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## Commentary

### Is It Time We Became Recovery Professionals?

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More than four decades ago, I decided to spend my life helping people recovery from alcohol and other drug (AOD) addictions. The subsequent years working in this unusual avocation have been filled with blessings beyond what I could have imagined as a young man. Yet in reflecting on my years in addiction counseling and the broader arena of addiction treatment and research, there seems to have been something missing within the organizing center of our field. This missed dimension is evident in both how addiction counselors (and other specialized addiction-related professionals) are trained and how we have defined ourselves. Put simply, our growing knowledge and expertise in the intricacies of AOD problem and the nuances of ever-briefer interventions into those problems has left little room for developing knowledge and expertise in the long-term solutions we seek.

Most of us are thrown so rapidly into the daily demands of working in addiction treatment that we quickly lose our capacity to see—really SEE—the field’s central focus or changes in that focus over time. In this short essay, I ask that you step back from such demands and look afresh at the field, not through the lens of addiction or the lens of addiction counseling/treatment but through the lens of long-term addiction recovery.

As part of our training, we are taught the pharmacology of alcohol and other psychoactive drugs, including the acute and chronic effects of excessive use. We are not taught which of these effects remit with sustained abstinence, when such remission of effects normally occurs, which effects may constitute a burden carried for years into the recovery process, and how such longer-term or permanent impairments and risks can be managed within the recovery process.

We are regularly provided detailed statistical tables of the latest drug use prevalence trends with recent changes in these patterns meticulously plotted against decades of past surveys. What we are not taught is the prevalence of long-term recovery in the United States and how this has changed over time, nor are we privy to the evolution of annual rates of recovery initiation. Are there more people in recovery in the U.S. and in your state today than a year ago? Did more people enter recovery this year than last year? We simply don’t know. Detailed profiles of those with alcohol and other drug problems are pervasive, but glaring by their omission are the demographic and health profiles of individuals and families in addiction recovery.

We are taught how to define addiction, the inclusion and exclusion criteria for a whole menu of substance use disorders as well as nuanced understandings of varying patterns of problem severity, complexity and chronicity. We are not taught a similarly uniform definition of recovery nor are we provided in-depth training on the multiple pathways and styles of long-term addiction recovery. We are taught what science and clinical practice reveal about problem progression and the late stages of addiction, but we are not taught the course and stages of long-term personal and family recovery.

We are taught the genetics and neurobiology of addiction as a brain disease with unending slides of drug-hijacked brains and promises that promotion of the brain disease model will reduce stigma, but we are not told how this very model could inadvertently increase stigma and discrimination. We are not taught the neurobiology of recovery (the likelihood of such recovery, the mechanisms of such recovery and when such recovery can be expected to occur). Nor are we taught how to answer a client's most basic questions about the personal implications of addiction-related genetic research: 1) Are all of my children higher risk for addiction because of my personal and family history? 2) Will my recovery status or failure to recovery affect my children's vulnerability or their chances of recovery if they should experience addiction? 3) Is there anything I can do as a parent to reduce these elevated risks for my children?

We know a great deal about how to facilitate acute biopsychosocial stabilization for people seeking addiction treatment, but we know very little about the transition to recovery maintenance and the stages of recovery that follow. We know a lot about the effects of addiction on the family and its members, but little about how to build the support scaffolding that can prepare the family for what Dr. Stephanie Brown has christened the "trauma of recovery"—a trauma whose greatest effects are seen after treatment professionals have terminated their brief service relationships..

We are trained in the basic treatment modalities of addiction treatment and a wide spectrum of counseling techniques, but we learn little about the role of community in recovery, the role indigenous helpers can play in recovery initiation and maintenance and how we can best collaborate with these recovery support resources. We know a great deal about how to counsel individuals in the earliest days of recovery but very little about how to counselor individuals and families with years or decades of recovery.

In recent years we have access to a robust body of information on AOD problems among historically disempowered populations (women, youth, ethnic and sexual minorities, persons with co-occurring (and often equally stigmatized conditions), but we are far less likely to learn about how such populations have resisted and recovered from these problems. For example, AOD problems in Native American and African American communities are visibly portrayed in the public and professional media, but the high rates of recovery and the recovery stories from these communities are missing from public reports and from the training of addiction counselors.

We are taught the laws, regulations, ethics and etiquette governing our profession while neglecting the very thing for which all of these exist. Without connection to long-term recovery as a measurable outcome, what value are any of these professional trappings?

We are taught to look to the “addiction studies” programs; “addiction medicine” specialists; national offices, institutes and centers on “Drug Control Policy,” “Alcohol Abuse and Alcoholism,” “Drug Abuse” and “Substance Abuse Treatment”; and regional “Addiction Technology Transfer Centers,” but there are no “recovery studies” programs, no “recovery medicine specialists,” no offices, institutes or centers on “recover” and no “recovery technology transfer centers.” We have journals of alcohol and drug studies, psychoactive drugs, substance misuse, addiction, addictive behavior, addiction research and theory, alcohol and drug dependence, alcoholism treatment, and substance abuse treatment, to name a few, but only one (*Journal of Groups in Addiction and Recovery*) that even suggests by its title an interest in the scientific study of recovery. Experts and resources abound on alcohol and other drug problems and their acute treatment. Where are the professional experts and professional resources on the long-term solutions to these problems?

If we examined the curricula of addiction studies programs in the United States, the content of certification and licensing exams required to work in addiction counseling and the topical content of continuing education programs for addiction counselors, what percentage of that content would we find focused the subject of recovery? We escaped the brand of “paraprofessional.” We evolved from seeing ourselves as addiction professionals to seeing ourselves as treatment professionals. Perhaps it is time we become recovery professionals.

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