guide the organizational life of A.A. in the same manner that the Twelve Steps had guided the personal recovery of A.A. members. What is striking about the Parkside story is that, after almost 150 years, the field of addiction treatment still has no counterpart to A.A.'s Twelve Traditions, and that some of the best programs in the field continue to self-destruct. The fall of Parkside, as much as any modern milestone in the field, underscores the field's need for a core set of values and principles that can help its organizations and individual practitioners focus on its primary mission. If that focus cannot be sustained, if the field cannot forge a set of core values and principles to guide its business and clinical practices, many other programs—and even the field itself—might share Parkside's fate.

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Chapter Twenty-Nine: Some Closing Reflections on the Lessons of History

My goal in this final chapter is to guide the reader beyond the details of this history we have shared, to an exploration of some of its meanings. There are many levels at which lessons can be extracted from this history, and each reader will need to draw his or her own conclusions about what this has all meant. For myself, I have chosen to bring this work to closure by focusing primarily upon the forces that have contributed to the cyclical birth, development, decay, death, and rebirth of addiction treatment in America.

Approaching History

The Dangers of History

We will need to steer our way through three dangers in our approach to this final task. The first is revealed in George Santayana's oft-noted observation that those who have no memory of history are doomed to repeat it. This danger is a failure to recognize the pendulum swings and cycles that lie within the rhythms of human history. An opposite danger is to over-interpret history, so that all we see in the present and anticipate in the future is the unfolding repetition of old dramas. This is the danger that we might blind ourselves to that which is fundamentally new in what is unfolding before our eyes. A third danger is the

White, W.L., Slaying The Dragon: The History of Addiction Treatment and Recovery in America. Chestnut Health Systems Publishing, Bloomington, IL, 1998

temptation to use isolated artifacts of this history as a platform for moralizing. While these dangers call for caution in our approach to this exercise, in the end each of us must stake his or her claim on the meanings we choose to take from these pages. What follows are merely a few of my own.

The Immediacy of History

The history we are reviewing lives through its lasting influence. It is at once a looking glass pointed backward and forward and a mirror of the present moment. When William Green writes to us so eloquently of the psychological and cultural wounds inflicted by slavery and the extension of that legacy into patterns of destructive drug use in the African-American community today, we must consider that the past has a long reach.[285] We must consider the possibility that, when a White counselor and an African-American addict face one another, the ghosts of slave and slave master shimmer in the air until that history is buried in each developmental stage of their relationship. We must consider that, when an African-American counselor first meets an African-American addict, the ghosts of the house slave and the field slave are there with them until an authentic, present-oriented relationship is forged. We must consider that the emotional memory of this history lives even where the detailed knowledge of this history has been lost to its current participants. We must consider the possibility that the strengths and flaws of character in those drawn to this field a century ago continue in our own era. And we must consider the possibility that those forces that dictated the fate of the 19th-century inebriate asylum movement may very well define the fate of the current system of addiction treatment. To consider all of these possibilities, we must look to history as a window to the present and a tool that can help us face the future with expanded choices.

Recovery

Pathways of Recovery

This history has catalogued three overlapping pathways of addiction recovery. The first is highly personal and involves a reorganization of identity in the face of sudden crisis or cumulative maturation. This pathway is embraced within what we have earlier referred to as natural recovery, spontaneous remission, and maturing out. The second pathway is highly social and involves the use of informal community resources that provide a sobriety-based framework in which one can stop drinking and sustain sobriety. This pathway, called "indigenous therapy" by Andrew Gordon, includes culturally proscribed rationales for radical abstinence, mutual-aid groups, religious institutions, and personal recovery guided by indigenous healers/elders.[286] The third pathway—formal, professional, and institutional—involves the guided movement into recovery via the mechanism of "treatment." What is most striking in this American history of addiction recovery is the incredible diversity of styles and media through which people have resolved their problematic relationships with alcohol and other drugs. Science is confirming Bill Wilson's 1944 observation that there are many roads to recovery.[287]

Addiction Science

Clinical Research and Clinical Practice

Astute observers of the addictions field have noted that the field's core concepts emerged, not through the articulation and testing of theory, but by proclamation and sloganeering. Some have even suggested that the concepts that drive mainstream clinical practice in addiction treatment exist, not because of research, but in spite of it.[288]

While a gap between research and clinical practice exists in every arena of health and human services, this gap might more aptly be called a chasm in the field of addiction treatment. Government-funded academic studies all too often generate reports whose implications are absorbed into bureaucratic black holes without ever reaching treatment practitioners. While research activity creates the illusion that the field is operating on a scientific basis, research and treatment constitute separate industries that have little awareness of, contact with, or regard for one another.

While few would challenge the contention that the addiction treatment field rests on a poor scientific foundation, such observations sometimes reveal a lack of awareness of two very different ways of knowing in the field. Where the scientist is searching for empirical truth, the alcoholic and addict are searching for a workable answer to their painful entrapment. The objectivity and detachment of the scientist stand in stark contrast to the passionate belief and commitment that marks most avenues of addiction recovery. A.A.'s program of recovery, for example, boasts—not that it is true—but that it works. While the scientist seeks objective truth, the addicts and those who work with them seek a truth that has the metaphorical power to incite change. The dialogue between these two worlds

is hampered by these different ways of knowing. Each side tends to perceive the other with a degree of blissful arrogance and condescension. While calls for cooperation and synergy between these two very separate worlds have become commonplace, science is not likely to become the driving force in addiction treatment until it moves beyond contributing to our knowledge of addiction, to a replicable technology of human transformation.

The Perceived Causes of Addiction

While addiction has long been defined as evil, the source of this evil alternately has been pointed toward the drug, the person, and—more rarely—the social, political, and economic environment in which addiction unfolds. When the focus shifts to the individual, quite different explanations are offered as to the source of personal vulnerability to addiction. These explanations, heavily influenced by the broader social climate, vacillate between theories that posit the source of addiction as biological, psychological, spiritual, moral, and criminal.

During periods in which alcohol and other drug addictions are medicalized, we view only a small percentage of the population as physiologically or psychologically vulnerable to addiction. During periods in which addiction is being criminalized, the entire population is portrayed as vulnerable to addiction. These vacillating views are not so much about the evolution of addiction science as they are about cultural sense-making. Science tends to be more the mirror than the mediator of cultural belief about addiction and recovery.

The Abuse of Technology

The real and imagined advances of science have a potentially malevolent side. In reviewing a history that includes the sterilizing, electroshocking, lobotomizing, and relentless drugging of alcoholics and addicts, we must pause to consider the potential abuses inherent in current and future addiction treatment technologies. We must similarly consider the potential that unintended harmful consequences might grow out of our broader approaches toward solving alcohol- and other drug-related problems.

The Disease Concept

What is most remarkable about the "disease concept" of alcoholism and other addictive disorders is the concept's sheer survivability. This concept has survived more than 200 years of attacks from theologians, philosophers, reformers, psychiatrists, psychologists, and sociologists, and yet continues to survive. This suggests that, as a people, we have both an individual and a collective need for this concept to be "true," regardless of its scientific status. This truth may be more metaphorical than scientific. Science is unlikely to destroy the popularity of the disease concept, but a better metaphor could.

The history of the disease concept may tell us something about the history of ideas. Michael Agar has suggested that what can appear to be radical changes in a professional field can, more often than not, be merely a cosmetic alteration of traditional ideas and practices held together with newly formulated "political cement." Conversely, the introduction of a change labeled as a minor refinement may constitute the touchstone of a radical shift in philosophy and practice.[289] The introduction of the disease concept of alcoholism into 19th-century medicine, and some of the concept's most recent refinements, may illustrate both Agar's principle and its corollary.

Misuse Versus Addiction

Throughout history, efforts have been made to reduce the plethora of personal and social problems created by drug consumption into a single theoretical mold. We have yet to produce a conceptual umbrella under which all of these problems will fit comfortably. In particular, we have failed to create an umbrella that facilitates differential diagnosis and the true individualization of treatment for the many variations of alcohol- and other drug-related problems experienced by American citizens. We will never address these problems effectively by forcing them into an addiction paradigm and enticing or coercing all people suffering from such problems into narrow approaches to treatment—and an equally narrow pathway of long-term recovery. The emergence of "multiple-pathway models" opens up the potential to distinguish between alcohol problems and alcoholism and to develop menus of intervention that will allow highly individualized approaches to the resolution of quite varied alcohol- and other drug-related problems.

Patient Classification Systems

The creation of taxonomies of addicts and addictive disorders has been an enduring pastime of American addictionologists and is an essential step in the true

individualization of addiction treatment. These classifications have been based on perceived etiological roots of addiction, patterns of addiction, and personality differences of addicts (to name just a few). But masked behind the illusion of scientific precision lurk moral judgements which declare some people worthy and others unworthy of treatment. Diagnoses can delineate whom we like and whom we do not like—in the name of delineating one disorder from another.

Toward a Core Addiction Treatment Technology

Every health-care profession and every health-care institution must establish a core technology—a consistently applied body of knowledge and technique. Throughout the health-care system there are technologies of assessment and diagnosis, models of clinical decision-making, established service procedures and techniques, and methods of systematic follow-up to monitor and increase patient compliance with continuing-care protocol.

In each era of addiction treatment, the central innovation has been the shift from treating the consequences of addiction to a focus on treating the addiction itself. This innovation has been discovered, lost, rediscovered, and lost again in what seems to be an unending cycle. For the addiction treatment field to sustain itself, we must find ways to develop and refine that core technology, to infuse that technology into the field's institutions, and to transmit that technology to new generations of workers. If it turns out that we have no such technology, then there is no long-term rationale for the field's existence.

On Blaming

Harold Hughes, the political Godfather of the modern alcoholism treatment system, often noted that alcoholism was the only disorder in which the patient was blamed when treatment failed.[290] Alcoholics and other addicts have suffered, not only as a result of poorly developed and at times harmful treatment technology, but also through being blamed for their failure to respond to such technology. For decades many addicts have been subjected to treatment interventions that had almost no likelihood of success; And when that success has indeed failed to materialize, the source of that failure has been attributed, not to the intervention, but to the addicts' recalcitrance and lack of motivation. The issue is, not just that such mismatches do not work, but that such mismatches generate their own iatrogenic effects via increased client passivity, helplessness, hopelessness, and dependence. Blaming protects the service provider and the service institution at the expense of the addicted client and his or her family. Defining failure at the personal level can also mask broader failures of social policy.

The Rise of Treatment Institutions and Mutual-Aid Societies

The Cultural Context of Addiction Treatment

Addiction treatment was birthed in a larger arena of cultural, legal, moral, and scientific thought; And this treatment—how it is conceived, what it involves, where and by whom it is delivered, and to whom it is provided—continues to evolve in tandem with advancements and regressions in the larger cultural ecosystem.[291] This society's willingness to invest resources in the addiction treatment enterprise has been extended and withdrawn in cyclical patterns of moralization, criminalization, medicalization, and demedicalization. These broader cultural rhythms dictate whether treatment resources exist, the nature of those resources, who has access to such resources, and the goals toward which this thing called "treatment" is directed.

Addiction treatment as a social movement must serve multiple personal and social utilities. It must serve its individual and institutional clients—and the community and culture in which it is nested—in both real and symbolic ways. The allocation of public resources toward addiction treatment, along with the diversion of addicts from the criminal justice system to the health-care system, serves as a symbolic act through which we collectively define ourselves as our brother's keeper. During this stage, the act of providing treatment meets broader needs of the culture that are unrelated to the actual effectiveness of the treatment offered.

When the culture demands rigorous evaluation to prove the effectiveness of treatment, such demands usually reflect that the treatment industry is failing to meet those larger social utilities. This usually occurs when broad social forces redefine one's "brother" as "perpetrator" and redefine "keeper" as "warden." Prisons serve similar symbolic functions that have little to do with their actual capacity to punish, protect, or rehabilitate. Caretaking and punishment are venues through which the culture expiates its most powerful emotions. The acts of caring and punishing are more about ourselves than about the consequences of those acts on the addict. The images of the addict that we create can alternately evoke empathy or disdain, and

it is through these images that we define, not the addict, but ourselves.

The Birth of Mutual-Aid Groups: Ecological Influences

While the stories of the rise of mutual-aid movements often focus on the roles of individuals, these movements are nurtured within a much broader social and economic climate. The rise of most alcoholism-related mutual-aid groups emerged during periods characterized by a decline in overall alcohol consumption. Three of the periods in which alcoholism-related mutual-aid recovery movements arose in America followed declines in per-capita alcohol consumption. The Washingtonians emerged after a decade (1830-1840) that saw per-capita alcohol consumption decline from four gallons to two gallons of per-capita alcohol consumption.[292] A.A. emerged following America's experiment with national prohibition, which had also produced significant decreases in alcohol consumption. The third period (1975-1985), in which Women for Sobriety (WFS), Secular Organization for Sobriety (SOS), Rational Recovery (RR), and other alternative mutual-aid recovery groups flourished, was marked by what some observers were calling a new era of temperance. Mutual-aid movements seem to rise when casualties have accumulated from a period of excessive use, but when the majority seems to be moving toward more temperate patterns of alcohol or drug use. Left in the lurch and unable to make such a transition by themselves, these casualties reach out to one another for support in reclaiming their injured bodies and stained identities.

Mutual-aid groups also seem to share a formal or informal function of mutual economic support. It may well be that shared economic hardship is a pre-condition for the rise of such movements. Mutual-aid movements are likely to arise following periods of widespread or pocketed economic depression or recession. Economic hardship creates a climate of increased cooperation and mutual-aid, and the focus on personal recovery from alcoholism may also serve metaphorically and practically as a framework for personal economic recovery.

In their explosive growth in the second half of the 20th century, mutual-aid groups emerged as surrogate family structures and as voluntary spiritual communities. Their cultural significance and future may have more to do with meeting these broader cultural needs than with their discovery of various programs of recovery for alcoholism.

Destigmatization and Professional Status

The movement to destigmatize addiction and addicts has been as much about enhancing the prestige of service providers as it has been about reducing the stigma on consumers of addiction treatment services. Destigmatization required a medicalized language and an altered image of the target population—from skid-row alcoholic to next-door neighbor. Marginalized clients were pushed out of the system to make room for more attractive clients, just as many marginalized staff were pushed out of the way to make room for a more socially attractive staff. The professionalization of addiction treatment required attractive and articulate clients and staff.[293]

Mutual-Aid Societies and the Rise of Addiction Treatment Institutions

Addiction treatment systems seem to rise out of the energy generated by mutual-aid movements. Treatment systems begin as an adjunct to mutual-aid societies, but as these systems acquire professional power, they turn mutual-aid societies into adjuncts of themselves. Professionalized addiction treatment is birthed to broaden the gate of entry into personal recovery, then enters a period of demise when it begins to conceive of itself as the power that initiates personal recovery.

A History of Contempt

Contempt, often mutual, is an enduring and troubling theme in the historical relationship between helping professionals and addicts. The addiction treatment industry as a specialized field grew out of the contempt in which other helping systems regarded alcoholics and addicts. For generations, physicians, nurses, social workers, psychologists, welfare workers, and other service professionals barely masked their contempt for the alcoholic and addict. Beneath the veneer of professional discourse about addicts during the past century lies a pervasive undertone: Most professionals simply do not like alcoholics and addicts.

The term "countertransference" has long been used to connote the feelings elicited in the therapist toward a particular patient. The history of the relationship between professional helpers and alcoholics and addicts is, to a very real extent, a story of countertransference gone awry. Addicts and professional helpers have maintained through much of American history a mutual disregard and a mutual

avoidance of one another. The ways in which contempt has influenced the evolution of treatment for addiction is a subject worthy of extended investigation. Many of the coercive and invasive "treatments" detailed in this book could have occurred only in a climate of such contempt. Alcoholics and addicts are uncanny in their ability to sense the most carefully disguised contempt—and even more adept at retaliating in kind.

It is clear from this history that alcoholics and addicts do not fare well in service relationships in which one party claims moral superiority over the other. It was this understanding that, more than 50 years ago, led Drs. C.E. Howard and H.M. Hurdam to suggest that therapists working with alcoholics should practice abstinence. It was their belief that the drinking therapist inevitably communicated a stance of psychological and moral superiority over his or her alcoholic patients.[294] It was not the drinking that stood in the way of clinical effectiveness, but the moral superiority that their ability to drink conveyed.

The delivery of effective services to addicts begins with the transcendence of contempt. We can learn much from some of the real pioneers in this field. What recovered people brought to this field was, first and foremost, a capacity for moral equality and authenticity. But what of those pioneers in our field who did not bring histories of addiction and recovery—Dr. Silkworth, Sister Ignatia, Sam Shoemaker, Willard Richardson, Frank Amos, Dr. Harry Tiebout, and Father Ed Dowling, to name only a few? Here's how Ernie Kurtz characterized these individuals.

> *They were not alcoholic, but they did all have something in common: each, in his or her own way, had experienced tragedy in their lives. They had all known kenosis; they had been emptied out; they had hit bottom....whatever vocabulary you want. They had stared into the abyss. They had lived through a dark night of the soul. Each had encountered and survived tragedy.*[295]

There are ways in which the "kinship of common suffering" can transcend such labels as "alcoholic" and "non-alcoholic." While the mechanism of identification between alcoholic and alcoholic and between addict and addict is crucial in the mutual-aid arena, what may be important in the professional arena is, not only technical knowledge and skill, but also a similar authenticity of emotional contact. Such authenticity transcends the issue of one's recovery status and provides a means of escaping the mutual contempt that has haunted the addict-professional relationship for more than a century.

The Segregation-Integration Pendulum

American history is replete with failed efforts to integrate the care of alcoholics and addicts into other helping systems. These failed experiments are followed by efforts to move such care into a categorically segregated system that, once achieved, is followed with renewed proposals for service integration. After fighting for 40 years to be born as an autonomous field of service, addiction treatment is once again in the throes of service-integration mania. This cyclical evolution in the organization of addiction treatment services seems to be part of two broader pendulum swings in the broader culture, between specialization and generalization and between centralization and decentralization. Once we have destroyed most of the categorically segregated addiction treatment institutions in America, a grassroots movement will likely arise again to recreate them. When the 21st century once again gives birth to specialized addiction treatment, perhaps this "new" institution will be given a colorful name fitted to its form and function—perhaps something like *inebriate asylum.*

Observations on the Treatment Field

Treatment as Religion, Social Movement, Science, and Business

The history of addiction treatment involves the synergy of religion, science (medicine), social movement, and business. The earliest treatment system in the U.S. was made up of four overlapping branches: the temperance movement, religiously influenced inebriate homes, medically oriented inebriate asylums, and the business-oriented cures of the private sanataria and the patent-medicine industry. The threads of these four branches have existed in the field since the 1870s, with each branch periodically rising and receding in influence.

Each branch represents a form of potential excess: reform zealotry that promises to eliminate drug problems by eliminating the drug, religious zealotry that appeals to only the smallest percentage of the addicted, medical experimentation whose alleged cure has sometimes proved quite injurious, and the unconscionable financial exploitation of addicted people and their families. The addictions-treatment field has operated at its highest levels during periods in which a reasonable balance existed that

reined in the potential excesses of each of these branches. The field has deteriorated when one of these elements has taken dominance over the others. If there is "truth" to be found in this field, it is probably not in the dogma of the true believers residing within each of these spheres, but in the questions raised by the synthesizers who operate across the boundaries of all of these spheres.

Defining Treatment

A definition of alcoholism/addiction treatment should be able, at a minimum, to: 1) distinguish between addiction treatment and other interventions of a medical, psychological, social or religious nature, and 2) distinguish between the activities of addiction treatment agencies and voluntary mutual-aid societies. We shall attempt such a definition, which might guide our continued observations.

> *Alcoholism/addiction treatment is the delivery of professionally directed services to the alcoholic or addict, with the primary goal of altering his or her problematic relationship with alcohol and/or other drugs.*

"Real" alcoholism or addiction treatment services are characterized by at least five elements: 1) Services are professionally directed in the context of a contractual, fiduciary relationship. One party has taken on professional responsibility for the care of the other; 2) The focus of the services is on the addiction itself, and not merely on the neurobiological, psychological, social, economic, and legal consequences of addiction; 3) There is a core technology of addiction treatment that is replicable; it can be articulated, codified, and taught to other caregivers. That technology outlines what is to be done (service protocol) and why (theory); 4) The relationship is governed by a set of legal and ethical standards designed to protect the client, the service provider, the institution, the profession, and the public. These standards include the definition of boundaries of what is and is not appropriate in the service relationship; 5) The assessment, diagnosis, clinical decision-making, interventions, and client responses to those interventions are carefully recorded and subject to peer, supervisory, and administrative review.

According to this definition, interventions that focus solely on resolving the problems created by and co-existing alongside addiction are not in and of themselves addiction treatment. Detoxification and medical stabilization may be provided in a treatment institution and may be valuable, essential services, but by themselves they do not constitute addiction treatment as defined above. Ernest Bishop understood this in 1920, when he insisted that the care of the addict had to be focused, not on the mechanics of drug detoxification, but on the actual "mechanism of narcotic drug addiction-disease."[296] Removing the drug from an addict's body is not the same as treating addiction—a truism reinforced throughout this history.

Based on this definition, we could say unequivocally that the mutual-aid groups described in this book—the Washingtonians, the fraternal temperance societies, the reform clubs, the Oxford Group, A.A./N.A./C.A., WFS, and SOS—do not constitute addiction "treatment," though individuals may use these frameworks to move from the status of addiction to the status of stable recovery. Many other institutions—"drying-out" places, some halfway houses, and nearly all recovery homes—similarly do not constitute treatment. So when did addiction treatment begin?

Defining the Birth of Treatment

The problem with defining precisely when alcoholism and addiction treatment began in the United States is complicated by the fact that the term "treatment" was not used routinely in the 19th century, and that its meaning has evolved throughout the 20th century. One's opinion regarding the time addiction treatment began will vary by one's definition of treatment. Here are my own conclusions, based on the just-offered definition.

Alcoholism treatment began in the United States when the first patient asked a physician to treat, not the physical ravages of drinking, but the compulsion to drink. Benjamin Rush, if not the first, was clearly one of the first to make this transition. Addiction treatment began when the first doctor went beyond tapering a patient off of morphine to attempting to remove the patient's continued cravings. Many 19th-century physicians made this transition before the first inebriate asylum was built. Providing housing for alcoholics over a temperance hall did not constitute treatment. Institution-based treatment began the first time the alcoholic (or someone else) began to pay for services directed at the permanent elimination of addiction. When the focus of the help shifted from the need for detoxification, housing, food, and employment and focused on the appetite for drink itself, treatment began.

The nominees for American "firsts" in the arena

of addiction treatment and recovery include the following. Samson Occom, Handsome Lake, Kah-ge-ga-gah-bowh, and William Apess were among the earliest Native Americans who, having recognized their own self-injury by alcohol, led local or regional temperance campaigns between 1770 and 1830. J.P. Coffin, J.F. Pollard, W.E. Wright, Jesses Vickers, Jesses Small, John Hawkins, and John Gough were among the most noted recovered alcoholics working to reform alcoholics in the temperance movement of the 1830s and 1840s. The earliest specialized home for inebriates was Washingtonian Hall, opened briefly in 1841 and re-opened in 1857. The first medically oriented institution specializing in the treatment of inebriety was the New York State Inebriate Asylum in Binghampton, New York, opened in 1864. The first mutual-support group birthed in a treatment institution was the Ollapod Club, founded at the New York State facility in 1869. The first specialized institution for inebriate women was the Martha Washington Home in Chicago, opened in 1869. One of the earliest institutions that specialized in the treatment of narcotic and cocaine addiction was the Brooklyn Home for Habitués, opened in 1891. There are three early candidates for the delivery of specialized outpatient services: The Keeley Institutes, beginning in 1879, set the model for what today would be called intensive outpatient or day treatment services; the Massachusetts Hospital for Dipsomaniacs and Inebriates operated 29 outpatient offices in the early 20th century; and the Emmanuel Clinic of Boston was among the first to deliver outpatient alcoholism counseling services out of a local community-based clinic, beginning in 1906. Courtenay Baylor was the first recovered alcoholic to work in a paid role as an alcoholism counselor (beginning in 1913), and his protégé Richard Peabody was one of the first alcoholism counselors to work in a solo private counseling practice (in the mid-1920s). All of these firsts predate the founding of A.A. and the rise of the modern alcoholism treatment system.

Who is the Client?

Each era of addiction treatment opens with a vision of addicts voluntarily entering treatment and closes when such treatment results almost exclusively from coercion. The "client" whom treatment institutions serve cyclically vacillates between the individual addict and community social and economic institutions. Addiction treatment swings back and forth between a technology of personal transformation and a technology of coercion. When the latter dominates, counselors become, not helpers, but behavioral police. The fact that today's treatment institutions often serve more than one master has created the ethical dilemma of "double agentry," wherein treatment staff profess allegiance to the interests of the individual client, while those very interests may be compromised by the interests of other parties to whom the institution has pledged its loyalty.[297]

Motivation, Treatment, and Pretreatment

The history of addiction as experienced by America's addicts is a history of ambivalence. Addicts simultaneously want—more than anything—both to maintain an uninterrupted relationship with their drug of choice and to break free of the drug. Behaviorally, this paradox is evidenced both in the incredible lengths to which the addict will go to sustain a relationship with the drug and in his or her repeated efforts to exert control over the drug and sever his or her relationship with it.

Views over the past century have varied considerably regarding the role of initial motivation in the addict's long-term prospect of recovery. Friedrich Erlenmeyer expressed the traditional view in 1899, when he asserted that the morphinist's desire for cure was essential to successful treatment.[298] But one of the constant rediscoveries in this history is that espoused motivation to be drug free at the time of admission to treatment is not a predictor of positive treatment outcome. This "discovery" was announced in the inebriate asylums; by Bradley and Anderson at the Willmar State Hospital in the 1950s; and by a long series of studies in the second half of the 20th century.[299] There has been a growing recognition that motivation is best viewed, not as a precondition of treatment, but as something that emerges out of an effective treatment process. Motivation is increasingly being viewed, not as something inside the client, but as something that emerges out of the interaction of the client, the client's intimate social network, the therapist and the broader treatment milieu.[300]

The Cyclical Nature of Treatment Fads

Ideas and approaches in addiction treatment do seem to recur in cycles, almost as if certain strains of thought and action in the field re-occurred every other generation in some inexplicable mechanism of professional heredity. There are also predictable life cycles for each new proclaimed cure—announcement, dissemination, institutionalization, decay and loss of faith, hibernation, and revival. These periodic cycles

of renewal suggest that treatment outcome is influenced in part by the infusion of hope surrounding each new treatment.

The profuse praise and promise heaped on treatment innovations have, to-date, slowly dissipated under the sober judgement of controlled studies and prolonged clinical experience. A century of specifics—from the gold cures to LSD, from spinal drainage to hypnosis, and from psychosurgery to psychotherapies with endless names—have offered promise and then disappointment. Each has been hailed as a breakthrough. Each promise in itself represented a jockeying for problem ownership and professional status.

What our sweeping review of addiction treatment tells us is that almost any treatment—be it drinking wine in which eels have been suffocated, taking the latest medication, or joining the latest group-therapy fad—will produce some successful outcomes. Any new intervention technology will produce cases in which cure can be claimed. Addicts make numerous attempts at aborting active addiction, and success and failure are all too often measured by a single intervention rather than combined or cumulative interventions. It is always the last attempt that is judged to be successful when, in fact, what may have proved the crucial factor was time, experience, maturity, the sudden opening of some developmental window-of-opportunity for change, or the cumulative effect of numerous interventions. What history tells us is that the early reports of such breakthroughs in the understanding and treatment of addiction are notoriously unreliable and should be treated with great caution and skepticism.

The Challenges of Model Replication

David Deitch, an early pioneer in the therapeutic-community movement, and Dr. Vincent Dole, the co-developer of methadone maintenance, have both suggested that many elements of model treatment programs may not be easily replicated without losing efficacy.[301] I would further add that the highest quality of treatment involves, not merely choosing the right program for the right client, but choosing the right program at the right time—that unique period in the developmental history of an organization when it is at its optimum effectiveness. Some aspects of the best treatment cannot even be sustained in the program in which that treatment was birthed, let alone replicated and mainstreamed within the larger treatment system.

The Therapeutic Underground

A mysterious element seems to be at work in the arena of addiction treatment—and perhaps also in the arena of addiction recovery mutual-aid groups. Each breakthrough in addiction treatment offers some formula for recovery that seems to have its followers and success stories. So perhaps there are some common threads that all of these approaches—lay and professional, spiritual and rational, medical and non-medical, altruistic and predatory—have in common. This therapeutic underground offers a rich field of investigation. We tend to strive to define what *within* a particular approach makes it uniquely successful. Perhaps we should also search for the common ground of experience that *crosses* all of these approaches. What affects positive treatment outcomes may be related, not to the treatment itself, but to unrecognized elements in the client, the client's environment, or the treatment milieu. As we suggested earlier, the most effective element of the Keeley cure may not have been the medicine, but what happened among the Keeley patients while they were standing in line four times a day waiting for their injections. No doubt similarly unrecognized influences operate in today's treatment environments.

Recovery as a Social Process

Alcoholics and addicts whose alcohol and other drug use is enmeshed in drug-using social institutions such as the saloon have always needed an alternative social structure to support their new-found sobriety. This need has given rise to lodging houses, patient-run temperance societies, temperance libraries and inns, coffeehouses, the Jacoby Club of the Emmanuel Clinic, A.A. clubhouses, halfway houses, and self-directed recovery homes. Those recovery frameworks that have been successful over time have had a deep understanding of the social ecology of alcoholism and have mirrored it.

Priests and Shaman

The noted mythologist Joseph Campbell often made distinctions between the roles of priests and shaman across different cultures. According to Campbell, priests were social functionaries who derived their legitimacy from social institutions and in turn supported the social order. In contrast, the shaman's legitimacy sprang from his or her passage through emotional death and rebirth. Where the priest had been prepared by the social order, the shaman was

prepared by his or her own personal experience.[302] "Professionals by education" and "professionals by experience" represent the priests and shaman of the addiction treatment field. For more than 100 years, tension has reigned in the relationship between our field's priests and shaman. That tension stems, in part, from two very different types of knowledge: the knowing of the mind and the knowing of the heart. The former involves the mastery of externally validated truth, while the latter springs from within one's own experiential truth.

On rare occasions (and that rarity is itself significant), someone raises the question of the future of recovered people in the addiction treatment field. The question has been rendered obsolete by three decades in which shaman were either pushed out of the field or turned into priests. If shaman are denied expression of that which distinguishes them from priests, then the question of the future of recovered people working in professional roles in the field is rendered irrelevant. The field at its best was energized by a unique synergy between the priests and the shaman, but we have lost, silenced, or transformed most of our shaman. The issue is not which is the more effective of these two groups. Treatment outcome has not been shown to be consistently related to counselor type.[303]

It is quite likely that clients need different experiences and perspectives at different developmental stages of their recovery, and that these diverse experiences can best be provided in a multidisciplinary team that brings a great diversity of professional, cultural, and personal backgrounds. Efforts to professionalize (such as credentialing and certification) may have inadvertently homogenized these differences and diluted the power of what a treatment team could bring to each alcoholic and addict. Credentialing, by focusing on that knowledge which could be codified and transferred to others, implicitly pushed the recovered counselor to emphasize physical and psychological, rather than spiritual, dimensions of the recovery process. Recovered and recovering people brought passion and energy to the treatment milieu. They brought a focus on direct service and a deep faith in the possibility of change derived from their own recovery and their participation in a community of recovered and recovering people. In the wake of their declining numbers, the presence of that hope in the field seems to be diminishing.

Programs Versus Systems of Care

The mental-health and public-health fields have been much more adept at organizing themselves into integrated and coordinated "systems of care" than has the addictions field. We still exist in relative isolation, whether as "freestanding programs" or as encapsulated units within broader service organizations. That isolation has historically been our greatest strength and our greatest vulnerability.

Treatment in Relationship to Community and Society

Dynamic Interactions: A Problem, a Profession, and a Society

One can often gauge the health of a field by observing its management of the boundary that separates it from other professional fields and the larger society. When that boundary is drawn too tightly, addiction treatment programs can become therapeutic cults. When the boundaries of competence become ill-defined and over-extended, the potential for loss of identity and mission is great.

Professional fields are always in dynamic relationship with the society in which they are nested. Born out of the needs of that society, they in turn shape the evolution of that society. Birthed to respond to one need, they must inevitably meet other societal needs in order to sustain their existence. Reciprocal adaptations occur at the boundary between the professional field and the society. It is through its success or failure to adapt to these larger economic, social, and political rhythms that a field evolves or becomes extinct.

The modern system of addiction treatment grew out of the broader medicalization of personal and social problems, and might fall victim to the current de-medicalization of such problems.[304] The reframing of personal problems in moral and characterological terms—along with a restructuring of responses to social problems that focuses more on managing their economic costs than on their personal outcomes—poses a significant threat to the future of the addiction treatment field, in terms of both the field's existence and its essential character.

Overselling Treatment

There has always been a propensity to oversell what treatment could achieve, both personally and socially. While such promises can help generate funding, they also create unrealistically high expectations of what treatment should achieve on a broad scale.

Jim Baumohl, in his review of the inebriate-

asylum era, pointed out the danger of suggesting addiction treatment as a panacea for the cure of complex social problems.[305] The overselling of the ways in which addiction treatment could benefit the home, the workplace, the school, the criminal justice system, and the broader community during the 1970s and 1980s sparked a subsequent backlash. When time—the ultimate leveler—began to expose the fact that these benefits were not forthcoming at the level promised, a rising pessimism fueled the shift toward increased criminalization of addiction. This recent history has underscored an enduring lesson: successful short-term strategies for generating public support for the funding of addiction treatment can have unanticipated and harmful long-term consequences.

Rhythms of Despair and Hope

The experiences of despair and hope that can move in and out of the lives of addicts and those close to them are replicated in the larger social responses to addiction. Despair over—and hope for—the addict co-exist throughout most of the history we have reviewed, but there clearly have been periods in which one emotion has dominated the other. When hope dominates, alcoholics and addicts are pulled into the rubric of "we" and cared for in medical and religious institutions. When despair and fear prevail, addicts and alcoholics become "they" and are controlled by police, courts, and prisons. In the transition between these two cycles, we can see addiction counselors who serve as therapeutic police—and judges and probation officers who serve as social workers. When despair and hope co-exist, gender, race, and social class operate to define who will be treated and who will be punished.

Alcoholism Treatment and the Alcohol Industry

The alcohol industry has, according to Alex Wodak, attempted to reframe what were being called "alcohol-related problems" as "alcohol misuse or abuse." In Wodak's view, such "liquorspeak" has served to shift the focus of the problem from the nature of the product to the nature of the drinker.[306] Since the days of the inebriate asylums, the treatment industry conducted itself in ways that prevented it from becoming a target of the alcohol industry. Both the conceptualization of inebriety as a disease and the disease conceptualization of alcoholism that followed it several decades later placed the focus on the personal vulnerability of the alcoholic, rather than on the "evilness" of alcohol as a product.

In 1983, Robin Room, in his classic essay "Sociological Aspects of the Disease Concept of Alcoholism," suggested that the "tacit coalition" that had existed between the alcoholism movement and the alcohol beverage industry was rapidly disintegrating. The cause of this change was a shift from "alcoholism" as the field's conceptual centerpiece to a broader "alcohol problems" perspective.[307] This shift produced a greater focus on alcohol as a drug and the practices of the industry that manufactures and promotes it.

As treatment expanded beyond its alcoholism focus to an alcohol-problems focus, two things occurred. First, ethical issues were raised regarding alcohol and drug prevention and treatment agencies' practice of accepting financial contributions from the alcohol industry. Second, there was a growing sense that the treatment field needed to "take on" the alcohol beverage industry—that this industry was "the enemy." This shift has brought the alcohol beverage industry and the alcoholism treatment industry into increasing conflict. While some would suggest that such tension is long overdue, others express concern about the long-term consequences of an already weakened addictions field's movement into an adversarial position with such a powerful enemy.

Issues surrounding the alcohol industry are part of a broader emerging question: What role should addictionologists—that whole host of people who work in the arena of addiction research, prevention, and treatment—play in the broader discourse on alcohol and other drug problems in this culture?

The Fall of Treatment Institutions and Mutual-Aid Societies

Seeds of Decline

Sometimes the seeds of demise are sown in the early success of a new treatment venture. Those institutions that discover something quite workable in the midst of their experiments in treating alcoholics and other addicts can sustain themselves over long periods of time without knowing precisely what it is that is producing these positive outcomes. Unable to identify the exact nature of their strength, they become inherently superstitious and resistant to change—a stance that sometimes squeezes the breath out of the very thing they are trying to protect.

Problem Ownership and Treatment System Instability

Joseph Gusfield has described how certain social

or professional groups emerge to "own" a social problem.[308] How alcohol and other drug problems are constructed is not merely a theoretical issue debated by academics. Whether we define alcoholism as a sin, a crime, a disease, a social problem, or a product of economic deprivation determines whether this society assigns that problem to the care of the priest, police officer, doctor, addiction counselor, social worker, urban planner, or community activist.[309] The model chosen will determine the fate of untold numbers of alcoholics and addicts and untold numbers of social institutions and professional careers.

The existence of a "treatment industry" and its "ownership" of the problem of addiction should not be taken for granted. Sweeping shifts in values and changes in the alignment of major social institutions might pass ownership of this problem to another group. Robin Room suggests that the institutional ownership of an intractable problem such as alcoholism is inherently unstable. Because so many aspects of the problem are not fully resolvable, new proposals with unknown outcomes always look more promising than the highly visible shortcomings of present practices.[310] What is required to unseat an existing model of response to an intractable problem is sometimes only a dynamic articulation of the existing model's failures and the expression of an alternative vision. This unseating can occur at the local community level or at the societal level.

The Fall of Treatment and Mutual-Aid Movements

Overlapping factors contribute to the fall of treatment as a system, of individual treatment institutions, and of mutual-aid societies.

The factors most likely to contribute to the fall of addiction treatment institutions include: 1) the image of such institutions as drying-out havens for the irresponsible—particularly the irresponsible rich, 2) ethical breaches that wound the field in the eyes of potential service consumers and the public, 3) poorly developed clinical technology, 4) ideological conflicts in the field and between the field and allied disciplines, 5) economic or social disruptions that trigger a shift toward de-medicalization or criminalization, 6) the failure to achieve or sustain public funding, and 7) the failure of the field to address problems of leadership development and leadership succession.

The factors that contribute to the fall of mutual-aid societies include 1) organization of the movement around a single charismatic figure, 2) failure to develop or sustain an exclusionary membership that ensures addict-to-addict identification, 3) conflicts over money and status, 4) ideological splintering, 5) diversion of purpose to broader social, political, or religious agendas, 6) failure to create a codified program of recovery, 7) failure to create standards of group life that can enhance organizational resiliency, and 8) professionalization.

Three of the most significant threats to treatment and recovery movements as a whole, and to individual treatment and recovery organizations, are the processes of implosion, diffusion, and diversion.

Implosion and Inversion

Addiction treatment programs, like other institutions charged with the care of historically stigmatized individuals, have a propensity to become closed, incestuous systems that cloister themselves socially and professionally and then die through a process of internal stagnation. Taking on the tenor of therapeutic cults, these systems migrate toward ideological extremism, then implode through the actions of their charismatic leaders; through ideological splits, coups or purges; or through the progressive physical and emotional depletion of institutional members. Implosion intensifies flaws of character and magnifies the best and the worst in interpersonal relationships. The result is a legacy of conflicting ideologies and personalities that have left many a treatment program in shambles. From the conflict between Dr. Edward Turner and Dr. Willard Parker that led to the demise of the first inebriate asylum in America, we can trace this thread through the Hargreaves-Keeley disputes, and on forward to a 20th century filled with such conflict. This turmoil is by no means unique to addiction treatment organizations, but there may be certain characteristics about these organizations that make them particularly vulnerable to the forces of implosion.

Implosion can also incite a process of inversion—an intense focusing on the personal and interpersonal problems of staff. There is a dangerous propensity for the energy of a treatment milieu to become directed inward toward staff self-exploration and self-healing, rather than outward in service to clients. There is danger that we—those professional helpers with and without addiction histories—treat ourselves in the name of treating others. There is a danger that we ourselves become intoxicated with the subject of intoxication, that we sublimate our own desire for excess into our work with those who have suffered from excess. This dynamic leaves the field as a whole and each individual agency vulnerable to a shift in focus regarding whose needs will drive clini-

cal decision making—our own or those of the clients we are pledged to serve.[311]

Diffusion and Diversion

Diffusion and diversion constitute two of the most pervasive threats in the history of addiction treatment institutions and mutual-aid societies. Diffusion is the dissipation of an organization's core values and identity, most often as a result of rapid expansion and diversification. Diffusion creates a porous organization (or field) that is vulnerable to corruption and consumption by people and institutions in its operating environment. Diversion occurs when an organization follows what appears to be an opportunity, only to discover in retrospect that this venture propelled the organization away from its primary mission.

The current absorption of addiction treatment into the broader identity of behavioral health is an example of a diffusion process that might replicate two earlier periods—the absorption of inebriate asylums into insane asylums and the integration of alcoholism and drug-abuse counseling into community mental health centers in the 1960s. This diffusion-by-integration has generally led to two undesirable consequences: 1) the erosion of core addiction treatment technologies, and 2) the diversion of financial and human resources earmarked to support addiction treatment into other problem arenas.

The Price of Profiteering

From the patent-medicine vendors, the exclusive drying-out hospitals and sanatoria, the private methadone clinics, and the private addiction treatment programs of the 1980s and 1990s, addiction has long been viewed as an entrepreneurial opportunity. The histories of profit-driven treatments present a pattern of hit and run. They fill a void; extract financial resources from addicts, families, third party payors, and communities; then flee to other, more profitable ventures, leaving institutions and professional helpers whose commitment to addiction treatment is more enduring to weather the backlash from the profiteers' excesses. The failure to define and enforce clear ethical standards governing our business practices has long rendered the addiction treatment field a predator's paradise. The price the field could pay for that failure might be the loss of its own future.

The Impermanence of Treatment Innovation

In the sweep of this history we have shared, there is a marked lack of permanence in the innovations pioneered within a single institution. Most of the institutions chronicled in this text were able to make great breakthroughs, but were unable to sustain that edge of vitality. One of the collective lessons drawn from all the programs we have profiled must surely be that treatment programs evolve dynamically through stages of expansion and contraction: stages of birth, growth spurts, plateaus, decay, and renewal or death. They span generations of clients and staff who each carry forward, re-interpret, or change the institution's core philosophy. They experience critical turning points—some that are easily recognizable and others that are visible only in retrospect. What is most clear from stories reaching from Keeley and Lexington to Synanon and Parkside is that no treatment institution is invulnerable, regardless of the intelligence and commitment of its staff or the sophistication and effectiveness of its treatment technology.

What are we to make of this impermanence? I think there are two possible conclusions. One is that the meaning in the life of an institution is the experience of one period of peak performance in which that institution makes its contribution to the larger whole. Perhaps what matters in the long run is not that the innovation at Willmar State Hospital was able to be sustained for 50 years, but that such innovation once existed and enriched an entire professional field. The second possible conclusion is that there are no lasting institutional legacies, that the only legacy possible is in the continuing lives of those who are briefly touched by an institution. Enduring careers and enduring personal recoveries often outlive the institutions in which they were birthed. Both staff and clients often carry the knowledge that their lives are forever different because of one brief period in the life of such an institution.

The Future of Treatment and Mutual Aid

Trend Summary

Trends in treatment have involved cyclical shifts between: medical and religious/psychological models; inpatient and outpatient settings; social sequestration and social integration; voluntary and involuntary engagement; public and private treatment agencies; delivery of addiction treatment services by generalists and the emergence of addiction specialists; and between the organization of services by drug choice

and the organization of services by age, gender, culture, geography, social class, or clinical sub-classification. Trends in mutual-aid have involved shifts from inclusive to exclusive membership, from the large-group meeting to the small-group meeting as the basic unit of organization, from multi-purpose to single-purpose groups, from culturally homogenous to heterogenous groups, and from groups that focus on initiating sobriety to groups that focus on sustaining sobriety.

The Future of Treatment

As this book goes to press, America is caught in a transition between two addiction paradigms: one that views addiction as a diseased condition emanating from biopsychosocial vulnerability, and the other that views addiction as willful and criminal behavior emanating from flaws of personal character. In a shift that began in the early 1980s, America is moving addiction once again from the arena of public health to the arena of public morality.

If this trend continues, it is likely that addiction will be de-medicalized and increasingly criminalized for all but the most affluent of our citizens. During the next decade more addiction programs will close, and many more will be integrated into larger behavioral-health organizations and networks. The field will continue to be buffeted in a highly turbulent operating environment, and many programs will risk losing their focus on personal recovery. There is considerable danger that much of the core technology of addiction treatment will be lost in the coming decade, eroding the field's ability to further develop that technology. In many communities, waiting lists for inadequate doses of specialized addiction treatment will—where they already have not—lengthen to the ridiculous. Alcoholics and addicts will once again drift to or be captured by other institutions: the jail cell, the prison cell, the hospital emergency room, the local psychiatric unit, the state psychiatric hospital, the urban mission, or the domestic-violence shelter.

Addiction treatment from 1965 to 1985 was characterized by increased accessibility, intensity, and duration; Addiction treatment from 1985 to 1998 has been characterized by decreasing accessibility, intensity, and duration. As we approach the 21st century, we have begun the wholesale movement of addicts —particularly poor addicts of color—from treatment programs to the criminal justice system. This reverses the trend toward integrating the treatment of addiction into local communities and re-initiates a pattern of isolation, sequestration, and punishment.

How much of the current system of addiction treatment will survive and be recognizable a decade from now is open to question, but one thing is certain. The movement to generate and sustain support systems for recovering alcoholics and addicts in this country has been, and will continue to be, unstoppable. Every time formal systems of treatment collapse, new grassroots movements rise up to rebuild or replace those systems. Hopefully the wheat of this last era can be threshed from the chaff and used to sow the seeds of a revitalized system of addiction treatment.

The Future Redefinition of Treatment

During the past 150 years, "treatment" in the addictions field has been viewed as something that occurs inside an institution—a medical, psychological, and spiritual sanctuary isolated from the community at large. In the future, this locus will be moved from the institution to the community itself. Treatment will be viewed as something that happens in indigenous networks of recovering people that exist within the broader community. The shift will be from the emotional and cognitive processes of the client to the client's relationships in a social environment. With this shift will come an expansion of the role of clinician to encompass skills in community organization. Such a transition does not deny the importance of the reconstruction of personal identity and other cognitive and emotional processes—or of the physical processes of healing—in addiction recovery. But it does recognize that such processes unfold within a social ecosystem and that this ecosystem, as much as the risk and resiliency factors in the individual, tips the scales toward recovery or continued self-destruction.

As these new community organizers extend their activities beyond the boundaries of traditional inpatient and outpatient treatment, they will need to be careful that they do not undermine the natural indigenous systems of support that exist in the community. The worst scenario would be that we would move into the lives of communities and—rather than help nurture the growth of indigenous supports—replace these natural, reciprocal relationships with ones that are professionalized, hierarchical, and commercialized.

Final Words

History as a Lesson in Humility

As a culture, we have heaped pleas, profanity, prayers, punishment, and all manner of professional

manipulations on the alcoholic and addict, often with little result. With our two centuries of accumulated knowledge and the best available treatments, there still exists no cure for addiction, and only a minority of addicted clients achieve sustained recovery following our intervention in their lives. There is no universally successful cure for addiction—no treatment specific. In 200 years of addiction treatment history, the most significant breakthroughs have existed alongside the most ill-conceived. Some of the most passionately claimed truths and best championed interventions have proven wrong, ineffective, and at times harmful. It is easy for us to smugly condemn the past imbecility of treating morphine addiction with cocaine, or to be outraged at the cruelty of sterilizing and lobotomizing alcoholics and addicts, but it would be the ultimate in arrogance and blindness for us to deny that such errors in understanding and judgement are likely present in our own era. Given this perspective, addiction professionals who claim universal superiority for their treatment disqualify themselves as scientists and healers by the very grandiosity of that claim. The meager results of our best efforts—along with our history of doing harm in the name of good—calls for us to approach each client, family, and community with respect, humility, and a devotion to the ultimate principle of ethical practice: "First, do no harm."

Keeping Our Eyes on the Prize

So what does this history tell us about how to conduct one's life in this most unusual of professions? I think the lessons from those who have gone before us are very simple ones. Respect the struggles of those who have delivered the field into your hands. Respect yourself and your limits. Respect the addicts and family members who seek your help. Respect (with a hopeful but healthy scepticism) the emerging addiction science. And respect the power of forces you cannot fully understand to be present in the treatment process. Above all, recognize that what addiction professionals have done for more than a century and a half is to create a setting and an opening in which the addicted can transform their identity and redefine every relationship in their lives, including their relationship with alcohol and other drugs. What we are professionally responsible for is creating a milieu of opportunity, choice and hope. What happens with that opportunity is up to the addict and his or her god. We can own neither the addiction nor the recovery, only the clarity of the presented choice, the best clinical technology we can muster, and our faith in the potential for human rebirth.

Slaying the Dragon

I have enmeshed myself in this history for the past ten years, and the most profound message that I have drawn from this work is the power of one individual and a single institution to change the future, often in the face of insurmountable odds. I think we can draw sustenance from many of these heroes and heroines, and extract important values and lessons from their lives to help keep us focused during the turbulent days ahead. I think we must ask these pioneers to help us keep our eyes on the prize, ask them to help us when we doubt ourselves, ask them to help us stay focused. I look back on 30 years of working with alcoholics and addicts with few illusions about this incredibly imperfect instrument we call "treatment," but still believing that, at its best, it has the power to heal bodies, touch hearts and transform lives. I would bid those of you who will carry this history forward to align yourselves as closely as possible with that power. When you strip away all the pomp and paper and procedures, it is that power that has and will continue to be the beacon of hope for us all. If the external structures of the field one day collapse, it is that power that will rise again in the future. The privilege to participate in this process of rebirth is the most sacred thing in our field. It is a prize worth protecting.

Slaying the dragon—for our clients and for ourselves—begins with waging war against our flawed selves and ends with the capacity to move forward through the acceptance and transcendence of our own imperfection. In this transition exists recovery, service, and life for us all. To those of you who choose to toil in the treatment of alcoholics and addicts, let me say that generations of humanly flawed but highly committed individuals have delivered this field to your care. You must write with your own lives the future chapters of this history. In accepting such a challenge, you must find a way to respect and learn from this history without getting trapped within it. I wish you Godspeed on your journey into that future.