Addiction Counselors in Recovery: Perceived Barriers in the Workplace

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Abstract

In the 1970’s when the substance abuse treatment field was still developing as a discipline, there was a great deal of workers needed to help with the large amount of substance abusers wanting help. And since specific credentials were not yet established for the field of addictions, individuals with sobriety were hired on and given on the job training. The literature has described many barriers that the counselor in recovery has been faced with over the decades. A common theme throughout the literature is that these individuals usually enter the field at an older age and have less formal education than the non-recovering counsellor. The role of the counsellor in recovery is often distorted within the field by the second-class citizen status to which they are sometimes subjected. By writing this paper we hope to resurrect topics that might be perceived as barriers by counsellors in recovery that were briefly discussed in the literature decades ago. To begin this process of reform, this paper reviews the literature in an attempt to examine the perceived barriers associated with the recovering addict working in the addiction field. It also addresses the limitations of the studies conducted to date, provides recommendations for further research and proposes that this topic be explored using a qualitative approach, so that this unique group of counsellors can construct their own narratives.

Keywords: Recovering counsellor, Perceived barriers, Stigma, Addiction field

Introduction

It was not until the mid half of the last century that people in recovery were considered as potential employees in the substance abuse treatment field. Due to a shortage of professional counsellors at the time, there grew a belief that the individual in recovery could be trained to enter the field of addiction treatment as a paraprofessional [1]. These early stages of addiction treatment and the emergence of the recovering substance abuser as counsellor fostered a discussion in the role played by the paraprofessional [2,3]. As the counsellor in recovery began to find a place in the field among non-recovering counsellors, it is understandable why the field was interested in examining how the paraprofessional might compare with the professional in the work being done. This discussion subsequently encouraged an accumulation of literature during the early stages of substance abuse treatment in North America, which later began to diminish as the field moved towards the new millennia.

By writing this paper we hope to resurrect topics that might be perceived as barriers by addiction counsellors in recovery that were briefly discussed in the literature decades ago. We also hope to encourage the creation of new discourse that is no longer fully determined, or sustained in certainty by knowable terms already established by the socially constructed perspectives of “others”. To begin this process of reform, this paper reviews the literature in an attempt to examine the perceived barriers associated with the recovering addict working in the addiction field. It also addresses the limitations of the studies conducted to date, provides recommendations for further research and proposes that this topic be explored using a qualitative approach, so that these counsellors can construct their own narratives.

Literature Review

To conduct the literature review, we searched the PsychInfo database and used terms like ex-addict*, adj2 therapist*, etc. (adj2 means within two words of each other in either order), and ORing this with the other strategy which is B. Counselor Terms (including Counselor Characteristics) ANDed with terms for ‘recovered addict’. Etc.

Medline has no terms for ‘counsellors’ so we primarily used the terms in A above.

One of the common areas quantitatively researched was the education status of the paraprofessional, with studies reporting that the person in recovery enters the field at an older age and has less education than the non-recovering counsellor [3,4-7]. Other quantitative studies have found that compared to the non-recovering counsellor, recovering counsellors are resistant to new learning [8,9], are overcommitted to one treatment modality due a personal loyalty to the 12 – step approach [7,10,11], and operate from a limited frame of reference because they view all clients in terms of being addicted or not, which might lead to over diagnosis [12].

Despite the literature conveying a disapproving view of the person in recovery, some authors have pointed to the advantages of hiring individuals with drug abuse history to work in methadone clinics. They mention that counselors in recovery act as a resource person for other non-past addicted staff lend street credibility to the program and act as a role model, helping to make it more acceptable to suspicious clients [13-17]. To substantiate these observations, studies report that when compared to the non-addict, patients surveyed found that the ex-addict counsellor contributed more helpful opinions and guidance [18,19], developed better relationships and understanding [6,20] and were able to spot abuse much better [21]. There are however two survey-based studies that found no difference between the ex-addict and non-ex-addict when patients were asked to rate performance [22], and perception of empathy [23].

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While the studies thus far presented in this paper are outdated, there are two recent quantitative studies that examine provision of clinical tasks distributed among recovering and non-recovering counsellors [24] and the determinants of intrinsic job motivation [25].

After an extensive review of the literature, we found that the majority of studies are quantitative and survey based. The leading data analysis instruments used in these studies are analysis of variance (ANOVA) and multiple regression and vary in methodology from interview based surveys, which are predominantly agency located, to questionnaires across various substance abuse treatment agencies [4-6,10,11,18,20,21,26,27]. There is however two studies that implement qualitative methodology in their research design. The more recent study by [28] uses qualitative interviews to analyze the pursuit of professional jurisdiction, concentrating on entry and socialization processes. An older study by McGovern and Armstrong (1987) surveyed alcoholism counsellors in an attempt to gather qualitative and quantitative data to explore areas that were regarded by counsellors as potential pitfalls to substance abuse relapse among fellow counsellors in recovery.

A further review of the literature exposed that the European community is limited in its research on the topic of relapse among counsel with a history of substance abuse. The one interview based qualitative study reports on the challenges faced by recovering counsellors’ dilemmas, as they maintain dual relationships, by virtue of being an ex-addict and coming in contact with clients that the counsellor is familiar with either through former using days, or from attending 12-step meetings [29]. The other three European survey based studies examine the influence of relating recovery status to the counsellor’s sensitivity to ethical dilemmas [30], the impact of addiction counsellor’s interactional style [31] and the effectiveness of former alcoholics as association workers in specialized addiction medicine structures [32].

Hecksher [29] writes that in Denmark, the employment of addiction counsellors with past substance abuse issues represents a new tendency. One reason for this development might be an increased interconnectedness in recent years between 12-step organizations and the public treatment services. Judging not only from the lack of literature, but also from these few studies being recent, the European substance abuse treatment community is following an evolution that occurred in North America decades ago with the Alcoholics Anonymous (AA) movement, which resulted in the 12 step approach to recovery and then the Minnesota Model of treatment programs.

Despite the “recovered”, “ex”, or “former” label, the majority of people will still choose to focus on the “addict”, and with it impose a negative connotation on the subject. Studies have shown that people in recovery from substance abuse will choose to keep their past a secret because of the stigma associated with their former addiction [33]. The stigma associated with methadone maintenance patients is also documented in the literature. An ongoing theme found in qualitative study despite their on going sobriety was that those prescribed methadone felt stigmatized, consequently necessitating the need for secrecy.

More recent evidence shows the influence that the psychiatric profession has over substance abusers. After viewing randomly allocated vignettes, psychiatrists were more likely to rate alcohol patients as difficult, annoying and less in need of admission [35]. This theme continues as research points to former addicts facing barriers when trying to access treatment for hepatitis C [36]. These views are also supported by the general public who rated drug addiction as the primary disorder in terms of danger to the public and lowest on the priority for accessing health care [37].

Disciplines as well will subjugate the “nonconformist” to constructed ways of behaving and talking; otherwise, there are things in place as a backlash that removes agency from the ex-addict [38]. Even the substance abuse treatment sector has historically wielded power over the recovering addict working in the addiction field when compared to the non-recovering counsellor. When comparing job-related activities [4], and [7] found that the counsellor in recovery had less decision influence than non-recovering counsellors in money, staffing, policy and clinical matters of the agency they were employed with. In a qualitative study exploring the recovering counsellor’s perception of their supervisor’s attitude, [39] discovered that respondents felt that their supervisor’s “commitment to the relationship was one of authority and power over me” (p. 349).

Stigma within the Field

Once the addict in recovery enters the field of addiction counselling, he or she is presented with certain barriers because of his or her past association with substance abuse. In the 1970s the field was still developing as a discipline and addiction counsellors were needed to assist with the large amount of substance abusers wanting help. And since specific credentials were not yet established for the field of addictions, individuals with at least one year of sobriety were hired on and given on the job training [40]. Their non-recovering counterparts saw these individuals as deteriorated or inferior [41]. Strachan [41] has observed that the role of the alcoholic in recovery is further distorted within the field by the second-class citizen status to which they are sometimes subjected. This has forced many to go underground with their past and drop all reference to former addiction and recovery. An example of staff bias towards these individuals is evident when methadone patients are later hired on as counsellors and methadone is viewed by many non-recovering staff as an undesired end-state [19], or incomplete recovery. This stigmatization is also associated with some non-recovering counsellors viewing the ex-addict as a volunteer because they usually entered the field without any formal education and did not receive a salary.

To date our review found no studies exploring the topic of co-worker stigma and an examination of this phenomena would be helpful in understanding if counsellors in recovery experience any stigma today. The literature that speaks to this topic is outdated and the field has gone through many changes since the 1970’s in requiring candidates seeking employment as addiction counsellors to have formal education and be associated with a governing body before being considered for employment. But are the moralistic attitudes of the past still present today and do many recovering counsellors still choose to maintain secrecy about their past for fear of being stigmatized? There are particular social factors that imply certain scripts of what makes a professional addiction counsellor. The counselor in recovery is expected to be a morally regulated person who is defined in terms of good, proper, professional and with appropriate knowledge. This is very loaded with judgment beyond the scientific attributions of the biological impact of drugs on the body, and therefore not scientific, but socially constructed as moral judgment. To the recovering counsellor, being an inappropriate subject implies reclaiming freedom in resistance to the constraints of an over-regulated society and its demands for conformity of the person to become non-threatening as a normalized law-abiding, rights-bearing citizen.
To help understand the reasoning behind the moralistic attitudes that might be held by some addiction counsellors toward the recovering counsellor, Thomas [42] taboo framework explains that drug users symbolically represent that which is not part of the social order. When the influx of ex-substance abusers were being hired because of a shortage of workers in the addiction field, the non-recovering counsellors might have seen their ordered and stable culture as threatened – disrupted by the individual who did not belong, giving rise to the taboo subject of the counselor in recovery. The taboo framework erases sensitivity to differences within specific communities and the dominant community is fearful from the belief that the community is changing [43]. This can be conceptualized in terms of social regulation and governance within the addiction field as paraprofessionals enter the field and are taught how to talk and behave.

Historically, independent institutions, such as treatment agencies are granted authority to define and direct human conduct. These authorities (based on the dominant non-recovering personnel) have acted largely through the incultation of norms of behaviour and subjectivity [44]. Modern individuals are obliged to be free, but in order to act freely we must first be shaped and molded into subjects capable of responsibility through systems of domination [44]. This can sometimes lead to resentment that manifests into resistance, which might give rise to a fragmented and polarized work place environment - recovering vs non-recovering counsellors.

Lack of Formal Education

A common theme throughout the literature is that the counselor in recovery usually enters the field at an older age and has less formal education than the non-recovering counsellor [4,5,7]. The academic credentials that a non-recovering staff presents with when entering the field can sometimes feel threatening to the recovering counsellor whose education is less impressive and compromised of on the job training. Rivers [45] states that many of these counsellors are extremely sensitive about their lack of formal education so they are cautious and circumspect when dealing with their better-educated co-workers. While this attitude might seem irrational, Rivers (1984) continues by stating that it is understandable when one is reminded of the self-esteem and lowered self-worth issues these individuals lived with during their former substance abusing days.

The academic inferiority the counselor in recovery might feel when surrounded by co-workers with higher learning may be intimidating and restrict the individual from offering valuable opinions based on experience. This lack of formal education when compared to the non-recovering counsellor may continue to perpetuate the lower status label that was thrust upon the paraprofessional who entered the field decades ago as a volunteer [41].

Many ex-addict counsellors use their recovery status as a credential, drawing on their personal experiences of substance abuse and recovery to promote modeling and provide tips about dealing with issues arising during rehabilitation [46]. In recent years these life experience credentials have become less valued when considering the education that is now required to enter into the field of addiction treatment. As more and more professionally trained individuals enter the field, the role of the para-professional has been challenged, and it is a critique of the recovering counsellor, the majority of who are less educated than their counter-parts.

In Ontario, counsellors working in the addiction discipline are often asked by agencies to register with a regulatory body, such as the Ontario College of Social Workers and Social Service Workers, or the Canadian Addiction Counselling Certification Federation. The latter means a minimum of a two year college diploma in a human services counselling program with addictions as a major. But even these community college based programs were cancelled in the new millennium. For example only one addiction program remains in Ontario based at Durham College and it requires a degree to enroll. What does this mean to those who have graduated with this potentially obsolete human services counselling diploma? The recovering addict who chooses to be an addiction counsellor in today’s millennium will have to commit to a four-year program, or run risk of being passed by when looking for employment. Might this be a deterrent for ex-addicts wanting to enter the field? Do the systemic barriers that exist for many to achieve a university based education create hardship for people in recovery? Might the field lose the personal expertise that the ex-addict brings with them? Given that studies report recovering counsellors enter the field at a later age, this means that they would have to put their career plans on hold for longer than they might want to in order to obtain a competitive level of education. This could be discouraging for some who have family members dependent on them and therefore take longer to complete their education on a part-time basis. The addiction field is known for counsellors who come from all walks of life, providing a mosaic of therapeutic styles based on formal education, life experience and social location, and it would be sad to think that the field and clients would lose out on a valuable asset [47].

The lack of education among recovering counsellors also creates a lack of opportunity to pursue professional growth within the field, limiting the individual to frontline work, with little hope to be influential in policy or supervisory positions. Almost a decade ago, Stoffelmayer et al. [3] stated that as more and more professionals enter the field, “program leadership is often assumed by non-recovering professionals; recovering paraprofessionals are then relegated to the role of frontline clinicians and support staff” (p. 126).

However, there are other agencies that maintain a 12 - step model of care and are known for hiring counsellors that are in recovery. How might these two agencies affect the potential ex-addict seeking employment in a substance abuse treatment setting? The 12-step run agency will openly welcome the addict in recovery in 12-step fashion, fostering a sense of belonging, where there is no need for hiding one’s past, because “the man [or woman] who is making the approach has had the same difficulty...” [48]. It is also understandable why this 12-step focused agency will attract people in recovery who might be among those who have been positively affected in their recovery by the 12 - step approach [49-51]. This might be the type of setting where academic competitiveness plays a smaller role while recovery status is more appreciated. The addiction field could lose significant human resources if ex-addicts seeking employment were discouraged from working in a non-12 – step setting among non-recovering counsellors because their recovery status was not appreciated, or to avoid stigma, or academic competitiveness [38].

Blume [1] predicted over two decades ago that educational standards may replace personal qualifications and past life experience as qualifications for positions in the addiction field. Unfortunately, this question may never evolve to fruition if we recall that some recovering counsellors choose not to disclose their past experience with substance abuse for fear of the stigma associated with it. Current research is needed to see if recovering counsellors still enter the field at a late age and if they are entering the field with higher learning due...
to the recent push to increase academic credentials.

Another observation noted by Brown and Thompson [22] is that since the counselor in recovery usually enters the field with less education than the non-recovering counsellor, it would be fiscally wise to hire the ex-addict who will give the greater return in dollars expended. Aiken et al. [4] believes that the lack of acceptance outside the drug treatment community and positive pressure from within the drug treatment community may be why ex-addicts counsellors have not been more widely employed.

12 - Step Influence

The large number of ex-addicts entering the field raised certain questions regarding the attitudes, effectiveness, knowledge and styles used by the recovering counsellor, which resulted in studies comparing them to the non-recovering counsellor. For example, studies have shown that compared to the non-recovering counsellor, counsellors in recovery are inflexible in their approach by virtue of being resistant to new learning [8,9]. Quite often, they are overcommitted to one treatment modality due a personal loyalty to the 12 – step approach [7,10,11] and operate from a limited frame of reference because they view all clients in terms of being addicted or not, which might lead to over diagnosis [12]. The belief is that the recovering counsellor's lack of formal education, combined with an agency's proposal for training conveys a mistrust of their intuitive feelings and minimizes their street knowledge. It can also be possible that the training that does not focus on a 12 - step model that the counsellor subscribes to is contrary to there own recovery belief. The individual may therefore not hold the training in high regard because they believe that they have all the tools necessary to provide good therapy – their personal experience and the teachings of 12 – steps. Of course, if a counsellor works in a 12 – step based treatment agency then there is much less conflict. Seen in a broader scope however, the 12 – step influence may limit the approaches used by the counselor in their practice, which may exclude individuals seeking help that may be interested in non-abstinence-based modalities such as harm reduction and moderate drinking.

Risk of Relapse through Work Related Cue Exposure

Despite a counsellor’s successful recovery from past substance abuse, they must be cognizant about their sensitivity to stress and cue-induced drug or alcohol craving. As addiction counselors, they are constantly exposed to possible triggers from clients who exhibit substance using behaviour and who may often glorify their substance use while sharing their stories. In addition, recovering counsellors may come in contact with former using acquaintances or partners who are now clients of the agency they work for, which triggers a memory recall of former substance using days [38].

Several studies report that cocaine addiction and its association with chronic relapse is often attributed to frequent bouts of intense cravings that are triggered by environmental cues and internal stimuli [52]. This means that people, places, things, actions and sensations are strongly associated with past drug use that represent conditioned cues, triggering a drug craving as a conditioned response [53-55].

Working in the addiction field presents the recovering counsellor with repeated personalized internal cues where autobiographical memories of drug use symbolize motivationally powerful conditioned drug cues [56]. These cues may provoke increased craving and susceptibility to relapse [57]. Several studies have shown that ongoing cue-exposure to substance related stimuli may produce an increase in self-reported negative mood [58,59].

My review of the literature revealed nothing that relates cue-exposure to ex-addicts working in the addiction field, but the research contributes to the possible burnout where recovered counsellors tend to put in more work hours than non-recovered counsellors [4]. This possible high rate of burnout or possible relapse is compounded if the individual is employed by a community outreach program, which meets clients in their own environment and is bombarded by multiple drug related stimuli [38].

Because stress and substance related cues are major factors contributing to relapse, it is important that recovered counsellors are able to speak openly about these matters without fearing a backlash. The individual who approaches a co-worker or supervisor to discuss concerns about feeling triggered should be commended for their bravery in facing possible stigma, and having the foresight in preventing a possible relapse [38].

Discussion

The substance abuse treatment field has gone through many changes since the moralistic attitudes of the 1940’s [60], where addiction was linked to poor choices and weak will [61], giving rise to the conviction that “once an addict, always an addict” [62]. As the ex-addict began to be viewed as a contributing member of the substance abuse treatment field, it is understandable why this subculture began to interest researchers, but we cannot look to this outdated information to illustrate what occurs today in the field.

One reason for this gap in the research is that the counsellor in recovery may no longer be under the critical microscope of evaluation within the field as it was in its earlier days of recruitment. It is quite possible that they have already proved their worth and by now have planted roots that are thriving as a sub-culture that has gained acceptance within the field. There might be the possibility that the judgement once experienced by some recovering counsellors is no longer apparent and has changed from being explicit to implicit. But without conducting current research we cannot understand the experiences of today’s recovering counsellor, nor can we begin to give voice to those who feel the need to claim freedom from many conformist ways of domination that may be seen by some as a present barrier.

Implications for Research

Addiction and recovery is not experienced in the same way by all, but constructing identity with one’s own past as a former addict is similar to survivors of trauma – history is always a part of who you are. These individuals despite their unique experiences with past substance abuse are all living and continuously experiencing similar phenomena – being recovered addicts working in the addiction field. The recovered counsellor has been historically excluded from seats of power traditionally held by non-recovering counsellors. Much of the research conducted so far has also been directed from a positivist approach to women’s use of drugs and let go of previous perceptions in order to construct new ones, the research and substance abuse treatment community have to allow recovering counsellors to participate more in constructing news ways of understanding. Furthermore, she contrasts a classical positivist approach to research.
and understanding with a postmodern approach that would be more attuned to gender sensitive issues [63]. Likewise, the use of narratives would be more sensitive in creating an open discussion of the perceived barriers among recovering counselors.

The qualitative research conducted thus far on recovering counselors has helped identify associations between variables, but this type of positivist approach cannot effectively deal with the specific features of social explanation [64].

Qualitative methods are beginning to gain acceptance and becoming more popular in the drugs field [65,66]. One of the major strengths of qualitative methods is the knowledge it provides through the dynamics of social process [67,68], and its distinct ability to answer how, and why questions [68]. The use of narratives produce distinct research outputs [44], that exposes contradictory and tangled complexities of real life experiences [69].

This topic can benefit greatly from a qualitative approach because it would create a communicative understanding of the participants’ experiences, meanings and interpretations, while the data gathered can raise compelling arguments with real life immediacy [68]. This approach will help uncover hidden, contextual meanings that can be deconstructed, giving voice to perspectives [70], which may be suppressed due to the stigma associated with recovering counselors.

The qualitative process may help participants construct their own narratives and encourage them to take responsibility in constructing their own identities [71] as recovered counselors, rather than accepting the fate that their identities are socially constructed by others. Consistent with Freirian research, taking this responsibility may “have an arousal effect,” to reorient participants’ perceptions of issues in ways that influence subsequent attitudes and behaviours” [72]. By helping to facilitate a sense of empowerment, participants may find it easier to discuss topics important to them.

One form of narrative that would be helpful in this area is focus groups. Focus groups use group interaction as part of the method, which allows participants to ask questions, exchange anecdotes and comment on each others’ experience [73]. They have also been found useful when examining people’s experiences of disease [74] and for exploring the attitudes and needs of staff [75], - domains that are essential in making sense of the individual’s view of barriers, along with their needs as counsellors. To help attain their needs, [76] suggests that focus groups are helpful in discovering service problems and allows for discussion in how to fix them.

Because the counselor in recovery belongs to a unique group within the addiction field, focus groups have the ability to tap into interpersonal communication and highlight information of sub-culture values or group norms [74]. And most appropriate for this topic, group work can actively facilitate discussion of taboo topics, because more out spoken members can help the shyer participants come out of their shell and voice their opinions. Participants can also provide mutual support for one another by expressing feelings and thoughts that are common to their group, but are considered to deviate from mainstream culture, such as the stigmatized or taboo topic of bereavement, sexual abuse [74]. Upon completion of the focus group, the analysis and interpretation of the data that follows allows “us to recollect our own experiences and to empathetically enter and reflect on the lived world of other persons in order to apprehend the meanings of the world as they are given to the first-person point of view” [77].

**Conclusion**

There has been a significant amount of literature written about people in recovery entering the addiction treatment field, but it is outdated and lacks a qualitative approach that can help identify the real life experiences of a sub-group within the field. Many writers discuss the stigma associated with being a counsellor who is also in recovery, but none have conducted research to understand this phenomenon. The literature describes the competition that sometimes arises between recovering and non-recovering counselors. Has the counselor in recovery become more widely accepted since they first entered the field decades ago as paraprofessionals, or is there still animosity between the two camps? This area as well has not been researched. The credentializing of the addiction field may have helped in this area because all counsellors regardless of recovery status have to be formally educated in today’s field. Despite this education, are they still entering the field with less education than their non-recovering co-workers because these co-workers are also seeking higher education, as the push for higher learning becomes more competitive within the field? Because the field has changed so much since the middle of the last century, only through current research can we begin to understand the evolution of the field from a perspective that has contributed so much, but has had little voice – the addiction counselor in recovery.

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