

White, W. (2004). Toward a recovery lexicon.

Toward A Recovery Lexicon
Prepared for Dr. H. Westley Clark
Center for Substance Abuse Treatment

William L. White, MA
Senior Research Consultant
Lighthouse Institute / Chestnut Health Systems
720 West Chestnut Street
Bloomington, IL 61701
Email: bwhite@chestnut.org

The term *recovery*, as used in the addictions field, is the sustained process through which severe and persistent alcohol and other drug (AOD) problems (meeting DSM-IV criteria for substance abuse or dependence) are resolved (no longer meeting DSM-IV criteria for substance abuse or dependence). In contrast to treatment interventions that focus on professional intervention technologies, recovery is about the needs, experiences and achievements of the individual/family seeking to resolve AOD problems.

The term *family recovery* conveys the processes through which family members impacted by severe and persistent AOD problems individually and collectively regain their health. Family recovery has three dimensions: 1) the healing of individual family members, 2) the healing of family subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships), 3) healing the family as a system, repairing family structure; redefining family roles, rule and rituals; and achieving recovery-conducive boundary transactions with people and institutions outside the family.

Like other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of *full recovery* (complete and enduring cessation of all AOD-related problems) or a state of *partial recovery*. Partial recovery conveys two different conditions: 1) the failure to achieve full recovery as just defined, but the achievement of a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems, or 2) the achievement of complete abstinence or stable moderation but the

failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery can constitute a stage preceding full recovery, constitute a permanent state, or constitute a hiatus in AOD problems with eventual reversion to their former level.

Persons who achieve full, uninterrupted recovery for five years, like persons who have achieved similar patterns of symptom remission from other primary health disorders, can be described as *recovered*. Those who achieve full symptom remission for less than five years or have achieved partial recovery (marked reduction of but some residual symptoms) can best be described as *in recovery* or *recovering*. While use of the latter term in later year (after five years) of recovery reminds the individual that recovery is an enduring process requiring sustained vigilance and recovery maintenance, such use of the term *recovering*, by inadvertently conveying to the public that there is no permanent solution for severe and persistent AOD problems, contributes to the stigma and pessimism attached to these problems.

Styles of recovery and *pathways of recovery* are phrases that reflect the varieties of ways people successfully approach the resolution of AOD problems. It is a recognition that (in the words of AA co-founder Bill Wilson), “The roads to recovery are many” (Wilson, 1944). *Cultural pathways of recovery* are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. Across varied cultural contexts, such pathways might be developmental (e.g., something to be resolved through maturation and marriage), medical (e.g., response to an alcohol-related health problem), religious (e.g., conversion and/or affiliation with an abstinence-based faith community), or political (e.g., rejection of alcohol as a “tool of genocide”).

The most critical variation involves differences in how one’s relationship with psychoactive drugs has changed.. The scientific literature on the resolution of AOD problems documents three such variations 1) *abstinence-based recovery* (complete abstinence from alcohol and other drugs) 2) *moderation-based recovery* (the deceleration of AOD use to a subclinical¹ level that no longer generates harm to the individual or society), and *medication-assisted recovery* (the use of medically-monitored, pharmacological adjuncts to support recovery from addiction e.g., detoxification agents, stabilizing agents, aversive agents, antagonizing agents, anti-craving agents or psychoactive drugs prescribed for the treatment of co-occurring physical or psychiatric disorders. Abstinence-

¹ No longer meeting DSM-IV criteria for abuse or dependence.

based and medication-assisted styles of recovery predominate in patterns of severe alcohol and drug dependence, whereas moderation-based styles of recovery predominate in patterns of less severe and enduring alcohol and other drug problems.

The concept of moderation-based recovery is linked to the understanding that alcohol and other drug problems exist on a wide continuum of severity and vary in their patterns of acceleration and deceleration. The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood. Most of these individuals do not go on to develop enduring substance-related problems, but instead quickly or gradually moderate their substance use through the progressive assumption of adult responsibilities (Fillmore, et al, 1988).

Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting that moderation was an option for some problem drinkers, but not “alcoholics” like themselves. The following two excerpts reflect their beliefs and attitudes about moderation-based recovery.

Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason—ill health, falling in love, change of environment, or the warning of a doctor—becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention (Alcoholics Anonymous, p. 31, first edition).

If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people! (Alcoholics Anonymous, p. 42, first edition).

Recovery can occur at different stages of problem development and progression. There are patterns of *high bottom recovery* (the initiation of recovery through a breakthrough of awareness of losses that could accrue from continued alcohol and other drug use) among people who have not yet suffered such losses, and there are patterns of *low bottom recovery* in which recovery is achieved by individuals in the latest stages of addiction who

have experienced great losses and anguish related to their drinking and drug use.

Variations in recovery styles are influenced by the degree of problem severity and by one's *recovery capital*. *Recovery Capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-disordering condition (Granfield and Cloud, 1999).

Recovery styles vary by their pattern of onset and course. Recovery can result from a process of sudden, *transformational change* (Miller and C'de Baca, 2001) or result from a process of *incremental change* marked by predictable stages of recovery (Prochaska, et al., 1992). Long-term, permanent recovery from severe and persistent AOD problems often involves four broad stages of change: 1) *recovery priming* (experiences that open a doorway of entry into recovery), 2) *recovery initiation* (discovering a workable strategy of problem stabilization), 3) *recovery maintenance* (achieving recovery stability and sustaining and refining broader strategies of problem resolution with a continued life-focus on the recovery process), and 4) *recovery termination* (achievement of global health with diminished preoccupation with recovery). These latter periods have also been referred to as *Stage II Recovery* ("rebuilding the life that was saved in Stage I") (Larsen, 1985, p. 15). Stage two recovery transcends the early concern with the addictive behavior and instead focuses on a reconstruction of personal character, identity, beliefs and interpersonal relationships. This stage has also been referred to as *complete recovery*--an "advanced state" of recovery marked by global health, a heightened capacity for intimacy, serenity and self-acceptance (Picucci, 2002).

Recovery styles vary by the degree and nature of resources within and outside the self that are used to initiate and sustain recovery. There are patterns of *natural recovery (solo recovery)*—the initiation and maintenance of recovery from addiction without involvement in professionally-directed treatment or recovery mutual aid societies. This type of resolution of AOD problems has gone by many names in the scientific literature: "maturing out" (Winick, 1962, 1964); "autoremission" (Vaillant, 1983; Klingeman, 1992); "self-initiated change" (Biernacki, 1986); "unassisted change" (McMurrin, 1994); "spontaneous remission" (Anthony and Helzer, 1991); "de-addiction" (Klingeman, 1991); "self-change" (Sobell, Sobell, Toneatto, and Leo, 1993); "natural recovery" (Havassey, Hall and Wasserman, 1991); "self-managed change" (Copeland, 1998) and "quantum change" (Miller and C'de Baca, 2001). There are also patterns of *affiliated (or assisted) recovery* in which the initiation and maintenance of recovery is achieved through

relationships with other individuals in recovery, and patterns of *disengaged recovery* in which the initiation of recovery through professionally-directed treatment and/or mutual aid participation is followed by the subsequent maintenance of that recovery without significant participation in addiction recovery mutual aid groups. A relatively recent phenomenon is the advent of *virtual recovery*—the achievement or maintenance of recovery through Internet support groups, with little or no participation in face-to-face support meetings.

Recovery styles also reflect different *recovery identity* patterns—variations in the extent to which AOD problems and the recovery process influence one's identity, and the degree to which one relates to other people who share this recovery process. There are those with recovery-neutral identities (persons who have resolved severe AOD problems but who do not self-identify themselves as “alcoholics” or “addicts” or “persons in recovery”) and those with recovery-positive identities (those for whom the status of recovery from addiction has become an important part of their personal identities). There are *acultural styles of recovery* in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery and without identification with a larger *recovery community* or *culture of recovery* (a social network of recovering people with their own history, language, rituals, symbols, literature, and values that collectively nurture and support long-term recovery from AOD problems). There are *bicultural styles of recovery* in which individuals sustain their recovery through simultaneous involvement in the culture of recovery and the larger “civilian” culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). There are *enmeshed styles of recovery* in which one initiates and maintains recovery in almost complete sequestration within the *culture of recovery*. *Communities of recovery* is a phrase coined by Ernest Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a reciprocity of “fit.” The growth of these divergent communities reflects the growing varieties of recovery experience (Kurtz, 1999). Style differences based on the evolution in how one relates, or does not relate, to these communities of recovery might be part of what could be described as one's *recovery career*. The concept of “career” has been used to describe the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, et al., 1997). Recovery career is an extension of this application and refers to the evolving stages in one's identity, one's

relationships with others, and, in some cases, styles of involvement with mutual aid groups.

There are considerable differences in recovery styles based on the presence or absence of religion and spirituality as an important dimension of the recovery process. There are patterns of *faith-based recovery* (the resolution of severe alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and within the mutual support of a faith community) and patterns of *secular recovery*--a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or religious rituals (prayer).

Because severe and persistent AOD problems impact many areas of life functioning, recovery from such problems must be measured across multiple dimensions. These *zones (or domains) of recovery* include alterations in 1) AOD consumption (measurable changes in presence, frequency, quantity, intensity [risks to self and others], and duration of primary and secondary drug use) 2) AOD-related consequences, 3) physical health, 4) psychological/emotional/spiritual health, 5) family/relational health, and 6) lifestyle health e.g., developmentally appropriate, pro-social and (White, 1996).

The shift from defining recovery solely in terms of what is deleted from one's life (alcohol or other drugs) to what is added to one's life (global health) is reflected in such terms as *emotional sobriety*--a phrase coined by A.A. co-founder Bill Wilson (1958) to describe a state of emotional health that far exceeded simply the achievement of not drinking. Wilson defined emotional sobriety as "real maturity . . . in our relations with ourselves, with our fellows and with God." It is also reflected in the word *Wellbriety*--a term used in Indian Country to depict recovery as more than just symptom suppression. Wellbriety implies the pursuit or achievement of global (physical, emotional, intellectual, relational, and spiritual) health, or "whole health" (Coyhis, 1999; *Red Road to Wellbriety*, 2002). It is marked by the emergence of such *recovery values* as honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000). The development of stable recovery and global health across recovery pathways tend to be marked by the presence of daily *recovery rituals*: 1) centering rituals, 2) mirroring rituals, 3) acts of self-care, and 4) unpaid acts of service (White, 1996).

Some individuals are involved in concurrent or sequential recovery processes from two or more conditions or experiences. The overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders is sometimes referred to as *serial recovery*.

Persons with severe and prolonged AOD problems fair poorly in systems of care organized to provide acute intervention (detoxification and brief psychosocial stabilization). There are growing calls to shift the focus of addiction treatment from acute intervention toward models of sustained recovery management. Recovery management models wrap traditional treatment in a continuum of professional and peer-based pre-recovery, recovery initiation and recovery maintenance support services, with a particular focus on post-treatment monitoring (recovery check-ups)(Dennis, Scott, & Funk, 2003), stage-appropriate recovery education, assertive linkage to communities of recovery, recovery community resource development and, when needed, early re-intervention. Peer-based recovery support services are services designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life in recovery. Recovery management models shift traditional intervention models from a focus on treatment planning to a focus on recovery planning (Borkman, 1997).

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