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## **Toward a Recovery Research Agenda: An Interview with Dr. Alexandre Laudet**

William L. White

### **Introduction**

Calls for the transformation of addiction treatment in the United States to larger recovery-oriented systems of care have been accompanied in the past 15 years with advocacy for a recovery research agenda whose findings could guide this systems transformation process. At the same time, recovery advocates have asked why some of the most basic questions related to addiction recovery remain unanswered from the standpoint of science at this late stage in national response to alcohol and other drug problems. Dr. Alexandre Laudet deserves special distinction among those research scientists who have advocated expanded recovery research. She was among the earliest researchers to shift the focus of her work from the study of addiction pathology to the prevalence, pathways, and processes of addiction recovery. I recently (May 2015) had the opportunity to interview Dr. Laudet about her work and her vision for the future of recovery research. Please join us in this engaging conversation.

### **Early Career**

**Bill White:** Dr. Laudet, how did you come to specialize in addictions-related research?

**Dr. Alexandre Laudet:** I wish there was a good story but, unfortunately, there isn't. I started work in the field at NDRI—the [National Development Resource Institute](#). I began as Assistant Project Director with Dr. Steve Magura, who is a one of the leading treatment experts in our field. We were evaluating a federally funded program for women who'd given birth to drug-exposed infants in New York City. The program was run locally through the child welfare system, and the ladies served were given the choice of going to this new model of family-oriented integrated treatment or losing custody of their children. This Family Rehabilitation Program (FRP) was ran by NYC's (then called) Administration of Children's Services; it operated within 31 agencies in the five boroughs in New York. I knew little about addiction services at the time so was forced to learn quickly (my degree is in social psychology-behavioral medicine). We started this study and then got a new mayor [Giuliani] who promptly cut funding for the programs. In response, we offered to the programs to conduct a a quick survey to ascertain the degree to which the program was helping the women and children being served. The immediate goal was to help preserve as much of the FRP funding as possible. This succeeded to some extent: 23 FRP sites remained funded. On this first project, I realized a couple of things. First, I liked doing research. Second, I was struck by the fact that most of the research in the field was focused on measuring failure—relapse rates were the main outcome measure. There were other outcomes measures which now, as a recovery scientist, I've come to appreciate as critical, such as family functioning, physical and mental health, and quality of life. All of that is the stuff of recovery. These aren't ancillary measures; they are the essence of what

we should be evaluating. But at the time, they were regarded as secondary outcomes in addiction research. So, I thought, I'd like to continue doing this work but I want to focus on recovery (although I was only peripherally aware of the term at the time, this was 1996-99). So, I started studying the transcripts of the ethnographic (qualitative) arm of the project to explore the experience of moving beyond addiction. Some of the ladies in this project were doing really well and I wanted to know how they were doing it. I was more interested in the process of success than the process of failure.

**Bill White:** Most of your career has been spent at NDRI. How did that opportunity arise?

**Dr. Alexandre Laudet:** When I completed my Ph.D. in social psychology, I didn't know what to do. As it happened, I saw an ad in the New York Times announcing that NDRI was seeking a Assistant Project Director for a study of drug-involved women. I'd never heard of NDRI, this was before Google and the internet, of course; there was no searching ahead of time, but I called and was eventually hired for the position. That's how I got to NDRI and into the field. So, it's not really a story about dreaming my entire life to help people with addiction. To my knowledge, and I may well be mistaken in that regard, my family had been spared the pain of addiction that I learned later befalls so many others. So I fell into this field. The best things in my life have always been the things (and people) that have come to me completely by accident when I was barely looking and often didn't know they existed.

### **Focus on Recovery**

**Bill White:** Your recovery focus started very early at NDRI.

**Dr. Alexandre Laudet:** Well, I'm an optimist by nature. I hope for the best in everything I do. Otherwise, I wouldn't start. I didn't want to intensely focus a career around people not doing well because I was rooting for these ladies and some were doing remarkably well. I also wanted to understand the process of doing well over the long run. In traditional addiction research, we look at very short-term outcomes. We do a treatment intervention and measure its effects some months down the road—mostly focusing on whether those treated have remained alcohol and drug free ('clean'), but we know little of these and broader outcomes over the course of years. This is what I wanted to find out.

I wrote my first NIDA [National Institute on Drug Abuse] grant in 1999 to explore how counselor knowledge and attitudes toward Twelve-Step programs affected referral practices to these groups. That idea had come about once I became aware of the popularity and purported benefits of 12-Step fellowships from the FRP study transcripts, I looked into how someone may find their way to such a place. Not much information was available but I did find some of the recent AA membership surveys reports (again, this was before the internet, it sounds funny but finding anything then was a bit of an ordeal). The most frequently cited source of referral to 12-Step in these surveys were addiction treatment counselors. So I did a little pilot study first with some program directors and counselors in New York that I'd met through my women's study to find out what they thought about 12-Step fellowships. One that stuck with me was 'the blind leading the blind'. Around that time (1997), I also found an article by Dr. Keith Humphreys documenting factors associated with referral to 12-Step groups among VA (Veteran's Administration) addiction counselors. Both that article and the small pilot I conducted had

similar findings. This allowed me to build a case for a research grant proposal to NIDA whose funding allowed me to examine both clients' and clinicians' beliefs and attitudes toward 12-Step fellowship. The ultimate goal for me was of course to debunk these misconceptions (and there were many) in view of maximizing the likelihood that people who needed it would at least give 12-Step a try, if for no other reason, because it was (and often remains) the only post treatment recovery support option that is easily available and free of charge.

**Bill White:** Was there a particular point in time you recall when you thought, "I want the focus of my career to be on recovery research?"

**Dr. Alexandre Laudet:** Well, I never thought of this as a career. I see myself as an explorer. As such, what I enjoy doing with my research is to identify a topic that I just cannot believe nobody's looked at before, investigate it rigorously so it is brought to the attention of others, and then go on to the next topic that no one has looked at but I feel, should be examined. With recovery, I wanted to point out to others that this was a very interesting topic to look, and there are people who get better, we don't know how they do, so let's find out and learn from them. They are the experts as far as I am concerned. We researchers merely document what they experience. I wasn't doing this in a posture of arrogance; it was just a fresh perspective that I was offering from someone coming into the addiction field from outside the field.

### **NDRI Recovery Studies**

**Bill White:** Your second project was a study of recovery mutual aid for people with concurrent substance use and psychiatric disorders. How did you come to do that project?

**Dr. Alexandre Laudet:** I think it grew out of the first study. In my early explorations of Twelve-Step programs, I came across an article about a group in New York City called Double Trouble in Recovery (DTR), which was an adaptation of the Twelve-Step program for people who are dually diagnosed with an addiction and mental health disorder, particularly a severe mental health disorder, such as schizophrenia. Dr. Steve Magura and I found Howie Vogel, the person who was spearheading DTR in New York City, and we were invited to attend Double Trouble in Recovery meetings. Steve and I decided to write a grant to the NIH to examine DTR and we eventually got three NIDA grants beginning in 1997, the first two on which I served as Co-Investigator. We recruited DTR members throughout the five boroughs of New York City and followed them for three years. It was one of the first focused studies on the role of recovery mutual aid in enhancing recovery outcomes among people with such co-occurring disorders.

**Bill White:** And that study was followed by your survey of members of the Connecticut Community of Addiction Recovery (CCAR)—one of the new generation of grassroots recovery advocacy and recovery support organizations. This seems to have solidified your focus on recovery.

**Dr. Alexandre Laudet:** Yes. Although looking back today, what really put recovery on the radar screen for me, ultimately, is you. I found out about your work from Robert Savage when he and I were co-presenters at a session of the annual American Public Health Association meeting, I believe it was 1999. I was presenting findings from the DTR study and Robert, who

was then head of CCAR, was presenting on the new recovery advocacy movement, of which at that time I was totally unaware. When I expressed interest in this, he referred me to some of your writings. I stayed in touch with Robert Savage after our first meeting and invited him to collaborate on a pilot study I wanted to conduct to have preliminary data for a grant proposal I was planning to submit to NIDA. I wanted to further explore “recovery”, which was the answer I had been searching for to the question, “Where are the people who are doing well?” Robert was leading this community of people in recovery so I did a pilot study of its members. That pilot survey was the basis for my application to the larger Pathways study. The study got funded and it was at that time that I contacted you to invite you to serve as Co-investigator on the Pathways (and subsequent) studies.

**Bill White:** I see the studies that you did as part of the Pathways Project as the beginning of the push for a recovery research agenda. Do you see it that way as well?

**Dr. Alexandre Laudet:** Absolutely. Actually, I wanted to call that study Pathways to Recovery, but my project director at NIDA, Dr. Jerry Flanzer, without whom I would not be in this field, told me that name had already been claimed (for a different project lead by your colleagues, Drs. Christy Scott and Michael Dennis, who have done outstanding, landmark work on recovery management). So I called the study Pathways to Long-term Abstinence. Other established researchers in the field also told me, “NIDA’s not interested” in what we now would regard as recovery outcomes and that I should focus the proposal on the measurement of abstinence. That was probably a good call on their part (for the record I am still told that). So I proposed abstinence as the primary outcome, but that’s not what I was most interested in. That’s why I built in all the other measures, like quality of life. So, for me, the first project I did on recovery was really that little pilot study, which I published with Robert Savage and my colleague, Daneyal Mahmood, in 2001. It was a mail-in survey where I basically asked CCAR members to tell us, in their own words questions about how and why they initiated and maintained their recovery. What they were describing about their recovery experience revolved around being miserable in active addiction and wanting a better life – quality of life.

**Bill White:** Your studies were among the first that looked at long-term recovery and did so in the community rather than treatment populations.

**Dr. Alexandre Laudet:** Yes. You once made a statement I have quoted a thousand times that “looking at treatment to understand recovery is like looking at birth to understand life”. I hadn’t fully formulated this understanding until the 2000 landmark article by McLellan and colleagues was published in JAMA (about drug addiction being best conceptualized and treated as a chronic condition on par with others such as diabetes and asthma), but I remember thinking to myself early on, “Addiction is not a problem for which you can treat people in a facility for thirty days or ninety days and send them on their way; this is crazy!” In other medical fields, that’s not how you treat people who have problems that ebb and flow over an extended period (i.e., a chronic condition). I just couldn’t understand how such acute models of addiction treatment could help those with the most severe patterns of addiction. I thought, so let’s look at people who do it well and find out how they started and are maintaining their recoveries. The people at CCAR were people who were doing well, some of them had twenty, thirty, and more years of recovery. To me, they were the ideal people to include in an addiction study to look beyond treatment to how

people achieved and maintained long-term recovery. When the Pathways grant was funded, those were the kind of people I recruited into the study. And I wanted to look at broad patterns of recovery. That called for looking way beyond the treatment setting. People in recovery had to be everywhere in the community... So we placed ads in NYC newspapers. When you graciously agreed to serve as Co-Investigator on that study, you told me, “Do not use the word ‘recovery’ in the recruiting ads; if you do, you’ll only get Twelve-Step people.” That’s how we ended up looking for people who “once had but no longer have a drug problem,” which is what we’ve used in a lot of other studies subsequently to get people who are, quote-unquote, “in recovery,” whether they’re going to Twelve-Step meetings or not. Note that I am absolutely not opposed to 12-Step, quite the contrary, but I wanted to find out about all the possible ways (now called ‘paths’) that people use to recover, not just 12-Step

**Bill White:** You have continued to investigate recovery outside the walls of treatment, including a recent study of campus-based recovery communities. How did that opportunity arise?

**Dr. Alexandre Laudet:** In 2009, I was contacted by Dr. Kitty Harris, who was the Director of the Center for the Study of Addiction and Recovery at Texas Tech University. She was involved in some research but her primary focus was helping recovering young people in college maintain their recovery while pursuing their education. They did this through the formation of [collegiate recovery communities](#). They had just published a book that the publisher had asked me to review. That is how she found me. She and I collaborated on a couple of grant proposals, one to NIAAA and one to NIDA, to study these campus recovery programs, which at that time had never been investigated. One of the two was funded in 2012.

**Bill White:** How would you summarize what we know about the relative effectiveness of those campus recovery communities to date?

**Dr. Alexandre Laudet:** Well, we haven’t yet done (I mean, being able to get funding for) any longitudinal studies that would allow me as a scientist to speak definitely about how effective these programs are and for what type of student. But we’ve surveyed the Directors of these programs and collected the data they have at the program level on key measures of effectiveness. They reported an average annual relapse rate of 8% - using a strict definition of relapse as ‘any use of alcohol or drugs’; this is quite low considering that recovery maintenance efforts are being attempted in what has been called an “abstinence-hostile environment.” The students’ academic outcomes in these campus recovery communities (CRC) are also superior to those of the overall student body in their respective institutions. The CRC-involved students have significantly higher GPAs, retention rates, and graduation rates than the overall student body at their respective schools. These programs have now been around long enough that we have now CRC graduates who are in law school, medical school, and other professional schools. What that tells me is that we have a next generation of professionals who are in recovery and who will carry this recovery orientation into their professional practices. Imagine having physicians who are in recovery and understand and know how to speak about recovery with their patients.

## **Effectiveness of Recovery Mutual Aid**

**Bill White:** You have been involved in multiple studies examining the influence of participation in recovery mutual aid societies on recovery outcomes. What can be said from the standpoint of science about such effects?

**Dr. Alexandre Laudet:** The first thing we have to keep in mind is that no single approach works for everyone seeking a solution to these problems. There are few areas of medicine in which one remedy works for all patients. For example, there are people for whom Twelve-Step participation may not be the best way for them to achieve recovery. My role as a research scientist is to study various approaches without trying to ‘sell’ any particular one. I’m just trying to understand what works for people so that they will have a menu of options to make informed choices. There is no question that Twelve-Step programs save the lives of people for whom this experience resonates. Nearly all of my friends in long-term recovery are in Twelve-Step meetings; some openly, some not. I’ve had the privilege of attending open Twelve-Step meetings in places like Mongolia and in Africa, so I’ve witnessed how this program can be life-saving and life-transformative, how its basic premises transcend culture, socioeconomic status, race, gender, age and every other human dimension you can imagine. I’ve also witnessed people for whom it didn’t work. There are also people for whom methadone won’t work. There are people for whom community behavioral therapy won’t work. There are also other mutual aid programs that you’ve written extensively about that are not Twelve-Step-based that may work better for some people, but which, unfortunately, are not yet widely available.

**Bill White:** I’m wondering as a scientist what your response has been to the recent books and articles asserting that AA and other Twelve-Step programs are ineffective.

**Dr. Alexandre Laudet:** I think it’s sad. Negatively portraying anything that may save lives and has no known negative side effect is unfortunate, particularly if such criticisms contain misinformation and misconceptions that would inhibit help-seeking. Denial is the major hallmark of addiction. You have to acknowledge you have a problem before it can be solved, which is the first step of the Twelve Steps of Alcoholics Anonymous. Media coverage of the flurry of books and articles attacking Twelve-Step programs provides a good excuse for people to say, “Well, see, it doesn’t work, I’m glad I didn’t go.” That’s extremely unfortunate. I think what the media should say is, “Try it. It’s like a new form of exercise, a new diet, or a new medication. Try it. See if it works for you. It may not have worked for your neighbors. Maybe it will work for you.” At least, you have to go with an open mind.

Note that talking about the science of mutual aid is difficult because Twelve-Step programs and other mutual aid groups cannot be easily studied using the gold standard of research in biomedical fields, which is the randomized clinical trial. Groups like AA are ubiquitous and anonymous. As a researcher, you can’t assign one person to go to AA, put others in a control group and forbid them from attending AA, which is what a randomized clinical trial would require. Even if you could physically do it, it’s not ethical to bar participation in something that could be helpful and lifesaving. So there is this vulnerability for criticism about causality (what goes directly to the point of ‘effectiveness’) pinned against the reality of millions of people all over the world who offer a different kind of evidence. It works for them.

## **Life in Recovery Surveys**

**Bill White:** You have played important roles in your work with Faces and Voices as their Scientific Advisor and in collaborations with the Betty Ford Institute. Could you describe those experiences?

**Dr. Alexandre Laudet:** Yes, thank you for asking. In 2006, the Betty Ford Center, now recently merged with Hazelden, created the Betty Ford Institute (BFI) within the Betty Ford Hospital Center. One of the early activities of BFI was to assemble a group of stakeholders, scientists, policymakers, and people in recovery, to define recovery. This came on the heels of SAMHSA/CSAT's 2005 National Recovery Summit which had produced a provisional recovery definition. What BFI wanted to do under the leadership of Tom McLellan was to create a definition of recovery that could be operationalized, meaning that we could measure--a recovery definition that could be used in research and systems performance evaluation. At the time, I was already doing research on quality of life in the context of the recovery. I had come upon the WHOQOL, the World Health Organization's Quality of Life Instrument, and I suggested at the BFI meeting that perhaps this WHOQOL instrument could be used in the measurement of recovery. By then, I had data from the Pathways study on what recovery means to people in recovery—and it boils down to broader quality of life issues: improved physical and mental health, social relations, feelings about the self. I wanted instruments that would capture such dimensions for researchers. The only quality of life instrument I knew about that could do that, and I still believe is the best for that purpose, is the WHOQOL, which is a highly psychometrically validated cross-cultural instrument that is the result of millions of dollars of investment from the World Health Organization. It could be a starting point to measure recovery, even if an additional module would need to be developed to tap context-specific issues.

We started looking at this instrument on the assumption that recovery is about broad enhancements to quality of life and that there are instruments that can measure such changes. In the BFI recovery definition, we had one dimension that we call citizenship, by which we meant being a good citizen, volunteering, paying your taxes, and being, for lack of a better term, an upstanding member of your community. None of us, as you'll remember, really liked the term, but we thought that what it represented was an important dimension of recovery. The BFI recovery definition and its related papers were published in 2007 and were quite influential. The BFI recovery definition has since been adapted in other countries' drug policies, such as in the UK and Scotland.

More recently, as 'recovery' was gaining grounds at the level of policy (e.g., ONDCP's newly formed recovery branch) and advocacy, I really wanted to start documenting scientifically whether people in recovery actually achieved these quality of life improvements they were seeking, beyond just the achievement of sobriety. Pat Taylor, who was then the Executive Director of Faces and Voices of Recovery, and I began talking about the need for a survey of people in recovery that would measure some of these aspects of recovery. Millions of taxpayers' dollars have been spent over decades on documenting the numerous costs of active addiction. Policy makers and the voters who elect them tend to think with their wallet and we don't really have any information on how much the nation (and individuals) could benefit from helping people stay in recovery. To me, without this evidence, getting funding for recovery support services (or research) is always going to be a hard sell. I wanted to be able to start documenting the gains to society and to the individual that were the potential outcomes of recovery. We did a very 'quick and dirty' study, methodologically speaking, because the budget was essentially nil.

The survey was cross-sectional and based on people's retrospective recall. But the

findings were very promising in terms of recovery benefits on personal, family, and community life. We got over 3,000 people nationwide to complete the [Life in Recovery Survey](#), representing recovery stages from very early to over 20 years, various recovery experiences (e.g., whether or not people had gotten treatment), and we disseminated the results not only in general media but also through several peer-reviewed journal articles and scientific conference presentations. That tends to lend legitimacy to a study, and the field of recovery research needs scientific legitimacy to keep growing.

**Bill White:** And very importantly, that first survey was the beginning of a series of Life in Recovery surveys that have confirmed and extended your early findings.

**Dr. Alexandre Laudet:** Indeed, and especially those conducted in other countries. We had already replicated some of our Pathways study in Australia because I wanted to document the fact that recovery is a universal phenomenon, even across countries where addiction and treatment are handled very differently from the way that they are handled in the United States. So, we began doing studies in other countries to find out what recovery meant to people in these diverse settings, including places that had no treatment system. What we found in this preliminary work in the US, Russia, and Australia is that people enter (seek) recovery for the same reason: they are “sick and tired of being sick and tired” and they want a better life for themselves and their families.

**Bill White:** And you found that when they seek and get recovery, they really get that better life.

**Dr. Alexandre Laudet:** Exactly! And that’s what all this research is starting to document. What we found is not only that people’s life improves significantly in key area (e.g., physical and mental health, employment and finances, family and social relations) from active addiction to recovery, but that the improvement continues to unfold over years. Stated differently, life keeps getting better! People in recovery may think this is a simplistic finding, but in Western society, you have to have the numbers to demonstrate such a conclusion to policymakers and the public. It takes more than someone standing up and saying, “My name is John Doe, I’m in recovery, and my life is better.” That by itself is not going to fly. You need hard data. That’s what I have been trying to do all this time.

**Bill White:** How do you see the current state of recovery research in the United States today? Are we getting close to what could be called a science of recovery?

### **The State of Recovery Research**

**Dr. Alexandre Laudet:** The short answer is absolutely not. Looking back at what I sketched out as [future directions to build a science of recovery](#) at a conference in Philly in 2008, we have made virtually no substantial significant progress except for one topic: medication-assisted recovery. That one could go under the need to elucidate multiple paths to recovery. Medication-assisted recovery is an important path for many. It was traditionally not talked about enough so I am glad that the topic is generating interest. It can save lives. What bothers me is why it is generating interest. Two things come to mind: 1) Someone can make money off of that, and 2) it’s right up the alley of what the NIH likes to fund. I know, I have to be tactful here but let’s



face it, recovery has become the ‘new black’ in our field now that it’s prominently featured in the President’s drug policy and elsewhere. Make no mistake: recovery is now a business. Not to me. Not to you. But to most everyone else in research, in clinical practice, and on the speaker circuit, RECOVERY SELLS. Little of what is being sold is of much use to those seeking recovery, especially people who don’t have unlimited resources. But it is big business. You wrote very eloquently and way ahead of your time as always, about this trend and called it “Old Wine in New Bottles.”

That’s where recovery stands. Many treatment and 12-Step researchers have repackaged themselves (and get funded) as recovery providers/researchers. A lot, though not all of what is passing for recovery research, is business as usual. That is very scary to me because it maintains the status quo within the illusion of progressive change. I’ll give you a parenthetic anecdote which may ring true to you. Back in 2008, SAMHSA got all of the single state alcohol and drug authorities in the country together in DC to start rolling out the new paradigm of recovery management and Recovery-Oriented Systems of Care (ROSC). These are the state agencies that provide and administer all the publicly funded drug treatment programs nationwide. Nearly two million people go through these programs in any given year. I’m originally from the state of New York, and I found myself in the elevator with the director of another very large state. I asked him what he thought of this ROSC model. He said, “Oh, we love it!” I was thrilled to hear this! So I asked what they were doing related to ROSC. He said, “Well, we’re putting ‘recovery’ on everything. That’s all we can do. We can’t afford to actually ‘do’ recovery services.” I hope it’s not strange but that led me to add an extra slide in my ROSC presentation saying that to pin the word ‘recovery’ on everything is *not* ‘doing’ Recovery-Oriented Systems of Care. Right?

**Bill White:** Yes. That does strike a chord with me.

**Dr. Alexandre Laudet:** I’m sure it does. And that’s what happening in my field of research. I couldn’t be more delighted to see the flourishing of the recovery community—from people in recovery sharing their stories through the media, films like *The Anonymous People*, and the growth of new models like collegiate recovery communities. But unfortunately, there’s still little research behind it, which is what matters in terms of funding services.

Recovery as a bona fide topic makes ‘professionals’ (clinicians and researchers whose peer reviewers are often... clinicians) nervous I believe, because a lot of what it takes to recover doesn’t make anyone any money and it doesn’t require an advanced degree. Think about the sponsor-sponsee type relationship, think about the person in recovery 3 or 10 years volunteering in their community to ‘give back’, changing their eating habits to be healthier, there isn’t much profit for anyone to make there. Sure, treatment does help some of the 30% of people who need it and eventually get it, but treatment is just a start. Treatment is NOT recovery. The recovery ‘lobby’ is an advocacy movement of persons who’ve been stigmatized and want respect for themselves, their experience and their suffering. Compare that to the big pharma lobby or even the treatment ‘industry’. And to be fair, individuals in recovery are not the ones who need research to ‘prove’ that recovery works. They know it. The ones who need recovery research are the ones not currently taking it seriously enough because there is no research. So it’s a vicious cycle. And I have no clue how to disrupt that cycle and wake people up in my field.

## **Career-to-Date Retrospective**

**Bill White:** As you look back over your career to date, what do you personally feel best?

**Dr. Alexandre Laudet:** I never think about this as about me. I see myself as a translator trying to give a voice to people in recovery as they express what works for them, what services are of greatest value to them, and what needed services are not available to them. I think the published papers I'm the most proud of as a human being are [the qualitative papers](#). And they are the hardest ones to publish. For example, I did a very simple one that I called, "What could the program have done differently?" It addressed the issue that so many people drop out of treatment and you've written extremely poignant pieces about people getting kicked out of treatment for exhibiting the symptoms of their disorder (i.e., using drugs or alcohol). When people patronize a service in other businesses, like Amazon or Home Depot, you get a survey: "Tell us about your experience. We want to know. We want your feedback." Well, in the addiction treatment world, we don't have anything like that. We naturally assume that if somebody drops out of treatment, they're bad people or not motivated and that we should move on to the motivated ones. So I wanted to examine from the client's perspective what a treatment program could have done to retain their involvement. Those are the kinds of questions I think are important to elicit the voices of people seeking recovery and in recovery. Questions such as, 'what does recovery mean to you?' not what it means to the clinician or to the researcher, but to the person we collectively in the biomedical fields are responsible for helping become what they want to be.

**Bill White:** I think your description of yourself as a translator is a good one. You've been a channel for getting voices of people in recovery into the scientific journals and to the field's policymakers. My compliments to you on doing that so effectively.

**Dr. Alexandre Laudet:** Thank you. That means a lot.

**Bill White:** Let me ask a final question. What guidance would you have for a young researcher who would like to do recovery research as part of their career focus?

**Dr. Alexandre Laudet:** The funding is the problem. I've met a lot of people who were presumably interested in what I and a few others do, but without money, there is little of significance you can do in the research arena. I think one thing we need as a society is to get serious about the issue of recovery and health. If we want people to get better, we need to put funding behind discovering how recovery is initiated and maintained over a lifetime. I get contacted by graduate students and people who are interested in doing recovery research and I wish I had an answer. You know as well as I do that recovery's a process that unfolds over years and no brief study is going to capture its essence. We have long-term studies of how people get sick but no infrastructure to provide long-term studies for how they get well and stay well. We have a three hundred billion dollar a year National Institutes of Health with, I believe, twenty-seven institutes each named for a disease. Not one of the institutes is actually focused on how people get well. I don't get that. But I am pretty certain at this stage that recovery research is not going to be funded by the NIH any time soon so we need to identify other significant sources of funding. The issue is the type of research needed isn't cheap. And it doesn't lead to quick results. But it is sorely needed so my advice to anyone else who shares this view is, DO NOT GIVE UP. Keep trying. Keep pushing. Keep building wellness measures in addiction research, keep building in whatever ethnographic/qualitative component you can in your research. Do not be

afraid to use the term ‘recovery’– to document it. People in recovery are finally becoming empowered to stand up for their struggles and their triumphs, to celebrate being in recovery, just like people who have overcome other challenges have been standing up for decades, their loved ones at their side, like cancer survivors and individuals with mental health issues. Focus on understanding wellness and health, and focus on the positive in yourself and in others. Most of what I have learned about growing as a human being I have been humbled and privileged to learn from the people I love who are in recovery. Recovery, overcoming challenge and pain, is a fundamentally human experience. We can all learn from the recovery experience and this needs to be documented. Giving up is absolutely not an option.

**Bill White:** Dr. Laudet, thank you for all you have done for people seeking and in recovery. It has been an honor for me to have worked with you over the course of your career.

**Dr. Alexandre Laudet:** I can never thank you enough. I wouldn’t have done half of what I’ve done were it not for your writings.

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### **Selected Publications / Recommended Reading**

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