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Addiction recovery: Its definition and conceptual boundaries

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Abstract

The addiction field's failure to achieve consensus on a definition of "recovery" from severe and persistent alcohol and other drug problems undermines clinical research, compromises clinical practice, and muddles the field's communications to service constituents, allied service professionals, the public, and policymakers. This essay discusses 10 questions critical to the achievement of such a definition and offers a working definition of recovery that attempts to meet the criteria of precision, inclusiveness, exclusiveness, measurability, acceptability, and simplicity. The key questions explore who has professional and cultural authority to define recovery, the defining ingredients of recovery, the boundaries (scope and depth) of recovery, and temporal benchmarks of recovery (when recovery begins and ends). The process of defining recovery touches on some of the most controversial issues within the addictions field.

Keywords: Addiction recovery; Remission; Recovered; Recovering; Definition; Language

1. Introduction

There is growing evidence that the alcohol and other drug (AOD) problems arena is on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused recovery paradigm. The former rested on the assumption that investigations into the etiology and patterns of AOD problems and studies of the professional treatment of these problems would reveal the ultimate solution to these problems. The recovery paradigm posits that solutions to severe AOD problems have a long history and are currently manifested in the lives of millions of individuals and families and that the scientific study of these lived solutions could elucidate principles and practices that could further enhance recovery initiation and maintenance efforts (White, 2005).

The shift toward a recovery paradigm is evident in a number of quarters: the international growth of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004a), a new recovery advocacy movement (White, 2006a), and calls to shift the design of addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (Dennis, Scott, & Funk, 2003; Flaherty, 2006; McKay, 2005; McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002). Such a shift is also evident in state and local efforts to transform addiction treatment into "recovery-oriented systems of care," calls to use recovery as a conceptual bridge to integrate addiction and mental health service systems (Davidson & White, in press; White, Boyle, & Loveland, 2004), and the emergence of recovery as the organizing center of national behavioral health policy recommendations (Department of Health and Human Services, 2003; Institute of Medicine, 2006).

This focus on recovery is occurring without a clear definition of recovery and at a time in which there are calls to reexamine and increase the clarity of the language used to depict AOD problems and their resolution (Center for Substance Abuse Treatment [CSAT], 2000; Kelly, 2004; Milgram, 2004). The lack of an accepted definition of *recovery* contributes significantly to the variability of reported outcomes of addiction treatment (Maddux & Desmond, 1986). The term's conceptual fuzziness has also

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produced contention within recovery mutual aid groups and recovery advocacy organizations over when the state of recovery is achieved, lost, and reacquired (White, 2006a). It is not surprising in the face of such confusion that researchers tend to avoid the term, clinicians and mutual aid advocates use the term but with different meanings, and the public tends to understand recovery as an *attempt* to resolve, rather than the successful resolution of, AOD problems (Faces and Voices of Recovery Public Survey, 2004). The stigma attached to severe AOD problems will continue unabated until the meaning of recovery is clarified, the prevalence of recovery across cultural communities is confirmed by scientists, and a large cadre of individuals and families in long-term recovery stand to offer themselves as living proof of the transformative power of recovery.

Recovery as an organizing concept poses financial and ideological threats to existing social institutions and professional roles that have been granted cultural authority to manage AOD problems. The recovery paradigm is spawning alternative institutions (e.g., recovery advocacy organizations, peer-based recovery support centers) and roles (e.g., recovery coaches, personal recovery assistants, recovery support specialists) that are challenging treatment institutions and competing with them for status and financial resources (Kirk, 2005). Through this process, the recovery concept risks reification, commodification, commercialization, and overextension. The innumerable threats to the promises of the recovery paradigm render the task of defining recovery and maintaining the integrity of that definition an extremely important task.

This essay proposes criteria for a viable definition of recovery, makes recommendations related to 10 questions critical to the construction of a definition of recovery, and then offers a working definition of recovery for the field's consideration. The primary goal of this article is to stimulate discussion on the process that should be used to achieve a clearer definition of *recovery* and such derivative terms as *recovering*, *in recovery*, and *recovered*.

The first challenge in defining recovery is crafting a single definition that can meet four quite distinct uses of the term: (a) recovery as a lived experience by individuals and families, (b) recovery experience as the connecting tissue within communities of recovery, (c) recovery as an outcome that can be measured by scientists and those responsible for monitoring and evaluating behavioral health care systems, and (d) recovery as both an organizing vision/goal and a benchmark of accountability for complex service systems. Toward those ends, an ideal definition of recovery would meet six criteria: (a) precision (captures the essential nature and elements of the recovery experience), (b) inclusiveness (encompasses diverse recovery experiences, frameworks, and styles), (c) exclusiveness (filters out phenomena lacking essential recovery ingredients), (d) measurability (facilitates self-assessment, professional evaluation, and scientific study), (e) acceptability (to multiple constituents), and (f) simplicity (elegant in its clarity and conciseness).

With those purposes and definitional criteria identified, we will explore 10 questions crucial to the task of generating a working definition of recovery.

2. Who has the authority to define recovery at personal, professional, and cultural levels?

Imposed or self-embraced words that convey one's history, character, or status have immense power to wound or heal, oppress or liberate. At a personal level, a definition of recovery will attract or repel people seeking to resolve AOD problems, provide a benchmark for when this state of recovery is achieved, and convey directly or indirectly what actions are required to sustain this status. A particular definition of recovery, by defining who is and is not in recovery, may also dictate who is seen as socially redeemed and who remains stigmatized, who is hired and who is fired, who remains free and who goes to jail, who remains in a marriage and who is divorced, who retains and who loses custody of their children, and who receives and who is denied government benefits.

Defining recovery also has consequences of great import for those competing institutions and professional roles claiming ownership of AOD problems. Choosing one word over another can shift billions of dollars from one cultural institution to another, for example, from hospitals to prisons. Medicalized terms such as *recover*, *recovery*, *convalescence*, *remission*, and *relapse* convey ownership of severe AOD problems by health care institutions and professionals, just as words such as *redeemed* and *reborn*, *rehabilitate* or *reform*, and *stop* and *quit* shift problem ownership elsewhere. It is important to recognize that rational arguments for particular definitions of recovery may mask issues of professional prestige, professional careers, institutional profit, and the fate of community economies.

The answer of who has authority to define recovery will vary depending on the question, "define for what purpose?" Given that defining recovery could generate unforeseen and harmful consequences, efforts to define recovery should include broad representation from (a) individuals and family members in recovery, (b) diverse recovery pathways and styles, (c) diverse ethnic communities, and (d) policy, scientific, and treatment bodies, including leaders of the major institutions that pay for behavioral health care services. The driving force behind current behavioral health system transformation efforts is individuals and families directly impacted by and recovering from severe substance use and psychiatric disorders. They are demanding the right to sit at tables at which decisions are made that affect their lives. Given the impact any definition of recovery could have on their lives, their voices should be prominent within any forum that seeks to define recovery.

There will likely be multiple efforts to define recovery, and complete consensus on a recovery definition between

all stakeholders in the AOD problems arena is unlikely. However, it may be possible to assure diverse representation in these efforts and to assure that the most critical questions are addressed within these deliberations. The recommendations contained in the following discussions are intended to stimulate dialogue and debate within such forums.

3. Should the term *recovery* be applied only to the resolution of particular types of AOD problems?

Recovery is a medical term that connotes a return to health following trauma or illness. The boundary of the concept of recovery in the AOD problems arena is greatly dependent on an understanding of what one is recovering from. Technically, there is no recovery if one has no condition from which to recover. AOD use exists on a continuum from AOD abstinence, nonproblematic AOD use, subclinical AOD problems (transient problems not meeting severity or persistence criteria for a substance use disorder), and the two broad diagnostic entities *substance abuse* and *substance dependence*, each of which represents a variable span of severity, complexity, and duration. Any definition of recovery should link this term to a previous clinical state. In a survey of natural cessation of illicit drug use, Cunningham (1999) described people who had ever used an illicit drug in their lifetime but had not used an illicit drug in the past year in terms of "recoveries" and "remissions." Such use of the term *recovery* medicalizes AOD use and transient AOD problems that bear little resemblance to severe and persistent substance use disorders. This has contributed to confusion and controversies about the best strategies for resolving AOD problems.

There is considerable evidence that casual users and persons who naturally resolve AOD problems differ significantly from the mostly dependent users admitted to addiction treatment programs. Comparisons of the characteristics of those who achieve natural recovery in community populations with the characteristics of those entering addiction treatment reveal that the former are distinguished by less personal vulnerability, lower problem severity, less medical/psychiatric comorbidity, and greater family and social supports (Dawson, 1996; Finney & Moos, 1995; Grella & Joshi, 1999; Ross, Lin, & Cunningham, 1999), as well as qualitatively different resolution processes (Biernacki, 1986; Cloud & Granfield, 1994; Tuchfeld, 1981). The term *recovery* is best reserved for those persons who have resolved or are in the process of resolving severe AOD-related problems that meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) criteria for "abuse" or "dependence" (American Psychiatric Association [APA], 1994). The less medicalized terms *quit* and *cessation* more aptly describe the problem-solving processes in cases marked by less severity. The broader term *resolution* embraces both patterns of problem solving.

4. What are the essential, defining ingredients of the recovery experience? (Is recovery a time-limited event or a long-term process?)

Recovery folklore, both within professional treatment and mutual aid circles, is replete with references that recovery is a process, not an event. Such folklore is buttressed by innumerable studies that frame recovery as a stage-dependent developmental process (see White & Kurtz, 2006b, for a review). However, both historical and contemporary evidence suggest that addiction recovery is sometimes the product of a sudden event that is unplanned, positive, and permanent (Miller & C'de Baca, 2001; White, 2004b). Known in the clinical literature as *quantum change* or *transformational change*, this medium of recovery initiation and consolidation often involves profound religious, spiritual, or secular experiences that radically redefine personal identity and interpersonal relationships and suddenly and completely alter one's prior pattern of AOD use.

An ideal definition of recovery would be broad enough to embrace both incremental and transformative styles of recovery initiation and consolidation. White and Kurtz (2006b) have explored diverse pathways (religious, spiritual, secular) and styles (with and without treatment, with and without medication, with and without mutual aid involvement, differences in relational styles and identity in recovery) of recovery. A definition of recovery should avoid restricting the boundaries of recovery to a particular framework, strategy, or style of recovery.

5. Does recovery from a substance use disorder require complete and enduring abstinence?

Recovery defined as a state of sustained abstinence from a drug or category of drugs to which one previously met *DSM-IV* diagnostic criteria for abuse or dependence is implied in treatment outcome studies that report findings in terms of the percentage of treated individuals who had achieved uninterrupted abstinence or who were abstinent at the time of follow-up. This abstinence focus is reflected in the American Society of Addiction Medicine's description of recovery as "a process of overcoming both physical and psychological dependence on a psychoactive drug with a commitment to abstinence-based sobriety" (Steindler, 1998) and in the centrality of "sobriety" and the use of "sobriety birthdays" in Alcoholics Anonymous (AA) and other recovery mutual aid groups. Recovery defined as sustained cessation of AOD *use* is also the centerpiece of the major antistigma messaging campaign of new recovery advocacy organizations (Faces and Voices of Recovery, 2006).

In contrast, addiction researchers often define the resolution of AOD problems in more measured gradations, spanning people (a) who are completely abstinent, (b) who are essentially abstinent (low volume of consumption on rare occasions that result in no measurable problems), (c)

who continue to use but have shifted from clinical to subclinical patterns of use, (d) who meet *DSM-IV* criteria for abuse or dependence but at lower levels of problem severity, and (e) whose use and related problems have remained unchanged or have accelerated. Considering a widened span of outcomes raises the question of whether abstinence is a defining element of recovery or one of many strategies for achieving recovery.

If abstinence is a defining element of recovery, then a moderated resolution of AOD problems would, by definition, not constitute recovery. The problem is that such a definition flies in the face of a growing body of evidence that such moderated outcomes are possible for many people with mild-to-moderate substance-related problems as well as for a much smaller percentage of people with substance dependence (Dawson, 1996; Finney & Moos, 1981; Larimer & Kilmer, 2000; Miller, 1983; Miller & Muñoz, 2005; Rosenberg, 1993). The moderated resolution of AOD problems seems to be most common among persons with less personal vulnerability (e.g., no family history of AOD problems, later developmental onset of AOD use), lower problem severity, lower rates of co-occurring psychiatric illness, and greater personal and family resources (Dawson, 1996; Cunningham, Lin, Ross, & Walsh, 2000; Granfield & Cloud, 1999). The question for the field is whether the moderated resolution of AOD problems will be embraced within the conceptual rubric of recovery.

Reactions to any such suggestion are likely to be very strong from the field's professional and recovery advocacy constituencies. The source of such resistance is often attributed to AA, but such attribution is erroneously placed. Moderation was a strategy that had not worked for early AA members, but they made no effort to deny that option to others.

> 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 (AA, 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! (AA, 1939, p. 42).

AA makes no claim that the experience of its members constitutes a universal truth applicable to the broader universe of AOD problems. By distinguishing themselves ("real alcoholics") from problem drinkers, early AA members defined their own recoveries in terms of abstinence because that is what in their experience had been most successful. Ironically, scientists are using the latest research findings to reconfirm AA's distinction that, in modern language, "Everyone who has AOD problems does not suffer from addiction brain disease" (Erickson, 2006). The point is that the meaning of recovery needs to be broad enough to encompass, or sufficiently precise to distinguish, these levels of problem severity.

Moving from the alcohol to illicit drugs arena presents further challenges. Groups like Narcotics Anonymous (NA) have defined recovery in terms of abstinence from drug use, but addiction scientists have generally defined recovery from illicit drug dependence in terms of problem resolution rather than absence of drug use. Simpson and Marsh (1986), for example, defined recovery from opiate addiction in terms of the indicators of "reduction of drug use, criminal involvement and unemployment"—a definition not requiring complete and enduring abstinence. Leukefeld and Tims (1986) similarly define recovery as a state in which "drug abuse and related behavior are no longer problematic in the individual's life" (p. 186).

Defining recovery broadly enough (e.g., the resolution of AOD-related problems rather than the method through which such problems are resolved) would allow measuring levels of outcomes over time and answer questions about the viability of particular problem-resolution strategies for particular populations. In the end, it would be helpful to distinguish moderated resolution (sustained deceleration of AOD use and absence of AOD-related problems following the experience of transient, mild-to-moderate AOD problems) from moderated recovery (sustained deceleration of AOD use and absence of AOD-related problems following the experience of sustained and severe AOD problems, e.g., substance dependence). The phrase *moderated recovery* would be best used to designate those individuals with severe AOD problems who have achieved sustained deceleration of the frequency and intensity of AOD use to subclinical levels.

6. Does recovery require abstinence from, or a deceleration of, *all* psychoactive drug use?

Defining recovery only in terms of an altered relationship with one or more "primary" drugs to which one previously met *DSM-IV* criteria for *abuse* or *dependence* ignores the propensity for concurrent or sequential problems with multiple drugs. There are a growing number of people entering mutual aid groups and addiction treatment for whom a "primary drug" defies clear identification. This has led to definitions of recovery as enduring abstinence from all traditionally defined drugs of "abuse" (Milam & Ketcham, 1983). The problem with universally declaring all substitute drug use as destructive is an emerging body of evidence that drug substitution can serve as an effective strategy through which some people ward off acute and postacute withdrawal during their early search for recovery, for example, the increased use of alcohol and marijuana during the first year of heroin cessation (Bacchus, Strang, & Watson, 2000;

Copeland, 1998; Simpson & Marsh, 1986; Waldorf, 1983). Many recovery stories depict the peeling away of different drugs over time in a process that might be aptly described as *serial recovery* (White & Kurtz, 2006b). Recovery from substance use disorders is best defined in terms of one's total relationship with psychoactive drugs, rather than in reference to a single substance.

Attempts to define recovery inevitably confront the question of nicotine dependence among those seeking recovery from other drug dependencies. (Do we give dispensation for some addictions but not for others, e.g., an alcohol-dependent individual can be in recovery if he or she continues nicotine addiction but not if he or she continues heroin addiction?) This may well be the most difficult of issues. A recent review of the literature (White, 2006b) reveals that

1. heavy smoking is highly correlated with the development of other severe substance use disorders,
2. most people (85–95%) admitted to addiction treatment in the United States are dependent upon tobacco,
3. people with alcohol problems exhibit more severe nicotine addiction than do smokers without alcohol problems and are less likely to stop smoking,
4. those with more severe nicotine dependencies have poorer treatment outcomes for the treatment of other drug dependencies,
5. continued smoking following treatment for other drug dependencies increases the risk of relapse, and
6. smoking-related diseases are a major cause of death of people who have successfully recovered from alcoholism and other drug dependencies.

This is likely to be one of the most contentious issues in any effort to define recovery. At a minimum, it may be time to conceive and report recovery outcomes in more nuanced categories that convey these variations in recovery status, for example, full recovery without secondary drug use, recovery with subclinical secondary drug use, and partial recovery marked by drug substitution.

7. Does the use of prescribed psychoactive drugs disqualify one from the status of recovery?

A problem that arises from recovery definitions that preclude the use of any psychoactive drugs involves the issue of prescribed psychoactive drugs, including those prescribed as adjuncts in the treatment of addiction, those prescribed for co-occurring psychiatric disorders, and those prescribed for other medical conditions, for example, acute or chronic pain. There is a deep antimedication bias in addiction treatment grounded in the long history of iatrogenic insults resulting from attempts to treat addiction with opium, morphine, cocaine, barbiturates, amphetamines, LSD, and tranquilizers of numerous varieties (White, 1998). This bias has decreased in professional and recovery circles as more people with co-occurring disorders have entered treatment and sought membership in recovery fellowships and as new drugs have arrived with less potential for harm (Meissen, Powell, Wituk, Girrens, & Artega, 1999; Rychtarik, Connors, Demen, & Stasiewicz, 2000). Breakthroughs in the neurobiology of addiction hold great promise for new pharmacological adjuncts in the treatment of addiction (Dackis & O'Brien, 2005), but stigma continues to be attached to some of the most scientifically grounded, medication-based addiction treatments.

The importance of the definitions of *recovery* and *abstinence* (or *sobriety*) in the context of medication-based treatment is evident in NA policy statements on methadone and other medications. NA guidelines for Hospital and Institution meetings in methadone clinics explicitly advise, "When the subject of methadone comes up, it is important not to judge" (H & I Service Bulletin # 3; NA World Services [NAWS], n.d.), but the NAWS Board of Trustees Bulletin *Regarding Methadone and Other Drug Replacement Programs* (Bulletin # 29, 1996; NAWS, 1996) affirms the right of NA meetings to refuse to allow those using medically prescribed methadone as "drug replacement therapy" to speak at meetings and refers to such individuals as "under the influence of a drug," "still using," and "not clean." The NA pamphlet *In Times of Illness* (NAWS, 1992) emphasizes alternatives to medications, suggests taking medication only when it is necessary, and leaves the issue of "clean time" under such circumstances as something to be resolved with one's sponsor and higher power.

How recovery is defined has consequences, and denying medically and socially stabilized methadone patients the status of recovery is a particularly stigmatizing consequence (Murphy & Irwin, 1992). A growing number of professional and recovery advocacy organizations are recognizing the legitimacy and potential effectiveness of medication-assisted recovery (Pennsylvania Recovery Organization-Achieving Community Together, 2006; White & Coon, 2003), and new recovery support fellowships such as Methadone Anonymous provide a supportive, recovery-focused milieu for those using medication as an aid to their recovery efforts.

The influence of prescribed psychoactive drugs on an individual's recovery status is best evaluated, not in terms of its presence, but in terms of the motivations for medication use and its effects. Using this principle, the same dose of the same drug could constitute relapse for one person (the use of 70 mg of unprescribed methadone for purposes of intoxication) and a recovery adjunct for another (the use of 70 mg of prescribed methadone for metabolic stabilization). Use of the phrase "medication-assisted recovery" would help legitimize the recovery status of people who are using medically monitored medications such as methadone, buprenorphine, naltrexone, acamprosate, or disulfiram as adjuncts to their recovery processes but might also risk creating a recovery class structure in which this group would be seen as less than full members of local recovery communities.

8. Is recovery something more than the elimination or deceleration of AOD problems from an otherwise unchanged life?

Discussions of recovery that focus exclusively on the presence or absence of AOD use ignore the fact that addiction is often intricately bundled (concurrently and sequentially) with other problems and that the resolution of addiction is often inseparable from the resolution of problems in which it is nested. Recovery definitions that place recovery within the context of global health (Foster, Peters, & Marshall, 2000; Rudolf & Watts, 2002) view the resolution of AOD problems not as a focal point but as a by-product of larger personal and interpersonal processes. Such definitions withhold the status of *recovery* from someone who has achieved abstinence but has failed to achieve levels of physical, emotional, relational, and ontological (spirituality, meaning, purpose) health.

Reports of temporary sobriety accompanied by poor emotional health have a long tradition in the clinical literature of addiction treatment. In 1933, 2 years before the founding of AA, Richard Peabody declared: "A man who is on the wagon may be sober physically, but mentally he may be almost as alcohol-minded as if he were drunk" (Peabody, 1933, p. 106). AA evolved historically through a narrow definition of recovery ("putting a cork in the bottle") to the development of such concepts as *dry drunk*, *emotional sobriety*, and *serenity* (Wilson, 1958). The current use of the term *wellbriety* by Native American recovery advocates (Coyhis, 1999; Coyhis & White, 2006) similarly reflects efforts to define recovery as sobriety plus global health or quality of life.

Defining recovery in terms that include personal character raises an important question: Why are changes of character applied to the definition of addiction recovery when no such changes are included in definitions of recovery from other health conditions? Recovery from any disorder is best measured within the precise areas affected by the disorder. Recovery from cancer is not measured in terms of reduced criminality because there is no known nexus between cancer and criminality. In the case of severe substance use disorders, recovery is defined in characterological terms because distortions in character mark the very essence of the addiction experience.

Attempts to define recovery face the challenge of distinguishing the resolution of AOD problems from an otherwise unchanged life from a broader transformation of personal character and identity. Most recovered and recovering people define recovery in terms of the resolution of AOD problems and the progress toward global health (physical, cognitive, emotional, ontological, relational, educational/occupational, financial, and legal). Congruent with this view, the field could consider using the term *remission* to depict the elimination of problems (persons no longer meeting *DSM-IV* criteria for abuse or dependence) and the term *recovery* to convey remission plus a broader achievement of global health (CSAT, 2006). The former would convey what has been removed from one's life; the latter would convey what has been added to one's life.

9. Is recovery an all-or-none proposition or, as with other health conditions, something that can be achieved in degrees?

Even if the definition of recovery is broadened to address the whole scope of psychoactive drug use and to encompass broader dimensions of global health, we are still left with the question of whether recovery is something that exists as a static state that one has or has not achieved or whether it is something that is best measured in more subtle gradations. There is growing evidence that many severe AOD problems constitute chronic disorders whose full stabilization follows multiple recovery initiation efforts (Dennis, Scott, Funk, & Foss, 2005; McLellan et al., 2000; Scott, Foss, & Dennis, 2005). The concepts of "addiction career" and "treatment career" (Anglin, Hser, & Grella, 1997; Frykholm, 1985; Hser, Anglin, Grella, Longshore, & Prendergast, 1997) have been used to conceptualize this prolonged process. It may be helpful to extend these concepts to speak of "recovery career" as the processes and stages that mark the resolution of severe and persistent AOD problems.

In their historical review of how the mental health and addictions fields have viewed recovery, White et al. (2004) note that the mental health field has organized its services around the goal of partial recovery but has, until recently, had no concept of full recovery for those experiencing serious mental illness. In contrast, the addictions field has reified the concept of full recovery (defined historically as complete and sustained abstinence) but has had no legitimized concept of partial recovery. White and Kurtz (2006b) advocate use of the term *partial recovery* to convey two different conditions: (a) a reduced frequency, duration, and intensity of AOD use and reduction of AOD-related personal and social problems or (b) the achievement of complete and sustained 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. White and Kurtz (2006b) also note the existence of an *enriched or transcendent state of recovery* —a state of amplified health, performance, and social contribution superior to one's preaddiction life. This acknowledges that some people achieve a peak level of functioning, not in spite of their addiction and recovery, but from the strength drawn from their survival of addiction and the personal transformations they experience throughout the recovery process.

The term *partial recovery* is best applied to patterns of problem resolution marked by decreases in the frequency,

duration, and intensity of AOD use and related problems and an increase in the length and quality of periods of sobriety or decelerated use. While the concept of *partial recovery* is included in the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* and *DSM-IV* diagnostic classification schemes (APA, 1994; World Health Organization [WHO], 1992), it has yet to be elevated and legitimized in the clinical world of addiction treatment.

10. Must recovery be conscious, voluntary, and self-managed?

For some, addiction is a transient experience—a fleeting involvement that, when replaced by other involvements, leaves no lasting mark on personal identity. For others, addiction and recovery become the defining elements of their lives—become who they are at a most personal level (White & Kurtz, 2006b). The importance of this point to our current discussion is that recovery can be a conscious process or the product of what sociologists call "drift" (Matza, 1964; Waldorf, 1983)—a movement out of addiction that is not marked by conscious planning, self-direction, or alterations in personal identity. Recovery does not have to be conscious. The choice to include or exclude "alcoholic/addict" and "recovery/recovering" into one's sense of self represents not a precondition for the status of recovery but stylistic differences among people who have resolved severe AOD problems. The term *recovery* and its derivatives should be applied in the scientific literature and in public discourse to all patterns of resolution of severe and persistent AOD problems (that previously met *DSM-IV* criteria for abuse or dependence), including those individuals for whom such resolution did not involve self-identification with the states of addiction and recovery.

A related question is the role of coercion in recovery. Recovery advocacy groups emphasize that external authorities can coerce exposure to mutual aid groups or treatment, but only the volition of the individual can sustain recovery. In their view, there is no such thing as coerced recovery (White, 2006a). Researchers are exhibiting sympathy toward this view by distinguishing voluntary abstinence in the community versus artificially induced abstinence in a controlled setting (Godley, Dennis, Godley, & Funk, 2004). Definitions of recovery are most meaningful when they distinguish volitional change from superficial and transient periods of AOD cessation/deceleration generated by institutionalization, rigorous monitoring by external authorities, or crisis-induced respites from active AOD use. It would be helpful if scientific studies of recovery used categories that convey the degree of volitional intent related to recovery, for example, reporting follow-up status in terms of degrees of freedom—problem abatement in an institutional environment, problem abatement under rigorous monitoring in the community, recovery in the community without external supervision—and for more extended time periods.

11. What are the temporal benchmarks of recovery?

The practice of celebrating sobriety birthdays in AA and NA suggests that recovery in these fellowships begins at the point of cessation of AOD use. Some researchers (Prochaska, DiClimente, & Norcross, 1992) contend that recovery begins before the cessation of AOD use, whereas others link the beginning of recovery to the point that AOD-related problems diminish or cease. Factors that complicate the process of defining a set point for addiction recovery include the fact that most severe AOD problems last a long time (patterns of chronicity) and ebb and flow over their course (patterns of periodicity; Maddux & Desmond, 1986). Short-term episodes of voluntary or other-imposed abstinence and treatment can mark a respite rather than a termination of addiction (Simpson & Sells, 1990). In short-term studies, brief or extended interludes of abstinence or asymptomatic use may be mistaken for enduring recovery. This requires distinguishing ebbs in the enduring course of addiction from early stages of long-term recovery from addiction. The phenomena of chronicity and periodicity prompted organizations such as the American Medical Association Committee on Alcoholism and Drug Dependence (1970) and researchers (Bejerot, 1975) to include in their definition of recovery time requirements ranging from 3 to 5 years.

One could argue that recovery has both qualitative (what essential elements must be present to declare this state?) and quantitative (how long must these conditions be present before one can be considered recovering or recovered?) dimensions. But one could also argue that dichotomous definitions of recovery (one either is or is not recovered/recovering) fail to capture the fluidity of recovery (something one achieves partially or a state one moves in and out of). There are also the questions: When, if ever, does recovery end? Is it a time-limited event/experience or a never-ending process? Can recovery be completed and rendered in the past tense? These questions are most evident in the debates over the terms *recovered* and *recovering*.

Recovered and *recovering* are terms used to describe the process of resolving, or the status of having resolved, severe AOD problems. Individuals who have resolved such problems have been referred to as redeemed (or repentant) drunkard, reformed drunkard, dry drunkard, dry (former) alcoholic, arrested alcoholic, sobriate, ex-addict, ex-problem drinker, and ex-alcoholic. They have been described as sober, on the wagon, drug free, clean, straight, abstinent, cured, recovered, and recovering (White, 1998). Modern debate has focused on the last two of these terms. Whereas *recovering* conveys the dynamic, developmental process of addiction recovery, *recovered* provides a means of designating those who have achieved stable sobriety and better

conveys the real hope for a permanent resolution of AOD problems. The period used to designate people recovered from other chronic disorders is usually 5 years of continuous symptom remission.

Many treatment outcome studies evaluate recovery between 6 and 24 months following admission or discharge from treatment, and the two major diagnostic classification systems define recovery in terms of periods of symptom remission ranging from 1 month ("early remission") to 1 year ("sustained remission"; APA, 1994; WHO, 1992). Defining recovery in terms of such short time periods is challenged by studies suggesting that recovery from severe substance use disorders is not stable (point at which the risk of future lifetime relapse drops below 15%) until after 4 to 5 years of sustained abstinence or subclinical use (Dawson, 1996; De Soto, O'Donnel, & De Soto, 1989; Jin, Rourke, Patterson, Taylor, & Grant, 1998; Nathan & Skinstad, 1987; Vaillant, 1996).

Persons with severe AOD problems often cycle in and out of problematic use and exhibit short periods of abstinence and subclinical use within the larger course of substance dependence. Both moderated and abstinence-based problem resolutions require time periods of symptom remission to determine if they are a sustainable pattern of problem resolution or a brief hiatus in one's addiction career. Short periods of self-imposed abstinence or moderation are not by themselves predictive of long-term problem resolution. This conclusion is confirmed by a recent 16-year follow-up study (Moos & Moos, 2006) noting that 60% of individuals who initially achieved natural recovery (defined as problem remission without the aid of professional treatment or recovery mutual aid groups) later experienced one or more relapses.

The terms *full recovery* and *recovered* are best reserved for those individuals previously meeting *DSM-IV* criteria for abuse or dependence who have sustained recovery (abstinence or nonproblematic use and enhanced global functioning) for a period of 5 years or more. Designation of the status of recovery (partial or full) should be based on the presence of three criteria:

- sustained cessation or reduction in the frequency, quantity, and (high risk) circumstances of AOD use following a sustained period of harmful use or dependence (meeting *DSM-IV* criteria for abuse or dependence);
- absence of, or a progressive reduction in, the number and intensity of AOD-related problems; and
- evidence of enhanced global (physical, cognitive, emotional, relational, educational/occupational, ontological) health.

The term *recovering* best depicts those persons who are making progress toward the achievement of the three above-noted recovery criteria but who have not yet reached the 5-year benchmark of recovery stability. Mutual aid groups have sometimes used one term (*recovering*) for intragroup communication and another term (*recovered*) for extragroup communications. This practice is intended to meet the psychological needs of group members (reinforcing the need for sustained vigilance and self-development) while conveying a message of hope for permanent recovery to the public and those still experiencing AOD problems (White, 2006a).

12. Defining recovery: A proposal

Having defined the criteria for an ideal definition of recovery within the AOD problems arena and made recommendations related to key questions related to the construction of such a definition, the following definition is offered for consideration.

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

By beginning the definition with the acknowledgement that recovery is an *experience*, we reinforce that recovery is deeply personal and filtered through other dimensions of self-age, gender, ethnicity, sexual orientation, cultural affiliation, degree of religiosity, and particular life-shaping experiences (e.g., personal or historical trauma). Defining recovery as an *experience* is inclusive of change processes that can be either a climactic, health-inducing event (positive, irrevocable, permanent) or marked by time-sustained improvements in health and functioning. Putting *experience* up front also underscores who is at the center of the recovery process—individuals and families—and not the helping professional. Recovery can be achieved with or without professional treatment or participation in peer-based recovery mutual aid groups, although the potential necessity of treatment and mutual aid participation increases as problem severity and complexity increase and recovery assets decrease (Cunningham, 2000; Granfield & Cloud, 1999).

Acknowledging that recovery is *a process* conveys that resolving severe AOD problems is more than a point-in-time decision and that the achievement of long-term recovery requires sustained effort. Depicting recovery as a process conveys that recovery initiation and recovery maintenance are qualitatively different processes (Humphreys, Moos, & Finney, 1995; Snow, Prochaska, & Rossi, 1994).

Acknowledging recovery as *a sustained status* confirms the ability of recovery to alter personal identity and engender meaning from having survived a potentially life-threatening condition. The phrase also suggests that recovery requires external validation. By analogy, one is not in recovery (or remission) from cancer simply by self-declaration. Recovery

from severe AOD problems is a status that must stand the test of external validation based on measurable criteria. It must also stand the test of time. Full recovery from severe AOD problems, like full recovery from other life-threatening chronic problems, cannot be declared until a point of durability has been reached in which the risk for future lifetime relapse has been dramatically reduced. Use of terms such as *full recovery*, *long-term recovery*, and *recovered* convey to people with AOD problems and their families, health and human service providers, and the public the real hope for permanent resolution of severe AOD problems (Faces and Voices of Recovery, 2006). In clinical and scientific arenas, it would be helpful to refer to recovery in temporal categories: early recovery (less than 1 year), continuing recovery (1 year to 5 years), and long-term recovery (more than 5 years).

Including *individuals, families, and communities* in the recovery definition transcends the traditional focus on the individual and affirms the interconnectedness between the individual, the family (defined nontraditionally), and the community. Family recovery can be measured through changes in the family system's boundary permeability, the global health of individual family members, changes in family subsystem relationships (e.g., adult intimate relationships, parent–child relationships, sibling relationships, relationships with the extended family and kinship network), and key dimensions of family life (e.g., roles, rules, and rituals; White & Savage, 2005). These radical readjustments of family life can be so traumatizing as to threaten the survival of the family as a system (Brown & Lewis, 1999). This broadened perspective on recovery also embraces the relationship between individual/family health and community health—a relationship very evident in the current Native American Wellbriety Movement. ("In the Red Road to Wellbriety, the individual, family and community are one. To injure one is to injure all; to heal one is to heal all" [White Bison, 2002].) Framing the multidimensional experience of recovery within the context of individual, family, and community is visually illustrated in the placement of personal recovery within the Native American Medicine Wheel (Fig. 1).

Limiting the application of recovery to those *impacted by severe AOD problems* precludes use of the term *recovery* for those who have experienced less severe and transient AOD problems. This definition would limit application of the term *recovery*, at least in scientific and clinical circles, to the resolution of AOD problems that met *DSM-IV* criteria for *abuse* or *dependence*. It affirms that lessons learned from those with mild-to-moderate AOD problems are inapplicable to those with severe and chronic AOD problems.

The phrase *utilize internal and external resources* affirms the existence of secular (White & Nicolaus, 2005), spiritual

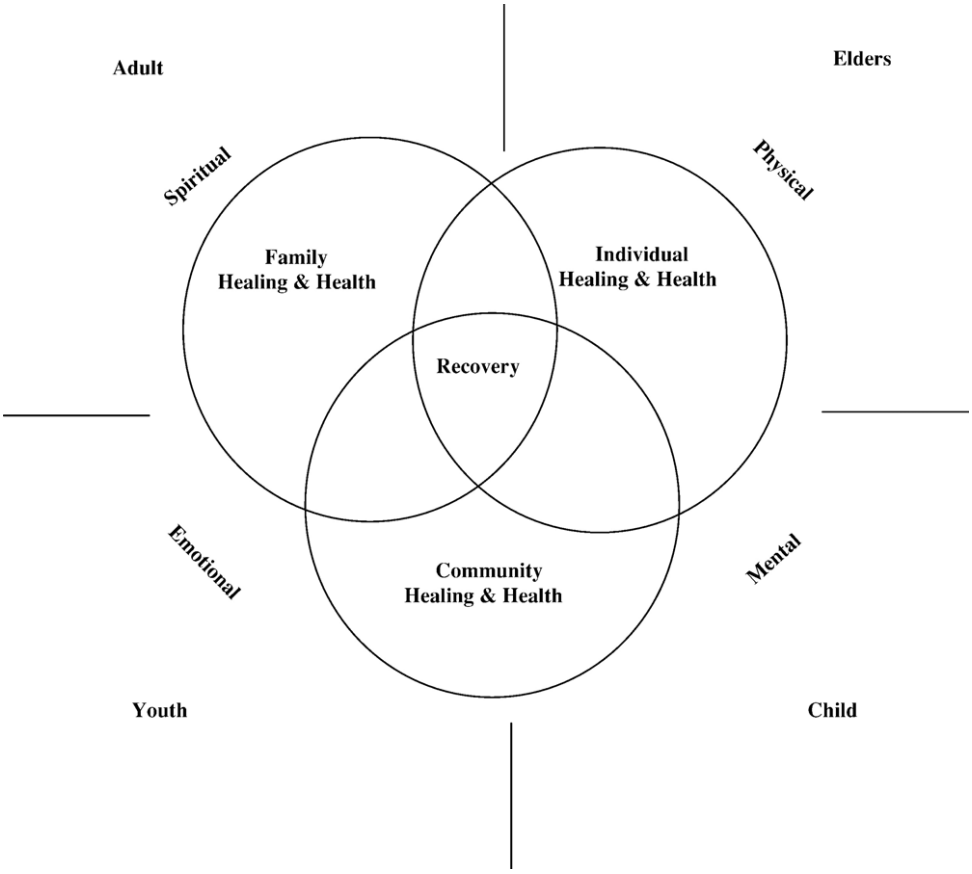

Fig. 1. Recovery and the life cycle of the individual, the family, and the community. Source: Charlene Belleau, Former Chief, Alkali Lake Band of Indians.

(Cook, 2004; Galanter, 1997; Laudet, Morgen, & White, 2006; Miller, 2003), and religious frameworks of recovery (White & Whiters, 2005). It affirms that recovery can come from an assertion of self or from a surrender and transcendence of self (White & Nicolaus, 2005). The phrase also acknowledges the role of internal and external assets in the recovery process—assets Granfield and Cloud (1999) have collectively christened *recovery capital*.

Use of the phrase *to voluntarily* precludes externally mandated respites in AOD use from the recovery definition and underscores the role of human volition in the maintenance, if not always the initiation, of radically altered relationships with psychoactive drugs. Its inclusion reflects the recognition that free will is neurologically compromised in addiction and progressively rehabilitated through the recovery process (Smith, 2005).

The phrase *resolve these problems* conveys action and movement over time—thus, the frequent recovery metaphors of steps, pathways, and journeys. *Resolve* conveys that some repairs of the wounds to self and others have already been completed while others are likely still underway. It conveys that the person, family, and community are in the process of freeing themselves from problems that have dominated their thoughts, feelings, relationships, and activities. For recovery to occur, certain things must be absent and other things must be present—a measurable accounting of withdrawals and deposits.

The use of *resolve these problems*, rather than behavioral criteria of abstinence from one or more drugs and the absence of references to professional treatment or mutual aid societies, makes AOD problem resolution the most essential ingredient of recovery, rather than a particular method of problem resolution. It is also respectful of the "philosophy of choice" that is gaining greater visibility within the recovery support literature (White & Kurtz, 2006a). *Resolve* means that the destructive pattern of AOD use has been aborted, the problems resulting from such use have been or are being rectified to the extent possible, and the chaos and unpredictability that so often characterize severe AOD problems have diminished or been eliminated. It also suggests that the problems arising from stigma related to this condition are also being actively managed at a personal level.

Substituting one destructive drug relationship for another is, in this definition, not recovery. Eliminating one drug dependency (e.g., alcohol) while retaining an equally life-threatening though less life-disrupting drug dependency (e.g., nicotine) would, in this definition, be viewed as partial recovery. The question of medication as an adjunct in one's search for recovery would be judged, not by its presence or absence but by the motivations for its use and its effects on the resolution process. Three specific questions could be asked to make such a judgment:

1. Does the medication incite or quell what people seeking recovery have personified for more than a century as the "beast," "monster," or "dragon" (cellular craving, addictive thinking and self-talk, and compulsive drug-seeking behavior)?
2. Does the medication enhance or inhibit broader dimensions of global health?
3. Does the medication result in an increase or decrease in injuries and costs inflicted on the individual, family, community, and culture?

These questions focus not on the presence of psychoactive drugs or the source of such drugs (prescribed or unprescribed) but on what role these substances play in the resolution or exacerbation of AOD problems.

The phrase *heal the wounds inflicted by AOD-related problems* acknowledges that severe AOD problems are often inextricably bundled with other problems, that recovery outcomes are closely linked to broader personal and social adjustment outcomes, and that healing and rebuilding individuals, families, and communities wounded by AOD problems take time (Miller, 1996).

The phrase *actively manage their continued vulnerability to these problems* conveys that there are, at the moment, no permanent technologies to eliminate future vulnerability to AOD problems for those who have arrested those problems. The implication is that individuals, families, and communities become experts on their own recovery processes and take responsibility for actively managing those recovery processes over time.

The final phrase in our definition, *develop a healthy, productive, and meaningful life*, reflects the near-universal belief in recovery support circles (across secular, spiritual, and religious groups) that recovery is more than an aborted or radically altered pattern of AOD use. The word *develop* is intended to convey movement forward—a "progress, not perfection" framework of change common in recovery mutual aid groups. Such progress can reflect internal changes (e.g., new knowledge, values, thinking patterns, attitudes, character traits, behaviors, skills, decisions, personal identity) or external changes (rituals of daily living, significant changes in interpersonal relationships—particularly with family and friends—and an altered relationship to community as measured by citizenship and service).

Dictionary definitions of *recovery* convey the process of retrieval—a return to a past state or the process of extracting valuable resources from seemingly unusable sources (Oxford English Dictionary, 2006). Such a definition fits the addiction recovery experience in the sense that something of great value has been drawn from the past addiction experience that potentially transforms those who were once a social problem into a valuable social asset. Recovery can also be depicted as a process of *procovery*, *uncovery*, or *discovery*—a movement into new, unexplored dimensions of one's life.

The phrase *a healthy, productive, and meaningful life* conveys the broad changes that often unfold as a means of achieving recovery or that are received as the benefits of the recovery experience. *Healthy* encompasses improvements in

quality of life: physical health, emotional health, and enhancement of one's intimate, family, and social relationships. *Productive* suggests the expectation that the antisocial behaviors often associated with severe AOD problems will be replaced by behaviors that contribute to rather than wound the community. *Meaningful* suggests that the new life of recovery is experienced as something of personal value—that one's life was saved for some reason. It implies that answers to the question "recover to do what?" are being actively sought.

13. Summary

Concerns about how the resolution of AOD problems is conceptualized and semantically expressed are far more than intellectual games played by addictionologists.

The choice of concepts and language shapes the fate of those experiencing AOD problems and exerts a profound influence on institutional economies and professional careers. *Recovery* is resurfacing as an advocacy paradigm for reengineering addiction treatment and addiction-related social policies, but the potential of recovery as an organizing paradigm is limited by the failure to define recovery and stake out its conceptual boundaries. Such definitional and boundary setting tasks have great import for clinical research, clinical practice, recovery mutual aid, recovery advocacy, and, most importantly, individuals and families impacted by severe AOD problems.

This essay discussed 10 key questions critical to establishing an operational definition of recovery and presented a definition for consideration that attempted to meet six criteria: (a) precision, (b) inclusiveness, (c) exclusiveness, (d) measurability, (e) acceptability (to multiple constituents), and (f) simplicity. It is hoped that this essay will stir needed discussion and debate. Our progress in intervening with individuals, families, and communities experiencing AOD problems will depend to a great extent on the clarity of our thinking and the clarity of our language.

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