Wizard of Oz Syndrome:

Who is the Most Qualified Professional to Treat Substance Use Disorders:

An Ongoing Yet Misguided Debate

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“Well, you've forced me into a cataclysmic decision. The only way to get Dorothy back to Kansas is for me to take her there myself!”

-*The Wizard* from the Wizard of Oz, Metro Goldwyn Mayer, 1939.

Abstract

This paper revisits a debate that sometimes occurs among addiction counselors and centers on personal assertions of the efficacy of treatment provided by professionals without a personal history of recovery compared to those with a personal history of recovery. The origins and tenets of the issue will be explored. Current relative research findings are considered in light of common-sense approaches to the argument. The argument is allegorically framed using the 1939 movie "The Wizard of Oz," in which the "Wizard" alleged that he could help the main character, Dorothy, not by any special qualifications other than the fact that he was from "Kansas." An exploration of ethical problems of self-disclosure of recovery status by the addiction professional. The article concludes with suggestions for future directions for those who would engage in counseling the person struggling with an addictive disorder.

Keywords: Addiction counselor, addiction treatment, personal recovery, professional efficacy, Wizard of Oz

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Those who work in addiction counseling are aware of the differing opinions, ranging from a friendly debate to a heated discussion occurring occasionally among those counseling professionals who work in the field. The debate is centered on "who" is the most qualified person to counsel the individual struggling with an addictive disorder- the professional who is in recovery or the professional who has never struggled with an addictive disorder. While this topic sometimes occurs in coursework for aspiring addiction professionals, it can also take place in the workplace. In clinical practice, I have seen it manifest in various ways, ranging from microaggressions to blatant statements of perceived clinician skill level through the use of statements like "Of course they don't understand; they aren't in recovery, so they can only tell you what they read in a book." The professional literature also contains studies suggesting that

It has long been my assertion that those who believe that a counselor must have a personal history of addiction in order to be effective as a counselor suffer from what I term the "Wizard of Oz Syndrome." While I have used this term many times, members of a recent clinical supervision group encouraged me to write on this topic, as they had never heard it before. I have written this paper at the behest of my supervisees, who were enthralled by my use of the term. In this article, I discuss this term. I will review the foundational tenets of the argument and explore relevant literature surrounding the debate. The paper concludes with a brief discussion of the ethical considerations related to self-disclosure of personal recovery status.

The Problem of Substance Use Disorder in America

The problem of addiction in America does not seem to be getting better. Statistics specific to substance use disorders continue to be a source of concern. While some measures may improve in one year, they can worsen the following year. Whether this is due to variances in sampling methodology or patterns in use is unclear, but the statistics demonstrate that people with addictive disorders continue to struggle. The Substance Abuse and Mental Health Services Administration annually reports on the results of the National Survey on Drug Use and Health. According to the 2019 statistics reported, it was found that

> among people aged 12 or older, the percentage with a past year substance use disorder (SUD) (i.e., alcohol use disorder, illicit drug use disorder, or both) remained stable between 2015 and 2019. Among the 20.4 million people aged 12 or older with a past year SUD in 2019, 71.1 percent (or 14.5 million people) had a past year alcohol use disorder, 40.7 percent (or 8.3 million people) had a past year illicit drug use disorder, and 11.8 percent (or 2.4 million people) had both an alcohol use disorder and an illicit drug use disorder in the past year (2020, p. 3).

The incidence of addictive disorders in America necessitates a mental health workforce skilled in treating addictive disorders. Having survived multiple court challenges, the Affordable Care Act has increased the demand for services as more individuals can access care and receive treatment for their substance use disorders and co-occurring disorders. As the United States continues to experience a shortage in the substance use disorder (SUD) treatment workforce (U. S. Department of Health & Human Services, 2019, p. vii), it would seem preposterous to debate about which “type” of addiction professional is better- one who has a personal history of addiction versus no personal history of addiction. However, the discussion does have not only

relevance but significant importance as it can have profound implications on both the acceptability and perceived efficacy of the care and services received by individuals with substance use disorders (SUDs).

Heart of the Debate

The debate that has been waged among some addiction counselors (practically since its inception) centers on "who" is the best-qualified individual to effectively treat someone who struggles with an addictive disorder- someone who is in recovery or someone who has an academic and clinical background, without the lived experience of having struggled with an addictive disorder. The basis of the debate is both tantalizing and ancient. Shadley and Harvey (2012) explain that the concept of the "wounded healer" is as old as Greek mythology itself. Asclepius, the son of Apollo, purportedly learned to become a healer only after being wounded himself. While this assertion certainly has an unmistakable air of romanticism, it does not mirror reality or contemporary findings from the literature on treatment efficacy.

Although Freud was the first to observe that the therapeutic alliance was central to effective treatment, an assertion that a meta-analysis of 37 studies would support (Baier et al., 2020), there was not a significant interest among the psychiatric community in undertaking treatment of those with addictive disorders. Despite Freud's early observations about the therapeutic alliance and its impact on the therapy situation, it was widely believed that "addicts do not develop analyzable transferences and induce countertransference reactions that are more intense than in traditional treatments" (Yalisove, 1997, p. 2). Sonnenberg (2010), in examining the lack of attention to addiction among psychoanalysts, noted that they were taught that "addicts were not treatable psychoanalytically so that even when an addiction came into clinical focus, the analyst observer was motivated to ignore it" (p. 105). As a result of these early beliefs,

individuals who had become psychoanalysts or obtained education that enabled them to become professional counselors, psychiatric clinical nurse specialists, social workers, and other mental health professionals tended to avoid the field of addictions. For these reasons, medicalized treatment of those with addictive disorders was largely ignored. This is in stark contrast to our contemporary approach to the treatment of addictive disorders in which a highly specialized team, often led by medical providers, works collaboratively to address the needs of the person who struggles with addiction. However, despite the modernization of addiction treatment, the "wounded healer" narrative remains firmly entrenched in the minds of some in our field.

Addiction Professionals In Recovery

Alcoholics Anonymous has left an unmistakable an indelible mark on the addiction field. Recovery from addiction often results in those individuals in recovery being more likely to become addiction treatment professionals. Yalisove (1997) noted that "gradually recovering alcoholics were hired by treatment facilities as lay therapists, then as paraprofessionals, and finally as alcoholism counselors" (p. 4), now representing a significant proportion of current addiction counselors.

Those familiar with Alcoholics Anonymous (AA) know that the twelfth step requires those in recovery to carry the message of recovery to others with addictive disorders. It states: "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs" (Alcoholics Anonymous World Services, Inc., 2003, p. 8). While this step does not require those who achieve abstinence to become an addiction professional, it certainly sets the stage for those who have achieved abstinence and have experienced a "spiritual awakening" to believe that they have achieved a special status that imbues them with an extraordinary capacity to help others who struggle with

addiction. From this perspective, we can appreciate that Alcoholics Anonymous arrived on the scene of treatment for addictive disorders first, and its message continues to resonate loudly in some treatment circles. Specifically, Alcoholics Anonymous has noted that no one can help the "alcoholic," including the client's family, doctors, or psychiatrist, asserting that

> the ex-alcoholic who has found this solution, who is properly armed with the facts about himself, can generally win the entire confidence of another alcoholic in a few hours. Until such an understanding is reached, little or nothing can be accomplished. That the man who is making the approach has had the same difficulty, that he obviously knows what he is talking about, that his whole deportment shouts at the new prospect that he is a man with a real answer… (Alcoholics Anonymous, 1939, p. 28).

It is also important to note that this discussion is not intended in any way to disregard the impact of Alcoholics Anonymous or the impact of their 12-step program on the lives of many. A 2020 Cochrane review by Kelly, Humphreys, and Ferri reexamined 27 studies containing 10,565 participants, with average participant ages ranging from 34 to 51. They concluded that there is

> high quality evidence that manualized AA/TSF [twelve-step facilitation] interventions are more effective than other established treatments, such as CBT for increasing abstinence. Non-manualized AA/TSF may perform as well as these other established treatments. AA/TSF interventions, both manualized and non-manualized, may be at least as effective as other treatments for other alcohol-related outcomes. AA/TSF probably produces substantial healthcare cost savings among people with alcohol use disorder (p. 2).

However, the author's methodology in this review has since been criticized for methodological flaws impacting internal and external validity (Heather, 2020). Therefore, the findings must be considered cautiously in light of these limitations.

It is also important to note that not every addiction professional who is in recovery achieved recovery through the Alcoholics Anonymous program. Some have used such programs as “Rational Recovery,” “SMART Recovery,” “Secular Organizations for Sobriety (S.O.S.),” and others. Unfortunately, from a research perspective, less is known about these counselors, and further studies are needed to learn more about their efficacy compared to other treatments, including AA.

Recovery status may also impact one’s commitment to working with those who struggle with addiction. Curtis & Eby (2010) concluded that substance abuse counselors in recovery have higher levels of work-related commitment; in other words, they identify with their profession (working in the field) more so than counselors who were not in recovery. From an organizational perspective, however, this higher commitment to the profession was not synonymous with commitment to their organization (which could reflect contemporary workplace dynamics associated with closures, downsizing, demands for increased “productivity” with fewer staff to increase revenue, etc.). The strong commitment can be related to the addiction professional's personal 12-step recovery journey, which mandates taking the message to others (helping others achieve recovery). Stoffelmayr, Mavis, Sherry, & Chiu (2012) found that being in recovery “was associated with more varied treatment techniques and a broader range of treatment goals” (p. 121). Stoffelmayr et al. (1999) found that counselors in recovery used more varied treatment techniques and had a wider range of treatment goals for their clients.

Challenges Facing Addiction Professionals in Recovery

Some challenges face many addiction professionals who have a personal history of recovery from substance use disorders. A 2009 study by Jones, Sells, and Rehfuss concluded that drug and alcohol counselors who were themselves recovering from addictions demonstrated overall relapse rates approaching 38%. While this statistic should not detract from the important role of addiction professionals in recovery, it does represent a potential challenge to their efficacy as counselors and can have significant program implications for those under their care (e.g., if the addiction professional in recovery relapses, might the recipient of services wonder "if my counselor cannot remain sober, what chances do I have?").

In an earlier paper, Jensen (1992) was succinct in articulating the challenges of addiction professionals with a personal history of recovery. He acknowledges that while they bring to the field the credibility and wisdom of their own experiences,

> unfortunately in far too many cases they bring very little else. In addition, because they are "working" a 12-step program personally and are employed, not coincidentally, as counselors at treatment facilities which espouse the same 12-step philosophy, the line between personal beliefs and professional judgment can and often does become indistinguishable. In short, the inability of recovering counselors to separate what works for them from what is in the best clinical interests of their patients is a major problem (para. 7).

Nielsen (2016) supported some of Jensen's assertions while simultaneously challenging the findings of Stoffelmayr, Mavis, Sherry, and Chiu (2012) by concluding that "counselors' recovery status and corresponding self-schemas may be related to counselor willingness to learn and practice specific treatments" (p. 1). Specifically, those counselors who were in recovery

tended to place themselves in the same category as their patients, while those professionals who were not in personal recovery drew no lines between those with an addictive disorder (patients) and those without. The author concluded that "these two distinct pathways seem to lead to similar feelings of understanding and empathy for patient struggles" (p. 7).

Jensen (1992) noted an important area that has yet to have been adequately refuted- the fact that addiction professionals in recovery may also be unaware of their own countertransference reactions, which can become overwhelming and result in interventions and approaches that may be less than helpful to the client who is struggling with abstinence. Consider the following clinical example that came to light during a supervision session:

I had been providing clinical supervision to a supervisee who insisted that a client was failing to progress in treatment because he was "in denial" over how the use of alcohol had been impacting his life. The client had acknowledged that his alcohol use had been (in his words) "destroying my life," but not in the way that his counselor had emphasized. On further assessment, it was concluded that the issue in question raised by the counselor was, in fact, not an issue in the client's own life. The client worked a full-time remote job. He could do his work during any eight-hour period of the day so long as he "clocked" eight hours of working time per day. The client would begin work after waking up in the late morning and began working by early afternoon into the evening. His day would end with a celebratory drink. The client was rewarded by his employer for "embracing" the evening hours when many customers would be home from work and sending emails/making customer service related inquiries. They felt that their needs were being addressed in a timely manner, and as a result, the client received outstanding performance reviews. As it related to this client, his alcohol use was not negatively impacting his job, but the counselor (who was himself in recovery) insisted that the client was

simply in “denial” over how the substance was impacting their work. In this case, the counselor’s countertransference clearly overshadowed the reality of the client’s actual experience and circumstances.

Recovery status may also impact one’s treatment orientation. Knox (2012) found that addiction professionals who were in active recovery, as well as those who were older, seemed to be more influenced by the abstinence-based disease model of addiction. This was in stark contrast to what was described as the “newer generation” of counselors who seem to gravitate more toward other evidence-based models. These findings were later supported by Simons, Haas, Masella, Young, & Toth (2017), who found that those addiction professionals who were in recovery used different modalities and subscribed to different theoretical orientations in comparison to those professionals who were not in recovery. This study found that professionals in recovery used twelve-step, faith-based, and group counseling approaches more often than those individuals who were not in personal recovery (p. 49), echoing the assertions of AA as they related to a “spiritual awakening.” Interestingly, the study also found that addiction professionals who had a history of substance abuse were less likely to work with clients who had comorbid psychiatric issues (e.g., depression, anxiety, and eating disorders). The authors concluded that perhaps those individuals who were in recovery had different experiences and differing levels of formal education when compared with those addiction professionals who were not in recovery (p. 49).

The Wizard of Oz Syndrome

Over the years, as I have heard the various arguments as to why those counselors in recovery were best suited to be addiction professionals, I often found myself thinking of the similarity between the rationale they provide for their self-proclaimed superior abilities and the

movie *The Wizard of Oz.* While the allusion may be lost on younger audiences, many people have seen reruns or at least heard of the 1939 movie *The Wizard of Oz.* A fanciful tale of Dorothy, a young woman who is transported to a magical world from which she wants to escape in order to return to the home and family (way of life?) she knew. At the end of the movie, the Wizard (who turns out not to be a wizard but a charlatan entertainer) explains away the problems of Dorothy's compatriots by producing a variety of baubles from a black bag and providing them with insights into the conditions which have troubled them all their lives. While his remedies seem to conjure momentary gratification, we know nothing of their longitudinal efficacy.

Dorothy expresses her doubts that the Wizard can help her, stating, "I don't think there's anything in that black bag for me" which forces the Wizard to declare, "well, you've forced me into a cataclysmic decision. The only way to get Dorothy back to Kansas is for me to take her there myself!" Dorothy, while dubious of the Wizard's ability, yet overwhelmed by her desire to return home, gives voice to her conflicting feelings exclaims "Oh will you? Could you? Oh! Oh, but are you a clever enough Wizard to manage it?" To win Dorothy's confidence in his ability, he engages in what contemporary therapists would describe as an act of self-disclosure by revealing his background and how he came to reside in the land of Oz. The Wizard admits to those present, "I'm an old Kansas man myself. Born and bred in the heart of the Western wilderness. Premiere Balloonist par excellence for the Miracle Wonderland Carnival Company until one day while performing spectacular feats of stratospheric skill never before attempted by civilized man, an unfortunate phenomena occurred. The balloon failed to return to the fair!" In the revelation of his own folly, he offers Dorothy what she accepts as sufficient evidence of his ability to get her home. The sole basis of his evidence that he could help her was founded on his being *native* of the land to which she sought to return. Being Hollywood, Dorothy never

bothered to ask what would happen if another “unfortunate phenomena” occurred, and they did not return to Kanas. Or, more succinctly stated, Dorothy was so desperate for help that she didn’t know enough to make some basic inquiries into the efficacy or safety of the proposed solution.

In the next scene, when Dorothy and the Wizard prepare to depart in his hot air balloon, Dorothy’s dog leaps from her arms to pursue a cat, forcing Dorothy to leave the balloon’s basket to catch her dog. Once she exits the balloon, it begins to take flight without her. After securing her dog, Dorothy pleads with the Wizard (already in flight) “don't go without me!” To which the defrocked Wizard admits, “I can't come back. I don't know how it works” (referring to the balloon) and wishes the group of onlookers in attendance a fond farewell as he floats out of sight. Presumedly bound for an arduous journey to Kansas…or wherever else the balloon may take him as his dominion over its navigation remains questionable.

Believing that she is stranded in the surreal landscape of Oz, Dorothy begins to despair as Glinda, the kindly witch whom Dorothy met shortly after arriving in Oz appears at the tragic scene. Glinda reveals to Dorothy that she has the power to go home without the Wizard’s help-much to Dorothy’s disbelief. Without having ever stepped foot in Kansas, Glinda helps Dorothy to get home. Interestingly, Glinda’s solution is less perilous than the one proposed by the Wizard, who came from Kansas.

While a fun work of fiction nearly 9 decades old, the work parallels the way we have come to view “effective” addiction treatment. The notion that only one who has “come from there” has the capacity to return the person from a strange and perilous land to the home and life that they left behind before their substance use disorder plucked them from their life seems to have permeated addiction counseling since the inception of Alcoholics Anonymous. As previously mentioned, Alcoholics Anonymous (through their 12-step program) suggests that

only someone in recovery can help another person in their recovery journey. While this assertion is limited to the AA program, it has somehow firmly entrenched itself in the addiction professions landscape and has born the question that many patients find themselves asking their therapist: “Are you in recovery?”

What is interesting about the assertion is that only the “wounded healer” can help the person struggling with an addictive disorder seems to be limited to the field of addiction treatment. The cardiologist need never have experienced congestive heart failure to treat congestive heart failure in another person effectively. Nor does the patient with kidney disease seeing his or her nephrologist for the first time ever bother to ask the nephrologist, “What stage of kidney failure are you in?” Yet we cling to the “wounded healer” narrative as integral to the treatment of addictive disorders. While some would point out that hearts and kidneys are not the same as mental health issues, I hasten to point out that the mental health professional helps many people struggling with depression or suicidal ideation- yet the professional may never have experienced depression or suicidal ideation in his/her life. The psychiatrist can effectively treat the client with Schizophrenia despite never having had a visual or auditory hallucination in his or her life. Addiction nursing professionals treat individuals with co-occurring disorders without ever having had a co-occurring disorder. Addiction professionals often treat individuals with personality disorders without having been diagnosed with a personality disorder themselves. Imagine if we did have to find a depressed psychiatrist to prescribe medications to us when we were depressed. Consider what would happen if we were ever diagnosed with cancer, but our chemotherapy could not be administered by anyone other than a professional nurse who was a cancer survivor. If such were the case, I submit that our civilization would be in peril.

Despite the preposterous assertions that we would require any of the aforementioned physical or mental health professionals to have survived the conditions they purport to treat, we continue to cling to the narrative that the treatment of addiction is so "special" and "unique" that only someone who comes from that "land" can rescue the client and return them to home.

Disclosure of Recovery Status by the Addiction Professional

An interesting phenomenon among addiction professionals in recovery has to do with the readiness and willingness to disclose to clients that they are in recovery from an addictive disorder. Certain theoretical orientations, such as classical psychoanalysis, consider self-disclosure taboo, as it decreases the ability of the client to project onto the therapist. However, in other psychotherapeutic orientations, self-disclosure may be appropriate if such disclosure is not exploitive, does not take the focus of the therapeutic work away from the patient, or causes the patient to want to protect or in some way care for the counselor who has engaged in the act of self-disclosure. The act of self-disclosure in and of itself can also reduce the therapeutic relationship to one of "old war buddies" sharing stories as opposed to engaging in the real work of addiction treatment.

In some instances, self-disclosure of the recovery status of the addiction professional appears to be, at times, expected, and at other times, spontaneous, and in some cases, is made whether the client is interested or not. Some therapists will even advertise on their websites or in their listings in professional directories (such as *Psychology Today*) that they are in recovery or that they have "been clean" (a pejorative phrase) for "x" number of years. These disclosures are made independent of the counselor's consideration of how self-disclosure can be in the service of the patient as opposed to the counselor's own needs or anxieties, for instance, attempting to show the clients that they are "legitimate" because, like the Wizard, they too are from Kansas, and can

safely bring the patient home from the “Land of Oz.” When confronted with these self-disclosures, I encourage the therapist to reflect on the reasons behind their exhibitionism.

Conclusion

While the current paper will not bring this ongoing debate to an end (in fact, it will probably cause a flurry of letters to the editor to assert points that letter writers will have asserted I have erred on), it is high time that these debates be pushed to the side in favor of working towards advancing the profession of addictions treatment. The profession should emphasize ensuring appropriate standards for entry into practice and ongoing requirements for clinical supervision, continuing education, and dissemination and utilization of evidence-based practices. While everyone wants to believe that their unique life experiences situate them to be the best addiction professionals, this cannot be asserted beyond our current acknowledgment that such factors as congruence and genuineness (Kolden et al., 2018), positive regard (Farber et al., 2018), and well as other elements of the personal relationship we develop with the client lead to positive treatment outcomes (Gelso et al., 2018; Baier et al., 2020).

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