

WHITE, W. (2014). GUEST BLOG: INTERVIEW WITH WILLIAM WHITE. RECOVERY RESEARCH INSTITUTE / HARVARD MEDICAL SCHOOL. ACCESSED DECEMBER 1, 2014 AT [HTTP://WWW.RECOVERYANSWERS.ORG/BLOG/INTERVIEW-WITH-WILLIAM-L-WHITE/](http://www.recoveryanswers.org/blog/interview-with-william-l-white/)

INTERVIEW WITH WILLIAM L. WHITE



William L. White is an Emeritus Senior Research Consultant at Chestnut Health Systems / Lighthouse Institute and past-chair of the board of Recovery Communities United. Mr. White has a Master's degree in Addiction Studies and has worked full time in the addictions field since 1969 as a streetworker, counselor, clinical director, researcher and well-traveled trainer and consultant. He has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 17 books. His book, *Slaying the Dragon - The History of Addiction Treatment and Recovery in America*, received the McGovern Family Foundation Award for the best book on addiction recovery. Mr. White's sustained contributions to the field have been

acknowledged by awards from the National Association of Addiction Treatment Providers, the National Council on Alcoholism and Drug Dependence, NAADAC: The Association of Addiction Professionals, the American Society of Addiction Medicine, and the Native American Wellbriety Movement.

In *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, you discuss on page 511 that “a science of addiction will have little relevance until it is accompanied by a science of recovery and a science of prevention.” What types of steps do addiction researchers and funders need to make in order to shrink this “gap”?

This comment reflects my belief that addiction science for more than 150 years has been a pathology-obsessed science. We know far more about the problem of addiction than we do about addiction-related resistance, resilience, and recovery. What is needed is a fully developed recovery research agenda that explores the prevalence, pathways, stages, styles, and durability of long-term personal and family recovery, including research on how to best break intergenerational cycles of addiction and related problems. It's an embarrassment that at this late stage of the field's development, and after billions of dollars in research expenditures, we still do not have answers to some of the most basic questions that arise within the processes of personal and family recovery. The field's infatuation with the problem has left elucidation of the solution (resistance, resilience and recovery) as the field's missing link. The stakes in this are high at personal, family, and cultural levels. For example, I believe that our obsession with the neurobiology of addiction and public portrayal of addiction as a brain disease will actually result in increased stigma and discrimination until there are tandem communications about the

prevalence, processes and personal and social fruits of long-term recovery.

The current research paradigm assumes that solutions will be found within studies of addiction pathology—its prevalence, patterns, and neurobiological and developmental pathways. A complementary and yet to be fully tested paradigm would involve equal emphasis on the study of recovery solutions that already exist in the lives of millions of individuals, and then extracting principles and practices from those lived solutions that can be professionally applied and publicly disseminated. Our two national addiction research institutes—[NIDA](#) and [NIAA](#)—need to bring recovery advocates, clinical leaders and the research community to the table to formulate and implement a fully-developed recovery research agenda and to establish systems to transfer knowledge garnered from this agenda to people seeking and in recovery, to addiction treatment and allied professionals, and to the public.

What do you think is the biggest accomplishment for the field of addiction and recovery to date?

Modern addiction treatment as a system of care achieved two things. First, it displaced the worst of the despicable interventions that historically preceded it, e.g., fraudulent boxed and bottled home cures, mandatory sterilization laws, “drunk tanks” in city and county jails, “foul cells” in community hospitals, prolonged institutionalization in psychiatric institutions, indiscriminate application of chem- and electroconvulsive “therapies,” prefrontal lobotomies, and toxic and potentially lethal drug therapies, to name a few of the worst. Second it diverted people with severe, complex, and chronic addictions from systems in which they had been shunned, extruded, and mistreated to a system of care designed specifically to address their needs. This new system of addiction treatment provided two equally critical elements to individuals and families affected by alcohol and other drug problems: A system free

from contempt and moral judgment, and a system committed to the treatment of addiction as a primary problem guided by a core base of knowledge and clinical technologies that distinguished it from other helping professions. That emerging system of care forged in the mid-twentieth century had many imperfections, but it far exceeded anything that preceded it both in its compassion and its clinical capabilities. While cultural and institutional ownership of alcohol and other drug problems continues to be contested, the basic federal/state/local and public/private partnerships that built a national network of specialized addiction treatment resources have been sustained as has access to specialized addiction treatment services. That survival for nearly half a century is itself a notable achievement.

What would you say is the most important aspect of current treatment and support? Why is it so important?

Most people who experience alcohol and other drug problems resolve these problems on their own. Addiction treatment stands as a safety net for those individuals with the most severe, complex and prolonged of such problems—individuals with the highest levels of personal vulnerability and the lowest levels of personal, family, and social recovery capital. For the latter individuals, professionally-directed addiction treatment offers the assistance needed to initiate and sustain recovery when prior personal and mutual aid efforts have failed to sustain recovery stability. There are hundreds of thousands of individuals in long-term recovery today who would not have achieved such recoveries in earlier eras when such specialized treatment and a broad range of recovery supports were not available. That is a modern public health success story that should be widely celebrated.

Why is continued care after detox so important for maintaining sustained remission and recovery? What types of programs are available?

There is one discovery at the heart of specialized support for addiction recovery. That lesson is that a brief period of abstinence or decelerated use does not in itself constitute a sustainable solution to addiction. In fact, such periods of respite are as apt to be a milestone in a prolonged addiction career as they are a milestone of entry into long-term addiction recovery. Individuals, families and professional helpers have too often mistaken such temporary flights into health as sustainable recovery. The beginning of wisdom in addiction recovery—at personal and professional levels—is the recognition that what is required to sustain recovery is quite different than what is required to initiate recovery. Medical or social detoxification programs—and brief treatment programs—can help initiate recovery more effectively and more safely than at any time in human history, but such brief stabilization does not on its own represent a sustainable achievement. It only addresses acute life-threatening medical crises and provides a window of opportunity for movement towards long-term recovery maintenance. What we know from research on the course of recovery is that the point of recovery stability (point at which risk for lifetime recurrence of a substance use disorder drops below 15%) is 5 years—the same remission stability point often noted for cancer survivors. What this means is that acute biopsychosocial stabilization needs to be followed, particularly for those with the most severe and complex addictions, by sustained professional, peer, and family support.

Looking at where treatment has come from historically, what do you think the trajectory of addiction treatment is in the next 25 years?

I think we will progressively disentangle widely varying patterns of drug problems and the solutions most suitable for each pattern. For the most severe of such problems, I have described five stages of recovery: 1) precovery (a recovery incubation period that rises within active addiction), 2) recovery initiation and stabilization, 3) the transition to recovery maintenance within one's natural environment or a new family/social environment, 4) enhanced quality of personal and family life in long-term recovery, and 5) efforts to break intergenerational cycles of addiction and related problems. We currently do exceptional work on the second of these stages, but we reach people too late (far into their addiction careers), we abandon them too soon (long before the transition to recovery maintenance and other developmental tasks of recovery have been mastered), and we have no widely utilized technologies focused on enhancing the resilience of the children of those we serve. Over the next 25 years, we will become more effective at treating less severe forms of alcohol and other drug problems, and we will become much more effective in treating the most severe and complex of such disorders. Efforts in both areas are already well under way. We would transform the state of public health in America if we were as successful at supporting the other four stages of addiction recovery as we are in supporting recovery initiation and stabilization (stage 2).

I think another great breakthrough in the next 25 years will be finding exceptionally potent combinations and sequences of interventions that will dramatically improve long-term recovery outcomes. For example, right now advances in psychosocial recovery supports and advances in medication-supported recovery often exist in isolation and as warring ideological camps. I think the future lies in the integration of services once thought to be incompatible. The turning point in the history of AIDS was discovering that treatments used in isolation that did little to alter the AIDS mortality rate could, when uniquely combined and

sequenced, transform the trajectory of this disorder. I think the same thing is possible with recovery from addiction.

What is the message that you would like the general public to learn about recovery?

Here is my top 10 list:

1. Addiction recovery in America is quite prevalent but, until recently, culturally invisible, with more than 23 million Americans and their families now reporting that they once personally experienced, but no longer experience, alcohol and or other drug-related problems.
2. There are multiple (secular, spiritual, and religious) pathways and styles of recovery and all are cause for celebration.
3. Addiction recovery is contagious: It can be interpersonally transmitted from people in recovery and their professional allies to people actively addicted.
4. At a community level, addiction recovery is spread by recovery carriers—people in recovery who make recovery infectious through the quality of their lives, their character, and their visible message of hope to others.
5. The density of recovery carriers within a community can be strategically increased, opening potentially new strategies for community outreach and long-term recovery support.
6. Communities can address problems of addiction, in part, by openly inviting and eliciting recovery commitments from its addicted citizens (“Recovery by any means necessary under any circumstances”) and by providing local landscapes (the physical, psychological, and social spaces and the policy environment) in which recovery can flourish.
7. The creation of recovery landscapes—science-based professional care, recovery mutual aid organizations, recovery support institutions (recovery community centers/homes/schools/industries/ministries) and vibrant local recovery cultures—shift the focus of support from one of “recovering from” to one of “recovering to” a meaningful and contributing life in the community.
8. There are whole communities wounded by addiction and related problems that are in need of a collective, community-wide recovery process; people in recovery can play a key role in sparking and supporting this healing process.
9. Recovery can give back to individuals, families and communities a portion of the toll addiction has taken.
10. People who were once part of the problem can be culturally mobilized to become part of the solution.