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Frontiers of Recovery Research

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Good morning, I am humbled by the opportunity to offer some brief reflections on the future of addiction recovery research. I will use this time to explore some of the critical "why, what, and how" questions related to the emerging specialty of recovery research.

Why

First is the question of why an explicitly defined recovery research agenda is needed. Four primary arenas of knowledge, or ways of knowing, exist within the alcohol and other drug problems (AOD) arena: 1) experiential knowledge, 2) common or public knowledge—popular folklore or myth, 3) professional/clinical knowledge, and 4) scientific knowledge. Whole libraries could be filled across these domains with what has been published on addiction and its related pathologies and brief clinical interventions, but until recently, only a few shelves would suffice for what is known from the standpoint of science about the prevalence, pathways, processes, styles, and stages of long-term personal and family recovery.

At the turn of the 21st century, people in recovery and their allies launched a new recovery advocacy movement. They proposed shifting the center of the AOD problems arena from pathology and brief intervention paradigms to a resilience and recovery paradigm. Recovery advocates championed the reality of recovery and challenged the professional/scientific community to measure its population prevalence. They affirmed the existence of multiple pathways of recovery and challenged scientists to map such pathways. They argued that recovery is as dependent on previously dormant internal and external assets as on personal vulnerabilities and pleaded with the professional and scientific communities to extend their focus from pathology assessment to the assessment of personal, family, and community recovery capital. They lamented that some of the most critical questions related to long-term recovery had yet to be addressed by the research community and pleaded with us to address such questions.

We are here in great part to affirm the legitimacy and importance of those requests and to celebrate the early fruits of the resulting work. The shift to a recovery paradigm, and within that shift pursuit of a recovery research agenda, is filled with unmarked hazards and opportunities. Such

a shift requires exploration of some of the most controversial and contentious issues within the alcohol and other drug problems field, with outcomes profoundly affecting individuals, families, organizations, and communities. Thus, the need for venues like our gathering today to carefully weigh the possibilities and pitfalls on our journey toward a science of addiction recovery.

What

The second foundational issue involves the most critical questions that need to be addressed within a recovery research agenda. I will briefly note twelve critical dimensions of recovery that warrant our focused attention.

1. *Definition and Measurement of Recovery* Recent controversies over the proper definition of recovery underscore its import to multiple stakeholders. No science of addiction recovery is possible without a working definition that meets the criteria of precision, inclusiveness, exclusiveness, measurability, acceptability, and simplicity. Comparing research findings across studies is only possible and productive with a shared definition of recovery and common elements of measurement. The implications of such a definition extends far beyond the scientific community to who is married or divorced, who retains or loses custody of their children, who goes to jail or is freed, who is hired or fired, who is approved or disapproved for a loan, who is accepted or rejected for college admission, who is deemed worthy or unworthy as a friend, and so forth. Recovery definitions and measures that serve our research agenda must move beyond vague, aspirational language to achieve the clarity and precision that its import demands.

2. *Neurobiology of Long-term Recovery* Tremendous progress has been made in recent decades in unraveling the neurobiology of addiction, while far less attention has been devoted to unraveling and disseminating information on the neurobiology of short- and long-term addiction recovery. People seeking and in recovery and their caregivers need normative data on the degree and stages of neurobiological repair following recovery initiation, and caregivers need science-informed guidelines on how to best provide stage-specific recovery support. Pathology-focused scientific findings that elicit despair and professional/public passivity are distorting and counterproductive if they do not include recent research findings on brain resilience and recovery that inspire hope and recovery aspirations.

3. *Incidence and Prevalence of Recovery* As a field, we meticulously measure year-to-year trends in the incidence and prevalence of drug use and the toll of addiction via death, disease, and multiple social cost categories, but have, until recently, remained clueless on parallel trends on the incidence and prevalence of recovery. Recent recovery prevalence and life in recovery surveys are challenging many prevailing myths about addiction recovery. Such efforts need to be systematized via integration into existing population-based substance use and broader public health surveys. Targeted interventions are not possible unless we are able to regularly measure with whom and where recovery is and is not flourishing. Recovery prevalence constitutes a valuable form of community recovery capital; we need to know if that capital is increasing or decreasing and what populations are and are not achieving recovery.

4. *Resolution and Recovery across the Severity Spectrum* Alcohol and other drug problems exist on a spectrum of severity, complexity and chronicity, and their course and outcome are highly influenced by levels of internal and external recovery capital. Studies of alcohol and other drug problems in clinical populations generally portray such problems as severe, self-accelerating over time, and resolved primarily through involvement in specialized addiction treatment, post-treatment recovery mutual aid participation, and lifelong drug abstinence. Studies of AOD problems in community populations conclude that most

such problems are mild to moderate, transitory, resolved without specialized professional care or formal peer recovery support, and are most often resolved via maturation, change in life circumstances, improved coping skills, and deceleration rather than complete cessation of drug use. The challenge we face as a field is avoiding indiscriminately transferring knowledge acquired from one population to the other as we disentangle, reconcile, and disseminate these findings.

5. *Pathways and Styles of Recovery Across Diverse Geographical/Cultural/Religious Contexts and Clinical Subpopulations* With and without complete drug abstinence. Sudden transformative change versus incremental change. Partial, full, and amplified recovery. Secular, spiritual, religious pathways of recovery. With and without embrace of a recovery identity. With and without participation in a recovery mutual aid fellowship. With and without specialized treatment. With and without medication support. Single versus multiple pathway involvement (dual citizenship in recovery). Pathway transitions over time in recovery. The risk of recovery pathways that inflict harm in the name of help. The work of mapping recovery pathways and styles is at an early stage and must be expanded and completed as a science-grounded guide for individuals, families, and caregivers.

Exploring the varieties of addiction recovery across diverse contexts has begun but is far from complete. The extent to which existing knowledge about addiction recovery is applicable across different geographical, cultural, or religious contexts remains unclear. There is evidence, for example, of distinct cultural pathways of recovery within communities of color, but the prevalence and variability of such pathways within these communities remains a mystery. Also unclear, is the potential for injury in the misapplication of mainstream concepts and practices drawn from existing research to populations not included within those foundational research studies. Given the long history of harm in the name of help in addiction treatment, such risk of iatrogenesis must be examined as future studies map the growing varieties of recovery experience and expose any potential risks for exploitation or harm found within those varieties.

6. *Recovery Across the Life Cycle* The bulk of what we know from the standpoint of science about addiction and recovery is based on studies of people entering specialized addiction treatment in mid-life at late stages of addiction. This resulting knowledge base has until recently excluded two critical groups: 1) adolescents and transition-age youth, and 2) older adults. How is recovery different when it is initiated at age 15 rather than at age 35 or 45? What special obstacles and opportunities exist when recovery is initiated early or late in one's life. Research touching on such questions can have life and death consequences. For example, there is considerable evidence that a point of recovery stability and durability is reached after 4-5 years of continuous recovery, but an exception to this rule exists among a subset of people who experience addiction recurrence after decades of recovery stability. What factors contribute to such recurrences? How can rapid re-stabilization of recovery be best achieved in these circumstances? These are the kinds of critical questions that lie unanswered within the existing body of addiction-related science.

7. *Stages of Recovery* Let's for a moment posit five stages of long-term addiction recovery: 1) precovery—a period of recovery incubation/priming, 2) recovery initiation and stabilization, 3) transition to long-term recovery maintenance, 4) enhanced quality of global health and social functioning in long-term recovery, and 5) efforts to break intergenerational cycles of addiction and related problems. Nearly everything we know about recovery from the standpoint of science is based on the study of people in the stage of recovery initiation. If we consider the possibility that distinct stages of recovery exist and that support needs of individuals and families evolve across these

stages, then the mapping of these stages, identifying stage-dependent needs, and evaluating stage-sensitive recovery support interventions becomes a critical recovery research agenda item. We have yet to create a comprehensive model of how problem severity/complexity, recovery capital, and service needs evolve across the long-term stages of addiction and recovery.

8. *Social Transmission of Recovery* One of the central discoveries of the recovery advocacy movement is imbedded within the slogan, "recovery is contagious," meaning that recovery can be socially transmitted and does not depend solely on the ebb and flow of intrapersonal motivation. Where the latter is often conceived as a pain quotient ("hitting bottom"), recovery advocates extoll instead the role of hope conveyed by exposure to "recovery carriers/champions"—people who make recovery infectious based on the power of their personal story and the quality of their character. Such processes of recovery transmission require disentanglement and testing as to whether recovery prevalence could be significantly increased by elevating the density of recovery carriers within a social network or local community. This potential also calls for research into recovery cascades—sudden and dramatic surges in recovery initiation--and the factors that incubate and sustain such cascades. The key question is whether it would be possible to strategically shorten addiction careers and extend recovery careers, amplifying years of recovery achievements and reducing the cumulative toll of addiction-related harm to individuals, families, and communities.

9. *Family Recovery* Stephanie Brown and Virginia Lewis conducted one of the first in-depth studies on the effects of addiction recovery on the family and drew an unexpected conclusion. They found that recovery initiation could destabilize families whose relationships, roles, rules, and rituals had for years or decades been frozen into self-protective but toxic patterns over the course of active addiction. Depicting this demand for radical recovery readjustment as the "trauma of recovery", Brown and Lewis called for scaffolding of support through the family reconstruction process. Studies are needed that inform the family recovery process and that can guide caregivers in the design and construction of the most effective family support scaffolding. Considerable attention has also been given to the intergenerational transmission of alcohol and other drug problems, but far less attention to mechanisms that may be used to break such cycles and promote intergenerational resistance, resilience, and recovery.

10. *Recovery Management and Recovery-oriented Systems of Care* In the closing years of the twentieth century a growing number of recovery advocates and addiction professionals expressed concern that addiction treatment had become disconnected from the processes of long-term recovery—that far too many patients were being recycled through ever-briefer episodes of treatment without achieving long-term recovery stability. This sparked calls to extend acute care models of addiction treatment to models of sustained recovery management nested within larger recovery-oriented systems of care (ROSC), with systems defined not as the treatment system but the larger mobilization of recovery support resources within the community. Emerging ROSC models involved assertive outreach and early intervention, global and strengths-based assessment protocol, partnership- rather than expert-based service relationships, evidence-based and integrated treatment methods, assertive linkage to indigenous recovery resources, prolonged post-treatment monitoring and support, and, if and when needed, early reintervention. The application of chronic disease principles and practices from primary medicine to the most severe, complex, and chronic substance use disorders offers great promise but requires rigorous and long-term evaluation.

As research scientists, we isolate and evaluate the effects of narrowly defined interventions, but I suspect the greatest

breakthroughs in enhancing future recovery outcomes will not lie within a single new personal or environmental intervention. They will instead lie in finding interventions that when uniquely combined or sequenced generate dramatically amplified recovery effects. What might well lie in our future is the bio/psycho/social/spiritual equivalent of the cocktail that radically altered the course and outcome of AIDS. We need solutions that mirror the complexity of the problems we face. The future lies in moving beyond fixed treatment "programs" to "treatment and recovery support menus" whose clinical and non-clinical recovery support services can be personally combined and sequenced across the stages of personal and family recovery. Those of you here may well determine whether this is a random, intuitive, or science-guided process.

11. *New Recovery Support Institutions, Service Roles, and Recovery Cultural Production* For more than 150 years, recovery mutual aid societies and professionally directed addiction treatment have coexisted as the two specialized institutions offering support to people seeking recovery from addiction. In the past 25 years, new recovery support institutions and roles have emerged that reach people at earlier stages of addiction and offer support over the long-term course of recovery. These new institutions include recovery advocacy organizations, recovery community centers, recovery residences, recovery high schools and collegiate recovery programs, recovery-focused employment programs, recovery ministries, recovery cafes, and recovery-focused sports and leisure activities. Newly conceived peer recovery coaches and recovery support specialists are serving in a wide variety of contexts. And people in recovery are expressing and celebrating their recoveries through the vehicle of recovery cultural production in the arenas of language, literature, art, music, theatre, film, and public recovery celebration events.

Collectively, these represent efforts to expand community spaces/landscapes in which recovery is welcomed, supported, and celebrated. There is a robust body of scientific knowledge about addiction treatment and recovery mutual aid societies, but only a paucity of research on these new recovery support institutions/roles and the extension of intrapersonal research to studies of the physical and social ecology of addiction recovery.

12. *Flourishing/Thriving in Recovery* Traditionally, addiction recovery has been viewed as a process of subtraction—deleting drug use and its progeny of allied problems. But a singular message across most recovery pathways is that recovery is far more than just the removal of drug use and related problems. Recovery in the view of recovery advocates also involves processes of addition (enhancement in global health and functioning and positive reconstruction of the person-community relationship) and the potential for processes of multiplication (getting "better than well" via enhanced acts of citizenship and community service). The study of thriving, flourishing, and mindful citizenship is one of the exciting frontiers of recovery research. We know a great deal about the cost addiction inflicts on individuals, families, and communities, but, until recently, little if anything has been revealed about the assets that recovery returns to the community.

How

The third foundation question involves the processes through which recovery research should be designed, conducted, and disseminated. Put plainly, most of the published studies on addiction recovery have not been directly informed by people in recovery nor have the fruits of such research reached the people in greatest need of science-grounded information on recovery. In this regard, all recovery research efforts could benefit from earlier work on cross-cultural research and the risk of cultural appropriation. We must scrupulously avoid cultural theft: representing ideas and language drawn from recovering individuals and communities of recovery as our own creation without proper

respect, permission, acknowledgement, or explanation of the source and historical and cultural context in which such ideas and language were developed. There are two related issues and strategies of import: 1) the need for recovery representation, and 2) the potential for recovery research coproduction.

Assuring recovery representation within recovery research addresses three concerns: 1) the adequacy of recovery representation (beyond token inclusion), 2) the authenticity of recovery representation (avoiding the problem of "double agentry"—masking of hidden personal/institutional interests behind the claim of recovery status), and 3) diversity of recovery representation (demographic, cultural, and recovery pathway diversity).

Recovery research coproduction goes beyond representation to a state of co-ownership in which people in recovery participate with other research team members on an equal footing. This would mean that recovery representatives are involved in all aspects of a study, including topic refinement, instrument development, site selection, subject recruitment, crafting informed consent procedures, data analysis, interpretation of findings, selection of publication outlets, co-authorship or acknowledgement of contributions, selection of post-publication information dissemination outlets, and co-ownership of study data.

The goals of recovery representation and coproduction go beyond enhancing study quality to first adhering to the ultimate ethical guideline "First do no harm"—in this case, to recovering individuals and families and their associated social institutions. Recovery representation and coproduction will also help assure study utility. It is not enough to publish recovery research findings in access-restricted scientific journals via papers couched in the equally inaccessible arcane language of science. What is needed is not just the conduct of recovery research, but the liberation of recovery research knowledge to people for whom that knowledge involves life and death decisions. To that end, people in recovery have a key role in shaping the why, what, and how of recovery research and in shaping study conclusions, dissemination venues, and the language through which study implications are publicly communicated.

Coproduction involves reciprocity of benefit. If value (e.g. indigenous knowledge) is extracted from a community through a research enterprise, then analogous value should be returned to that community by those responsible for the conduct of the research. If value (e.g., profit, prestige) accrues to those leading a research enterprise, then analogous value should be shared with the subjects/community under investigation or their representative institutions. We have many topical and methodological aspects of recovery research to explore, but we must include in that process the ethics and etiquette of recovery research.

Closing

In closing, let me say that a now passed and aging generation of recovery advocates dared dream of a science of addiction recovery. We envisioned and worked for years towards a day when research scientists from diverse backgrounds would be called to pursue a well-funded recovery research frontier. Today with the opening of this event, our hearts are soaring. The degree to which our dreams will be fulfilled is in the hands of those of you here today.