Topical Quotes from William White and Co-authors' Recovery Writings

Introduction

In June 2010, I launched the website www.williamwhitepapers.com with the singular goal of creating an online resource library that would serve as a repository of my collected writings on addiction recovery. My hope was to make these papers and related resources available to current and future generations interested in recovery and the recovery advocacy movement. What I did not anticipate was that the volume of these writings would get so large as to make it difficult to locate materials on particular topics even with excellent search engines for the main papers and blogs posted on the website. The present resource is an attempt to make this material more accessible through a selected collection of topical quotes that can provide the reader a sampling of what I (and my co-authors) have written on selected recovery-related topics. The date following each selected quote notes the year in which the statement was written. Typing in any portion of the quote in the website search engine should link to the full article from which the quote was excerpted.

Bill White

"Abuse"

The term abuse applied to substance use disorders is technically inaccurate. To suggest that people with serious alcohol and other drug problems disregard, mistreat, or defile the psychoactive substances they consume is a ridiculous notion. They do not abuse alcohol or drugs; they treat these substances with the greatest devotion and respect at the expense of themselves and everyone and everything else of value in their lives. (2010)

The terms alcohol/drug/substance abuse/abuser reflect the misapplication of a morality-based language to depict a medical condition. The historical roots of the application of the term abuse to severe and sustained alcohol and other drug problems are found not in medicine but in religion. References to alcohol/drug/substance abuse are rooted in centuries of religious and moral censure (Benezet, 1774).

The terms abuse/abuser contribute to the social and professional stigma attached to substance use disorders and may inhibit help-seeking. To refer to addicted individuals as alcohol, drug, or substance abusers misstates the nature of their condition and may contribute to their social rejection, sequestration, and punishment (Kelly, 2004). (2010)

The terms abuse/abuser inaccurately portray the role of personal volition in substance use disorders. These terms define AOD problems exclusively in terms of personal values, character, and personal decisionmaking. By implying that AOD problems are a function of bad choices and that people should be accountable for such choices, the terms provide a rationale for policies of forced sequestration and mass incarceration of people with severe AOD problems. Use of these terms ignores how volitional control over AOD-related decision-making can be compromised by personal vulnerabilities and drug-induced neurological changes in the brain. The terms, by

focusing on the individual casualties of AOD consumption, also deny the culpability of corporations whose financial interests are served by promoting high frequency, high quantity AOD consumption. (2010)

The use of the abuse diagnosis by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) perpetuates and legitimizes the continued stigmatization of people with AOD problems. (2010)

The terms abuse and abuser should be now and forever abandoned in reference to alcohol and other drug-related problems and those experiencing such problems. Such an action would include dropping abuse from the field's diagnostic language and changing the names of the field's major research and policy organizations: The National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment (White, 2006). If we truly believe that substance use disorders constitute serious health problems, legitimate medical disorders, and at their core, brain diseases, then why do we continue to have departments and centers of substance abuse? It is time—no, past time—that the terms abuse/abuser were dropped from the lexicon of addiction professionals and recovery advocates. (2010)

Adolescent Recovery

Greater attention must be given to the ecology of recovery from adolescent substance use disorders. The advancements in the treatment of substance use disorders point toward the family, the peer culture, the school and the larger community as important mediators in post-treatment recovery or relapse. It is becoming increasingly clear that the substance-impacted adolescent cannot be treated without treating the environment in which he or she resides. What is needed is nothing short of building indigenous cultures of recovery that can nurture adolescents during and following their experiences in professionally-directed treatment. This requires constructing and utilizing recovery support systems within the world the adolescent inhabits: within the family, the school, the neighborhood, and the wider community. For those adolescents most deeply involved in substance use, the goal is to move them from a drug-saturated culture of addiction to a youth-oriented culture of recovery (2002)

As a country, we have focused attention on adolescent AOD [alcohol and other drug] problems for more than 200 years and have admitted and studied adolescents within American treatment institutions since the 1860s. We know a lot about the pathology of addiction and the mechanics of intervention. It is time we studied the lived solutions to AOD problems among young people and their families and the lessons these solutions hold for the redesign of community-based treatment and school-based recovery support services. (2007)

Addiction as Chronic Condition

If we really believed addiction was a chronic disorder on par with cancer (and other chronic primary health disorders), we would provide every person seeking assistance:

- Clear and consistent communications regarding the intrapersonal, interpersonal, and environmental factors that contribute to the development of a substance use disorder.

- An assessment process that is comprehensive, transparent, and continual.
- Objective data upon which a substance use disorder (SUD) diagnosis is based (with normative data for comparison to the general population and to other patients being treated for SUDs).
- Objective information on the severity (stage) of the SUD.
- Objective information on treatment options matched to the type and severity of the SUD.
- A declaration of potential professional/institutional biases related to diagnosis and treatment recommendations.
- A menu of treatment options before making a final decision on the course of treatment.
- Access to the experiential knowledge of former patients who have experienced a variety of SUD treatments and who represent diverse pathways and styles of long-term recovery management.
- Personalized refinements in treatment-based assessment data and individual responses to initial treatment.
- At least five years of monitoring and support following completion of primary treatment.
- Assertive re-intervention and recovery re-stabilization in response to any signs of clinical deterioration.
- A long-term, person- and family-centered recovery support relationship based on mutual respect that is free of contempt or condescension.

It really is that simple. If we believe that addiction in its most severe forms is a chronic disorder, then let's treat it like we really believed it. (2012)

Addiction Treatment (Limitations of)

Addiction treatment as a stand-alone intervention is an inadequate strategy for achieving long-term recovery for individuals and families characterized by high problem severity, complexity, and chronicity and low recovery capital. In isolation, addiction treatment is equally inadequate as a national strategy to lower the social costs of alcohol and other drug-related problems. Here's why. Specialized addiction treatment as a system of care in the U.S.:

- attracts too few—only about 10% a year of people in need of it and only a lifetime engagement rate of 25%,
- begins too late—with years and, in some studies, decades of dependence preceding first treatment admission,
- retains too few (less than 50% national treatment completion rate),
- extrudes too many (7.3% of all admissions—more than 130,000 individuals--administratively discharged, most for confirming their diagnosis),
- ends too quickly, e.g., before the 90 days across levels of care recommended by the National Institute on Drug Abuse,
- offers too few evidence-based choices,
- fails to engage and support affected family members and friends,
- is too disconnected from indigenous recovery community resources,
- offers minimal continuing care--far short of the five-year point of recovery durability, and

- fails to alter treatment methods in response to patient non-responsiveness, e.g., blaming substance use disorder recurrence on the patient rather than the treatment methods. (2014)

Professionally-directed addiction treatment should not be the first resort for AOD-related problems; it should be the last resort—a safety net to protect individuals, families, and communities. The first line of response should be support imbedded within relationships that are natural, reciprocal (non-hierarchical), non-professionalized, non-commercialized, and potentially enduring. Such relationships are to be found, not within a treatment center, but within the larger community environment. However, significant effort is required to build and sustain such natural resources. (2014)

Administrative Discharge (Kicking People out of Addiction Treatment)

Administratively discharging clients from addiction treatment for AOD use is illogical and unprecedented in the health care system. A client is admitted to addiction treatment on the grounds that he or she has a chronic condition, the essence of which is the inability to abstain from or willfully limit their intake of psychoactive drugs in spite of escalating problems related to such use. Significantly, the just-admitted client is told that AOD use is a violation of program rules and grounds for his or her termination from treatment. The client then consumes alcohol or other drugs in spite of the promised consequence—confirming the grounds upon which their diagnosis was made and their need for professional assistance. As a result of manifesting the primary symptom of the disorder for which the client was admitted to treatment, he or she is expelled from treatment. …We know of no other major health problem for which one is admitted for treatment and then thrown out for becoming symptomatic in the service setting. For other chronic health care problems, symptom manifestation serves as a confirmation of diagnosis or feedback that alternative methods of treatment and alternative approaches to patient education and motivation are needed. In marked contrast, symptom manifestation in the addictions field is grounds for expulsion from service. (2004)

Expelling a client from addiction treatment for AOD use—a process that often involves thrusting the client back into drug-saturated social environments without provision for alternate care—makes as little sense as suspending adolescents from high school as a punishment for truancy. The strategy should not be to destroy the last connecting tissue between the client and pro-recovery social networks, but to further disengage the client from the culture of addiction and to work through the physiological, emotional, behavioral and characterological obstacles to recovery initiation, engagement, and maintenance. (2004)

The euphemisms for the AD practice—"throwing" or "kicking" someone out of treatment—would suggest the act involves a discharge of anger from the staff toward the offending client. Such anger springs from a client's ability to stir feelings of disappointment, ineptitude, and frustration within service providers. The AD can constitute the abrupt end of a therapeutic relationship that has deteriorated into a contempt-laden struggle for power and face, e.g., "my way or the highway." (2004)

Administratively discharging clients often involves behaviors that are unrelated to, or have only a weak connection to, the prospects or processes of recovery or safety issues within the treatment milieu. One example is the use of AD as punishment for sexual activity between clients in addiction treatment. One is hard-pressed to find other arenas of health care in which sexual prohibitions are a condition of continued service access. Sexual activity between clients can constitute a legitimate clinical issue (behavior previously linked to addiction or that serves as an obstacle to recovery) and a milieu management issue (effect of behavior on other clients/staff), but this issue is best addressed clinically as part of the treatment process rather than as a disciplinary issue warranting expulsion from treatment. (2004)

It is time that we as a field dramatically reduce the circumstances within which we expel clients from addiction treatment….Our clients are not at their best at the times they are on the verge of being thrown out of treatment, but we are quite often not at our best at such moments either. It is time we were. (2004)

Advocacy

Today, we stand, here and abroad, reaching across geographical, political, racial, and cultural barriers, to mobilize our growing numbers and influence. Today, we stand to reach our goal of engaging those who still suffer and creating a world in which recovery is supported and celebrated. Today, we stand to remind ourselves and to send a message to those still wounded: Recovery is contagious. If you want it, you have to get close to it and stay close to it. You have to catch it and keep catching it. And you have to pass it on to others! For far too long we have knelt with bowed heads, not in humility or prayer, but in shame. Today, we stand as one—in our gratitude for the fruits of recovery and in our commitment to service. Today, we stand to write the future of addiction recovery in America. (2010)

Advocacy and Anonymity

A.A.'s predecessors had been wounded by leaders and members who either used visibility as a springboard for financial profit or whose public downfall brought discredit to the organization. A.A. avoided both of these pitfalls by declaring that no one with a name (at least a full name) could speak for A.A. Anonymity, while practiced as a spiritual exercise, also protected A.A. as an organization and brought many individuals into recovery who saw in anonymity a shroud of protection from the injury that can result from one's being linked to a socially stigmatized condition. (2001)

Radical recovery is not an invitation to violate the anonymity traditions of Alcoholics Anonymous, Narcotics Anonymous, and other twelve-step fellowships. It is an invitation for some individuals and family members in twelve-step recovery and those from other pathways of recovery to talk publicly about their recovery status without reference to the means by which that recovery was achieved, e.g., without specific references to AA/NA affiliation at the level of press. It is an invitation for people to become a messenger of recovery apart from their particular identities as members of AA, NA, CA, WFS, WFS, SOS, LSR, or other recovery societies. (2004)

Anonymity served many practical functions in the early decades of AA, and quite animated discussions continue on the extent to which these functions continue or do not need to continue in the twenty-first century. Three such practicalities were most prominent. First, anonymity at the level of press (and the cultural etiquette of not using last names within meetings and admonitions of "who you see here, what you hear here, when you leave here, let it stay here") helped attract and protect the identities of alcoholics whose affiliation with AA, if publicly known, could cause harm to them or other parties. Second, anonymity at the level of press protected AA from public damage to its reputation that could occur if a publicly identified AA member or leader experienced a resumption of destructive drinking and related mayhem. The principle of anonymity and the practice of leadership rotation also helped AA avoid the organizational pitfalls of charismatic leadership and a centralized hierarchy that publicly personified AA. That function was particularly significant at an organizational level within a fellowship that defined the central problem of its members in terms of "self-centeredness," "self-will run riot" and "playing God." (Alcoholics Anonymous, 1939, pages 23, 74, 75). An argument could be made that the social stigma attached to alcoholism has declined in recent decades, making the first two functions less vital, although I don't think this same argument could be made in such 12-Step groups as Narcotics Anonymous, Cocaine Anonymous, Heroin Anonymous, and other 12-Step groups for persons addicted primarily to illicit drugs. (2013)

I still see the value of anonymity at the level of press as a protection of all 12-Step programs, and leaders within the new recovery advocacy movement distinguish public disclosure of recovery status (including at the level of press) with disclosure of one's affiliation with AA or another 12-Step program at the level of press. I think disclosure of recovery status at the level of press without reference to affiliation with AA or another 12-Step program complies with the letter of Traditions Ten & Eleven, but it may not always meet the spirit of the Traditions (Tradition Twelve)….I think the practical justifications for anonymity change and may even be lost as cultural contexts change, but anonymity as "spiritual foundation" comes from a quite different source—not cultural context and the personal or organizational threats such context pose, but from the essential dilemma of individuals seeking recovery within a 12-Step framework. One of the central discoveries within AA was that the alcoholic could not recover using only resources within the self. The alcoholic's essential problem, whether as a cause or consequence of alcoholism, was in AA's view entrapment within the self. The most cursory scan of AA's basic text, Alcoholics Anonymous, is informative. AA's founding generation viewed such things as self-awareness, self-knowledge, self-control, self-discipline, self-assertion, self-reliance, and self-confidence not as virtues but as part of the central pathology of alcoholism (along with other self-hyphenated conditions, e.g., self-justification, self-pity, and self-deception). So what AA constructed via its steps and rituals was a "we program" rather than an "I program" of recovery that allowed the alcoholic to escape entrapment within the self—a program that required nothing less than the "destruction of self-centeredness" (AA, 1939, p. 30). When AA literature speaks of anonymity as a "spiritual principle," it does so out of a profound understanding of the importance of self-transcendence as the vehicle for sobriety and serenity. You can hear people depicting AA as a "selfish program" to mean that the alcoholic must get sober for self and not for others, but you find a quite different orientation on the issue of anonymity. The "spiritual substance" of anonymity according to AA's core literature is not selfishness but "sacrifice." (Alcoholics Anonymous 1952/1981, p. 184). What is sacrificed in AA (and in acts of heroism) are one's "natural desires for personal distinction," which in AA are eschewed in favor of "humility,

expressed by anonymity" (Alcoholics Anonymous, 1952/1981, p. 87). Applying this understanding, one could see how an AA or NA member choosing public recovery advocacy could technically meet the letter of Tradition Eleven (not disclosing AA affiliation at the level of press), but violate the pervading spirit of the Traditions (Tradition Twelve). This could occur when advocacy is used as a stage for assertion of self (flowing from ego / narcissism / pride and the desire for personal recognition) rather than as a platform for acts of service, which flow from remorse, gratitude, humility, and a commitment to service. (2013)

There is a purity—perhaps even a nobility—to recovery advocacy when it meets the heroism criteria. There is a zone of service and connection to community within advocacy work, and I think we must do a regular gut check to make sure we remain within that zone and not drift into advocacy as an assertion of ego. The intensity of camera lights, the proffered microphone, and seeing our published words and images can be as intoxicating and destructive as any drug if we allow ourselves to be seduced by them. If we shift our focus from the power of the message to our power as a messenger, we risk, like Icarus of myth, flying towards the sun and our own self-destruction. To avoid that, we have to speak as a community of recovering people and avoid becoming recovery celebrities—even on the smallest of stages. We must stay closely connected to diverse communities of recovery and speak publicly not as an individual or representative of one path of recovery, but on behalf of all people in recovery. The fact that no one is fully qualified to do that helps us maintain a sense of humility even as we embrace the very real importance of the work to be done. The spirit of anonymity—that suppression of self-centeredness—can be respected when we speak by embracing the wonderful varieties of recovery experience rather than as individuals competing for attention and superiority. (2013)

Advocacy and Recovery

Pursuing avocations/vocations in addiction treatment or community education and advocacy does not constitute a viable strategy for personal recovery. The history of addiction in America is strewn with the bodies of those who believed otherwise. (2000)

The enduring message in all of these stories is clear: Working as an addictions educator, advocate, or counselor does not constitute a program of personal recovery. Those who forget that lesson court injury to themselves and to the very movements to which they claim allegiance. The primacy of personal recovery cannot be forgotten. (2005)

Alcoholics Anonymous

The creation of a sustainable alcoholic mutual aid society takes more than a workable framework of personal recovery. As the history of the pre-A.A. mutual aid societies teaches us, such groups must also position themselves within the larger culture, create their niche within the broader alcohol problems arena, construct viable operating structures and procedures, and, perhaps most importantly, find ways to transcend and manage the foibles of their leaders and members. A.A. discovered and then institutionalized via its Twelve Traditions strategies to manage the forces that posed the greatest threat to their existence and character: conflicts about purpose, position, property, politics, personalities, and, of course, money. (2001)

Addiction professionals and representatives of alternative recovery mutual aid groups ask, sometimes resentfully, why AA constitutes the standard by which all other recovery support groups are measured. That status at present is based on AA's size (measured by total membership and number of groups), the scope of its international dispersion, the range of its adaptation to address other problems, its influence on the design professionally-directed addiction treatment, the quantity and increasing quality of AA-related scientific research, and AA's growing visibility as a cultural institution. But even more than these, AA has earned this benchmark status by its survival, raising the question of why AA survived and thrived when its predecessors collapsed or were diverted from their recovery-focused missions. (2010)

Creating a sustainable alcoholic mutual aid society takes more than a workable framework of personal recovery. A.A., through its Twelve Traditions, found ways to manage those things that had destroyed its predecessors: conflicts over purpose, position, property, politics, personalities, and, of course, money. (2005)

Defining what AA does and does not believe or does and does not practice is difficult in light of the variability across Twelve Step programs, the lack of central leadership within such programs, and the varieties of local practices that can be found under the Twelve Step umbrella. We have been struck by the number of people we have encountered who have talked with a few AA members or attended an open AA meeting where they talked to a few willing informants and left such experiences feeling as if they understood AA. As long-time researchers of AA, it is our experience that the person most willing to speak first on behalf of AA is, by definition, the least qualified to do so. (2010)

A central tenet of AA is that recovery from alcoholism involves far more than the removal of alcohol from an otherwise unchanged life. AA's Twelve Steps and core concepts within the culture of AA (e.g., dry drunk, emotional sobriety, spiritual awakening) convey a vision of recovery as a radical transformation in character, identity, and interpersonal relationships. AA's "promises" speak not of an escape from drunkenness but from fear, selfishness, self-pity, and regret and the acquisition of freedom, happiness, serenity, peace, confidence, and authentic connection to others. (2010)

Scientific knowledge and experiential knowledge represent two radically different traditions of knowing, yet scientists and AA members are finding common ground as both groups try to more deeply understand how AA works and seek to widen the doorway of entry into long-term recovery from severe alcohol-related problems. Science can pose both threats and opportunities to recovery mutual aid societies, but there seems little question that we are entering an era of confluence between key elements of AA folklore and the findings of rigorous scientific studies. (2010)

When the larger cultural influence of AA is written in the centuries to come, these radical principles of organizational management may well be celebrated as a contribution even greater than AA's framework of alcoholism recovery (Room, 1993). AA's Twelve Steps exist within a preexisting tradition of alcoholism recovery movements, but the Twelve Traditions fueled a fundamentally new type of organization—one that broke all the prevailing rules about how organizations must be structured and managed. (2010)

The twin challenges faced by any recovery mutual aid group are to define a program of personal recovery and to define how it will operate as an organization, including its membership boundaries. Alcoholics Anonymous achieved these through its Twelve Steps and Twelve Traditions. Since their initial formulation, the Steps and Traditions have been continually reinterpreted in light of changing personal and cultural contexts. As historians of A.A. and similar movements, what we find most significant in recent decades are the growing varieties of recovery experience within and beyond A.A. (Kurtz & White, 2014)

Strains related to questions of religious belief, or the lack of such belief, are deeply rooted in the history of A.A., and those strains have recently heightened. While "spiritual but not religious" is a common self-descriptor of A.A., the degree of overt religiosity found within A.A. meetings varies considerably by country, region, city and from group to group. There have been efforts by some within A.A. to Christianize A.A. history and practices, and there have been simultaneous efforts to forge more tolerant space for agnostics and atheists within A.A. Each trend has been sometimes castigated by alarmists as a sign of the corruption and impending downfall of A.A. We view such diversification within A.A. as an inevitable process of adaptation to the increasingly diverse religious and cultural contexts inherent within A.A.'s worldwide growth. It also reflects adaptation to the forces of religious diversification and secularization in the United States. The future growth and vibrancy of A.A. may well hinge on these adaptive capacities. It remains to be seen whether such adaptations will nurture and celebrate the growing diversity within A.A., or whether A.A. boundaries will be reactively tightened to trigger group schisms, member attrition, and flight to existing or new secular and religious alternatives to A.A….The challenge internationally and in the U.S. as we see it is for A.A. to adapt to both religious renewal movements and simultaneous trends of cultural secularization without losing its essential character. (Kurtz & White, 2015)

Alternatives to AA

A.A. stands out in this history for having reached more alcoholics in more places and over a longer period of time than any alcoholic mutual aid society that came before or after. It may take a large menu of support structures to expand the entryway to recovery for the mass of alcoholics. As these groups emerge to seek their own niche in a growing multi-branched culture of recovery, they would do well to study the keys to A.A.'s resilience–keys that have as much or more to do with A.A.'s Twelve Traditions than A.A.'s Twelve Steps. (2001)

The more recent non 12-step mutual-help alternatives may never grow as large as AA for some of the reasons outlined above. Nevertheless, they play a vital role in our society's overall response to the prodigious social, medical, and economic burden attributable to substance misuse by providing an array of potentially appealing alternatives. These alternatives merely reflect the demographic diversity as well as the varieties of addiction experiences and recovery preferences held by individuals suffering from SUD. Providing and supporting greater choice and more options will broaden the base of addiction mutual help. This, in turn, is very likely to enhance the chances of recovery for more individuals. (2012)

Amplified Recovery

Recovery from a life-threatening condition can bring far more than the removal of pain and sickness from an otherwise unchanged life. Confronting one's mortality through the experiences of illness and recovery can bring unexpected gifts. Surviving heart disease, cancer, addiction or other life-threatening experiences can be an unlikely source of renewal and personal transformation—catalysts for living more fully and more meaningfully. There may be something to that notion of being stronger at the broken places….Ernie Kurtz and I used the term *amplified recovery* to depict individuals who, through these processes of saving and rebuilding their lives, experience positive and profound changes in the their character and interpersonal relationships and sustained acts of public service—a quality of service surpassed only by the degree of gratitude and humility through which they are performed….We should convey the expectation of remission to everyone we serve at the same time we convey the potential for recovery and a quality of life beyond that which can be presently envisioned. To sustain our faith in that potential for others, we must stay connected to the potential of that life for ourselves and stay connected to people in whom such potential is being fulfilled. Amplified recovery is as unpredictable as recovery itself. The unattractive, even repulsive, caterpillar before us today could well be tomorrow's butterfly of uncommon beauty and grace. (2014)

Surviving a discredited condition/status can be a meaningful source of strength, potentially allowing one a depth of experience, character, and quality of life that might otherwise not have been possible without such challenges. Lecturing at the 1945 Yale School of Alcohol Studies, AA co-founder Bill Wilson referred to this as "the sublime paradox of strength coming out of weakness." (2014)

Authenticity of Representation (within recovery advocacy movements)

Authenticity of representation is the assurance that the organization is led by and on behalf of individuals and families in recovery and their vetted allies. It is a pledge of watchfulness on the issue of double-agentry—persons who may present themselves as representatives of the recovery community who, unconsciously or with intent, represent other personal, ideological, institutional or financial interests. This is not to say people who wear such multiple hats cannot contribute to the movement, but it does say that these other potential influences on the movement must be acknowledged and minimized. Nor as we noted earlier does this mean that persons without recovery experience should be denied roles in a recovery advocacy movement. Such movements have always been aided by persons not in recovery, but the majority of its core leadership must remain with people in recovery. (2011)

Metaphors as Recovery Catalysts

Hope is conveyed within CIRSR [culturally indigenous recovery support resources) through catalytic metaphors that are culturally vibrant ("hot"). Such metaphors encompass words, ideas, and stories that, by creating dramatic breakthroughs in perception of self and the world, spark and anchor processes of personal transformation. These catalytic metaphors are linked to recovery and integrated as prominent themes in an overarching culture of recovery. In a very real sense, culture and its stories and metaphors become the "treatment." (2012)

Choice

The problem with choice for the alcoholic/addict has often been framed as a problem of the split self. The question is, "Who's really choosing: Dr. Jekyll or Mr. Hyde?" How can we as professionals distinguish a client's authentic choice from what A.A. calls "stinkin' thinkin'", what Rational Recovery calls the addictive voice or "Beast," what Secular Organization for Sobriety refers to as the "lizard brain," what LifeRing Secular Recovery calls the "addict self" (versus the "sober self"), and what Christian recovery groups sometimes refer to as the "voice of the Devil"? If we offer each client enhanced choices, will it be the client or the disorder/devil making the decisions? (2008)

One way to partially reconcile the dilemma between the traditional and emerging views of choice is to first acknowledge that free will in addiction and recovery is not an all or none phenomena. The capacity for volitional control over AOD use and related decisions is variable across individuals (as a function of the interaction between problem severity/complexity and recovery capital) and is dynamic (shifts incrementally on a continual basis within the same individual through both addiction and recovery processes). Recovery can be viewed as progressive rehabilitation or reclamation of the will—the power to reclaim personal choice. There are times the recovery process may involve consciously not choosing—relying on resources and relationships outside the self, and times that the next recovery steps require an assertion of self. At a practical level, this means that the first hours of acute detoxification are not the best time to rely exclusively on client choice. And yet long-term recovery is not possible without choice. If there is no rehabilitation of the 4 power to choose and encouragement of choice, we are left with, not sustainable recovery, but superficial treatment compliance. (2008)

A philosophy of choice is viable only with persons who have the neurological capacity for decision-making, who believe they have the right to make their own choices, and who are aware of and can evaluate available service and support options. Creating informed, assertive consumers of addiction treatment and recovery support services can be enhanced by: 1) affirming the service consumer's right to choose, 2) distributing and reviewing consumer guides on treatment and recovery support services published by local recovery advocacy organizations, 3) teaching service consumers how to recognize quality treatment services and healthy support groups, 4) informing consumers about the potential of harmful side effects of treatment and mutual aid group participation, 5) encouraging consumers to visit and sample service/support options, 6) defining the criteria by which 6 the client and service specialist will know if participation in a particular activity is working or not working, and 7) monitoring each client's responses to treatment and support services. (2008)

Citizenship in Recovery

The addictive relationship with the drug drains and distorts the self, progressively displacing all other needs in importance and recasting others as objects to be used in service to the drug relationship. As the drug assumes the central value and ever-growing space in one's life, addiction becomes a disease of disconnection—from one's own aspirational self, from family and friends, and from identification with and relationship to community and culture. Addiction wears the mask of narcissism, but it produces a self-centeredness that is more aptly described as

drug-centeredness. The self is actually lost in the process—a loss further magnified by family and community disconnection and social alienation….Recovery from addiction is thus rediscovery or development of an authentic self, a reconnection or reformulation of family, and a new social contract with one's community and culture. Citizenship is a component of recovery because addiction so often leads to the abandonment of one's connection and commitment to community. For some, this involves withdrawing their assets from the life of the community; for others, this involves threat to or inflicting harm on the community and its citizens. It is therefore not surprising that for nearly two centuries, addiction recovery frameworks have involved public confession, public commitment, socially supported recovery maintenance, and amends by the individual to the community via various forms of service work. (2010)

Thus, over its long course, the recovery process for many must involve:

- a renewal or reformulation of self (visibly evident through the acts of story reconstruction and storytelling—the cleaving of one's life into categories of before and after to depict both addiction and recovery),
- a shift in social identity from outsider to insider—seeing oneself as a piece of the community whole,
- community connection via the expansion of non-drug social relationships, and
- community service—a shift from being a community burden to being a community asset. The process of recovery involves reconstructing character (an alteration in beliefs, values, and behaviors) to redefine a person's relationship to community. (2010)

To guide this new or renewed social contract, certain key values need to be cultivated or re-embraced. These recovery-grounded values include:

- primacy of recovery (maintaining recovery by any means necessary—under any circumstances),
- identification (empathizing; recognizing self in others),
- humility (accepting personal imperfection; when wrong, admitting it),
- respect (considering the needs of others),
- nonmaleficence (stopping injury to others),
- service (helping others),
- responsibility (doing our duty),
- restitution (making amends to those we've injured),
- forgiveness (letting go of past grievances),
- honesty (telling the truth),
- discretion (respecting confidences; avoiding gossip),
- loyalty and fidelity (keeping promises and commitments),
- justice (being fair),
- gratitude (passing on good fortune to others), and
- tolerance (respecting differences) (2010)

Some people in recovery remain cloistered within the culture of recovery while others participate in the recovery culture and become fully involved in the larger life of the community. Still others initiate and sustain recovery without connection to communities of recovery. These variations of addiction and recovery have been described as culturally enmeshed, bicultural, and acultural

styles of recovery (White, 1996). For people with the most severe, complex, and chronic alcohol and other drug problems, extreme disconnection from mainstream community life is likely. These individuals may need guidance in reconnecting to community and assuming their citizenship rights and responsibilities. (2010)

Common Ground

We need to find common ground of solidarity among those who were once afflicted but are today well and free. We must find a common recovery advocacy language that transcends the differences we have as groups and individuals. The most serious struggles need to be waged not with each other but with the more formidable forces in our communities and our culture that seek to objectify and demonize those who have experienced alcohol- and other drug-related problems. (2001)

Community Recovery

Community recovery is a voluntary process through which a community uses the assertive resolution of AOD-related problems as a vehicle for collective healing, community renewal, and enhanced intergenerational resilience. Community recovery is: 1) voluntary in the sense that it involves a breakthrough in community consciousness and sustained community commitment, 2) a process in that it must unfold and be sustained over a prolonged period of time, and 3) assertive in that the diminishment of AOD and related problems occurs as a result of concerted, collective and sustained action. (2010)

The ultimate test of the community recovery process is not the mass recovery of one generation, but breaking intergenerational cycles of problem transmission and imbedding personal, family, and cultural resistance and resilience as an enduring intergenerational legacy within the deepest fabric of a community. (2010)

Community recovery elevates the prognosis for personal/family recovery by elevating external recovery capital and creating the physical, psychological, and cultural space where recovery can flourish. (2010)

One of the most riveting metaphors emerging from the Native American Wellbriety movement is that of the Healing Forest. In this metaphor, the clinical treatment of addiction is seen as analogous to digging up a sick and dying tree, transplanting it into an environment of rich soil, sunshine, water, and fertilizer only to return it to its original deprived location once its health has been restored. What is called for is treating the soil—creating a Healing Forest within which the health of the individual, family, neighborhood, community, and beyond are simultaneously elevated. The Healing Forest is a community in recovery. (2010)

As behavioral health care systems shift from a focus on pathology to a focus on recovery and resilience, their vision and service technologies will inevitably be forced to see the individual nested within the ecology of family and community. As that happens, the interconnectedness of personal, family, and community health will become increasingly apparent, and talk of individual and family recovery will be extended to that of community recovery. (2010)

The history of recovery mutual aid societies, specialized addiction treatment and new recovery community organizations indicates a potential shift in focus from facilitating the intrapersonal recovery experience to creating supportive community environments in which such recoveries can flourish. This new understanding of the ecology of recovery will increase the transformative potency of professional treatment institutions and peer recovery support groups at the same time it sharpens their understanding of the social contexts in which addiction and recovery are nested. (2010)

Interventions into AOD and related problems must move beyond micro-level (individual) interventions to the creation of "naturally occurring, healing environments" that simultaneously elevate personal, family, and community health (Bloom, 1997, p. 117). (2013)

Community recovery is a voluntary process through which a community uses the assertive resolution of AOD-related problems as a vehicle for collective healing, community renewal, and enhanced intergenerational resilience. Community recovery is more than the personal recovery of community members; it involves strengthening the connective tissue between those with and without such problems while restoring and sustaining the quality of community life. (2013)

Collective healing, renewal, and resilience are aspects of recovery measured by what is added to family and community life. These outcomes include the enhanced health of individuals, families, and neighborhoods; the repair of strained or severed relationships within the community; the renewal and rise of indigenous leaders; the enhanced health of key community institutions; intergenerational connectivity; and the enhanced resilience of individuals (particularly children, adolescents, and transition age youth), families, and neighborhoods. (2013)

…a profound understanding of the concept of wounded community and the potential for community recovery can be found within historically disempowered groups, particularly within Native American and African American communities. One of the most riveting metaphors emerging from the Native American Wellbriety movement is that of the Healing Forest. In this metaphor, the clinical treatment of addiction is seen as analogous to digging up a sick and dying tree, transplanting it into an environment of rich soil, sunshine, water, and fertilizer only to return it to its original deprived location once its health has been restored and subsequently lost again. What is called for in this metaphor is treating the soil— creating a Healing Forest within which the health of the individual, family, neighborhood, community, and beyond are simultaneously elevated. The Healing Forest is a community in recovery. (2013)

Our past efforts have focused so much on the intrapersonal journey of recovery that we have given little thought to creating a world that nurtures recovery and intergenerational resiliency. That world is now under construction. Some of you reading this today may be yet unaware that part of your personal destiny will be to help build this world. If we are able to create communities where personal and family recovery can flourish, we may through that process also begin to heal whole communities and spur a renewed vision of a healed world. You could be an instrument of such healing. (2013)

The phrase "the streets" has long been a metaphor for the space in which addiction flourishes; "the streets" have now become places where recovery is finding its niche in community after community. If we as a country were really serious about addressing addiction, we would infuse recovery carriers within the very physical spaces in which addiction is growing exponentially. That is what is happening under the direction of an army of people in recovery.
"Paying it forward" (PIA) has long been part of the service ethic of communities of recovery—long before the PIA phrase was popularized. What is changing is that whole communities are becoming the recipients of these payments. To those on the frontlines of this movement to extend recovery from the rooms to the streets, you are my heroes. (2014)

If people who have courted death and experienced the darkest corners of human despair and desperation can discover hope, meaning and purpose, common ground and community across a rainbow of differences, then why can't we do that as a country and as a world? Perhaps in years to come we will witness a Recovery Effect—recovery communities, through their expanding size and maturity, exerting a collective healing influence on our larger communal life. (2014)

Community Recovery Capital

People in personal/family recovery are an important source of recovery capital that can be mobilized to serve as recovery carriers in their daily interactions within the community. With rising recovery capital, push forces out of addiction (experienced and feared pain and consequences of AOD use) become balanced with pull forces for addiction recovery (attraction to the promises of recovery as exemplified in the lives of recovery carriers). (2010)

Supporting the development and mobilization of culturally indigenous recovery support resources that are non-hierarchical, reciprocal, non-commercialized, and neighborhood- and family-based may be particularly important within communities whose historical experiences have engendered distrust of offers of help from culturally dominant social institutions. (2012)

The cultural management of AOD problems has historically focused on two targets: the individual and the community environment, with the activities of traditional recovery support institutions (i.e., professionally directed treatment and mutual aid organizations) focused almost exclusively on the individual. The trends outlined in this paper mark a movement into the chasm between the individual and the community. It is our expectation that greater attention will be given to improving recovery outcomes through strategies aimed at increasing community recovery capital (White & Cloud, 2008). This will involve a blending of traditional clinical strategies of intervention with strategies of cultural revitalization and community development. With that will come 14 studies of the role of community recovery capital (including the emerging resources described in this paper), as distinguished from the role of personal vulnerabilities and assets, in predicting long-term recovery outcomes. (2012)

Contagiousness of Recovery

If we are really serious about addiction, then we should reach those who are at early stages of their addiction careers and not wait until decades of devastation finally bring them to the doors of a treatment center. We need to correct the community conditions in which addiction flourishes.

We need to protect those most vulnerable to addiction. We need assertive intervention programs that shorten addiction careers and extend recovery careers. To achieve those goals, we must carry resilience and recovery into the very heart of local drug cultures. We must make the transformative potential of recovery visible to those who need it the most. The contagion of addiction is transmitted through a process of infection—the movement of addiction disease from one vulnerable person to another. The contagion of recovery is spread quite differently—not through infection, but affection. (2010)

Today, we stand to remind ourselves and to send a message to those still wounded: Recovery is contagious. If you want it, you have to get close to it and stay close to it. You have to catch it and keep catching it. And you have to pass it on to others! (2010)

Folk wisdom says recovery comes only when we hit our own personal bottom. But recovery did not come to some of you in this room by hitting bottom. Some of you lived on the bottom, and recovery remained a stranger. Some of you were drowning in pain, had lost everything but your life to addiction—and recovery still did not come. When it finally arrived, it wasn't forced on you and you didn't initially choose it. You caught recovery in spite of yourself. And you caught it from other people in recovery. (2010)

This night is a celebration of the contagiousness of recovery and the fulfilled promises recovery has brought into our lives. Some of you did not leave the streets to find recovery; recovery came to the streets and found you. And it did so through volunteers of the NET Consumer Council walking those streets. They put a face and voice on recovery. They told you that recovery was possible, and they offered their stories as living proof of that proposition. They told you they would walk the road to recovery with you. Some of you hit low points in the early days of that journey, and it was your brothers and sisters in this room that lifted you back up—who called when you missed group, who, in some cases, went and got you. Many of you were buried deep within a culture of addiction—a way of thinking, feeling, acting, and relating as powerful as the drugs you were taking. The NET community and the larger recovery community of Philadelphia helped you escape and welcomed you into membership in another world—a culture of recovery. And this moment we are sharing together tonight stands as witness to the vitality of that recovery culture. (2010)

The contagion of recovery is spread quite differently—not through infection, but affection.1 Those who spread such affection are recovery carriers. Recovery carriers—because of the nature of their character and the quality of their lives—exert a magnetic attraction to those who are still suffering. Recovery carriers affirm that long-term recovery is possible and that the promises of recovery are far more than the removal of drugs from an otherwise unchanged life. They tell us that we have the potential to get well and to then get better than well. They challenge us to stop being everyone's problem and to become part of the solution. They relate to us from a position of profound empathy, emotional authenticity, respect and moral equality—lacking even a whisper of contempt. Most importantly, they offer us love. Yeah, some of us got loved into recovery, and I don't mean in the way some of you with smiles on your faces may be thinking. (2010)

We all have the potential to be recovery carriers. Becoming a recovery carrier requires several things. It requires that we protect our recoveries at all cost—Recovery by any means necessary

under any circumstances. It requires that we help our families recover. It requires the courage to reach out to those whose lives are being ravaged. It requires that we give back to NET and other organizations that helped us along the way. And it requires that in our new life, we try to heal the wounds we inflicted on our community in our past life. Addiction is visible everywhere in this culture, but the transformative power of recovery is hidden behind closed doors. It is time we all became recovery carriers. It is time we helped our community, our nation, and our world recover. To achieve this, we must become recovery. We must be the face and voice of recovery. We must be the living future of recovery. (2010)

Catching recovery means that one can initiate recovery even while actively resisting it, e.g., consciously trying to hustle your way through treatment or peer mutual aid to get people off your back only to "catch recovery" in spite of yourself. (2012)

Culture as an Agent of Healing

One of the underlying premises of many CIRSR [culturally indigenous recovery support resources] is that AOD problems rose in tandem with the loss of cultural traditions and that the renewal of those traditions and their adaptation to contemporary needs can provide a framework for recovery of the person, family, and community. (2012)

Culture of Recovery

The most critical tipping point in recovery is the transition from recovery initiation to long-term recovery maintenance. The success or failure of this transition often has as much to do with community recovery capital as personal recovery capital. As local communities of recovery come to see themselves as members of a larger and more embracing recovery community and build new institutions and services that address their common needs, greater numbers of our clients will find a world in which to recover. These clients will need addiction professionals to serve as knowledgeable guides of this recovery terrain. We must all become students of this burgeoning culture of recovery in America. (2008)

Addiction recovery often involves a journey between two physical and cultural worlds—passage from a culture of addiction to a culture of recovery. 20 The weight of personal and historical baggage can delay and impede this journey, particularly where alcohol and other drugs have been used as tools of colonization and oppression. (2012)

…we contend that: 1) local communities of recovery are best viewed as indigenous cultures (indigenous understood here to mean rooted within and naturally arising from the community; natural support as opposed to professionalized support within a formal health care institution), 2) many forms of inadvertent harm in the name of help can flow from these professional-indigenous collaborations, 3) the ethical issues and ethical guidelines noted in the professional literature on the relationships between addiction professionals/researchers and historically disempowered ethnic communities can be applied to relationships with communities of recovery, and 4) professionals can use a process of self-inventory to help heighten their effectiveness, ethical sensitivities and ethical decision-making abilities within these collaborative relationships. (2013)

Disease

Superficial lip service that alcoholism is a disease will not change how the culture views the alcoholic if the reality of recovery is not brought into the direct experience of the citizenry. (2000)

Agreeing that alcoholism (as opposed to drunkenness) is a disease (rather than a vice) says more about ourselves and our social being than it does about the science of alcohol pathology. Pioneers within the "modern alcoholism movement" such as Dwight Anderson and Marty Mann, understood much more than the scientists with whom they worked, that the success of that movement hinged not so much on new scientific discoveries about alcoholism as on changing social perceptions of alcoholism and the alcoholic. Words and images, not scientific evidence, were the tools used to launch this social revolution. What the modern alcoholism movement brilliantly achieved was to make how one spoke about alcoholics a symbol of one's degree of personal compassion and social enlightenment. (2004)

I would suggest the following hypotheses: 1) communicating the neuroscience of addiction without simultaneously communicating the neuroscience of recovery and the prevalence of long-term recovery will increase the stigma facing individuals and families experiencing severe alcohol and other drug problems, and 2) the longer addiction science is communicated to the public without conveying the corresponding recovery science, the greater the burden of that stigma will be. (2007)

Shifting the public view of the etiology of addiction from one of volitional misconduct to a brain disease may not alter social distance between alcohol and drug dependent individuals and the larger citizenry. …The vivid brain scan images of the addicted person may make that person's behavior more understandable, but they do not make the person whose brain is being scanned more desirable as a friend, lover, spouse, neighbor, or employee. In fact, in the public's eye, there is short distance between the perceptual categories of brain diseased, deranged and dangerous. We should not forget that a century ago biological models of addiction provided the policy rationale for prolonged sequestration of addicted persons and their inclusion in mandatory sterilization laws. Further, christening addiction a CHRONIC brain disease—as I have done in innumerable presentations and publications, may, without accompanying recovery messages, inadvertently contribute to social stigma from a public that interprets "chronic" in terms of forever and hopeless ("once an addict, always an addict") . (2007)

Conveying that persons addicted to alcohol and drugs have a brain disease that alters emotional affect, compromises judgment, impairs memory, inhibits one's capacity for new learning, and erodes behavioral impulse control are not communications likely to reduce the stigma attached to alcohol and other drug problems, UNLESS there are two companion communications: 1) With abstinence and proper care, addiction-induced brain impairments rapidly reverse themselves, and 2) millions of individuals have achieved complete long-term recovery from addiction and have gone on to experience healthy, meaningful, and productive lives. (2007)

Disconnect of Treatment from Recovery

Tenured addiction counselors are suffering from increased disenchantment in their professional lives. They regularly lament that it is getting harder and harder to feel good about what they are doing. This deep dissatisfaction comes from a feeling that treatment institutions have become places where addicts are billable commodities more likely to be repeatedly processed than changed. There is a sense among "oldtimers" that something indefinable has been lost as the field has matured. Many are referring to the field's crisis as spiritual in nature-a crisis in values. There are suggestions that the field has become disconnected from its roots and even suggestions that the treatment field needs to conduct its own fearless and searching moral inventory. There is an emerging consensus that new clinical technologies cannot make up for a lost sense of mission and core values. Paramount among such dissatisfactions is the sense that addiction treatment has become disconnected from its historical roots, detached from the larger and more enduring process of addiction recovery, and divorced from the grass roots communities out of which it was born. (2002)

By the mid- 1990s, there was a growing sense among a new generation of recovery advocates and many long-tenured addiction counselors that the multibillion dollar addiction treatment industry had become disconnected from the larger and more enduring process of addiction recovery and from the grassroots communities whose efforts had had birthed the field…. Efforts to increase the recovery orientation of addiction treatment/counseling are underway across the United States under the conceptual rubrics of recovery management and recovery-oriented systems of care. The success or failure of these efforts will exert a powerful influence on the future of addiction recovery in America and the fate of specialty-sector addiction treatment as a cultural institution. (2012)

Disease (chronic)

Acute illness is something you have ("I have a cold"); chronic illness is something you are ("I am a diabetic"). With acute illnesses, one experiences the onset of the illness, one is professionally treated or self-treated, and one recovers without a lasting imprint on personal or social identity. Chronic illness bears a greater stigma burden, in part, because of the uncertainty with which the concept of recovery is applicable to a condition that is prolonged, is not in a technical sense "cured," and will require sustained self-management and in many cases, periodic professional treatment. Chronic illness can inflict social death, a loss of self, and a struggle to define a "time horizon" for recovery. (2009)

Ecology of Recovery

Within CIRSR [culturally indigenous recovery support resources], personal recovery is nested in broader concerns for the survival and healing of families, neighborhoods, and communities—recovery as a people. Recovery is often framed as a political as well as a personal act—a means of cultural survival and revitalization. Recovery of the person, family, and community are viewed as inseparable, suggesting that one part of the recovery ecosystem cannot be treated or healed without treating and healing the whole. (2012)

Excessive Behavior in Recovery

Addiction is at its core a disorder of excess. The cells and the psyche scream in harmony, "higher, higher, ever higher," fueling flights that, like Icarus, many addicts do not survive. The Icarus story is a story about self-intoxication—"self-will run riot" as AA co-founder Dr. Robert Smith characterized it. Addiction for many is not just about a drug, but a broad pattern of excessive behaviors that touches most areas of one's life. So where does that leave the modern day Icarus? There are really only three broad choices. One is to succumb to the voices, ever pushing the boundary toward death and a life of crashing consequences and devastation to self, family, and community. The second is to stem this propensity for excess through self-talk (personal mantras of moderation) and by developing daily rituals of moderation in one's life as antidotes to this drive toward excess. The final option is to channel this propensity for excess into areas that are less destructive. This final option can bring unanticipated rewards. The addict's capacity for self-destruction is matched only by his or her potential capacity for creative contribution. Both may spring from the same source—this zeal for excess that can be expressed in infamy or greatness. A good lesson: the excess that has caused us so much pain can be transformed into a virtue when properly channeled. (2013)

Family

Family members impacted by alcohol and other drug problems have been long-cursed by social stigma, public neglect, and professional misunderstanding. Parents, spouses, and children of the addicted have hidden their most life-shaping experiences behind a veil of silence and secrecy. The personal stories that they eventually shared with professionals were all too often interpreted in terms of personal psychopathology, rather than normal adaptations to a disorder both baffling and devastating. Throughout the history of addiction in America, family members have been castigated more as causative agents and sources of recovery sabotage than as recovery resources or individuals deserving services in their own right. (2005)

The response of families to alcoholism and other addictive diseases is not a homogenous one that can be depicted in a single reductionist model. The diversity of family life is as wonderful in its capacity for resilience as it is sometimes horrifying in its capacity for cruelty. Each family must be its own model. Intervention into families must by characterized by gentleness and humility rather than by clinical arrogance born of knowing THE truth about the impact of addiction and recovery on the family. (2005)

For two centuries, families have been as likely to be blamed for the addiction of one of their members as offered support in responding to that addiction and its impact on themselves. And yet through this period family members have played an important role in advocating for more enlightened attitudes and social policies related to alcohol and other drug-related problems. As a new recovery advocacy movement seeks to define itself locally and nationally, we believe that is it time to honor the historical legacy of family members by embracing them as co-leaders of this movement. It is also time to define the family as the basic unit in the design of addiction treatment and sustained recovery support services. (2005)

Family Recovery

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 involves enhanced health across three dimensions: 1) individual family members, 2) family subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships), and 3) the family as a system (redefinition of family roles, rules, and rituals; recovery-conducive boundary transactions with people and institutions outside the family). (2006)

Family members of individuals recovering from addiction have been welcomed since the early days of the new recovery advocacy movement, but we are now witnessing something on an unprecedented scale in the U.S. and other countries: the mobilization of people who are transforming grief over the drug-related death of a loved one into advocacy and political action. It remains to be seen whether these grieving family and friends will form their own movement or become a new constituency and a new set of voices within the recovery advocacy movement. I am suggesting that we warmly welcome them at all levels of the movement and that their support be embraced within the movement's recovery focus. (2013)

I think THE recovery advocacy issue of the 21st century is breaking cycles of intergenerational transmission of addiction and related problems. We need to assemble the best minds and best science we can muster to formulate a decades-long plan to achieve this goal and then mobilize the political power to initiate and sustain such an effort. (2013)

Harm in the Name of Help

Well-intentioned but uninformed attempts to treat substance use disorders can result, and have resulted, in significant harm to individuals and their families. (2012)

There is a long tradition of iatrogenic effects (harm in the name of help) within the history of addiction treatment (White, 1998; White & Kleber, 2008), but patients entering addiction treatment are not routinely apprised of such risks or of their frequency of occurrence, even though some data related to such risks are available in the scientific literature (Ilgen & Moos, 2005; Moos, 2005). (2012)

Harm Reduction & Recovery

My vision is a simple one: all treatment should seek to reduce harm; all HR strategies should encompass the option, encouragement and support for full, long-term recovery. HR has traditionally been framed in the MM context as the subtraction of negatives—the risks and injuries to self and others that can be eliminated from someone's life; ROMM emphasizes what can be added to someone's life. I think the future rests in seeing HR and recovery as strategies to be uniquely combined and sequenced across the stages/styles of drug use / drug addiction and the stages of recovery rather than as warring ideologies. (2011)

ROMM [recovery-oriented methadone maintenance] and harm reduction (HR) strategies are best viewed as complementary rather than contradictory. All addiction treatment, including MAT, should facilitate and celebrate the reduction of personal and social harm; all HR strategies should encompass the option of and support for recovery. HR and recovery support strategies are interventions that can reach different populations and be of benefit to the same individuals at different stages in their respective use/addiction/recovery careers. (2012)

The chasm between HR and AATR principles and practices is being bridged with hybrid approaches that integrate public health and clinical perspectives. Such integration may constitute the future for the management of the most severe, complex, and chronic AOD problems. (2013)

Heroism and Recovery

Recovery from addiction is a challenging and valuable achievement, but it should not bestow nobility on the recovering person greater than that given persons who have never experienced addiction. I should not expect accolades from my community because I stopped harming myself and ceased harming nearly everyone within my sphere of influence. Recovery from addiction does not, and I don't think should, come with that kind of cultural entitlement and privilege. America loves second acts and we have long celebrated the person who rises in triumph from the ashes of defeat. Such stories confirm our aspirational value (or myth) of unlimited possibilities for all, but I don't think recovery in and of itself rises to the level of heroism as we've defined it in this discussion. The potential for heroism comes not from recovery status but from heroic acts that some choose to take within or beyond the recovery process. (2013)

I think heroic acts in recovery—those meeting the criteria we have discussed—can do two things. At a personal level, there is the paradox that such acts can serve as an antidote to the narcissism that is an integral component of addiction, but this antidote does not work if consciously sought for that purpose. The moment heroic acts are sought for personal gain—for their therapeutic value—the antidote ceases to work and the acts no longer qualify as heroic. At a social and cultural level, heroic acts by people in recovery, and particularly by people in recovery acting in concert, challenge and break down the myths and misconceptions that feed our demonization as a people and the criminalization of AOD problems. The essential problem is that people who personify addiction and its worst manifestations achieve great cultural visibility through every media outlet, but the mass of people who could personify long-term recovery and what recovery gives back to the community have remained culturally invisible. The heroism of going public with one's recovery at great personal risk and for the benefit of others when that status could remain hidden is what shatters stereotypes and stigma, particularly when that act also involves larger acts of service to the community. (2013)

Historical Trauma

A third form of community strain is that of historical trauma—a unique form of distress created by the physical or cultural assault on a people via attempted genocide or sustained colonization. Such trauma erodes indigenous sources of cultural and personal resilience and heightens vulnerability to a wide spectrum of personal and social problems. What distinctive about historical trauma is the propensity for its effects to be transmitted intergenerationally over

extremely prolonged periods of time (Brave Heart & DeBruyn, 1998). When historical trauma and contemporary distress align, communities, community institutions, neighborhoods, families, and individuals become particularly vulnerable to AOD problem (Brave Heart, 2003; Morgan, 1983). Over time, learned helplessness hopelessness in the face of such problems can become become part of the community culture absorbed across generations. (2010)

Alcohol and other drugs serve multiple functions in distressed and historically traumatized communities. They serve as a balm for emotional distress, an escape from feelings of powerlessness, and a trigger and excuse for the discharge of anger (Douglass, 1855). They serve as symbols of cultural protest (Lurie, 1974). They serve as the centerpieces of subcultures within which those most disconnected from mainstream community life find mutual support (White, 1996). They spawn underground economies and careers (Waldorf, 1973). They serve as instruments of financial exploitation by predatory industries, and they serve as tools of personal and cultural pacification (Douglass, 1855; Hacker, Collins, & Jacobson, 1987; Morgan, 1983). (2010)

(Recovery) History

These lessons of history can provide a source of technical guidance, a source of individual and organizational protection, a source of refreshment and renewal, and, most importantly, a source of unquenchable hope. We would be well advised to sit at history's feet and absorb the lessons of her stories. Perhaps if we listen carefully, she will not have to repeat herself. (2000)

Hope as a Recovery Catalyst

CIRSR [culturally indigenous recovery support resources] rise from communities whose members have lived a literal and metaphorical "bottom." In this context, hope is a greater motivator for addiction recovery than new increments of physical or psychological pain. CIRSR serve communities, families, and individuals with unfathomable capacities for prolonged physical and psychological pain. Pain in this context is not viewed as a motivator for recovery in the absence of hope. Hope is viewed as the key catalytic ingredient in recovery initiation. (2012)

Humility and Tolerance in Recovery

Humility: the recognition and acceptance that one is neither all nor nothing. In an era that worships celebrity, humility does not enjoy a good press. Some might wish to be thought humble, but no one wants the real thing or what is commonly mistaken to be the real thing, a sycophantic creepiness. But real humility is simply the acceptance that one is of some value, but not of infinite value: one is "not God". To be human is to be middling. More vividly, in the memorable phrasing of anthropologist Ernest Becker: "Man is a god who shits". On the one hand, we are capable of love and altruism and generosity and many wonderful things, but it is also true that periodically, we have to squat down and be reminded that we are also made of decay and will one day return to stinking decay….Humility is simply what keeps both of those realities in appropriately close awareness. …Tolerance, of course, flows from "all of the above". It is difficult to be self-righteously judgmental when one is aware of one's middling status as a receiver of the gift of a fundamental freeing. Having "hit bottom", one learns to look up and

around rather than down. Recognizing, really experiencing the realities laid bare by humility, aware of the gifts one has received, it does not necessarily become easier to put up with the inanities of others, but if we see those in the context of what we are learning about ourselves we may become able to smile a bit at our own upset. There are many wisdom stories in which the self-righteous person asks the god for what she/he "deserves"; and then is crushed by the discovery of what that will in fact entail. The recovering alcoholic knows better. Aware of that wisdom, one hesitates to judge. In fact, one is likely to be terrified at the very possibility. (Kurtz & White, 2015)

Language

One of the challenges of the recovery movement will be how to reduce the stigma attached to a condition and those who suffer from it with a cultural language that is heavily laden with that stigma. (2000)

For more than two centuries, addicted and recovering people in America have been the object of language created by others. People experiencing severe and persistent alcohol and other drug problems have inherited a language not of their own making that has been ill suited to accurately portray their experience to others or to serve as a catalyst for personal change. (2001)

By claiming the right to speak publicly and to frame their experience in their own language, recovering people are politicizing (in the best sense of this term) what up until now have been their own private experiences. Words have been used to wound addicted and recovering people--to declare their status as outcasts. Words can also be used to heal addicted and recovering people and invite them into fellowship with each other and the larger society. (2001)

To refer to people who are addicted as alcohol, drug or substance abusers misstates the nature of their condition and calls for their social rejection, sequestration and punishment. There is no other medical condition to which the term "abuse" is applied. If we truly believe that addiction is a serious health problem, then why do we continue to have departments and centers of substance <u>abuse</u>? The terms abuse and abuser should be now and forever be abandoned in discussions of people with severe and persistent alcohol and other drug-related problems. (2001)

The language used to label alcohol and other drug use provides a menu of symbols through which each individual can create, or make sense out of, his or her own relationship with these substances. Language can play a prohibiting, moderating, promoting, or transformative influence in the construction of this person-drug relationship. (2004)

Certain words can serve as keys to unlock frozen, compulsive patterns of drug use. The words that possess such face-saving and transformative power, however, vary from individual to individual and from culture to culture. The label "alcoholism" and the view of alcoholism as a "disease" may serve as a powerful face-saving and sense-making device for one individual while having little meaning to another person who may respond more powerfully to the construction of alcoholism as a "tool of genocide." It is not necessary for language to be scientifically "true" to serve this catalytic function, but it must be metaphorically and emotionally true to the addict and his or her family. The language must also be culturally true in that it allows the addict and his or

her family to construct a life story and a sobriety-based identity within the cultural context in which they live…. In the end, it is personal and cultural viability, not scientific validity, that determines the power of language to incite and solidify the process of addiction recovery. (2004)

The language of addiction might be compared to a projective word test revealing prominent or emerging features of the national temperament. Words move into and out of prominence as they reflect or fail to reflect the dominant emotion of the culture. Addiction rhetoric becomes more personalized and medicalized during periods of collective introspection and optimism--optimism about the power of our scientific technology and the potential for human transformation. Addiction rhetoric takes on moral and criminal connotations during periods of lost faith in ourselves and our technology and during periods of increased social disorder. Whether we use language that calls for toleration or language that calls for punishment says as much about our own collective temperament as it does about addicts and addiction….Science is not the driving force, but more often a self-absorbed bystander in the evolution of this language. (2004)

The language used to construct alcohol and other drug problems is also an economic commodity. It is a designator of who has problem ownership and any associated power and status, but also determines who shall receive the financial resources society has invested in managing the problem. Transforming "drunks" into diseased "alcoholics" created not only a new professional arena but also a new billable diagnosis and a new legitimized medical patient who could serve as a replacement for the diminishing raw materials (patients) that fueled a hospital-based health care industry. (2004)

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. In general, this means that the risk of future lifetime relapse has approached the level of addiction risk for persons without a history of prior addiction. Those who achieve full symptom remission for less than five years or who have achieved partial recovery (marked reduction of AOD use and related consequences) can best be described as in recovery or recovering. Use of the term recovering in later years (after five years) of recovery reminds the individual that recovery is an enduring process requiring sustained vigilance and recovery maintenance. However, such use, by inadvertently conveying the lack of a permanent solution for severe AOD problems, may contribute to the stigma and pessimism attached to these problems. (2006)

Words have immense power to wound or heal. The wrong words shame people with AOD problems and drive them into the shadows of subterranean cultures. The wrong words, by conveying that people are not worthy of recovery and not capable of recovery, fuel self-destruction and prevent or postpone help-seeking. The right words serve as catalysts of personal transformation and offer invitations to citizenship and community service. The right words awaken processes of personal healing, family renewal, and community and cultural revitalization. The wrong words stigmatize and disempower individuals, families and communities. (2007)

It is time people in recovery rejected imposed language and laid claim to words that adequately convey the nature of our experience, strength and hope. We must forge a new vocabulary that

humanizes AOD problems and widens the doorways of entry into recovery. We must forever banish language that, by objectifying and demonizing addiction, sets the stage sequestration and punishment. We must counter the clinical language that reduces human beings to a diagnostic labels that pigeon-hole our pathologies while ignoring our strengths and resiliencies. We must also reject the disrespectful and demeaning epithets (e.g., "retreads", "frequent flyers") professionals sometimes use to castigate those who need repeated treatment episodes. (2007)

The addictions field could learn much from the larger disabilities movement of recent decades. Some of the central ideas of this movement include the following:

- Language matters. It is far more than superficial concerns about political correctness.
- Language is imbedded with values and judgments of a culture; cultural change involves a transformation in language.
- The labels applied to individuals affect how they are perceived by others and how they perceive themselves.
- Language is a vehicle of social control and social isolation. Stigma and discrimination are couched in a language that reinforces stereotypes and elicits fear.
- Recovery and community integration require claiming one's own language.
- Language that focuses on the person is more respectful and less stigmatizing than language that defines a person in terms of an illness. (2009)

It will be interesting to see how the language of addiction treatment and recovery evolves in tandem with the dramatic changes that are unfolding within these worlds. I hope we will not be talking much longer about "consumers" or "consumer councils" but will instead be talking about people in recovery and recovery (or citizen) advisory councils. I also hope that the paternalistic "our patients," "our clients," and "those we treat" will evolve in the near future to "people we serve." (2009)

The term abuse applied to substance use disorders is technically inaccurate. The terms alcohol/drug/substance abuse/abuser reflect the misapplication of a morality-based language to depict a medical condition. The terms abuse/abuser contribute to the social and professional stigma attached to substance use disorders and may inhibit help-seeking. The terms abuse/abuser inaccurately portray the role of personal volition in substance use disorders. The use of the abuse diagnosis by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) perpetuates and legitimizes the continued stigmatization of people with AOD problems. The terms abuse and abuser should be now and forever abandoned in reference to alcohol and other drug-related problems and those experiencing such problems. Such an action would include dropping abuse from the field's diagnostic language and changing the names of the field's major research and policy organizations: The National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment. (2010)

The language used to label alcohol and other drug (AOD) problems exerts a significant influence on people experiencing such problems and on how professional helpers, policy makers, and the public view such people. Whether AOD-related problems are viewed primarily in terms of medicine (illnesses), psychology (habits), sociology (norms), morality (vices), religion (sins), or law (crimes) rests on a choice of concepts and words. America's enduring and ambivalent relationship with psychoactive drugs is replete with cycles of stigmatization/de-stigmatization/re-

stigmatization, criminalization/decriminalization/recriminalization, and medicalization/demedicalization/re-medicalization. Put simply, we can't seem to make up our collective minds about these substances and the people who use them to excess. As a result, we have not achieved any enduring consensus on the language that best depicts AOD-related problems. (2010)

Leadership

The leadership of the recovery movement must come from the recovery community and the movement's agenda must be those of recovering people and their families.(2000)
Advocacy movements need strong leadership and yet can be wounded by that very style of leadership. (2000)

What advocacy movements demand of their most visible leaders is not perfection but continual vigilance and a reasonable congruence between the life lived and the implicit and explicit values of the movement. The weight of this mantle of leadership can be a considerable one. (2000)

When a whole movement is linked to the reputation of a single man or woman, whose reputation is then publicly wounded, such wounding can prevent the full emergence of a movement or, once emerged, lead to the premature diminishment or death of that movement. (2000)

Mutual aid, advocacy and treatment organizations can die due to their failure to adequately address the issue of leadership development and leadership succession.(2000)

…the greatest social movements have often been sparked and sustained by the small acts of imperfect and often unknown individuals. If a recovery movement waited for those with perfect credentials, that movement would not be born, and if it was, could not succeed with such credentials. The message of recovery has always been able to transcend the imperfections of its messengers. (2000)

For the alcohol beverage industry, framing alcohol as an addictive poison or focusing on the misuse of alcohol by the majority have always been much more financially threatening conceptualizations of alcohol problems than defining such problems in terms of alcoholism. Alcoholism defines the problem inside the drinker and allows the industry to divert attention from the much broader and more pervasive problems created by their product--problems that have nothing to do with alcoholism as it has been medically defined. Both the licit alcohol and drug industries have a financial investment in linguistically framing America's alcohol and other drug problem in ways that separate those problems from their own products and promotional activities. (2004)

Our leaders need to understand the tendency of stigmatized groups to elevate individuals to leadership and then undermine and scapegoat their leaders, only to later deify the most successful of such leaders. Leadership in historical hindsight looks pure and noble. In the present tense, it is messy and involves imperfect individuals and organizations involved in what are often primitive processes. Our leaders need to understand such processes. It is time we took seriously the challenge of leadership development and the need for succession planning. (2005)

I have seen people burn themselves out (and occasionally self-destruct) from the intensity of this work, but I have also observed people doing this work with great dignity, grace, and health for decades. I've found four daily rituals that distinguish the lives of this latter group that I would like to share with you. The first is centering rituals: daily self-appraisal, goal-setting, and meditation/prayer that help keep one's "eyes on the prize" and help maintain personal integrity. Such rituals also keep one focused on the primacy of personal recovery by reminding us that recovery advocacy is not a program of personal recovery. The second is mirroring rituals: regular communion with mentors and kindred spirits who share our passion for this work. The third is acts of self-care: personal repair and replenishment, but this also includes care for one's family and other primary relationships. The best advice I have ever been given as an advocate is captured in the following statement: "One must be careful when carrying light to the community to not leave one's own home in darkness." The fourth replenishment ritual is unpaid acts of service outside of our advocacy activities. These activities exercise our service muscles and connect us to kindred spirits outside the world of addiction recovery. (2013)

Listening and Recovery Initiation

The power of listening extends beyond the person seeking recovery. I am daily asked how a family member, friend, or service professional can help someone escape addiction. Those seeking my counsel are often hoping I can share magic words they can speak that will serve as a catalyst of recovery. There are many such things that can be said and many actions that can be helpful, but nothing is more important than to listen—to silence all that you fear and hope and simply listen. No helping act is more powerful. (2014)

Masks of Addiction/Recovery

The metaphor of masks captures the duplicity and imposterhood that often rests at the experiential core of addiction, but these masks could also be thought of as onion-like skins. The notion of skins conveys a deeper level of attachment and something that cannot be as easily attached or removed—something closer to what many reptiles experience as they mature. Skins can be thought of as the disturbed thoughts, feelings, actions and traits of character one brings into the recovery process and the burdens of past actions carried into one's effort to construct a new life. Such baggage must be peeled away to free one to walk upright and to face others and face oneself. To shed old skins, find or create one's mature skin and to live comfortably within that skin are essential tasks of addiction recovery. Each new self requires a period of incubation and growth before the next incarnation can emerge….You can think and feel your way through this process, but ultimately you must act your way through it. We must shudder, slough and scrape off layers of the old self to stimulate new growth. This is a journey through "act as if" (and the feelings of imposterhood that this "fake-it-til-you-make-it" stage elicits) to a state of acting out of an aspirational core with full awareness and acceptance of one's continued imperfection. We must embrace each new skin without getting too attached to it—with full knowledge that this newly drying self will also one day be shed. (2014)

Media Images of Recovery

We must contend with twin dangers. First is the saturated press coverage of iconic deaths and other dramatizations of addiction. Second is the repeated portrayal of people representing recovery who know little if anything about it–celebrities recycling in and out of "rehab" following their latest crash and burn experiences, or persons freshly out of rehab still in the throes of the recovery honeymoon who want to convert the world. The resulting public image is one of recovery pessimism and the image of recovery as someone hours or days sober or not sober at all who is self-destructive, self-absorbed and pleading to escape the consequences of their latest indiscretions—in short, someone who got caught! Such an image conveys a definition of recovery as someone who, at best, is trying to stop their drug use or, at worst, someone who is using a feint towards recovery as a manipulative gambit. (2011)

Now the first inclination to counter these stereotypes is to march several thousand of us into the streets to proclaim that we have not used alcohol or drugs for years and that our lives in recovery could not be more perfect. This is the recovery version of The Stepford Wives movie, for those who remember it—a compliant, giddy happiness that mistakenly conveys that the achievement of recovery is an exhilarating leap into "and he/she lived happily ever after." As a movement, it is tempting to march into public our prettiest, smartest, most articulate, least threatening members and fill the media cameras with smiles and recovery slogans, but that is a temptation we must resist or quickly escape. And it is easy for us to get seduced by this image at a personal level through misguided efforts in recovery to become the perfect person, to create the perfect life and to project this perfect image of recovery to others. This is a poor choice personally because it creates an image none of us can live up to, and it also invites attack from those who refuse to believe that intelligence, attractiveness, industriousness and service to community cannot co-exist with addiction recovery. Presented with such images of perfection, people will seek to revoke either our addiction stories or recovery stories to keep their own stereotypes and their view of themselves intact. These stereotypes must be shattered by the authentic, but imperfect stories of the daily lives of thousands of people in recovery. The alternative to the "recovery is a sham/hustle" and "recovery is a panacea for all life's problems" is an authentic portrayal of the complexity, intensity and, at times, emotional rawness of recovery. Recovery requires climbing through a mountain of garbage before we become as clean inside as we appear outside. Recovery bears wonderful fruit, but it is also about struggle and suffering because life is about struggle and suffering. Recovery is about imperfection and brokenness because all humans are imperfect and broken—some of us more than others. Recovery is about escaping secrets because all humans have secrets that we spend a good deal of our lives running from. So we need recovery stories that tell the story of whole people and the whole recovery experience. We need people who can say "Recovery is my most sacred possession" and also say there are days when "recovery sucks"—that it's complex and confusing and uncomfortable and emotionally messy—and that yes it is all worth it!" What we need are stories of authentic experience rather than stories whose intent is to sell something. Above all we must be careful in not replacing alcoholic and dope fiend caricatures with equally stereotyped caricatures portraying all people in recovery as deliriously happy, spiritually enlightened super-citizens. (2011)

Medication and Recovery

We must collaborate with the individuals and families we serve to define what this long-term recovery orientation means in the context of medication-assisted treatment. Proponents

(recipients and providers) of medication-assisted treatment must become active participants and leaders in this movement or risk being further marginalized by this movement. (2009)

There is growing consensus that recovery is far more than the removal of addictive substances from an otherwise unchanged life. The early cultural and professional misunderstandings and stigma attached to methadone led to justifications that focused on what methadone could subtract from an addicted individual's life in terms of crime and broader threats to public safety and health. It is time we told the story of what the use of methadone and other medications combined with comprehensive and sustained clinical and recovery support services can add to the quality of life of individuals, families and communities. To achieve that, we will need to extend our vision beyond programs of medication management toward the broader vision of sustained and person/family-centered recovery management. (2009)

It is time a vanguard of people in long-term medication assisted recovery, who are personally called, whose life circumstances allow, and who are prepared and supported for this role, to stand collectively and tell their recovery stories to this country. Our job is to help create a cultural climate in which those stories can be safely told and to help with that preparation and support process. It is time to end the iconic image of medication-assisted recovery from a shadowed face sipping methadone. It is time that image became one of the faces and voices of real people expressing the role medication-assisted treatment played, or continues to play, in their recovery from addiction. That day will not come without the support of those of you in this room (2009 AATOD Annual Conference). The time for such a movement is now. It is time we connect the field's pharmacological treatments to the larger and more enduring process of addiction recovery. That vision must and will be fulfilled. (2009)

Addiction/treatment/recovery-related stigma is manifested in a broad range of attitudes, behaviors, and policies that range from social shunning to discrimination in such areas as access to medical/dental care, governmental benefits, training/employment opportunities, and housing and homelessness services. Stigma/discrimination related particularly to participation in methadone maintenance includes: denial of access to methadone maintenance or medically-supervised withdrawal in jail, denial of admission to other addiction treatment modalities and recovery support services, denial of pain medication, denial of the right to speak and assume leadership roles in local AA/NA meetings, and loss of child custody due to participation in MMT. Stigma-influenced methadone maintenance treatment practices include arbitrary dose restrictions, restrictions on duration of MMT, lowering methadone dose, disciplinary discharge for drug use, and shaming rituals (public queues to receive methadone, supervised consumption, separate bathrooms for staff and patients, observed urine drops for drug testing, discouragement of peer fraternization). (2009)

Medication or no medication, I know that recovery involves a reconstruction of personal identity, interpersonal relationships and daily lifestyle. The fact that some people need medication to achieve and sustain stable recovery does not change these broader recovery needs. Adding medication to a treatment milieu does not mean that other critical ingredients of recovery support can or should be deleted. It is my contention that combining the best of "drug free" treatment, medication-assisted treatment and peer-based recovery support services will create long-term recovery outcomes greater than any of these elements could achieve in isolation. When that day

comes, our past sectarian arguments over which approach is best will look petty, if not ridiculous. (2011)

When visible recovery role models promote an ineffective medication, the medication's lack of scientific support does little to reduce its potential cultural popularity (e.g., the Keeley Cure in the 1880s and 1890s); where medication-assisted recovery role models are professionally and culturally invisible, scientific evidence alone will not lead to a medication's professional or cultural acceptance (e.g., methadone). (2011)

Scientific validation of a medication's positive effects on clinical and recovery outcomes does not mean inevitable acceptance by policymakers, 2 service professionals, patients, patients' families, or the public. Historically, stigma trumps science. The greatest reduction in medication-related stigma comes not from acceptance of the belief that addiction or mental illness are brain diseases, but through identification with a beloved figure in recovery or persons in recovery from one's family, social, or occupational network that benefited from the particular medication.4 Stigma flourishes in the absence of clear, consistent, multi-year educational campaigns that convey and affirm the validity of scientific studies of addiction and its effective treatment. (2011)

One of the legacies of this history is that existing and new breakthroughs in the pharmacotherapeutic treatment of addiction may fail to be accepted and mainstreamed into clinical practice not because of lack of clinical effectiveness but due to unfounded fear of their potential iatrogenic effects. That early ineffective, harmful, and/or fraudulent medications used in the treatment of addiction wrapped themselves in the mantle of science (via fraudulent advertising or bad science) requires current clarification of who has the medical and moral authority within the US to make the definitive declaration of a medication's effectiveness or ineffectiveness. (2011)

People addicted to alcohol and other drugs are culturally perceived as hedonists concerned only with their relentless pursuit of unearned pleasure. Cultural acceptance of a medication used to treat addiction is thus contingent upon the medication being perceived as not providing further pleasure or, preferably, denying pleasure from drug use (e.g., naltrexone in the treatment of opioid addiction), or punishing further drug use (e.g., disulfiram in the treatment of alcohol addiction). Any medication depicted as a "replacement" or "substitute" for a primary intoxicant will be culturally rejected (e.g., methadone perceived as "legal heroin" and rejected on the grounds that it extends such unearned pleasure). Such rejection is unwittingly reinforced by otherwise knowledgeable addiction treatment professionals equating the effects of heroin and methadone and viewing medication-assisted recovery as not "real" recovery. (2011)

The clinical rationale for the use of medications must be reframed from what they suppress (e.g., withdrawal symptoms, crime, infectious disease transmission) to what they promote (metabolic stabilization, recovery initiation/maintenance, enhanced quality of personal/family life). (2011)

Recovery status is best defined by factors other than medication status. Neither medication-assisted treatment of opioid addiction nor the cessation of such treatment by itself constitutes

recovery. Recovery status instead hinges on broader achievements in health and social functioning – with or without medication support. (2012)

Groups associated with mainstream, abstinence-based treatment, such as the Betty Ford Institute Consensus Panel, have in recent years taken the position that the remitted, stabilized methadone maintenance patient who does not use alcohol or illicit drugs and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners meets the first of these defining elements of recovery. For MAT patients who achieve recovery via these three dimensions, continued participation in medication maintenance or eventual tapering and recovery without medication support represent varieties of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery. (2012)

Defining recovery within the context of MAT requires cultural and professional understanding of the distinction between addiction and physical dependence and, for the MAT patient/family, an understanding of the distinction between use of a medication as an aid to recovery and use of a drug as a threat to recovery. Debate will continue into the foreseeable future over whether the terms recovery and remission should be synonymous 4 or whether recovery involves more than remission (and whether recovery applies only to abstinence-based remissions). These are important distinctions. Remission involves the subtraction of pathology from a patient's life; recovery conveys ingredients added to a patient's life, e.g., remission plus the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and enhanced quality of personal/family life in the community. The emerging three-component definition of recovery has profound implications for the future design, conduct, and evaluation of addiction treatment and related recovery support services. (2012)

Methadone Maintenance

My personal views on methadone maintenance (MM) have undergone profound changes over the course of four decades and through my work on this project. In my early career, I exhibited great animosity toward methadone as a result of my enculturation in drug-free therapeutic communities and Minnesota Model alcoholism programs of the 1960s and 1970s. My early opinions were acquired first by osmosis and then from direct contact with people who had used illicit methadone as an intoxicant or who had used methadone to support their addiction careers—use for respite rather than recovery—and from contact with the least stabilized methadone patients and the worst MM clinics—clinics more nested in the culture of addiction than the culture of recovery. Those experiences all reflect part of the story of methadone and MM treatment, but I had interpreted these experiences as the whole truth. My attitudes toward methadone began to change when I went back to school and was forced to review the scientific evaluations of MM, but even that stage could be depicted as a begrudging intellectual acceptance of the value of MM for some people. In my gut, I still had deep reservations about MM. I simply had not seen living proof of the connection between methadone and long-term recovery. Then I began to meet a small number of people in methadone-assisted recovery who I admired a great deal and who exemplified what I judged to be an exceptional quality of life and service in recovery—on par with people I admired in recovery without the aid of medication. But I now realize that I still saw these few methadone success stories as morally enlightened exceptions.

When the ROMM project started, I believed in the potential of MM as a recovery aid intellectually, but I really did not know if there existed a large pool of people who had achieved full, long-term recovery within the framework of MM. I knew that if they existed in large numbers, they were well-hidden. It turned out they did exist and that they were exceptionally well-hidden. (2011)

Nothing has more profoundly changed my views on methadone maintenance than the voices of stabilized methadone patients. Their stories left me convinced of the potential role of methadone in long-term recovery, but appalled by the ways so many of these patients were forced to forge their recoveries not with the help of, but in spite of, the attitudes they encounter from professionals, from local communities of recovery, their own families and their local communities. These patients helped me understand MM in a new way, but even more importantly they changed how I felt about methadone in my belly. (2011)

The biggest surprise I had in researching the history of MM is that its scientific effectiveness has been established in spite of the absence of important recovery support ingredients as MM was mainstreamed in the U.S. and internationally. It made we wonder what MM outcomes would look like if MM was nested in a vibrant recovery culture and a rich menu of person-centered, professional and peer-based recovery support resources. (2011)

Methadone maintenance has never achieved full legitimacy as a medical treatment by the public, health care professionals, and the recovery community in spite of the overwhelming body of scientific evidence supporting it. The person enrolled in methadone maintenance has never received full status as a "patient," and the methadone clinic has yet to be viewed as a place of healing on par with hospitals or outpatient medical clinics. The professional status of methadone treatment has suffered from the absence of theoretical models of opioid addiction treatment and recovery that transcend a focus on the medicine to address the larger movement towards global health and community integration. (2009)

This tension between a milieu of engagement and empowerment versus a milieu of distrust and control left those being served caught between the status of a patient and the status of a prisoner/probationer and left the physician/nurse/counselor caught between their aspirations to serve as healers and onerous, regulatory-imposed policing functions. The result is a demedicalized system of methadone maintenance in which people entering methadone maintenance are treated more like criminals (or recalcitrant children) than patients within a relational world more dominated by surveillance and control than compassion and choice. (2009)

A campaign to lower stigma related to medication-assisted treatment/recovery must involve a set of clear messages related to the nature of addictive disorders, the nature of addiction recovery, the role of medication in recovery, and a statement of the harmful effects of stigma on treatment/recovery outcomes and on the family and larger community. These core ideas must be science-based, clear, capable of translation into educational slogans, and capable of altering perceptions, attitudes, and actions (as measured by pilot testing). (2009)

Recovery-oriented practices (those now known to be linked to elevated long-term recovery outcomes) within the early MM model included: 1) rapid access to treatment in early sites (e.g.,

New York City, Washington, D.C.); 2) patient involvement in clinical decision-making; 3) methadone doses (usually 80-120 mgd with no dose ceilings) capable of suppressing withdrawal distress, reducing craving, and inducing a "blockade effect" to other opioids; 4) therapeutic responses to any continued drug use; 5) a chronic care perspective that placed no arbitrary limits on duration of MM participation; 6) emphasis on creating a strong therapeutic alliance with each patient; 7) use of recovering staff as role models; 8) development of programs for populations with special needs; and 9) the broader mobilization of community resources to respond to addiction, including long-term recovery support needs. (2010)

The regulation and mass diffusion of MM in the 1970s and 1980s was accompanied by changes in treatment philosophy and clinical protocols. The most significant of these changes in terms of recovery orientation included a shift in emphasis from personal recovery to reduction of social harm; increased preoccupation with regulatory compliance; widening variation in the quality of MM programs; the reduction of average methadone doses to subtherapeutic levels; arbitrary limits on the length of MM treatment; pressure on patients to taper and end MM treatment; the erosion of ancillary medical, psychiatric, and social services; and a decreased emphasis on therapeutic alliance between MM staff and MM patients….The public face of MM became defined by the worst MM clinics and the least stabilized MM patients. Professional, political, and public support for MM as a medical treatment for opioid addiction declined through the late 1970s and early 1980s until the value of MM was revived in the late 1980s as a public health strategy to address the spread of HIV/AIDS. In spite of these challenges, many MM treatment staff continued to promote a vision of recovery, and many MM patients achieved but were forced to hide their achievement of that vision to avoid the social and professional stigma attached to MM. (2010)

Since the early 1990s, there has been a revitalization of MM in the United States. This process has included: 1) the scientific reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies; 2) increased advocacy efforts by MM patients; 3) an expansion of national MM treatment capacity—most notably within the private sector; 4) national efforts to professionalize and elevate the quality of newly rechristened and accredited Opioid Treatment Programs (OTPs); and 5) an expansion of pharmacotherapy choices in the treatment of opioid addiction, e.g., buprenorphine/Suboxone/Subutex. These developments occurred amidst renewed efforts to publicly and professionally portray opioid addiction as a brain disease that can be medically managed with the aid of methadone and other pharmacotherapies. In spite of such advancements, resistance and hostility toward methadone continue from many quarters. (2010)

The future of MM in the United States rests on the collective ability of OTPs to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of public education and political/ professional influence. It also rests on the mobilization of a grassroots advocacy movement of MM patients and their families. An important next step in the developmental history of MM is to define recovery within the context of methadone maintenance and within the broader pharmacotherapeutic treatment of substance use disorders. (2010)

There is growing professional consensus that the stabilized methadone maintenance patient who does not use alcohol or illicit drugs, and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners, meets the first criterion for recovery. MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the use of methadone as a medication. For the stabilized MM patient, methadone is NOT a substitute for heroin: the motivations for, effects of, and cultural symbolism of using methadone as a medication are vastly different from those associated with heroin use. (2010)

The stabilized MM patient is caught in an ambiguous world—separated from cultures of active drug use, denied full membership in cultures of recovery, and socially stigmatized in the larger community. It is time for recovering MM patients to be welcomed into full membership in the culture of recovery and afforded opportunities to pursue full citizenship in their local communities. (2010)

It is unlikely that the recovery status of the MM patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MM patients and their families stand together to offer living proof of the role methadone can play in long-term recovery from opioid addiction. The faces and voices of healthy, fully functioning MM patients will be the most powerful antidotes to the stigma attached to opioid addiction and methadone maintenance treatment. (2010)

There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering. Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or buprenorphine/Suboxone/Subutex) represent personal styles of recovery and should not be framed in categories of superiority or inferiority, right or wrong, or recovery inclusion or recovery exclusion. Rather than a source of disqualification from recovery status, methadone, provided as a medication under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized. (2010)

Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines methadone pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—recovery defined here as remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration. (2010)

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—referred to here as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery

support resources). Eight arenas of service practice will be profoundly transformed in the move toward ROMM: 1) attraction, access, and early engagement; 2) assessment and service planning; 3) service team composition; 4) service relationships; 5) service quality and duration; 6) locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term recovery check-ups, stage-appropriate recovery support, and, when needed, early re-intervention. (2010)

At a conceptual level, few would argue that an otherwise abstinent opioid addicted person who took statins for high cholesterol, insulin for diabetes, SSRIs for depression or a nicotine patch to prevent return to smoking would still be considered 'in recovery'. Is that same, otherwise abstinent individual who takes maintenance doses of methadone or buprenorphine as prescribed so very different? (McLellan and White, 2012)

Key aspects of methadone maintenance (MM) critical to recovery outcomes were weakened during the period of increased regulatory control and mass dissemination of MM. These changes included a shift in focus from personal recovery of the patient to reduction of social harm; decreased emphasis on the therapeutic alliance between MM staff and MM patients; a move toward standardized versus individualized dosing protocols (e.g., minimal variation in prescribed dosages); the reduction of average methadone doses to suboptimal levels; arbitrary limits on the length of MM; pressure on patients to taper and end MM; and the progressive erosion of medical, psychiatric, and social services within MM clinics. The call for recovery-oriented methadone maintenance (ROMM) is an effort to retrieve and amplify a patient-centered approach to the treatment of opioid addiction. (2012)

Money

It is better to have an unfunded or under-funded movement than to have a well-funded movement whose mission is corrupted by the source or level of that funding. It is better to have the inception of a movement postponed than to have that birth prematurely induced by money that deforms its subsequent development. (2000)

Carefully heed the adage 'he who pays the piper picks the tune'; find your own voice and sing only your own song. Be aware of seeking funding from any source that changes, no matter how subtly, your thinking, your vocabulary, your mission, or your methods. (2000)

The principle of stewardship demands that we monitor the resources that flow into and out of recovery movement organizations to assure that resources that once passed through the organization into the community, do not begin to remain in the organization. (2000)

…too much money, too little money, ill-timed money and tainted money could kill this [recovery advocacy] movement. (2001)

Multiple Pathways of Recovery

If there is anything modern research on recovery is teaching us, it is two critical lessons: people with alcohol and drug problems—even the most severe of such problems—are not a

homogenous population, and there are many pathways and styles of long-term recovery. These growing varieties of recovery experience should be cause for celebration, not a trigger for defensiveness. As Professor Strang suggests, "We need to come to terms with the imperfection of any one model, and recognize that we need different-sized beds for people of different sizes." (2013)

Narcissism, Recovery and the Power of Listening

…addiction recovery through Twelve Step programs provides a fundamentally different approach to Narcissus—the "destruction of self-centeredness." That approach is not to get further into oneself (although it includes some intermediary steps that do just that), but to connect with resources and relationships BEYOND the self. Twelve Step programs are at heart about breaking out of the narcissistic shell. The language of the Steps is not a language of "I and my" but a language of "we and our." Twelve Step programs are about mutual identification, repairing past relationships, forging new authentic relationships, forging a relationship with a "power greater than myself," and service to others. In the view of AA, NA, and other Twelve Step Programs (and many faith-based pathways to recovery), the ultimate antidote for Narcissus is not getting deeper into oneself, but getting out of oneself. (2013)

Addiction shrinks one's world to a state of stark self-imprisonment. As the person-drug relationship devours everything else of value, nothing remains that cannot and will not be sacrificed. And as the drug then devours the self, what remains are only manipulative masks interchanged so quickly that any sense of "true self" remains as only a faint memory. This shell, now masquerading as a person, burns its way through the world leaving human wreckage in its wake--all wounded by addiction's self-centeredness, dishonesty, disloyalty, depravity, and brutality. …Extreme narcissism—*self-will run riot* in the language of Alcoholics Anonymous—is the essence of addiction regardless of whether one sees this trait as a cause or consequence of addiction. It is a paradoxical entrapment manifested in self-absorption (self-inflation and exploitation or self-deflation and serial victimization) and deteriorating capacities for self-care. These styles of self-deception exist within a person fighting to retain and assert his or her fading humanity. These are the Janus faces of addiction—the Dr. Jekyll and Mr. Hyde of addiction fame. For many, recovery begins not in getting deeper into that split self, but finally getting out of oneself. Listening can be the beginning of that leap out of self into community—the essential step in a process of mutual identification. It also can be, and often is, the first act of service in recovery. Identity reconstruction and story reformulation are critical components of addiction recovery. Such restorying—what it was like, what happened, and what it is like now—is shared across secular, spiritual, and religious pathways of recovery. But reconstructing that new identity/story requires building blocks of ideas, words, and sentiments that are best acquired through acts of listening. Recovery is about breaking out of isolation into connection and community. Listening is the first step out of *I* and the first step into *we*. Listening is the way we place our own story within the context of a larger community of recovering people. Hearing the testimony of others—truly listening with heart as well as ears—stirs belief that a new redeemed self can rise from the ashes of a damaged and depleted self.

Narcotics Anonymous

All 12-Step programs are distinguished by the belief that the central mechanism of addiction recovery is a process of spiritual awakening, and that this awakening can occur as an experience of sudden transformational change or (more commonly) unfold over an extended period of time. This spiritual transformation, which is generally viewed as a product of "working" the 12 Steps, begins with an admission of the need for complete surrender ("We admitted that we were powerless over our addiction, that our lives had become unmanageable"). Through this act of submission and the rise of hope ("Came to believe that a Power greater than ourselves could restore us to sanity") comes the willingness to do anything to recover and the acknowledgment that no future drug use of any kind is possible if insanity and death are to be avoided. NA's philosophy of complete abstinence is rooted in the collective experience of its members that all past half measures resulted in pain and tragedy in spite of great and repeated assertions of personal will. (2011)

The growing varieties of NA experience may or may not in the future include room for people in medication-assisted recovery. Only history can answer the question of whether or not local NA groups' stance on restriction of participation for persons in medicationassisted addiction treatment will come to be viewed on par with early AA groups' restrictive membership rules designed to keep out "beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women, " 201 or whether that stance will be viewed as a critical step through which NA protected the integrity of its program of recovery and, by doing so, contributed to the development of new addiction recovery support societies. (2011)

The consensus forged in the 1980s on the need for a distinct NA culture has continued to grow and solidify. With this consensus came more widespread abandonment of AA- and treatment-infused language (e.g., "drugs and alcohol," "cross-addicted," "addict and alcoholic," "clean and sober," and "sobriety") and the embrace of NA language ("addiction," self-identification as an "addict," "clean," and "recovery from the disease of addiction"). Etiquette surrounding meeting language and rituals was further clarified through the widespread distribution of the "Clarity Statement" (an excerpt from NA World Services Board of Trustees Bulletin #13) and the pamphlet An Introduction to NA meetings. Those attending NA today are more likely to encounter only NA literature and NA speakers, a focus on solution-focused rather than problem-focused communications, heightened and sustained NA service activity, and rigorous efforts to adhere to NA Traditions. Also evident are NA members in long-term recovery remaining active in NA rather than disengaging or migrating to another fellowship. (2011)

No addiction recovery mutual aid organization in American history was birthed in a more culturally hostile environment than that faced by NA in the 1950s. (2014)

NA is the only major recovery mutual aid organization that defines the addict's essential problem as powerlessness over a process of addiction rather than powerlessness over a particular substance.(2014)

NA openly acknowledges modeling itself on AA in its beginnings, but today's NA has its own distinct program of recovery and its own recovery culture. (2014)

NA has distinguished itself through its survival as an organization and its 60 years of service toward the singular goal of addiction recovery. It has earned a position of honor within the growing menu of secular, spiritual, and religious recovery mutual aid organizations. As addiction professionals, we have a responsibility to become knowledgeable about NA and the culture of local NA groups, to orient those we serve about NA and other recovery support options, and to assertively link those individuals who are interested in exploring NA as a pathway of long-term addiction recovery. NA's coming of age is a milestone worthy of acknowledgement and celebration. NA will continue to confront the internal and external challenges faced by all recovery mutual aid organizations, but in the year of its 60th anniversary, NA's future could not look brighter. (2014)

Powerlessness in Twelve Step Recovery

The paradox in the Sisyphus story is that one wins the struggle for control by abandoning the effort—experiencing power through the acknowledgment of powerlessness. The mountain and its endlessly repeated ritual constitute forms of imprisonment in which the cell door has always been unlocked. All you ever had to do was open the door and leave. Release and recovery are first and foremost a shift within one's own mind and a turning and walking away. In retrospect, it was so difficult and yet so simple. (2014)

Precovery

Precovery involves several simultaneous processes: physical depletion of the drug's once esteemed value, cognitive disillusionment with the using lifestyle (a "crystallization of discontent" resulting from a pro/con analysis of "the life"), growing emotional distress and self-repugnance, spiritual hunger for greater meaning and purpose in life, breakthroughs in perception of self and world, and (perhaps most catalytic in terms of reaching the recovery initiation tipping point) exposure to recovery carriers--people who offer living proof of the potential for a meaningful life in long-term recovery. These precovery processes reflect a combustive collision between pain and hope. …Unfortunately, it can often take decades for these processes to unfold naturally. If there is a conceptual breakthrough of note in addictions field in recent years, it is that such processes can be strategically stimulated and accelerated. Today, enormous efforts are being expending to accelerate precovery processes for cancer, heart disease, diabetes, asthma and other chronic disorders. We as a culture are not waiting for people to seek help at the latest stages of these disorders at a time their painful and potentially fatal consequences can no longer be ignored. We are identifying these disorders early, engaging those with these disorders in assertive treatment and sustained recovery monitoring and support processes. Isn't it time we did the same for addiction? (2013)

Radical Recovery

Radical recovery is the use of one's recovery from addiction as a platform to advocate social change related to the sources of and solutions to community-wide AOD problems. (2004)

Radical recovery is the discovery that changing oneself and changing the world are synergistic. (2004)

Radical recovery recognizes that visibility and voice come at a price within a society that continues to stigmatize those linked to AOD problems. It seeks only a vanguard of recovered and recovering people whose personal circumstances allow them to stand as living proof of the proposition that recovery is a reality for millions of people around the world. (2004)

Radical recovery is a sustained reflection on the sociopolitical and economic influences that influence AOD problems and policies. Radical recovery recognizes the existence of predatory industries that promote and profit from addictive products (see the work of Dr. Jean Kilbourne). When those with AOD problems are sequestered in ever-increasing numbers in jails and prisons, radical recovery asks: what individuals and institutions profit from such circumstances? It openly confronts the ways in which public health can be sacrificed for corporate gain. Radical recovery is the recognition that young men and women of color and disenfranchised whites have become the raw materials that feed the institutional (prison) economies of many communities. Radical recovery is willing to confront treatment professionals and treatment institutions that view people with AOD problems as a crop to be harvested for personal and institutional profit. Radical recovery is willing to expose hustlers masked as healers. (2004)

Radical recovery makes no claim other than one's own experience and is not threatened by experiences that are different. It affirms choice in recovery and celebrates the diversity of those choices. Stated simply, its motto is "recovery by any means necessary." Radical recovery also recognizes that shared pain and redemption are the foundation of communities of recovery and that such kinship of suffering and rebirth transcends the boundaries of gender, race, social class, developmental age, sexual orientation, religious beliefs, and political affiliation. It seeks to extend the influence of those relational communities outward into the world. (2004)

A radical recovery movement is now rising in America. That movement is flowing from the realization that addiction and its progeny of problems are visible everywhere, while recovery from addiction lies hidden. It is rising in the recognition that the stigma attached to AOD problems has increased in recent decades and has fueled the demedicalization and recriminalization of these problems. What started out as "zero tolerance" for drugs rapidly evolved into zero tolerance for people with AOD-related problems. It is in this regressive climate that a style of recovery is emerging that is radical in its scope (focus on environmental as well as personal transformation), radical in its inclusiveness (celebration of multiple pathways and styles of recovery), and radical in its synthesis of social responsibility and personal accountability. People in recovery are looking beyond their own addiction and recovery experiences to the broader social conditions within which AOD problems arise and are sustained. A radicalized vanguard of people in recovery is using personal transformation as a fulcrum for social change. They are living Gandhi's challenge to become the change they wish to see in the world. Those who were once part of the problem are becoming part of the solution. (2004)

A radicalized recovery—even a culturally and politically conscious recovery—recognizes that recovery is a political as well as personal act. A day may come when recovery will be

initiated as an act of cultural protest—a strike through which we refuse to feed licit and illicit drug industries, the prison industrial complex, predatory treatment institutions (those that care more about corporate profit than patient progress) and all their sub-industries. We need people to remind us that addiction is a story of personal vulnerability, but that it is at the same time a story of collective vulnerability—vulnerability rooted in particular historical, social, economic and political circumstances. We need people who remind us that addiction is also a manifestation of historical trauma, class warfare and community degeneration. (2011)

Secular, spiritual, and religious recovery mutual aid groups will continue to expand within the U.S. prison system as will other programs of peer recovery support. But a more radicalized approach to recovery is also coming in which indigenous leaders will castigate those individuals, industries, and institutions that profit from addiction and call for recovery as a political as well as personal act—an act of collective liberation as well as personal redemption. Make no mistake, that day is coming. (2014)

As a treatment and recovery historian, I have noted with great fascination the potential link between personal destiny and historical progress. Some of you may not yet be aware of it, but you were born for this moment in time. Some of you may still be wondering if there is a larger purpose behind why you achieved recovery against so many odds. There may be a larger purpose buried within the answer to that question. Are you ready to help make some history? (2014)

Recovery (Defining)

"Recovery" can entail a complete elimination of AOD use and AOD problems AND it can also entail a significant reduction in such use and problems. Recovery from addiction, like recovery from other serious medical disorders, can involve patterns of full or partial remission. AA recognized this continuum of outcomes from its inception; it was one of the first alcoholic mutual aid societies that did not threaten to expel members who relapsed. AA asked not for perfection but for progress; the requirement for membership was defined not as the achievement of permanent sobriety but a "desire to stop drinking." Recovery is the process of bringing alcohol and drug problems into a state of stable remission. From individual to individual, that process may require many diverse strategies and steps. (2000).

Ironically, generating consensus on a definition of recovery may be the most difficult part of building this conceptual foundation. The proposition that there are multiple pathways to recovery has been one of our key kinetic ideas. It is time for us to define recovery, chart those pathways and then protect this precious concept from commodification and commercialization as the movement spreads and matures. (2005)

Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for substance abuse or substance dependence) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational, and occupational health. (2006).

The addiction field's failure to achieve consensus on a definition of "recovery" from severe and persistent alcohol and other drug problems undermines clinical research, compromises clinical practice, and muddles the field's communications to service constituents, allied service professionals, the public, and policy makers. (2007)

…the recovery concept risks reification, commodification, commercialization, and over-extension. The innumerable threats to the promises of the recovery paradigm render the task of defining recovery and maintaining the integrity of that definition an extremely important task. (2007)

…an ideal definition of recovery would meet six criteria: 1) precision (captures the essential nature and elements of the recovery experience), 2) inclusiveness (encompasses diverse recovery experiences, frameworks, and styles), 3) exclusiveness (filters out phenomena lacking essential recovery ingredients), 4) measurability (facilitates self-assessment, professional evaluation, and scientific study), 5) acceptability (to multiple constituents), and 6) simplicity (elegant in its clarity and conciseness). (2007)

A particular definition of recovery, by defining who is and is not in recovery, may also dictate who is seen as socially redeemed and who remains stigmatized, who is hired and who is fired, who remains free and who goes to jail, who remains in a marriage and who is divorced, who retains and who loses custody of their children, and who receives and who is denied government benefits. (2007)

The term "recovery" is best reserved for those persons who have resolved or are in the process of resolving severe AOD-related problems that meet DSM-IV criteria for "abuse" or "dependence" (APA, 1994). The less medicalized terms, quit and cessation, more aptly describe the problem-solving processes in cases marked by less severity. The broader term resolution embraces both patterns of problem solving. (2007)

A definition of recovery should avoid restricting the boundaries of recovery to a particular framework, strategy, or style of recovery. (2007)

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD- related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (2007)

The term recovery refers to the process through which individuals with severe AOD problems resolve these problems, improve their global health and enhance their participation in and contributions to the life of their communities. (2012)

The cultural and professional stigma linked to MM [methadone maintenance] and other forms of MAT [medication-assisted treatment] has been fueled by street myths, exploitive media caricatures, and inflammatory rhetoric from those with vested interests in competing treatment modalities. It has been further fueled by the cultural and professional isolation of OTPs and by

the entire addiction treatment field's inability to provide sustained education to patients and their families, addiction and allied professionals, policy makers, and the public on the clinical and scientific foundations and effectiveness of MAT. At the very core of this stigma is the deeply imbedded idea that recovery from opioid addiction does not begin until the day the use of medications like methadone and buprenorphine ends. Recovery from no other chronic health condition rests on such a proposition. (2012)

For us, recovery has three potential meanings. The first is the movement from a state of illness and isolation to a state of health and connectedness. In the addictions arena, this end state has been recently defined in terms of sobriety, improvement in global health, and citizenship. In the mental health arena, recovery has been described in terms of medical/clinical recovery (no longer meeting diagnostic criteria of active illness) and functional recovery (a socially connected and meaningful life in the community). Many people who have suffered severe behavioral health disorders achieve such full remission, with "recovery" depicting the process through which hope and health have been initiated and sustained. A second meaning of recovery is the process through which one actively manages and transcends the symptoms of persistent illness to achieve improved quality of life and functioning. This means that some symptoms of the illness may continue to ebb and flow (e.g., cravings, obsessive thoughts, emotional distress), but they cease being the controlling center of one's personal, family, and social life. For historically traumatized and oppressed populations, recovery may also involve drawing upon the historical resilience of a people and the assertion of personal and family health as an act of political resistance or cultural survival. We see in these patterns of recovery quite different styles of personal relationship to illness: escaping illness, making peace with illness, and doing battle with illness. (2013)

Recovery

If by people you mean the public, they need to know what it is (most of the public sees recovery as people who are trying to get their lives together rather than as an achieved and stable status). They need to know that recovery is a vibrant reality in the lives of millions of individuals and families. They need to know that there are many pathways and styles of recovery. And they need to know that participation in professional treatment, peer-based recovery support services, and recovery mutual aid societies are particularly important for people with the most severe and complex substance use disorders. They need to know that recovery flourishes in supportive communities. Communities cannot expect recovery if they do not provide the physical, psychological, and social space for it to grow. (2011)

The beginning of wisdom in addiction recovery—at personal and professional levels—is the recognition that what is required to sustain recovery is quite different than what is required to initiate recovery. Medical or social detoxification programs—and brief treatment programs—can help initiate recovery more effectively and more safely than at any time in human history, but such brief stabilization does not on its own represent a sustainable achievement. It only addresses acute life-threatening medical crises and provides a window of opportunity for movement towards long-term recovery maintenance. What we know from research on the course of recovery is that the point of recovery stability (point at which risk for lifetime recurrence of a substance use disorder drops below 15%) is 5 years—the same remission stability point often noted for cancer survivors. What this means is that acute biopsychosocial stabilization needs to

be followed, particularly for those with the most severe and complex addictions, by sustained professional, peer, and family support. (2013)

What is the message that you would like the general public to learn about recovery? Here is my top 10 list:

1. Addiction recovery in America is quite prevalent but, until recently, culturally invisible, with more than 23 million Americans and their families now reporting that they once personally experienced, but no longer experience, alcohol and or other drug-related problems.
2. There are multiple (secular, spiritual, and religious) pathways and styles of recovery and all are cause for celebration.
3. Addiction recovery is contagious: It can be interpersonally transmitted from people in recovery and their professional allies to people actively addicted.
4. At a community level, addiction recovery is spread by recovery carriers—people in recovery who make recovery infectious through the quality of their lives, their character, and their visible message of hope to others.
5. The density of recovery carriers within a community can be strategically increased, opening potentially new strategies for community outreach and long-term recovery support.
6. Communities can address problems of addiction, in part, by openly inviting and eliciting recovery commitments from its addicted citizens ("Recovery by any means necessary under any circumstances") and by providing local landscapes (the physical, psychological, and social spaces and the policy environment) in which recovery can flourish.
7. The creation of recovery landscapes—science-based professional care, recovery mutual aid organizations, recovery support institutions (recovery community centers/homes/schools/industries/ministries) and vibrant local recovery cultures—shift the focus of support from one of "recovering from" to one of "recovering to" a meaningful and contributing life in the community.
8. There are whole communities wounded by addiction and related problems that are in need of a collective, community-wide recovery process; people in recovery can play a key role in sparking and supporting this healing process.
9. Recovery can give back to individuals, families and communities a portion of the toll addiction has taken.
10. People who were once part of the problem can be culturally mobilized to become part of the solution. (2013)

Recovery without justice is a strained and haunted recovery. The earliest members of Alcoholics Anonymous learned on the anvil of their experience that key actions were required to bring justice to their lives and the forgiveness from others and self-forgiveness that it could garner. Those essential steps included rigorous self-inventory (honest accounting), confession (admission of guilt), restitution to those harmed (amends), and unpaid acts of service (helping others). Whether one is recovery within a Twelve-Step fellowship or through another pathway of recovery, those four steps are the best strategies ever developed to ameliorate guilt for past injury to others….We may fear justice within the recovery experience, but recovery without justice is an incomplete and festering recovery. Recovery with justice allows us to bury the ghosts of the past and to live with ourselves in the present. Any talk of rights in recovery must

be tempered with and grounded upon justice—the embrace of responsibility that is at the heart of recovery. (2014)

We are only at the beginning of our understanding of the long-term trajectories of addiction and recovery and identifying the types, intensities and durations of supports that exert the most positive effects on such trajectories. (2014)

….addiction recovery is often portrayed as a slowly unfolding process with the potential for progression and regression along the journey. And the stories of many people in addiction recovery precisely fit these depictions. But there is another style of recovery initiation that differs significantly from staged change (SC) in that it is sudden, unplanned, profound, positive, and permanent—a recovery conversion experience in which one's life is forever cleaved into the categories of "before" and "after" in a matter of moments. This style of recovery has been christened *quantum change* or *transformational change* (TC). SC is like spilled molasses inching its way across a table; TC is like a lightning strike to one's brain or heart….The TC experience serves as a catalyst for addiction recovery, not by removing alcohol and drugs from an otherwise unchanged person, but by birthing a new self in which alcohol and other drugs have no role. We who have been called to work in this ministry of recovery would be well advised to respect the potential for such mysterious and positive processes of change—in those we seek to help and in ourselves. (2014)

…the promise of recovery must offer more than the removal of alcohol and other drugs from one's life. For the person staring into the abyss, the promise of recovery to a life of meaning and purpose may be far more potent than the promise of recovery from addiction. That's why as a world we need more than the faces and voices of people who have recovered from addiction; we need the faces and voices of people in recovery who have recovered to do things of great personal and social meaning with their lives. The message must move beyond recovery is possible to the declaration that, with recovery, anything is possible….I am not calling for tales of extraordinary achievement by a small cadre of recovery superheroes. Nor am I calling for more recovery celebrity stories. I am instead calling for a greater emphasis on the personal and social contributions of the mass of people in long-term addiction recovery. (2014)

To those who've been given a new life, what are you doing to put recovery into the wind? Is it time you further extended your heart, your voice, your hands? There are people just beyond your present reach who need your experience and your guidance. They will soon be searching for you. Get ready. To addictions professionals, what are you doing to carry recovery outside the confines of your paid duties? When civilians ask you about how difficult your work must be, do you tell them the joys of your work—what it is like to see individuals and families transformed by the miracle of recovery? Are you putting the good news of recovery into the wind? New expectations are coming for you to do so. Get ready. To the recovery advocates whose faces and voices are already in the wind, are you doing what you need to do to sustain this special form of service work? Are you aware that others are coming to join you? They will arrive soon. Get ready. To those still suffering, listen for the wind. It is coming to get you. You must be prepared to step into it. Recovery is in the wind. Its season has begun. We must all get ready. (2013)

Recovery Advocacy Movement

It is time for a recovery movement. The central message of this new movement is not that "alcoholism is a disease" or that "treatment works" but rather that permanent recovery from alcohol and other drug-related problems is not only possible but a reality in the lives of hundreds of thousands of individuals and families.…It is time we (the remnants of the existing alcoholism/treatment movements) redirected our energies from an emphasis on pathology to an emphasis on resilience and recovery. (2000)

The major pitfalls of AOD-related mutual aid and advocacy groups have included mission diversion, ill-conceived or ill-defined core ideas, ideological extremism, commercialization, professionalization, charismatic leadership, organizational isolation, external co-optation, premature and superficial success, and unmanageable growth or attrition. (2000)
The twin threats of professionalization (preoccupation with power/status) and commercialization (preoccupation with money/property) have often proved fatal to advocacy movements. (2000)

The successes and potential vulnerabilities of mutual aid societies, treatment institutions, and social advocacy organizations often flow out of how they relate to the wider community. The gravest dangers emerge from two excesses. The first is sustained isolation from the community, a stance that is often a precursor to cult-like extremism…. The opposite danger lies in such over-involvement in the community that the organization is vulnerable for colonization by more powerful forces…. Effective recovery movement leaders carefully monitor changes in their operating environment and regularly ask, "What does this unfolding event and the culture's response to it reveal about the status of our mission and our methods?" (2000)

There is danger that movements focusing on reducing stigma prematurely claim victory in the face of a positive media attention or sudden (but often superficial) shifts in public opinion. The fastest way to kill anything in America is to turn it into a superficial fad that dies from distortion and over-exposure. The most insidious death of the recovery movement could occur if the essence of that movement died while the illusion of its continued existence remained. This would be an invisible death--a death by value dilution and corruption. (2000)

The means used by movements to achieve their mission must be congruent with that mission. Recovery movements must be, above all, grounded in recovery values: honesty, simplicity, humility, gratitude, and service. (2000)

Before the recovery movement can confront stigma in the larger society, it must confront how that same stigma gets acted out as a destructive force inside the movement. (2000)
Movements that are created to advocate on behalf of the most disempowered often leave these very individuals behind as the focus of the movement seeks wider social acceptance. (2000)
Three overlapping roles can be found in the history of destigmatization movements: moral entrepreneurs, business entrepreneurs, and technocrats. A movement's fate is dictated in part by which of these roles dominate at different stages of the movement. (2000)
Movements that acquire visibility and influence often generate their own counter-movement….
Counter-movements germinate within the soil of a movement's excesses. (2000)

A day is coming when we will gather at state capitals and in our nation's capital and you will see recovering people in every direction as far as the eyes can see--all offering themselves as LIVING PROOF that recovery is not just a possibility but a living reality. On that day, young people with a month of hard-earned sobriety will march beside men and women with 50 years of sobriety. On that day, families will walk to honor their survival as a family and to celebrate their own personal recoveries. On that day, those who have lost a loved one to this disease will walk to save others. On that day, AA and NA members will walk beside SOS and WFS members. Those in supported recovery will walk beside those in solo recovery. Those from therapeutic communities will walk beside those in methadone-assisted recovery. On that day, we will set aside our differences and march arm-in-arm as a multi-hued network of local communities of recovery. (2001)

It is only by constructing our own identity as people in recovery and transcending the categories that separate us that we can transform our personal experiences into a new recovery advocacy movement. It is time we celebrated this coat of many colors that the recovery community has become. Our goal must not be to speak with one voice, but to share a recovery identity out of which we will speak with thousands of voices that achieve harmony on one issue: the potential for transforming and enduring recovery from addiction. (2001)

There are whole professions whose members share an extremely pessimistic view of recovery because they repeatedly see only those who fail to recovery. The success stories are not visible in their daily professional lives. We need to re-introduce ourselves to the police who arrested us, the attorneys who prosecuted and defended us, the judges who sentenced us, the probation officers who monitored us, the physicians and nurses who cared for us, the teachers and social workers who cared for the problems of our children, the job supervisors who threatened to fire us. We need to find a way to express our gratitude at their efforts to help us, no matter how ill-timed, ill-informed and inept such interventions may have been. We need to find a way to tell all of them that today we are sane and sober and that we have taken responsibility for our own lives. We need to tell them to be hopeful, that RECOVERY LIVES! Americans see the devastating consequences of addiction every day; it is time they witnessed close up the regenerative power of recovery. (2001)

Some of you don't know it yet, but you were born to play a role in this movement. To those with long-tenured recovery, we need your wisdom, your stability, your hard-earned serenity. To those new in recovery, we need the freshness of your pain and the fervor of your passion. To those family members who have lived through the devastation of addiction and the demands of recovery, we need your love and patience and invite you as equal partners into the leadership of this movement. To the children who have lived in the shadow of parental addiction, we need your courage to break the intergenerational transmission of these problems. To those who have lost someone to addiction, we call on you to give that lost life meaning by wrapping it within your own story and passing it on to others. To professional helpers and other friends of recovery, we invite your involvement and challenge you to help us create recovery-oriented systems of care within local communities across the country. (2001)

The New Recovery Advocacy Movement is declaring that it is time for a vanguard of recovering people to stand up and announce their presence in this culture--NOT as members of any

identified recovery fellowship, but as members of a larger recovery community. This invitation explicitly includes family members in recovery. Even those of us who have lost loved ones to addiction must become more than saddened spectators of such loss. We must find a way to tell our lost person's story wrapped within our own story. We must witness for them as well as ourselves. (2001)

It is only when we reach a critical mass of people in America who personally know someone in stable recovery that attitudes toward addiction and the possibility of recovery will change. This is how attitudes toward a number of illnesses changed. The death sentence connotations of cancer, for example, changed only when known survivors of cancer reached a point of critical mass in the culture. The problem with addiction recovery is this: Most people already know someone in stable recovery from addiction but they don't know of this individual's recovery status because it has been withheld. It is when that status becomes known that people have to confront their own stereotypes about addiction and recovery. That's why "coming out" or "going public" (declaring one's stigmatized identity) is a political act. What the New Recovery Advocacy Movement is advocating is "reverse passing"--the creation of a cadre of people declaring their recovery status who could continue to "pass" if they chose to. One wonders what it would mean to those actively addicted and to the citizens of this country to witness people in incomprehensible numbers marching in Washington to proclaim their stable and enduring recovery from addiction. (2001)

The New Recovery Advocacy Movement does not need, is not asking, nor would desire, that all recovering people disclose their recovery status. What is needed is a vanguard of recovering people from all walks of life to challenge the stereotypes about addiction and recovery and to challenge the most objective forms of prejudice and discrimination. This vanguard will be to the New Recovery Advocacy Movement what the Freedom Riders were to the Civil Rights Movement. (2001)

The New Recovery Advocacy Movement is in part a declaration that recovering people should be speaking for themselves--should be playing a part in shaping the knowledge base of addiction medicine and addiction counseling as well as having a role in shaping social policies that affect the lives of addicted and recovering people. It is in the transition from personal recovery to social/political advocacy that recovering people discover the connection between telling their stories and changing the world. (2001)

If you think about individuals in recovery as a group of people with a common history, a distinct culture and a linked destiny, then you can look beyond addiction and recovery as a personal story and begin to see a larger story of people becoming aware of their status as "a people" and joining together for common cause. Where AA and other recovery mutual aid groups seek to reshape the personal story, the new recovery advocacy movement seeks to reshape the collective story. The former seeks to change the individual; the latter seeks to change the world. (2011)

You can reach a point individually and collectively where continued silence becomes an act of spiritual suicide. You can reach a point as a people where you must speak or never again be able to look each other in the eyes. You can reach a point personally where you must speak or never

be able to look into your own eyes without seeing the mask of an impostor. Pain can create such a collective/personal crisis, but only hope can turn it into a movement. (2011)

For a movement to flourish, selected members of closed groups must rise above their sectarian identities and forge a broader understanding of WE—a broader circle of identification of "my people." (2011)

I think recovery advocacy movements start with conversations from which rise both collective hope and a shared vision of how the doorway of entry into recovery could be widened. The vision must captivate and elevate, but it must also contain elements that are attainable in the short run. Movements feed on small successes that raise the possibility of big successes. One of my favorite verses from the Bible is, "Where there is no vision, the people perish," but a movement can exhaust itself with a vision disconnected from the realities of the movement's resources. "I have a dream" speeches are only as effective as the plans and programs that follow. The challenge of making a movement work "on the ground" is to chart a course between the dreamers and the doomsayers. Great achievements and great defeats produce equal threats to the future of a movement because they make it seem like everything is possible or that nothing is possible. (2011).

The spark for us was reaching a critical mass of people in addiction recovery who felt that the guiding visions of past generations of recovery advocates had been lost and that we had a duty to speak out not just as individuals but as a community. By speaking, I am not referring to the kind of emotional hemophilia that is in vogue in confessional writing and television exposés. I'm not talking about gushing the details of our past lives in public forums—details that offer great drama but offer little personal or policy guidance. And, most importantly, I am not talking about isolated individuals doing such speaking; I'm talking about thousands of people standing in unison to speak. I'm talking about the act of declaring one's status as a person in recovery in appropriate contexts and at appropriate times. I'm talking about proclaiming that recovery is both possible and a living reality for millions of individuals and families. I'm talking about offering living proof that people who have once been part of a problem are today part of its solution. Something very magical happened when we came together, not as AA or NA or SMART Recovery or Celebrate Recovery members, but as people in recovery—something none of us had experienced within our 5respective personal pathways of recovery. For the first time, we looked beyond our own stories and our own pathways of recovery and began to see ourselves as a people with a unique history and a shared destiny. What our shared stories revealed was that addiction crushed everything of value — everything we ever were or hoped to be, even the desire for life itself. And yet we learned that from these very ashes a recovery process can rise that leads to hope and a new life. The new recovery advocacy movement that is spreading around the world is a movement built on the hope and gratitude of the resurrected. (2011)

There is a new age cultural shtick suggesting that we must each find our own song to sing. That's easy for people in recovery. We have always felt pathologically unique and socially disconnected—always sung our own song, usually out of harmony with everyone around us. A movement of such emotional and relational iconoclasts, if it ever could be called a movement, would sound more like a Tower of Babel than a choir. The question for us as a people is not. "Can we each find our own personal song?" It is, "Can we find a place and a song that we can

sing with others in harmony?" And this is not just an issue of whether a movement can develop a central message and stay on message. It is about how to protect those who choose to participate in the movement. It is the awareness that standing by the hundreds and thousands reduces the enormous vulnerability that comes from standing in isolation to confront stigma and its multiple manifestations. (2011)

What we have achieved was born within a profound respect for the diversity of recovery experience and the legitimacy and wonder of such diversity. We spoke of a rainbow and a coat of many colors to capture our vision of a most culturally diverse movement, and we shared an ecumenical vision of a day when AA and NA members would walk beside people in secular recovery, faith-based recovery, medication-assisted recovery, and natural recovery with each of us not wearing our pathway identities but a larger identity: people in long-term recovery. (2013)

As early as 2000, five simple ideas emerged from the very heart of the movement—ideas that were foundational and kinetic (capable of inspiring action). Those five ideas were: 1) addiction recovery is a living reality for individuals, families, and communities, 2) there are many (religious, spiritual, secular) pathways to recovery, and all are cause for celebration, 3) recovery flourishes in supportive communities, 4) recovery is a voluntary process, and 5) recovering and recovered people are part of the solution: recovery gives back what addiction has taken from individuals, families, and communities. In retrospect, the selection of this particular set of ideas was critical to avoiding the schisms that have destroyed so many social movements. The first two of these ideas became the foundation for much of the consciousness raising and mobilization that went on in the early years and that continues today. (2013)

All social movements risk mistaking methods for mission and getting frozen at an early stage of movement development. We must avoid infatuation with the growing numbers of people participating in recovery celebration events and continually ask and answer, "Mobilization for what purpose?" Mission clarity is critical to movement maintenance. Implosion….All social movements at national and local levels are prone to centralized leadership, ideological closure, leadership and core membership exhaustion and the collapse of key organizations. These processes often spawn major schisms and mass movement defections. The greater the centralization of leadership, the greater is the risk of such things occurring. Strategies of leadership development, succession planning, and participatory models of decisionmaking are crucial preventatives and antidotes to such processes. All social movements are at risk of being hijacked by more powerful forces within their operating environment….If the recovery advocacy movement morphs solely into a PRSS [peer-recovery support services] appendage to the addiction treatment system, the movement will have failed and will recreate conditions that will set the stage for a future revitalized recovery advocacy movement. (2013)

No successful social movement has avoided a cultural backlash. Such backlashes are spawned by excesses within the movement itself and by established interests who experience threat from the movement's achievements and potential power. Such backlashes are intensified when they allow full expression of dormant prejudices related to highly stigmatized issues, e.g., addiction. (2013)

There are several steps needed to protect our leaders and our organizations. These steps include 1) rigorous adherence to financial stewardship, best practices related to fiscal management, and

financial transparency of our organizations, 2) development of ethical guidelines and ethical decision-making models to guide recovery advocacy and peer recovery support services, 3) rigorous self-evaluation and training related to how private behavior could harm leadership and organizational credibility, and 4) making sure the "faces and voices" of this movement are diverse and constantly rotating to minimize the targeting of any core leadership. Finally, when any person who has been a visible part of the movement experiences a fall from grace, whether through a recurrence of addiction or other delegitimizing behavior, it is important that we offer that person our full support for recovery re-stabilization, as we would for all others in need of such support. (2013)

I believe the next stage of movement development will be one of economic development. I envision a day soon when recovery community centers across the country will collaborate with recovery-friendly businesses and serve as incubators for small businesses started by and employing people in recovery. Such businesses will be particularly valuable for people in recovery who have been marginalized from the mainstream economy and/or who face special obstacles to employment due to their re-entry into the community from jail or prison. And I see a growing cadre of recovery philanthropists (large and small) investing in this economic development as well as supporting our core organizations. (2013)

There is a point in all social movements where the true ownership of that movement is tested. The new recovery advocacy movement is at that point. The question is whether people in personal or family recovery will take ownership of the future of this movement by financially supporting the national organization that coordinates the day-to-day work of the recovery advocacy movement. It is time that we who have harvested the fruits of recovery pay it forward with our time, our talents, and yes, our financial contributions. (2014)

Recovery Advocacy Participation by People without Recovery Experience

What is needed to connect to this movement is not a past status of addiction, nor a particular set of professional credentials, but experiences that allow a person to relate to recovering people from a position of humility and emotional authenticity and to enter into these relationships from a position of moral equality. It is also important to acknowledge that family members have been fully welcomed into the heart of this movement, including in leadership roles, and friends and allies are playing important roles in this movement. (2011)

Recovery Advocacy Movement Leadership

Who in recovery has not had messianic aspirations of saving oneself and then saving the world? But the last thing a recovery advocacy movement needs is a messiah. Few people in recovery could survive the pressure of such a role, and I don't know of a single successful movement that relied on a single charismatic leader or even a small cadre of such leaders. The long-term strength of these movements comes from what we do together. I-movements rise and fall while WE-movements endure. ….it is not safe for us to stand along. Attention can make the most stable recovery tremble. The glare of the camera and the beckoning microphone can be as intoxicating as any drug. Like Icarus flying too close to the sun, we are doomed in the face of such self-absorption—whether from overwhelming feelings of unworthiness or, perhaps worse,

from the feeling that we are the most worthy. It is only when we speak from a position of WE that safety and protection of the larger cause is assured. When asked, "Who is your leader?" we should declare that we are without leaders or that we are all leaders. The media wants a hero they can deify today and castigate tomorrow. The latter can be prevented only by preventing the former. Enemies of the movement want individual targets. Such targets must be either denied or carefully protected. (2011)

Charisma is a blessing and a curse to recovery mutual aid and recovery advocacy movements. It is something of a paradox that such movements often cannot survive their infancy without charismatic leaders, but cannot reach maturity without transcending charismatic styles of leadership…..The longer the intellectual, emotional and social life of the movement is centered on a charismatic leader, the less the long-term viability of the organization or movement. (2011)

Such [leadership] roles can bring deep fulfillment, but they also come with hidden risks. Vulnerability may be an aspect of all leadership roles, but this may be particularly pro- 9nounced in organizations organized by and on behalf of persons from historically disempowered groups. I recall one of my friends once noting of the civil rights organizations in which he was involved, "We don't elect leaders; we elect victims." He was referring to the tendency of these organizations to scapegoat their leaders while the leaders are living only to later reify them–often after their deaths. Within any stigmatized group, we want our leaders to excel—to model the best of what we can be. And yet the shadows of shame and inferiority buried inside us get projected onto our leaders in the form of doubt, criticism and attack. (2011)

Even under the best circumstances, these transitions can be difficult for the organization and for the individuals involved. We have a tendency toward strong, charismatic leaders because it is so difficult to launch and sustain recovery advocacy organizations. Once successful, we then have to figure our how to live with and without such leaders. And we have to manage the more common transitions of people entering and leaving participation in the movement. We need to build in permissions, procedures and processes for people to leave active participation in the movement. The movement itself is best conceptualized as a marathon run as a relay—people engaging and disengaging as needed over a prolonged period of time. Many people will come and go or return at particular times in the life of the movement, while others will be part of the daily struggles of the movement for the duration. That's just the way social movements are; this is not to say one style is superior to another. I am a great admirer of endurance and tenacity, but movements also need those who help in short bursts. (2011)

The alternatives to cult-like leaders require concerted leadership development efforts and the progressive decentralization of decision-making throughout the organization. AA and NA have done this through the framework of their traditions and service structures. Now this does not mean that we have to challenge and extrude our charismatic figures to achieve maturity, but it does mean that we have to help such figures redefine their roles and relationships—in short, to join the movement as members. When that doesn't happen, the organization/movement moves towards incestuous closure and the risk of eventual implosion (See Janzen's book, The Rise and Fall of Synanon). (2011)

Recovery Advocacy Movement (Internal Dissension and external Backlash)

As we are coming of age, we are also becoming more visible. Our growing numbers and influence will render us targets of powerful political and economic interests. Threatened interests from treatment agencies to the alcohol industry will seek to influence us, colonize us and, in some cases, discredit us. We need to develop protective shields for our organizations and our leaders. We need to examine our own internal vulnerabilities and make sure everything from our personal conduct to our finances can pass close public scrutiny. We need guidance on how to negotiate our way through the world of hard-core politics without losing our founding vision and core values. (2005)

Put simply, it is not safe for us to stand along. Attention can make the most stable recovery tremble. The glare of the camera and the beckoning microphone can be as intoxicating as any drug. Like Icarus flying too close to the sun, we are doomed in the face of such self-absorption—whether from overwhelming feelings of unworthiness or, perhaps worse, from the feeling that we are the most worthy. It is only when we speak from a position of WE that safety and protection of the larger cause is assured. When asked, "Who is your leader?" we should declare that we are without leaders or that we are all leaders. The media wants a hero they can deify today and castigate tomorrow. The latter can be prevented only by preventing the former. Enemies of the movement want individual targets. Such targets must be either denied or carefully protected. (2011)

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 (Granfield & Cloud, 1999). The interaction of problem severity and recovery capital shapes both the prospects of recovery and the intensity and duration of resources required to initiate and sustain recovery. (2006)

Recovery Capitalism

Recovery capitalism is a term that depicts the shift from a purely volunteer social movement to a movement with financial capital and other resources. As an example, successful recovery advocacy movement will speed the rise of an elaborate culture of recovery. The question is, "Who benefits from the sale of recovery culture trappings or the jobs created in the wake of the movement?" Historically disempowered communities (e.g., Native American tribal communities) have been invaded and plundered for generations by persons claiming to help who drew resources out of those communities and left nothing in return but feelings of betrayal and abandonment. That same thing could happen to communities of recovery. (2011)

There's a difference between a recovery community organization selling recovery trappings (T-shirts, books, tapes, etc.) whose profits underwrite local recovery advocacy and recovery support activities and a private vendor who chooses to exploit this personal renaissance for personal or institutional profit. In the former, resources are recycled as a continual process of recovery community development; in the latter, these products become pornographic via their lack of authenticity and their exploitive intent. Recovery capitalism within the latter tradition reduces the

movement to marketing slogans and trinkets and trash. The nature of capitalism is to objectify and commercialize everything. Movements of the heart must find a way to protect the spiritual from the material—to rise above such temptations within the movement and to protect the movement from such exploitation by outside forces. We must remind ourselves that at the core of this movement is a priceless gift—recovery—that cannot be purchased. The potentially corrupting influence of money must be actively managed. (2011)

Recovery Carriers

Those who spread such affection are recovery carriers. Recovery carriers—because of the nature of their character and the quality of their lives—exert a magnetic attraction to those who are still suffering. Recovery carriers affirm that long-term recovery is possible and that the promises of recovery are far more than the removal of drugs from an otherwise unchanged life. They tell us that we have the potential to get well and to then get better than well. They challenge us to stop being everyone's problem and to become part of the solution. They relate to us from a position of profound empathy, emotional authenticity, respect and moral equality—lacking even a whisper of contempt. (2010)

Recovery carriers are people, usually in recovery, who make recovery infectious to those around them by their openness about their recovery experiences, their quality of life and character, and the compassion for and service to people still suffering from alcohol and other drug problems….What they share in common is three observable traits: 1) people are almost magnetically drawn to them—even those needing but not actively seeking recovery, 2) they exude a kinetic energy that elicits confidence and readiness for action in those around them, and 3) people who spend time with them and stay connected to them seem to recover and achieve a high quality of life in recovery. (2012)

Credibility of recovery carriers inside communities of color is based on experiential knowledge (lived knowledge of the problem and its solution) and experiential expertise (the ability to translate personal knowledge into skills in helping others within the community—living proof of one's power as a healer). This vetting is guided by community elders and conveyed through community storytelling. It constitutes a credential that no university, professional association, or governmental body can bestow. (2012)

Recovery prevalence in a neighborhood, social institution (e.g., school or workplace), community, or culture is influenced by the density of recovery carriers—persons in recovery who are committed to carrying a message of hope to those individuals and families still experiencing AOD problems. The density of recovery carriers within a local community can be strategically increased through such activities as hosting regular recovery celebration events, honoring local recovery carriers, training recovery advocates and recovery coaches, and offering storytelling training to all persons in recovery. (2012)

Recovery Checkups

Imagine a day when everyone entering recovery will have an addiction-trained primary care physician and an addiction medicine specialist as sustained resources through the long-term

recovery process. On that day, we will have finally escaped acute care models of medical intervention that have treated addiction like it was a broken arm or a bacterial infection. On that day, addiction recovery and addiction medicine will have come of age in America. (2014)

Recovery Coaching

How do we understand how various support structures incite change in some addicts and resistance to change in others? It is in the unique match between the ingredients of such groups and particular individuals that we find the transformative power of mutual aid. To have this effect, the elements of group culture must strike cords of resonance at both personal and cultural levels. Where resonance exists, these elements become the raw materials used by the addict to reconstruct a sobriety-enhancing life story. The elicitation of this resonance involves an almost electrical mutuality of fit. There is in this dynamic interaction as much a sense of having been chosen as there is a sense of choosing a particular framework of recovery. It is both a "you belong with us" connection between the group and the individual and a "this is where I belong" connection between the individual and the group. The job of the guide is to help expand the community menu of such resources, to warmly introduce each client to these resources, to help eliminate the obstacles that stand between the client and his or her involvement in such resources, and to then witness and validate the potential power of these special connections between individuals and indigenous groups. The emergence of "guides" or "recovery coaches" could re-capture the best of what has been lost in the professionalization of the role of the addiction counselor. (2002)

What is most significant for the future of recovery mutual aid fellowships is that this new role of recovery coach is being rapidly commodified, professionalized, and commercialized. As noted above, this could have the potential of heightening ambiguity and conflict between the roles of sponsor, recovery coach, and addiction counselor in the short run and, in the long run, potentially eroding the service ethic within communities of recovery. It will also stir heightened controversy about whether people are trying to "sell the program." Any trend that increases paid recovery support at the expense of volunteer service work in support of one's own recovery and as an expression of gratitude has the potential of injuring recovery mutual aid societies and the larger community. (2010)

The rise of new peer-based recovery support roles also promises, at personal and at systems levels, a reconnection of acute addiction treatment to the larger and more enduring process of long-term recovery. (2010)

My personal vision is that the RC will provide the human connecting tissue within an increasingly fragmented and impersonal professional service system, and will serve, for some, as an alternative to that system. I see the RC as the person who has your back through the process of pre-recovery engagement, recovery initiation, the transition to stable recovery maintenance, and the achievement of enhanced quality of personal/family life in long-term recovery. (2011)

RCs are now being employed within addiction treatment organizations (particularly in the areas of outreach and post-treatment continuing care) and child welfare and criminal justice initiatives. They are working in paid and volunteer roles within recovery community organizations, and they

are working in independent roles within a new form of private practice. Everyone else in the system is acting like recovery is a hundred yard dash; the RC is saying, "Pace yourself, this is a marathon!" (2011)

Recovery Coaching versus Sponsorship

"If there are sponsors (SP), why is there a need for a recovery coach (RC)?" In spite of key similarities between these roles (e.g., their recovery focus and service relationships grounded in moral equality and emotional authenticity), there are marked differences. Where the SP works within a particular framework of recovery (e.g., a Twelve Step program), the RC is trained to work across the span of religious, spiritual and secular frameworks of recovery. Where the SP is free and even expected to impose his or her view of recovery on the sponsee, the RC refrains from imposing such biases and is guided instead by a choice philosophy that recognizes the legitimacy of multiple pathways of recovery. Where the sponsorship relationship is based on reciprocity (the sponsor is there first and foremost to strengthen his or her own sobriety), the RC relationship is based on a fiduciary relationship in which the RC has a legal and ethical obligation to those receiving RC services. Compared to the sponsor role, most recovery coaches have more hours available per week to devote to recovery support services, work with a larger number of people at a time, perform duties that far transcend traditional sponsorship roles, are involved in activities that would be specifically precluded as a sponsor (e.g., advocacy) and are guided by organizational codes of ethics and professional supervision. (2006).

Recovery and Coercion

Coerced recovery is an oxymoron; one cannot be forced to be free. (2000)

Recovery Community

When we speak of "recovery community," these qualities take on added significance because of the shared wounds its members bring to their membership in this community. It is here that those who have never experienced sanctuary often discover a place where they feel physically and psychologically safe for the first time. Here one is accepted not in spite of one's imperfectness but because of the very nature of that imperfectness. It is here that, in discovering one's self in the stories of others, people discover both themselves and a "narrative community" whose members not only exchange their stories but possess a "shared story." Within such a community, one can find a deep sense of fit--a sense of finally discovering and connecting to the whole of which one is a part. The recovery community is a place where shared pain and hope can be woven by its members into life-saving stories whose mutual exchange is more akin to communion than communication. This sanctuary of the estranged fills spiritual as well as physical space. It is a place of refuge, refreshment and renewal. It is a place that defies commercialization--a place whose most important assets are not for sale. (2002)

A "recovery community" exists only to the extent that multiple and diverse recovery communities reach beyond their own geographical and cultural boundaries to embrace such an identity. Ernest Kurtz has suggested that the phrase "communities of recovery" may more precisely describe the actual nature of the recovery advocacy constituencies. I think this

suggestion is one worthy of consideration. Reminding ourselves that we are many communities bound together only by shared experience and a shared vision may counter efforts to foist an overly centralized and hierarchical structure upon this evolving movement. (2001)

Recovery Community Center

One of the most significant recent trends in the addictions field (and in related mental health, public health, and child welfare fields) is the emergence of peer-based and other recovery support services that are distinct from professionally-directed clinical services offered by addiction treatment organizations or other helping institutions. Peer-based recovery support services cover a wide range of activities not generally offered by treatment providers. Such services include but are not limited to peer support (e.g., recovery coaching), housing, transportation, vocational training, employment services, telephone support, support groups, system navigation, recovery resource dissemination, life skills training and sober social activities. A recent trend is to deliver these services through Recovery Community Centers. (2007)

Recovery Community Organizations

A recovery community organization (RCO) is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS). The broadly defined recovery community – people in long-term recovery, their families, friends and allies, including recovery-focused addiction and recovery professionals – includes organizations whose members reflect religious, spiritual and secular pathways of recovery. The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved. (2007)

Authentic RCOs are organized by and for individuals and families in recovery. Toward that end, they:

1. Assure recovery representation (maintain recovery representation greater than 50% at membership, board, and staff levels)
2. Assure recovery leadership (leaders are drawn from individuals and family members in recovery or allies vetted by communities of recovery; RCO is committed to peer leadership development activities)
3. Maintain singularity of purpose (focus is on addiction recovery as evidenced by their mission, core values, plans and activities)
4. Minimize problems of "double agentry" (people in key leadership roles do not also represent other institutional--ideological, political, financial-- interests that could undermine the mission of the RCO)
5. Seek diversification of funding (efforts are made to minimize the risk of colonization or corruption of organizational values by external authorities; funding is rejected that comes with

requirements that would compromise service relationships and relationships with communities of recovery)
6. Focus on long-term recovery at personal, family and community levels (recovery viewed as a process of intrapersonal, interpersonal and environmental transformation)
7. Distinguish their roles (from recovery mutual aid fellowships, professional treatment agencies and other agencies within the alcohol and other drug problems arena)
8. Respect multiple pathways of long-term recovery (recognize the legitimacy of multiple pathways of recovery and the rights of individuals/families to choose those pathways that best fit their needs and values)
9. Cautiously collaborate with kindred organizations (while resisting affiliations that would compromise their autonomy, integrity and mission)
10. Are responsible stewards (places recovery-focused services over personal or institutional aggrandizement and profit). (2009)

Recovery Disclosure

Recovery disclosure at the public level often flows from the transformation of personal experience into political awareness. Disclosure of recovery status at the public level is commonly followed by a period of acute self-consciousness that can give way to a feeling of personal liberation—what some experience as a "state of grace" (Goffman, 1963, p. 102). (2014)

Changing attitudes and policies towards addiction and recovery does not require that everyone in recovery disclose their recovery status at a public level. Such changes require only a vanguard of people in recovery who are temperamentally suited for such a role and whose life circumstances minimize any harm to self or others that can result from disclosures. (2014)

Recovery concealment ("passing") offers some level of protection to the individual, but buttresses the social conditions (e.g., public misperceptions, prejudices, policies, and overt acts of discrimination) that make concealment a necessary option. To be silent about one's recovery status is at the social/political level an act of conscious or unconscious complicity in addiction/recovery-related stigma. What is unsettling about the agitation of advocacy movements within stigmatized communities is that they bring past and present acts of such complicity into full awareness. (2014)

Disclosure of a socially stigmatized condition does not imply abandonment of rights to privacy. Each person has the right to disclose or not disclose and to define the boundaries of such disclosure. The decision to share one's recovery status and the decision to share the details of one's recovery story are quite different decisions as they represent far different levels of intimacy and vulnerability and require attention to the way in which these different levels of disclosure serve different purposes. (2014)

Recovery Identity

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 identifies with 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 as "alcoholics," "addicts," or "persons in recovery"), those with recovery-positive identities (those for whom the status of recovery from addiction has become an important part of their personal identities), and those with recovery-negative identities (those whose addiction/recovery status is self-acknowledged but not shared with others due to a sense of personal shame derived from this status). These identities, rather than being mutually exclusive, can constitute different points in a prolonged recovery career. (2006)

Recoveryism

Horvath rightly called our attention to a special form of bigotry sometimes exhibited by people who are grateful for their own brand of recovery. There are those in secular, spiritual, and religious pathways of recovery who have claimed ultimate eminence for their particular ideas and methods and viewed alternatives as inherently inferior. Radical abstentionists and radical medicationists continue acrimonious debates marked by more heat than illumination. Those who enter recovery with and without specialized addiction treatment have each claimed a form of superiority, as have those who maintain recovery with and without participation in recovery mutual aid groups. Each of these approaches is in turn subject to internal dissension about how that approach should best be pursued. (2013)

Internalized stigma can lead to status hierarchies and aggression toward members of one's own group. Members of one recovery pathway claiming superiority over another is analogous to status-based skin tone gradations dating from African American slave communities. Verbal attacks between representatives of different recovery pathways are psychologically analogous to Black-on-Black crime. Stigma is a form of psychological and social violence that elicits violence in kind as the oppressed mimic their oppressor. In the extreme, if you teach a people to hate themselves, you do not have to kill them; they will kill each other. Thus in active addiction, we see addicts preying on each other, and in recovery we see conflict within and between organized approaches to recovery support and addiction treatment….There is a healthy place within the recovery experience for self-satisfaction of one's achievement, but there is a line one can cross into the realm of self-pride, arrogance, and intolerance – a stance of "my way is the only way." This latter stance infuses recovery with the distorted thinking and character excesses of active addiction and represents an immature way we act out our damaged selves in our relationships with each other. It also represents a form of bigotry that mirrors the current paralyzing political wars in the U.S. and the violent religious and cultural clashes that seem to be tearing our world apart. (2013)

Recovery Journalism

Recovery journalism is using writing as a tool to reach our most important constituents: people seeking or in recovery, their family members and allies, and the people on the frontlines of helping them. It is a way of conveying experience, strength and hope to all of these constituents. It is also a way to carry a message of hope and the reality of long-term addiction recovery to the larger culture. The focus of this writing is not on the problem or methods of personal or cultural intervention but on the solutions that recovery offers individuals, families and communities. It is natural in one's early career in the addiction field to get captivated by the diverse menu of

psychoactive drugs and their psychopharmacology and to get enamored with learning about all manner of clinical pathologies. But the ultimate question in terms of our contribution lies in what we know about the solutions to the problem of addiction. I hope your students will get solution-focused far earlier in their careers than I did. That is all I am interested in at this stage of my life, and it is reflected in this style of recovery journalism I am pursuing. (2011)

Recovery Landscapes

Addressing AOD problems at a community level involves shrinking addiction spaces and expanding recovery spaces. The latter is happening at an unprecedented rate around the world based on the growing awareness that addiction recovery requires more than a personal decision. It requires a recovery-conducive world—physical and social environments and a diversity of community-supported recovery lifestyles within which individual and family recovery flourish. It is that world that recovery advocates are trying to create by expanding the recovery space within local communities. It is in this context that we are witnessing the growth and diversification of recovery mutual aid fellowships and the spread of recovery advocacy organizations, recovery community centers, recovery residences, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-focused sporting events and innumerable projects related to recovery and the arts (e.g., writing, theatre, film). What is occurring is recovery community building at a level of intensity never before seen in history. (2014)

How many spaces exist within your community within which addiction thrives compared to the number of recovery-friendly spaces? A young woman just home from weeks cloistered in an addiction treatment facility steps out of her doorway. Where will she go? Will she find spaces in which her fragile recovery status is welcomed, celebrated and strengthened? Or will she find…..? (2014)

Recovery Management

Mike Boyle and I began writing about recovery management in the late 1990s— advocating a fundamental redesign of addiction treatment that would move beyond brief, self-contained episodes of care toward a framework of longterm recovery support comparable to the best approaches to the management of chronic disease. We wrote and wrote, and it felt for the longest time that we were writing for only our own benefit. It was like yelling in an empty room and hearing nothing but our own echoes. But in a few years, everyone seemed to be talking about recovery management and recovery-oriented systems of care. It was then that we encountered people who told us how they completely changed their treatment programs after reading our early papers. We had no idea that was going on until much later. (2011)

Recovery and the Media

1. Distorted media coverage of active addiction fuels social stigma and contributes to the discrimination that many people in recovery face as they enter the recovery process
2. Media coverage of addiction recovery is rare and tangential.

3. The media mistakenly conflates recovery with active addiction and addiction treatment with recovery.
4. Media outlets portray addiction recovery as an exception to the rule.
5. Media coverage of drug-related celebrity mayhem and deaths contributes to professional and public pessimism about the prospects of successful, long-term addiction recovery.
6. When the story of recovery is told, it is most often told from the perspective of the initiate rather than the perspective of long-term recovery.
7. When personal recovery is conveyed by the media as a dramatic story of redemption, the media often inflate and elevate the recovering person to a pedestal position and then circle like piranhas in a feeding frenzy at the first sign of any failure to live up to that imposed image.
8. The media seeks to make the personal recovery story as dramatic as possible by emphasizing the details of the addictions story while glossing over the processes and fruits of long-term personal and family recovery.
9. The media fixation on celebrity addiction and recovery is a diversion from a much larger and more important story.
10. The media tell the story of recovery only as a personal story rather than a larger story of the role of family and community in addiction recovery.
11. The rare media portrayals of recovery often depict only a single pathway of addiction recovery—specialized addiction treatment followed by lifelong affiliation with a 12-Step recovery program.
12. The media is only just beginning to recognize newly emerging recovery support institutions and the existence of an ecumenical culture of recovery that are uniting people from diverse pathways and styles of long-term recovery. (2014)

As the eternal optimist, I await with great anticipation a new quality of media coverage of addiction recovery. The Breaking Bad stories have been told ad nauseam. It's time for a new generation of journalists, scriptwriters, and filmmakers to convey the Breaking Good stories. (2014)

Recovery Mutual Aid

Each recovery support group must wrestle with the twin risks of drawing that boundary of inclusion too narrowly—and shutting out many who are still suffering—or too broadly—and losing the chemistry of mutual identification critical to mutual support. It is a delicate balance. Currently, the changing characteristics of people in recovery and people seeking recovery are stretching and testing the capacity for such identification. When mutual identification weakens or is lost, groups shrink, dissipate, and die and/or spawn new groups. (2010)

Groups established as an alternative to AA and NA will be similarly challenged to maintain their unique identities and niches within the global recovery community in light of both the changing patterns of AOD problems and the growing varieties of recovery experience within AA and NA. These groups have often criticized the narrowness of approach of the Twelve Step fellowships, but it is actually the growing diversity within AA, NA, and other Twelve Step fellowships that most threatens the future growth of nonTwelve step recovery support groups. (2010)

Imagine a day in the future when more people participate in online (or other electronic media) recovery support groups than attend face-to-face meetings. That day has already arrived for many non-Twelve Step recovery support groups, and that day could also arrive for AA and NA far faster than might be imagined. (2010)

Profit, property, power, prestige, politics and personalities have historically constituted the most significant threats to recovery mutual aid societies, and the relationship between recovery mutual aid societies and professional treatment has always brought a mix of benefits and risks to both parties. (2012)

…addiction treatment organizations and addiction counseling as a distinct profession must articulate organizational values and codes of ethical and professional practice to assure role clarity and separation between professional treatment/counseling and service roles within recovery fellowships. If treatment is nothing more than a superficial introduction to recovery principles and practices available without charge from AA, NA and other recovery support groups, then addiction treatment has no foundation for its present or future legitimacy as a cultural institution. Further, if professionalized support progressively supplants the voluntary service ethic within indigenous recovery communities, then addiction treatment as an institution will have done great harm in the name of good….Sponsorship in the name of counseling and counseling in the name of sponsorship are not acceptable on either side of the treatment-AA/NA equation. (2012)

Recovery Prevalence/Rates

How many persons are in recovery from substance use disorders in the United States? This question was answered by extrapolating national estimates from the major governmental surveys of the course of alcohol and other drug use and related problems (including the Epidemiologic Catchment Area Study; the National Comorbidity Survey and its replication, the National Health Interview; the National Longitudinal Alcohol Epidemiologic Survey; and the National Epidemiologic Survey on Alcohol and Related Conditions) and from a 2010 recovery survey conducted by the Public Health Management Corporation in Philadelphia, PA and six surrounding counties. Based on this analysis, the percentage of adults in the general population OF the United States in remission from substance use disorders ranges from 5.3% to 15.3%. These rates produce a conservative estimate of the number of adults in remission from significant alcohol or drug problems in the United States at more than 25 million people, with a potential range of 25 to 40 million (not including those in remission from nicotine dependence alone). (2012)

What percentage of those who develop AOD problems eventually achieve remission/ recovery? Of adults surveyed in the general population who once met lifetime criteria for substance use disorders, an average of 49.9% (53.9% in studies conducted since 2000) no longer meet those criteria. In community studies reporting both remission rates and abstinence rates for substance use disorders, an average of 43.5% of people who have ever had these disorders achieved remission, but only 17.9% did so through a strategy of complete abstinence. One footnote to this high prevalence of non-abstinent remissions in community populations: Alcohol and other drug problems in the community, even problems that meet diagnostic criteria for substance use

disorders, are generally less severe, less complex, and less prolonged than those problems found among people entering addiction treatment in the United States. (2012)

What is the rate of remission/recovery for persons whose problems are severe enough to warrant professional treatment? In an analysis of 276 addiction treatment follow-up studies of adult clinical samples, the average remission/recovery rate across all studies was 47.6% (50.3% in studies published since 2000). Within studies with sample sizes of 300 or more and studies with follow-up periods of five or more years—two factors used as proxy for greater methodological sophistication— average remission/recovery rates were 46.4% and 46.3%, respectively. In the 50 adult clinical studies reporting both remission and abstinence rates, the average remission rate was 52.1%, and the average abstinence rate was 30.3%. Based on available information, this 21.8% difference appears to reflect the proportion of persons in post-treatment follow-up studies who are using alcohol and/or other drugs asymptomatically or are experiencing only subclinical problems (problems not severe enough to meet diagnostic criteria for substance use disorders). – 3 – 4. Does the rate of remission/recovery for adolescents following specialized addiction treatment differ from that of adults who have completed such specialized treatment? Yes. This analysis compares 276 adult addiction treatment outcome studies conducted between 1868 and 2011 with 60 adolescent addiction treatment outcome studies conducted between 1979 and 2011. The average recovery/remission rate following specialty treatment reported in the adolescent studies was 42% (an average of 35% for studies conducted since 2000), compared to an average recovery/remission rate of 47.6% reported in the adult studies (50.3% average for studies conducted since 2000). (2012)

Recovery-oriented Systems of Care (ROSC)

Recovery-focused systems transformations involve more than minor refinements to existing models of addiction treatment. Such transformations require a fundamental reconstruction of service concepts, practices, and policies. They start with the realization that no one person, episode of care, system of care, or governmental entity has the resources to support long-term individual and family recoveries for all who need it. Partnerships are fundamental to achieving transformation. We have used the metaphor of the chameleon and the caterpillar to underscore that systems transformation must involve a deep and enduring change in the character and identity of addiction treatment and all of the relationships involved in it rather than superficial commitment to new rhetoric and a few new service appendages. (2009)

…there was growing consensus that a new recovery-focused philosophy was needed not only for clients and families but for the system as a whole. Several emerging tenets of that philosophy emerged, including the following core ideas:

- We are all wounded (imperfect).
- Both the elements of the service system and the service system as a whole are wounded (imperfect).
- The service system and its practitioners have taken on some of the characteristics of the disorders they are expected to treat, e.g., denial, projection of blame, grandiosity, self-centeredness, preoccupation with power and control, and manipulation.
- We all need to recover—individually and as a system of care.
- We need to recover together. (2009)

As system administrators, we had to shift from a speaking position to a listening position, from a stance of direction to one of facilitation, and from a position of authority to one of true partnership and collaboration. As those relationships were forged one agency at a time, it was also necessary to create rituals that provided an opportunity to set aside "bad blood" that had developed in the past and negotiate new ground rules for proceeding forward. This was not an easy or quick process and entailed much testing and minor and major relapses on both sides. The following mutual understandings and commitments helped:

- We will occasionally regress to old patterns of thinking and acting, and we will continue to make mistakes.
- When wrong, we will promptly admit it, make direct amends, and recommit ourselves to the partnership and the new ground rules.
- We will periodically evaluate the partnership relationship to evaluate the extent to which we are achieving our aspirational values and take action to move us closer to those values. (2009)

There is a tendency to grossly underestimate the time that will be required to transform a complex service system. This has important implications for partnership development within systems transformation. More specifically, key institutional partnerships cannot be based solely on the relationships involving a small number of key individuals. What we painfully learned in Philadelphia is that unexpected events such as job reassignments and prolonged sick leaves can disrupt partnership development when such partnership efforts are based on a small number of key leaders. The lesson here is that partnerships between organizations must be built from the top down and across organizations so that these are institutional relationships rather than person-dependent relationships. (2009)

So what does this call for increased recovery orientation really mean for the future of addiction treatment? It means that system resources are strategically allocated toward the vision of long-term personal, family, and community recovery and wellness. It means that the principles imbedded within the care process are drawn from the lived experience of personal and family recovery and that people in recovery have visibility and voice throughout the system. It means that the benchmarks used to measure the performance of roles, organizations, and systems all have a direct or indirect nexus to personal and family recovery. It means that measures of traditional systems health (e.g., number of people served, number of units of service, number of organizational staff, service costs, organizational budgets) have virtually no meaning and value unless linked to measurable, sustainable long-term recovery outcomes. As outlined, ARM/ROSC will touch nearly every aspect of addiction treatment, including issues of attraction, access, engagement, locus of service delivery, service team composition, service menu, service dose, linkage to indigenous recovery community resources, and the expansion of post-treatment recovery check-ups and stage-specific recovery supports. (2014)

The "system" in ROSC is first and foremost not a treatment provider or even a network of formal treatment providers. Instead, the "system" is a larger mobilization of recovery supports within a neighborhood, community, state, or nation. RM is a philosophical framework for organizing behavioral healthcare services; ROSC is a framework for creating the physical, psychological, and social space in the larger community ecosystem where recovery can flourish. While

treatment providers can serve as a catalyst in mobilizing a ROSC, they cannot themselves be a ROSC. The ultimate goal of a ROSC is not an ever-expanding professional services system. While professional services are an important component of any ROSC, such services do not in and of themselves constitute an ROSC. A purported ROSC consisting only of recovery support available within funded agencies would violate the very meaning of a ROSC. (2013)

Creating recovery-oriented systems of care involves a radical re-orientation of approaches to the long-term resolution of mental health and substance use disorders. The ROSC vision is more focused on personal possibilities than pathologies and more focused on continuity of long-term support in natural community relationships than the intensity of short-term professional interventions. Professional interventions can play crucial roles as aids to personal and family recovery, but such services are not a substitute for community relationships that are natural, continually accessible, reciprocal, enduring, and non-commercialized. ROSC is an approach to expanding and integrating these diverse forms of helping. The ultimate measure of ROSC is not the size and scope of professional services but a community's capacity for compassion, support, and inclusion. (2013)

Recovery Paradigm

The knowledge upon which the field has evolved is drawn primarily from the study of addiction-related pathologies and clinical interventions aimed at acute biopsychosocial stabilization. As a field, we know a great deal about addiction and the processes of brief professional intervention, but we know very little about the pathways and processes of long-term recovery. (2009)

They [aging recovery advocates that fought to create modern addiction treatment] see "addiction studies" curricula in colleges and universities but no "recovery studies" curricula. They see scientific journals whose names reflect an interest in alcohol and other drugs (e.g., *Journal of Studies on Alcohol*, *Journal of Psychoactive Drugs*, *Addiction*, *Contemporary Drug Problems*) and professional intervention into AOD problems (e.g., *Journal of Substance Abuse Treatment, Alcoholism Treatment Quarterly*), but they see no peer-reviewed journals focused on the scientific study of addiction recovery. They read innumerable studies that meticulously describe who uses which psychoactive drugs and with what consequences, but see only a few recovery prevalence studies….They see national institutes of "alcohol abuse and alcoholism" and "drug abuse" and national centers of "substance abuse prevention" and "substance abuse treatment" but they see no "national institute/center of addiction recovery." They see "addiction technology transfer centers" but no "recovery technology transfer centers." In short, they see a field that knows a lot about addiction and a lot about treatment but which they perceive to have lost its focus on the goal and processes of long-term recovery. These advocates are joining with visionary policy leaders, treatment professionals, and the addictions researchers to shift the field's kinetic ideas and slogans from the nature of the problem ("addiction is a disease") and the alleged effectiveness of its interventions ("treatment works") to the living proof of a permanent solution to AOD problems ("recovery is a reality"). Collectively, these voices are saying that it is time to use the foundations laid from the study of the problem and its treatment to build a fully developed recovery paradigm. (2004)

Pathology (addiction focus) and intervention (treatment focus) paradigms have long dominated the alcohol and drug problems arenas, but only recently is recovery emerging as a central organizing paradigm. This shift is more than a superficial play of words and ideas—a flavor of the month. If successful, it will transform everything it touches—including national policy and nearly ever aspect of the design and delivery of addiction treatment…..Embracing recovery as an organizing paradigm, nesting personal recovery within the larger rubric of community recovery and the new methods being proposed to achieve these goals do constitute a revolutionary leap within the history of addiction treatment and recovery. For treatment systems, this requires a fundamental realignment of values, relationships and service practices. (2011)

Embracing recovery as an organizing paradigm, nesting personal recovery within the larger rubric of community recovery and the new methods being proposed to achieve these goals do constitute a revolutionary leap within the history of addiction treatment and recovery. For treatment systems, this requires a fundamental realignment of values, relationships and service practices. (2011)

The certification exams used to judge the competency of addiction professionals (from addiction counselors to physicians specializing in addiction medicine) rely almost exclusively on questions that test one's knowledge of the psychopharmacology of drugs, addiction and its related pathologies and the theories and methods of addiction counseling and treatment. Striking by their absence are questions about the stages, styles, pathways and processes of long-term recovery and the history and philosophies of American communities of recovery. (2012)

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? (2012)

The next stage of the "recovery revolution," if it is to really be that, is to define in extremely concrete terms what recovery is and is not, how recovery orientation changes prevailing practices in addiction treatment, how new recovery roles differ from the service roles that preceded them, and what recovery-focused benchmarks should be used to evaluate role performance, organizational performance and systems performance. (2013)

It is time we moved beyond the superficial rhetoric calling for increased recovery orientation in the design of addiction treatment (and community-based recovery support services) and began the much harder work of building and then infusing a recovery-focused foundation of knowledge and skills into the education and training of addiction professionals, recovery support specialists

and the broader arena of allied health and human service professionals. Work towards that goal is already underway. (2013)

Only time will tell whether recovery as a new organizing paradigm will reap its potential promises or will be colonized, corrupted, and commercialized in ways that will render it one more "flavor of the month" cast into the dust bin of history. But make no mistake, the "recovery movement" so briefly described here does have the potential to transform addiction treatment as a system of care and transform local community life in the United States. (2014)

Recovery Pathways

The phrase *pathways of recovery* refers to different routes of recovery initiation…. The phrase *styles of recovery* depicts variations in beliefs and recovery support rituals that exist within particular pathways of recovery. (2006)

Cultural pathways of recovery are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. (2006)

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 recovery-based history, language, rituals, symbols, literature, and values)…. In contrast, there are *bicultural styles of recovery*, in which individuals sustain their recovery through simultaneous involvement in a culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). There are also *enmeshed styles of recovery*, in which one initiates and maintains recovery in almost complete sequestration within a culture of recovery. These styles are not mutually exclusive and can change over the course of recovery, with some individuals exhibiting very enmeshed styles of early recovery, only to migrate toward a bicultural or acultural style of recovery later in their lives. (2006).

Recovery Representation

Critical sources of hope within addiction treatment have included the representation of recovering people in the addiction treatment field's paid and volunteer workforce and close linkages between treatment settings and indigenous communities of recovery.

Recovery Research

The future of the recovery movement does not hinge solely on recent or future scientific data on the etiology of AOD problems/addictions. It hinges on the emergence of a science of recovery extracted from the lives of those who have achieved such recovery. (2000)

It is time the recovery community created an activist-based, solution-focused research agenda: an agenda that seeks not merely understanding but one that seeks knowledge that can make a difference in the lives of individuals, families and communities. Support for recovery research

could be made contingent upon whether the findings of a proposed study will help initiate, sustain, or enhance the quality of recovery. (2000)

We need a comprehensive recovery research agenda, and that agenda needs a strong component focused on the neurobiology of addiction recovery. The financial investment in a recovery research agenda is unlikely to be forthcoming without concerted advocacy. Every time an addiction scientist presents brain scans illustrating the neurobiology of addiction, a recovery advocate needs to be present to request the brain scans that illustrate the neurobiology of recovery. (2007)

Why, after decades of addiction research, do we not have answers to these questions [question related to breaking intergenerational cycles of addiction and related problems]? Why, after decades of addiction research, have we not even had studies that asked these questions? We will know a recovery research agenda is a reality when such questions are asked and answered within the country's leading research centers. We will know that achievement is real when the fruits of that knowledge are accessible to all individuals and families in recovery. That day is long overdue. (2008)

Millions of individuals and families in sustained recovery from severe AOD problems have learned important lessons about how to navigate the long-term recovery process; yet their voices are absent from the field's research and popular discourse. As a result, individuals and families in recovery face critical decisions regarding their health, family life, faith, work, and play without a science of long-term recovery to guide these decisions. The time for research and treatment authorities—the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Center for Substance Abuse Treatment as well as state authorities and private foundations—to pursue a recovery-focused research agenda is long overdue. (2009)

People in late-stage recovery (more than 5 years) and very late-stage recovery (more than 20 years) appear in only a small number of the field's research studies. There is no science-based cartography of recovery— particularly later stage recovery. Beyond the folk wisdom found in recovery support groups, little is available to guide professional interventions and peer-based supports for individuals and families experiencing LSR [late stage relapse]. It is time we answered questions related to late-stage relapse and the most effective responses to it. As a field, we need a new vanguard of addiction scientists who redefine themselves as addiction recovery scientists. We need recovering people to pursue education and professional careers in the field in order to forge a new science of addiction recovery. We need collaborations between scientists and people in recovery to design, conduct, and interpret studies of long-term addiction recovery. We suspect that this movement has already begun. We hope you will be part of it. (2009)

What we don't know about recovery is killing people. Recovery advocates have been calling upon (i.e., begging and pleading) the National Institutes of Health—the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism—to pursue a recovery research agenda for more than a decade. The prolonged governmental failure to 9 develop and substantially fund a clearly define, solution-focused, recovery research agenda to elucidate the prevalence, pathways, processes, stages, and styles of personal/family recovery contributes to the

loss of life from addiction and compromises the quality of life of individuals and families in recovery. Some of the most critical questions related to recovery initiation and maintenance—the questions most critical to individuals/families needing, seeking and in recovery--remain unanswered. This is completely unacceptable. Our approach to NIH/NIDA/NIAAA on this critical need must become more confrontational and engage the constituencies and political powers to which the Institutes are accountable. Media dissemination of the existing research focus with its obsession with "hijacked brains" may, by increasing rather than decreasing social stigma related to addiction, be doing more harm than good to people in need of, seeking, and in recovery. (2013)

Scientific studies can tell us much about recovery outcomes under the most ideal and controlled circumstances, but recovery is rarely achieved under such pristine conditions. The processes of addiction and addiction recovery are messy—confounded by all manner of past and co-existing conditions, innumerable internal and external obstacles, previously unknown internal and external assets, and unexplainable life-changing experiences (sometimes labeled "miracles") that are difficult if not impossible to quantify and scientifically disentangle. And if there is anything science detests, it is messiness. Perhaps that is one reason that science has for so long avoided the subject of addiction recovery. It is far easier to catalogue addiction-related pathologies than to explain the process of human transformation that unfolds in addiction recovery. What is needed is a recovery-informed research agenda. (2014)

Recovery Stages (also see Precovery)

The stage models of recovery summarized earlier collectively portray four broad stages of recovery: 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 focus on the recovery process), and 4) recovery termination (achievement of global health with diminished preoccupation with recovery). (2006)

PRSS [peer-based recovery support services] can be effectively delivered across the stages of long-term recovery: 1) precovery, 2) recovery initiation and stabilization, 3) recovery maintenance, 4) enhanced quality of personal/family life in long-term recovery, and 5) efforts to break intergenerational cycles of addiction and related problems. (2014)

Recovery Stories (as advocacy)

And it is easy for us to get seduced by this image at a personal level through misguided efforts in recovery to become the perfect person, to create the perfect life and to project this perfect image of recovery to others. This is a poor choice personally because it creates an image none of us can live up to, and it also invites attack from those who refuse to believe that intelligence, attractiveness, industriousness and service to community cannot co-exist with addiction recovery. Presented with such images of perfection, people will seek to revoke either our addiction stories or recovery stories to keep their own stereotypes and their view of themselves intact. These stereotypes must be shattered by the authentic, but imperfect stories of the

daily lives of thousands of people in recovery.The alternative to the "recovery is a sham/hustle" and "recovery is a panacea for all life's problems" is an authentic portrayal of the complexity, intensity and, at times, emotional rawness of recovery. Recovery requires climbing through a mountain of garbage before we become as clean inside as we appear outside. Recoverybears wonderful fruit, but it is also about struggle and suffering because life is about struggle and suffering. Recovery is about imperfection and brokenness because all humans are imperfect and broken—some of us more than others. Recovery is about escaping secrets because all humans have secrets that we spend a good deal of our lives running from. So we need recovery stories that tell the story of whole people and the whole recovery experience. We need people who can say "Recovery is my most sacred possession" and also say there are days when "recovery sucks"—that it's complex and confusing and uncomfortable and emotionally messy—and that yes it is all worth it!" What we need are stories of authentic experience rather than stories whose intent is to sell something. Above all we must be careful in not replacing alcoholic and dope fiend caricatures with equally stereotyped caricatures portraying all people in recovery as deliriously happy, spiritually enlightened super-citizens. (2011)

Recovery Support Services

For more than 150 years, the transition from intractable addiction to stable recovery has often involved two quite different worlds: 1) professionally-directed addiction treatment aimed at biopsychosocial stabilization and recovery initiation, and 2) recovery mutual aid that has served as a medium of recovery initiation/stabilization and long-term recovery maintenance. A third sphere, non-clinical recovery support services, is rapidly emerging as a portal of entry into and a bridge between these two worlds. (2010)

There is a danger that accompanies the growing recognition of the need for recovery support services. If the treatment field does not find a way to develop adequate recovery support services, these services may emerge as a separate system developed out of recovery advocacy organizations. The danger here is a separation between recovery support services and treatment services similar to the split that has long existed between the treatment and prevention fields. That split would not benefit the people both treatment and recovery advocacy organizations are pledged to serve and could result in recovery advocacy organizations competing with treatment agencies for a shrinking pool of funding. (2001)

Recovery Trends

Such changes included the growth and diversification of recovery mutual aid societies, the rise and increased vibrancy of a new recovery advocacy movement, the growth of grassroots recovery community organizations, new recovery support institutions (e.g., recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes), and a more fully developed culture of recovery with its own history, heroes, values, language, literature, and folkways that transcended those of particular recovery mutual aid societies. It is within this context that the addictions field has witnessed increased interest in the varieties of recovery experience, expansion of peer-based recovery support services, pioneering models of post-treatment monitoring and support, and calls for a recovery research agenda. Also

of note are efforts to apply the recovery concept in different clinical and cultural contexts. (2012)

"Relapse"

"Relapse is part of recovery": 1) blurs the distinction between pathology and health, 2) fails to acknowledge the potential for permanent recovery with no continued episodes of drug use, 3) minimizes the pain and potential loss of life involved in the resumption of alcohol and other drug use, 4) offers the person seeking recovery an invitation and excuse for continued use, 5) is a thin line away from the "once an addict, always an addict" mantra that has fueled decades of addiction-related social stigma, and 6) provides addiction treatment programs an escape from accountability for post-treatment recovery outcomes. (2010)

It is my suggestion that the phrase "relapse is part of recovery" be immediately replaced with statements that are more morally neutral (See White & Ali, 2010), behaviorally precise, scientifically defensible, and therapeutically beneficial. In summary, such statements could include the following:

- Episodes of continued alcohol or drug use by people addicted to such substances are not an inevitable dimension of long-term addiction recovery.
- Many people who commit themselves to an addiction recovery process will never resume alcohol or other drug use in their lives following this commitment to self and others.
- More than half of all people who seek abstinence as a solution to alcohol and other drug problems via their admission to addiction treatment will use alcohol or other drugs at least once following their initial resolution to stop use and before they achieve stable (permanently sustainable) recovery.
- An episode of drug use following recovery initiation does not mean that permanent recovery in the future is not possible, but such episodes constitute part of the residual addiction process, not part of the recovery process.
- Episodes of resumed drug use are not part of long-term recovery, but the self-evaluation and recommitment following such episodes may for some individuals serve to bolster future recovery stability.
- There are sources of heightened recovery commitment (other than renewed episodes of drug use) that do not involve such risks of harm to self and others (e.g., prolonged addiction, disability, and death).
- Not everyone who achieves a period of prolonged recovery who then resumes drug use is able to re-initiate recovery. The adage that people may have another binge in them but possibly not another recovery is confirmed anew every day. Any potential lesson gained from renewed drug use is more than neutralized by threats such use poses to others and to oneself. Continued episodes of drug use fuels guilt and shame, exhausts relational recovery capital, and reduces the prognosis for long-term recovery and quality of life in recovery.
- Quality of addiction treatment is best measured via long-term addiction recovery—recoveries within which episodes of posttreatment AOD use are eliminated or reduced in number, duration, intensity, and consequences.

- Rates of post-treatment recovery and post-treatment AOD use vary considerably across treatment programs and across addiction counselors. Programs and individual counselors should be held accountable for such outcomes. (2010)

The lapse/relapse terms are rooted in morality and religion, not health and medicine, and come with considerable historical baggage. The early and contemporary meanings of these terms include:

- abandonment of religious faith, e.g., lapsed Catholic,
- moral failing, e.g., lapse in grace, wrongdoing, violation of a moral standard,
- neglect of one's personal or social responsibilities, e.g., lapse in insurance coverage or membership due to failure to make payment,
- return of slovenly character, e.g., lapse into bad habits,
- deviation from accepted standards as a result of carelessness, negligence or lack of effort, e.g., lapse in judgment,
- deterioration in discipline or ability, e.g., lapse in memory, and
- fall, fail, regress, backslide, descend, revert. (2010)

The moral overtones created by the lapse/relapse language shaped broader communications in which those who were drug free were referred to as clean while people who were using drugs were viewed as dirty. The moral roots of lapse/relapse are further illustrated in the synonyms for clean (e.g., pure, unblemished, faultless, flawless, good, innocent, sinless) and for dirty (e.g., stained, tainted, polluted, infected, defiled, foul, filthy, immoral, lewd, vile, vulgar). (2010)

The effects of the term relapse extend far beyond the treatment environment. The moral judgment that has historically been attached to the term relapse sets the stage for disaffiliation (e.g., divorce, family estrangement, social shunning, job loss, loss of housing), disenfranchisement (e.g., loss of parental rights, denial of access to public benefits), and sequestration (e.g., violation of probation/parole and imprisonment). (2010)

The use of a morality-based language to depict the prolonged, cyclical course of substance use disorders misidentifies the essential etiology of these disorders (as a problem of moral character rather than brain disease), fails to look at contextual (e.g., treatment-related, environmental) factors that also influence in-treatment and post-treatment AOD use, and contributes to punitive rather than corrective approaches to long-term recovery management. We are not proposing that the functions and skills traditionally embraced within the rubric of relapse prevention be abandoned, but we are suggesting that these arena be rechristened with language that is more behaviorally precise and less personally stigmatizing. (2010)

The common contention that "relapse is part of recovery" should be abandoned. Relapse is NOT part of recovery. A resumption of alcohol and drug use is an expression of the disorder, not of the recovery process. (2010)

AA historian Ernest Kurtz has suggested through his writings that the acceptance of imperfection—accepting that one is "Not-God"—is at the very core of AA spirituality. Such acceptance requires knowledge and acknowledgement of the precise nature of that imperfection. Not taking the next drink in AA parlance and in professional models of "relapse prevention"

requires knowing and protecting one's Achilles' heel. Such vulnerabilities can be rooted in certain physical and emotional states, certain patterns of thinking or in encounters with particular "people, places, and things" that reawaken the sleeping dragon within. The lesson of Achilles is that we must remain vigilant in protecting the points of our greatest vulnerability. (2013)

Responsibility before Rights

The emerging New Recovery Advocacy Movement is as much a responsibility movement as a rights movement. The message is a fresh one.

Through our addiction, we have wounded ourselves, our families and our communities. In gratitude for the gift of recovery, we declare our responsibility to manage our own recovery, to make restitution for the injuries we have inflicted on others, to carry a message of hope to others, and to contribute to the larger health of the community. (2001)

Recovering people, long-silenced, are now declaring their presence within and contributions to this culture. We are speaking out against objectifying stereotypes and discriminatory policies that narrow the doorway of entry into recovery. We are confronting discrimination in health and life insurance, housing, education, employment, and social services and are demanding the privileges and benefits available to other American citizens. We are moving beyond our own personal recoveries to become catalysts of social change. The time to define the American recovery advocacy movement as a civil rights movement has arrived. (2005)

Role of Community in Recovery

I would suggest that the focus of addiction counseling today should not be on addiction recovery-that process occurs for most people through maturation, an accumulation of consequences, developmental windows of opportunity for transformative or evolutionary change, and through involvement with other recovering people within the larger community. The focus of addiction counseling today should instead be on eliminating the barriers that keep people from being able to utilize these natural experiences and resources. Our interventions need to shift from an almost exclusive focus on intervening in the addict's cells, thoughts and feelings to surrounding and involving the addict in a recovering community. (2002)

In many communities, professionally-directed addiction treatment needs to be reduced to its most critical dimensions; it needs to become smaller, not larger. What does need to become larger is the web of support in the community itself for recovering addicts and their families. Treatment should not be the first line of response for addiction but a safety net for those individuals facing special problems in their ability to find and utilize these larger and more natural support networks. The job of treatment is to do what the community at any given moment cannot do. If one believes that recovery involves a transcendence of self-an experience of relationships and resources beyond the self-then the most legitimate role for addiction treatment providers is that of removing barriers that stand in the way of connection to such resources and helping enhance the variety and viability of such resources. (2002)

All of us-physicians and nurses, addiction counselors, researchers and teachers, supervisors and managers-need to leave our offices and rediscover the social ecology within which both addiction and recovery are nested within our communities. We need to be meeting with the service committees of local addiction mutual aid societies. We-those in recovery and those not in recovery-need to get to know the recovering community by attending (within the prescribed guidelines for participation) meetings and social events of such organizations. We need to be visiting with the leaders of religious and cultural revitalization movements in our communities. We need to break bread with those working within our local union counseling programs. Rather than waste our lives obsessing about managed care, we need to relearn the cultural terrain outside our agencies and help create spaces within our communities that can serve as sanctuaries and places of renewal for recovering addicts and their families. And most importantly, we must enter into relationship with these indigenous resources as students rather than as teachers. (2002)

Brief biopsychosocial stabilization should not be mistaken for sustainable recovery from addiction; recovery is not durable until it is firmly nested in the community—within the physical and cultural environment of each patient/family. (2012)

Secrets in Recovery

Each of us is the box of Pandora and within us resides primitive thoughts and emotions and closely guarded secrets all protected with the admonition that they cannot be released to the world. And so each of us is left with the burden of what precisely to do with this shadow side of ourselves that is so often the source of guilt and shame. We are often told that this shadow feeds our addiction: "You're only as sick as your secrets." Twelve Step programs—the steps of self-inventory, confession, amends, and service to others—provide a framework to address this shadow. Similarly, numerous schools of addiction psychotherapy are based on the assumption that recovery comes only through purging the hidden, distressing emotions that have long been self-medicated with drugs….In the Pandora story, hope only becomes visible and accessible after the evil spirits have escaped. And so we have the peculiar situation of an illness, addiction, whose remedy involves a most unusual form of medicine: honesty with self and others. But there is a second lesson and that is the unpredictability of opening the box via the risks to self and others. Buried within the Twelve Steps are an understanding of this risk and certain limitations on disclosure of past wrongs (e.g., defining the context of disclosure and prohibiting disclosures that would do harm to others). Releasing powerful emotions requires, like bleeding, the ability to clot—to bring emotion back under control once released. There may well be people who lack this ability to emotionally clot—a condition that could be thought of as a form of emotional hemophilia—and who would be harmed rather than helped by such release. There is also the issue of context—the degree of safety in the choice of timing and place for opening oneself in this manner. All this adds a note of caution and care about how this process is managed and the recognition that recovery for some involves not a release of emotion but mastery of how such emotion can be controlled. Like so many areas of recovery, the message, "easy does it," is quite apt. (2013)

Secular Recovery

Secular recovery is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or rituals (prayer). Secular recovery rests on the belief in the ability of each individual to rationally direct his or her own self-change processes. (2006)

Self-Care and Recovery Advocacy

Primacy of personal recovery recognizes that the initiation and maintenance of personal recovery is the foundation of our organizations and our larger movement. It is through this principle that we acknowledge that organizational health is contingent upon personal health—that recovery advocacy is not and cannot be a substitute for a personal program of recovery maintenance. The history of recovery advocacy movements is strewn with the bodies of those who thought otherwise. More than any other social movement, we know that we cannot save the world unless we first save (and keep saving) ourselves. (2011)

Movements have insatiable appetites for time and talent and they can suck us dry even as they fill us with deep meaning and purpose. Maintaining balance is critical to sustaining our health during movement participation which is a problem since, as a people, balance has not exactly been our dominant character trait. Our natural inclination is to over-extend so such risks must be consciously self-monitored and achieved through our care and support of one another. Sustaining our health requires the management of impatience and fatigue, a thick skin and sense of humor and careful attention to one's personal and relational health. I've also been recently thinking about what it means to families to have someone deeply invested in these movements. I think we have to find ways to involve our families in movement activities or be extremely careful in balancing family and movement time. Someone I once had in training shared the following admonition which had been passed down through his family of social activists: "One must be careful in carrying light to the community to not leave one's own home in darkness." Those are very profound words. (2011)

Self-talk in Recovery

For centuries, people in recovery have personified addiction as beasts, dragons, and devils whose inviting voices must be resisted. In AA traditions, such self-talk has been castigated as "stinkin' thinkin'" and early NA members referred to such thoughts as "needling oneself". Christian recovery literature similarly warns of the Devil's voice, and secular recovery literature is filled with reference to the "Pavlovian Pull" (Christopher, 1988) and to the amplified voice of "the beast" (Trimpey, 1989). Put simply, addiction is often fueled by a pattern of self-talk whose troubling presence can continue long into the recovery process. Recovery is in part about changing how we talk to ourselves. (2013)

Smoking

How we as addiction professionals respond or fail to respond to the issue of nicotine addiction exerts significant effects on the long-term health outcomes of those we serve. (2011)

A growing number of addiction counselors are refusing to model a behavior (smoking) that could take years from their own lives and the lives of those who could be influenced by their example. (2011)

Many of the pioneers of twentieth century addiction treatment and recovery mutual aid societies died of smoking-related disorders.

- Bill Wilson (emphysema) and Dr. Robert Holbrook Smith (cancer), co-founders of Alcoholics Anonymous;
- Mrs. Marty Mann (cancer), founder, National Council on Alcoholism and Drug Dependence;
- Danny C. (cancer) and Jimmy K. (emphysema and cancer), key figures in the founding of Narcotics Anonymous;
- Charles Dederich (cardiovascular disease), founder of Synanon;
- Dr. Marie Nyswander (cancer), co-developer of methadone maintenance; and
- Senator/Governor Harold Hughes (emphysema), sponsor of landmark alcoholism treatment legislation and founder of the Society of Americans for Recovery. (2011)

People in recovery are dying from smoking-related diseases in large numbers, but they are also dying from conceptual blindness: the failure to see the contradiction between claiming recovery status in the presence of continued addiction to nicotine. Too many recoveries and too many lives are going up in smoke. (2014)

Through our silence, addiction professionals and peers in recovery participate in those [smoking-related] deaths—collective acts for which we will be judged harshly in historical retrospect. (Can you hear the future voices: "Celebrating addiction recovery in smoke-filled rooms? What the hell were they thinking back then?!") (2013)

State of Addiction Treatment Industry (Vulnerability as a Cultural Institution)

The institutional infrastructure of addiction treatment is quite vulnerable, as indicated by limited funding diversification, aging leadership, workforce development challenges (including high clinician turnover), weak capacity for implementation of evidence-based innovations in treatment, and weak technological capabilities to face the growing integration of addiction treatment, mental health and primary healthcare. But the cultural fate of addiction treatment may well be dictated by a more fundamental flaw in the very design of addiction treatment and the field's capacity or incapacity to respond to that design flaw. Modern addiction treatment emerged as an acute care model of intervention focused on biopsychosocial stabilization. This model can work quite well for people with low to moderate addiction severity and substantial recovery capital, but it is horribly ill-suited for those entering treatment with high problem severity, chronicity, and complexity and low recovery capital. With the majority of people currently entering specialized addiction treatment with the latter profile, the acute care model's weaknesses are revealed through data reporting limited treatment attraction and access, weak engagement, narrow service menus, ever-briefer service durations, weak linkages to indigenous recovery support services, the marked absence of sustained post-treatment recovery checkups, and the resulting high rates of post-treatment addiction recurrence and treatment readmission.

Addiction treatment was developed in part to stop the revolving doors of hospital emergency rooms, jails and prisons. For far too many, it has become its own revolving door. (2014)

Stigma

The social stigma attached to certain patterns of psychoactive drug use has a long history in the United States and is inseparable from cultural strain related to such issues as race, religion, social class, gender roles, and intergenerational conflict. (2009)

Addiction-related social stigma constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the cultural resources allocated to alcohol- and other drug-related problems. (2009)

The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities. Goffman (1963) referred to this stigma by association as "courtesy stigma." The social stigma attached to families affected by addiction carries the implication that the family somehow failed to prevent this problem, contributed to its onset, and/or played a role in failing to prevent or inciting relapse episodes. Children may be socially shunned due to the perception that they have been contaminated by the addiction of their parents or siblings. (2009)

Individual strategies to deal with stigma include:

- secrecy/concealment
- social withdrawal
- preventative disclosure
- compensation (using personal strengths in another area to counter the imposed stigma)
- strategic interpretation (comparing oneself to others within the stigmatized group rather than to those in the larger community), and
- political activism (2009)

Stigmatization is not an accidental by-product of these [anti-drug] campaigns. It is a reflection of policies that "unashamedly aim to make the predicament of the addict as dreadful as possible in order to discourage others from engaging in drug experimentation" (Husak, 2004). An outcome of this complex social history is that many addiction professionals and recovery advocates see the stigma produced by "zero tolerance" policies as a problem to be alleviated, whereas preventionists see the stigma produced by such policies as a valuable community asset. A key question thus remains, "How do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities?" (2009)

Any campaign to counter addiction/treatment/recovery-related stigma must ask the question, "Who profits from stigma?" Efforts by one group to define another group as deviant can serve psychological, political, and economic interests. (2009)

Too many of us hide within our own professionally and socially cloistered worlds while boldly challenging our clients to re-enter the life of communities from which we have long been

disengaged. We need to reenter those communities and stand in partnership with those we serve to confront the social stigma attached to addiction/treatment/recovery. It is not enough to personally help each client initiate a recovery process. We need to assure a community/world that welcomes and nourishes such recoveries. (2009)

Members of historically disempowered and stigmatized groups are prone to internalize culturally-dominant beliefs about themselves and act them out in their intragroup relationships. The development of status hierarchies and elaborate pecking orders and displacement of aggression within such groups is common. Such hierarchies have long existed in the American drug culture, from the "righteous dope fiend" to the "gutter hype." People in addiction recovery without medical support looking down on people recovering from addiction with medication support is the psychological equivalent of light-skinned African Americans expressing superiority over dark-skinned African Americans, the house slave looking down on the field slave, and the continued pervasiveness of Black-on-Black crime. I think these mechanisms of introjection and displacement of shame and aggression are at work in the gulf that exists between those recovering with and without the support of medication. I also think these patterns will progressively dissipate as people in recovery and their families mobilize culturally and politically. I think science is also going to help speed this process. We are quite likely to discover that the ability to recovery with or without medication is not a function of strength of character or motivation but differences in genetically-mediated neurophysiology, problem severity and recovery capital. I do think a day is coming when we will see recovery 6with or without medication as differences in styles of recovery and that recovery by any means necessary under any circumstances will be cause for universal celebration and a prevailing mantra across communities of recovery. (2011)

Three broad social strategies have been used to address stigma related to addiction and related disorders and their treatment: 1) personal or mass protest (advocacy), 2) public and professional education, and 3) strategies that increase interpersonal contact between stigmatized and non-stigmatized individuals and groups.32 It is unlikely that the recovery status of the MAT patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MAT patients and their families stand together publicly to declare, "We are the evidence"—the living proof of the role methadone and other medications can play in long-term recovery from opioid addiction. Stigma-related research would suggest that changes in attitudes toward MAT are most likely to occur not from acceptance of addiction as a brain disease, but through identification with an admired public figure or persons in recovery from one's family, social, or occupational network who have benefited from MAT. (2012)

My fears are captured in the following three propositions. First, communicating the neuroscience of addiction without simultaneously communicating the neuroscience of recovery and the prevalence of long-term recovery will increase the stigma facing individuals and families experiencing severe alcohol and other drug problems. Second, the longer the neurobiology of addiction is communicated to the public without conveying the corresponding recovery science, the greater that burden of stigma will be. Third, the brain disease paradigm could create new obstacles for social inclusion of people in recovery and provide a rational for coercive, invasive and harmful interventions. Conveying that persons addicted to alcohol and drugs have a brain

disease that alters emotional affect, compromises judgment, impairs memory, inhibits one's capacity for new learning, and erodes behavioral impulse control are not communications likely to reduce the stigma attached to alcohol and other drug problems, UNLESS there are two companion communications: 1) With abstinence and proper care, addiction-induced brain impairments rapidly reverse themselves, and 2) millions of individuals have achieved complete long-term recovery from addiction and have gone on to experience healthy, meaningful, and productive lives. (2013)

Mobilizing a vanguard of recovering people who are living drug-free, productive lives to put public faces and voices on addiction recovery will do far more to decrease social stigma than another decade of brain slides and the constant media fixation on celebrities heading to rehab or dying. This month, more than 100,000 people in recovery will be marching in recovery celebration events across the United States. The images of their faces within crowds marching as far as the eyes can see will tell the other side of the addiction story—a story far different than that conveyed by brain slides. (2013)

The stigma attached to addiction is more than a social designation of difference; it is an imposed stain of shameful difference. This ascribed defect is not visible; its application is contingent on shared or discovered knowledge of one's addiction/recovery status. Recovery concealment is a stigma avoidance strategy; recovery disclosure can be a powerful stigma protest strategy. (2014)

Symbolic Firsts in Recovery

What symbolic firsts in recovery collectively do is elevate our imaginations—replacing the "recovery from" focus (escape from the painful consequences of addiction) with a vision of "recovery to" (achievement of a personally fulfilling and purposeful life in recovery). Symbolic firsts in recovery trigger breakthrough perceptions of the potential of a life that was not earlier thought to be possible. Symbolic firsts have the potential to ignite in each of us a fierce determination—an irrevocable commitment—to not allow our own demons, the ignorance of others, or incidents of social and professional exclusion to stand in our way….People in recovery who have and are making notable achievements and social contributions already exist in every imaginable sphere of cultural activity. What remains is for a vanguard of people in recovery within these diverse sectors to jointly stand to declare their status as "symbolic firsts." That collective act will do more to widen the doorways to addiction recovery than all of the professional efforts that have preceded it. (2014)

Systems Failure

Accepting the mantra that "Treatment Works," families, varied treatment referral sources and the treatment industry itself believe that responsibility for any resumption of alcohol and other drug use following service completion rests on the shoulders of the individual and not with the treatment program. This is unique in the annals of medicine. With other medical disorders, continuation or worsening of symptoms is viewed as an indication that the initial treatment is not effective for this particular patient and that changes in the treatment protocol are needed. In contrast, when symptoms continue or worsen following addiction treatment, it is the patient who is blamed and often punished. The stance is, "You had your change and you blew it! You must

now suffer the consequences of your actions." And those consequences are often quite dire, including divorce, loss of children, loss of housing or educational opportunities, termination of employment, discharge from the military under less than honorable conditions, loss of professional license, loss of driving privileges, and incarceration, to name just a few. Such punishments are often meted out with an air of righteous indignation in the belief that the person for whom we have done so much has failed this chance we have given them. The question I am raising in this blog is: Was it really a chance? Put simply, we are routinely placing individuals with high problem severity, complexity and chronicity in treatment modalities whose low intensity and short duration of service offer little realistic hope for successful post-treatment recovery maintenance. By using terms like "graduation" and ending the service relationship following such brief clinical interventions, we convey to the patients, to families and to all other interested parties at "discharge" from treatment that recovery is now self-sustainable without continued professional support. And this is true just often enough (but often attributable to factors unrelated to the treatment) that this expectation is maintained for all those treated. For those with the most severe problems and the least recovery capital, I believe this expectation is not a chance, but a set-up for failure with potentially greater consequences than might have naturally accrued. (2013)

Tolerance

On a personal level, as we mature in recovery, such needs to elevate ourselves over others dissipates. The masks of arrogance and intolerance give way to greater humility and acceptance. When we accept the imperfection in ourselves, it becomes easier to forgive what we see as imperfections in others, some of which later become understood not as imperfections but differences. The differences cease to be a threat, and we can experience true joy for another whose pathway of recovery is different than our own and others whose ideas about what is best for the movement are different from our own. We stop claiming that our way is the TRUE way and instead claim only that it works for us—today. There are very real issues in this movement over which people of good will could and do disagree, but far too much conflict comes from these more primitive processes. (2011)

This month, recovering people will stand together—transcending all manner of differences in our addiction histories; our distinctive religious, spiritual, and secular pathways of recovery; and our diverse life circumstances. We will stand as a people with a shared past and a shared destiny declaring to all: "If we can heal, you can heal. If we and our families can heal, then neighborhoods and communities can heal. And if communities can heal, then the wounds of our country and the world can also heal." (2011)

In our own recoveries, each of us found truths—some personally unique and others shared with many—that we attribute today as the source of our recovery experience, but it is danger when we elevate our personal truth to the status of THE truth. We are a people prone to excess and that excess needs to be tempered with humility and tolerance and a true sense of celebration for all recoveries—no matter how markedly they differ from our own. What we have tried to do, not always successfully, is cultivate these key recovery values (humility, tolerance, gratitude and celebration) into the larger recovery advocacy movement. I think the lesson we learned is that we all have to become students of recovery. There are no teachers in this movement, only students.

The tendency of any stigmatized group is for its members to socially isolate themselves. I think one of the mistakes that can be made is that we spend to much time talking with each other about changing attitudes of those outside our circle and fighting with each other about how best to do that while spending far too little time communicating with people outside that circle. The first challenge in confronting community stigma, for example, is confronting and escaping that propensity for isolation and our propensity to pick fights inside the circle so that we don't have to face the more formidable challenges outside. The bottom line is that we can't change attitudes of communities if we don't fully enter the life of those communities. And the first challenge to entering those communities is confronting internalized stigma inside our own selves, our organizations and within our movement - purging the shame that tells us we are not worthy of leaving our closed circles. We can hardly expect communities to accept us when we have not yet accepted ourselves and each other. I think that acceptance for self and for each other comes through the grace of sharing our stories - first with each other and then with the world. (2011)

Treatment

Treatment is best considered, not as the first line of response to addiction, but a final safety net to help heal the community's most incapacitated members. The first avenue for problem resolution should be structures that are natural, local, non-hierarchical and non-commercialized. (2000)

"Treatment Works"

Treatment Works, the central promotional slogan of the addiction treatment industry, misrepresents the nature of addiction treatment and its probable outcomes and misplaces the responsibility for such outcomes. The slogan should be abandoned and replaced by a cluster of messages that shift the emphasis from the intervention (treatment) to the desired outcome (recovery), extol the importance of personal choice and responsibility in the recovery process, portray the variable outcomes of addiction treatment, celebrate multiple pathways of recovery, affirm the roles of family and community support in addiction recovery, invite participation in professional treatment and recovery support services, and incorporate catalytic metaphors drawn from diverse medical, religious, spiritual, political and cultural traditions. (2004)

Writing (Excerpts from *The Call to Write*, 1995)

Most of the great writers experience something that separates them from their fellow human beings. They live in a state of psychological exile. They use their detachment as fuel for their art. It's the source of the writer's independence of spirit—their willingness to test boundaries and challenge authority. (1995)

We go down into ourselves or look into the souls of others and then come back and tell the world what we have seen and learned. Each time we go on such a quest, we're not entirely sure of the way back. When writers bring their work to the world, they're like Lazarus rising from the dead, Jonah emerging from the belly of the whale, or Dorothy returning to Kansas. (1995)

Ralph Waldo Emerson rightly observed that imitation is suicide. In imitating others, we suffocate our own creative self. If one mimics the style and voice of others, acceptance or rejection by

others is a betrayal of oneself. If the mimicked work succeeds, one feels an impostor because the work didn't come from one's true self. If the mimicked work fails, it's a double failure—a failure in courage to reveal one's own voice and a failure in copying the voices of others who are successful. (1995)

The passion to write often comes to me when I feel otherwise powerless in the face of some injustice. Writing is my antidote to powerlessness. It counteracts my sense of helplessness when other areas of action are not possible. I've always experienced writing as a subversive act, as an act of resistance. I still believe in the power of the written word to inspire hope, heal individuals, and transform the world, and I must confess some embarrassment with that belief. Part of me views this belief as incredibly naive, and yet I continue to believe. (1995)

I think what writers are ultimately struggling to achieve is a definition of the big picture, to tell THE story behind the little stories. Young writers can sometimes catch this big picture through the freshness of their vision; seasoned writers discover the big picture through slow revelations of the tissue that connects a lifetime of little stories. (1995)

Our writing is ultimately only as good as the clarity, originality and value of what we see, think and feel. Writers are people who have something to say. Where there's a message, there's a writer waiting to be born. (1995)

You may have a thousand fears and insecurities, but at the moment you sit down to begin a creative project, you must write with the power and authority of God. When you stand up, you re-embrace your humanity with all your petty foibles, but in the writing hour, you must write as if you controlled the universe. I'm not talking about ego here. I'm talking about using the self as an instrument. The boldness I describe is not an assertion of ego but a refusal to let one's petty ego stand in the way of the words that need to be written. (1995)

In a world of darkness, the writer must determine whether the mission is to document the darkness or create light. That choice separates the reporters from the healers and visionaries. Writers don't need to have all the answers but I believe they have an obligation to bring a healing message—a message of hope. (1995)

Life isn't going to rearrange itself for anyone; it moves forward with all its beauty and ugliness in unrelenting progression. Our only choice is to find the sweetness of daily life even when such sweetness is hidden in the midst of injustice, cruelty, stupidity and vulgarity. Each of us can be the antidote to the poison we find around us. Writers can provide part of the antidote to poisons that harm us individually and collectively. I really believe that when we experience and share joy, we decrease the infectiousness of pain and hatred. (1995)

There are yet-to-be-born writers who aren't naturally drawn to putting words on paper. They write not with pen and paper, but out of the action of their daily lives. Writers can give added meaning to the lives of such people by passing on their experiences to new generations of explorers. From this perspective, the function of the writer within the field is a clerical one. We are scribes whose job it is to capture and interpret the words of our people (clients, service providers and citizens). Our job is to help all of them tell their stories. (1995)

Writing combines two very different processes: unrestrained creation and critical self-appraisal. If we can't force a separation between these two functions, each will destroy the other. If creation overwhelms self-appraisal, we spew out work, good and bad, on a readership who may not have the patience to find our pearls in the sand. If self-appraisal overwhelms creation, we become paralyzed or produce work that is cold and constrained. It's the separation and balance of these two functions that creates great writing. (1995)

There is a very private place within each of us hidden from the outside world. The diversions of daily living and our fear of what we may find in this inner place mean that most of us visit this private retreat rarely, if at all. The writing self resides within this place. It is to this place of raw, unedited experience that the best writers visit again and again. (1995)

I'm not a soloist. I'm part of a chorus of thinkers and writers. I seek to harmonize my ideas, writing with an awareness of others in the chorus and a sensitivity to what each of us can best contribute. One of the things that makes the isolation of writing tolerable is the knowledge that other kindred spirits are simultaneously pursuing this same muse for the same purpose. Although I write alone, I have a very real sense of participating in this collective effort. I think each of us has to find our own voice and then join the chorus that is singing our kind of music. (1995)

I think the most creative writers always scrape themselves across the grain of the culture in which they're nested. When the cultural focus is on the collective, the writer must celebrate the individual; when the cultural focus is on individual self-interests, the writer must call for affiliation and community; when pessimism and cynicism become fashionable, it is the writer whose words must sing a song of hope. The writer is the antidote to the excessive swings of the pendulum of change. We are part of the feedback system that helps the culture re-center itself following its cyclical appetite for excess. (1995)

This world is as likely to die from detached disinterest as it is to die from hatred. There are more people who don't care than those who either love or hate. It is with this mass of wallflowers who fail to raise their voices to promote love or to quell hatred that lies our perilous future. Writers have importance to the extent they induce the wallflowers into the dance. (1995)

I pay homage to history because I want to make sure my reader realizes that my challenge to some prevailing ideas does not come out of ignorance of the field's history and traditions, nor out of an adolescent need to challenge my elders. I try to demonstrate my knowledge and respect for where we have been in order to build my case that we must go beyond the present to write a new history that embraces and extends rather than destroys that which preceded it. (1995)

Aspiring writers can get frozen as they stare at a blank computer screen. That moment is not when writing begins. We are writing when we observe and listen to the field. We are writing 1 when we listen to our own hearts to identify those subjects that seem to be personally calling us. We are writing when we are conducting literature searches on a topic and when we are reading. We are writing when we are posing questions to ourselves and others? We are writing when we are sketching out random thoughts and ideas, outlining and envisioning central themes we want to convey in a piece of writing. By the time we get to the computer screen to compose, a great

deal of writing has already occurred. These earlier steps are an essential incubation or gestation period. Only when such steps are completed will the words flow with any depth to them. (2011)

I think the first task of the writer is to live—to build a foundation of experience that can be drawn on to create writing of depth. While that body of experience is building, we can work on the craft of writing. I would recommend that your students seek as broad an experience base as possible and that they develop two simple writing habits—jotting random notes on ideas and experiences that can be filed for future use and regular journaling. I recently incorporated some observations in a paper from a journal I kept while working at a psychiatric facility in 1967. There is a freshness and clarity to such immediate observations that is hard to recapture through the vehicle of memory. (2011)