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Bill Moyers Interview with Bill White, Spring, 1998E

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The following is the editing transcript of an interview by Bill Moyers with Bill White on the policies and realities of drug enforcement and treatment. White is a Senior Research Consultant at Chestnut Health Systems in Bloomington, Illinois. Portions of this interview appear in the CLOSE TO HOME television series that first aired in March, 1998.

Moyers: How do you see addiction? Do you see it as a biological disorder, a psychological distress, or environmental conditioning?

White: The history of addiction science is a history of everybody trying to find the one key thing which defines addiction, the one and only cause. In my own career over about three decades, you could probably plot how I've progressed from very narrow models to very expansive ones. Because addiction presents itself with very homogenous characteristics, people believed it would only respond to a very narrow treatment approach and that there was only one legitimate way to recover. And there were many different schools of thought about what that one true way was. Where we have

painfully matured to as a field is a place where we recognize that addiction is in fact multiple disorders. There are multiple causes of addiction. They present themselves in very diverse patterns and characteristics. And the treatment for the varying types needs to be very, very different. Even the prevention strategies for those different subgroups need to be very different, and there are countless ways to recover.

Moyers: So addiction is not any one thing? It's not enough to know that someone is addicted if you want to help him?

White: We can say that addicts all share in common some problems in their life related to their relationship to alcohol or other drugs, but the nature of those problems and how those problems develop may be very, very different, and resolving those problems may require some very different strategies.

Moyers: What did you mean when you wrote that for an addict, it's as if he wandered into a magical world?

White: We tend to think of addiction as a relationship between a drug and person, but we often forget that there's an entire, elaborate social world that surrounds that person/drug relationship and for some people that world can be as addictive as the substance itself.

Moyers: What do you mean?

White: It's a world with its own language and value and rituals. A world where whole ranges of human needs can be met. To let go of the drug is not just to let go of a chemical relationship, but also a connection with an entire social world.

Moyers: The people, places, and things that we talk about.

White: Absolutely. And it's not just the drug that leaves a vacuum, but it's the entire social network. If I've been immersed in what I call cultures of addiction and suddenly I leave this residential program, I have committed myself to recovery, but now what do I do? It's Saturday morning, I just got home from treatment. Every relationship, every place, every thing, every word out of mouth in my home community ties me to relapse -- to returning to my addictive lifestyle. I've got to replace not only the hole inside myself that that drug filled, but I've got to create an entirely new set of friendships and relationships.

Moyers: So addiction is a way of life.

White: Yes. And giving it up requires a huge change.

Moyers: What do you mean when you say that alcohol is a celebrated drug in our culture?

White: These are drugs in a culture which are almost synonymous with the culture. It's practically unpatriotic not to use them. We ritualize their use. We promote them. We subsidize them. One of the things we do with these drugs as well is that we don't define them as drugs.

Moyers: Only recently did the FDA win the right to classify tobacco as a drug. And we talk about "alcohol and drugs," because otherwise people wouldn't think alcohol was included.

White: Yes. Our historical, celebrated drugs have been alcohol and tobacco and caffeine, even though we've played out ambivalence, particularly with tobacco and alcohol. It's interesting right now, because we're in a transition. In the last 30 years, tobacco has been moving from being a celebrated drug toward becoming a highly stigmatized drug choice in America. As a result, we're actually beginning to see what some people might call "dope fiend behavior" by smokers as they band together and create a deviant subculture to support their use. Watch smokers huddled outside an office building in the snow to see what I mean. Thirty years ago there was no need for deviance, because the culture itself celebrated this drug and made it very easy for those of us who were addicted to tobacco to use it.

Moyers: Do you think it's hypocritical that we celebrate alcohol and denigrate the opiates like heroin, or does that make sense to you?

White: If you're asking me if it makes any rational sense, you would be hard-pressed to build the case why in certain cultures opiates are celebrated and in other cultures alcohol is celebrated. I would suggest that it has little to do with science or pharmacology in either culture. It has much more to do with the historical niche that a drug fills within that culture. Most importantly, drug policy depends on whom we associate with that drug. We almost always confuse our feelings about drugs with our feelings about the people we believe to use those drugs.

Moyers: What do you mean?

White: One example would be if one culture conquers or colonized another. The first thing the dominant culture will do is destroy the celebrated drugs of the vanquished. Part of colonization is implanting our celebrated

drugs in their place. It's part of the destruction of the native culture. It's not about science or public health or which drugs are harmful. It's about dominance. So in the '60s, when an 18-year-old made a choice between smoking pot or drinking martinis, it had little to do with science, but in fact was a political act. Our reaction to those drug choices has as much to do with the symbolism involved in them as with the potential harm which could result. I'm sure you remember a time when parents were relieved when their children drank alcohol, rather than taking illegal drugs. Now in retrospect, we know that an awful lot of young people got in trouble with alcohol in the '60s and '70s when we lowered the drinking age, but it's understandable in light of those categories.

Moyers: I remember a time when parents put candy cigarettes in the children's stockings at Christmas.

White: Yes. Part of what we do with celebrated drugs is we teach children rituals to allow them to practice use. We not only had candy cigarettes, but how many kids didn't practice acting drunk and drinking growing up? I mean you know exactly what the doses, what the brands are. Candy cigarettes are to smoking what training wheels are to bicycling.

Moyers: Is it also because it takes longer for alcohol and tobacco to work their harm, whereas opiates can act much faster in creating anti-social and individually destructive behavior?

White: Medically, the dilemma we have is that alcohol and tobacco are both related to chronic diseases. It takes large lifetime doses to produce many of the most devastating consequences. Now, that's not true for alcohol in terms of consequences like accidents or fights, but in terms of liver disease or brain damage it is. With the opiates, while overdose tends to kill young people, chronic use itself is actually not associated with medical problems, and we don't know what percentage of overdoses

are a result of poor knowledge of drug content because illegal drugs aren't labeled for purity. Anti-social behavior tends to have to do more with who the user of the drug is, so you don't see rich heroin addicts, for example, mugging old ladies.

Moyers: How, then, were our drug laws developed?

White: They grew out of racial and class struggles, particularly on the West Coast and in the South. The first state laws were based on this sort of "dope fiend" caricature -- showing somebody of a different race and a different culture. In California, it was Chinese railway workers smoking opium; in the South, it was black men using cocaine. The reality is that the vast majority of people addicted to narcotics in the late 19th century were white affluent women, who were primarily addicted through traditional medicine or over-the-counter "patent" medicines. The caricature which drove the prohibition campaigns in the late 19th century bore little resemblance to reality. And, to give you a modern version of that, in the mid-1980s, when cocaine was overwhelmingly a white phenomenon in America, the images which began to appear on television were overwhelmingly of African-Americans, particularly young African-Americans enjoying crack cocaine on a street corner. If you look at all the exposes of drug exposed infants, we see young African-American infants, trembling in neonatal intensive care units. But that image was not the reality of cocaine addiction in the United States in 1985.

Moyers: Why?

White: At that exact point in time, those who were addicted to this drug were overwhelmingly white and affluent. The best predictors of cocaine use at that point were education and income. As years of education went up and annual income went up, the probable use of cocaine went up. Yet the image was and still is that we have poor inner-city African-Americans involved in all of these criminal illegal markets. Much of the

anti-coke rhetoric and the changing of laws it generated was based on that early image. But in 1985, it had little relationship with reality.

Moyers: I grew up on the Red River between Oklahoma and Texas, and at that time 45 years ago we had an expression "drunk as an Indian." Is this the same sort of racist stereotyping?

White: Yes, and what's fascinating is that in the last 20 years, there have been several studies which have forced us to completely rethink our understanding of the initial contact between Native Americans and alcohol. That research shows that at the very earliest contact, not only were native people not particularly vulnerable, many of them were not attracted to this drug at all. And many who were exposed to that drug did not exhibit the kind of drunken mayhem which came to be the drunken Indian stereotype. In retrospect, the image of the drunken Indian - particularly in our early history -- may have very much been part of an overall effort to devalue native people and provide one more justification for the notion of manifest destiny, which said it is our right to sweep from coast to coast and destroy these native cultures.

Moyers: What do you think this kind of caricaturing does to our drug policy and to our ability as a society to come grips with addiction?

White: What it's done for a long time -- both our image of drug addicts and also the traditional stereotype of the skid row alcoholic -- is to almost guarantee that there would not be a public health response to this problem. When we create images that do not engender empathy in most people, then our policy is going to be to isolate and sequester and punish those individuals for their deviance. We end up criminalizing as opposed to medicalizing the problem. We talked earlier about celebrated drugs. What our image of addicts and alcoholics also does is to help people addicted to legal substances avoid facing their problems. As a society, we push these drugs very, very hard,

and suddenly somebody close to us is struck by this disorder. It becomes almost unthinkable that a "nice middle-class white person" could be an alcoholic. I remember in my early years working in treatment a vivid image of a family bringing their mother in. Superficially, she looked like she just stepped out of Vogue -- until we began to get her medical reports back. This woman had the highest liver profiles I've ever seen -- she had advanced liver disorder. This woman never took another drink in her life but she died anyway. Now what she died of was alcoholism, but she also died of a myth. The myth was she can't be an alcoholic because she's a woman and even more than that, she's a beautiful, well-dressed, middle-class woman. It was very much apart of her defense structure to keep herself beautiful, because if she was beautiful she couldn't possibly be a drunken bum.

Moyers: Who are the women you work with in Project Safe?

White: Very different women from the one I just described. The majority of Project Safe women have extensive histories of substance use and domestic violence. They come to our attention because they have been abusing their children and have either lost custody of them or are in danger of having them taken by the state. These are poor women, with many, many problems. Some of those problems have been carried down from generation to generation. If you were going to describe a client that has little probability of making it through treatment, I would describe the typical Project Safe woman. They have incredible risk factors both in terms of their own characteristics and in terms of the drug-filled environments in which they live.

Moyers: What determines whether someone is at high risk for addiction?

White: There are a number of sub-populations of individuals who are at high risk. Family history is one factor. Over 74% of Project Safe women have alcoholism or addiction in their families of origin. We know

that individuals are at higher risk if they have particular psychiatric disorders. The majority of our women have prior psychiatric histories involving depression or borderline personality disorder. And there's another important category of risk. Large numbers of these women -- in fact, between 65 and 95% of them -- have extensive histories of sexual victimization and severe abuse or neglect during their childhood.

Moyers: I've read studies which find that between 75-80% of women who come for addiction treatment were sexually abused.

White: Yes. In fact, we've looked at that somewhat closely. It's not simply that sexual abuse increases the risk of substance abuse. We have a lot of people in this culture who were physically and sexually abused as children who grow up without becoming addicted. But with these clients, it's not just the fact that they were abused, it's the intensity and duration of the trauma that increases risk. When we compared their victimization to that of other people who had been abused but not become addicted, what we found was the following: our women were abused at a younger age, the abuse lasted longer, often for many years. It frequently involved multiple perpetrators. It almost always involved perpetrators from the family, which means a greater violation of trust. Also, they grow silent about this because when they've told somebody -- and all of them told at least one person -- they either weren't believed or they were believed and then blamed for what had happened. Most importantly, after they told someone, the abuse did not stop. In fact, in many cases, it even escalated. And the abuse was more invasive. An example would be if someone exposed themselves to me at age seven, I would be sexually abused by any definition, and the same would be true if someone sodomized me, but the latter is a much more boundary-invasive form of sexual abuse.

Moyers: So you mean there were particular patterns of abuse which were linked with increased risk for addiction?

White: Yes. The intensity and duration of childhood victimization dramatically elevated risk for adult substance use patterns. The more severe and prolonged the abuse, the greater the likelihood of addiction.

Moyers: What does that tell you about addiction?

White: That trauma to children is at least one category of elevated risk. If we were going to talk about prevention, one of the things that we could do was find ways to saturate resources to stop the abandonment and brutalization and victimization of children. With women, particularly, it seems as though that would make a huge difference.

Moyers: And what would you do about the high-risk kids who come out of the alcoholic womb or the alcoholic father?

White: I think the same ideas we've developed for treatment apply for prevention. If we have multiple sub-populations, we need multiple interventions that maybe look very different from each other. I don't think there's ever going to be a generic prevention that's effective, because the sub-populations are so different. In fact, there is a danger of iatrogenic effects -- unintended harm which results from efforts which might work to reduce substance use in say, 90% of the population, but can actually increase the risk in 10% of the population. We know that some early substance abuse prevention programs actually incited experimentation. The levels of use went up as a result of what we did in the name of prevention. In terms of sub-populations, if we know that there are multiple sub-populations, then probably what we need is a menu of prevention strategies specific to addiction. Not alcohol or drug use, but addiction prevention, specifically focused on those target populations.

Moyers: So what does your research tell you about why people who have been abused turn to drugs? What does the drug do for them? Does it medicate the pain?

White: I wish I could say it was one thing, but it's probably a combination, and there's clearly a role for anesthesia there. When our women get into situations of emotional crisis, it reactivates much of that historical pain related to victimization in their childhood. Their response is often to reach out and self-medicate that, but they can do other things as well. Some of these women are as addicted to crisis as they are to the drugs. Intervening with them is like intervening in a hurricane. There is just so much going on, and what creating crises does is exactly what the drug does. It offers another way to defocus.

Moyers: Defocus?

White: Yes. When I'm beginning to experience emotional pain related to abuse, all I've got to do is create a crisis in my environment and suddenly I'm pulled out of myself into a dramatic and distracting situation.

Moyers: So what do they do? How do they create a crisis?

White: Well, if we took 100 women with that developmental history to age 22, do you have any idea what their intimate relationships might look like? These women have an incredible capacity to involve themselves in destructive intimate relationships. One of the clients that I interviewed not too long ago, I've asked her many times, "Of all the things you've been through now in almost nine years clean, what's the most difficult?" Early on, she had told me that not using cocaine was the hardest thing for her. This last year, I asked her again, and she said, "In the long run, I think it's been this thing about losers," and she began to describe to me this long, long series of very destructive intimate relationships. Not while she was addicted, but during her early years of recovery. The only good news was that each one got a little less toxic. I asked her, "What sense have you made out of that for yourself?" and I'll never forget what she said. She got this sort

of pensive look on her face and said, "What I understand today is if I'm attracted to them, they're high risk," and what she meant is that when she walks into a room and feels powerful attraction to a man or a woman, it is not what your friend Joseph Campbell called the "zeal of the organs" for one another. It is not healthy sexuality for her -- it is like a very destructive drug choice. Because, due to her background, a man whom she feels "chemistry" with is almost bound to be abusive.

Moyers: So in her case the alcohol and cocaine were just satellites of a deeper disorder that she had to deal with?

White: Yes. Even though, over time, alcohol and drugs may have taken on a very primary role in her life and may need to be treated as a primary disorder, if we look at the etiology -- how did this woman become addicted? -- we need to go back to that notion that there are many different pathways to addiction. For her, as we look at the trauma in her life, she may have reached out to drugs for a number of reasons. It might have been for anesthesia; it could have been part of her incredible impulsivity; it could have been part of her propensity for risk-taking; it could be the fact that she has great difficulty initiating and sustaining personal relationships. In fact, the drug may be the most consistent relationship she's got.

Moyers: Given all of that, for these women, what could possibly bring about change?

White: It's a fascinating question, and what we learned was surprising to me after spending two decades in the field. When I began to evaluate this project in 1986, what I expected is what I always expected -- I'm waiting for a crisis that's going to be the point of transformation. The classic hit-bottom ping!, and then out of that comes an opportunity for change. We didn't have that in Project Safe. I kept going back and interviewing clients and interviewing outreach workers, and what they told me was not at all what I thought I would hear. I had outreach workers saying, "You don't

understand, my clients don't hit bottom, they live on the bottom. Bottom is not new for them." What they said is -- think again in terms of histories of victimization -- these women's capacity for physical and psychological pain is almost limitless. If we wait for them to hit bottom they will die. The issue is not an absence of pain in their lives. They've got more pain than most of us can even comprehend. The issue is an absence of hope. Now, that's a radical rethinking of how people are motivated to enter into the recovery process.

In my field, historically, we said, "Number one, you've got to hit bottom, got to feel that the drugs now bring more pain than pleasure. Until that happens," we said, "there's nothing we can do."

The next stage, historically, was that we said the only reason it takes so long for people to recover is that alcoholics and addicts manipulate these "enablers" -- their families and friends -- to protect them from those consequences. So we decided to educate the enablers so that the alcoholic or addict would hit bottom quicker. The third stage was the idea that we can bring the bottom up -- and we began with both workplace interventions and family interventions. We began to stage these loving confrontations, and we found that it worked. We staged those interventions for the most part in the 1970s and '80s on culturally empowered white alcoholic men, and sometimes on their wives. It was amazing technology. We would have those people in treatment within 72 hours. But we never asked, "What happens when you do that loving confrontation to someone who brings no hope to that experience?" What we had in Project Safe was a very, very different group of people. The men in the 1980s had experienced hope because as white men in this culture they had been given a gift, the experience of power. They had been able to make decisions which affected their personal destinies, and in fact, as they began to deteriorate in their addictions, they often responded with grandiosity and narcissism. Some of them would be dying of alcoholism, and they still thought they were going to pull

this thing off by sheer will. But the Project Safe women didn't have that grandiosity or arrogance, so programs designed to confront it and make them feel powerless merely reinforced their negative self-images.

Moyers: White men who recovered had other things to live for?

White: Yes. They had pre-existing foundations of family and skills and levels of achievement. Some may have lost jobs, but they still had a core belief that they could make it. In contrast, we found with Project Safe that if you escalate pain where there's no pre-existing foundation of hope, not only do you not spark this wonderful transformative experience, what you actually do is increase the risk of self-destructive behavior and flight.

Moyers: What do you mean if you increase pain? You mean if you take away their drugs, if you take away their culture of addiction?

White: No, I mean threats by Child Protective Services like taking away their children, for one. The assumption we have is that this threat gives us enormous power. They will say, "Oh my gosh, where's treatment? Let me get there right now." But what we found was when we knocked on doors and threatened to take the children, women said, "Which one do you want or do you want them all?" What we thought was our great power to coerce based on threatening pain, when you think of the amount of pain in their lives, was not significant. They didn't feel they could do anything to avoid the pain, so it didn't give us any power over them. Later, I'm interviewing women who are doing incredibly, who have turned around their lives and their families, and I'm asking, "Can you describe to me how you got started in treatment?" and I'm waiting to hear the crisis, and the escalation of pain, and it's not there.

Moyers: What had happened? Had they actually hit bottom?

White: I didn't hear "I hit bottom" stories. What I heard were stories like this. One woman said, "It's that outreach worker. I couldn't get rid of her." She told me, "The second time she came she caught me at a weak moment," and what she meant was at that time this woman, in a moment of vulnerability began to reveal an enormous amount about her life, and began to disclose herself as a person.

Moyers: To the person who had knocked on the door?

White: Yes. Now you would think this is a great breakthrough and we're going to get this woman to treatment the next day. In reality, the outreach worker couldn't find the woman for three weeks, because behind that self-disclosure she had panicked and taken flight. But the outreach worker kept coming, and the client would later say to me, "My babies had already been taken. I was out in The Life, running the streets, I was stopping back to my place for clothes, and, I swear to God, every time I stopped by my place, that woman was waiting for me or there was a note on my door from her."

So I asked her to describe the day she finally went to treatment, because I'm still expecting a crisis or some defining moment, but she said, "It was like a hundred other days; I stopped by to pick up clothes. There's a knock on the door, I open the door, and here's this woman one more time, and I looked at that woman and said, 'Don't say a word. Let's go.'" Now what happened here? There's no pain and there is no crisis. What happened from the time the outreach worker first knocked on her door several months later when the woman agreed to go to treatment?

Moyers: Was it that she developed hope? How can hope spur recovery?

White: At the point when the pain of late-stage addiction is experienced acutely, without hope, you will get suicide. We may not even know that it's suicide, but what we will see is death in the face of incredible pain. The essence of recovery is a collision

between that experience of pain and consequences and simultaneously an experience of hope that there is a different way, some other life, not the same old drinking and drugging.

It can happen in many ways. The collision could come together like in the Bill Wilson story in 1934 at Charles Town's hospital. A late-stage alcoholic admitted for the third or fourth time, Bill Wilson suddenly, in his desperation, screams out, "If there's a God let him show himself," and experiences a profound spiritual awakening. We can say from that moment forward he is a person in stable recovery who will go on to be one of the co-founders of Alcoholics Anonymous. That blinding conversion experience is just one example. But if we only have the pain without the hope, we might have had a suicide in that hospital, or Bill Wilson might have gotten out of his bed and gone to a bar. So what our outreach workers bring to the Project Safe women is not a message about pain and consequences. They bring hope, they just kept saying it could be different, it can be different. You can do it, you are worthwhile. They slowly build a relationship and penetrate all that distress and all that fear and out of that relationship come some sparks that say maybe it can be different.

Moyers: Once they get to treatment, what are the techniques of change that produce hope?

White: Well, first, we needed to redefine it for these women, because again, it was designed for empowered white men. For them, once you overcome the arrogance and denial, there's usually a breakthrough and then they do treatment very well. There may be relapse issues down the road, but they do well in treatment. But our women didn't know how to play the client role quite as graciously as our traditional clients. They wanted to keep coming to treatment, but they also wanted to keep using cocaine. Or they would come into treatment one afternoon, blow up in a group and shout profanities at everybody, storm out of the place, and call back two hours later wanting to make sure it was still OK to come back tomorrow. We

would have a woman that we were putting through parenting training, and she would just walk out of the parenting class and go downstairs to the childcare that we had to pick her children up. The child would go running the opposite direction, and this woman, in maybe her second or third parenting class, would put her hands on her hips and bellow, "Jeremy, if you don't get back here right now, I'm going to whip your ass." But then she'd get this pained look on her face and say, "But I'm going to talk to you first." All of those behaviors began to teach us that we're not going to have conversions here. We're going to have destructive and very fragile healthy behaviors existing side by side. Our only goal is each day we've got to get the destructive side weaker and the healthy side stronger, but we've got to tolerate this stage of boundary testing. We almost call it pre-treatment. Many of our clients needed a sort of grace period, where they could learn the rules.

Moyers: I want to understand how allowing that kind of flexibility -- they're still using, they're not following the rules -- could help someone overcome a serious addiction?

White: Well, traditionally what we would do, and I know it sounds irrational, but we would say, "If you're coming into treatment, what we're asking you to do is to give up the primary symptom of what we call your disease, and if you exhibit that symptom then we're going to throw you out." Think about the logic involved in that! We're saying that this person has a disease characterized by their inability to control their drug use. Because of that, they come into treatment. They then exhibit immediately a symptom of the disease which ought to convince us they need to be here, but historically, we expelled them instead. What I'm suggesting with these women is that if we took that traditional approach, the vast majority would have been discharged from treatment in the first seven to ten days. Not only would they not have completed treatment, the vast majority would not have even started. We had to rethink our goals. Instead of requiring people to come in motivated, we decided that achieving

motivation for abstinence, not just teaching abstinence skills, are appropriate goals for treatment.

Moyers: So what do you do about motivation? How do you create motivation where for years there was none?

White: We needed to show them that there was hope, that women just like them could and have recovered. Many of our outreach workers are former clients, and in treatment we continue to expose them to other similar women who have gotten better.

Moyers: So they can see an example: Six weeks from now I could be like that.

White: Yes. Especially because the first thing a client is going to say is, "But you don't understand, you've never -- ." All of our role models can say, "Oh yeah?"

Moyers: Been there, done that.

White: Been there, done that more times than you have, in many cases. It wasn't the threats which provided the major incentive, it was these powerful, powerful issues related to hope that begin to move the process.

Moyers: But the tone of the earlier abuse is still there. The sexual abuse is still there. The poverty is still there.

White: Which makes the early stages even more difficult and crucial. If I've got somebody who their whole life has been either victimized or abandoned by everyone close to them, imagine the difficulties when I knock on the door and say, "I work for the government; I'm here to help you."

Moyers: What's your measure of success?

White: We used many. We looked very concretely at issues of substance use, pre- and post-treatment. We looked at emotional health of the mother -- self-esteem, anxiety, and depression were the three things we measured. We measured mother/child relationships, because, again, a major

reason these women are in treatment is because of issues of neglect and abuse of their children.

Moyers: What have you found? How many of them "succeed?"

White: We found significant reductions in substance use; we found dramatic improvements in both self-esteem and in lowering of anxiety and depression scales on women who successfully completed treatment, and we found significant changes in mother/child relationships. We also evaluated it in terms of, Did we have significant reduction in reports of neglect and abusive behavior, and again we got dramatic reductions in both of those categories, so these were two state agencies who looked at that and said, You know, my gosh, this data is so dramatic we can't afford not to continue to put resources into this.

Moyers: Do we know how many people in this country are helped by Alcoholics Anonymous, AA?

White: AA figures, from their own membership surveys, run anywhere from a million to a million and half people in long-term stable recovery in that fellowship.

Moyers: Do you think AA helps people?

White: I don't think there's any question but that AA and a number of other sobriety-based support structures are essential for a large number of people to move into long-term recovery. I say AA and the others for this reason. There are some people who will connect to AA more powerfully than others. The ideas and concepts and rituals within that fellowship which are absolutely transformative for some leave others cold. That doesn't mean those individuals aren't ready for recovery -- some may find alternative sobriety-based support structures that may be every bit as transformative to them. I can give you an example. In some of our outcome studies, when we looked at African-American women in Illinois, in the early weeks and months

they were participating in AA and NA and CA. But they were living in a recovery home, so they had a pretty traditional recovery framework. When we came back a year or later, we found significant numbers of those women were using the traditional African-American church as their primary sobriety-based support structure, not the 12-Step fellowships.

Moyers: Someone said to me, if addiction is Rome, there are many roads to Rome and many roads out of Rome. Although the experience is much the same.

White: Absolutely. If you look at the earliest stages of development of addiction problems, they look very, very different. By the time you get to the late stage, it's amazing how similar large numbers of them look, but then we begin to look at people moving out of that and into recovery. The farther you go out, the more roads you discover. We have research on spontaneous remission and maturing out of addiction. I think there's probably a large hidden population of recovered addicts who had significant problems in their relationship with alcohol or other drugs, but moved forward and maintained abstinence without any formal program.

Moyers: But that doesn't happen often enough, does it, that we could take that as policy? There are people who still need treatment.

White: Yes, that's true. The people who mature out may, for example, have less severe problems. They might not be enmeshed in a culture of addiction where all their friends are other users, so they might not need a culture of recovery.

Moyers: What do you conclude from this, what do you say to a family whose son or daughter, husband or wife -- what do you say to a family that's in trouble?

White: Well, clearly, it's not a good idea to tell them to sit back and wait till the person matures out. I think the message still has to

be that this is a disorder with enormous risk, and the risk includes lethality. Large numbers of alcoholics and addicts in this culture die from accidents. Large numbers die from suicides. Significant numbers die from alcohol- and drug-related medical disorders. So I'm going to tend to have the family take an active stance, and at the same time, they also need to know that they cannot change the person if he's not ready.

Moyers: But if we see alcohol and addiction as a disease, can that person take responsibility for his or her own life?

White: It probably depends on what stage of addiction we're talking about. I really believe that there are stages where biology takes over and dominates everything, and if we're asking, Can this person spontaneously, of their own free will, initiate their own recovery?, I think that's probably not possible at such times. And that's important because historically we've always said that nobody can recover unless they get this sort of pure spontaneous desire for long-term sobriety. That's an absolute myth. The vast majority of people that are in long-term recovery got there almost by accident. They stumbled into it and only in retrospect did they reconstruct a story that had a crisis point and motivation that came out of it. They got caught up in recovery in the same way that they got caught up in addiction. In some ways, in spite of themselves. And families and treatment providers can create environments which are most likely to engender that change.

Moyers: What is the impact of addiction on the families as you've seen it?

White: It's dependent on the patterns of addiction. You can have some patterns -- believe it or not, I can have a man sitting in a bed with alcoholic pancreatitis, and I see few problems with his family. The man hasn't missed a day of work in 23 years. However, the dominant pattern that we see in treatment is characterized by a few things which are devastating to families. One is loss of control, and the other one is radical

personality change while drinking. A Dr. Jekyll/Mr. Hyde transformation. What this does for families is that it renders family life totally unpredictable. From moment to moment, I don't know if I'm dealing with Dr. Jekyll or Mr. Hyde. In those cases, the addict and alcoholic's role in the family deteriorates so rapidly and so progressively that it restructures all the other roles in the family, and you get all of the traditional problems we have associated with alcoholic families. My favorite metaphor for it is that there's an elephant living in the middle of the living room and no one talks about it until very, very late in the game.

Moyers: What do you say to your own daughter about addiction?

White: I've got a somewhat colorful history, at least on one side of my family, which would suggest a fairly significant risk for addictive disorders, so from the time she's been 9 or 10, I've told her that she needs to be aware of that risk. I tell her that if she has those problems it's got nothing to do with her. It's almost like I'm apologizing ahead of time in terms of any potential genetic responsibility I may have. I don't expect those communications to stop her from having contact with alcohol in this culture, but what I do want to do is have her be an incredibly informed consumer, to make her hypersensitive to the risks. The idea being that if she does develop a problem, it would be difficult for her to maintain denial and minimization.

Moyers: What brought you into this field?

White: I was part of the early community mental health movement, and my niche in that movement was finding a way to organize community alcohol and drug services back in the late 1960s, early 1970s. It really was a reaction to seeing late-stage, highly institutionalized alcoholics in the back wards of state hospitals. I was doing emergency work in jails, and routinely getting called in the aftermath of an alcoholic hanging himself. At that time, hospitals wouldn't take alcoholics with acute medical

trauma, let alone need for detox. Now, paradoxically, 20 years later, those same hospitals have fancy chemical dependency units. They're actively recruiting alcoholics. But the scary thing is it's coming full circle -- in some ways we're swinging back to replicate what I saw early on. We've had an incredible collapse of parts of the treatment system.

Moyers: But the reason for that, as I understand it, is politicians, legislatures, others who say that treatment doesn't work; it has a lousy track record.

White: Yeah, but that is not an accurate assessment of treatment. If you look at the definition of what works, particularly in terms of public institutions, and the issue is, Can we lower the number of hospitalizations of alcoholics through treatment? Can we lower the costs alcoholics cause to society? In terms of all of those social-cost interventions, there are dramatic benefits to a community from treatment, even if people don't even achieve a permanent long-term recovery. The backlash has less to do with the issue of treatment outcome. Most of the time when I hear people say, "Treatment is simply not effective," the people saying that generally have no more data than the people who are standing out there preaching that treatment is effective. They're starting from existential positions of either they're for treatment or they're against it, and everything which comes out of their mouths afterwards justifies wherever they start. However, we are clearly having a backlash against treatment right now, which grew out of abuses in the industry. In the late '80s and early '90s, there was a lot of profiteering. There was a kind of "one model fixes all" idea. And we tried to pound an awful lot of people into one type of treatment which wasn't necessarily appropriate for them. That wasn't particularly successful and may have done some harm. At the same time, I think there's a cultural shift going on right now where we're working to demedicalize the addictions, and recriminalize our approach. It took 40 years of a sustained social movement to get that alcoholic

admitted to that hospital bed I was describing, but in a very short period of time we're shutting the doors of those hospitals.

Moyers: What determines now who gets treatment in America?

White: That has changed dramatically in the last five years or so. Through the '80s and early '90s, we had this tremendous explosion in the availability of addiction treatment in the United States. Lots of hospital-based programs, numerous private programs, and fairly well-funded public programs. Between about 1989 and 1992, between 40 and 50% of those private programs closed. Also, in many areas, we had cuts in public funds as well. The main losers here are probably in the middle. We continue to have private treatment programs for the most affluent individuals. The poorest people in this culture can get access to some publicly funded programs. But the middle class in the United States have seen substance-treatment-related benefits erode significantly.

Moyers: What are the barriers to their getting treatment?

White: A decade ago, almost all mainstream insurance companies had a fairly significant substance abuse benefit package. Most people could go, in some cases for multiple episodes, for treatment to the classic 28-day inpatient program. But there were abuses. People were given longer stays than was appropriate, some were repeatedly re-admitted, people whose problems weren't severe enough to warrant inpatient care were hospitalized, often for months. Until somebody ran out of money, and then they were almost abandoned.

Those kind of abuses began to create an incredible backlash within the entire health care system. Suddenly, there were lifetime limits, and then an erosion of inpatient benefits. We began to see aggressive managed care that almost guaranteed that there would be nothing but intensive outpatient programs left, and now we're

even seeing an erosion of coverage for that. Now, in the public sector, managed care is just beginning to swing full force. There are some clients who will do very well in a managed care system. They've got enough stability in their life, family supports, economic stability, etc., that they may do very well in that model, but the women like we've described in Project Safe and other individuals will have great difficulties in those models. In fact, what we're doing is putting them in these very short-term models and then when they fail, we are blaming them for their failure even though we put them in a modality that had almost no reasonable likelihood of success to begin with.

Moyers: That seems almost like a hopeless scenario.

White: It is, and my concern is that as we begin to criminalize this problem, it will only get worse. We may, for example, give this person at the door of the criminal justice system one or two tries at treatment. We give them two very brief little intensive outpatient episodes when they're living in a drug-saturated environment and are coming out of 20 years of addiction. When they relapse, we're then going to say, "OK, you had your chance, now you're going to the penitentiary." What we will have is what we're having now -- penitentiaries absolutely filling up with people on drug-related offenses, busting that system to its breaking point. So recently, we've started coming back with things like the drug court movement, which wants to reinvent the treatment system and reintensify access to care.

Moyers: Talk to me a little bit about harm reduction. One example is needle exchange, which doesn't explicitly seek to stop IV drug use, but tries to reduce the harm caused by dirty needles, like AIDS.

White: The historical controversy around harm-reduction strategies has been the assumption if we provide people needles, or even as a preventionist, if I teach people information about drugs -- like what dose

constitutes an overdose -- to lower the likelihood that they will be a casualty of that drug, I am enabling them, encouraging them, actually increasing drug problems in my community. It's the distinction between preventing drug use and preventing drug casualties. Harm reduction is primarily focused at reducing drug casualties. We're going to reduce the number of drug-related deaths; hospital emergency room admissions; HIV- and AIDS-related cases related to substance abuse. I don't think that there's any question that programs like needle exchange have the ability to provide some of that harm reduction outcome. The surprise from my standpoint is that they often have another result. If the person wants to continue to use drugs, as long as they continue to come back and exchange dirty needles for clean needles, it's fine. There's no morality about it. But what we find is that the outreach workers at the needle exchange slowly build a relationship with the addicts. Out of that process, people who previously avoided medical help or treatment began to ask questions about getting into treatment. So harm-reduction strategies can actually help bring people towards abstinence. It's a tremendous, unexpected outcome of some of those strategies. The original assumption that removing the threat of HIV or "enabling" the use of clean needles would reduce the motivation for treatment was wrong.

Moyers: Why do we have such a hard time making up our mind about addiction?

White: If you look at American history, we are eternally ambivalent about these substances. On the one hand, in America we bring a voracious appetite for them. At the same time, the flip side of that is that the efforts to suppress these substances are every bit as intense and animated and aggressive as the search for a good high. So we keep playing out both sides of that almost cyclically for the last couple of hundred years.

Moyers: What is the relationship between science and substance abuse policy?

White: I wish I could tell you that in my reviews of the history of addiction and social policy in America, I've found that science has been the driving force behind that policy, but I can't. Science is more often a self-absorbed bystander than it is a driving force in social policy. We have a long history in this country of state, local, and federal governments generating scientific advisory bodies who then bring the best minds in the country together to ask, "What should we do with this particular aspect of the drug problem?" They then take a year or two or three years and study it meticulously and generate recommendations that are immediately rejected.

Moyers: Because they don't fit the desirable bias?

White: Yes. There's a brief story I can share from the post-repeal area. Ron Roizen's research revealed it. In 1936, the legislature of Virginia decided that, following the repeal of Prohibition, alcohol education needed to be re-evaluated. So they picked two of their leading institutions to study this problem, and they generated a report. Immediately, the draft of this report came under such incredible attack by "dry" forces in the state that the state legislature voted unanimously to have the 1000 copies of this report guarded until such time as they could be burned.

Moyers: What did the report say?

White: It basically described a fairly straightforward objective understanding of what the effects of alcohol in the body were, but given the fact that it didn't immediately come out and demand radical abstinence from all alcohol, it came under very, very bitter attack.

Moyers: It didn't support popular opinion.

White: Right. And we've had others, the marijuana commissions, which tend to support decriminalization, the Ford Foundation report -- we've got a whole host

of them. Enormous amount of time and money spent to generate these, and they are completely ignored. On the other hand, we can have a glimpse of a brief scientific report that hardly wouldn't even be called established science. Robert Dupont's early report that methadone programs in Washington, D.C., demonstrated a significant reduction in criminal activity -- that brief preliminary report on a small number of clients drove national social policy. Not because of the science, but because the preliminary conclusion that it drew was very congruent with Nixon's desire to radically reduce urban crime before the 1972 presidential election.

Moyers: So he got behind methadone as alternative.

White: It became the magic bullet. Not as treatment, mind you. It was a way to reduce urban crime in the United States by the quickest means possible.

Moyers: So what can we learn from drug policy history?

White: Drug policy is sort of like a sponge. It absorbs every piece of latent conflict within the culture. And racism plays a very permanent role in most campaigns to criminalize drugs.

Moyers: The fear that blacks will use drugs and alcohol and commit crimes?

White: Well, the campaign to prohibit opium overwhelmingly linked that drug to the Chinese. The movement to increase controls on cocaine was overwhelmingly associated with racist images of blacks. If we move forward, we have the link between heroin and foreign immigrants, particularly in New York City. And at the time we prohibited alcohol -- there's a strong anti-Catholic sentiment tied to it. There's an anti-German feeling tied to the experiences coming out of World War I that's part of the media campaign which led to Prohibition. We have the link between marijuana and Mexican-Americans in the 1930s, which led to the

banning of that drug. If we look at the focused campaigns which result in significant shifts in policy, particularly in terms of criminalization, we see issues of race and social class dominating.

Moyers: If a third of all the white men in Washington, D.C., which would include some members of Congress, were in the criminal justice system because of some drug-related offense instead of it being a third of all young black men, what do you think would be our policy?

White: We have some experience which sheds light on that. We criminalized cocaine and heroin in 1914 through a series of Supreme Court decisions. In 1937, we added marijuana to our list of prohibited drugs. Went into the '50s and dramatically escalated penalties for all those drugs for possession and sale. The men who wrote and passed those laws, in their wildest fantasies, could not have conceived that they would be applied to their own children in the 1960s. As long as it wasn't their family members, they continued to push for harsher and harsher sentences and more enforcement. As soon as we begin to get a large number of middle- and upper-class individuals arrested on drug charges in the 1960s, we know what happened. There was suddenly a movement towards decriminalization. There was a movement towards diversion from prison to alternative sentences. We may be coming back into that kind of cycle right now. Because we're seeing a resurgence of drug use across the board, which will mean that more middle- and upper-class whites will be coming up against these harsh policies.

We're seeing increased use of hallucinogens, LSD, ecstasy. We're seeing increased use of stimulants, but not the cocaine that dominated the '80s, methamphetamine and amphetamine instead. Increased use of solvents. Sedatives are coming back, Rohypnol and other such drugs. All of that is giving a lot of us flashbacks to the 1960s and early '70s. There's also a significant rise in middle-class and affluent heroin use for the first time since

the late '60s, early '50s. What that all tells us is that the criminalization which put large numbers of poor African-American men in particular in the criminal justice system since 1980 will now ensnare a significant number of middle-class, affluent, white individuals. I would predict that we will see the same thing. I think the drug court movement will be fueled in non-urban areas by a desire to move middle-class and affluent individuals out of the criminal justice system. Our view of the people who take drugs determines how we will treat them.

Moyers: At the same time, isn't society trying to put some boundaries on substance abuse, trying to say something about its values and about the dangers it senses from uncontrolled transformation of human consciousness with these laws?

White: When we criminalize a drug, probably the real control mechanism there is not the attempt to control supply and punish users and dealers. I think it's a way that the culture can express a value and a judgment. That cultural judgment probably does more to shape whether people use or don't use than the law enforcement does. I think that's a very legitimate function of the law. The difficulty gets to be what happens when we express that judgment, but we have a significant portion of our culture who disagree and breach the law. What they encountered during Prohibition was this sort of difficulty. Are we on the verge here of destroying respect for all law by having certain laws on the books that are blatantly violated by large number of individuals in the culture?

Moyers: Do you think of addiction as a disease?

White: I think there are multiple sub-groups of addicts, and many types of addiction, but yes, there are a number of those subtypes that can accurately be called diseases. I want to lay that out in historical perspective. The very notion of disease starts early. There was Dr. Benjamin Rush in the 1700s, who wrote about the sickness of drunkenness. It

moves into the 1800s, where we get the American Association for the Studying and Cure of Inebriety organized. That organization was founded on the notion that inebriety, which is what they called addiction, was a disease. A whole system of treatment grew up around these notions, but between about 1900 and 1920 it collapses, and we literally lost that whole understanding of addictive disorders as diseases until, following the founding of AA in 1935, we get the rise of the modern alcoholism movement. And there, in the '40s and later, we get a rebirth of the disease concept. They couched the rebirth in scientific language regarding new discoveries about the nature of alcoholism, but the reality was that the science hadn't been completed. The modern alcoholism movement was actually based on a declaration that the alcoholic is indeed sick and is worthy of our help. By the '60s and '70s, when people were surveyed about whether alcoholism is a disease, an overwhelming majority agreed. They weren't talking about science. They were talking about the fact that they believed the alcoholic was sick and that public resources ought to go to support the treatment of that person. But the treatment system born in the 1970s had a pretty narrow idea about what alcoholism was. They saw it as a unitary, progressive disorder which could only be treated in one way. We brought huge numbers of people into treatment that way, and I really want to emphasize that when that model and that language connected with the right people, it was incredibly transforming. The problem was that the science began to catch up with us and began to erode some of the premises of that historical model, so now not only are we experiencing a financial backlash to the treatment system, there's also been an ideological backlash. What we told people was true for all alcoholics simply wasn't, and the science was showing that, as well as people's own experiences. For example, alcohol problems are often not progressive. If anything, they're the opposite. Many people get in trouble with alcohol early, particularly during their late teens and early adulthood, and then mature out of that and

never go into the self-accelerating cycle of alcoholism. So the backlash against treatment was not only because of financial abuses, but because providers had defined alcoholism in an overly simplistic manner which didn't fit many of their patients.

That doesn't mean we should throw away the disease concept, just that we may need to refine it. It has done two very important things. The concept itself was probably the most important piece of social engineering in modern history in terms of taking a highly stigmatized disorder and within about two to three decades radically changing how this culture viewed the alcoholic. From that standpoint, the framework of viewing alcoholism as a disease made an enormous contribution by creating an empathetic treatment response. The second thing it has done is to provide a metaphor that alcoholics can use to label what had happened to them and to come to understand it. Whether in fact alcoholism is a disease or not is insignificant compared to the clinical utility of that idea in helping people make sense out of their experiences.

Moyers: It helps them change.

White: Yes. And it's metaphorically true regardless of its scientific status. When we have hundreds of thousands of people standing up saying, I am an alcoholic and I have experienced the disease of alcoholism and now I am in stable long-term active recovery, to the extent that that language helps that process, then it has been a very powerful health-promoting metaphor within our culture.

Moyers: People often change in response to metaphors, and when cultures change their metaphors have to change. So there is an importance to the way we see the world, and the way we see alcoholism.

White: The key part of that is that the metaphors need to fit particular people, because, as you well know, different people use very different kinds of ideas and metaphors in their life to drive change. The

metaphor that is transformative for me could leave you untouched. I could say that the concept of alcoholism as a disease is a way to literally make sense out of 20 years of tragedy in my life, but somebody next to me who shares that same tragedy may stand up and use the metaphor that alcoholism is genocide and use that metaphorical conceptualization to drive radical change in his life as well. Both of us may be abstinent using two radically different ideas.

Moyers: What did you mean when you said in your book, "Follow the money" if you want to understand the problems in regulating alcohol and tobacco?

White: I was trying to convey that there's this struggle within our culture. We have forces that work to inhibit usage of alcohol and other drugs, and we have forces that work to promote those. If you want to understand which side is winning, look at the money. Look at the bottom line. If we compared the advertising budgets of the tobacco industry and the alcohol industry -- just taking two, I'm not even talking about the pharmaceutical industry or any others -- and compared those to what we put in dollars into local primary prevention programs, it might tell us something. If I've got one alcohol brewery which is spending a million dollars a day to promote their product with some of the most sophisticated advertising this century has produced, and I'm given \$30,000 for a little prevention program in my community, and we're talking about this is the inhibiting force and this is the promoting force, do we have any guesses of how things may play out? "Follow the money" says that one of the primary strategies of prevention ought to simply be to reduce the promotion forces in the culture. The problem that the government has being the agent for promoting prevention is an enormous conflict of interest. If I tax tobacco and I tax alcohol and generate enormous amounts of money, but, at the same time, my goal is to protect health by dramatically reducing consumption, there's an obvious inherent financial conflict of interest.

Moyers: But how would you go about devising a public health strategy to cut consumption of these drugs?

White: The problem is that it's not just consumption you need to focus on with alcohol, but excessive consumption, because that's where the real profit is. If I can get people to consume more days a week, more beers a week, more beers a day, that means more profits. Of course, those profits don't equate to public health, because as those dosages go up, we get larger ranges of alcohol-related problems. My strategy would be to try to reduce the promoting forces that are pushing people to stretch the boundaries. The primary control mechanism a culture has is rituals to reduce and manage drug consumption. It generates ideas about who can use and when they can use, and where they can use and how much and under what circumstances without being considered deviant. What promoting forces want to do is loosen those controls. And right now, we have incredible promotional forces. We can go in and do all the little prevention programs we want, but in the face of them, those are fairly impotent.

Moyers: So, to reduce alcohol and drug problems, you'd work to increase those cultural controls, those rituals? Right now, the advertising promotes alcohol as a sign of power and success and fellowship, so you'd want to change that?

White: Yes. If we have promotional forces which manipulate images to make these products exceptionally attractive to late adolescents and young adults, we have some major health concerns. The issue is not the presence of those drugs in the culture, but the promotion of those drugs in ways which push excessive use.

Moyers: And that's what we have now.

White: Yes. With crazy contradictions. For almost 25 years, we've had a fairly sustained campaign to stigmatize drunk driving. But at the same time, we provide alcohol at sporting events. The majority of people are

going to get there by driving. We provide, we license the sale of alcohol in filling stations, where you can get cold beer to go in a single container in a bag. Incredible contradictions between, on one hand, what we say is our policy around stigmatizing this, and at the same time we almost ritualize drinking and driving.

Moyers: There are forces in this country who do not want to destigmatize addiction because they think a lot of people don't use because of the stigma.

White: There's probably some truth in that. It's back to that debate over preventing drug use versus preventing drug casualties. If, for example, we begin to move towards decriminalization and even particularly if we went to legalization, imagine turning cocaine over to the advertising sophistication of Anheiser Busch. Obviously the casualty data would just would skyrocket beyond belief.

So if we stigmatize drugs by law, we probably do in some ways contain the number of users. And presumably, if we destigmatize by way of decriminalization, we'll probably have a larger user pool. Some people who wouldn't use the drug illegally, will, if it becomes legal, try that drug. Others would argue that, yes, the user pool will get larger, but the casualty pool would decrease, because the harm related to some of those drugs is not related to their psychopharmacology, it's related to their legal status. An example of that would be heroin. In and of itself, it does not produce HIV and AIDS transmission. HIV transmission comes from the use of shared needles within an illicit drug culture. It's the status of that drug in the culture, not the drug, that makes addiction a primary route of HIV transmission in the United States, because if shooting heroin were legal, no one would need to share needles. So it's the old debate of, Do we shrink the total pool of users or do we try to shrink the casualty population? Our drug policy has been based on the overall assumption that if you shrink the total pool, casualties will go down, but we've had periods where that's not been

true. Between 1982 and 1992, by all the surveys, the overall number of illicit drug users in the United States was shrinking, but at the same drug casualties were dramatically escalating. Even though the total number of people using illicit drugs was going down, casualties were going up, because those who were still using were poorer and were using more dangerous drugs, and more dangerous routes of administration, particularly crack cocaine. In 1986, when Project Safe started, there were 297 drug-exposed infants in Illinois. Four years later there were 2,399 drug-exposed infants in my state, almost overwhelmingly related to cocaine use. In four years, even though the total number of users was shrinking, we had this dramatic rise in casualties related to children and families in my state.

Moyers: What does that suggest for drug policy?

White: It means we've got some very, very tough choices ahead of us. I think the trade-off is that, on the one hand, you may want to accept some level of drug casualties. In fact, some people would say we need drug casualties, because drug-related deaths and all those things discourage other people from using. The other side says that we could do some things here by way of harm reduction that as far as we know do not dramatically expand the pool of users. There's fairly good evidence that needle exchanges do not encourage new people to begin using heroin. At the same time, we may be able to dramatically reduce HIV transmission through a needle exchange program. There's going to be a sustained tough debate about, Do we focus our prevention efforts on drug use, or Do we focus those efforts on drug addiction and related problems. A significant area of debate, and enormous controversy surrounding it.

Moyers: Recovering people are largely invisible in our culture. What's the consequence of their invisibility?

White: Let me give you a historical perspective. The alcoholism movement which grew out of the 1940s and generated today's treatment system was powerfully influenced by AA and its traditions of anonymity. That meant that many people believed that standing up publicly and talking about their alcoholism would mean violating the tradition on which their recovery was based. The National Council on Alcoholism started a project called Operation Understanding in the '70s and began not to publicly identify people with AA, but to have large numbers of people from all walks of life publicly declare their prior history of alcoholism and the fact that they had recovered. We see large numbers of drug casualties. Every day we're assaulted by some new baseball player going into treatment for the fifth time, but we don't see visibly as a culture the power of long-term recovery and the stability that it can have. What they did in the 1970s, early 1980s, was to generate some of that kind of movement. Since then my sense is that that kind of visibility has really deteriorated, and we really are back to seeing the worst conceivable images. The current image of treatment is of a ballplayer who just got out for the seventh time and has tested positive again for cocaine.

Moyers: Or a rock singer who dies of an overdose.

White: Yes, so we're seeing casualties, but we don't have the counterpart to that of people who are visibly standing up proclaiming their long-term recovery. I think these things always do tend to go in cycles, so my guess is within the next decade I think we will see the rebirth of a new recovery movement. An advocacy movement to reaffirm this notion that recovery really is possible for a large number of people. And which can hopefully help us tackle some of the difficult choices we need to make in our drug policy.