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Recovery: Its History and Renaissance as an Organizing Construct Concerning Alcohol and Other Drug Problems

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Abstract

Characterizing the resolution of severe alcohol and other drug problems in moral (reformation), religious (redemption), psychological (reconstruction), criminal (rehabilitation), or medical (recovery, remission) language reflects larger conceptualizations of the sources, solutions and claims for institutional ownership of alcohol and other drug problems. This article traces the history of the concept of recovery in America as applied to alcohol and other drug problems and describes the addiction field's evolution through problem (pathology) and intervention (treatment) paradigms to the call for a recovery paradigm as its central "governing image."

Key words: addiction recovery, recovery advocacy, recovery paradigm, history

Recovery: Its History and Renaissance as an Organizing Concept

Professional fields are often birthed to meet the needs of a culture at a particular point in time. Their survival or extinction depends to a great extent on how well the profession and its institutions are able to evolve from a problem paradigm (defining the problem in a way that creates and sustains the profession claim to cultural ownership of the problem) through an intervention paradigm (developing, institutionalizing and refining problem resolution technologies with perceived effectiveness and value) to a solution paradigm (achieving sustainable, visible proof that the problem definitions and proffered technologies "work"). These evolving organizing models reflect what Room (2001) has characterized as "governing images" within the alcohol and other drug (AOD) problems arena. Governing images are concepts that imply particular frameworks of problem definition, intervention and resolution. In an earlier essay (White, 2004a), the author

described the evolution of the addictions field's conceptual center from a focus on pathology (the study of AOD problems as medical diseases) to treatment (medical/psychiatric/psychological interventions into AOD problems) to recovery (prospects and processes for long-term resolution of AOD problems). This essay elaborates on this proposition by describing the history of the concept of recovery and the call to make recovery the "governing image" of a maturing addictions field.

The Discovery of Recovery

A dramatic rise in alcohol consumption in the late 18th and early 19th centuries led to a shift from moral/religious/legal conceptualizations to medical conceptualizations of chronic drunkenness—a shift that was subsequently applied to the chronic use of opium, morphine, and cocaine. This "discovery of addiction" (Levine, 1978) led to new ways of characterizing alcohol and other drug-related problems and the processes through which such problems could be resolved. The intemperate drunkard became first the inebriate, then the dipsomaniac, and then the alcoholic/addict. The source of alcohol problems shifted from moral character to the disease processes of inebriety, dipsomania, alcoholism, and addiction. The perception of chronic drunkenness shifted from a characterologically-rooted assertion of volitional choice (a bad person choosing to do bad things) to a biologically-rooted disease of the will (a good person doing bad things over which he or she has limited volitional control). The perception of the solution to these problems at an individual level shifted from vice and reformation (moral model) to sin and redemption (religious model) to sickness and recovery (medical model).

The roots of the medical model can be traced to a social reformer (Anthony Benezet, 1774), a physician (Benjamin Rush, 1784) and a member of the clergy (Lyman Beecher, 1827). In this new medicalized view, chronic drunkenness was defined as a medical disorder (an "odious disease" that "resembles certain hereditary, family and contagious disease") (Rush, 1784, p. 8). The word *cure*, rather than *recovery*, was initially applied to the resolution of drunkenness as it was similarly applied to the reversal of other disorders of health. Optimism about cure was inherent in Benjamin Rush's early call to create special institutions for the care of the inebriate (Rush, 1810). Where *cure* placed the center of focus on the medical professional, the term *recovery* both extended the time frame involved and shifted the focus to the actions and experience of the person making the transition from chronic drunkenness to stable sobriety. Dr. Samuel Woodward made one of the earliest references to the term *recovery* as applied to addiction when he called for the creation of inebriate asylums.

God forbid that we should erect asylums for our own children! But God forbid, if our own children become drunkards, that they should fail to find asylums for seclusion and recovery! (Woodward, 1836, p. 29)

Three years earlier, Gerrit Smith (Sigorney and Smith, 1833) had penned an essay entitled "Reformation of the Intemperate" in which he described thirty-eight cases of *reformed* drunkards. Smith noted the public sentiment that the drunkard was beyond *cure*, but provided evidence of the permanent "reformation of intemperate persons." The

transition from Smith's "reformation" to Woodward's "recovery" marks a significant shift from moral to medical frameworks of understanding the source and solution to severe and persistent alcohol problems.

Sobriety-based and moderation-based mutual support groups flourished in the mid-nineteenth century, but nearly all of these groups—the Washingtonians, the fraternal temperance societies, the ribbon reform clubs, the Businessmen's Moderation Society—viewed the personal solution to drunkenness as a process of moral and religious reformation achieved through public commitment to sobriety or restricted consumption (pledge signing), mutual surveillance and support, and rescue work with other drunkards. The "drunkards tales" (alcoholic biographies and autobiographies) of this era characterize the transition from chronic drunkenness to stable sobriety using a variety of terms: "reformation," "restoration" (of body, mind and social position), "redemption," "repentance," "rebirth," "resurrection," "rescue and deliverance," and "liberation" (see Gale, 1842; Woodman, 1843; Green, 1849; Gough, 1870; Berry, 1871; McKenzie, 1875).

There was an emerging consciousness that achieving sobriety following chronic drunkenness was an on-going process rather than point-in-time "pledge of perpetual hate to all that can intoxicate" (Gale, 1842). This process came to be understood as something more than a renunciation of alcohol and a sobriety resolution. Harrison reported in 1860 that the Washingtonian Society of Boston "fitted up rooms under their hall for the temporary accommodation of reformed, or rather, reforming, men". The debate over whether abstinent alcoholics were *recovered* or were *recovering* had begun. A portion of this debate emerged from the growing realization that recovery required and involved more than the absence of drinking. McKenzie declared in 1876 that, "The only safety for men who have once yielded to their appetite for drink, is in a change of heart, involving a complete change of life." While the terms *recovery* and *recovered* appear a few times in this literature (e.g., McKenzie, 1876, p. 94), their use generally refers to the brief period of physical convalescence following an acute drinking episode rather than the broader and more sustained resolution of addiction to alcohol. There are only occasional references to a larger understanding of an inebriate having "recovered from their [distilled spirits or intemperate habits] power" (Gale, 1842, p. 75).

As inebriate homes and asylums spread between 1860 and the end of the 19th century, the nation's first inebriety specialists viewed inebriety as a disease and used the term *recovery* to depict the inebriate's return to health. Dr. Albert Day in his 1867 text, *Methomania*, spoke not only of recovery for his patients, but even suggested the concept of "partial recovery"—dramatic improvements in the functioning of chronic drunkards who had yet to achieve sustained abstinence (Day, 1867, p. 33). Dr. Robert Parrish, the driving force behind the founding of the American Association for the Cure of Inebriety, similarly spoke of "recovery from a life of inebriation to a life of sobriety" and noted the ability of some inebriates to "recover naturally, that is of their own unaided efforts" (Parrish, 1886, pp.84, 126) Parrish went on to describe recovery as an enduring process that required what today would be called relapse prevention.

The paroxysms may be arrested, prevented, or controlled, by becoming familiar with the prodromic symptoms, and giving timely heed to their admonitions by the use of remedial measures. (Parrish, 1886, p. 181)

Pioneers like Parrish did not view the transition from perpetual drunkenness to enduring sobriety as a moral decision (pledge signing) or as an outcome of religious experience (conversion, redemption). They instead viewed recovery as a sustained process requiring both medical supervision and the inebriate's active and sustained participation in his or her own convalescence. These first addiction medicine specialists called for the quarantine of the inebriate where "he could be treated for his malady until he recovered" (Crothers, 1893). In their view, the disease of inebriety proceeded "either to recovery or death" (Willet, 1877, p. 14). The literature of the inebriety treatment movement sustained its proposition that intemperance was a disease but vacillated between references to cure and references to recovery, with the latter eventually replacing the former (Proceedings, 1870-1875).

Recovery: Lost and Found

Most inebriate homes and asylums and recovery mutual aid societies collapsed during the opening decades of the twentieth century. The medicalization of alcohol problems faded in a wave of pessimism about the prospects of long-term recovery from alcohol and other drug addiction (White, 1998). The alcoholic was again seen as incorrigible, and the solution to drunkenness shifted from personal reformation or rebirth to depriving the present and future drunkards' legal access to alcohol. In the wake of growing stigma attached to alcoholism, a new generation of addiction specialists tried to explain that hope for recovery would be poor for any disease that came under treatment so late. They argued that good recovery rates were possible but only if treatment was provided earlier in the course of alcoholism (Cooper, 1913, p. 97). But amidst the rising stigma of alcoholism and the drives for county, state and then federal Prohibition, professional advocacy for treatment and recovery waned and the public voices of recovering people fell silent.

A psychotherapy clinic established at the Emmanuel Church in Boston in 1906 marked a pocket of continued hope for recovery from alcoholism. The clinic, which integrated medicine, religion, and psychology in the treatment of alcoholism, trained lay therapists who had been successfully treated for alcoholism at the clinic. Courtenay Baylor, the first of the Boston lay therapists, described this resolution of alcoholism in terms of "recovery" and "reconstruction"—the latter referring to fundamental changes that had to occur in the alcoholic's personality (Baylor, 1919, p. 38). Richard Peabody, the most famous of the lay therapists, later abandoned the concept of recovery, embracing instead a demedicalized view of the source and solution to alcoholism. Peabody saw alcoholism not as a disease of the body but as a "disease of immaturity" that required the alcoholic (who Peabody characterized as a "spoiled child"), not to recover, but to grow up via a reconstruction of personal character. When this moral and psychological reconstruction had occurred, the alcoholic was viewed not in a state of continuing recovery but as a person who had "rid himself of his habit once and for all"—"an ex-alcoholic" (Peabody, 1933, pp. 170-171, 187). The Emmanuel Clinic was joined by a new generation of private hospitals and sanatoria that boasted of their abilities to treat alcoholism. For a brief time, the concept of *cure* again competed with the concept of *recovery*.

The founding of Alcoholics Anonymous (AA) in 1935 marked the re-emergence of *recovery* as a word and concept centrally linked to the resolution of alcoholism. The first (1939) edition of AA's basic text contained more references to *recovery* than any previous text, using the term *recovery* in the book's subtitle (*The Story of How More Than One Hundred Men Have Recovered from Alcoholism*) and proclaiming its purpose to describe "PRECISELY HOW WE HAVE RECOVERED" (caps in original text). Various forms of the word *recovery* appear more than 70 times in the first edition of AA's "Big Book" (Alcoholics Anonymous, 1939).

AA portrayed the resolution of alcoholism not as a decision or an event but an enduring process. It is with AA that we see the movement of *recovery* from a peripheral to a central, organizing construct. Prior to AA, the word *recovery* tended to imply the extended convalescence often required to reverse the physical ravages of alcoholism. It is in AA that we find the term used as the central concept depicting the ongoing cognitive, emotional, behavioral and spiritual reconstruction of the sobered alcoholic. Also significant was AA's shift in emphasis from recovery initiation (how to stop drinking) to recovery maintenance (how to not start drinking) and from chemical sobriety to "emotional sobriety" (Wilson, 1945). Positive coverage of AA by the American press in the mid-twentieth century stirred a resurgence of faith in the prospects that at least some alcoholics could permanently stop drinking. AA declared in the first edition of its basic text: "We are not cured of alcoholism. What we really have is a daily reprieve contingent on the maintenance of our spiritual condition" (AA, 1939, pp 104-105). The focus had shifted again from cure to recovery as a time-extended and multi-dimensional process.

Recovery, Treatment, and Backlash

Alcoholics Anonymous was part of a larger "modern alcoholism movement" that between 1935 and 1970 redefined America's conception of alcoholism and the alcoholic (Johnson, 1973; Roizen, 1991). The centerpiece of the modern alcoholism movement was a set of "kinetic ideas" that focused on the nature of alcoholism ("is a disease") and the alcoholic ("can be helped" and "is worthy of help") (Anderson, 1942; Mann, 1944). Through the efforts of the National Committee for Education on Alcoholism (the precursor to today's National Council on Alcoholism and Drug Dependence), the federal, state and local investment in alcoholism education and treatment expanded with a fully developed alcoholism field emerging in the 1970s. Public support for alcoholism treatment rose as Americans came to see alcoholism in medical rather than moral terms and as the popular image of the alcoholic shifted from that of the "Skid Row" wino to that of a family member, friend, neighbor or co-worker. Recovery also became more visible as many prominent Americans publicly declared their recovery from alcoholism in the late 1970s.

The eventual fruits of the modern alcoholism movement included a multi-billion dollar treatment industry; a broadened conceptual and institutional scope from alcoholism to chemical dependency, substance abuse, and addiction; the extension of the latter into the realm of "process addictions" (excessive and harmful relationships with people, work, money, gambling); and a shift in focus from the nature of AOD problems to the availability of effective interventions ("Treatment Works"). All were embraced within an amorphous, highly commercialized "recovery movement" that became something of a cultural phenomenon in the late 1980s and 1990s (White, 1998), with one social commentator referring to it as "recovery fever" (Blau, 1991). This phenomenon was marked by an explosive growth of Alcoholics Anonymous, the adaptation of AA to virtually every human problem, a recovery publishing boon, and an unending parade of celebrities entering and returning from "rehab."

The brief super-success of the recovery movement was followed in the 1990s by a backlash to this movement. The backlash took many forms, including attacks on the medicalized concept of addiction (Davies, 1997; Schaler, 2000), criticisms of the conceptualization of addiction as a disease (Fingarette, 1989; Peele, 1989); and challenges to the related concept of co-dependency (Kaminer, 1992; Katz and Liu, 1991). There were also sustained attacks on

addiction treatment (Peele and Brodsky, 1991) and on Alcoholics Anonymous and other Twelve Step programs (Bufe, 1991; Ragge, 1998; Peele and Bufe, 2000). There were financial backlashes against the treatment industry in the form of an aggressive system of managed care that led to the downsizing or closure of many hospital-based and private addiction treatment programs. These ideological and financial backlashes unfolded within the larger restigmatization, demedicalization and recriminalization of AOD problems during the 1980s and 1990s (White, 2000).

A Recovery Renaissance

In the wake of ideological and financial backlashes against the ill-defined and highly commercialized “recovery movement” (Kurtz, 1995), there is an emerging recovery renaissance within the alcohol and other drug problems arena.

In the sphere of recovery mutual aid, there are increasing varieties of Twelve Step experience (Kurtz and White, 2003), increasing numbers of adjuncts and alternatives to Twelve Step programs (Humphreys, 2004; White, 2004b), and a growing celebration of the diversity of American communities of recovery (White, 2000, 2002).

At national policy levels, this focused attention on recovery is evident in:

- President Bush’s Access to Recovery Initiative which expands funding for recovery support services, broadens the range of agencies who can provide such services, and increases consumer choice in selecting providers of recovery support services (<http://www.whitehousedrugpolicy.gov/treat/initiative.html>).
- the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse’s growing interest in the biological foundations of recovery, patterns and styles of long-term recovery, and development of new, post-detoxification, pharmacological aids to recovery.
- the Center for Substance Abuse Treatment’s Recovery Community Support Program (<http://www.treatment.org/Topics/archive/rcsp.htm>) which has sought to involve recovering people and their families and allies in the enhancement of treatment and recovery support services, and Recovery Month activities which have promoted recovery-themed public education and recovery celebratory events (<http://www.recoverymonth.gov/2002/links.htm>).
- private foundation support for recovery-focused treatment system enhancements, e.g., Robert Wood Johnson’s \$9.5 million Paths to Recovery Initiative to enhance addiction treatment access and retention (<http://www.pathstorecovery.org/>)

There are also national efforts to survey the “recovery community” (Road to Recovery, 1998) and mobilize recovering people and their families into a “new recovery advocacy movement” (White, 2000). This movement is visible at a national level through the Faces and Voices of Recovery Campaign (www.facesandvoicesofrecovery.org) and is visible at state and local levels through the growing network of recovery advocacy organizations (e.g., www.ccar.org), a vibrant “wellbriety movement” in Indian Country (Coyhis, 1999; see www.whitebison.org), and the growth of faith-based recovery ministries, especially in communities of color (Sanders, 2002). Collectively these groups are pushing for recovery representation at AOD-related policy tables, recovery-focused community needs assessment processes, and the development of a full continua of local treatment and recovery support services (White, 2000).

Within the treatment arena, there is also a renewed recovery focus. There are calls to get treatment reconnected to the larger and more enduring process of recovery and to shift the focus of treatment from initiating recovery in the institutional environment to anchoring recovery within

the client's natural environment (White, 2002). There are calls to shift addiction treatment from an acute model of care (assess, admit, treat, discharge) to a model of long-term recovery management (RM) (White, Boyle, and Loveland, 2002; Edwards, Davis, and Savva, 2003; Moore and Budney, 2003). The (RM) model parallels approaches used in the treatment of other health disorders characterized by chronicity, course variability, and functional fluidity (McLellan, Lewis, O'Brien and Kleber, 2000; Dennis, Scott and Funk, 2003). There are also increased experiments with "peer-oriented recovery support services", recovery-focused service roles (recovery coaches/mentors/guides), and expanded recovery support structures (self-directed recovery homes) (Jason, et al, 2001).

In the arena of clinical research, there are researchers (e.g., Keith Humphreys, Alexandre Laudet) specializing in the study of recovery support groups, as well as calls for a recovery research agenda (White, 2000; Edwards, Davis, and Savva, 2003), increased meetings between researchers and recovery advocates, and significant new studies of post-treatment monitoring and recovery support services (Godley, Godley, Dennis, Funk & Passetti, 2002; Dennis, Scott and Funk, 2003).

A New Recovery Paradigm

This emergence of the recovery concept as a governing image for the field could be simply a passing fad or it could mark a major shift in the central organizing constructs that have shaped American responses to AOD problems. I have argued (White, 2004a) that this renaissance of interest in recovery is the latter. The pathology paradigm has focused on the nature of AOD problems and the nature of individual vulnerability to such problems. It has been based on the assumption that discovering the sources of AOD problems will provide keys to their resolution. Work within this paradigm has deeply enriched our understanding of addiction and has led to many refinements in the treatment of substance use disorders. The intervention paradigm has focused on methods and strategies of resolving AOD problems. This paradigm has been based on the assumption that the evaluation of active responses to AOD problems (whether at social policy levels or through individual-focused early intervention and treatment programs) will result in evidence-based solutions to these problems. The cumulative work within this paradigm has revealed both the benefits and limitations of addiction treatment as it is currently delivered in the United States. Recovery advocates and their professional allies within the treatment and research arenas are calling upon America and the addictions field to move beyond its central focus on AOD problems and their treatment to a more fully developed recovery paradigm. The assumption is that enduring solutions already exist to AOD problems in the lives of hundreds of thousands of individuals and families and in many communities and that a greater understanding of these individuals, families and communities will reveal more global solutions to AOD problem.

Advocates of the emerging recovery paradigm are calling upon treatment agencies and personnel to become more knowledgeable of, and involved within, local communities of recovery. They are pushing treatment programs to shift their focus from acute interventions to models of long-term recovery support services. Recovery advocates are calling for an intensification of pre-treatment recovery support services that strengthen the engagement process, enhance motivation for change, remove environmental obstacles to recovery, determine whether the individual/family can initiate and sustain recovery without formal, professionally-directed treatment services, or link the individual/family to the most appropriate treatment services. This recovery paradigm also suggests an intensification of in-treatment recovery support services to enhance treatment retention and enhance transfer of learning from institutional to natural environments. It is altering the nature and duration of the traditional service relationship. And it is shifting the focus of treatment from acute stabilization to post-treatment recovery management, e.g., post-stabilization monitoring (recovery check-ups), stage-

appropriate recovery education, recovery coaching, active linkage to communities of recovery, recovery community resource development, and early re-intervention. Creating recovery-oriented systems of care will require a reconceptualization of the continuum of care, changes in the selection and training of care providers and a reformulation of systems of service reimbursement. Some states (e.g., Connecticut and Arizona) have formally begun this process.

The concept of recovery as a governing image has had a long birth and a stormy adolescence but is poised to emerge as the central organizing construct within the addictions field. That emergence represents not so much an alternative to the pathology and treatment paradigms as a developmental extension of these earlier paradigms. That said, the recovery paradigm could dramatically alter the future of addiction treatment and broader responses to AOD problems in America.

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