White, W. & Ali, S. (2010). Lapse and relapse: Is it time for a new language. Posted at www.facesandvoicesofrecovery.org.

Lapse and Relapse:
Is it time for new language?

April 2010

William L. White & Sadé Ali

A new addiction recovery advocacy movement in the United States is challenging many of the concepts and terms that have historically portrayed alcohol and other drug (AOD) problems (Ali, 2010; Kelly, 2004; Substance Use Disorders, 2004; White, 2006, 2007a). Recovery advocates contend that language has been an important tool in the stigmatization, demedicalization, and criminalization of AOD problems and the marginalization of people affected by these problems (White, 2007b). Recovery advocates are calling attention to new research studies that confirm these effects (Kelly, Dow, & Westerhoff, in press; Kelly & Westerhoff, 2010).

The authors have been part of these extended debates about language in the addiction, treatment, and recovery arenas. In this essay, we discuss two words—*lapse* and *relapse*—that we argue are rooted in moral and religious conceptions of AOD problems and should be replaced with terms that are morally neutral and precise and that more aptly depict the processes involved in the experiences of people with AOD problems who resume AOD use following voluntary periods of sobriety.

Origin and Moral Meanings

The addictions field has long used the term *relapse* to describe a return to drinking or drug use following a period of voluntary abstinence by those who have a history of AOD-related problems. The field has more recently attempted to distinguish *lapse* or *slip* (a brief episode of AOD use) from *relapse* (the resumption of more extended and excessive AOD use involving the return of symptoms meeting diagnostic criteria for a substance use disorder). Rates of lapse and relapse are difficult to compare across studies due to different definitions of these terms (Maisto, Pollack, Cornelius, Lynch, & Martin, 2003; McKay, Franklin, Patapis, & Lynch, 2006; Simonelli, 2005).

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

- abandonment of religious faith, e.g., lapsed Catholic,
- moral failing, e.g., lapse in grace, wrongdoing, violation of a moral standard,
- neglect of one's personal or social responsibilities, e.g., lapse in insurance coverage or membership due to failure to make payment,
- return of slovenly character, e.g., lapse into bad habits,
- deviation from accepted standards as a result of carelessness, negligence or lack of effort, e.g., lapse in judgment,

- deterioration in discipline or ability, e.g., lapse in memory, and
- fall, fail, regress, backslide, descend, revert.

These terms entered medicine at a time health conditions were thought to be inextricably linked to a person's religious or moral conduct. The onset and recurrence of many complex health problems were once shrouded in shame because of such associations. The implied moral connections between the relapse of tuberculosis, cancer, epilepsy and schizophrenia slowly faded as the etiology and course of these disorders became more clearly understood.

In the alcohol and drug problems arena, the lapse/relapse language emerged during the temperance movement to refer to individuals who had returned to drinking after publicly signing a temperance pledge. "Falling off the water wagon" was linked in the public mind to lying, deceit, and low moral character and was viewed as a product of badness rather than sickness (White, 1998). The moral overtones created by the *lapse/relapse* language shaped broader communications in which those who were drug free were referred to as *clean* while people who were using drugs were viewed as *dirty*. The moral roots of *lapse/relapse* are further illustrated in the synonyms for *clean* (e.g., pure, unblemished, faultless, flawless, good, innocent, sinless) and for *dirty* (e.g., stained, tainted, polluted, infected, defiled, foul, filthy, immoral, lewd, vile, vulgar).

The Scope of Application of Lapse/Relapse

Internet search technologies provide a way to investigate the frequency at which two terms are associated. Table 1 reveals the frequency with which references to lapse and relapse appear in conjunction with various terms used to convey the presence of alcohol- or other drug-related problems. It can be seen that this pairing is most frequent in reference to the terms alcoholism and addiction. It is noteworthy that references to *lapse* and *relapse*—terms associated with moral choice—rise when paired with the term *abuse*—another term that conveys a person of contemptible character. (Note in Table 1 how references to *lapse* and *relapse* increase in the shift from *alcohol dependence* to *alcohol abuse*.) The *lapse/relapse* terms combined with references to *abuse* convey a greater sense of personal culpability, and as recent research reveals in the case of the *abuse* language, elicits more punitive attitudes (Kelly et al., in press; Kelly & Westerhoff, 2010).

To compare the pervasiveness of the link between *lapse/relapse* and AOD problems, we compared these references to those for the link between these same search terms and the word *recovery*. It can be seen from Table 1 that the terms *lapse* and *relapse* are as pervasively linked to AOD problems as is the term *recovery*.

Table 1: Number of Internet Lapse/Relapse References Linked to Terms used to Depict Alcohol and other Drug Problems (Google Advanced Search on February 8, 2010)

AOD-related Disorder	Number of Internet Lapse References	Number of Internet Relapse References	Total Lapse / Relapse References	Number of Internet Recovery

				References
Alcoholism	11,200,000	8,490,000	19,690,000	2,610,000
Alcohol Addiction	8,930	121,000	129,930	465,000
Alcohol Dependence	43,600	142,000	185,600	159,000
Alcohol Abuse	97,800	622,000	719,800	890,000
Addiction	520,000	1,490,000	2,010,000	2,290,000
Drug Addiction	161,000	484,000	645,000	1,390,000
Drug Dependence	11,000	131,000	142,000	282,000
Drug Abuse	762,000	130,000	892,000	2,000,000

To compare the application of the *lapse/relapse* terms to alcohol and other drug problems and other chronic medical disorders, a similar search was done on the pairing of references to *lapse/relapse* with other chronic disorders. Table 2 reveals the wide application of the terms *lapse/relapse* to other medical and behavioral health conditions. This would seem to indicate the medical legitimacy of these terms, but three points challenge such a conclusion. First, many of the conditions listed contained moral overtones during earlier historical periods, and continued use of the *lapse/relapse* language may reflect such residual effects. Second, the term *relapse* is being abandoned in fields such as cancer treatment for more medically precise and morally neutral terms, e.g., *recurrence*. Third, *lapse* and *relapse* are not applied to these conditions nearly as frequently as they are to AOD problems. The terms *lapse* and *relapse* are applied to alcoholism more than to any other single medical condition listed in Table 2.

Table 2: Number of Internet Lapse/Relapse References Linked to other Chronic Disorders (Google Advanced Search on February 8, 2010)

Chronic Health Disorder	Number of Internet Lapse References	Number of Internet Relapse References	Total Lapse / Relapse References
Diabetes	506,000	8,060,000	8,566,000
Type I Diabetes	31,600	147,000	178,600
Type 2 Diabetes	45,000	182,000	227,000
Cancer	1,500,000	3,020,000	4,520,000
Tuberculosis	1,300,000	3,910,000	5,210,000
Hypertension	1,600,000	4,910,000	6,510,000
Epilepsy	1,740,000	3,220,000	4,960,000
Asthma	2,850,000	4,990,000	7,840,000
Depression	1,220,000	2,010,000	3,230,000
Schizophrenia	118,000	5,330,000	5,448,000
Mental Illness	216,000	702,000	918,000
AIDS	887,000	955,000	1,842,000

The applications of the terms *lapse* and *relapse* are by no means restricted to medical conditions. Table 3 illustrates the widespread application of these terms to a spectrum of immoral and criminal behaviors.

Table 3: Number of Internet Lapse/Relapse References by Immoral or Criminal Behavior (Google Advanced Search on February 8, 2010)

Immoral or Criminal Behavior	Number of Internet Lapse References	Number of Internet Relapse References	Total Lapse / Relapse References
Adultery	1,480,000	595,000	2,075,000
Lying	1,180,000	4,460,000	5,640,000
Assault	672,000	4,260,000	4,932,000
Rape	304,000	3,420,000	3,724,000
Murder	941,000	5,340,000	6,281,000

Table 3 illustrates the close connection between the terms *lapse* and *relapse* and immoral and criminal conduct. It is noteworthy that these terms are as likely to be linked to lying or murder as they are to cancer, tuberculosis, epilepsy, AIDS, or schizophrenia. The blurring of the boundary between the language of moral judgment and the language of medical diagnosis and treatment raises important questions about the use of terms such as *lapse* and *relapse* in addiction treatment and recovery support contexts.

Miller's Early Critique of Relapse

In 1996, William Miller challenged the addiction field's use of the *relapse* concept/term. Miller argued that the relapse concept/term:

- suffers from definitions that are ambiguous, variable, and arbitrary,
- presents outcomes in a binary classification of complete success (perfect abstinence) or complete failure (any AOD use) without reference to threshold (amount of AOD use), window (span of time being judged), reset (period of abstinence preceding AOD use), polydrugs (range of drugs used that would constitute a relapse), consequences (use versus problems resulting from use), and verification (methods other than self-report to verify AOD use or non-use),
- imbues judgment and shame on complex addictive behaviors that are more likely to be changed incrementally over time than through transformational change experiences that are sudden, unplanned, and permanent (Miller & C'de Baca, 2001),
- may elicit the very behaviors it seeks to prevent via self-fulfilling prophecy ("one drink-one drunk")—what Marlatt (1996) christened the "abstinence violation effect" (demoralization that results in forsaking recovery efforts and escalation of AOD use), and
- equates health (recovery) with the absence of pathology rather than global measures of health and functioning.

Miller concluded: "…it may be useful, for both clinical and research applications, to abandon the term 'relapse' and focus instead on concepts and models that are more descriptive of the normal course of human behavior change" (Miller, 1996, p. S26). It is our intent in this essay to revive and extend Miller's discussion and recommendation.

Lapse/Relapse: Health Condition or Moral Choice?

The way that we as a culture and as service professionals talk about and perceive people with AOD problems affects how we care for them and whether or not we are willing to invest in helping them find long-term recovery. It makes a difference if they are perceived as having a legitimate health condition requiring medical care or perceived as sinful or recalcitrant misfits and criminals. If AOD problems are seen as the consequence of a brain disease that erodes volitional control over AOD-taking decisions, people seeking recovery will be deemed worthy of care and support. If people seeking recovery are viewed as moral agents who have failed to exercise full volitional control over their decisions, they will be viewed as deserving punishment for their perceived refusal to stop using alcohol and other drugs. If post-treatment AOD use decisions can be profoundly influenced by changes in the neural circuitry of the brain—as suggested by recent scientific studies (e.g., see review by McKay and colleagues, 2006)— then exclusively moral or characterological depictions of AOD-use decision-making need to be seriously re-evaluated if not discarded.

The moral overtones imbedded within the *lapse/relapse* terms are manifested in the following ways addiction treatment programs have responded to persons using AOD after the initiation of professional treatment.

1. They may be administratively discharged (also called disciplinary discharge or therapeutic discharge) for becoming symptomatic during their care—making addiction treatment the only arena of health care where a patient can be thrown out of treatment for exhibiting a symptom of the condition being treated.
2. If they return to treatment, they may be punished (refused admission without a firm referral to other treatment) on the grounds that they had their chance (and blew it!). They may also be told that further treatment in this setting would be counterproductive for them and demoralizing to people receiving care for the first time. Such policies would be unthinkable for other health conditions. In the medical treatment of other health problems, a treatment that does not result in symptom alleviation is followed by adjustments in the treatment or different treatment, not punishment of the patient.
3. They may be subjected to arbitrary time periods that must pass before they will be considered for re-admission, a requirement unthinkable in other health care settings.
4. They may be required to commit to a longer (and more life-disrupting) period of treatment, although it may be the same type of treatment previously received. This suggests that the responsibility for post-treatment resumption of AOD use is a personal failure and not the failure of the treatment provided or the lack of post-treatment support.

5. People returning to treatment are often subjected to a variety of shaming rituals as a condition of re-entry. As a result, when people who resume AOD use following their discharge from treatment are asked why it took them so long to return to treatment, their answers resound with the theme of shame.
6. People re-entering addiction treatment are subjected to pejorative labels that lower staff expectations related to their long-term recovery outcomes. Terms like *retread* and *frequent flyer* are all too common.

The effects of the term *relapse* extend far beyond the treatment environment. The moral judgment that has historically been attached to the term *relapse* sets the stage for disaffiliation (e.g., divorce, family estrangement, social shunning, job loss, loss of housing), disenfranchisement (e.g., loss of parental rights, denial of access to public benefits), and sequestration (e.g., violation of probation/parole and imprisonment). More recently, efforts to cast addiction as a "chronically relapsing disease" may inadvertently misrepresent recovery outcomes and create a "no-fault" condition, meaning that it is expected that people will resume using alcohol and drugs because that's part of the condition. This perspective renders treatment programs and those seeking recovery "equally powerless to battle with the fates" (Brown, 1998, p. 2518; White & McLellan, 2008).

Event or Process?

Depicting addiction and recovery as binary states demarcated only by the initiation or cessation of AOD use is challenged by a growing body of research suggesting these states are more aptly described on a more graded continuum. In fact, it may be helpful to think of that continuum marked by three broad zones of action and experience: 1) a stage of excessive, compulsive, and problematic AOD use, 2) a stage of recovery stability, and 3) a transitional stage in which people pass back and forth between addiction and recovery. This third transitional stage is important in escaping the definition of lapse/relapse as a self-encapsulated behavioral event. Recognition of this broader continuum and its three stages acknowledges several key understandings and raises important questions.

- The earliest steps of the recovery process begin in active addiction, e.g., via destabilization of addiction and incremental steps towards the transition stage. What self, family, and professional intervention strategies could be utilized to speed the destabilization of addiction and movement into the transition zone?
- The act of alcohol or drug use following sustained abstinence is preceded by a destabilization of recovery and entrance into the transition zone—a period in which interventions could be targeted to re-stabilize recovery. Substantial work has been achieved on identifying the precursors to recovery destabilization (e.g., decreased self-efficacy, negative emotional states, isolation, negative social support, interpersonal conflict, traumatic distress, exposure to AOD-using environments).
- The transition zone represents more than the status of AOD use and encompasses broader changes in global health/distress—*global* here embracing the physical,

cognitive, emotional, relational, occupational, and spiritual (broadly defined in terms of life meaning and purpose) aspects of one's life. What patterns of change within these dimensions typify the most common stages of long-term recovery and the recurrence of addiction? How can increases in recovery capital in these other areas be used to prime pro-recovery decisions related to AOD use?

- The transition zone is more than addiction but less than recovery. It is experienced as a war of conflicting needs and desires in which incongruent ideas, emotions, and behaviors co-exist—though with considerable disharmony, e.g., wanting to get high and also wanting to stop using, reading recovery literature or calling hotlines while intoxicated, making recovery support meetings but maintaining contact with using peers, and sustained emotional discomfort—both drug-free and drug-intoxicated. How can addiction ambivalence be increased to heighten motivation for recovery and recovery ambivalence decreased to reduce vulnerability for re-addiction?
- Entry and directional movement within the transition zone are marked by catalytic experiences that can move one toward recovery (e.g., transformational change experiences, participation in recovery mutual aid groups) or toward a reactivation of addiction (e.g., craving, selective memory, selective attention, emotional distress, exposure to drug cues) and are also marked by personal responses to those experiences (e.g., successful or failed coping strategies). How can recovery self-management skills be most effectively enhanced?

All of these understandings—many the product of existing *relapse prevention* research—call for a language that is process-focused rather than event-focused. While embedded in such a process, there remains what McKay and colleagues (2006) depict as a "moment of truth"—a decision that results in use or continued abstinence (and the further decisions that follow). This process of recovery erosion and that final act of crossing out of recovery back into active AOD use needs greater illumination. We support the expansion of existing research on what has been christened *relapse*, but suggest that what is being studying warrants a more precise and morally neutral language.

Toward a Morally Neutral Language

Choosing words that work within the AOD problems arena is not easy. Such terms must work at many levels--personal, family, professional, social, and policy. The fact that a word choice often works at one level but not other levels produces constant tension to shift from one word or phrase to another. The debate continues because these words matter to the lives of affected individuals and families. They matter to the professionals charged with the care of these individuals and families, and they matter to industrial and community economies. Billions of dollars can be transferred from one industry to another and one community to another (with the concomitant rising and falling of professional careers) based on a shift in words that moves cultural ownership of AOD problems from one arena to another (e.g., from the criminal justice system to specialty sector addiction treatment, or vice versa; White, 2004).

The existing *lapse/relapse* language matters at all of these levels, and to some extent, this language has worked. References to *relapse* are commonly heard in any

arena in which AOD problems are discussed. The term captures the essence of the problem with addiction—that the act of stopping AOD use is often not the end of the addiction story and is often a cyclical benchmark in prolonged addiction careers. *Relapse prevention* has been a core idea in the modern personal and professional management of addiction recovery (e.g., Marlatt & Gordon, 1985). The prevention of relapse has been a central goal in the design of exemplary programs ranging from drug courts to physician health programs. Given this evident utility, why should we change the lapse/relapse language?

The answer to this question, as we have suggested, is that the lapse/relapse language has harmful side-effects for affected individuals and families, for professional models of problem intervention, and for communities affected by AOD problems. The use of a morality-based language to depict the prolonged, cyclical course of substance use disorders misidentifies the essential etiology of these disorders (as a problem of moral character rather than brain disease), fails to look at contextual (e.g., treatment-related, environmental) factors that also influence in-treatment and post-treatment AOD use, and contributes to punitive rather than corrective approaches to long-term recovery management. We are not proposing that the functions and skills traditionally embraced within the rubric of relapse prevention be abandoned, but we are suggesting that these arena be rechristened with language that is more behaviorally precise and less personally stigmatizing.

So how do we depict the resumption of AOD use in a person who has committed himself or herself to sustained sobriety? Such a language should meet several key criteria.

First, it should help individuals, families, and professional helpers understand and label such events or processes and suggest future strategies for their prevention. What is needed is a medical language that has not been imbedded with the moral baggage contained in the words *lapse/relapse*. That term or phrase may not yet have been coined.

Second, the ideal language should encourage individuals experiencing AOD problems to assume personal responsibility for resolving these problems. The “slip” vernacular of Alcoholics Anonymous may not be ideal in that the term implies an accident over which one has no control. Considerable effort has been extended in AA to generate folk wisdom that places responsibility back on self, e.g., “If you don’t want to slip, stay away from slippery places,” “a slip is a premeditated drunk,” etc. The vernacular for relapse in Narcotics Anonymous reflected in the slogan “don’t pick up” places greater emphasis on drug use as a personal decision and act.

Third, the language should be capable of depicting the resumption of AOD use in the context of a larger process rather than an inexplicable act—more a process of drift than a singular decision. The *lapse/relapse* language is event-focused rather than process-focused. The ideal replacement for *lapse/relapse* should convey the physical, cognitive, emotional, spiritual, and social processes that precede and trigger the act of resuming AOD use.

Fourth, while promoting personal responsibility and accountability, the language should also reflect an understanding that extra-personal factors (e.g., the family and social environment, the quality of particular treatment protocols) also influence post-treatment AOD use.

Fifth, the language should be able to distinguish levels of severity of symptom reactivation. The distinction between lapse and relapse seeks such a distinction but does so in less than ideal language.

Some Preliminary Recommendations

Language that meets the above criteria and that fully works at personal, family, professional, and community/cultural levels may not be possible, and will not be possible without sustained discussion and debate across multiple stakeholders. We have offered quite specific language recommendations in the past (White, 2001, 2002, 2004, 2006; White & Kelly, 2010), but our recommendations here are less clear. As a starting point for discussion, we offer some closing thoughts about the future of the lapse/relapse language within the addiction, addiction treatment, and recovery support arenas.

1. *Individuals and families who are seeking to resolve AOD problems should be encouraged to embrace or construct whatever language works for them (i.e., serves as a catalyst for positive change).* These sense-making and change-eliciting metaphors may differ across the stages of recovery, and they also differ markedly within and across cultural settings. The lapse/relapse choices may "work" for many until better language emerges without their unintended side effects.
2. *Recovery mutual aid groups and recovery community organizations may choose to use one set of words for intra-group communication to convey the resumption of AOD use and another set of words for communications to the public.* It has been our experience that language that works at a personal level for intra-group communication (e.g., use of the term *recovering* to depict recovery as a life-long process) may not work for extra-group communication (e.g., use of the term *recovered* to avoid the public interpreting *recovering* to mean that people never really recover from addiction). There may be multiple sets of language emerging to span this range of communication venues.
3. *Professional references to lapse and relapse and future alternatives to such terms should apply only to a return to AOD use and related problems AFTER evidence of stabilization of the substance use disorder.* We would propose that any AOD use before 90 days of voluntary cessation of AOD use in the community constitutes not a return of a substance use disorder, but a continuation of the disorder. The absence of AOD use in a controlled environment does not constitute evidence of such stabilization. In short, reactivation of a disorder cannot occur until the disorder has first been deactivated. Much of what in the addictions and related fields is characterized as lapse or relapse behavior actually constitutes continued symptoms of a disorder that has not been brought into stable remission. Similarly, brief episodes of abstinence often constitute brief respites in one's addiction career, not a milestone of recovery.
4. *The terms lapse and relapse should be dropped from the professional lexicon of the addictions field and be replaced by more morally neutral, behaviorally descriptive, and medically precise language.*

5. *The professional addictions field should embrace a person-centered, strengths-based language that focuses not on pathology but the reality and processes of long-term recovery*. We recommend that "relapse prevention programs" be reframed and redesigned as "recovery support programs." The focus should be more on what is being embraced rather than what is being avoided.
6. *In defining alternatives to lapse/relapse, the field should focus on language that embraces all dimensions of recovery rather than just the status of using or not using alcohol or other drugs*, e.g., terms like wellness, global health, quality of life, life meaning/purpose, community inclusion, and citizenship that capture broader dimensions of personal and social health.
7. *The common contention that "relapse is part of recovery" should be abandoned. Relapse is NOT part of recovery*. A resumption of alcohol and drug use is an expression of the disorder, not of the recovery process.
8. *In defining alternatives to lapse/relapse, the field should elevate language that focuses on recovery-supporting skills (e.g., resist, desist, refuse) rather than language that conveys a process of passively succumbing to AOD use.*

The table below illustrates possible alternatives to the lapse/relapse language.

Common Language	**Problem**	**Language Alternatives**
John *relapsed* after his discharge from addiction treatment.	Language implies moral failure.	John *resumed* (or *reinitiated*) drinking following his discharge from addiction treatment. John experienced a *recurrence* of his alcohol dependence four months after his discharge from addiction treatment.
John is a chronic *relapser*.	John ceases to be a person through such objectifying language. He becomes instead a "thing"—a category.	John is a person who has experienced recurring episodes of alcohol-related problems. John continues to experience intermittent episodes of substance use. John has not yet achieved stable recovery in the community.
John has *relapsed*, but things are not as bad as they used to be.	Language conveys degrees of John's "badness."	John is in *partial remission* from alcohol dependence. John continues to experience some alcohol-related problems, but he has reduced the frequency and intensity of his drinking.

John has not *relapsed* since his last treatment.	Focus is on what John has not done rather than what he has achieved.	John has maintained stable recovery. John's alcohol dependence is currently in *full remission*. John is a person in long-term recovery: he has not used alcohol or other drugs since _____ (date)—or for _____ years (See Faces and Voices of Recovery, 2009).
John needs to go through a *relapse prevention* program/plan.	Relapse prevention is a negative framing of recovery—a focus on what behavior is to be eliminated from one's life rather than what is to be added, e.g., sickness prevention orientation versus health promotion orientation—the equivalent of a baseball hitting coach focusing on "strikeout prevention."	John could benefit from a program of sustained *recovery management* (or *recovery support*—strategic increases in personal, family, and community recovery capital). John needs a *recovery plan*. Focus is not on subtracting but adding three defining elements of recovery: sobriety, improvement in personal and family health, and positive connection to community (citizenship) (Betty Ford Institute Consensus Panel, 2007).
Relapse is part of recovery.	This normalizes the presence of pathology as a dimension of recovery. For persons with severe substance use disorders, AOD use is part of the disorder, NOT part of the healing process. (See earlier discussion of "Transition Zone").	Addiction is often characterized by cycles of excessive AOD use/problems interspersed with voluntary or coerced periods of abstinence. Recovery is the replacement of these cycles with stable and sustained health. While this process may be marked by diminished frequency and severity of AOD use, depicting such use as a dimension of the recovery experience is a misnomer.

Like other essays on language in this extended series, it is hoped that this latest essay will stir discussion and debate. Challenging prevailing language in the addictions field is not an attempt to forge a politically correct lexicon; it is about forging language that can best incite and sustain long-term addiction recovery and create a community milieu in which such recoveries are welcomed and supported. We don't expect that the

lapse/relapse language will be shed quickly, but if anti-stigma campaigns achieve increased momentum and effectiveness, we do think the *lapse/relapse* language will be more critically evaluated and eventually abandoned. It is time for this discussion to begin anew.

About the Authors: William L. White is a Senior Research Consultant at Chestnut Health Systems and a volunteer consultant for Faces and Voices of Recovery. Sadé Ali is Deputy Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services.

Acknowledgement: This topic was addressed at the request of the Philadelphia Department of Behavioral Health and Mental Retardation Services. We would like to thank William Miller for his pioneering essay on the relapse language and John Kelly, Pat Taylor, Tom Hill, Paul Poplawski, and Pat Scoles for their comments and suggestions on early drafts of this paper.

References

Ali, S. (2010). *One size shouldn't ever fit all: Moving toward making your services more person-directed*. Philadelphia Department of Behavioral Health and Mental Retardation Services.

The Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*, 221-228.

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

Faces & Voices of Recovery. (2009). *Recovery messaging from Faces & Voices of Recovery*. Retrieved March 29, 2010 from http://www.facesandvoicesofrecovery.org/publications/recovery_messaging/about_recovery.php.

Kelly, J. F. (2004).Toward an addiction-ary: A proposal for more precise terminology. *Alcoholism Treatment Quarterly, 22*, 79-87.

Kelly, J. F., Dow, S., & Westerhoff, C. (in press). Does our choice of substance-related terminology influence perceptions of treatment need? An empirical investigation with two commonly used terms. *Journal of Drug Issues*.

Kelly, J. F., & Westerhoff, C. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*, 202-207.

Maisto, S. A., Pollock, N. K., Cornelius, J. R.. Lynch, K. G., & Martin, C. S. (2003). Alcohol relapse as a function of relapse definition in a clinical sample of adolescents. *Addictive Behaviors, 28*, 449-459.

Marlatt, G. A. (1996). Taxonomy of high-risk situations for alcohol relapse: Evolution and development of a cognitive-behavioral model, *Addiction, 91*, S37-S50.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

McKay, J., Franklin, T., Patapis, N., & Lynch, K. (2006). Conceptual, methodological and analytical issues in the study of relapse. *Clinical Psychology Review*, *26*(2), 109-127.

Miller, W. R. (1996). What is relapse? Fifty ways to leave the wagon. *Addiction*, *91*(Supplement), S15-S27.

Miller, W. R., & C'de Baca, J. (2001). *Quantum change: When epiphanies and sudden insights transform ordinary lives*. New York: Guilford Press.

Simonelli, M. C. (2005). Relaspe: A concept analysis. *Nursing Forum*, *40*(1), 3-10.

Substance use disorders: A guide to the use of language. (2004). Prepared by TASC, Inc. under contract for the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS).

White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2001). The rhetoric of recovery advocacy. In W. White, (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement* (pp. 37-76). Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

White, W. (2002). An addiction recovery glossary: The languages of American communities of recovery. In W. White (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement* (pp. 225-288). Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

White, W. (2004). The lessons of language: Historical perspectives on the rhetoric of addiction. In S. Tracy & S. Acker (Eds.), *Altering American consciousness: Essays on the history of alcohol and drug use in the United States, 1800-2000* (pp. 33-60). Amherst: University of Massachusetts Press.

White, W. (2006). *Let's go make some history: Chronicles of the new addiction recovery advocacy movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

White, W. (2007a). The new recovery advocacy movement in America. *Addiction, 102*, 696-703.

White, W. (2007b). Language and recovery advocacy: Why we worry about the words. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*, Winter, 1, 3.

White, W., & Kelly, J. (2010). *Alcohol/drug/substance "abuse": The history and (hopeful) demise of a pernicious label*. Retrieved from www.facesandvoicesofrecovery.org.

White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor, 9*(3), 24-33.