RECOVERY MANAGEMENT

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Preface

Dear Colleague,

The Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC) is part of a national network that includes 14 regional centers and a national office, funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. Great Lakes' primary goal is to help elevate the quality of addiction treatment by designing and delivering culturally competent, research-based training, education, and systems-change programs for addiction treatment and other allied health professionals. Great Lakes ATTC is very pleased to be able to offer its professional constituents a new monograph on the topic of Recovery Management.

Many of the central ideas contained in this monograph were birthed over the past eight years inside the Behavioral Health Recovery Management project — a joint venture by Fayette Companies in Peoria, Illinois and Chestnut Health Systems in Bloomington, Ilinois. Many of the core strategies outlined in this monograph have been and are being tested within the Lighthouse Institute (Chestnut Health Systems' research division) and within other addiction research centers around the country.

This monograph contains a synthesis of findings from scientific studies and recommendations from new grassroots recovery advocacy and support organizations that are collectively pushing a fundamental redesign of addiction treatment in the United States. Based on growing evidence of the chronicity and complexity of severe substance use disorders, we are faced with an increasing need to shift the current acute care model of treatment toward a model of assertive and sustained recovery management.

This monograph introduces the recovery management model through a collection of four papers.

- *The first paper, entitled "Recovery: The New Frontier," describes the historical shift in the addictions field from a pathology paradigm (knowledge derived from studies of the problem), through an intervention paradigm (knowledge derived from the clinical treatment of the problem), to an emerging recovery paradigm (knowledge derived from individuals, families, and communities that have solved the problem). It concludes with a discussion of ways in which this latter paradigm will reshape the future of treatment and recovery in the United States.*
- *The second paper, "The Varieties of Recovery Experience," describes what we as a country know from the standpoint of science and cultural experience about the long-term resolution of alcohol and other drug problems, as well as the implications of this knowledge for the design of addiction treatment.*
- *The third paper, "Recovery Management: What if we really believed addiction was a chronic disorder?" defines the core principles, changes in clinical practices, implementation obstacles, and potential pitfalls of the recovery management model.*
- *The final paper, "Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities," describes the special advantages the recovery management model offers to communities of color in the United States.*

Special thanks are due to Fayette Companies and Chestnut Health Systems, whose early pioneering work laid the foundation for this monograph; to the authors — William White, Ernest Kurtz, and Mark Sanders — for their work on these papers; and to the many addiction professionals in the states of Illinois, Indiana, Michigan, Ohio, and Wisconsin whose input in workshops over the past several years helped refine many of the ideas in these pages. Special gratitude is also extended to Herminio Rodriguez, whose brilliant and creative design and production work brought this publication to life; and to Pamela Woll, author and Great Lakes partner, who lent her magical "eyes" to the copy editing of this document.

Great Lakes ATTC is offering this monograph, not as the last word on this subject, but as a catalyst for renewed discussion about the future of addiction treatment and recovery in America. We invite you to be an active voice in these discussions. Recovery management is an idea whose time has come. It will be up to addiction treatment professionals and recovery support specialists across the country to bring that idea to life within the individuals, families, and communities we are committed to serve. The journey toward that goal will require courage and sustained commitment. Great Lakes ATTC and its staff look forward to sharing that journey with you.

Lonnetta Albright
Director
Great Lakes ATTC

Recovery Management

Recovery: The Next Frontier

William L. White, MA

This article was originally published in *Counselor: The Magazine for Addiction Professionals* (2004, 5/1: 18-21) and is reprinted here with permission.

The history of the addictions field has been one of evolving paradigms (organizing constructs), evolving core technologies, and evolving definitions of the field's niche in the larger culture whose needs it must serve. This article traces the evolution of the field's organizing paradigms through three overlapping stages: a problem-focused stage, an intervention-focused stage, and an emerging solution-focused stage. These paradigms can be viewed as competing models but are best viewed as developmental stages, with each preparing for the emergence of the next.

The Pathology Paradigm

The first stage was launched by what Levine (1978) has christened "the discovery of addiction." This birthing stage in the late eighteenth century was sparked by a break from prevailing moral and religious frameworks of understanding and responding to chronic drunkenness. Compulsive and destructive AOD use became defined as a disease of the body and the will, a redefinition that has sustained more than 200 years of research on the nature of psychoactive drugs, their acute and chronic effects, the multiple sources of individual vulnerability to AOD problems, and the stages of AOD problem development. An enormous body of literature exists and continues to be generated on the psychopharmacology and epidemiology of AOD problems. Elaborate systems of data collection exist to measure the slightest shifts in drug-related attitudes, beliefs, and behaviors. A research industry exists whose sole mission is studying drugs, their patterns of consumption, and their personal and social costs. As a culture and a professional field, we have a knowledge of psychoactive drugs and drug addiction that is impressive. This cultural investment in studying the nature of AOD problems reflects a pathology paradigm — the assumption that knowledge of the sources of a problem will lead to its eventual solution. Knowledge gained within this paradigm provided significant benefits and laid the foundation for policy, educational, and clinical responses to AOD problems.

The Intervention Paradigm

Attempts to resolve AOD problems personally and socially also have a long history in America. These attempts span AOD-related social policies, education, and prevention efforts; early intervention programs; and addiction treatment. A voluminous body of knowledge and resources (including this journal) exists that focuses on when and how to intervene in these problems. The readers of this journal have been part of this country's unprecedented investment in the professionally directed treatment of AOD problems. Some readers are old enough to have witnessed the transition of treatment from an unfunded folk art to a highly professionalized and commercialized industry. We have learned within this modern era of treatment how to interrupt addiction careers. We know a lot about engagement, detoxification, problem stabilization, and recovery initiation. We

know a lot about what people look like in the years before they were admitted to treatment. We know a lot about what people look like during treatment. And we know a little bit about what people look like in the months following treatment.

The knowledge gained from this intervention paradigm has advanced the field and allowed hundreds of thousands of individuals to initiate and sustain recovery. The majority of drug-dependent persons who achieve sustained recovery do so after participating in treatment (the percentage varies by substance: cannabis (43%), cocaine (61%), alcohol (81%), and heroin (92%) (Cunningham et al., 1999, 2000). That knowledge has also illuminated the limitations of our current treatment system. For persons with severe AOD problems, it often takes three to four episodes of acute treatment over a span of eight years to achieve stable and enduring recovery (Dennis, Scott, Funk, & Foss, under review). These findings challenge models of brief treatment; short-term aftercare; and follow-up studies whose designs, until recently, extended only several months following discharge from treatment. These shortcomings have led to calls for more recovery-sustaining models of intervention and support and more recovery-focused research and evaluation activities. In short, there is growing interest in extending the pathology and intervention paradigms into a more fully developed recovery paradigm.

Agitation for Change

For readers who think they and their programs and the larger field are already recovery-focused, it may be helpful to view this issue through the eyes of the recovery advocates (of the 1950s-1960s) who were the midwives of modern addiction treatment. It is among these advocates that the need and call for this recovery paradigm is most poignantly articulated. The advocacy leaders in local alcoholism and "drug abuse" councils were inspired by a vision of an ever-expanding recovery community. They championed the birth of professionally directed treatment as a special doorway of entry into that community for the many people who could not make the transition from addiction to recovery on their own. Decades later, these advocates see an ever-growing treatment industry that views recovery as an afterthought or adjunct to itself. While this view may seem harsh to the reader, consider the world through the advocates' eyes. They 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 confront the public perception that people do not recover despite rarely acknowledged epidemiological studies finding that 58% of people with lifetime substance dependence eventually achieve sustained recovery (Kessler, 1994; see also Dawson, 1996; Robins & Regier, 1991). 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 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.

The Recovery Paradigm

The movement forward to a recovery paradigm is already underway. The evidence of this shift in grassroots communities includes the:

- growth and diversification of American communities of recovery (White, in press);
- emergence of a multi-branched new recovery advocacy movement (White, 2001);
- rapidly spreading Wellbriety movement in Indian Country (see www.whitebison.org);
- growth of faith-based recovery support structures, particularly within communities of color (see Sanders, 2002);
- organization of recovering ex-felons into mutual support networks, (e.g., the Winners Circle in Chicago);
- growth of self-managed recovery homes (see http://www.oxfordhouse.org) and recovery schools (e.g., the Association of Recovery Schools); and
- spread of recovery employment co-ops (e.g., Recovery at Work in Atlanta).

The shift to a recovery paradigm is evident at the federal level in President Bush's Access to Recovery Initiative, increased NIDA and NIAAA support for studies of long-term recovery, and CSAT's Recovery Community Support Program and Recovery Month initiatives. It is evident in state initiatives pushing treatment toward a "recovery-oriented system of care" (see http://www.dmhas.state.ct.us/policies/policy83.htm). It is evident in the research community's call to shift addiction treatment from serial episodes of acute intervention to models of sustained "recovery management" (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002, 2003). And it is evident in local experiments with peer-based models of recovery support, new recovery-focused service roles (recovery coaches, recovery support specialists), and the shift from traditional "aftercare" services to models of "assertive continuing care" (White & Godley, 2003; Dennis, Scott, & Funk, 2003)

Recovery Management

How will the transition toward a recovery-focused future differ from our past? The shift

from acute intervention to recovery management for those persons with severe and persistent AOD problems will involve three changes in the continuum of care. First, it will intensify pre-treatment recovery support services to strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, and determine whether the individual/family can initiate and sustain recovery at this stage without additional professional intervention. (The latter may be quite possible for those with lower problem severity and indigenous supports for recovery.) Second, recovery management will intensify in-treatment recovery support services to enhance treatment retention and effects (by keeping treatment recovery focused). Traditional treatment methods will change in a number of important dimensions (e.g., from single-agency to multi-agency intervention, from categorical to global assessment, from institution-based to neighborhood- and home-based service delivery). Most important, it will differ in the nature and duration of the service relationship. Third, recovery management will shift the focus of treatment from acute stabilization to support for long-term recovery maintenance. Professionally directed recovery management, like management of other chronic health disorders, shifts the focus of care from one of "admit, treat, and discharge" to a sustained health management partnership. This means that the traditional discharge process will be replaced with post-stabilization monitoring (recovery check-ups); stage-appropriate recovery education; recovery coaching; active linkage to communities of recovery; recovery community resource development; and, when needed, early re-intervention. Rather than cycling individuals through multiple self-contained episodes of acute treatment, recovery management provides an expanded array of recovery support services for a much greater length of time but at a much lower level of intensity and cost per service episode.

A New Language

New paradigms bring new ways of perceiving, thinking, and speaking. As we move deeper into this recovery paradigm, we will need to forge new concepts and a new language. We will need better words and concepts to:

- delineate the conceptual boundaries of *recovery;*
- describe types of recovery, e.g., partial versus full, serial recovery, solo versus assisted, medication-assisted recovery;
- evaluate recovery assets, e.g., Granfield and Cloud's (1999) concept of "recovery capital";
- chart the pathways of recovery, e.g., secular, spiritual, religious;
- distinguish styles of recovery initiation, e.g., incremental versus transformational change;
- depict variations in identity reconstruction, e.g., recovery-positive versus recovery-neutral identities; and
- describe variations in recovery relationships (with other recovering people, e.g.,

acultural, bicultural, and culturally enmeshed styles) (see White, 2002 for a detailed discussion of this new language).

We will all need to stretch our understanding of recovery and become multilingual as we expand the words and metaphors that reflect the growing varieties of recovery experiences in America.

A New Vision

Since its inception, the purpose of this column has been to enhance the addiction professional's understanding of the history of treatment and recovery in America. This article is about the living history that is unfolding before us in this moment. It is about the opportunity for recovery advocates, policy leaders, treatment professionals, and researchers to form a partnership that will write the future history of addiction treatment and recovery in America. Destiny will call some of you reading this to help lead this leap into the future. I wish you and your clients Godspeed on your journey from the problem we know so well to the recovery vision that lies ahead of us.

References and Recommended Reading

Cunningham, J. A. (1999). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*, 60, 463-466.

Cunningham, J. A. (2000). Remissions from drug dependence: Is treatment a prerequisite? *Drug and Alcohol Dependence*, 59, 211-213.

Dennis, M., Scott, C.K. & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning* 26(3), 339-352.

Dennis, M.L., Scott, C.K, Funk, R., & Foss, M.A. (under review). The Duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*.

Dawson, D.A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20, 771-779.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Kessler, R. (1994) The National Comorbidity Survey of the United States. *International Review of Psychiatry* 6:365-376.

Levine, H. (1978). The discovery of addiction: Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol*, 39(2), 143-174.

McLellan, A. T., Lewis, D. C., O'Brien, C. P, & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695.

Robins, L.N., & Regier, D.A. (1991). *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. Free Press: New York.

Sanders, M. (2002). The response of African American communities to alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 20(3/4), 167-174.

White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor*,

2(6), 64-67.
White, W. (2002). An addiction recovery glossary: The languages of American communities of recovery. Retrieved from www.facesandvoicesofrecovery.org
White, W. (in press). Alcoholic mutual aid societies. In J. Blocker & I. Tyrell (Eds), *Alcohol and Temperance in Modern History*. Santa Barbara, CA: ABC-CLIO.
White, W., Boyle, M., & Loveland, D. (2002). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, 3/4, 107-130.
White, W., Boyle, M., & Loveland, D. (2003). Recovery management: Transcending the limitations of addiction treatment. *Behavioral Health Management*, 23(3), 38-44 (http://www.behavioral.net/2003_05-06/featurearticle.htm).
White, W., & Godley, M. (2003). The history and future of "aftercare." *Counselor*, 4(1), 19-21.

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The Varieties of Recovery Experience:

A Primer for Addiction Treatment Professionals and Recovery Advocates

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Abstract

The study of alcohol and other drugs (AOD) is historically marked by three stages: 1) the investigation of AOD-related social and personal pathologies, 2) the development of personal and social interventions aimed at resolving AOD problems, and 3) a focus on the prevalence and patterns of long-term recovery from AOD problems. This essay honors this transition from addiction and treatment paradigms to a recovery paradigm by exploring the growing varieties of pathways and styles through which people are resolving serious and persistent AOD-related problems. A review of scientific and mutual aid literature is used to catalogue variations in:

- *scope of recovery (primary and secondary chemical health and global health),*
- *depth of recovery (partial, full, and enriched),*
- *types of recovery (abstinence-based, moderation based, medication assisted),*
- *context of recovery initiation (solo, peer assisted, treatment assisted),*
- *frameworks of recovery initiation (religious, spiritual, secular),*
- *temporal styles of recovery initiation (transformative change, incremental change, drift),*
- *recovery identity (positive, neutral, negative),*
- *recovery relationships (acultural, bicultural, and enmeshed styles; virtual recovery),*
- *recovery stability/durability (At what point does present remission predict future remission?), and*
- *recovery termination (Is recovery ever completed?).*

After exploring the wide diversity of recovery styles and experiences that exist within Twelve-Step fellowships and other recovery mutual aid societies, the article explores the implications of the wide diversity in recovery experiences to the design and conduct of addiction treatment.

Keywords: addiction recovery, natural recovery, transformative change, stages of change, virtual recovery, religion, spirituality, secularity.

Addiction, Treatment, and Recovery Paradigms

Alcohol- and other drug-related (AOD) problems constitute a significant public health problem within American and world history (Lender & Martin, 1982; Musto, 1999; Courtwright, 2001). Responses to these problems over the past two centuries reflect three organizing paradigms. From the late eighteenth century through the era of alcohol prohibition, pathology provided an organizing framework, whether religiously or medically conceived. The pathology paradigm fueled the debate over whether alcoholism was a sin or a sickness; guided studies of the incidence, prevalence and personal/social costs of AOD problems; and sparked the sustained search for the etiological roots of these problems. The hope upon which the pathology model was built was that knowledge of the scope and sources of AOD problems would generate specific solutions to these problems in the same way isolating and attacking particular pathogens had earlier led to the elimination or control of many infectious diseases. While failing to achieve this ultimate goal to-date, the pathology model has made significant contributions to our understanding of the multidimensional processes that interact to initiate and sustain addiction.

The failure to find the singular pathogen underlying AOD problems led to the testing of numerous strategies and techniques of intervention, both social and personal. To this day, the intervention model buttresses multi-billion-dollar industries aimed at preventing drug use, controlling drug supplies, punishing drug offenders, and treating those with severe AOD problems. The intervention model assumes that the scientific evaluation of AOD-related social policies and biopsychosocial interventions will reveal the most effective prevention, intervention, and control strategies, and that those strategies that can be best matched to particular communities, demographic/clinical subpopulations, and individuals. This model has generated significant new understandings that are sparking widespread calls to bridge the gap between clinical research and clinical practice in addiction treatment.

The historical intractability of AOD problems at a societal level has led to disillusionment with the pathology and intervention paradigms and a recent shift in focus toward resilience and recovery (Morgan, 1995a; Elise, 1999; White, 2000, 2004a). As early as 1984, Edwards was calling for the field to explore the “natural processes of recovery.” This was followed by calls for “recovery-oriented psychotherapy” (Zweben, 1986) and “recovery-sensitive counseling” (Morgan, 1995b). The recovery paradigm focuses on at-risk individuals, families, and communities who have avoided the development of severe AOD problems and the lives of individuals, families, and communities with severe AOD problems who have successfully resolved or are resolving these problems. Advocates of this model suggest that studying the lived solutions to AOD problems will reveal principles and strategies upon which broader, more effective social policies and professional interventions can be built (Morgan, 1995a; White, 2005).

Knowledge about AOD problems is substantial, but comparatively little is known from the standpoint of science about the long-term solutions to these problems. In recent epidemiological studies of individuals who once met criteria for alcohol dependence, 63% to 75% no longer met dependence criteria at the time they were surveyed, suggesting a

substantial long-term recovery rate (Helzer, Burnam, & McEvoy, 1991; Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). The Workgroup on Substance Abuse Self-help Organizations (2003) estimates the total U.S. membership of recovery mutual aid groups at more than 1.6 million people and reports that more than six million adults each year have some contact with these groups. In spite of a substantial body of recovery experience in the U.S., the addictions field does not draw its primary knowledge base from this source. Today, addiction professionals routinely assert the existence of multiple pathways of recovery, but from the standpoint of science, we know little about such pathways. As addiction treatment interventions become ever briefer, treatment professionals have less and less contact and knowledge of the long-term recovery process.

AOD problems arise out of quite different personal, family, and cultural contexts and unfold in variable patterns and trajectories. These same forces generate heterogeneous recovery experiences. The goals of this paper are to: 1) conceptually map the diverse patterns and styles of AOD problem resolution, 2) introduce a lexicon through which such variations can be described, and 3) explore the implications of the diversity of recovery experience for the design and conduct of professional interventions into such problems. This conceptual map is based primarily on scientific studies on the course of AOD problems in community and in clinical samples. The literature of multiple recovery mutual aid societies and biographical and autobiographical depictions of recovery are also used to illustrate key findings. We hope this preliminary recovery map will spark new scientific studies of the prevalence, patterns, stages, and personal styles of long-term recovery from AOD problems.

Recovery Definition

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.

AOD problems vary in their course, including adverse reactions to a single episode of AOD-intoxication, problems that span only a few months or years, and problems that span significant periods of one's life. Such problems also vary in their intensity and overall severity, including:

- subclinical problems (transient AOD problems that do not meet DSM-IV criteria for abuse or dependence);

- AOD problems meeting DSM-IV criteria for substance abuse — Clinically significant impairment marked by one or more of the following in a 12-month time period: repeated substance use that results in failure to perform major role obligations, repeated use in situations that are physically hazardous, repeated substance-related legal problems, and continued substance use in spite of adverse AOD-related problems; and

- AOD problems meeting DSM-IV criteria for substance dependence — Clinically

> significant impairment marked by at least three of the following in a 12-month period: tolerance, withdrawal, loss of control (erosion of volitional control over quantity and duration of use), failed efforts to cease or reduce use; significant time involved in drug procurement, drug use, and recovery from drug effects; social, occupational, or recreational activities forsaken or reduced due to drug use; and continued use in spite of adverse physical or psychological problems caused by substance use (American Psychiatric Association, 1994).

The term *recovery*, because of its medical connotations, is most applicable to the process through which severe and persistent AOD problems (meeting DSM-IV criteria for substance abuse or dependence) are resolved. Terms such as *quitting*, *cessation,* and *resolution* more aptly describe the problem-solving processes of individuals who have transient and less severe AOD problems. Recovery implies reversal of a greater level of debility and a more involved and enduring problem-solving process (White & Scott, draft manuscript). Our continued discussion of varieties of recovery experience will focus on these more severe forms of AOD problems.

The term *family recovery* conveys the processes through which family members impacted by severe and persistent AOD problems individually and collectively regain their health. Family recovery 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) (White, 1996). The recovery of an addicted family member can destabilize and threaten the survival of the family unit if professional and social supports are not available to soften what Stephanie Brown and Virginia Lewis (1999) have christened the "trauma of recovery" (See also Rouhbakhsh, Lewis, & Allen-Byrd, 2004).

Recovery Prevalence

Elaborate systems exist to measure the subtlest of changes in the prevalence of AOD use and its consequences, but no similar system exists to measure the incidence and prevalence of recovery from AOD problems. However, individual researchers have conducted long-term treatment follow-up studies and community surveys over the past 25 years that reveal significant recovery rates: 41% (Ojesjo, 1981); 63% (Helzer, Burnam & McEvoy, 1991); 72% (Dawson, 1996); 30% (Schutte, Nichols, Brennan, & Moos, 2001); 59% (Vaillant, 2003); and 48% (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Factors such as differing demographic and clinical characteristics of study participants and different definitions of recovery influence variations in reported recovery rates.

The Scope and Depth of Recovery

Recoveries from addiction can differ in their scope (the range of measurable changes) and depth (degree of change within each measured dimension). Aborting a destructive relationship with a particular drug or combination of drugs is at the core of addiction recovery, but recovery experiences can range from complete cessation of AOD use in an otherwise unchanged life to a complete transformation of one's personal identity and

interpersonal relationships.

There are quite varied trajectories in the relationship between primary and secondary drug use among people seeking recovery from substance use disorders. One pattern of drug dependence can be aborted while a co-occurring pattern continues. For example, there are high rates of nicotine dependence among adults and adolescents before and after treatment for dependence upon alcohol, opiates, cocaine, and cannabis (Maddux & Desmond, 1986; Myers & Brown, 1990; Hughes, 1995, 1996; Bien & Barge, 1990; Hoffman & Slade, 1993).

A second pattern involves the escalation of secondary drug use following cessation of primary drug use, e.g., an increase in alcohol or cocaine use following the cessation of heroin use. Such drug substitution is a common problem in treated adults and adolescents, particularly among those with a history of polydrug use (Vaillant, 1979; Edwards, Duckitt, Oppenheimer, Sheehan, & Taylor, 1983; Toneatto, Sobell, Sobell, & Rubel, 1999; Maddux & Desmond, 1980, 1981, 1992; Anglin, Almong, Fisher & Peters, 1989; Simpson & Sells, 1990; Carmelli & Swan, 1993).

A third pattern involves individuals who use secondary drugs therapeutically during early recovery to manage acute and post-acute withdrawal and to help ameliorate the psychological stresses of early recovery (e.g., heroin users consuming cannabis following opiate abstinence to prevent relapse) (Willie, 1978; Waldorf, 1983; Biernacki, 1986; Copeland, 1988). In this pattern, secondary drug use ceases or decelerates within the first two years of recovery (Waldorf, 1983; Vaillant, 1979; Copeland, 1988; Bachus, Strang, & Watson, 2000).

The ability to understand when drug substitution is an effective, time-limited strategy for managing early recovery (requiring professional understanding, if not tolerance) and when drug substitution is a mutation of the existing problem (requiring prevention, early intervention, or focused treatment) is an important research agenda. Some investigators have found that secondary drug use is more likely to be problematic for persons with family histories of AOD problems, those who begin AOD use at an early age, and those who experience problems with a secondary drug before developing their primary addiction (Simpson & Sells, 1990; Maddux & Desmond, 1992). Also needed is a greater understanding of how sequential drug problems are resolved over time. The factors that contribute to the cessation of co-occurring dependencies or secondary drug use may differ from those factors associated with the cessation of primary drug use (Downey, Rosengren, & Donovan, 2000).

The scope of recovery can extend far beyond altered patterns of primary and secondary drug use. Historically, the definition of recovery has shifted from a focus on what is deleted from one's life (alcohol and other drugs, arrests for criminal acts, hospitalizations) to what is added to one's life (the achievement of health and happiness). This shift is reflected in such terms as *mental sobriety* (Mental Sobriety, 1946) and *emotional sobriety* — a phrase A.A. co-founder Bill Wilson coined to describe a state of emotional health that far exceeds the achievement of not drinking. Wilson defined emotional sobriety as "real maturity . . . in our relations with ourselves, with our fellows and with God" (Wilson, 1958). This broadened vision of recovery is also reflected in the term *Wellbriety* that is currently

being used within the Native American recovery advocacy movement to depict recovery as the pursuit and achievement of physical, emotional, intellectual, relational, and spiritual health, or "whole health" (Coyhis, 1999; *Red Road to Wellbriety*, 2002). Wellbriety within the Native American context is also related to a new set of core *recovery values*: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

Because severe and persistent AOD problems impact many areas of life functioning, recovery from such problems must be measured across multiple *zones* (or *domains*) *of recovery*: 1) the relationship(s) with the substance(s) for which one previously met DSM-IV criteria for abuse or dependence; 2) the presence, frequency, quantity, intensity, and personal and social consequences of secondary drug use; 3) physical health; 4) psychological/emotional/ontological health; 5) family/relational health; and 6) lifestyle health, e.g., a developmentally appropriate, pro-social style of work and leisure (White, 1996). Seen as a whole, the goal of recovery is what we refer to as *global health*.

Like that of other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of *full recovery* (complete and enduring cessation of all AOD-related problems and the movement toward global health) or a state of *partial recovery* (Jorquez, 1983). The term *partial recovery* can convey two different conditions: 1) a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems; or 2) the achievement of complete abstinence or stable moderation, but the failure to achieve parallel gains in physical, emotional, ontological, relational, or occupational health. Partial recovery can constitute a permanent state, a stage preceding full recovery, or a hiatus in AOD problems with eventual reversion to a previous or greater level of problem severity.

Falling between the parameters of no recovery and full recovery are individuals who cycle in and out of periods of moderate use, problematic use, and abstinence (Hser, Hoffman, Grella, & Anglin, 2001). A recent review of alcoholism treatment outcome studies drew three major conclusions: 1) treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third of those treated, 2) substance use (measured by days of use and volume of use) decreases by an average of 87% following treatment, and 3) substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). People who are constitutionally incapable of permanent sobriety at particular points in their lives may achieve *partial recovery* — significant decreases in AOD-related problems, improved levels of health and social functioning, and significant reductions in the costs and threats they pose to the larger community (Zweben 1996).

Partial recovery is reflected in individuals who cycle through multiple episodes of treatment, recovery initiation, and relapse (Scott, Foss & Dennis, 2005; Dennis, Scott, Funk & Foss, 2005). Such cycling is evidence that recovery is not fully stabilized, but the continued help seeking within such cycles also suggests that addiction is no longer stable. Cycling in and out of recovery (with reduced frequency, intensity, and duration of use episodes) can be a precursor to stable recovery or a chronic state.
Partial recovery can also refer to residual levels of impairment that continue after the ces-

sation or deceleration of AOD use. While most recovering alcoholics establish levels of personal and family functioning comparable to non-alcoholics (Moos, Finney, & Cronkite, 1990; Chapman, 1987), early recovery can be marked by poor levels of adjustment, e.g., depression, anxiety, poor self-esteem, guilt, and impaired social functioning (Kurtines, Ball, & Wood, 1978; Polich, Armor, & Braiker, 1980; Gerard & Saenger, 1962; Behar, Winokur, & Berg, 1984). De Soto and colleagues (1985) distinguished recovery status by length of recovery in a study of 312 members of Alcoholics Anonymous. They concluded that: 1) the early months and years of recovery from alcoholism are marked by continued impairment of emotional and social functioning, 2) these symptoms continue to improve and remit over the first ten years of recovery, and 3) some residual symptoms of cognitive dysfunction may continue in long-term recovery. The achievement of only a partial reversal of alcohol-related cognitive impairments is most common in alcoholics who began their recoveries after long drinking careers (Goldman, 1983; Schutte, 1994, 2001). The principle that global health and functioning improve with earlier onset of recovery and length of sobriety is further confirmed in follow-up studies of persons recovering from cocaine addiction (Selby, Quiroga, Ireland, Malow, & Azrin, 1995).

Some individuals experience changes so profound across these zones of recovery that they come to view addiction and recovery as "gifts" that have brought a depth of experience and meaning far superior to their pre-addiction lives. Such individuals achieve an enriched *state of recovery*. This enriched state of recovery is evident across recovery traditions:

> *The walls crumpled — and the light streamed in. I wasn't trapped. I wasn't helpless. I was free, and I didn't have to drink to "show them." This wasn't "religion" — this was freedom! Freedom from anger and fear, freedom to know happiness and love.* (From *Alcoholics Anonymous*, 1976, p. 228.)

> *It is impossible to put on paper all the benefits I have derived . . . physical, mental, domestic, spiritual, and monetary. This is no idle talk. It is the truth.* (From *Alcoholics Anonymous*, 1976, p. 481.)

> *My life is well-rounded and I am becoming a more comfortable version of myself, not the neurotic, boring person that I thought I would be without drugs…..I have a way to live cleanly, honestly and comfortably. I have all I need.* (From *Narcotics Anonymous*, 1988, p. 262.)

> *It's been a very long, long struggle but worth every single minute of it. I'm really happy to be alive, and life is truly great and wonderful for me right now.* (Women for Sobriety member, From Kirkpatrick, 1986, p. 258.)

> *Back in 1970 I found myself dying from the abuse of my body….The Creator had something he had for me to learn. First, I had to learn who he was. Then I had to learn who I was. I began to visit with my Elders….I had to come to grips with who I am as an Indian, as being a castaway, as being an unloved person. The Creator has love for each of us but we have to find that foundation.* (From *Red Road to Wellbriety*, 2002, p. 187.)

A final scope-and-depth dimension of recovery involves individuals who are engaged in concurrent or sequential recovery processes from two or more conditions or experiences, e.g., developmental trauma, psychiatric illness, AIDS. The overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders might be described as *serial recovery*.

Problem Severity and Recovery Capital

Recovery can occur at different stages of problem progression. There are patterns of *high-bottom recovery* among people who have not yet suffered severe losses related to their AOD use. There are also patterns of *low-bottom recovery* achieved by individuals in the latest stages of addiction who have experienced severe personal and social disintegration and anguish before achieving stable recovery (High Bottom, 1949).

In addition to the degree of problem severity, one's recovery capital influences one's prognosis for recovery. *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.

Pathways and Styles of Recovery

The phrase *pathways of recovery* refers to different routes of recovery initiation. This phrase recognizes the varieties of ways people successfully resolve AOD problems. One of the earliest origins of this notion of paths and choices of recovery frameworks was A.A. co-founder Bill Wilson's 1944 observation that "The roads to recovery are many" (Wilson, 1944). *Cultural pathways of recovery* are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. Such culturally prescribed avenues might be a product of:

- developmental consciousness (e.g., something to be resolved through maturation and assumption of adult role responsibilities),
- medical consciousness (e.g., response to an alcohol-related health problem),
- religious consciousness (e.g., conversion to and/or affiliation with an abstinence-based faith community), or
- political consciousness (e.g., rejection of alcohol as a "tool of genocide").

The phrase *styles of recovery* depicts variations in beliefs and recovery support rituals that exist within particular pathways of recovery. For example, Twelve-Step programs constitute one of the major pathways of recovery from addiction, but the close observation of several Twelve-Step groups would reveal wide variation in styles of "working the program," e.g., patterns of meeting attendance, approaches to "Step work," conceptual-

izations of “Higher Power,” and utilization of sponsors.

Abstinence-based, Moderation-based, & Medication-supported Recoveries

One of the variations in recovery from substance use disorders involves differences in the ways in which one’s relationship with psychoactive drugs is changed. The scientific literature on the resolution of AOD problems documents three such variations. *Abstinence-based recovery* has historically been the culturally prescribed approach to the resolution of severe AOD problems. This approach, which has guided mainstream addiction treatment in the United States in the modern era, calls for complete and sustained cessation of one’s primary drug(s) and the non-medical use of other psychoactive drugs (with nicotine and caffeine historically excepted). Over the past several decades, scientific evidence has grown on moderated approaches to AOD problem resolution. *Moderation-based recovery* (the sustained deceleration of AOD use to a subclinical level — continued AOD use that no longer meets DSM-IV criteria for substance abuse or dependence) has triggered great debates in America, spanning the 1976 Rand Report[1], the extended controversies over Mark and Linda Sobell’s research at Patton State Hospital[2], and later controversies surrounding Moderation Management, a moderation-based mutual support group (Kishline, 1994). There has also been growing interest in *medication-assisted recovery* (the use of medically monitored pharmacological adjuncts to support recovery from addiction, e.g., detoxification agents, stabilizing agents, aversive agents, antagonizing agents, anti-craving agents, or psychoactive drugs prescribed for the treatment of co-occurring physical or psychiatric disorders).

Discussion of these approaches is best grounded in the finding that substance-use problems exist across a continuum of problem severity and that problem severity influences pathways of problem resolution. Abstinence-based and medication-assisted styles of recovery predominate in patterns of severe alcohol and drug dependence, whereas moderation-based styles of recovery predominate in individuals with lower problem severity and greater recovery capital (younger, married, employed, higher socioeconomic status, higher social support and social stability, positive marital and work relationships) (Finney & Moos, 1981; Polich, et al., 1980; Vaillant, 1983; Armor & Meshkoff, 1983; Edwards et al., 1983; Rosenberg, 1993; Dawson, 1996; Cunningham, Lin, Ross, & Walsh, 2000; Vaillant, 1996).

The moderated resolution of substance use disorders is well documented in general population surveys. Dawson (1996), in a community survey of treated and untreated adults who previously met DSM-IV criteria for alcohol dependence, found that in the year prior to the survey 49.9% were drinking but no longer met criteria for abuse or depen-

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[1] The initial Rand Report included the finding: “...it appears that some alcoholics do return to normal drinking with no greater likelihood of relapse than alcoholics who choose abstention...” (Quoted in White, 1998). Controversies surrounding this report led to a second report that softened the initial report’s findings.

[2] Drs. Mark and Linda Sobell published a series of scientific reports documenting that some alcoholics achieve controlled drinking (Sobell and Sobell, 1973, 1976, 1978). These reports were followed by a re-evaluation by Pendery, Maltzman, and West (1982) that challenged the Sobell’s findings and their professional integrity. The Sobell weathered blistering personal and professional attacks in spite of being later cleared of wrongdoing by two separate scientific panels (Dickens, Doob, Warwick, & Winegard, 1982; Trachtenberg, 1984)

dence (27.8% met criteria for alcohol abuse or dependence, and 22.3% were abstinent). Two other studies (one a Canadian national study and the other an Ontario study) used a broader definition of "alcohol problems" and found that 38% and 62.7% (respectively) of those with alcohol problems had later resolved those problems via moderate drinking recoveries (Sobell, Cunningham, & Sobell, 1996). Moderated recovery at much lower rates of prevalence has also been noted in follow-up studies of those treated for alcohol dependence (Finney & Moos, 1981; Rosenberg, 1993; Vaillant 1996) and drug dependence (Levy, 1972; Willie, 1978; Harding, Zinberg, Stelmack, & Michael, 1980). Treatment outcome studies of adolescents have also found a subgroup of treated teens who "may evidence intermittent substance use, typically alcohol, but do not exhibit any ongoing alcohol-or-drug-related problems" (Brown, 1993).

Given the propensity for substance-related problems to wax and wane over time, one could rightly question whether subclinical use following addiction is sustainable. In the longest follow-up study of alcoholic men to-date (60 years), Vaillant (2003) found that 4% of inner-city men and 11% of college men sustained controlled drinking over the course of the follow-up. Most migrated from dependence to efforts at control to eventual abstinence. In the largest and most recent alcohol dependence and recovery prevalence survey (recovery defined as meeting DSM-IV alcohol dependence criteria prior to the last year but not meeting these criteria during the past year), 25% of those with prior alcohol dependence continued to meet dependence criteria, 27% were in partial remission (subclinical symptoms of dependence or presence of alcohol abuse), 12% were asymptomatic risk drinkers (drinking in a pattern predictive of risk for future relapse), 18% were low-risk drinkers, and 18% were abstainers (Dawson et al., 2005). As problem severity declines, the prevalence of moderated outcomes increases. This is most frequently noted in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood but later moderate their substance use (Fillmore, Hartka, Johnstone, Speiglman, & Temple, 1988).

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

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason — ill health, falling in love, change of environment, or the warning of a doctor — becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention* (*Alcoholics Anonymous*, 1939, p. 31).

> *If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people!* (*Alcoholics Anonymous*,1939, p. 42).

Medication-assisted recovery continues to generate considerable controversy within the

American culture, within communities of recovery, and within the professional addiction treatment community, in spite of evidence that attitudes toward medications as an adjunct to recovery may be softening (Rychtarik, Connors, Demen, & Stasiewicz, 2000). Influencing these shifts in attitudes are new pharmacological adjuncts in the treatment of alcohol dependence (e.g., naltrexone, acamprosate) and opiate dependence (e.g., clonidine, buprenorphine) (Vopicelli & Szalavitz, 2000).

One of the most widespread approaches to medication-assisted recovery is methadone maintenance treatment (MMT). There are an estimated 900,000 narcotic addicts in the United States and approximately 179,000 individuals enrolled in MMT (Kreek & Vocci, 2002). The major health policy authorities in the United States have weighed in on MMT and have universally concluded that optimal dosages of methadone combined with psychosocial supports and administered by competent practitioners: 1) decrease death rates of opiate addicts by as much as 50%; 2) reduce transmission of HIV, hepatitis B, hepatitis C and other infections; 3) eliminate or reduce illicit opiate use; 4) reduce criminal activity; 5) enhance productive behavior via employment and academic/vocational functioning; 6) improve global health and social functioning; and 7) are cost-effective (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998; White & Coon, 2003). In spite of such evidence, misunderstanding and social stigma attached to MMT (the perception that MMT simply substitutes one addictive drug for another) leave many in methadone-assisted recovery hiding their recovery status and stories from their employers and co-workers, their friends, and even their own family members (Murphy & Irwin, 1992).

The Context of Recovery Initiation

The context in which people achieve remission from substance use disorders varies considerably and includes styles of solo recovery, treatment-assisted recovery, and peer-assisted recovery.

Solo (natural) recovery involves the use of one's own intrapersonal and interpersonal resources (family, kinship, and social networks) to resolve AOD problems without benefit of professional treatment or involvement in a recovery mutual aid community. This phenomenon is extensively documented in the professional literature under such descriptors as *maturing out* (Winick, 1962, 1964), *autoremission* (Vaillant, 1983; Klingeman, 1992), *self-initiated change* (Biernacki, 1986), *unassisted change* (McMurran, 1994), *spontaneous remission* (Tuchfield, 1981; Anthony & Helzer, 1991), *de-addiction* (Frykholm, 1985; Klingeman, 1991), *self-change* (Sobell, Sobell, & Toneatto, 1991), *self-managed change* (Copeland, 1988), and *natural recovery* (Havassey, Hall, & Wasserman, 1991). Natural recovery is, according to some studies, the most common recovery pathway (Fillmore, et al., 1988; Sobell, Sobell, Toneatto, & Leo, 1993; Cunningham, Sobell, Sobell, & Kapur, 1995; Cunningham, 1999; Sobell, et al., 1996), but the prevalence of this style declines as problem duration and severity increase. Natural recovery is a more viable pathway for people with shorter and less severe AOD problems and for those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell, et al., 1996; Larimer & Kilmer, 2000).

Natural recovery exists across the spectrum of drug choices (Biernacki, 1986; Waldorf, Reinarman, & Murphy, 1991; Klingeman, 1992; Shaffer & Jones, 1989; Cohen & Sas, 1994; Toneatto et al., 1999; Kandel & Raveis, 1989) and seems to be influenced by two age-related patterns: 1) a young adult pattern associated with maturation and the assumption of adult role responsibilities, and 2) a later-life pattern associated with cumulative consequences of alcohol and other drug use (Fillmore, et al., 1988; Sobell, Ellingstad, & Sobell, 2000).

Those who achieve natural recovery report multiple reasons for avoiding formal treatment institutions and mutual aid societies. These reasons include a desire to protect their privacy (aversion to sharing problems with others), a desire to avoid the stigma of being labeled, a belief that they can solve their problems without professional treatment, and a perception that treatment and mutual aid groups are ineffective or not personally suited for them (Tuchfield, 1981; Jordan & Oei, 1989; Cloud & Granfield, 1994; Burnam, 1997; Sobell, Ellinstad, & Sobell, 2000).

Treatment-assisted recovery involves the use of professional help in the initiation and stabilization of recovery. More than 1.5 million people are admitted to addiction treatment in the United States each year, but multiple factors complicate the relationship between treatment and recovery:

- Less than 10% of people with a substance use disorder in the U.S. seek professional treatment in a given year (SAMHSA, 2003), and only 25% of individuals with such disorders will receive treatment in their lifetime (Dawson et al., 2005).

- Addiction treatment in the United States is not a homogenous entity, but a network of service organizations with diverse philosophies and techniques that vary significantly in their effectiveness (Wilbourne & Miller, 2003).

- Those who seek professional treatment are characterized by high personal vulnerability (e.g., family history of AOD problems, lowered age of onset of use, traumatic victimization), greater problem severity and complexity, weaker social supports, fewer occupational opportunities, and less success (Polich, Armour, & Braiker, 1980; Room, 1989; Weisner, 1993; Tucker & Gladsjo, 1993; Cunningham et al., 1995).

- Recovery outcomes are compromised by high treatment attrition rates (more than 50%) (SAMHSA, 2002) and doses of treatment services (measured in days of care or number of sessions) that often fall below standards recommended for optimal effects (NIDA, 1999).

- Individuals may have experienced professional treatment, but such treatment may not have played a role in their later achievement of stable recovery.

In spite of such limitations, the vast majority of persons who suffer from substance dependence (in contrast to less severe AOD-related problems) enter recovery through the vehicle of professionally directed treatment (Cunningham 1999a,b, 2000). But this link is not as direct as one might think. Recent studies have shown that a significant portion of

people with the most severe substance use disorders achieve stable recovery only after multiple treatment episodes spread over a number of years (Anglin, Hser, & Grella, 1997; Hser, Grella, Chou, & Anglin, 1998; Dennis, Scott, & Hristova, 2002), suggesting a possible cumulative effect of such interventions.

Peer-assisted recovery involves the use of structured recovery mutual aid groups to initiate and/or maintain recovery from AOD problems. Addiction recovery mutual aid structures of many varieties exist in the United States (see discussion below). Alcoholics Anonymous is the most widely used community resource for the resolution of alcohol-related problems (Room, 1989; Weisner, Greenfield, & Room, 1995), with 3.1% of U.S. citizens reporting having attended A.A. meetings sometime in their life for an alcohol problem and 1.5% reporting attendance at A.A. meetings for an alcohol problem in the past year (Room & Greenfield, 1993). Mutual aid involvement, as measured by studies of A.A., can play a significant role in the movement from addiction to recovery (Timko, Moos, Finney, & Moos, 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Emrick, Tonigan, Montgomery, & Little, 1993; Tucker, Vuchinich, & Gladsjo, 1994; Morgenstern, Labouvie, McCray, Kahler, & Frey, 1997; Humphreys, Wing, McCarty, Chappel, & Galant, 2004). This positive effect extends to:

- adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000; Kelly, Myers, & Brown, 2002),

- women and cultural minorities (Denzin, 1987; Caetano, 1993; Humphreys, Mavis, & Stoffelmayr, 1994; Kessler, Mickelson, & Zhoa, 1997; Bischof, Rumpf, Hapke, Meyer, & John, 2000; Winzelberg & Humphreys, 1999),

- persons experiencing substance use and psychiatric disorders (Meissen, Powell, Wituk, Girrens, & Artega, 1999; Ouimette, Humphreys, Moos, Finney, Cronkite, & Federman, 2001),

- persons using medications to support their recovery (Rychtarik, Connors, Demen, & Stasiewicz, 2000), and

- agnostics and atheists (Winzelberg & Humphreys, 1999; Weiss, Griffin, Gallop, Onken, Gastfriend, Daley, Crits-Christoph, Bishop, & Barber, 2000).

For those seeking support from recovery mutual aid groups, there is a dose effect related to meeting participation. The probability of stable remission rises in tandem with the number of meetings attended in the first three years of recovery (Hoffmann, Harrison, & Belille, 1983; Pisani, Fawcett, Clark, & McGuire, 1993; Humphreys, Moos, & Cohen, 1997; Chappel, 1993). Recovery prospects also rise with the intensity of mutual aid involvement, as measured by active application of program concepts, meeting participation (speaking, interacting, leading), participation in pre- and post-meeting rituals, use of mutual aid networks for fellowship and leisure, reading program literature, being sponsored, sponsoring others, and involvement in other service work (Sheeren, 1988; Cross, Morgan, Moonye, Martin, & Rafter, 1990; Johnson & Herringer, 1993; Emrick et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, &

Cohen, 1997). This intensity of participation effect also applies to adolescents (Margolis, Kilpatrick, & Mooney, 2000).

Peer-assisted recovery is also reflected in the growing recovery home movement (most visibly in the Oxford Houses) (Jason, Davis, Ferrari, & Bishop, 2001) and the rapid growth of non-clinical, peer-based recovery support services (White, 2004c).

Natural recovery, treatment-assisted recovery, and peer-assisted styles of recovery are not mutually exclusive. A.A.'s 2004 membership survey reveals that 64% of A.A. members received some type of treatment or counseling prior to joining A.A. and that 65% received professional treatment or counseling after they entered A.A. (Alcoholics Anonymous, 2005). In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to" alcohol and other drugs, 25% reported initiating and sustaining recovery without treatment or mutual aid (Faces & Voices of Recovery, 2001).

Recovery Initiation Frameworks (Religious, Spiritual, Secular)

There are considerable differences in recovery styles based on the presence or absence of religion or spirituality as an important dimension of the recovery process. There are *religious frameworks of recovery* (sometimes referred to as *faith-based*) in which severe alcohol and other drug problems are resolved within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship, and support of a community of shared faith. Within various religious traditions, the abandonment of addiction is viewed as a byproduct of the experience of religious conversion/affiliation and the reconstruction of a faith-based personal identity and lifestyle. In this framework, recovery is a divine gift of grace rather than something that one does. Religion is viewed, not as an enriching dimension of recovery, but as the catalytic agent that initiates and sustains recovery (White & Whiters, 2005). Religious pathways of recovery are marked by:

- a religious rationale for the roots of addiction (e.g., the Islamic interpretation of alcoholism as a fruit of the tree of *Jahiliyyah* (ignorance/idolatry) (Badri, 1976);
- a mytho-magical personification/demonization of drugs and the addiction process, e.g., the Islamic interpretation of drink and drunkenness as an "infamy of Satan's handiwork" (Badri, 1976, pp. 3-5);
- a religious rationale for restraint and temperance (e.g., the body as the temple of God) (Bible, 1 Cr 3:16-17; Miller, 1995);
- rituals of confession, restitution, and forgiveness as tools of psychological reconstruction;
- the use of prayer, reading, and service to others (e.g., witnessing) as daily rituals of recovery; and
- enmeshment in a community of faith that meets needs once met within the culture of addiction.

Religious and spiritual frameworks of recovery can closely co-exist. For example, there are societies that help A.A. members who share a particular religious orientation pursue work on A.A.'s Step Eleven: "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." Two of the oldest Eleventh Step groups are the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS). Eleventh Step groups usually serve as adjuncts rather than alternatives to A.A. participation (White, 1998).

Spiritual frameworks of recovery overlap with religious pathways of recovery in the sense that both flow out of the human condition of wounded imperfection (what William James, 1902, referred to as "torn-to-pieces-hood"), involve experiences of connection with resources within and beyond the self, and involve a core set of values (e.g., humility, gratitude, and forgiveness) (Kurtz & Ketcham, 1992). Spiritual frameworks of recovery such as Alcoholics Anonymous focus on defects of character (self-centeredness, selfishness, dishonesty, resentment, anger, preoccupation with power and control) as the root of addiction, and provide a means of reaching both into oneself (e.g., self-inventory, developing the traits of honesty, humility, and tolerance) and outside oneself (reliance on a Higher Power, prayer, confession, acts of restitution, acts of service, participation in a community of shared experience) (Miller & Kurtz, 1994; Green, Fullilove, & Fullilove, 1998). Spirituality as a framework of recovery involves the embrace of paradox (e.g., "sober alcoholic"), gaining a degree of control by admitting one's powerlessness, and becoming whole by accepting one's imperfection (Kurtz, 1999). Spirituality as a medium of recovery is rooted in the understanding that: 1) human beings are born with a vacuum inside themselves that craves to be filled with meaning, 2) we can artificially and temporarily fulfill this need through the medium of drug intoxication, and 3) more authentic and lasting frameworks of meaning can displace the craving for intoxication. Religious and spiritual frameworks can overlap (e.g., religion as a vehicle of spirituality) or exist as distinct experiences (spirituality without religion, religion without spirituality). One of A.A.'s innovations was its emancipation of spirituality from its explicitly religious roots.

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. Secular recovery groups view the roots of addiction more in terms of irrational beliefs about oneself and the world and ineffective coping strategies than in terms of biology, morality, character, or sin. Secular frameworks of recovery such as Secular Organization for Sobriety and LifeRing Secular Recovery reinforce the "Big Decision" or "Sobriety Priority" ("not using no matter what") through a variety of cognitive and behavioral self-change techniques. Where spiritual and religious frameworks of recovery involve a transcendence of self, secular frameworks of recovery involve an assertion of self (White & Nicolaus, 2005). Where spiritual frameworks of recovery emphasize wisdom (emphasis on experience, search for meaning, freedom rooted in the acceptance of limitation, self-transcendence by connection to a greater whole, strength flowing from limitation), secular frameworks of recovery emphasize knowledge (emphasis on scientific evidence, an assertion of control, self-mastery through knowledge of self and knowledge of one's problem, and strength flowing from personal competence).

All three recovery initiation frameworks share what Morgan (1995a) has described as a 1) re-visioning of self, 2) a re-visioning of one's life-context, and 3) a restructuring of life-stance and lifestyle. All three frameworks share a three-part story-style in which people in recovery report "in a general way what we used to be like, what happened, and what we are like now" (Alcoholics Anonymous, 1939, p. 70). And yet listening to these tales of "rescue and renewal" (Morgan, 1995b), one finds critical differences in the instrument of recovery (the grace/gift of having been changed versus personal ownership of that change), different metaphors and rituals used to initiate and sustain recovery, and different views of the role of a community of shared experience in the recovery process.

Recovery Initiation Styles

There are three styles of recovery initiation: *quantum change*, conscious *incremental change,* and a less conscious process that sociologists refer to as *drift*.

Quantum change, also referred to as *transformational change*, is distinguished by its vividness (emotional intensity), suddenness (lack of intentionality), positiveness, and permanence of effect (Miller and C'de Baca, 2001). Quantum change can occur as a breakthrough of self-perception or insight (an epiphany) or as a mystical or religious experience. Both experiences produce fundamental alterations in one's perception of self and the world. The liberation from alcohol and other drug problems and related changes flow from these core alterations of identity and values. Quantum change is sometimes experienced as a Damascus-type[3] conversion (religious, spiritual, or secular in nature) that precisely and forever demarks addiction and recovery. Such recovery conversion experiences are rooted in calamity — often referred to as "hitting bottom." Recovery-catalyzing breakthroughs have been described in the research literature as an "existential crisis" (Coleman, 1978), a "naked lunch experience" (Jorquez, 1993), a "rock bottom experience" (Maddux and Desmond, 1980), a "brief developmental window of opportunity" (White, 1996), a "crossroads" (Klingemann, 1991, 1992), an "epistemological shift" (Shaffer and Jones, 1989), and a "radical reorientation" (Frykholm, 1985). Quantum change as a pathway of addiction recovery has a long history and is often the ignition point of historically important abstinence-based healing and religious/cultural revitalization movements (White, 2004b). Quantum change occurs in religious, spiritual, and secular forms. Illustrative of this experience is the report of Samuel Hadley, whose religious conversion at the Water Street Mission in New York City marked the beginning of a lifetime of service to God and other alcoholics.

> *Although up to that moment my soul had been filled with indescribable gloom, I felt the glorious brightness of the noonday sun shine into my heart. I felt I was a free man….From that moment till now I have never wanted a drink of whiskey, and I have never seen money enough to make me take one. I promised God that night that if he would take away the appetite for strong drink, I would work for him all my life. He has done his part, and I have been trying to do mine* (Quoted in James, 1902, p. 203).

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[3] The reference to Damascus refers to the Biblical account of the transformation of Saul of Tarsus, the orthodox Jew and persecutor of Christians, into St. Paul, the Christian missionary, on the road from Jerusalem to Damascus.

While there is a tendency to grant a special quality to these recovery conversion experiences, Bill Wilson cautioned against such glorification.

> *There is a very natural tendency to set apart those experiences or awakenings which happen to be sudden, spectacular or vision-producing….But as I now look back on this tremendous event* [his own transformative change experience]*….it now seems clear that the only special feature was its electric suddenness and the overwhelming and immediate conviction that it carried to me. In all other respects, however, I am sure that my own experience was not different than that received by every AA member who has strenuously practiced our recovery program* (Wilson, 1962).

In contrast to the lightning strike of quantum change, incremental recovery involves a time-encompassing and stage-dependent process of metamorphosis. Researchers have described many stage models of addiction recovery, including:

- Frykholm's (1985) 3-stage model (ambivalence, lengthening periods of abstinence, and emancipation);
- Biernacki's (1986) four-stage model (a resolution to quit either through drift, rational decision, or "rock bottom" experience; a detachment from the physical and social worlds of addiction; managing cravings and impulses and staying clean (abstinent); and becoming ordinary);
- Waldorf's (1983, 1990) six-stage model (going through changes; forming a resolve; cessation experiments; becoming an ex-addict; learning to be "ordinary"; filling the physical, psychological, social, lifestyle void with family work, religion, politics, and mutual aid);
- Brown's (1985) four-stage model (drinking, transition, early recovery, and ongoing recovery);
- Shaffer and Jones' three-stage model (experiencing turning points, active quitting, and relapse prevention);
- Klingemann's (1991) three-stage model (motivation, action, maintenance); and
- Prochaska and colleagues' (1992) six-stage model (precontemplation, contemplation, planning, action, maintenance, and termination).

Stage models suggest that the process of recovery begins <u>before</u> AOD use is moderated or terminated and that, while linear movement through particular stages is possible, the more common experience is a recycling through these stages before permanent recovery is achieved. The repeated sequence that predates recovery stability might be constructed as follows: escalating AOD-related pain (I need to recover), the desire to change (I want to recover), belief in possibility of change (I can recover), commitment (I am going to recover), experiments in abstinence (I am recovering), and movement from sobriety experiments to sobriety identity (I am an ex-addict; I am a recovered/recovering alcoholic/

addict; I no longer use or misuse alcohol or other drugs). Stages of change models are very popular among addiction professionals, but have come under attack for the lack of empirical evidence supporting them (Sutton, 2001; West, 2005).

Quantum change and incremental change have been described as two discrete phenomena, but we have listened to recovery stories in our travels that have dimensions of both. For example, we have seen individuals who repeatedly cycled through preparatory stages of recovery (what we have here referred to as recovery priming) but whose point of recovery stabilization was marked by a profound, life-altering quantum change experience.

The third style of recovery initiation is one of *drift* — the gradual cessation/reduction of AOD use and related problems as a matter of circumstance rather than choice. Here the addict simply "goes with the flow," only to find in retrospect that events and circumstances lead away from drugs and the culture in which his or her drug use was nested (see Waldorf, 1983; Biernacki, 1986, 1990; Granfield & Cloud, 1999). Developmental maturation and environmental change can elicit changes in alcohol and other drug use in some individuals in ways that do not follow the conscious, self-engineered styles of change depicted in stages of change models. For example, some studies of female heroin addicts depict recovery, not as a central goal, a but as an inadvertent outcome of severing contact with former drug-using environments and relationships (Gerstein, Judd, & Rovner, 1979). Some individuals drift out of addiction through processes similar to the processes by which they drifted into addiction, including finding an intense alternative pursuit that gives new meaning to one's life (Cloud & Granfield, 2001).

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. For example, we have witnessed such evolution in the modern history of recovering people working as addiction counselors. Early addiction counselors boldly proclaimed their recovery status as their primary credential, but began withholding that recovery status in the 1980s and 1990s behind their accumulating credentials and the restigmatization of AOD problems. In the face of a new recovery advocacy movement calling upon recovering people to put a face and voice on recovery, many of those same addiction counselors are again going public with their recovery status. In our experience, evolution in identity is the norm in addiction recovery.

Recovery Relationships

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). This is not to say that this style of recovery is void of social support, but that support usually comes from one's inner family and social circle rather than from a larger community of recovering people. Gerry Spense, the noted trial lawyer, describes this style of recovery:

> *We (Gerry and his new wife) sort of became each other's A.A. We quit together, and we hung on to each other. Although I have never attended an Alcoholics Anonymous session, we must have had the kind of experience that people have there.* (Quoted in *Wholey, 1984, p. 106.)*

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 (White, 1996).

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. Some individuals use recovery mutual aid groups for recovery initiation and maintenance, where others seem to initiate recovery through such resources, but then sustain that recovery through their own personal, family, and social resources. Some continue Twelve Step or other recovery maintenance practices without meeting participation, while others find other sources of long-term recovery support (Tonigan, Miller, Chavez, Porter, Worth, Westphal, Carroll, Repa, Martin, & Tracy, 2002). A relatively recent phenomenon is the advent of *virtual (Internet) recovery* — the achievement or maintenance of recovery through Internet support groups, with little or no participation in face-to-face support meetings. Web-based recovery support services include email and instant messaging systems, newsgroups, bulletin boards, chat rooms, self-assessment instruments, and recovery coaching (Walters, Hester, Chiauzzi, & Miller, 2005). The Internet seems to elicit a much higher degree of participation among women and individuals in high-status occupations than do either professional treatment or face-to-face recovery mutual aid groups (Hall & Tidwell, 2003).

Communities of recovery is a phrase coined by Ernest Kurtz to convey the existence of multiple recovery communities. Addiction treatment professionals should refer people to these communities with the goal of achieving reciprocity of fit between the individual and the group. Style differences based on the evolution in how one relates (or does not relate) to these communities of recovery are part of what could be described as one's *recovery career*. The concept of *career* has been applied to the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Timko, Moos, Finney, Moos, & Kaplowitz, 1999;

Dennis, Scott, Funk, & Foss, 2005). *Recovery career* is an extension of this application and refers to the evolving stages of recovery stability and one's identity and recovery support relationships over time.

Varieties of Twelve-Step Experience

Peer-based support groups constitute a major resource for the resolution of alcohol and other drug problems (Room & Greenfield, 1993; Kessler, Mickelson, & Zhoa, 1997; Kissin, McLeod, & McKay, 2003). Such groups are attractive, are geographically accessible and affordable, require no formal admission procedures, and place no limits on length of participation (Humphreys, et al., 2004). Twelve-Step groups began with the founding of Alcoholics Anonymous in 1935. Although there were dozens of recovery mutual aid societies that pre-dated A.A. (White, 2001), A.A. continues to be the standard by which other mutual aid groups are measured due to its size (2.1 million members in 100,766 groups), geographical growth (150 countries), and longevity (Kurtz & White, 2003). Varieties of A.A. experience were evident from its inception (e.g., differences between A.A. in Akron and New York City) and have grown throughout A.A.'s history.

Varieties of A.A. experience are reflected in the diversity of A.A. meeting formats (e.g., open vs. closed meetings, speaker meetings vs. discussion meetings), in the trend to organize A.A. around special populations and special needs, and in the wide variance of styles of "working" the A.A. program. Local A.A. meeting lists reflect such specialization, e.g., meetings organized by age (young people's meetings, old-timers meetings), gender (women-only and men-only meetings), sexual orientation (lesbian, gay, bisexual, transgender), language (Spanish, Polish, no profanity), profession (physicians, lawyers, airline pilots), social status (off-the-books meetings for celebrities and those in high-status positions), relationship status (single, couples), co-occurring problems (psychiatric illness, HIV/AIDS), and smoking status (non-smoking), to name just a few. There are differences in A.A. that transcend filtering the A.A. program through particular types of categorical/cultural experience. Significant differences can be found in A.A. meetings related to such factors as degree of religious orientation (from efforts to Christianize A.A. to A.A. groups for atheists and agnostics), meeting rituals, pre- and post meeting activities; and basic interpretations of the nature of the A.A. program (Kurtz & White, 2003). Such varieties multiply exponentially when one examines the range of adaptations of A.A.'s Twelve Steps to other drug problems (e.g., Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, Pills Anonymous, Methadone Anonymous) and to co-occurring problems (e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery).

The explosive growth of A.A. in the 1970s and 1980s and the growing influence of the addiction treatment industry and the criminal justice system upon A.A. (via mandated A.A. attendance) led to concerns among A.A. old-timers that the core of A.A.'s program was being corrupted. This concern led to efforts to define and recapture the historical A.A. A.A. historian Ernest Kurtz (1999, pp. 131-138) proposed five criteria to distinguish "real A.A." from meetings that had taken on the flavor of treatment groups: 1) A.A. vocabulary (defects of character, self-inventory, Higher Power) rather than treatment vocabulary; 2) humor and the appreciation of paradox; 3) a story style that "describes in a general way what we used to be like, what happened, and what we are like now"; 4) respect for and

adherence to A.A. traditions; and 5) a conviction by those attending meetings that they NEED rather than WANT to be there.

The growing varieties of A.A. experience triggered efforts in the scientific community to define the "active ingredients" of A.A. These scientists, confronted with the large menu of concepts and activities that make up the A.A. experience, attempted to define which aspects of the A.A. experience were the most potent in altering the course of alcoholism and strengthening the recovery experience. To-date, these studies have focused on such mechanisms as motivational enhancement, development of Twelve-Step cognitions (e.g., commitment to abstinence and continued A.A. participation), recovery coaching (advice), mastery of behavioral prescriptions for coping, exposure to recovery role models, enhanced self-efficacy, changes in friendship networks, and the therapeutic benefits of helping others (Morgenstern, et al., 1997; Humphreys, Mankowski, Moos, & Finney, 1999; Pagano, Friend, Tonigan, & Stout, 2004). Scientists have also plotted a continuum of response to Twelve-Step involvement across three populations: optimal responders, nonresponders, and partial responders (Morgenstern, Kahler, Frey, & Labouvie, 1996).

Other areas of diverse experience within Twelve-Step groups include patterns of co-attendance of Twelve Step and other groups, e.g., attending A.A. and Al-Anon, A.A. and N.A., A.A. and Women for Sobriety; patterns of primary affiliation (e.g., shifting primary allegiance from N.A. to A.A.); patterns of intensity of participation (frequency of meeting attendance and other Twelve-Step practices); and duration of participation over time (e.g., decreasing involvement or disengagement from regular involvement in meetings and rituals).

Still Other Varieties

The existence of those who did not respond or only partially responded to spiritually oriented Twelve-Step programs set the stage for the emergence of explicitly religious and secular frameworks of peer-based recovery support (Humphreys, 2004). Religious recovery support groups include (with their founding dates where available) Alcoholics Victorious (1948), Teen Challenge (1961), Alcoholics for Christ (1976), Overcomers Outreach (1977), Liontamers Anonymous (1980), Mountain Movers, High Ground, Free N' One, Victorious Lady, Celebrate Recovery, Millati Islami, and innumerable local recovery-support ministries. As noted earlier, these groups share a religious interpretation of the roots of addiction (e.g., as a sin of the flesh, idolatry, or demonic possession), recovery founded on total surrender to a religious deity, a religiously based reconstruction of personal identity and values, and immersion in a faith-based community (White & Whiters, 2005).

Secular recovery support groups (with their founding dates) include Women for Sobriety (WFS) (1975), Secular Sobriety Groups (later renamed Secular Organization for Sobriety — Save Our Selves (SOS) (1985), Rational Recovery (RR) (1986), Men for Sobriety (MFS) (1988), Moderation Management (MM) (1994), SMART Recovery® (1994), and LifeRing Secular Recovery (LSR) (1999). Secular groups are distinguished by their meeting locations (homes and religiously neutral sites); lack of reference to religious deities; discouragement of self-labeling ("alcoholic" and "addict"); emphasis on personal em-

powerment and self-reliance; openness to crosstalk (direct feedback and advice between members); lack of formal sponsorship; encouragement to complete a recovery process and move on to a full, meaningful life (rather than sustain meeting participation for life); and use of volunteer professional advisors (persons not in personal recovery) to facilitate and speak at meetings (White & Nicolaus, 2005).

Individuals who participate in Twelve-Step alternatives may do so exclusively, concurrently with A.A. meetings, or sequentially (using one framework to initiate recovery and another framework to maintain and enrich that recovery over time (Kaskutas, 1992; Connors, Dermen & Duerr, 1992; White & Nicolaus, 2005).

Recovery Durability

Interest has grown over the past decade in the prospects and processes involved in long-term recovery stabilization (Morgan, 1995; Chappel, 1993), as it has become clear that short periods of sobriety or decelerated AOD use are not predictive of sustained recovery. Some researchers have claimed that stable remission can be predicted by as little as six months of sobriety (Armor, Polich, & Stambul, 1978). Vaillant (1983), in a prospective study of alcoholic men, found that the stability and durability of addiction recovery increases with length of sobriety, with no relapses in his study among those who had achieved six or more years of continuous sobriety. A growing number of studies are suggesting that the point at which most recoveries from alcohol dependence become fully stabilized is between four and five years of continuous remission (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, O'Donnel, & De Soto, 1989; Dawson, 1996; Jin, Rourke, Patterson, Taylor & Grant, 1998). Once attained, recovery from alcohol dependence is more stable for those with late-onset alcohol problems compared to those with early-onset alcohol problems (Schutte, Brennan & Moos, 1994).

Studies of heroin addicts further confirm the fragility of short periods of abstinence. Follow-up studies have demonstrated that only 42% percent of those abstaining from opiates in the community at two-year follow-up were still abstinent at five-year follow-up (Duvall, Lock, & Brill, 1963). One third of those who achieve three years of abstinence eventually relapse (Maddux & Desmond, 1981), and one quarter of heroin addicts with five or more years of abstinence later return to heroin use (Hser, Hoffman, Grella, & Anglin, 2001).

While recovery stability seems to vary somewhat across drugs used, the principle that recovery becomes more stable over time seems to apply to all patterns of addiction. In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to alcohol or other drugs," half reported being in stable recovery more than five years, and 34% reported having achieved stable recovery lasting ten or more years (Faces & Voices of Recovery, 2001). The average length of continuous sobriety reported in the latest membership survey of Alcoholics Anonymous was 8 years, with 36% of A.A. members reporting continuous sobriety of more than 10 years (*A.A. Grapevine*, July, 2005).

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.

Recovery Termination

One of the recent controversies related to recovery from addiction involves the question of whether addiction recovery is ever fully completed. 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). This last stage, referred to as *Stage II Recovery* ("rebuilding the life that was saved in Stage I") (Larsen, 1985, p. 15), transcends the early concern with the addictive behavior and focuses on a reconstruction of personal character, identity, beliefs, and interpersonal relationships. This stage is also referred to as *completed recovery* or the *real thirteenth step*[4] — an "advanced state" of recovery marked by global health and a heightened capacity for intimacy, serenity, self-acceptance, and public service (Picucci, 2002; Tessina, 1991).

Implications for the Professional Treatment of AOD Problems

This review contains critical understandings that could help shape recovery-oriented systems of care. Some of the most important of these include the following.

Paradigmatic Shift: There will be increasing calls to shift addiction treatment and addiction counseling from a problem-focused or intervention-focused paradigm to a recovery paradigm. This will shift the emphasis of treatment from one of brief biopsychoscial stabilization to one of sustained recovery management (pre-recovery engagement; recovery initiation; sustained monitoring; stage-appropriate recovery education and coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention) (White, Boyle & Loveland, 2003).

Recovery Definition and Scope: The shift to a recovery paradigm will require considerable discussion between the professional addictions field and diverse communities of recovery about the very definition of recovery. These discussions will be contentious, but we would make the following predictions:

1. Abstinence will shift from its status as a *goal* and definitional requirement of recov-

[4] The thirteenth step is a euphemism for romantic involvement between AA members and, more specifically, the sexual overture by an older AA member to a newly sobered AA member.

ery to the status of *one method* of achieving recovery (and the preferred method for those with the most severe AOD problems). The goal will shift to the resolution of AOD problems by any means possible — a goal that will legitimize moderated outcomes for those with less severe AOD problems.

2. The focal point of recovery (changes in one's primary drug relationship) will broaden to include a healthy relationship or non-relationship with all psychoactive drugs and the achievement of global health. Addiction treatment programs will increasingly be held accountable for multiple recovery outcomes, e.g., changes in primary and secondary drug use as well as changes in physical, emotional, family/relational, and occupational/academic health and functioning. There will be a shift in focus from what recovery eliminates (AOD use and related problems) to what recovery adds to individuals, families, and communities (global health, occupational and academic productivity, active citizenship) (http://www.samhsa.gov/Matrix/SAP_treatment.aspx).

3. Re-elevating the concept of *family recovery* will exert pressure for new technologies of family assessment, intervention, and sustained monitoring as well as impetus for a family-oriented recovery research agenda.

4. The concept of *partial recovery* will receive greater elucidation and legitimacy within the addictions treatment field, and cases of *enriched recovery* (dramatically elevated health, functioning, and community service) will be documented and culturally elevated to help ameliorate the social stigma that continues to be attached to AOD problems.

Recovery Capital: The pathology and intervention paradigms that have guided addiction treatment have shaped assessment and placement protocol so that they focus almost exclusively on problem severity and complexity. The resiliency/recovery paradigm calls for measuring recovery capital; distinguishing the role of recovery capital in *natural*, *treatment-assisted*, and *peer-assisted* recoveries; and giving prominence to an individual's/family's recovery capital within the process of clinical decision-making. The most important implication of the concept of recovery capital is the premise that not all individuals experiencing AOD problems need professional treatment. Individuals with lower problem severity and high recovery capital can be encouraged to explore natural and peer-based resources as less restrictive, less expensive, and less stigma-laden alternatives to addiction treatment. Monitoring responses to such resources can be used to determine if and when professional services are necessary.

Medication-Assisted Recovery: Tension is growing between an anti-medication bias within the field of addiction treatment (and within American communities of recovery and the larger American culture), the growing availability of a wide variety of pharmacological adjuncts in the treatment of addiction, and the growth in scientific evidence supporting their effectiveness. We anticipate a day when the legitimacy of such pharmacological adjuncts will be widely recognized in professional and recovery communities and integrated within the large spectrum of treatment and recovery support services. If such legitimacy is not achieved, we would anticipate a schism within the field in which more scientifically and medically based treatments split off into a separate field within primary medicine. We

would consider this further splitting of body from mind and soul a tragic event in the history of the field.

Recovery Frameworks: Religious, spiritual, and secular frameworks of recovery must be more completely charted and evaluated, with a particular focus on their applicability to particular cultural and clinical populations. For example, researchers have extensively studied (some would say over-studied) AOD problems in Native American and African American communities, but no comparable quantity of literature exists on the varieties of recovery experience within these communities. How many African Americans initiate and sustain recovery through the historical Black church? How many African Americans initiate recovery through A.A. or N.A. and then migrate into the Black church to sustain their recoveries? How many Native Americans use indigenous cultural or religious revitalization movements as a framework for long-term sobriety? In the same vein, how do members of secular frameworks of recovery differ from those in religious or Twelve-Step frameworks of recovery? What mechanisms of change are shared across religious, spiritual, and secular frameworks of recovery; and what mechanisms of change distinguish such frameworks from each other? Definitive, scientifically researched answers to such questions do not yet exist.

Recovery Styles: Variations in how recovery is initiated and how recovery shapes personal identity and interpersonal relationships illustrate the diversity of experiences that constitute recovery from AOD problems. Further documentation of such styles and their relative prevalence across cultural and clinical subpopulations is needed to guide the delivery of treatment and recovery support services. The elucidation of recovery styles is part of a larger recovery research agenda that is currently gaining prominence.

Varieties of Recovery Mutual Support Societies: The numerical expansion and growing diversity of peer-based recovery support groups suggests the need for all addictions professionals to become students of such groups, develop relationships with these groups, provide clients information about such groups, and develop a style of active linkage to these groups. The diversity of recovery support groups has prompted calls for matching individual clients to particular groups by such factors as age, gender, socioeconomic status, drug of choice, smoking status, and attitudes toward religion and spirituality (Forman, 2002; White & Nicolaus, 2005). Celebration of the growing diversity of recovery pathways and a philosophy of choice permeate the philosophies of the best treatment programs. Recent reviews of treatment effectiveness have linked this philosophy of choice to enhanced motivation and treatment outcomes (Hester & Miller, 2003). All recovery support structures, like all treatments, will have optimal responders, partial responders, and non-responders. This calls for continued monitoring and support to get the best possible fit between each individual and a particular method of treatment or recovery support. Combinations of natural resources, peer recovery networks, and professional treatment may generate amplified recovery outcomes for those individuals and families with the greatest problem severity and complexity.

Summary and Conclusions

The extension of the pathology and intervention paradigms toward a recovery paradigm

will generate significant new understandings about the varieties of recovery experience. However, our understanding of those varieties is in its infancy. It is time the recognition of multiple pathways and styles of recovery moved beyond the level of superficial rhetoric. It is time the field aggressively pursued a recovery research agenda. It is time that the recognition of multiple pathways and styles of recovery fully permeated the philosophies and clinical protocols of all organizations providing addiction treatment and recovery support services.

References and Recommended Reading

Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism. (1939). New York: Works Publishing Company.

Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism. (1976) New York: A.A. World Services, Inc.

Alcoholics Anonymous (2005). Survey profiles today's AA members. *About AA: A Newsletter for Professionals*, Fall, p. 1.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Anglin, M. D., Almong, I. J., Fisher, D. G. & Peters, K. R. (1989). Alcohol use by heroin addicts: Evidence for an inverse relationship. A study of methadone maintenance and drug free treatment samples. *American Journal of Drug and Alcohol Abuse*, 15(2), 191-207.

Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. *Psychology of Addictive Behaviors*, 11(4), 308-323.

Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. *Psychology of Addictive Behaviors*, 11, 308-323.

Anthony, J. C., & Helzer, J. E. (1991). Syndromes of drug abuse and dependence. In L. N. Robins, & D. A. Regier. (Eds.). *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (pp. 116-154). New York, NY: The Free Press.

Armor, D. J. and Meshkoff, J. E. (1983). Remission among treated and untreated alcoholics. In N. K. Mello. (Ed.), *Advances in Substance Abuse: Behavioral and Biological Research: Volume 3* (pp. 239-269). CN: JAI Press.

Armor, D. J., Polich,J. M., & Stambul, H. B. (1978). *Alcoholism and Treatment.* New York: Wiley.

Bacchus, L, Strang, J, and Watson, P. (2000). Pathways to abstinence: Two-Year follow-up data on 60 abstinent former opiate addicts who had been turned away from treatment. *European Addiction Research*, 6(3),141-147.

Badri, M. B. (1976). *Islam and alcoholism*. Tacoma Park, MD: Muslim Students Association of the U.S. and Canada.

Behar, D., Winokur, G. & Berg, C. J. (1984). Depression in the abstinent alcoholic. *American Journal of Psychiatry*, 141(9),1105-1107.

Bien, T. & Barge, R. (1990). Smoking and drinking: A review of the literature. *International Journal of the Addictions*, 25(12), 1429-1454.

Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery Without Treatment*. Philadelphia, PA: Temple University Press.

Bischof, G., Rumpf, H., Hapke, U., Meyer, C. & John, U. (2000). Gender differences in natural recovery from alcohol dependence. *Journal of Studies on Alcohol*,

61(6),783-786.
Borkman, T. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, 15(1), 37-42.
Brown, S. (1985). *Treating the Alcoholic: A Developmental Model of Recovery.* New York: Wiley.
Brown, S., & Lewis, B. (1999). *The Alcoholic Family in Recovery: A Developmental Model.* New York, NY: Guilford.
Burman, S. (1997). The challenge of sobriety: Natural recovery without treatment and self-help programs. *Journal of Substance Abuse*, 9, 41-61.
Caetano, R. (1993). Ethnic minority groups and Alcoholics Anonymous: A review. In B. McCrady and W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp.209-231). New Brunswick, NJ: Rutgers Center of Alcohol Studies.
Caldwell, P. E., & Cutter, H. S. G. (1998). Alcoholics Anonymous affiliation during early recovery. *Journal of Substance Abuse Treatment*, 15(3), 221-228.
Carmelli, D. & Swan, G. (1993). The relationship between quitting smoking and changes in drinking in World War II veteran twins. *Journal of Substance Abuse*, 3(5), 103-116.
Chapman, R. E. (1987). Personality characteristics of alcoholics in long-term recovery. *Dissertation Abstracts International*, 48(2), 338-A.
Chappel, J. N. (1993). Long-term recovery from alcoholism. *Psychiatric Clinics of North America*, 16(1), 177-187.
Cloud, W. & Granfield, R. (1994). Terminating addiction naturally: Post-addict identity and the avoidance of treatment. *Clinical Sociology Review*, 12:159-174.
Cloud, W. & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, 1(1), 83-104.
Cohen, P. & Sas, A. (1994). Cocaine use in Amsterdam in non- deviant subcultures. *Addiction Research*, 2(1), 71-94.
Coleman, J. (1978) *A theory of narcotic abstinence*. Paper presented at the 1978 Conference of the Society for the Study of Social Problems, San Francisco, California.
Connors, G. J., Dermen, K. H. & Duerr, M. (1992). SOS membership survey: Preliminary results. In J. Christopher (Ed.), *SOS Sobriety* (pp. 61-65). Buffalo, NY: Prometheus Books,
Copeland, J. (1988). A qualitative study of self-managed change in substance dependence among women. *Contemporary Drug Problems*, 25(2), 321-345.
Courtwright, D. (2001). *Forces of Habit: Drugs and the Making of the Modern World.* Cambridge: Harvard University Press.
Coyhis, D. (1999). T*he Wellbriety Journey: Nine Talks by Don Coyhis.* Colorado Springs, CO: White Bison, Inc.
Coyhis, D. (2000). Culturally specific addiction recovery for Native Americans. In: Krestan, J. (Ed.), *Bridges to Recovery* (pp. 77-114). New York: The Free Press.
Cross, G., Morgan, C., Moonye, A., Martin, C., & Rafter, J. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism Clinical and Experimental Research*, 14(2), 169-173.
Cunningham, J. A. (1999a). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*,

60(4), 463-466.
Cunningham, J. A. (1999b). Untreated remissions from drug use: The predominant pathway. *Addictive Behaviors*, 24(2), 267-270.
Cunningham, J. A. (2000). Remissions from drug dependence: Is treatment a prerequisite? *Drug and Alcohol Dependence*, 59(3), 211-213.
Cunningham, J. A., Lin, E., Ross, H. E., & Walsh, G. W. (2000). Factors associated with untreated remissions from alcohol abuse or dependence. *Addictive Behaviors*, 25(2), 317-321.
Cunningham, J., Sobell, L. Sobell, M. & Kapur, G. (1995) Resolution from alcohol problems with and without treatment: Reasons for change. *Journal of Substance Abuse*, 7(3), 365-372.
Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20(4), 771-779.
Dawson, S. A., Grant, B. F., Stinson, F. S., Chou, P. S. Huang, B. & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction*, 100(3), 281-292.
Dennis, M. L., Scott, C. K, & Hristova, L. (2002). The duration and correlates of substance abuse treatment careers among people entering publicly funded treatment in Chicago [Abstract], *Drug and Alcohol Dependence*, 66(Suppl. 2), 44.
Dennis, M.L., Scott, C.K., Funk, R. & Foss, M.A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, 28, S51-S62.
Denzin, N. K. (1987). *The Recovering Alcoholic*. Newbury Park, CA: Sage.
De Soto, C. B., O'Donnell, W. E., Allred, L. J. & Lopes, C. E. (1985). Symptomatology in alcoholics at various stages of abstinence. *Alcoholism Clinical and Experimental Research,* 9(6),505-512.
De Soto, C. B., O'Donnel, W. E. & De Soto, J. L. (1989). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research*, 13(5),693-697.
Dickens, B.M., Doob, A.N., Warwick, O.H., & Winegard, W.C. (1982). *Report of the Committee of Inquiry into Allegations Concerning Drs. Linda and Mark Sobell*. Toronto, Canada: Addiction Research Foundation.
Downey, L., Rosengren, D. B., & Donovan, D. M. (2000). To thine own self be true: Self-concept and motivation for abstinence among substance abusers. *Addictive Behaviors*, 25(5), 743-757.
Duvall, H. J., Lock, B. Z. & Brill, L. (1963). Follow-up study of narcotic drug addicts five years after hospitalization. *Public Health Reports*, 78(3),185-193.
Edwards, G. (1984). Drinking in longitudinal perspective: Career and natural history. *British Journal of Addiction*, 79, 175-183.
Edwards, G., Duckitt, A., Oppenheimer, E., Sheehan, M. & Taylor, C. (1983). What happens to alcoholics? *The Lancet*, 2(8344), 269-271.
Elise, D. (1999) Recovering recovery. *Journal of Ministry in Addiction And Recovery*, 6(2),11-23.
Emrick, D. C., Tonigan, J. S., Montgomery, H. & Little, L. (1993). Alcoholics Annonymous: What is currently known? In B. McCrady and W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp. 41-78). Brunswick, NJ: Rutgers Center of Alcohol Studies.
Faces & Voices of Recovery (2001). *The Road to Recovery: A Landmark National Study*

on the Public Perceptions of Alcoholism and Barriers to Treatment. San Francisco, CA: Peter D. Hart Research Associates, Inc./The Recovery Institute.
Fillmore, K. M., Hartka, E., Johnstone, B. M., Speiglman, R., & Temple, M. T. (1988). *Spontaneous Remission of Alcohol Problems: A Critical Review*. Washington, D.C.: Institute of Medicine.
Finney, J. & Moos, R. (1981). Characteristics and prognosis of alcoholics who become moderate drinkers and abstainers after treatment. *Journal of Studies on Alcohol*, 42(1), 94-105.
Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, 25(1), 93-116.
Fiorentine, R., & Hillhouse, M. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment*, 18(1), 65-74.
Forman, R.F. (2002). One AA meeting doesn't fit all: 6 keys to prescribing 12-step programs. *Psychiatry Online*, 1(10), 1-6.
Frykholm, B. (1985). The drug career. *Journal of Drug Issues*, 15(3), 333-346.
Gerard, D., Sanger, G. & Wile, R. (1962). The abstinent alcoholic. *Archives of General Psychiatry*, 6, 83-95.
Gerstein, D., Judd, L.L., & Rovner, S.A. (1979) Career dynamics of female heroin addicts. *American Journal of Drug and Alcohol Abuse*, 6(1), 1-23.
Goldman, M. S. (1983). Cognitive impairment in chronic alcoholics: Some causes for optimism. *American Psychologist*, 38(10),1045-1054.
Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment*. New York, NY: New York University Press.
Green, L. L., Fullilove, M. T. & Fullilove, R. E. (1998). Stories of spiritual awakening: The nature of spirituality in recovery. *Journal of Substance Abuse Treatment*, 15(4), 325-331.
Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, 24(2), 161-167.
Harding, W. M., Zinberg, N. E., Stelmack, S. M. & Michael, B. (1980). Formerly-addicted-now-controlled opiate users. *International Journal of the Addictions* 15(1), 47-60.
Havassy, B. E., Hall, S. M., & Wasserman, D. A. (1991). Social support and relapse: Commonalities among alcoholics, opiate users, and cigarette smokers. *Addictive Behaviors*, 16(5), 235-246.
Helzer, J. E., Burnam, A. & McEvoy, L. T. (1991). Alcohol abuse and dependence. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (pp. 81-115). New York: The Free Press.
Hester, R. K., & Miller, W. R. (Eds.) (2003). *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (3rd ed.). Boston, MA: Allyn & Bacon.
High Bottom. (1949). *A.A. Grapevine*, October.
Hoffman, A. & Slade, J. (1993). Following the pioneers: Addressing tobacco in chemical dependency treatment. *Journal of Substance Abuse Treatment*, 10(2), 153-160.
Hoffmann, N., Harrison, P. & Belille, C. (1983). Alcoholics Anonymous after treatment: Attendance and abstinence. *International Journal of the Addictions*, 18(3), 311-318.
Hser, Y. (2000). Substance Abuse and Aging Project: Drug Use Careers: Recovery and Mortality. Retrieved on March 24, 2005 from http://www.oas.samhsa.gov/aging/

chap3.htm.
Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment*, 14(3), 1-16.
Hser, Y., Grella, C., Chou, C. & Anglin, M.D. (1998) Relationship between drug treatment careers and outcomes: Findings from the National Drug Abuse Treatment Outcome Study. *Evaluation Review.* 22(4):496-519.
Hser, Y., Hoffman, V., Grella, C. & Anglin, D. (2001) A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58(5), 503-508.
Hughes, J.R. (1996). Treating smokers with current or past alcohol dependence. *American Journal of Health Behavior*, 20(5), 286-290.
Hughes, J. R. (1995). Clinical implications of the association between smoking and alcoholism. In J. B. Fertig & J. P. Allen (Eds.), *Alcohol and Tobacco: From Basic Science to Clinical Practice*. (NIAAA Research Monograph No. 30, NIH Publication No 95-3931, pp. 171-185). Washington, Government Printing Office.
Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.
Humphreys, K., Mankowski, E., Moos, R. & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, 21(1), 54-60.
Humphreys, K., Mavis, B. E., & Stoffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, 11, 165-180.
Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58(3), 231-238.
Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., et al, (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 151-158.
James, W. (1902, 1982). *The Varieties of Religious Experience*. New York: Penguin.
Jason, L.A., Davis, M.I., Ferrari, J.R. And Bishop, P. D. (2001) Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, 31(1):1-27.
Jin, H., Rourke, S. B., Patterson, T. L., Taylor, M. J. & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol*, 59(6), 640-646.
Johnson, E. & Herringer, L. (1993). A note on the utilization of common support activities and relapse following substance abuse treatment. *Journal of Psychology*, 127(1), 73-78.
Jordan, C. M. & Oei, T. P. S. (1989). Help-seeking behavior in problem drinkers: A review. *British Journal of Addiction,* 84, 979-988.
Jorquez, J. (1983). The retirement phase of heroin using careers. *Journal of Drug Issues,* 18(3), 343-365.
Kandel, D. B. & Raveis, V. H. (1989). Cessation of drug use in young adulthood. *Archives of General Psychiatry*, 46(2), 109-116.
Kaskutas, L. (1992). Beliefs on the source of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems*,

19(4), 631-648.
Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63(3), 293-304.
Kessler, R. C., Mickelson, K. D. & Zhoa, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, 27(3), 27-45.
Kessler R. C., Nelson, C. B., McGonagle, K. A., Edlund, M. J., Frank, R. G., & Leaf, P. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*, 66(1), 17-31.
Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life*. New York: Ballantine Books.
Kishline, A. (1994). *Moderate Drinking*. Tucson, Arizona: See Sharp Press.
Kissin, W., McLeod, C. & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, 26, 311-323.
Klingemann, H. K. H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of the Addictions,* 86(6), 727-744.
Klingemann, H. K. H. (1992). Coping and maintenance strategies of spontaneous remitters from problem use of alcohol and heroin in Switzerland. *International Journal of the Addictions*, 27(12), 1359-1388.
Kreek, M. & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment*, 23(2), 93-105.
Kurtines, W. M., Ball, L. R.& Wood, G. H. (1978). Personality characteristics of long-term recovered alcoholics: a comparative analysis. *Journal of Consulting and Clinical Psychology*, 46(5), 971-977.
Kurtz, E. (1999). *The Collected Ernie Kurtz.* Wheeling, WV: The Bishop of Books.
Kurtz, E. & Ketchum, K. (1992). *The Spirituality of Imperfection: Modern Wisdom from Classic Stories*. New York: Bantam Books.
Kurtz, E. & White, W. (2003). Alcoholics Anonymous. In J .Blocker and I. Tyrell (Eds.), *Alcohol and Temperance in Modern History* (pp. 27-31). Santa Barbara , CA: ABC-CLIO.
Larimer, M. E. & Kilmer, J. R. (2000). Natural history. In G. Zernig, A. Saria, M. Kurz, & S. S. O'Malley, (Eds.), *Handbook of Alcoholism* (pp. 13-28). Boca Raton, FL: CRC Press.
Larsen, E. (1985). *Stage II Recovery: Life Beyond Addiction*. New York, NY: HarperCollins Publishers.
Lender, M & Martin, J. (1982). *Drinking in America*. NY: The Free Press.
Levy, B. S. (1972) Five years later: A follow-up study of 50 narcotic addicts. *American Journal of Psychiatry*, 128(7),102-106.
Maddux, J. & Desmond, D. (1986). Relapse and recovery in substance abuse careers. In F. Tims & C. Leukefeld, (Eds.), *Relapse and Recovery in Drug Abuse. (NIDA Monograph Series* 72, pp. 49-72).
Maddux, J. F. & Desmond, D. P. (1980). New light on the maturing out hypothesis in opioid dependence. *Bulletin on Narcotics*, 32(1),15-25.
Maddux, J. F. & Desmond, D. P. (1981). *Careers of Opioid Users*. New York: Praeger.
Maddux, J. F. & Desmond, D. P. (1992). Ten-year follow-up after admission to methadone. *American Journal of Drug and Alcohol Abuse*, 18(3),289-303.

Margolis, R., Kilpatrick, A., & Mooney, B. (2000). A retrospective look at long-term adolescent recovery: Clinicians talk to researchers. *Journal of Psychoactive Drugs*, 32(1), 117-125.

McMurran, M. (1994). The Psychology of Addiction. Washington, D.C.: Taylor and Francis.

Meissen, G., Powell, T. J., Wituk, S. A., Girrens, K. & Artega, S. (1999). Attitudes of AA contact persons toward group participation by person with mental illness. *Psychiatric Services,* 50(8), 1079-1081.

Mental sobriety means spotting danger signals. (1946). *AA Grapevine*, March.

Miller, W. R. (1995). Toward a Biblical perspective on drug use. *Journal of Ministry in Addiction & Recovery*, 2(2), 77-86.

Miller, W. & C'de Baca, J. (2001). *Quantum Change: When Epiphanies and Sudden Insights Transform Ordinary Lives*. New York, NY: Guilford Press.

Miller, W. & Kurtz, E. (1994). Models of alcoholism used in treatment: contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, 55(2), 159-166.

Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol*, 62(2), 211-220.

Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment*, 12(4), 241-246.

Moos, H., Finney, M., & Cronkite, R.C. (1990). *Alcoholism treatment: Context, process and outcome.* New York: Oxford University Press.

Morgan, O.J. (1995a). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly*, 12(1), 59-71.

Morgan, O.J. (1995b). Recovery-sensitive counseling in the treatment of alcoholism. *Alcoholism Treatment Quarterly*, 13(4), 63-73.

Morgenstern, J., Kahler, C. W., Frey, R. M. & Labouvie, E. (1996). Modeling therapeutic response to 12-step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, 8(1), 45-59.

Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65, 768-777.

Murphy, S. and Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs*, 24(3), 257-264.

Musto, D. (1999). *The American Disease: Origins of Narcotic Control*. New York: Oxford University Press.

Myers, M. & Brown, S. (1990). *Cigarette smoking and health in adolescent substance abusers.* Paper presented at the Society of Behavioral Medicine, Chicago, IL.

Narcotics Anonymous. (1988). Van Nuys, CA: NA World Service Office, Inc.

Nathan, P. & Skinstad, A. (1987). Outcomes of treatment for alcohol problems: Current methods, problems and results. *Journal of Consulting and Clinical Psychology*. 55(3), 332-340.

National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association*, 280(22):1936-1943. (See http://odp.od.nih.gov/consensus/cons/108/108_statement.htm)

National Institute on Drug Abuse. (1999). *Principles of Drug Addiction Treatment* (NIH Publication No. 00-4180). Rockville, MD: NIDA.

Ojesjo, L. (1981). Long-term outcome in alcohol abuse and alcoholism among males in Lundby general population, Sweden. *British Journal of Addiction*, 76, 391-400.

Ouimette, P., Humphreys, K., Moos, R., Finney, J. Cronkite, R. & Federman, B. (2001). Self-help participation among substance use disorder patients with posttraumatic stress disorder. *Journal of Substance Abuse Treatment*, 20(1), 25-32.

Pagano, M. E., Friend, K. B., Tonigan, J. S., & Stout, R. L. (2004). Helping other alcoholics in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol,* 65(6), 766-773.

Pendery, M., Maltzman, I., West, L. (1982). Controlled drinking by alcoholics? New findings and a reevaluation of a major affirmative study. *Science*, 217, 169-175.

Picucci, M. (2002). An Interview with Dr. Michael Picucci; *Terms and Definitions*.

Pisani, V. D., Fawcett, J., Clark, D. C., & McGuire, M. (1993). The relative contributions of medication adherence and AA meeting attendance to abstinent outcome of chronic alcoholics. *Journal of Studies on Alcohol*, 54,115-119.

Polich, J. M., Armor, D. J., & Braiker, H. B. (1980). *The Course of Alcoholism: Four Years after Treatment.* New York: Wiley.

Prochaska, J., DiClimente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9),1102-1114.

The Red Road to Wellbriety. (2002). Colorado Springs, CO: White Bison, Inc.

Room, R. (1989) The U.S. general population's experiences of responding to alcohol problems. *British Journal of Addiction*, 84(11), 1291-1304.

Room, R. & Greenfield, T. (1993). Alcoholics Anonymous, other 12-step movements, and psychotherapy in the U.S. Population, 1990. *Addiction*, 88(4), 555-562.

Rosenberg, H. (1993). Prediction of controlled drinking by alcoholics and problem drinkers. *Psychological Bulletin*, 113(1), 129-139.

Rouhbakhsh, P., Lewis, V., & Allen-Byrd, L. (2004). Recovering Alcoholic Families: When is normal not normal and when is not normal healthy? *Alcoholism Treatment Quarterly*, 22(2), 35-53.

Rychtarik, R. G., Connors, G. J., Demen, K. H. & Stasiewicz, P. R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, 61(1), 134-138.

Schutte, K., Brennan, P. & Moos, R. (1994). Remission of late-life drinking problems: A 4-year follow-up. *Alcoholism: Clinical and Experimental Research*, 18(4), 835-844.

Schutte, K. K., Nichols, K. A., Brennan, P. L., & Moos, R. H. (2001). Successful remission of late-life drinking problems. *Journal of Studies on Alcohol*, 64(3), 367-374.

Scott, C.K., Foss, M.A. & Dennis, M.L. (2005). Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, 28, S63-S72.

Selby, M., Quiroga, Ireland, S, Malow, R. & Azrin, R. (1995). Neuropsychological recovery in alcoholics and cocaine users. In L. Harris (Ed.), *Problems of Drug Dependence, 1994: Proceedings of the 56th Annual Scientific Meeting, the College on Problems of Drug Dependence, Inc.* Volume 2 (NIDA Research Monograph 153). Rockville, MD: National Institute on Drug Abuse.

Shaffer, H. J. & Jones, S. B. (1989). *Quitting Cocaine: The Struggle Against Impulse*. Lexington, MA: Lexington Books.

Sheeren, M. (1988). The relationship between relapse and involvement in Alcoholics Anonymous. *Journal of Studies on Alcohol*, 49(1), 104-106.

Simpson, D. D. & Sells, S. B. (1990). *Opioid Addiction and Treatment: A 12-year Follow-up*. Malabar, FL.: Krieger.

Sobell, M.B. & Sobell, L.C. (1973). Indivdiualized behavior therapy for alcoholics. *Behavior Therapy*, 4, 49-72.

Sobell, M.B. & Sobell, L.C. (1976). Second year treatment outcome of alcoholics treatment by individualized behavior therapy: Results. *Behavior Research and Therapy*, 14, 195-215.

Sobell, M.B. & Sobell, L.C. (1978). *Behavioral Treatment of Alcohol Problems*. New York: Plenum.

Sobell, M. B., Sobell, L. C. & Toneatto, T. (1991). Recovery from alcohol problems without treatment. In N. Heather, W. R. Miller and J. Greeley (Eds.) *Self Control and the Addictive Behaviors* (pp. 198-242). New York: Maxwell Macmillan. Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. American Journal of Public Health, 86(7), 966-972.

Sobell, L. C., Ellingstad, T., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addiction*, 95(5), 749-764.

Sobell, L.C., Sobell, M.C., Toneatto, T., & Leo, G.I. (1993). What triggers the resolution of alcohol problems without treatment? *Alcoholism: Clinical and Experimental Research*, 17, 217-224.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2002). *Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services.* (DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2003). *Results from the 2002 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NHSDA Series H-22, DHHS Publication No. SMA 033836). Rockville, MD.

Sutton, S. (2001). Back to the drawing board? A review of the applications of the transtheoretical model of substance use. *Addiction*, 96, 175-186.

Tessina, T. (1991). *The Real Thirteenth Step: Discovering Confidence, Self-reliance and Autonomy beyond the 12-Step Programs.* Los Angeles, CA: Jeremy P. Tarcher, Inc.

Timko, C., Moos, R., Finney, J. & Moos, B. (1994). Outcome of treatment for alcohol abuse and involvement in Alcoholics Anonymous among previously untreated drinkers. *The Journal of Mental Health Administration*, 21(2),145-160.

Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, 60(4), 437-447.

Toneatto, A., Sobell, L. C., Sobell, M. B., & Rubel, E. (1999). Natural recovery from cocaine dependence. *Psychology of Addictive Behaviors*, 13(4), 259-268.

Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V, Carroll, L., Repa, K., Martin, A & Tracy, L. A. (2002). *AA participation 10 years after Project MATCH treatment: Preliminary findings*. Poster presentation, Research Society on Alcoholism, San Francisco, July.

Trachtenberg, R.L. (1984). *Report of the Steering Group to the administrator Alcohol,*

Drug Abuse and Mental Health Administration regarding its attempt to investigate allegations of scientific misconduct concerning Drs. Mark and Linda Sobell. Alcohol, Drug Abuse and Mental Health Administration. Rockville, MD.

Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol*, 42, 626-641.

Tuchman, B. (1981). *Practicing History*. New York: Alfred A. Knopf.

Tucker, J. A., & Gladsjo, J. A. (1993). Help-seeking and recovery by problem drinkers: Characteristics of drinkers who attended Alcoholics Anonymous or formal treatment or who recovered without assistance. *Addictive Behaviors*, 18(5), 529-542.

Tucker, J. A., Vuchinich, R. E. & Gladsjo, J. A. (1994). Environmental events surrounding natural recovery from alcohol-related problems. *Journal of Studies on Alcohol*, 55(4), 401-411.

Vaillant, G. (1983). *The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery*. Cambridge, MA: Harvard University Press.

Vaillant, G. (2003). 60 year follow-up of alcoholic men. *Addiction*, 98(8), 1043-1051.

Vaillant, G. E. (1979). Paths out of alcoholism. In *Evaluation of the Alcoholic: Implications for Research, Theory and Treatment* (Research Monograph No. 5, pp. 383-394). Rockville, MD: National Institute of Alcohol Abuse and Alcoholism.

Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry*, 53(3). 243-249.

Volpicelli, J. & Szalavitz, M. (2000). *Recovery Options*. New York: Wiley.

Waldorf, D. (1983). Natural recovery from opiate addiction: Some social-psychological processes of untreated recovery. *Journal of Drug Issues*, 13(2), 237-80.

Waldorf, D., Reinarman,C. & Murphy, S. (1991). *Cocaine Changes: The Experience of Using and Quitting*. Philadelphia, PA: Temple University.

Walters, S., Hester, R., Chiauzzi, E. & Miller, E. (2005). Demon rum: High-tech solutions to an age-old problem. *Alcoholism: Clinical & Experimental Research*, 29(2), 270-277.

Weiss, R.D., Griffin, M.L., Gallop, R., Onken, L., Gastfriend, D.R., Daley, D., Crits-Christoph, P., Bishop, S. & Barber, J. (2000). Self-help group attendance and participation among cocaine dependent patients. *Drug and Alcohol Dependence* 60(2), 169-177.

Weisner, C. (1993). Toward an alcohol treatment entry model: A comparison of problem drinkers in the general population and in treatment. *Alcoholism Clinical and Experimental Research*, 17(4), 746-752.

Weisner, C, Greenfield, T & Room, R. (1995). Trends in the treatment of alcohol problems in the U.S. population. *American Journal of Public Health*, 85(1), 55-60.

West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, 100, 1036-1039.

White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals* (2nd ed.). Center City, MN: Hazelden.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, April 3-5, 2000. Retrieved July 31, 2004 from http://www.facesandvoicesofrecovery.org/pdf/toward_new_recovery.pdf.

White, W. (2001) Pre-AA Alcoholic Mutual Aid Societies. *Alcoholism Treatment Quarterly*

19(1), 1-21.
White, W. (2004a). Recovery: The next frontier. *Counselor*, 5(1), 18-21.
White, W. (2004b). Transformational Change: A Historical Review. IN SESSION: *Journal of Clinical Psychology*, 60(5), 461-470.
White, W. (2004c). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Retrieved on September 19, 2005 from http://www.facesandvoicesofrecovery.org/pdf/peer-based_recovery.pdf
White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.
White, W., Boyle, M. & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, 20(3/4),107-130.
White, W. & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor*, 4(5), 58-63.
White, W. & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, 6(4), 58-61.
White, W. & Scott, C. (Draft Manuscript) Addiction recovery: Its definition and conceptual boundaries.
White, W. & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor*, 6(5), 58-62.
Wholey, D. (1984). *The Courage to Change: Personal Conversations about Alcoholism with Dennis Wholey*. New York: Warner Books.
Wilbourne, P., & Miller, W. (2003). Treatment of alcoholism: Older and wiser? *Alcoholism Treatment Quarterly*, 20(3/4), 41-59.
Willie, R. (1978). Preliminary communication--cessation of opiate dependence: processes involved in achieving abstinence. *British Journal of Addiction*, 73(4), 381-384.
Wilson, B. (1944). Bill's comments on Wylie ideas, hunches. *A.A. Grapevine*, 1(4), 4.
Wilson, B. (1958). The next frontier: Emotional sobriety. *A.A. Grapevine*, January, 2-5.
Wilson, B. (1962). Spiritual Experiences. *A.A. Grapevine*, July, 2-3.
Winick, C. (1962). Maturing out of narcotic addiction. *U.N. Bulletin on Narcotics*, 14,1-7 (January-March).
Winick, C. (1964). The life cycle of the narcotic addict and of addiction. *U.N. Bulletin on Narcotics*, 16(1),1-11.
Winzelberg, A. & Humphreys, K. (1999). Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Counseling and Clinical Psychology*, 67(5), 790-794.
Workgroup on Substance Abuse Self-Help Organizations (2003). *Self-Help Organizations for Alcohol and Other Drug Problems: Towards Evidence-based Practice and Policy.* (February 2003 Technical Report). SAMHSA.
Zweben, J. E. (1996). Psychiatric problems among alcohol and other drug dependent women. *Journal of Psychoactive Drugs*, 28(4), 345-366.
Zweben, J.E. (1986). Recovery oriented psychotherapy. *Journal of Substance Abuse Treatment*, 3, 255-262.

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Recovery Management

What if we really believed that addiction was a chronic disorder?

William L. White, MA

A quiet revolution is unfolding within the worlds of addiction treatment and recovery support. This revolution is founded on new understandings of the nature of substance use disorders and their management. It calls for shifting the treatment of severe and persistent alcohol and other drug (AOD) problems from an emergency room model of acute care (AC) to a model of sustained recovery management (RM). The RM model wraps traditional interventions in a continuum of recovery support services spanning the pre-recovery (recovery priming), recovery initiation and stabilization, and recovery maintenance stages of problem resolution. Particularly distinctive is the model's emphasis on post-treatment monitoring and support; long-term, stage-appropriate recovery education; peer-based recovery coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention.

Promotional Forces

There are several forces pushing the addiction field toward a redesign of its treatment processes. Frontline addiction professionals are articulating (and a growing number of scientific studies are confirming) the limitations of addiction treatment as currently practiced. Grassroots recovery advocacy organizations are calling upon the treatment industry to reconnect professional treatment to the larger and more sustained process of addiction recovery. Pioneer states (e.g., Connecticut) are building research, clinical, and recovery advocacy coalitions to infuse the recovery management model into new "recovery-oriented systems of care." And finally, technological advances in the management of primary chronic health care problems (e.g., diabetes, heart disease, asthma, arthritis, cancer, chronic lung disease, glaucoma, irritable bowel syndrome) are suggesting alternative approaches through which severe and complex behavioral health disorders might be managed more effectively.

Premises

The shift from acute care to sustained recovery management models rests upon six propositions.

1. *Alcohol and other drug problems present in transient and chronic forms*. The transient forms vary in intensity, from the clinical (*substance abuse* and *substance dependence*) to the subclinical (problems not meeting DSM-IV criteria for abuse or dependence). Transient forms share a short duration (a single episode or period of problematic use) and a propensity for natural resolution or resolution through brief professional intervention. Transient AOD problems are common in community populations, but are more rarely represented among populations entering addiction treatment. Compared to community populations, clients entering addiction treatment

are distinguished by:

- greater personal vulnerability (e.g., family history of substance use disorders, early age of onset of AOD use, developmental trauma),
- greater severity and intensity of use and related consequences,
- high concurrence of medical/psychiatric illnesses,
- greater personal and environmental obstacles to recovery, and
- less "recovery capital" (the internal and external resources required to initiate and sustain recovery).

2. *The evidence is overwhelming that the course of severe substance use disorders and their successful resolution (addiction, treatment, and recovery careers) can span years, if not decades.* Alcohol and other drug dependencies resemble chronic disorders (e.g., type 2 diabetes mellitus, hypertension, and asthma) in their etiological complexity (interaction of genetic, biological, psychological, and physical/social environmental factors), onset (gradual), course (prolonged waxing and waning of symptoms), treatment (management rather than cure), and clinical outcomes. To characterize addiction as a chronic disorder is not to suggest that recovery is not a possibility. There are millions of people in stable, long-term recovery from addiction. The notion of addiction as a chronic disorder does, however, underscore the often-long course of such disorders and the sustained "treatment careers" that can precede stable recovery. Recent studies have confirmed that the majority of people with severe and persistent substance use disorders (e.g., substance dependence) who achieve a year of stable recovery do so following 3-4 treatment episodes over a span of eight years.

3. *Severe and persistent AOD problems have been collectively depicted as a "chronic, progressive disease" for more than 200 years, but their historical treatment more closely resembles interventions into acute health conditions (e.g., traumatic injuries, bacterial infections)*. If we (the practitioners of addiction treatment) really believed addiction was a chronic disorder, we would not:

- view prior treatment as a predictor of poor prognosis (and grounds for denial of treatment admission);
- convey the expectation that all clients should achieve complete and enduring sobriety following a single, brief episode of treatment;
- punitively discharge clients for becoming symptomatic;
- relegate post-treatment continuing care services to an afterthought;
- terminate the service relationship following brief intervention; or

- treat serious and persistent AOD problems in serial episodes of self-contained, unlinked interventions.

4. *Acute models of treatment are not the best frameworks for treating severe and persistent AOD problems*. The limitations of the acute model of addiction treatment as currently practiced include:

   - Failure to Attract: Less than 10% of U.S. citizens who meet DSM-IV criteria for substance abuse or dependence currently seek treatment, and most of those admitted to treatment arrive under coercive influences.

   - Failure to Engage/Retain: More than half of the people admitted to addiction treatment in the U.S. do not successfully complete treatment, and 18% of people admitted to addiction treatment are administratively discharged from treatment.

   - Inadequate Service Dose: A significant percentage of individuals completing treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.

   - Lack of Continuing Care: Post-discharge continuing care can enhance recovery outcomes, but only one in five clients actually receives such care.

   - Recovery Outcomes: The majority of people completing addiction treatment in the U.S. resume AOD use in the year following treatment, most within 90 days of discharge from treatment.

   - Revolving Door: Of those admitted to publicly funded addiction treatment, 60% already have one or more prior treatment admissions, and 24% have three or more prior admissions. Between 25% and 35% of clients who complete addiction treatment will be re-admitted to treatment within one year, and 50% will be re-admitted within 2-5 years.

   A large number of people are undergoing repeated episodes of brief interventions whose designs have little ability to fundamentally alter the trajectory of substance dependence and its related consequences. This failure does not result from client foibles or the inadequate execution of clinical protocol by service professionals. It flows instead from a fundamental flaw in the design of the intervention — an acute-care model of treating addiction that is analogous to treating diabetes or asthma through a single, self-contained episode of inpatient stabilization. In the AC model, brief symptom stabilization is misinterpreted as evidence of sustainable recovery.

5. *Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months, and years following treatment. Recent studies have confirmed the fluidity of post-treatment adjustment.* One such study conducted quarterly monitoring interviews of 1,326 clients over three years following an index episode of addiction treatment. Each client was categorized each quarter as 1) in the community using, 2) incarcerated, 3) in treatment, or 4) in the community not using. More than 80% of the clients changed status one or more

times over the course of the three years. Beyond the groups of clients who categorically succeed or do not succeed stands a larger body of clients who vacillate between periods of recovery and periods of re-addiction. The precarious nature of early recovery is further confirmed by longer-term studies finding that stable recovery from alcoholism (the point at which the future risk of lifetime relapse drops below 15%) is not achieved until 4-5 years of continuous recovery, and that stable recovery from opiate addiction takes even longer. Such findings beg for models of sustained post-treatment monitoring and support.

Promises and Prospects

Recovery management models hold great promise in treating severe and complex substance use disorders. Chronic disorders are disorders that resist cure via brief intervention but can often be successfully managed (the achievement of full or partial recovery). Such management entails care and sustained support aimed at enhancing the strength, quality, and durability of remission periods and shortening the frequency, duration, and intensity of relapse episodes. This longer-term vision of the treatment and recovery process is based on several critical assumptions:

- A single brief episode of treatment rarely has sufficient effect for those with the most severe substance use disorders to sustain recovery following the intervention.
- Multiple episodes of treatment, if they are integrated within a recovery management plan, can constitute incremental steps in the developmental process of recovery.
- Treatment episodes over time may generate cumulative effects.
- Particular combinations and sequences of professional treatment interventions and peer-based recovery support services may generate synergistic effects (dramatically elevated long-term recovery outcomes).

RM models are focusing initially on the power of post-treatment monitoring and recovery support services. Early studies are confirming the potential utility of such approaches. One study of recovery management checkups (RMC) and early re-intervention over 24 months following treatment found that members of the RMC group had significantly fewer post-treatment days of substance use, were more likely to return to treatment, were more likely to return to treatment sooner, received treatment on a greater number of days following discharge from the index episode, and experienced fewer quarters during follow-up in which they were in need of treatment.

Treating alcohol and other drug dependence solely through repeated episodes of detoxification and brief stabilization is clinically ineffective and constitutes a poor stewardship of personal and community resources. It contributes to the pessimism of clients, service providers, policy makers, and the public regarding the prospects for permanent resolution of alcohol and other drug problems. It is time we acted as if we really believed addiction was a chronic disorder. Today millions of people are reaping the fruits of recovery while others continue to suffer. It is time we widened the doorway of entry into recovery

for those with the most severe and persistent substance use disorders. To achieve that will require changes in our thinking, changes in our clinical technologies, and changes in systems of service reimbursement.

Model Definition

The recovery management model of addiction treatment shifts the focus of care from professional-centered episodes of acute symptom stabilization toward the client-directed management of long-term recovery. It wraps traditional interventions within a more sustained continuum of:

- pre-recovery support services to enhance recovery readiness,
- in-treatment recovery support services to enhance the strength and stability of recovery initiation, and
- post-treatment recovery support services to enhance the durability and quality of recovery maintenance.

The influence of this emerging model is evident in many quarters. It is evident in the research community's exploration of addiction as a chronic disease (O'Brien & McLellan, 1996; McLellan, Lewis, O'Brien, & Kleber, 2000). It is reflected in the work of the Behavioral Health Recovery Management project in Illinois (White, Boyle, & Loveland, 2003a/b) and other pioneer state efforts to reshape addiction treatment into a "recovery-oriented system of care" (e.g., see http://www.dmhas.state.ct.us/recovery.htm). Interest in recovery management at the federal level is revealed in the move toward a more recovery-oriented research agenda at NIAAA and NIDA, in SAMHSA and CSAT's growing interest in peer-based models of recovery support services (particularly within CSAT's Recovery Community Support Program), and in the White House-initiated Access to Recovery program funded amd administered by CSAT. Private sector interest in recovery-focused treatment system enhancements is reflected in the Robert Wood Johnson Foundation's Paths to Recovery Initiative (http://www.pathstorecovery.org). The shift from acute intervention models to models of sustained recovery support are further reflected in the policy agendas of new grassroots recovery advocacy organizations across the country (see http://www.facesandvoiceofrecovery.org).

Describing the emerging "model" of recovery management is a bit like describing a painting while it is being created, but there are broad principles and early changes in clinical practices that are becoming visible. There may be no single program in the country that reflects all the changes described below, but these changes do collectively represent what is increasingly being characterized as a model of *recovery management*.

Model Principles

There are several cornerstone beliefs that distinguish the recovery management model from acute models of addiction treatment. These principles and values include:

- emphasis on resilience and recovery processes (as opposed to pathology and disease processes),
- recognition of multiple long-term pathways and styles of recovery,
- empowerment of individuals and families in recovery to direct their own healing,
- development of highly individualized and culturally nuanced services,
- heightened collaboration with diverse communities of recovery, and
- commitment to best practices as identified in the scientific literature and through the collective experience of people in recovery. (http://www.bhrm.org/papers/principles/BHRMprinciples.htm and http://www.dmhas.state.ct.us/corevalues.htm)

Model Practices

White, Boyle, and Loveland's (2003a/b) review of recovery management (RM) pilot programs reveals several critical differences between the RM models and traditional acute care (AC) models of intervention. These differences span seven broad areas of clinical practice.

Engagement and Motivational Enhancement: RM models place great emphasis on engagement and motivational enhancement. This emphasis is reflected in low thresholds of engagement (inclusive recruitment and admission processes), an investment in outreach and pre-treatment support services, and high retention and low post-admission extrusion (administrative discharge) rates. Within the RM model, motivation is viewed as an important factor in long-term recovery, but is viewed as something that emerges within the service relationship rather than a precondition for service initiation. This emphasis is based on two premises: 1) chronic disorders increase in complexity and severity over time, and 2) recovery outcomes are enhanced by the earliest possible point of recovery initiation and stabilization. AC models of addiction treatment are essentially reactive in their wait for individuals to enter states of crisis that bring them to treatment. RM models reach out to people prior to such crises and sustain contact with them to re-nurture motivation for recovery following such crises.

Assessment and Service Planning: In traditional treatment, the clinical assessment is categorical (focused on substance use and its consequences), is pathology-based (focused on the identification and elucidation of problems), and is an intake activity. Problem severity dictates level of care, and the problems list drives the development of the treatment plan. In recovery management models, assessment is global (focused on the whole life of the recovering person), asset-based (focused on recovery capital — internal and external assets that can help initiate and sustain recovery), and is continual over the span of the service relationship. This altered view of the assessment process is based on three propositions:

1. Chronic disorders beget other acute and chronic problems; therefore, all aspects of

the life of the recovering person must be assessed and incorporated into an integrated recovery process.

2. Service intensity and duration are dictated by the interaction of problem severity and recovery capital; therefore, problem severity alone is an inadequate and disempowering framework for service planning.

3. There are developmental stages of long-term recovery, and service and support needs can shift dramatically in the transition from one stage to another; therefore, stage-dependent service needs must be continually reevaluated.

The traditional professionally directed, short-term treatment plan of the acute care model is replaced in the RM model by long-term and short-term recovery plans prepared by the person seeking recovery. The former focuses primarily on reducing pathology; the latter focuses on building recovery capital and a meaningful life.

Service Duration and Emphasis: Acute care models do an excellent job of biopsychosocial stabilization, but often fail to facilitate the transition between recovery initiation and recovery maintenance. The evidence of such failure can be found in post-treatment relapse and treatment re-admission rates (see previous article in this series). Recovery management models rest on the assumption that the factors required to sustain recovery over a lifetime are different than those factors that spark brief sobriety experiments. The recovery management model emphasizes four post-treatment service activities: sustained post-stabilization monitoring; stage-appropriate recovery education and coaching; assertive linkage to local communities of recovery; and, when needed, early re-intervention. Detoxification and traditional treatment exist within RM models, but the focus of service shifts from crisis intervention to post-treatment recovery support services.

Locus of Services: The institutional focus of the acute care model ("How do we get the addicted person into treatment?") shifts within the RM model to the larger community ("How do we nest the process of recovery within the client's natural environment?"). With this shift, there is a greater emphasis on home- and neighborhood-based services and indirect monitoring technology (e.g., telephone, mail, Internet), as well as an emphasis on organizing indigenous recovery support services within the client's physical and social environment. The RM model also pushes treatment agencies toward greater advocacy responsibilities related to stigma and discrimination, the removal of environmental obstacles to recovery, and the development of needed recovery support resources within local communities.

Role of the Client: In acute care models of intervention, the person entering treatment is viewed as the major obstacle to his or her own recovery, and thus is dependent upon an expert who assumes fiduciary responsibility for diagnosis and treatment. RM models champion the necessity and right of the person who is seeking recovery to self-manage his or her own recovery process. Each client must become an expert on his or her condition and its management. This emphasis is reflected in the client's role in service planning and evaluation, as well as in the RM model's inclusion of recovering people and family members in policy-making positions and as volunteers and paid service providers.

Service Relationship: The service relationship within the RM model shifts from one that is hierarchical, time-limited, and highly commercialized (the AC model) to one that is less hierarchical, more time-sustained, and more natural. In the RM model, the service provider role is more that of a teacher and ally within a long-term health care partnership. RM models are also pioneering new approaches to peer-based recovery support services that utilize new service roles, e.g., peer counselors, recovery coaches, recovery support specialists (White, 2004). The RM model emphasizes the importance of sustained continuity of contact in a primary recovery support relationship. This relationship would be analogous to the long-term alliance between a primary care physician and his or her diabetic patient or the long-term support that exists within addiction recovery mutual aid societies.

Model Evaluation: The evaluation of acute care models of addiction treatment focuses on measuring the short-term effects of a single, brief episode of intervention. Evaluation within the RM model focuses on measuring the long-term effects of multiple service interventions. The goal is to identify particular combinations or sequences of clinical and recovery support services that generate dramatically elevated (cumulative or synergistic) effects upon recovery outcomes within particular populations. The RM model also balances science-based evaluations of service outcomes with consumer and community/tribal evaluations of service processes and recovery outcomes.

Today, elements of the RM model exist within many traditional treatment programs that have evolved toward more client-responsive clinical policies and practices. Elements of the model exist within CSAT's Recovery Community Support Program and RWJ's Paths to Recovery grantee sites. The model is being tested within research studies that are evaluating elements of the RM model. It exists within the growing network of recovery homes and recovery support centers. The recovery management model of intervening with severe substance use disorders marks a dramatic change in the design of addiction treatment in the United States. Time will tell whether this model will struggle as a loosely attached appendage to the existing system of addiction treatment or whether it will transform addiction treatment in the United States into a truly recovery-oriented system of care and long-term support.

Implementation Challenges

The scientific evidence documenting the need to shift addiction treatment from an acute model of intervention to a model of sustained recovery management is so overwhelming it leaves one wondering why this model is not yet fully implemented. The roots of this failure are historical, conceptual, financial, organizational, and technical.

The first barriers to treating addiction as a chronic disorder are the forces of historical and conceptual momentum. The modern field of addiction treatment is rooted in an acute biopsychological model of intervention. Addiction treatment programs were created in the image of the acute care hospital (via the profound influence of hospital-derived accreditation standards). The central service role in addiction treatment was similarly modeled after the therapy disciplines of psychiatry, psychology, and social work (via addiction counselor certification and licensure standards). For those of us steeped in the modern

world of addiction treatment, it is almost impossible to think of treatment in terms other than number of days or number of sessions, and hard to think about continuing care as anything beyond the availability of a short regimen of "aftercare" sessions. We have viewed addiction treatment in terms of multiple levels of care and theory-based modalities, but have failed to recognize that all of these approaches are nested within an acute care model of assess, admit, treat, and discharge. To escape this closed conceptual world, programs exploring the RM model are re-educating their service workers and are conducting a rigorously honest, recovery-focused inventory of their current service practices.

All of the reimbursement and regulatory systems that govern addiction treatment are based on the acute care model. These structures, originally designed to elevate the consistency and quality of addiction treatment, now constitute a major barrier to shifting to more recovery-oriented systems of care. When programs embracing the RM philosophy seek to admit families rather than individuals, create multi-agency service teams that include indigenous institutions and cultural healers, utilize long-term recovery plans rather than short-term treatment plans, incorporate peer-based recovery support roles/teams, develop non-clinical recovery support systems in local communities, and provide long-term monitoring and early re-intervention services, they find themselves facing almost insurmountable fiscal and regulatory barriers. It is tragic and ironic that the major challenges of recovery management are posed, not by the complex needs of individuals and families seeking recovery, but by the systems originally set up to help facilitate that recovery. The mainstream implementation of recovery management will require a major overhaul of the reimbursement and regulatory systems governing addiction treatment. States like Connecticut that have begun this overhaul process are making a significant contribution to the future of addiction treatment and recovery in America (http://www.dmhas.state.ct.us/recovery.htm).

Slowing the development and implementation of RM models are the weak organizational infrastructures and high staff turnover rates that pervade the world of addiction treatment (McLellan, Carise, & Kleber, 2003). RM is founded on the continuity of relationship between an organization and the communities it serves and the capacity for sustained continuity of contact between each organization's front-line service professionals and the individuals and families within those communities who suffer from severe and persistent AOD problems. If there is an Achilles heel of the RM model, it is in the combined effects of organizational instability and staff turnover within the addictions field (Roman, Blum, Johnson, & Neal, 2002). If the process of RM is to parallel that of the long-term relationship between a primary care physician and a patient/family impacted by a chronic disease, that instability and turnover must be reversed.

The lack of a science-based understanding of long-term recovery constitutes a significant obstacle to the design of RM programs. As a field, our scientific knowledge about addiction and brief models of treatment has grown exponentially in recent decades, but our science has yet to connect the problem and the intervention to the process of long-term recovery. We know comparatively little from the standpoint of science about the prevalence, pathways, and styles of long-term recovery. The ability to find potent combinations and sequences of professionally directed treatment interventions and peer-based

recovery support services rests on the emergence of a recovery research agenda at the federal level. Without scientific data, RM pioneers will lack a reliable compass to navigate the recovery frontier.

A fifth obstacle in implementing RM models of care involves the integration of professional-directed treatment services and peer-based recovery support services (particularly within the newly emerging role of recovery coach). Questions abound related to such integration. Are recovery support services best provided by addiction treatment organizations or by free-standing recovery support and recovery advocacy organizations? Should recovery support services be added to the role of addiction counselor or segregated within a new specialized role? What are the best ways to recruit, train and supervise recovery support specialists? What are the boundaries of competence of these new recovery support specialist roles, and how do they fit into larger multidisciplinary teams? Which models of integrating or coordinating professional and peer-based recovery support services are associated with the best long-term recovery outcomes? Answers to such questions are crucial to the future evolution of the RM model, and their absence constitutes a major implementation obstacle.

The service capacity of an organization or service professional within the RM model has yet to be clearly defined. If, for example, an addiction counselor is responsible for providing ongoing monitoring and support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention services for those leaving traditional inpatient or outpatient treatment, what is a reasonable caseload for such a counselor? The answer is that we do not know. RM will require a significant reallocation of resources — a shift that will de-emphasize expensive, high-intensity acute care and emphasize lower-intensity, lower-cost, and more enduring recovery support services. Service capacities for organizations and individual workers will have to be redefined in that transition.

The ethical guidelines that have guided addiction treatment agencies and addiction counselors for the past three decades grew out of the acute care service relationship and were closely modeled after the ethical guidelines for psychologists and social workers (e.g., discouragement or prohibition of self-disclosure, prohibition of all dual relationships, prohibition of gifts, etc.). These guidelines, which presupposed a short-term, expert-based fiduciary service relationship, do not easily fit the less hierarchical and more enduring service relationships that characterize the RM model. It is crucial that ethical standards evolve to guide the provision of professionally delivered and peer-based recovery support services. The lack of current ethical guidelines for recovery support services raises the ethical vulnerability of service organizations and service professionals.

Potential Pitfalls

This three-part series on the recovery management model of addiction treatment and recovery support would be incomplete without an exploration of some of the potential pitfalls of the RM model. Experience to-date suggests three potential pitfalls beyond the implementation challenges noted above.

Not everyone with an AOD-related problem needs RM services. Many individuals with such problems will resolve these problems on their own or will do so through mutual aid or brief professional intervention. Misapplying an RM model to persons with low problem severity and high recovery capital could generate iatrogenic effects within the RM model. Such misapplication could injure persons with transient AOD problems by inappropriately attaching a stigma-laden diagnosis and delivering services that are ineffective, a financial burden, and potentially harmful.

The emphasis on addiction as a chronic disorder within the RM model could inadvertently contribute to cultural pessimism about the resolution of AOD problems and heighten the stigma and discrimination attached to those problems (Brown, 1998). To counter such effects, RM models must constantly emphasize the reality of full recovery in the lives of millions of people who have suffered from severe and prolonged AOD problems.

The 1980s witnessed a period of institutional profiteering in which persons with alcohol and other drug problems were viewed as a crop to be harvested for financial profit. A too-rapid shift to RM models of reimbursement could unleash the same forces. Profiteers could garner large, capitated contracts for recovery support services, but then minimize the services delivered through such contracts to maximize institutional and personal profit. These profiteers could escape accountability for recovery outcomes behind the rhetoric that addiction is a chronic disease. To avoid this, RM models of reimbursement must include a high level of accountability for recovery outcomes. This will require clinical information systems that can track clinical outcomes and other performance indicators across multiple episodes of care.

Attempts to shift addiction treatment from a revolving emergency room door (via unending cycles of brief intervention) to a model of sustained recovery management face many implementation obstacles and potential pitfalls. These obstacles and pitfalls are offset by the potential of the RM model to align the design of addiction treatment with the growing body of scientific evidence documenting the chronicity of severe AOD problems and the complexity of long-term recovery. That potential and what it means for millions of people suffering from addiction will inspire many addiction professionals and addiction treatment organizations to experiment with this fundamental redesign of addiction treatment.

References and Recommended Reading

Anglin, M. D., Hser, Y. I., & Grella, C. E. (1997). Drug addiction and treatment careers among clients in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors,* 11(4), 308-323.

Brown, B.S. (1998). Drug use: Chronic and relapsing or a treatable condition? *Substance Use and Misuse*, 33(12), 2515-2520.

Brown, S., Mott, M. & Stewart, M. (1992) Adolescent alcohol and drug abuse. In: Walker, C.E. Ed., *Handbook of Clinical Child Psychology* (2nd ed.), pp. 677-693.

Dawson, D.A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20, 771-779.

Dennis, M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery

management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning*, 26(3), 339-352.

Dennis, M.L., Scott, C.K., & Hristova, L. (2002). The duration and correlates of substance abuse treatment careers among people entering publicly funded treatment in Chicago. (Abstract). *Drug and Alcohol Dependence*, 66(Suppl. 2).

Dennis, M.L., Scott, C.K., Funk, R.R., & Foss, M.A. (2005). The duration and correlates of addiction and treatment. *Journal of Substance Abuse Treatment*, 28 (Supplement 1), S51-S62.

Finney, J. & Moos, R. (1995). Entering treatment for alcohol abuse: a stress and coping model. *Addiction*, 90:1223-1240.

Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2004). Findings from the assertive continuing care experiment with adolescents with substance use disorders. In W. Dewey *Problems of Drug Dependence, 2003: Proceedings of the 65th Annual Scientific Meeting, The College on Problems of Drug Dependence, Inc*. (NIDA Research Monograph Series 184. pp. 123-124).

Godley, S. H., Godley, M. D., & Dennis, M. L. (2001). The assertive aftercare protocol for adolescent substance abusers. In E. Wagner, & H. Waldron (Eds.), *Innovations in Adolescent Substance Abuse Interventions* (pp. 311-329). New York: Elsevier Science.

Grella, C.E. and Joshi, V. (1999) Gender differences in drug treatment careers among the National Drug Abuse Treatment Outcome Study. *American Journal of Drug and Alcohol Abuse*, 25(3), 385-406.

Hser, Y., Hoffman, V., Grella, C. & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58:503-508.

Hubbard, R. L., Flynn, P. M., Craddock, S. G. & Fletcher, B. W. (2001). Relapse after drug abuse treatment. In F. M. Tims, C. G. Leukefeld, & J. J. Platt (Eds.), *Relapse and Recovery in Addictions* (pp. 109-121). New Haven: Yale University Press.

Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, H.J. Cavanaugh, E.R. & Ginzburg, H.M. (1989). *Drug Abuse Treatment: A National Study of Effectiveness*. Chapel Hill, NC: University of North Carolina Press.

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J. & Grant, I. (1998) Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol*, 59:640-646.

Johnson, E. & Herringer, L. (1993). A note on the utilization of common support activities and relapse following substance abuse treatment. *Journal of Psychology*, 127:73-78.

McKay, J.R. (2001). Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term effects. *Evaluation Review*, 25, 211-232.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695.

McLellan, A.T., Carise, D. & Kleber, H.D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment*, 25:117-121.

McLellan, A.T., Carise, D., and Kleber, H.D. (2003). Can the national addiction treatment

infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment*, 25:117-121.

NIDA (1999). Principles of Drug Addiction Treatment. Rockville, MD: National Institute on Drug Abuse (NIH Publication No. 00-4180) (available at http://www.nida.nih.gov/PODAT/PODATIndex.html)

O'Brien, C. & McLellan, T. (1996). Myths about the Treatment of Addiction. *Lancet*, 347:237-240.

Roman, P.M., Blum, T.C., Johnson, J.A., & Neal, M. (2002). *National Treatment Center Study Summary Report* (No 5). Athens, GA: University of Georgia.

Roman, P.M., Blum, T.C., Johnson, J.A., & Neal, M. (2002). *National Treatment Center Study Summary Report* (No 5). Athens, GA: University of Georgia.

Ross, H. E., Lin, E., & Cunningham, J. (1999). Mental health service use: A comparison of treated and untreated individuals with substance use disorders in Ontario. *Canadian Journal of Psychiatry*, 44, 570-577.

Scott, C. K, Foss, M. A., & Dennis, M. L. (2003). Factors influencing initial and longer-term responses to substance abuse treatment: A path analysis. *Evaluation and Program Planning*, 26(3), 287-295.

Scott, C. K, Foss, M. A., & Dennis, M. L. (2005). Pathways in the relapse-treatment- recovery cycle over three years. *Journal of Substance Abuse Treatment*, 28(Supplement 1), S63-S72.

Simpson, D.D., Joe, G.W., & Broome, K.M. (2002). A national 5-year follow-up of treatment outcomes for cocaine dependence. *Archives of General Psychiatry*, 59, 539-544.

Substance Abuse and Mental Health Services Administration Office of Applied Studies. (2001). Treatment Episode Data Set (TEDS) *1994-1999: National Admissions to Substance Abuse Treatment Services*. Table (4.16.01). DASIS Series S14, DHHS Publication No. (SMA) 01-3550. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration Office of Applied Studies (2002). Treatment Episode Data Set (TEDS): 1992-2000. *National Admissions to Substance Abuse Treatment Services*, DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727, Rockville, MD, 2002. http://wwwdasis.samhsa.gov/teds00/TEDS_2K_Highlights.htm; http://wwwdasis.samhsa.gov/teds00/TEDS_2K_Chp6.htm#Length of Stay).

Substance Abuse and Mental Health Services Administration. (2003). *Results from the 2002 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NHSDA Series H-22, DHHS Publication No. SMA 03–3836). Rockville, MD.

White, W. (2004). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. (Available at http://www.bhrm.org).

White, W., Boyle, M. & Loveland, D. (2003a) Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, 3/4:107-130.

White, W., Boyle, M. & Loveland, D. (2003b) Recovery Management: A model to transcend the limitations of addiction treatment. *Behavioral Health Management* 23(3):38-44. (http://www.behavioral.net/2003_05-06/featurearticle.htm).

White, W., Boyle, M. And Loveland, D. (2003). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, 3/4:107-130.

Wilbourne, P and Miller, W. (2003). Treatment of alcoholism: Older and wiser? In T. McGovern & W. White (eds.), *Alcohol Problems in the United States: Twenty Years of Treatment Perspective*. New York: Haworth Press, pp. 41-59.

White, W., Boyle, M. And Loveland, D. (2003). Recovery Management: Transcending the Limitations of Addiction Treatment. *Behavioral Health Managemen*t 23(3):38-44.

White, W. (2004). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.

Recovery Management and People of Color:

Redesigning Addiction Treatment for Historically Disempowered Communities.

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Abstract

Communities of color have been ill-served by acute care models of treating severe alcohol and other drug (AOD) problems that define the source of these problems in idiopathic (biopsychological) terms and promote their resolution via crisis-elicited episodes of brief, individual interventions. This article explores how approaches that shift the model of intervention from acute care (AC) of individuals to a sustained recovery management (RM) partnership with individuals, families, and communities may be particularly viable for historically disempowered peoples. The advantages of the RM model for communities of color include: a broadened perspective on the etiological roots of AOD problems (including historical/cultural trauma); a focus on building vibrant cultures of recovery within which individual recoveries can be anchored and nourished; a proactive, hope-based approach to recovery engagement; the inclusion of indigenous healers and institutions with the RM team; an expanded menu of recovery support services; culturally grounded catalytic metaphors and rituals; and a culturally nuanced approach to research and evaluation.

Introduction

Addiction has been characterized as a "chronic, progressive disease" for more than 200 years (White, 2000a), but interventions into severe alcohol and other drug (AOD) problems continue to be based on serial episodes of self-encapsulated, acute intervention (O'Brien & McLellan, 1996; Kaplan, 1997). Recent research has confirmed the chronic nature of severe AOD problems (Simpson, Joe, & Lehman, 1986; Hser, Anglin, Grella, Longshore, & Pendergast, 1997) and compared such problems to other chronic health disorders (e.g., type 2 diabetes mellitus, hypertension, and asthma) in terms of their etiological complexity, variability of course, and recovery and relapse rates (McLellan, Lewis, O'Brien, & Kleber, 2000). Calls for shifting addiction treatment from an acute care (AC) model to a model of sustained recovery management (RM) are increasing (White, Boyle, & Loveland, 2002, 2003; Compton, Glantz, & Delaney, 2003; Edwards, Davis, and Savva, 2003; Moore & Budney, 2003), and components of such models are currently being evaluated with adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002) and adults (Dennis, Scott & Funk, 2003). The emerging model of recovery management has been defined as:

> *…the stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a time-sustained, recovery-focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe*

behavioral health disorders until full remission has been achieved or until recovery maintenance can be self-managed by the individual and his or her family (White, Boyle, Loveland and Corrigan, 2003).

This article contrasts the application of AC and RM models of intervention into severe AOD problems within communities of color[1]. We will focus specifically on those American Indian/Alaskan Native[2], African American, Hispanic/Latino, and Asian and Pacific Islander communities whose members present unique challenges and resources as they enter publicly funded treatment for severe AOD problems. Our contrast of AC and RM models is drawn from the pioneering work of McLellan, Lewis, O'Brien, and Kleber (2000) and from the descriptions of the RM model set forth by White, Boyle, and Loveland (2002, 2003). We argue that historically disempowered persons, and, in particular, communities of color, have been ill-served by acute, biomedical models of intervention into AOD problems, and that models of recovery management hold great promise in providing more effective solutions to AOD problems within communities of color. We will explore elements of RM that tap deep historical traditions within communities of color and that are highly congruent with contemporary, abstinence-based religious and cultural revitalization movements within communities of color.

Great care must be taken that discussions of the needs of ethnic communities do not inadvertently contribute to stereotypes about communities of color. To determine whether RM models of intervention hold greater promise than AC models within communities of color, we will need to explore those characteristics of communities of color that have relevance to the viability of these models. Given the enormous differences within and between ethnic communities and the changes in communities over time, we would ask readers to keep all observations, ideas, and strategies set forth in this article on probation pending their validation within particular communities and with particular individuals and families. "People of color" and "communities of color" do not constitute a monolithic group to which any single explanatory or intervention model can be indiscriminately applied. We also recognize that the concepts set forth here may not be limited to communities of color and may also apply to particular white communities. Testing of components of the RM model will need to be conducted in all ethnic communities and across multiple subpopulations within those communities. To achieve this will require redesigning addiction treatment in light of new recovery management models and doing this within the larger framework of cultural competence.[3] We hope this introductory paper will stand as an invitation for such sustained exploration. Our vision is the development of culturally competent models of recovery management within all communities and the dynamic evolution of RM principles and practices based on experience within and dialogue between communities.

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[1] While we have limited our discussion to communities of color, many reviewers (including Hennessey and Simonelli) of early drafts of this paper were struck by how applicable the ideas and strategies set forth in this paper are to women of all ethnic backgrouds.

[2] All future references to American Indians or Native Peoples are intended to include Alaskan Natives.

[3] Culltural competence has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance. Center.

We will begin by contrasting how AC and RM models conceptualize the sources and solutions to AOD problems and then explore the RM model's emphasis on proactive engagement, the use of indigenous healers and institutions, catalytic rituals and metaphors, new technologies of monitoring and recovery support, a sustained recovery management partnership, and the need for culturally nuanced approaches to recovery research and evaluation.

AC and RM Models: The Source of AOD Problems

> *American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon…contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism and other social problems among American Indians.*
>
> — Brave Heart & DeBruyn, 1998

> *When people are taught to hate themselves, they will do bad things to themselves.*
>
> — Sanders, 1993.

Acute care (AC) models of intervention have assumed that the sources of and solutions to AOD problems reside within the individual, and that brief interventions to alter an individual's physical, cognitive, and emotional vulnerabilities can produce a permanent resolution of these problems. When the AC model fails to resolve AOD problems, the root of that failure is viewed as residing inside the individual. The professional response, in practice if not in theory, is to prescribe additional repetitions of the failed intervention. Of people admitted to publicly funded addiction treatment in the U.S., 60% have been in treatment before (including 23% 1 time, 13% 2 times, 7% 3 times, 4% 4 times, and 13% 5 or more times) (OAS, 2000). An aggressive system of managed behavioral health care has lowered the intensity and duration of these treatment episodes, further lessening the viability of addiction treatment for persons within communities of color who present with high problem severity and chronicity. Awareness of this inadequacy has triggered the rise of indigenous recovery movements, including the Wellbriety Movement in Indian Country (see www.whitebison.org) and Afrocentric frameworks of recovery, e.g., faith-based recovery ministries (Glide Memorial Church, One Church — One Addict, Free N' One, African American Survivors Organization, Turning Point) (Sanders, 2002). Recovery within these movements is seen, not as a singular goal, but as a therapeutic byproduct of participation in larger cultural and religious revitalization processes.

The premises of the RM model contrast sharply with those of the AC model. RM models posit that AOD problems spring from multiple, interacting etiologies; unfold (suddenly or progressively) in highly variable patterns; ebb (remission) and flow (relapse) in intensity over time; and are resolved at different levels (from full to partial) via multiple long-term pathways of recovery. This opening proposition has particular relevance to communities of color. It suggests that people of color may be at risk for AOD problems but that these risk factors differ between and within ethnic groups (Matsuyoshi, 2001). It suggests that historical, political, economic, and socio-cultural circumstances can also serve as etiological agents in the rise of AOD problems. Client discussions about cultural pain (e.g.,

slavery, the loss of land, attempted extermination, epidemic diseases, the purposeful break-up of tribes and families, the loss of families and culture via immigration or forced deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism, and discrimination) are viewed, not as defocusing or acting out, but as a medium of a consciousness raising and catharsis that can open doorways to personal and community healing and transformation (Green, 1995). This approach is much more congruent with beliefs within communities of color that their AOD problems result as much from historical trauma[4], economic and political disempowerment, and cultural demoralization as from biological vulnerability (Manson, 1996; Brave Heart & DeBruyn, 1998; Brave Heart, 2003). This view recognizes that historical trauma and cultural oppression elevate risk factors for substance use problems and erode resiliency factors that operate as a protective shield against AOD problems and speed their natural resolution (Brave Heart, 2003). Culturally nuanced models of RM reflect an understanding of the effects of intergenerational trauma (grief, rage, self-hatred, self-medication) upon whole communities. Positing multiple pathways of long-term recovery also opens up the potential for culturally prescribed frameworks of AOD problem resolution (abstinence-based religious and cultural revitalization movements, e.g., Nation of Islam) as well as cultural adaptations of existing recovery support structures (e.g., the "Indianization" of Alcoholics Anonymous and the adaptation of A.A. within Hispanic/Latino communities) (Womak, 1996; Hoffman, 1994).

RM models assume that severe AOD problems constitute complex, chronic disorders that require sustained individual, family, community, and cultural interventions for their long-term resolution. In this view, treating severe and persistent AOD problems via AC models of intervention is as ineffective as treating a bacterial infection with half the effective dose of antibiotics. While providing temporary symptom suppression, such treatment results in the subsequent return of the problem, often in a more virulent and treatment-resistant form. In the RM model, the treatment of severe and persistent AOD problems is best done within a sustained recovery management partnership that provides ongoing recovery support and consultation and anchors the recovery process in indigenous supports within the client's natural environment.

Chronic disorders such as diabetes and heart disease take an undue toll on communities of color, but substantial efforts are underway within communities of color for the prevention, early intervention, and sustained management of such chronic health problems. People of color are learning that the successful management of these disorders requires an understanding of:

- personal/family vulnerability;
- the influence of environmental conditions on the ebb and flow of these disorders;
- the propensity for these disorders to generate collateral health and family problems; and

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[4] Maria Yellow Horse Brave Heart (2003) has defined historical trauma as "cumulative emotional and psychological wounding over the lifespan and generations, emanating from massive group trauma experiences."

- the role of daily lifestyle decisions (eating, sleeping, exercise, etc), and the need for sustained self-vigilance, in the management of these disorders.

As communities of color learn more about the nature and treatment of chronic primary health disorders, that knowledge base can be extended to severe AOD problems. There is already some recognition of addiction as a chronic disorder via people of color sustaining hope for a family member or friend's recovery, long after the rest of the world has lost such hope. That capacity for patience, compassion, and forgiveness is not a sign of pathology (codependency), but an unheralded resource of hope and support within communities of color upon which the RM model seeks to build.

The acute model rests on the assumption that AOD problems are self-contained and that individuals have the internal and external resources to sustain recovery and assume full social functioning following detoxification and brief treatment. It assumes a foundation of pre-morbid skills and social functioning. This rehabilitation model promises the client that he or she will regain prior levels of functioning and status lost via the accelerating severity of AOD problems. This model is poorly suited to individuals who have not achieved such prior levels of successful functioning and who have no significant support for recovery within their family and social networks. The model is particularly unsuited to those poor communities of color whose members often present with high AOD problem severity, numerous co-occurring problems, and low "recovery capital" (internal and external resources that help to initiate and maintain recovery) (Granfield and Cloud, 1999).

In contrast, the RM model assumes that clients have widely varying degrees of problem severity and recovery capital and that the degree and duration of need for recovery support services requires differential allocation of services across these levels of functioning. Where levels of care within traditional treatment are dictated primarily by problem severity, RM models set service intensities and duration based on the unique interaction of problem severity and recovery capital. For example, the African American business executive with high AOD problem severity but high recovery capital would be viewed as needing less intensive and sustained recovery support than an African American adolescent with low AOD problem severity but with many co-occurring problems and low recovery capital. For those with little recovery capital, RM provides a framework for sustained habilitation.[5] The RM shift in emphasis is from recovery initiation to recovery maintenance (the movement toward global physical and emotional health; a reconstruction of personal identity and interpersonal relationships; and the development of a recovery-based, pro-social lifestyle). This habilitation emphasis is one of the driving forces behind the expanded menu of recovery support services (described below). This same habilitation emphasis is also extended to the families and communities within which AOD problems are enmeshed.

The RM Solution: Personal, Family, and Community Renewal

Ultimately, it is the community that cures....To cure the wounded, one need only

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[5] Rehabilitation assumes the existence of and need for replemishment of recovery capital; habilitation assumes the lack of pre-existing recovery capital and the need to dramatically reconstruct personal identity, interpersonal relationships, and a sobriety-based lifestyle.

return them to their community or construct a new one.
— Philip Rieff, 1987

Community healing along with individual and family healing are necessary to thoroughly address historical unresolved grief and its present manifestations.
— Brave Heart & DeBruyn, 1998

The unit of service within the AC model is the individual with an AOD problem. Professional interventions are designed to lower the biological vulnerability and alter the beliefs and behaviors thought to sustain addiction. Within the RM model, individuals with AOD problems are viewed as being nested within a complex web of family, social, and cultural relationships. Each level of this social ecosystem can contribute to the development of, help resolve, or sabotage the solution of these problems. As a result, it is the whole ecosystem rather than the individual that is the target of the RM intervention. RM moves beyond the clinical skills of assessment, diagnosis, and treatment of individuals to encompass the skills of family reconstruction, community resource development, and nation-building (see the work of White Bison for examples of the latter).[6] RM in communities of color is premised on the belief that the community — experienced through group solidarity with a historical and geographical community — is an essential dimension of personal healing (Murphy, Personal Communication).

In the AC model, the family is a stimulus for help-seeking, a source of emotional and financial support for treatment retention, and a target for brief education and referral to peer-support (e.g., Al-Anon). The assumption is that whatever wounds the family suffered through the addiction experience will naturally and quickly reverse themselves following the addicted family member's recovery initiation. In contrast, the RM model assumes the following:

- Addiction is but one wound families of color have suffered via the intergenerational transmission of historical trauma (e.g., the forced breakup of family units in slavery, the Indian boarding schools and their prolonged aftermath, traumatic separation via immigration), and the family unit itself needs a sustained process of recovery from these wounds (Brave Heart & DeBruyn, 1998).

- The addiction-related transformation of family roles, relationships, rules, and rituals is deeply imbedded within family members and habitual patterns of family interaction and will not spontaneously remit with recovery initiation.

- There are developmental stages of family recovery that entail personal healing, a realignment of family subsystems (adult intimate relationships, parent-child relationships, and sibling relationships), and the family's relationship with the outside environment — tasks that consume the first 3-5 years of stable recovery (See Brown, 1994; Brown & Lewis, 2002).

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[6] Nation-building as used here refers to the process of linking the disempowered community into a larger cosciousness and identity and a process of healing that seeks to heal historically disempowered communities AND the dominant culture of which they are such integral parts. One of our reviewers (Simonelli) called this "the next frontier of healing."

- Families who do not have sufficient supports to make these difficult transitions are at high risk for disintegration — in spite of their having remained intact through years of addiction (Brown & Lewis, 2002).

- Sustained recovery monitoring and support for family members is as crucial as it is for the individual recovering from severe AOD problems.

- RM services for families must be refined based on the unique family and kinship patterns that exist within particular ethnic communities.

A major focus of RM is to create the physical, psychological, and social space within local communities in which recovery can flourish. The ultimate goal is not to create larger treatment organizations, but to expand each community's natural recovery support resources. The RM focus on the community and the relationship between the individual and the community are illustrated by such activities as:

- initiating or expanding local community recovery resources, e.g., working with A.A./N.A. Intergroup and service structures (Hospital and Institution Committees) to expand meetings and other service activities; African American churches "adopting" recovering inmates returning from prison and creating community outreach teams;

- educating contemporary recovery support communities about the history of such structures within their own cultures, e.g., Native American recovery "Circles," the Danshukai in Japan;

- introducing individuals and families to local communities of recovery;

- resolving environmental obstacles to recovery;

- conducting recovery-focused family and community education;

- advocating pro-recovery social policies at local, state, and national levels;

- seeding local communities with visible recovery role models;

- recognizing and utilizing cultural frameworks of recovery, e.g., the Southeast Asian community in Chicago training and utilizing monks to provide post-treatment recovery support services; and

- advocating for recovery community representation within AOD-related policy and planning venues.

The importance of community in understanding AOD problems within communities of color is perhaps most evident within the rising Wellbriety movement in Indian Country. A central idea within this movement is the "Healing Forest" metaphor developed by Don Coyhis (1999). In Coyhis' work, the AC model of treatment is analogous to removing a sick tree from diseased soil, nursing it back to health in well fertilized and well watered soil, and then returning it to the diseased soil from which it came. Coyhis suggests that

we would need fewer tree hospitals if we treated the trees AND the soil in which the trees suffer or thrive. He calls for the creation of a "healing forest" to nurture sobriety and wellness. This broader vision of creating healthy communities that resist AOD problems and within which recovery can thrive is pervasive in communities of color but is markedly absent within the professional field of addiction treatment.

In communities of color, the individual, the family, and the community are inseparable. To wound one is to wound the other; to heal one is to heal all (Red Road to Wellbriety, 2002). When asked how the Shuswap tribe in Alkali Lake, British Columbia successfully reduced its alcoholism rate from nearly 100% to less than 5%, Chief Andy Chelsea declared simply, "the community is the treatment center" (quoted in Abbot, 1998; See also Chelsea and Chelsea, 1985 and Taylor, 1987). Frameworks of recovery within communities of color have always been, and continue to be, defined in terms of an inextricable link between hope for the individual and hope for a community and a people. The most effective and enduring solutions to AOD problems among people of color are ones that emerge from within the very heart of communities of color. The RM model seeks to tap this vein of resistance and resilience by recognizing and enhancing the recovery support capacities of families, kinship networks, indigenous institutions (e.g., mutual aid groups, churches, clans), and whole communities and tribes. The focus of RM interventions is not restricted to the individual, the family, or the community, but is focused on all levels of this recovery ecosystem and their inter-relationships.

Proactive Engagement

> *My clients don't hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.*
>
> — Outreach Worker (Quoted in White, Woll, & Webber, 2003)

The AC model of intervention is essentially crisis oriented. It relies on internal pain or external coercion to bring individuals to treatment, and places the responsibility for motivation for change squarely and solely on the individual. It assumes that people move from addiction to recovery when the pain of the former state reaches a point of critical mass. The AC model is also characterized by a high threshold of engagement (extensive admission criteria and procedures), high rates of client disengagement (terminating services against staff advice) and high rates of client extrusion ("administrative discharge" for noncompliance). In contrast, the RM model is characterized by assertive models of community outreach, pre-treatment recovery support services, and the resolution of personal and environmental obstacles to recovery. Motivation for recovery is not assumed to be static — a dichotomous ("you have it or you don't") entity — but is an entity that emerges out of and is sustained by an empowering service relationship. It is assumed that such motivation waxes and wanes and that active recovery coaching can help the client transcend periods of heightened ambivalence, diminished confidence, and recovery-induced anxiety. One of the earliest examples of such proactive outreach was the work of the East Harlem Protestant Parish among New York City's Puerto Rican heroin addicts in the 1950s. This faith-based program recruited addicts from the streets and enmeshed them within pro-recovery social clubs and a larger religious community within which they were

welcomed and respected (White, 1998).

The proactive engagement of the RM model is particularly suited for individuals whose personal/cultural experiences have engendered an exceptionally high physical and emotional tolerance for pain, and for those who have never known anyone in recovery. Proactive engagement is also important for people of color who:

- lack the knowledge, skills, and financial resources required to navigate complex health and human service systems;
- fear bringing shame to their families (losing "face") by breaking prohibitions on disclosing personal problems outside the family and/or kinship network — shame dramatically enhanced for women;
- have had negative experiences within or distrust formal service systems;
- bring special obstacles to accessing services (e.g., language barriers, undocumented status); and
- possess beliefs about illness and health that conflict with the explanatory metaphors of mainstream service systems.

The RM model of engagement is particularly well suited for people of color whose resistance to treatment flows from the inertia of hopelessness. Where AC models are most effective with individuals ready to take action related to their problems, RM models place great emphasis on the pre-action stages of change and the long-term maintenance stages of change (See Prochaska, DiClemente, & Norcross, 1992 and Prochaska, Norcross, & DiClemente, 1994 for a description of the stages of change)[7]. The model assumes that the scales of long-term recovery are tipped, not by the sobriety decision (alcoholics/addicts make many such decisions), but by the interaction of what precedes and follows such decisions.

Of all the obstacles that proactive engagement is designed to address, perhaps the most difficult in both AC and RM models is the issue of language. Key informants from many ethnic communities emphasized the need for more bilingual professionals and service volunteers. This language barrier will have to be overcome if RM models are to fulfill their potential within ethnic communities. The outreach and assertive continuing care functions, in particular, will require a high level of cultural and linguistic fluency. The RM emphasis on building service capacity within communities offers some hope for expanding such competence.

While this assertive model of engaging and supporting individuals through the stages of

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[7] Research on developmental stages of change is in its infancy, and the emerging models tend to portray recovery for individuals and families in very linear terms. We suspect, and thank Tom Murphy for reminding us, that these processes are much more dynamic than what is conveyed in a linear, four-to-five-step model. Recovery, particularly for historically disempowered people, may be much more comparable to the subtle patterns and surprise-revealing pathways of a Japanese garden than that of a ladder.

recovery is well suited to the obstacles and complex needs presented by many people of color, great care will have to be taken with this aspect of the RM model. The values of benevolence, generosity, and service co-exist with the value of noninterference in the affairs of others within communities of color. The implementation of RM models in communities of color will require considerable care to avoid violating this latter value. The key will be to use RM's assertive approach to engagement and post-treatment monitoring and support, but to do so only with the continuing consent of the community, family, and individual client.

Another dimension of the RM model (emerging from its view of multiple pathways of recovery) is its respect for the power and legitimacy of transformative change as a medium of recovery initiation (Miller & C'de Baca, 2001)[8]. Non-ordinary experiences (e.g., dreams, visions, climactic conversions) have long marked a pathway of addiction recovery for people of color, particularly among those who have led religious and cultural revitalization movements (e.g., Handsome Lake, Malcolm X). In contrast to the conversion style of induction, recovery may also be marked by a reaffirmation and deepening of existing religious/spiritual beliefs and practices, as Morjaria and Orford (2002) found in their study of South Asian American men (see also Manik et al., 1997). Where traditional AC models of treatment tend to discount the power and durability of religious experiences and the role of religious institutions as viable sobriety-based support structures, the RM model celebrates the legitimacy of these experiences and support institutions. It is clear that sustained sobriety can be a byproduct of religious and cultural affiliation and a heightened ethnic identity, whether this occurs within the Nation of Islam, the Indian Shaker Church, or a Buddhist or Hindu Temple. Such recoveries involve not just a redefinition of personal identity, but also a redefinition of oneself as an Indian, African American, Latino, or Asian person. For example, Spicer's studies of recovery in Native American communities found that recovery initiation was associated with heightened Indian identity and the incompatibility between drinking and emerging beliefs about how Indian people should conduct their lives (Spicer, 2001). This recognition of the power of culturally mediated transformative change provides a foundation of respect upon which RM-based organizations can collaborate with religious and cultural revitalization movements within communities of color.

Indigenous Healers/Institutions and the Recovery Management Team

> *Many individuals maintain sobriety only after they resume or begin regular involvement in traditional spiritual practices.*
>
> — Brave Heart & DeBruyn, 1998

> *The persistence and revival of indigenous Amerindian healing is due not to a lack of modern treatment services, but to a need for culture-congenial and holistic therapeutic approaches.*
>
> — Jilek, 1978

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[8] Miller and C'de Baca describe transformative change as dramatic alterations of personal identity and character that are "vivid, surprising, benevolent and enduring." (p.4).

The AC service approach is based on the recognition of AOD problems as a biopsychosocial disorder. As a result, AC treatment interventions are delivered by an interdisciplinary team of physicians, nurses, psychologists, social workers, and addiction counselors. In contrast, the RM model recognizes other dimensions of AOD problems (e.g., economic, political, cultural, spiritual, religious) and broadens the recovery management team to include indigenous community institutions and healers. People of color utilize cultural healing therapies as alternatives or adjuncts to mainstream medicine and psychiatry, with the majority not reporting visits to alternative practitioners to their mainstream service providers (Keegan, 1996). Studies of the course of alcohol problems among American Indians have found remission/recovery rates as high as 60%, with few such recoveries attributable to formal alcoholism treatment (See Spicer, 2001 for a review). American Indians have a long history of abstinence-based religious and cultural revitalization movements, indigenous healers as mediums of alcoholism recovery, and the use of Native medicines and ceremonies as adjunctive supports for recovery (White, 2000b; Coyhis & White, 2002). Growing awareness of this history has spurred calls for culture-congenial therapeutic approaches via an integration of Western treatment methods and traditional Native American healing practices (Jilek, 1974; Weibel-Orlando, 1987; and Westermeyer, 1996). There is similar evidence for indigenous recovery frameworks in the Hispanic/Latino (Thomas, 1967; Singer & Borrero, 1984; Núñez Molina, 2001), Asian (Das, 1987; Yamashiro, & Matsuoka, 1997) and African-American communities (Leong, Wagner, & Tata, 1995). These indigenous recovery frameworks place great emphasis on the healing power of *regalos* — cultural values and ceremonies. Where traditional treatment programs question the viability and durability of these cultural and religious pathways of recovery (in practice if not in theory), the RM model is open to the inclusion of such institutions and their representatives within the recovery management team. In the RM model, the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist may each play a role within the RM team.

A recent evaluation of gender-specific addiction treatment programs in Illinois found that a significant number of recovering and recovered[9] African-American women are using the Black Church as their primary sobriety-based support structure, but most do so only months after initiating recovery and addressing issues of shame related to their addiction (White, Woll, & Webber, 2003)[10]. Similar documentation exists on the use of religious frameworks of addiction recovery in other communities of color (Núñez Molina, 2001; Coyhis & White, forthcoming). This raises an interesting point about the differences between the ways in which individuals initiate recovery and the ways in which they sustain that recovery over time. More specifically, it suggests that some clients of color may use one institution to initiate recovery (e.g., professionally directed treatment, Alcoholics Anonymous, or Narcotics Anonymous), but use culturally indigenous institutions to sustain recovery (e.g., the Black Church). Failure to sustain recovery could thus be viewed, not as a need for more recovery initiation services (the AC treatment model), but as a need to find a cultural pathway of long-term recovery maintenance (the RM model).

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[9] See White, 2002 for a discussion of the distinction between *recovered* and *recovering*.

[10] The source of that shame transcends self-perceived sins of omission and commission and reaches to the very core of their identities as women and as African-American women.

The RM model assembles professional and indigenous service teams to meet the unique recovery support needs of each client and family. The rationales for the use of such non-traditional teams are to expand the recovery support services available to individual clients and to decrease the number of people needing professional services by expanding natural recovery supports within the larger community. The inclusion of indigenous healers and recovery support institutions rests on a simple assumption: the natural community is an oasis of human and spiritual resources that can be tapped to resolve personal and family problems (McKnight, 1995). In the RM model, the centerpiece of recovery is not the treatment institution, but the client and his or her relationship to this larger community.

The inclusion of non-traditional roles within the RM service team raises the question of credibility and credentialing of service providers within communities of color. Credibility bestowed from the dominant culture has value within communities of color only when the individual with such credentials is further vetted inside the community. This is typified by the concepts of *respeto*, *personalismo*, *dignidad*, and *confianza* within Hispanic/Latino communities — concepts that dictate respect based on personhood rather than financial or occupational status (Soriana, 1995). Credibility in communities of color is more likely to be bestowed upon those with nonjudgmental attitudes, knowledge of the culture, and demonstrated resourcefulness and effectiveness (Sue & Sue, 1999).

Credibility as a healer inside communities of color requires two things: *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge requires wisdom gained about a problem from close up — first-hand versus second-hand knowledge. Experiential knowledge comes from having experienced, lived with, or done battle with addiction and from having participated in one's own or other's recovery. This does not explicitly require that all volunteer or paid support staff be recovered or recovering, but it does require that they have learned about addiction and recovery from close proximity. Experiential expertise requires the ability to use this knowledge to effect change in self or others. This latter credential — granted through the community "wire" or "grapevine" (community story-telling) — bestows credibility that no university can grant. It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes, not from their preparation, but from their character, relationships, and performance within the community. RM models capitalize on such experiential expertise by recruiting indigenous healers as legitimate members of recovery management teams, e.g., outreach workers, recovery coaches, and culturally grounded therapists/nurses/physicians.

RM also turns those seeking help into sources of support for others via their involvement in mutual support groups, peer-based service models, and recovery advocacy organizations. Within communities of color, there is a long history of the concept of "wounded healer" (the idea that surviving a life-threatening illness or experience bestows knowledge and an obligation to help others facing this illness or experience), and a tradition of helpers credentialed by "calling" (White, 2000b). By transforming the process of recovery from an interaction between a professional and a patient to reciprocal support among

members of a community of recovering and recovered people, RM taps this wounded healer tradition and utilizes what has been christened the "helper-therapy principle" (the therapeutic effects of helping others) (Reissman, 1990, 1965). Converting service recipients into service dispensers exponentially expands indigenous recovery resources within communities of color. Reaching out to the suffering alcoholic/addict has been espoused by leaders of American recovery communities, from the Washingtonian mantra, "You've been saved, now save another" (White, 1998) to what Malcolm X referred to as "fishing for the dead" (Myers, 1993, p. 82). With its emphasis on transforming people who have been part of the problem into part of the solution, RM creates a cadre of people whose living example and recovery advocacy activities can help neutralize the particularly intense stigma that has long been attached to addiction in communities of color.

People of Color and the Criminal Justice and Child Welfare Systems

People of color, particularly African Americans, are over-represented within America's criminal justice and child welfare systems. Constituting only 12.1% of the U.S. population (U.S. Census Bureau, 2000) and 15% of illicit drug consumers (SAMHSA, 1998), African Americans constitute 56.7% of those currently in state prison on drug offenses (Harrison & Beck, 2003). Studies have also shown that race plays an important role in involvement in child protection services. Although rates of drug use during pregnancy are nearly identical for African American and White women, African American women are ten times more likely to be reported to child protection authorities for prenatal drug exposure (Neuspiel, 1996; Chasnoff, Landress, & Barret, 1990). Any intervention into alcohol and other drug problems in communities of color must recognize the dominant role of the criminal justice and child welfare systems as treatment referral sources.

The AC model of intervention is strongly linked to these systems, and that is in itself a problem. People of color with high problem severity and complexity (e.g., multiple problems) continue to be routinely placed in brief interventions that have little chance of success, and then are punished (via incarceration or loss of custody of children) when those failed outcomes occur, on the grounds that "they had their chance." The financially motivated collaboration of the treatment system in this process is altering the perception of treatment institutions from institutions of service and care to institutions of coercion and control. Masked behind euphemisms such as "treatment works" is the story of how addiction treatment programs have become an extension of the criminal justice and child protection systems within communities of color. We would argue that it is not enough to deflect people of color into treatment as an alternative to incarceration or family disintegration. The treatment received must be designed in such a way as to offer a realistic chance of success. Punishing people with high problem severity for failing to achieve sustained abstinence following treatment within an AC model is part of a long history of "blaming the victim" within communities of color.

It remains to be seen whether RM models will offer a more viable option for people of color involved in the criminal justice and child welfare systems, but RM models do have several characteristics that make success more likely. First, the longer duration of service contact in the RM model is more realistic and constitutes more of a real "chance" than treatment based on the AC model. The RM emphasis on engagement and sus-

tained monitoring and support is very congruent with such criminal justice initiatives as intensive probation, drug courts, and sentence circles. It is also congruent with the gender-specific addiction treatment models emerging within the child welfare system (White, Woll, & Webber, 2003). What RM may contribute is the birth of collaborative models that combine the surveillance functions of the criminal justice and child protection systems with sustained mechanism of recovery support and early re-intervention. Such models could span a continuum of intervention points from diversion programs to community re-entry from prison. More effective systems of intervention and support could decrease the number of people entering, and widen the doorways of exit from, the criminal justice and child protection systems. RM models could be built on the peer-based engagement and support models that have been used to reach addicted people of color within the CJ system, e.g., the Nation of Islam, Winner's Circle.

Expanded Menu of Services and Catalytic Metaphors

> *Metaphors are culturally-grounded figures of speech that in their subtlety, complexity and power strike deep emotional cords that ignite processes of personal transformation.*
>
> — White & Chaney, 1993

> *…transformations of the self and its relationship to core symbols in a particular cultural system of meaning appear to lie at the heart of how people are restored to wholeness following their problematic involvements with alcohol.*
>
> — Spicer, 2001

The AC model of addiction treatment is based on the development of "programs" (a prescribed combination and sequence of therapeutic activities) that clients experience with minimal variation. Program activities and protocols focus on detoxification, problem stabilization, and recovery initiation. RM models, by placing equal or greater emphasis on pre-treatment engagement and post-treatment recovery maintenance, expand the service menu considerably and, in the process, redefine the very identity of treatment institutions.

The RM service menu is based on three premises:

1. People with AOD problems represent multiple clinical subpopulations with diverse needs: the effectiveness of treatment and support services varies considerably across clinical subpopulations and individuals within these subgroups.

2. There are developmental stages of long-term recovery: the same individual may need different treatment and support services at different stages of his or her addiction and recovery careers.

3. There are qualitative differences between AOD problems and the processes used in their resolution within communities of color.

RM replaces the treatment "program" with a large menu of service and support activities that are uniquely combined and supplemented to meet the stage-dependent needs of

people in recovery. In this model, the service menu is constructed using frameworks of healing drawn first from the client's own cultural background, e.g., the use of specialized therapies such as the Japanese psychotherapeutic approach known as *Naikan,* in which the patient is sequestered for self-reflection on his or her character and relationships under the guidance of periodic visits from the therapist (*sinsei*) (Das, 1987). RM seeks to initiate and sustain recovery within the framework of cultural values using methods that markedly differ from client to client (See Flores, 1985-86). The shift toward a multicultural menu of values and service activities requires a high degree of individualization and a more sophisticated, comprehensive knowledge of the personal, intracultural, and trans-cultural processes of long-term recovery.

RM proponents are also interested in the kinds of words, ideas, metaphors, and rituals that initiate and strengthen recovery, mark the shift from one stage of recovery to the next, and sustain recovery over a prolonged period of time. This interest is congruent with the belief in the power of words (speeches, sermons, and stories) and healing ceremonies within communities of color. The following assumptions describe the potential role of words, ideas, metaphors, and rituals in the addiction recovery process.

1. Words, ideas, metaphors, and rituals can exert an enslaving or liberating effect on one's relationships with alcohol and other drugs (White & Chaney, 1993; White, 1996).

2. Words, ideas, metaphors, and rituals that serve as a catalyst for change in one person or cultural group may have no such power with other persons or cultural groups. There are specific ethnic/cultural worldviews, and the elements of these worldviews constitute the raw materials from which pathways of resilience to and recovery from AOD problems must be constructed (Taylor, 1992).

3. Catalytic metaphors[11] evolve and recycle within cultures over time. Their use as agents of transformation rests on their contemporary power; they must resonate within the present cultural and personal experience of the individual seeking recovery.

4. The growing phenomenon of biculturalism suggests that individuals may be able to combine or sequence metaphors from two or more cultures to initiate recovery or shift from one stage of recovery to the next.

5. Addiction treatment programs serving heterogeneous populations must provide a diverse menu of organizing words, ideas, metaphors, and rituals to widen the doorways of entry into recovery and support culturally mediated stages of long-term recovery (White, 1996).

The following observations reflect the ways in which words, ideas, metaphors, and rituals have been used by historically disempowered peoples to initiate and sustain recovery from addiction.

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[11] Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite beliefs, behavior, identity, and relationships.

1. During the peak period of contact and colonization, people of color are prohibited from drinking or provided only controlled opportunities for drinking (e.g., Slave Code prohibitions on drinking, Federal prohibition of the sale of alcohol to American Indians) and are targeted via drug prohibition laws (e.g., anti-opium ordinances aimed at Chinese immigrants, anti-cocaine laws aimed at African Americans, anti-peyote laws aimed at American Indians, and anti-marijuana laws aimed at Mexican immigrants) (See Musto, 1973; Helmer, 1975; Morgan, 1983).

2. Patterns of psychoactive drug use and their effects upon people of color are exaggerated or fabricated as part of a racial mythology that justifies colonization and cultural domination (e.g., Native American "firewater myths") (Coyhis & White, forthcoming; Morgan, 1983)

3. People of color, in their early struggles for liberation, use the consumption of alcohol and other drugs to cope with feelings of hopeless and to deal with historical trauma.

4. Political and religious leaders within communities of color subsequently link AOD use to historical oppression, portray alcohol and other drugs as weapons of continued colonization and domination of their communities (Tabor, 1970; Herd, 1985), and portray sobriety as an act of resistance and liberation (Douglas, 1855; Cheagle, 1969).

5. Recovery mutual aid movements arising out of historically disempowered people emphasize metaphors of resistance, emancipation, and power, e.g., "I have a problem that once had me" (Kirkpatrick, 1986), "I will take control of my life" (Williams & Laird, 1992).

6. Heightened consciousness of racial history and identity can be a pathway of entry into recovery, or it can be part of a process of discovery in the later stages of recovery (Green, 1995).

By recognizing multiple pathways and styles of long-term recovery, the RM model embraces and works within these alternative frameworks of recovery. It views tenets of belief about AOD problems and their resolution within their historical context and in terms of their utility for initiating or anchoring recovery. This requires considerable knowledge of indigenous cultures and fluency with prevailing cultural or religious metaphors that can incite or strengthen the process of addiction recovery. The viability of a particular metaphor for understanding AOD problems and ways in which they can be resolved varies widely between cultures and varies widely across individuals (e.g., by degree of acculturation). The question is not: Which explanatory metaphor is true? The question is: Which organizing metaphor, by explaining things that are otherwise inexplicable, serves as a catalyst for personal, family, and community healing? There are many people of color who have found recovery through mainstream treatment and recovery support organizations (e.g., A.A./N.A.), but there are also many people of color who have recovered from addictions who neither portray themselves as having suffered from the disease of alcoholism/addiction nor portray themselves today as alcoholics or addicts in recovery. They have found alternative rationales for sobriety and different metaphors to explain who they once were and who they are today (see Spicer, 2001).

There is no dominant organizing metaphor for recovery within the RM model. With its operational motto, “recovery by any means necessary, ” the RM model is broad enough to embrace clients who talk about their addictions in terms of:

- disease and recovery,
- habit and choice,
- badness (crime) and reformation,
- sin (idolatry, demon-possessed) and redemption (God-touched),
- cursed (for breaking cultural taboos) and healed,
- excess and harmony (balance),
- shame and honor (face),
- genocide and personal/cultural survival, or
- messed up and worn out (“sick and tired of being sick and tired”).

The goal of RM is not to impose an organizing metaphor for recovery, but to work within whatever metaphors individuals and families find most personally and culturally meaningful.

The same broad perspective applies to transformative rituals. Where the dominant AC models of intervention into AOD problems rely on rituals of getting into oneself (e.g., psychotherapy), RM models are open to other cultural frameworks of recovery that involve a process of getting out of oneself and relying on resources and relationships beyond the self. Where the former view recovery as a process of self-exploration, the latter recognize the potential of recovery initiation via processes of self-transcendence — a value much more congruent with the spiritual-focused and community-focused ethos of communities of color.

Sustained Monitoring and Support

> *Chronic diseases require chronic cures*.
>
> — Kain, 1828

> *If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients.*
>
> — McLellan, 2002

Communities of color have become distrustful of promised quick fixes because so many of those promises have been betrayed. Professionals come and go; programs come and go; agencies come and go. Arguments over whether addiction treatment should consist

of five sessions or 25 sessions, five days or 30 days, cognitive or family therapy are all arguments inside the acute care model of admission, treatment, and discharge. The inherent brevity of acute interventions into complex, chronic problems is often experienced as superficial pacification, professional disinterest, and abandonment. People of color, who tend to enter addiction treatment at later stages of problem severity and with a greater number of co-occurring problems (Bell, 2002), are ill-served by service models whose low intensity and short duration offer little opportunity for success. At a practical level, the acute model provides few options: regular readmission for detoxification and respite, demoralization and a cessation of treatment-seeking, or a search for recovery maintenance outside the realm of professionally directed treatment.

Communities of color need stable recovery support institutions that can move beyond brief experiments in recovery initiation toward prolonged recovery maintenance. It is this very need that has contributed to the dramatic growth of A.A., N.A., and recovery-focused ministries in communities of color. For those who need sustained professional support, RM provides a culturally viable model of addiction treatment that replaces crisis intervention with a much longer, but lower-intensity, continuum of pre-treatment, in-treatment, and post-treatment recovery support services.

A Recovery Management Partnership

> *Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work.*
>
> — Albert Schweitzer, From *Reverence for Life*, 1993

The service relationship within acute care approaches to addiction treatment is based on an "expert" model of problem intervention. In this model, the service professional is assumed to have considerable knowledge, resources, and power, while the service recipient is assumed to suffer from one or more problems that he or she does not understand and cannot resolve. The role of the expert is to diagnose the problem, treat the problem, and briefly educate the client regarding his or her continued self-care responsibilities related to the problem. Failure to resolve the problem is usually attributed to the lack of "patient compliance" with the expert's recommendations. The service relationship within the AC model of intervention, whether in the form of an emergency room visit for a broken bone or brief addiction treatment, is hierarchical, transient, and commercialized. It reflects what Eisler (1987) has christened the "dominator model" of interpersonal relationships.

The historical victimization and abandonment of people of color have left a legacy of mistrust and caution when approaching relationships characterized by high discrepancies of power, brevity of contact, and paid helpers. Given this legacy, developing trust in service relationships with people of color requires testing and time, and time is the one commodity the AC model, by definition, cannot provide.

RM models provide an alterative by providing continuity of contact in a sustained service relationship, shifting the nature of that relationship from one based on hierarchy to

one based on a recovery management partnership, and incorporating support relationships that are natural (reciprocal) and non-commercialized. In the RM partnership, it is assumed that strengths and weaknesses exist on both sides of the relationship, and that there is no universally effective professional intervention for severe AOD problems. Where the expert model is based on a teacher-student relationship, the partnership model assumes that learning will be mutual within the service relationship. A number of recovery initiation and maintenance strategies are co-developed and tried within the partnership relationship until the most effective strategy is found. At any point, if previously successful strategies are no longer working, experiments are reinitiated to develop new, more stage-appropriate strategies. This approach rests on the assumption that strategies that work to achieve stability in early recovery may not work in the later stages of recovery. Continuity of contact over time is crucial to the RM model, making the issue of high staff turnover a potential Achilles heel of the RM model.

A second Achilles heel of the RM partnership model is the danger that it could evolve into patterns of prolonged dependency that already exist in the AC model. Cultivating professional dependence and creating "system-sophisticated" clients who know how to "do treatment" and manipulate resources to sustain active addiction is counterproductive and constitutes another form of colonization (using such clients as a cash crop to run the institutional economies of service industries and sustain the careers of service professionals). The goal of RM is a habilitation process that replaces dependency on formal service systems with interdependency within a larger social and cultural community. The essential principle is that professionally directed services are the last, not the first, line of response to AOD problems, and that professionally delivered RM services should provide only what cannot be provided within the larger network of family and indigenous community supports.

Another aspect of the RM service relationship is that the roles of service professionals within this model are multidimensional rather than specialized. In the RM model, the functions of outreach, engagement, assessment, case management, therapy, advocacy, and prevention may all exist over time within the same service role and relationship. This requires a higher level of cross-training than is necessary in the AC model. This broadening of the service role and extension of the duration of the service relationship also forces a rethinking of some of the ethical and relationship boundary guidelines that have governed the delivery of addiction treatment. Such guidelines in the AC model are based on the standards governing professional-client relationships in medicine, psychiatry, psychology, and social work. As they have developed in the modern evolution of addiction counseling, such guidelines have generally prohibited or discouraged disclosure of one's recovery status, emotional self-disclosure, contact with clients in their natural environment, gift giving and receiving with clients, and contact with clients after the period of primary treatment (See White and Popovits, 2002). Such guidelines require rethinking in the transition from AC models to RM models, with the ultimate arbitrator of the level of authority and formality within the RM relationship defined by the cultural context and the comfort level of the individual and family receiving services (See Matsuyoshi, 2001). While RM models retain a clear sense of behaviors in the service relationship that are "never okay," the zone of behaviors that are "sometimes okay and sometimes not okay" is significantly expanded. This requires a higher degree of supervision regarding boundary

appropriateness in different cultural contexts and over the stages of a long-term recovery support relationship.

RM models may also force agencies to fundamentally redefine their institutional identities from one of a service-oriented business to that of a member of multiple communities of recovery — membership that brings its own demands for accountability related to competence, consistency, and sustained access to services. Providing continuity of support and defining oneself in terms of personal and institutional membership in local communities of recovery are much more congruent with the natural patterns of helping within communities of color than are the "expert" or "business" models of delivering acute addiction treatment services.

Culturally Nuanced Research and Evaluation

> *Indian communities recognize all too well that the research process can be intrusive and the results invidious, divisive, and scandalous.*
>
> — Beauvais & Trimble, 1992

> *…attempts to evaluate service programs must have a dual acceptability; that is, they must be acceptable to the rigors of scientific exploration as well as the African-American ethos and worldview.*
>
> — Butler, 1992

Both the acute model and the recovery management model aspire to be evidence based, but the former is based primarily on short-term scientific studies of the efficacy (what works under ideal conditions) and effectiveness (what works under real conditions) of a single episode of brief intervention (McLellan, 2002). The first change within the RM approach to research and evaluation is to extend the time frame under which judgments of efficacy and effectiveness are rendered (White, Boyle, & Loveland, 2002). Evidence that short-term effects of intervention (e.g., brief periods of sobriety) predict later therapeutic outcomes (e.g. sustained recovery) (see Weisner, et al., 2003) tells only part of the story. Time-related deterioration of effects, delayed positive effects, and delayed iatrogenic (harmful) effects of service interventions can be identified only via longitudinal studies. It is also possible that multiple interventions into chronic disorders may have cumulative or synergistic effects (from particular service combinations and sequences) not identifiable through the evaluation of a single service episode.

Because RM is based on a long-term health management partnership with individuals, families, and communities, it calls for a heightened level of sensitivity to constituency attitudes toward scientific research. In communities of color, researchers encounter two significant issues: 1) the distrust of culturally dominant research and 2) different ways of knowing.

People of color and communities of color have been wounded in a number of ways by culturally dominant research studies. They have been subjected to grossly unethical research practices (e.g., withholding medical treatment from 399 African American sharecroppers in the Tuskegee Syphilis Study). They have been stereotyped via reports char-

acterizing the presence or absence of AOD problems in terms of racially dictated biological vulnerability — from the "firewater" myths of racial vulnerability of Native Americans (Westermeyer, 1974; Leland, 1976) to the myth of racial invulnerability of Asians (O'Hare & Tran, 1998[12]). They have been wounded by the assumption of universal applicability — the misapplication of research findings from studies in which no people of color were included. Communities of color have been injured by bad ("junk") science, such as the now-discredited sensationalist literature on crack cocaine and "crack babies" that turned the criminal justice and child welfare systems into occupying institutions within poor communities of color (See Frank, Augustyn, Knight, et al., 2001). They have been shamed by research designs and interpretations that dramatized the problems within communities of color while ignoring their strengths and resiliencies (Coyhis & White, 2002). Observers from within ethnic communities (Casas, 1992) have also been very critical of how communities of color have been used as a valuable resource to enrich individual careers and institutions in exploitive processes that returned nothing to communities of color.

Given this history, science, scientists, and scientific institutions bear a continued burden of proof regarding their safety, relevance, and benefit to communities of color. Achieving such credibility will require, at a minimum, the inclusion of community of color leaders and members in the design, conduct, interpretation, and dissemination of research and evaluation studies (Hermes, 1998). It will require plotting the long-term pathways of addiction recovery in communities of color. It will require coming to grips with different ways in which communities of color determine what is true and what works in the addiction recovery arena. What is most significant, it will shift ultimate ownership of research from academic and funding institutions to the community being studied.

Scientific knowledge assumes that truth can be discovered through professional observation and the rational analysis of findings from controlled experiments. It is predicated upon distance and objectivity (knowledge from outside) and is judged to exist only when it has been documented in writing and subjected to professional peer review. There are two other ways of knowing within communities of color, and these exist more in oral tradition than in written words. The first, *historical/cultural truth*, asks, "What has been our past experience on this issue?" Racial memory is an important source of knowledge in communities of color — a source that seems alien to the highly individualist values and "now" orientation of the dominant American culture. Within communities of color, community elders rather than scientists are the ultimate authorities.

The second way of knowing, *experiential knowledge*, is based on the contemporary experiences of individuals, kinship networks, and fellow community members. This way of knowing tends to be concrete, pragmatic, holistic, and commonsensical (Borkman, 1976). One of the authors (Sanders) once attended a seminar in which a renowned researcher on problem gambling declared based on his research that Blacks and Latinos did not have significant problems with gambling. This conclusion did not match his historical/cultural truth as an African American, or the experiential knowledge drawn from his extended

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[12] The so-called "Asian flushing response" to alcohol among some Asians does not constitute a universal protective factor against alcoholism and alcohol-related problems in Asians. There is growing evidence that cultural, not biological, factors shape the prevalence and patterns of alcohol problems across highly diverse Asian populations.

family and neighborhood (within which underground and state-sponsored lotteries were a prominent feature). When Sanders asked about the nature of the expert's research, he learned that it was based on a membership survey of Gamblers Anonymous conducted at predominately suburban meeting sites. When Sanders did his own research using focus groups with African Americans and Latinos in urban areas, he discovered clear patterns of problem gambling within these communities.

Word-of-mouth knowledge, captured in the collective stories of a community or a people, constitutes a key source of truth in communities of color. Communities of color do not reject science as much as require that its findings be filtered through the sieve of personal and community experience. In contrast to scientific knowledge, this way of knowing assumes that truth can be discovered only through proximity and experience (knowledge from inside). The authors have witnessed mainstream scientists speaking at "town meetings" in African American communities. When these scientists decry the lack of evidence on the effectiveness of indigenous frameworks of recovery (e.g., faith-based and other cultural mediums of recovery), they are somewhat flummoxed to see members of the audience stand to declare that they or their family members are the "living proof" of such effectiveness. David Whiters of Recovery Consultants of Atlanta, Inc. notes, "I have watched many among the African American community begin their recovery in traditional recovery programs, only to find sustained recovery in the Black Church" (Personal Communication, December, 2003). Such long-term observations over spans of time that far exceed the follow-up periods in most research studies constitute their own form of collective truth. Living stories (experiential authority) have more power and cultural credibility than statistics (professional/scientific authority) within many communities of color. Living stories are best viewed as a unique and legitimate type of evidence rather than "myths" or "folklore" (Hermes, 1998). This does not mean that the usual methods of scientific analysis are abandoned, but that voices of the community are allowed to reach directly those who hear and read about the community through the medium of scientific research.

RM models will be required to pass the litmus test of multiple ways of knowing if they are to achieve credibility within and outside communities of color. The development of evidence-based services is a fundamental tenet of RM, but in communities of color the nature of that evidence will have to be broadened via qualitative studies that capture the historical and contemporary experience within communities of color. RM models in communities of color will also have to shift from an exclusively academic to a more activist orientation (studying questions of importance to the community, focusing on knowledge that can facilitate positive personal, family, and community change), enter into a research partnership with the community (e.g., control over design, conduct, interpretation, and dissemination), and respect the community's ownership of its own knowledge. We also anticipate that research in communities of color will shift from summative evaluation (measuring the effects of an intervention only after it is concluded) to formative evaluation (measuring and communicating the effects of an intervention at multiple points during and after its delivery, so that it can be refined and improved).

A Recovery Management Agenda

This paper has contrasted acute care (AC) and recovery management (RM) models of in-

tervention into serious AOD problems. It is suggested that RM models offer advantages to communities of color in eight specific areas:

- an ecological perspective on the etiology of AOD problems;
- a broadened target of intervention (including families, kinship networks, and communities);
- a proactive, hope-based model of service engagement;
- the inclusion of indigenous healers and institutions;
- an expanded menu of culturally grounded recovery support services and catalytic metaphors;
- an extended time-frame of recovery support;
- a partnership-based service relationship; and
- a culturally nuanced approach to research and evaluation.

The reader may ask, "Where are these models of recovery management?" The answer is that there may not be any treatment organizations that have fully developed all of the elements of RM described in this paper. RM exists as an emerging model whose service elements are currently being piloted and evaluated. The RM model exists within progressive treatment programs that are experimenting with new approaches to pre-treatment engagement and post-treatment continuing care. The model exists within the growing number of experiments with peer-based recovery support services. It exists within the growing network of peer-managed recovery homes in the United States. And, perhaps most significantly, its potential is demonstrated in the growing number of recovery-focused religious and cultural revitalization movements within American communities of color. That potential exists in a vibrant Wellbriety Movement in Indian Country. It exists within Glide Memorial Church, where a majority of parishioners are in recovery. It exists in the Nation of Islam's outreach to addicted African Americans in prison. It exists in the hundreds of thousands of people of color who each day use Twelve-Step programs and other recovery mutual aid societies to quietly achieve another day of sobriety and wellness. The challenge is to build connecting tissue between treatment and recovery by building bridges between these indigenous recovery movements and addiction treatment institutions.

RM holds great promise in communities of color, but fulfillment of that promise hinges on:

1. involving clients, families, and service professionals from within communities of color in a process of shifting existing interventions from AC models to locally designed, operated, and evaluated RM models;
2. developing recovery management teams and advocacy coalitions via the integration of AOD service providers and indigenous institutions;

3. confronting forces in the community that promote excessive AOD use;

4. enhancing "community recovery capital" (Granfield & Cloud, 1999);

5. increasing the presence and visibility of indigenous sobriety-based support structures;

6. providing recovery education within communities of color; and

7. using recovery role models that illustrate the viability and variety of recovery pathways within communities of color.

Achieving that vision will require that the field of addiction treatment fundamentally redefine the sources of and solutions to AOD problems and, in the process, redefine itself.

The authors conclude this paper as we started it, not as authorities, but as students. Any errors of perception or omission in these pages stand as testimony that this learning is, and will forever remain, incomplete. We submit this paper as a work-in-progress to the communities that helped spawn it and welcome continued guidance as we continue the task of making this alternative vision a reality in communities across America.

References and Recommended Reading

Abbott, P.J. (1998).Traditional and western healing practices for alcoholism in American Indians and Alaskan Natives. *Substance Use and Misuse*, 33(13), 2605-2646.

Beauvais, F. and Trimble, J.E. (1992). The Role of the Researcher in Evaluating American Indian Alcohol and Other Drug Abuse Prevention Programs. In: Orlandi, M.A., eds. *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working with Ethnic/Racial Communities*, pp. 23-54, Rockville, MD: Office of Substance Abuse Prevention.

Bell, P. (1992). *Cultural Pain and African Americans: Unspoken Issues in Early Recovery*. Center City, MN: Hazelden Educational Materials.

Bell. P. (2002). *Chemical Dependency and the African American*. Center City, MN: Hazelden.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456.

Brave Heart, M.Y. & DeBruyn, L.M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal*, 8(2), 60-82.

Brave Heart, M.Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7-13.

Brown, S. (1994). What is the family recovery process? *The Addiction Letter*, 10(10), 1, 4.

Brown, S. and Lewis, V. (2002). *The Alcoholic Family in Recovery: A Developmental Model*. New York: Guilford Press.

Butler, J. (1992). Of kindred minds: The ties that bind. In: Orlandi, M.A., Ed. *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Preven-*

tion Practitioners Working with Ethnic/Racial Communities, pp. 23-54, Rockville, MD: Office of Substance Abuse Prevention.

Casas, J.M. (1992) A Culturally Sensitive Model for Evaluating Alcohol and Other Drug Abuse Prevention Programs: A Hispanic Perspective. In: Orlandi, M.A., Ed. *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working with Ethnic/Racial Communities*, pp. 75-116, Rockville, MD: Office of Substance Abuse Prevention.

Chasnoff, I.J., Landress, H.J., and Barrett, M.E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine*, 322:1202-1206.

Cheagle, R. (1969). *The colored temperance movement* (Unpublished thesis). Washington, DC: Howard University, 1969.

Chelsea, P and Chelsea, A. (1985), *Honour of All: The People of Alkali Lake*. (Video) British Columbia, Canada: The Alkali Lake Tribal Council.

Christmon, K. (1995). Historical overview of alcohol in the African American community. *Journal of Black Studies*, 25(3), 318-330.

Compton, W.M., Glantz, M. & Delaney, P. (2003). Addiction as a chronic illness—putting the concept into action. *Evaluation and Program Planning* 26, 353-354.

Coyhis, D. (1999). T*he Wellbriety Journey: Nine Talks by Don Coyhis*. Colorado Springs, CO: White Bison, Inc.

Coyhis, D. and White, W. (2003) Alcohol problems in Native America: Changing paradigms
and clinical practices. *Alcoholism Treatment Quarterly*, 3/4, 157-165.

Coyhis, D. and White, W. (forthcoming). *Alcohol Problems in Native America: The Untold Story of Resistance, Resilience and Recovery*. Colorado Springs, CO: White Bison, Inc.

Das, A. K. (1987). "Indigenous models of therapy in traditional Asian societies." *Journal of Multicultural Counseling & Development*. 15(1), 25-37.

Dennis, M. L., Scott, C. K., & Funk R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning*, 26, 339–352

Douglass, F. (1855). *My Bondage and My Freedom*. New York, NY: Miller, Orton, & Mulligan.

Edwards, G., Davis, P., & Savva, S. (2003). Scanning the addiction horizons, 2003: Report on a consultation. *Addiction*, 98(11), 1471-1481.

Eisler, R. (1987). The Chalice and the Blade: Our History, Our Future. Cambridge, MA: Harper and Row.

Flores, P.J. (1985). Alcoholism treatment and the relationship of Native American cultural values to recovery. *International Journal of Addiction*, 20(11-12), 1707-26.

Frank, D.A., Augustyn, M., Knight, W.G., et al, (2001). Growth development and behavior in early childhood following prenatal cocaine exposure: A systematic review. *Journal of the American Medical Association*, 285, 1613-1625.

Godley, M., Godley, S., Dennis, M., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32.

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction without Treatment*. New York: New York University Press.

Green, W. (1995). *Dysfunctional by Design: The Rebirth of Cultural Survivors*. Evanston,

IL: Chicago Spectrum Press.
Harrison, P.M. and Beck, A.J. (2002). *Prisoners in 2002*. US Dept. of Justice, Bureau of Justice Statistics. Washington D.C.: US Dept. of Justice, July 2003), Table 15, p., 10.
Helmer, J. (1975). *Drugs and Minority Oppression*. New York: Seabury Press.
Herd, D. (1985). We cannot stagger to freedom: A history of Blacks and alcohol in American politics. In L. Brill and C. Winick, *The Yearbook of Substance Use and Abuse: Volume III*. New York, NY: Human Sciences Press, Inc.
Hermes, M. (1998). Research methods as a situated response: Towards a First Nations'methodology. *Qualitative Studies in Education*, 11(1), 155-168.
Hoffman, F. (1994). Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations. *International Journal of the Addictions*, 29(4), 445-460.
Hser, Y-I, Anglin, M.D., Grella, C., Longshore, D., and Pendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment*, 14(6), 543-558.
Jilek, W.G. (1974) Indian healing power: Indigenous therapeutic practices in the Pacific Northwest. *Psychiatric Annals* 4(11), 13-21.
Jilek, W.G. (1978) Native renaissance: The survival of indigenous therapeutic ceremonials among North American Indians. *Transcultural Psychiatric Research* 15, 117-147
Kane, J.H. (1828). On intemperance considered as a disease and susceptible of cure. *American Journal of Medical Sciences*, 2(7), 291-295.
Kaplan, L. (1997). A disease management model for addiction treatment. *Behavioral Health Management*, 17(4), 14-15.
Keegan, L. (1996). Use of alternative therapies among Mexican American in the Texas Rio Grande Valley. *Journal of Holistic Nursing*, 14(4), 277-94.
Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life* NY: Ballantine Books.
Leland, J. (1976). *Firewater Myths: North American Indian Drinking and Alcohol Addiction*. New Brunswick, New Jersey: Rutgers Center of Alcohol Studies Monograph No. 11.
Leong, F.T.L., Wagner, N.S., & Tata, S.P. (1995). Racial and ethnic variations in help-seeking attitudes. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 415-438). Thousand Oaks, CA: Sage.
Lurie, N. (1974). The world's oldest on-going protest demonstration: North American Indian drinking patterns. In: Hundley, N., Ed., *The American Indian*. Santa Barbara, California: CLIO Books, pp.55-76.
Manik, G.S., Cameron, D., Bird, R.H., and Sinorwala, A. (1997). *Resolution of Problem Drinking without Formal Treatment: Comparing Ethnic Minority and Indigenous Caucasian Populations*. Department of Psychiatry: University of Leicester.
Manson, S.M. (1996). The wounded spirit: a cultural formulation of post-traumatic stress disorder. *Culture, Medicine & Psychiatry*, 20(4), 489-98.
Matsuyoshi, J. (2001). Substance abuse interventions for Japanese and Japanese American clients. In: S.L.A. Straussner, Ed., *Ethnocultural Factors in Substance Abuse Treatment*, New York, NY: The Guilford Press, (pp. 393-417).
McKnight, J. (1995). *The Careless Society: Community and its Counterfeits*. New York: Basic Books.
McLellan, A.T., Lewis, D.C., O'Brien, C.P, and Kleber, H.D. (2000). Drug dependence,

a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association* 284(13), 1689-1695.
McLellan, T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, 97, 249-252.
Merrill, S. & Borrero, M.G. (1984). Indigenous treatment for alcoholism: the case of Puerto Rican Spiritism, *Medical Anthropology*, 8(4), 246-273.
Miller, W. R., & C'de Baca, J. (2001). *Quantum change*. New York: Guilford.
Moore, B.A., & Budney, A.J. (2003). Relapse in outpatient treatment for marijuana dependence. *Journal of Substance Abuse Treatment* 25, 85-89.
Morgan, P. (1983) Alcohol, disinhibition, and domination: A conceptual analysis. In *Alcohol and Disinhibition: Nature and Meaning of the Link*, Ed. by Room and Collins, pp. 405-436, Washington D.C.: U.S. Government Printing Office.
Morjaria, A. & Orford, J. (2002). Role of religion and spirituality in recovery from drink problems: A qualitative study of Alcoholics Anonymous members and South Asian men. *Addiction Research and Theory*, 10(3), 225-256.
Musto, D. (1973). *The American Disease: Origins of Narcotic Control*. New Haven: Yale University Press.
Myers, W. D. (1993). *Malcolm X: By Any Means Necessary*. New York: Scholastic.
Neuspiel, D.R. (1996). Racism and perinatal addiction. *Ethnicity and Disease* 6:47-55.
Núñez Molina, M, (2001) Espiritismo: Community healing among Puerto Ricans: Espiritismo as a therapy for the soul. In M. Fernández Olmos (Ed.), Healing Cultures, New York: St. Martin Press.
Office of Applied Studies (OAS). (2000). *National Household Survey on Drug Abuse: Main Findings* 1998. Rockville, MD, Substance Abuse and Mental Health Services Administration.
Office of Applied Studies (OAS). (2001). *Treatment Episode Data Set (TEDS) 1994-1999: National Admissions to Substance Abuse Treatment Services.* DASIS Series S14, DHHS Publicatoin No. (SMA)01-3550. Rockville, Maryland, 2001: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. (Table 4.16.01)
O'Brien, C. and McLellan, T. (1996). Myths about the treatment of addiction. *Lancet*, 347, 237-240.
O'Hare, T.; Tran, T.V. (1998). Substance abuse among Southeast Asians in the U.S.: Implications for practice and research. *Social Work in Health Care*, 26(3), 69-80.
Prochaska, J., DiClimente, C. and Norcross, J. (1992). In search of how people change. *American Psychologist* 47, 1102-1114.
Prochaska, J., Norcross, J. and DiClemente, C. (1994). *Changing for Good*. New York: Avon Books.
The Red Road to Wellbriety (2002). Colorado Springs, CO: White Bison, Inc.
Rieff, P. (1987). *The Triumph of the Therapeutic*. Chicago: University of Chicago Press.
Riessman, F. (1965). The "helper-therapy" principle. *Social Work*, 10, 24-32.
Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990s. *American Journal of Community Psychology*, 18, 221-230.
SAMHSA (1998) *National Household Survey on Drug Abuse: Summary Report 1998*. Rockville, MD: National Institute on Drug Abuse.
Sanders, M. (1993). *Treating the African American Male Substance Abuser*. Chicago: Winds of Change Publishing Company.
Sanders, M. (2002). The response of African American communities to addiction: An

opportunity for treatment providers. *Alcoholism Treatment Quarterly*, 20(3/4), 167-174.

Simpson, D.D., Joe, G.W., and Lehman, W.E. (1986). *Addiction Careers: Summary of Studies Based on the DARP 12-year Follow-up*. National Institute on Drug Abuse. Treatment Research Report (ADM 86-1420).

Singer, M and Borrero, M.G. (1984). Indigenous treatment for alcoholism: the case of Puerto Rican spiritualism. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*. 8, 246-273.

Soriano, M. (1995).Latinos in rehabilitation: Implications for culturally-appropriate counseling. *NARPPS Journal*, 19(2), 67-72.

Spicer P. (2001). Culture and the restoration of self among former American Indian drinkers. *Social Science & Medicine*, 53(2),227-40.

Sue, DW & Sue, D. (1999). Counseling the Culturally Different: Theory and Practice. New York: John Wiley and Sons.

Schweitzer, A. (1993). (Compiled by Harold Robles) *Reverence for Life: The Words of Albert Schweitzer* New York: HarperCollins Publishers.

Tabor, M. (1970) Capitalism plus Dope Equals Genocide. Black Panther Party, U.S.A.

Taylor, T.B. (1992). Imago Dei: A discussion of an Afrocentric spiritual model of prevention. *In Spirituality and Prevention*, pp. 49-57, Springfield, IL: Prevention Resource Center.

Taylor, V. (1987). The triumph of the Alkali Lake Indian band. *Alcohol Health and Research World* Fall, 57.

Thomas, P. (1967). *Down These Mean Streets*. New York: Alfred-A. Knopf.

U.S. Cencus Bureau, Dept. of Commerce, Census 2000. http://www.census.gov/population/cen2000/phc-tl/tab01.txt.

Weibel-Orlando, J. (1987) Culture-specific treatment modalities: Assessing client-to-treatment fit in Indian alcoholism programs. In: Cox, W., Ed., *Treatment and Prevention of Alcohol Problems: A Resource Manual*. Orlando: Academic Press.

Weisner, C., Ray, G.T., Mertens, J.R., Satre, D.D., and Moore, C. (2003). Short-term alcohol and drug treatment outcomes predict long-term outcome. *Drug and Alcohol Dependence* 71, 281-294.

Westermeyer, J. (1974). "The drunken Indian:" Myths and realities. *Psychiatric Annals*, 4(11):29-36.

Westermeyer, J. (1996). Alcoholism among New World Peoples: A critique of history, methods, and findings. *American Journal on Addictions* 5(2),110-123.

White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, MN: Hazelden.

White, W. (1998) *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, 20, 3 / 4, 107-130.

White, W., Boyle, M. And Loveland, D. (2003) Recovery management: Transcending the limitations of addiction treatment. *Behavioral Health Management* 23(3):38-44. (http://www.behavioral.net/2003_05-06/featurearticle.htm).

White, W., Boyle, M, Loveland, D, and Corrigan, P. (2003). What is Behavioral Health Recovery Management? A Brief Primer. http://www.bhrm.org.

White, W. and Chaney, R. (1993) *Metaphors of Transformation: Feminine and Mascu-*

line. Bloomington, IL: Chestnut Health Systems.
White, W. (2000a) Addiction as a disease: The birth of a concept. *The Counselor* 1(1):46-51, 73.
White, W. (2000b) The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*. 18(1), 1-23.
White, W. and Popovits, R. (2002). *Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*. Bloomington, IL: Chestnut Health Systems.
White, W., Woll, P and Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.
Williams, C. with Laird, R. (1992). *No Hiding Place: Empowerment and Recovery for Troubled Communities*. New York, NY: Harper San Francisco.
Womak, M.L. (1996). The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements. Master's thesis, Department of American Indian Studies, University of Arizona.
Yamashiro, G., & Matsuoka, J.K. (1997). Help-seeking among Asian and Pacific Americans: A multiperspective analysis. *Social Work*, 42(2), 176-186.

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About the Great Lakes Addiction Technology Transfer Center

The Great Lakes Addiction Technology Transfer Center (ATTC) is part of a national network that includes 14 regional ATTC's and a National Office. Funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT), the ATTCs have been charged with the mission of unifying science, services, and education to transform lives. Established in 1998, the Great Lakes ATTC is part of the Jane Addams College of Social Work, University of Illinois at Chicago. The Great Lakes ATTC uses educational products, training, technical assistance, information dissemination, collaboration, systems-change initiatives, and other technology transfer interventions to help prepare the addiction treatment field and allied health fields for the most effective evidence-based practice. The Great Lakes region includes Illinois, Indiana, Michigan, Ohio, and Wisconsin.

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