Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61. Posted at **www.williamwhitepapers.com**

The Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates

William White, MA and Ernest Kurtz, PhD

ABSTRACT

The study of alcohol and other drugs (AOD) is historically marked by three stages: 1) the investigation of AOD-related social and personal pathologies, 2) the development of personal and social interventions aimed at resolving AOD problems, and 3) a focus on the prevalence and patterns of long-term recovery from AOD problems. This essay honors this transition from addiction and treatment paradigms to a recovery paradigm by exploring the growing varieties of pathways and styles through which people are resolving serious and persistent AOD-related problems. A review of scientific and mutual aid literature is used to catalogue variations in:

- *scope of recovery (primary and secondary chemical health and global health),*
- *depth of recovery (partial, full, and enriched),*
- *types of recovery (abstinence-based, moderation based, medication assisted),*
- *context of recovery initiation (solo, peer assisted, treatment assisted),*
- *frameworks of recovery initiation (religious, spiritual, secular),*
- *temporal styles of recovery initiation (transformative change, incremental change, drift),*
- *recovery identity (positive, neutral, negative),*
- *recovery relationships (acultural, bicultural, and enmeshed styles; virtual recovery),*
- *recovery stability/durability (At what point does present remission predict future remission?), and*
- *recovery termination (Is recovery ever completed?).*

After exploring the wide diversity of recovery styles and experiences that exist within Twelve-Step fellowships and other recovery mutual aid societies, the article explores the implications of the wide diversity in recovery experiences to the design and conduct of addiction treatment.

Keywords: addiction recovery, natural recovery, transformative change, stages of change, virtual recovery, religion, spirituality, and secularity.

ADDICTION, TREATMENT, AND RECOVERY PARADIGMS

Alcohol- and other drug-related (AOD) problems constitute a significant public health problem within American and world history (Lender & Martin, 1982; Musto, 1999; Courtwright, 2001). Responses to these problems over the past two centuries reflect three organizing paradigms. From the late eighteenth century through the era of alcohol prohibition, pathology provided an organizing framework, whether religiously or medically conceived. The pathology paradigm fueled the debate over whether alcoholism was a sin or a sickness; guided studies of the incidence, prevalence and personal/social costs of AOD problems; and sparked the sustained search for the etiological roots of these problems. The hope upon which the pathology model was built was that knowledge of the scope and sources of AOD problems would generate specific solutions to these problems in the same way isolating and attacking particular pathogens had earlier led to the elimination or control of many infectious diseases. While failing to achieve this ultimate goal to-date, the pathology model has made significant contributions to our understanding of the multidimensional processes that interact to initiate and sustain addiction.

The failure to find the singular pathogen underlying AOD problems led to the testing of numerous strategies and techniques of intervention, both social and personal. To this day, the intervention model buttresses multi-billion-dollar industries aimed at preventing drug use, controlling drug supplies, punishing drug offenders, and treating those with severe AOD problems. The intervention model assumes that the scientific evaluation of AOD-related social policies and biopsychosocial interventions will reveal the most effective prevention, intervention, and control strategies, and that those strategies that can be best matched to particular communities, demographic/clinical subpopulations, and individuals. This model has generated significant new understandings that are sparking widespread calls to bridge the gap between clinical research and clinical practice in addiction treatment.

The historical intractability of AOD problems at a societal level has led to disillusionment with the pathology and intervention paradigms and a recent shift in focus toward resilience and recovery (Morgan, 1995a; Elise, 1999; White, 2000, 2004a). As early as 1984, Edwards was calling for the field to explore the "natural processes of recovery." This was followed by calls for "recovery-oriented psychotherapy" (Zweben, 1986) and "recovery-sensitive counseling" (Morgan, 1995b). The recovery paradigm focuses on at-risk individuals, families, and communities who have avoided the development of severe AOD problems and the lives of individuals, families, and communities with severe AOD problems who have successfully resolved or are resolving these problems. Advocates of this model suggest that studying the lived solutions to AOD problems will reveal principles and strategies upon which broader, more effective social policies and professional interventions can be built (Morgan, 1995a; White, 2005).

Knowledge about AOD problems is substantial, but comparatively little is known from the standpoint of science about the long-term solutions to these problems. In recent epidemiological studies of individuals who once met criteria for alcohol

dependence, 63% to 75% no longer met dependence criteria at the time they were surveyed, suggesting a substantial long-term recovery rate (Helzer, Burnam, & McEvoy, 1991; Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). The Workgroup on Substance Abuse Self-help Organizations (2003) estimates the total U.S. membership of recovery mutual aid groups at more than 1.6 million people and reports that more than six million adults each year have some contact with these groups. In spite of a substantial body of recovery experience in the U.S., the addictions field does not draw its primary knowledge base from this source. Today, addiction professionals routinely assert the existence of multiple pathways of recovery, but from the standpoint of science, we know little about such pathways. As addiction treatment interventions become ever briefer, treatment professionals have less and less contact and knowledge of the long-term recovery process.

AOD problems arise out of quite different personal, family, and cultural contexts and unfold in variable patterns and trajectories. These same forces generate heterogeneous recovery experiences. The goals of this paper are to: 1) conceptually map the diverse patterns and styles of AOD problem resolution, 2) introduce a lexicon through which such variations can be described, and 3) explore the implications of the diversity of recovery experience for the design and conduct of professional interventions into such problems. This conceptual map is based primarily on scientific studies on the course of AOD problems in community and in clinical samples. The literature of multiple recovery mutual aid societies and biographical and autobiographical depictions of recovery are also used to illustrate key findings. We hope this preliminary recovery map will spark new scientific studies of the prevalence, patterns, stages, and personal styles of long-term recovery from AOD problems.

RECOVERY DEFINITION

Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for *substance abuse* or *substance dependence*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational, and occupational health.

AOD problems vary in their course, including adverse reactions to a single episode of AOD-intoxication, problems that span only a few months or years, and problems that span significant periods of one's life. Such problems also vary in their intensity and overall severity, including:

- subclinical problems (transient AOD problems that do not meet DSM-IV criteria for abuse or dependence);
- AOD problems meeting DSM-IV criteria for substance abuse — Clinically significant impairment marked by one or more of the following in a 12-month time period: repeated substance use that results in failure to perform major role obligations, repeated use in situations that are physically hazardous, repeated substance-related legal problems, and continued substance use in spite of adverse AOD-related problems; and
- AOD problems meeting DSM-IV criteria for substance dependence — Clinically significant impairment marked by at least three of the following in a 12-month period: tolerance, withdrawal, loss of control (erosion of volitional control over quantity and duration of use), failed efforts to cease or reduce use; significant time involved in drug procurement, drug use, and recovery from drug effects; social, occupational, or recreational activities forsaken or reduced due to drug use; and continued use in spite of adverse physical or psychological problems

caused by substance use (American Psychiatric Association, 1994).

The term *recovery*, because of its medical connotations, is most applicable to the process through which severe and persistent AOD problems (meeting DSM-IV criteria for substance abuse or dependence) are resolved. Terms such as *quitting*, *cessation,* and *resolution* more aptly describe the problem-solving processes of individuals who have transient and less severe AOD problems. Recovery implies reversal of a greater level of debility and a more involved and enduring problem-solving process (White & Scott, draft manuscript). Our continued discussion of varieties of recovery experience will focus on these more severe forms of AOD problems.

The term *family recovery* conveys the processes through which family members impacted by severe and persistent AOD problems individually and collectively regain their health. Family recovery involves enhanced health across three dimensions: 1) individual family members, 2) family subsystems (adult intimacy relationships, parent-child relationships, and sibling relationships), and 3) the family as a system (redefinition of family roles, rules, and rituals; recovery-conducive boundary transactions with people and institutions outside the family) (White, 1996). The recovery of an addicted family member can destabilize and threaten the survival of the family unit if professional and social supports are not available to soften what Stephanie Brown and Virginia Lewis (1999) have christened the "trauma of recovery" (See also Rouhbakhsh, Lewis, & Allen-Byrd, 2004).

RECOVERY PREVALENCE

Elaborate systems exist to measure the subtlest of changes in the prevalence of AOD use and its consequences, but no similar system exists to measure the incidence and prevalence of recovery from AOD problems. However, individual researchers have conducted long-term treatment follow-up studies and community surveys over the past 25 years that reveal significant recovery rates: 41% (Ojesjo, 1981); 63% (Helzer, Burnam & McEvoy, 1991); 72% (Dawson, 1996); 30% (Schutte, Nichols, Brennan, & Moos, 2001); 59% (Vaillant, 2003); and 48% (Dawson, Grant, Stinson, Chou, Huang, & Ruan, 2005). Factors such as differing demographic and clinical characteristics of study participants and different definitions of recovery influence variations in reported recovery rates.

THE SCOPE AND DEPTH OF RECOVERY

Recoveries from addiction can differ in their scope (the range of measurable changes) and depth (degree of change within each measured dimension). Aborting a destructive relationship with a particular drug or combination of drugs is at the core of addiction recovery, but recovery experiences can range from complete cessation of AOD use in an otherwise unchanged life to a complete transformation of one's personal identity and interpersonal relationships.

There are quite varied trajectories in the relationship between primary and secondary drug use among people seeking recovery from substance use disorders. One pattern of drug dependence can be aborted while a co-occurring pattern continues. For example, there are high rates of nicotine dependence among adults and adolescents before and after treatment for dependence upon alcohol, opiates, cocaine, and cannabis (Maddux & Desmond, 1986; Myers & Brown, 1990; Hughes, 1995, 1996; Bien & Barge, 1990; Hoffman & Slade, 1993).

A second pattern involves the escalation of secondary drug use following cessation of primary drug use, e.g., an increase in alcohol or cocaine use following the cessation of heroin use. Such drug substitution is a common problem in treated adults and adolescents, particularly among those with a history of polydrug use (Vaillant, 1979; Edwards, Duckitt, Oppenheimer, Sheehan, & Taylor, 1983; Toneatto, Sobell, Sobell, & Rubel, 1999; Maddux & Desmond, 1980, 1981, 1992; Anglin, Almong, Fisher &

Peters, 1989; Simpson & Sells, 1990; Carmelli & Swan, 1993).

A third pattern involves individuals who use secondary drugs therapeutically during early recovery to manage acute and post-acute withdrawal and to help ameliorate the psychological stresses of early recovery (e.g., heroin users consuming cannabis following opiate abstinence to prevent relapse) (Willie, 1978; Waldorf, 1983; Biernacki, 1986; Copeland, 1988). In this pattern, secondary drug use ceases or decelerates within the first two years of recovery (Waldorf, 1983; Vaillant, 1979; Copeland, 1988; Bachus, Strang, & Watson, 2000).

The ability to understand when drug substitution is an effective, time-limited strategy for managing early recovery (requiring professional understanding, if not tolerance) and when drug substitution is a mutation of the existing problem (requiring prevention, early intervention, or focused treatment) is an important research agenda. Some investigators have found that secondary drug use is more likely to be problematic for persons with family histories of AOD problems, those who begin AOD use at an early age, and those who experience problems with a secondary drug before developing their primary addiction (Simpson & Sells, 1990; Maddux & Desmond, 1992). Also needed is a greater understanding of how sequential drug problems are resolved over time. The factors that contribute to the cessation of co-occurring dependencies or secondary drug use may differ from those factors associated with the cessation of primary drug use (Downey, Rosengren, & Donovan, 2000).

The scope of recovery can extend far beyond altered patterns of primary and secondary drug use. Historically, the definition of recovery has shifted from a focus on what is deleted from one's life (alcohol and other drugs, arrests for criminal acts, hospitalizations) to what is added to one's life (the achievement of health and happiness). This shift is reflected in such terms as *mental sobriety* (Mental Sobriety, 1946) and *emotional sobriety* — a phrase A.A. co-founder Bill Wilson coined to describe a state of emotional health that far exceeds the achievement of not drinking. Wilson defined emotional sobriety as "real maturity . . . in our relations with ourselves, with our fellows and with God" (Wilson, 1958). This broadened vision of recovery is also reflected in the term *Wellbriety* that is currently being used within the Native American recovery advocacy movement to depict recovery as the pursuit and achievement of physical, emotional, intellectual, relational, and spiritual health, or "whole health" (Coyhis, 1999; *Red Road to Wellbriety*, 2002). Wellbriety within the Native American context is also related to a new set of core *recovery values*: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

Because severe and persistent AOD problems impact many areas of life functioning, recovery from such problems must be measured across multiple *zones* (or *domains*) *of recovery*: 1) the relationship(s) with the substance(s) for which one previously met DSM-IV criteria for abuse or dependence; 2) the presence, frequency, quantity, intensity, and personal and social consequences of secondary drug use; 3) physical health; 4) psychological/emotional/ontological health; 5) family/relational health; and 6) lifestyle health, e.g., a developmentally appropriate, pro-social style of work and leisure (White, 1996). Seen as a whole, the goal of recovery is what we refer to as *global health*.

Like that of other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of *full recovery* (complete and enduring cessation of all AOD-related problems and the movement toward global health) or a state of *partial recovery* (Jorquez, 1983). The term *partial recovery* can convey two different conditions: 1) a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems; or 2) the achievement of complete abstinence or stable moderation, but the failure to achieve

parallel gains in physical, emotional, ontological, relational, or occupational health. Partial recovery can constitute a permanent state, a stage preceding full recovery, or a hiatus in AOD problems with eventual reversion to a previous or greater level of problem severity.

Falling between the parameters of no recovery and full recovery are individuals who cycle in and out of periods of moderate use, problematic use, and abstinence (Hser, Hoffman, Grella, & Anglin, 2001). A recent review of alcoholism treatment outcome studies drew three major conclusions: 1) treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third of those treated, 2) substance use (measured by days of use and volume of use) decreases by an average of 87% following treatment, and 3) substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). People who are constitutionally incapable of permanent sobriety at particular points in their lives may achieve *partial recovery* — significant decreases in AOD-related problems, improved levels of health and social functioning, and significant reductions in the costs and threats they pose to the larger community (Zweben 1996).

Partial recovery is reflected in individuals who cycle through multiple episodes of treatment, recovery initiation, and relapse (Scott, Foss & Dennis, 2005; Dennis, Scott, Funk & Foss, 2005). Such cycling is evidence that recovery is not fully stabilized, but the continued help seeking within such cycles also suggests that addiction is no longer stable. Cycling in and out of recovery (with reduced frequency, intensity, and duration of use episodes) can be a precursor to stable recovery or a chronic state.

Partial recovery can also refer to residual levels of impairment that continue after the cessation or deceleration of AOD use. While most recovering alcoholics establish levels of personal and family functioning comparable to non-alcoholics (Moos, Finney, & Cronkite, 1990; Chapman, 1987), early recovery can be marked by poor levels of adjustment, e.g., depression, anxiety, poor self-esteem, guilt, and impaired social functioning (Kurtines, Ball, & Wood, 1978; Polich, Armor, & Braiker, 1980; Gerard & Saenger, 1962; Behar, Winokur, & Berg, 1984). De Soto and colleagues (1985) distinguished recovery status by length of recovery in a study of 312 members of Alcoholics Anonymous. They concluded that: 1) the early months and years of recovery from alcoholism are marked by continued impairment of emotional and social functioning, 2) these symptoms continue to improve and remit over the first ten years of recovery, and 3) some residual symptoms of cognitive dysfunction may continue in long-term recovery. The achievement of only a partial reversal of alcohol-related cognitive impairments is most common in alcoholics who began their recoveries after long drinking careers (Goldman, 1983; Schutte, 1994, 2001). The principle that global health and functioning improve with earlier onset of recovery and length of sobriety is further confirmed in follow-up studies of persons recovering from cocaine addiction (Selby, Quiroga, Ireland, Malow, & Azrin, 1995).

Some individuals experience changes so profound across these zones of recovery that they come to view addiction and recovery as “gifts” that have brought a depth of experience and meaning far superior to their pre-addiction lives. Such individuals achieve an *enriched state of recovery*. This enriched state of recovery is evident across recovery traditions:

> *The walls crumpled — and the light streamed in. I wasn’t trapped. I wasn’t helpless. I was free, and I didn’t have to drink to “show them.” This wasn’t “religion” — this was freedom! Freedom from anger and fear, freedom to know happiness and love.* (From *Alcoholics Anonymous*, 1976, p. 228.)

> *It is impossible to put on paper all the benefits I have derived . . . physical, mental, domestic, spiritual, and monetary. This is no idle talk. It is the*

*truth. (*From *Alcoholics Anonymous*, 1976, p. 481.)

My life is well-rounded and I am becoming a more comfortable version of myself, not the neurotic, boring person that I thought I would be without drugs…..I have a way to live cleanly, honestly and comfortably. I have all I need. (From *Narcotics Anonymous*, 1988, p. 262.)

It's been a very long, long struggle but worth every single minute of it. I'm really happy to be alive, and life is truly great and wonderful for me right now. (Women for Sobriety member, From Kirkpatrick, 1986, p. 258.)

Back in 1970 I found myself dying from the abuse of my body….The Creator had something he had for me to learn. First, I had to learn who he was. Then I had to learn who I was. I began to visit with my Elders….I had to come to grips with who I am as an Indian, as being a castaway, as being an unloved person. The Creator has love for each of us but we have to find that foundation. (From *Red Road to Wellbriety*, 2002, p. 187.)

A final scope-and-depth dimension of recovery involves individuals who are engaged in concurrent or sequential recovery processes from two or more conditions or experiences, e.g., developmental trauma, psychiatric illness, AIDS. The overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders might be described as *serial recovery*.

PROBLEM SEVERITY AND RECOVERY CAPITAL

Recovery can occur at different stages of problem progression. There are patterns of *high-bottom recovery* among people who have not yet suffered severe losses related to their AOD use. There are also patterns of *low-bottom recovery* achieved by individuals in the latest stages of addiction who have experienced severe personal and social disintegration and anguish before achieving stable recovery (High Bottom, 1949).

In addition to the degree of problem severity, one's recovery capital influences one's prognosis for recovery. *Recovery capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery (Granfield & Cloud, 1999). The interaction of problem severity and recovery capital shapes both the prospects of recovery and the intensity and duration of resources required to initiate and sustain recovery.

PATHWAYS AND STYLES OF RECOVERY

The phrase *pathways of recovery* refers to different routes of recovery initiation. This phrase recognizes the varieties of ways people successfully resolve AOD problems. One of the earliest origins of this notion of paths and choices of recovery frameworks was A.A. co-founder Bill Wilson's 1944 observation that "The roads to recovery are many" (Wilson, 1944). *Cultural pathways of recovery* are culturally or subculturally prescribed avenues through which individuals can resolve alcohol and other drug problems. Such culturally prescribed avenues might be a product of:

- developmental consciousness (e.g., something to be resolved through maturation and assumption of adult role responsibilities),
- medical consciousness (e.g., response to an alcohol-related health problem),
- religious consciousness (e.g., conversion to and/or affiliation with an abstinence-based faith community), or
- political consciousness (e.g., rejection of alcohol as a "tool of genocide").

The phrase *styles of recovery* depicts variations in beliefs and recovery support rituals that exist within particular pathways of recovery. For example, Twelve-Step

programs constitute one of the major pathways of recovery from addiction, but the close observation of several Twelve-Step groups would reveal wide variation in styles of "working the program," e.g., patterns of meeting attendance, approaches to "Step work," conceptualizations of "Higher Power," and utilization of sponsors.

ABSTINENCE-BASED, MODERATION-BASED, & MEDICATION-SUPPORTED RECOVERIES

One of the variations in recovery from substance use disorders involves differences in the ways in which one's relationship with psychoactive drugs is changed. The scientific literature on the resolution of AOD problems documents three such variations. *Abstinence-based recovery* has historically been the culturally prescribed approach to the resolution of severe AOD problems. This approach, which has guided mainstream addiction treatment in the United States in the modern era, calls for complete and sustained cessation of one's primary drug(s) and the non-medical use of other psychoactive drugs (with nicotine and caffeine historically excepted). Over the past several decades, scientific evidence has grown on moderated approaches to AOD problem resolution. *Moderation-based recovery* (the sustained deceleration of AOD use to a subclinical level — continued AOD use that no longer meets DSM-IV criteria for substance abuse or dependence) has triggered great debates in America, spanning the 1976 Rand Report[1], the extended controversies over Mark and Linda Sobell's research at Patton State Hospital[2], and later controversies surrounding Moderation Management, a moderation-based mutual support group (Kishline, 1994). There has also been growing interest in *medication-assisted recovery* (the use of medically monitored pharmacological adjuncts to support recovery from addiction, e.g., detoxification agents, stabilizing agents, aversive agents, antagonizing agents, anti-craving agents, or psychoactive drugs prescribed for the treatment of co-occurring physical or psychiatric disorders).

Discussion of these approaches is best grounded in the finding that substance-use problems exist across a continuum of problem severity and that problem severity influences pathways of problem resolution. Abstinence-based and medication-assisted styles of recovery predominate in patterns of severe alcohol and drug dependence, whereas moderation-based styles of recovery predominate in individuals with lower problem severity and greater recovery capital (younger, married, employed, higher socioeconomic status, higher social support and social stability, positive marital and work relationships) (Finney & Moos, 1981; Polich, et al., 1980; Vaillant, 1983; Armor & Meshkoff, 1983; Edwards et al., 1983; Rosenberg, 1993; Dawson, 1996; Cunningham, Lin, Ross, & Walsh, 2000; Vaillant, 1996).

The moderated resolution of substance use disorders is well documented in general population surveys. Dawson (1996), in a community survey of treated and untreated adults who previously met DSM-IV criteria for alcohol dependence, found that in the year prior to the survey 49.9% were drinking but no longer met criteria for abuse or dependence (27.8% met criteria for alcohol abuse or dependence, and 22.3% were abstinent). Two other studies (one a Canadian national study and the other an Ontario study) used a broader definition of "alcohol problems" and found that 38% and

[1] The initial Rand Report included the finding: "…it appears that some alcoholics do return to normal drinking with no greater likelihood of relapse than alcoholics who choose abstention…" (Quoted in White, 1998). Controversies surrounding this report led to a second report that softened the initial report's findings.

[2] Drs. Mark and Linda Sobell published a series of scientific reports documenting that some alcoholics achieve controlled drinking (Sobell& Sobell, 1973, 1976, 1978). These reports were followed by a re-evaluation by Pendery, Matzman,& West (1982) that challenged the Sobell's findings and their professional integrity. The Sobell weathered blistering personal and professional attacks in spite of being later cleared of wrongdoing by two separate scientific panels (Dickens, Doob, Warwick, & Winegard, 1982; Trachtenberg, 1984).

62.7% (respectively) of those with alcohol problems had later resolved those problems via moderate drinking recoveries (Sobell, Cunningham, & Sobell, 1996). Moderated recovery at much lower rates of prevalence has also been noted in follow-up studies of those treated for alcohol dependence (Finney & Moos, 1981; Rosenberg, 1993; Vaillant 1996) and drug dependence (Levy, 1972; Willie, 1978; Harding, Zinberg, Stelmack, & Michael, 1980). Treatment outcome studies of adolescents have also found a subgroup of treated teens who "may evidence intermittent substance use, typically alcohol, but do not exhibit any ongoing alcohol-or-drug-related problems" (Brown, 1993).

Given the propensity for substance-related problems to wax and wane over time, one could rightly question whether subclinical use following addiction is sustainable. In the longest follow-up study of alcoholic men to-date (60 years), Vaillant (2003) found that 4% of inner-city men and 11% of college men sustained controlled drinking over the course of the follow-up. Most migrated from dependence to efforts at control to eventual abstinence. In the largest and most recent alcohol dependence and recovery prevalence survey (recovery defined as meeting DSM-IV alcohol dependence criteria prior to the last year but not meeting these criteria during the past year), 25% of those with prior alcohol dependence continued to meet dependence criteria, 27% were in partial remission (subclinical symptoms of dependence or presence of alcohol abuse), 12% were asymptomatic risk drinkers (drinking in a pattern predictive of risk for future relapse), 18% were low-risk drinkers, and 18% were abstainers (Dawson et al., 2005). As problem severity declines, the prevalence of moderated outcomes increases. This is most frequently noted in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood but later moderate their substance use (Fillmore, Hartka, Johnstone, Speiglman, & Temple, 1988).

Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting that moderation was an option for some problem drinkers, but not for "alcoholics" like themselves. The following two excerpts reflect their beliefs and attitudes about moderation-based recovery.

> *Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason — ill health, falling in love, change of environment, or the warning of a doctor — becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention* (*Alcoholics Anonymous*, 1939, p. 31).

> *If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people!* (*Alcoholics Anonymous*,1939, p. 42).

Medication-assisted recovery continues to generate considerable controversy within the American culture, within communities of recovery, and within the professional addiction treatment community, in spite of evidence that attitudes toward medications as an adjunct to recovery may be softening (Rychtarik, Connors, Demen, & Stasiewicz, 2000). Influencing these shifts in attitudes are new pharmacological adjuncts in the treatment of alcohol dependence (e.g., naltrexone, acamprosate) and opiate dependence (e.g., clonidine, buprenorphine) (Vopicelli & Szalavitz, 2000).

One of the most widespread approaches to medication-assisted recovery is methadone maintenance treatment (MMT). There are an estimated 900,000 narcotic addicts in the United States and approximately 179,000 individuals enrolled

in MMT (Kreek & Vocci, 2002). The major health policy authorities in the United States have weighed in on MMT and have universally concluded that optimal dosages of methadone combined with psychosocial supports and administered by competent practitioners: 1) decrease death rates of opiate addicts by as much as 50%; 2) reduce transmission of HIV, hepatitis B, hepatitis C and other infections; 3) eliminate or reduce illicit opiate use; 4) reduce criminal activity; 5) enhance productive behavior via employment and academic/vocational functioning; 6) improve global health and social functioning; and 7) are cost-effective (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998; White & Coon, 2003). In spite of such evidence, misunderstanding and social stigma attached to MMT (the perception that MMT simply substitutes one addictive drug for another) leave many in methadone-assisted recovery hiding their recovery status and stories from their employers and co-workers, their friends, and even their own family members (Murphy & Irwin, 1992).

THE CONTEXT OF RECOVERY INITIATION

The context in which people achieve remission from substance use disorders varies considerably and includes styles of solo recovery, treatment-assisted recovery, and peer-assisted recovery.

Solo (natural) recovery involves the use of one's own intrapersonal and interpersonal resources (family, kinship, and social networks) to resolve AOD problems without benefit of professional treatment or involvement in a recovery mutual aid community. This phenomenon is extensively documented in the professional literature under such descriptors as *maturing out* (Winick, 1962, 1964), *autoremission* (Vaillant, 1983; Klingeman, 1992), *self-initiated change* (Biernacki, 1986), *unassisted change* (McMurran, 1994), *spontaneous remission* (Tuchfield, 1981; Anthony & Helzer, 1991), *de-addiction* (Frykholm, 1985; Klingeman, 1991), *self-change* (Sobell, Sobell, & Toneatto, 1991), *self-managed change* (Copeland, 1988), and *natural recovery* (Havassey, Hall, & Wasserman, 1991). Natural recovery is, according to some studies, the most common recovery pathway (Fillmore, et al., 1988; Sobell, Sobell, Toneatto, & Leo, 1993; Cunningham, Sobell, Sobell, & Kapur, 1995; Cunningham, 1999; Sobell, et al., 1996), but the prevalence of this style declines as problem duration and severity increase. Natural recovery is a more viable pathway for people with shorter and less severe AOD problems and for those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell, et al., 1996; Larimer & Kilmer, 2000).

Natural recovery exists across the spectrum of drug choices (Biernacki, 1986; Waldorf, Reinarman, & Murphy, 1991; Klingeman, 1992; Shaffer & Jones, 1989; Cohen & Sas, 1994; Toneatto et al., 1999; Kandel & Raveis, 1989) and seems to be influenced by two age-related patterns: 1) a young adult pattern associated with maturation and the assumption of adult role responsibilities, and 2) a later-life pattern associated with cumulative consequences of alcohol and other drug use (Fillmore, et al., 1988; Sobell, Ellingstad, & Sobell, 2000).

Those who achieve natural recovery report multiple reasons for avoiding formal treatment institutions and mutual aid societies. These reasons include a desire to protect their privacy (aversion to sharing problems with others), a desire to avoid the stigma of being labeled, a belief that they can solve their problems without professional treatment, and a perception that treatment and mutual aid groups are ineffective or not personally suited for them (Tuchfield, 1981; Jordan & Oei, 1989; Cloud & Granfield, 1994; Burnam, 1997; Sobell, Ellinstad, & Sobell, 2000).

Treatment-assisted recovery involves the use of professional help in the initiation and stabilization of recovery. More than 1.5 million people are admitted to addiction treatment in the United States each year, but multiple factors complicate the relationship between treatment and recovery:

- Less than 10% of people with a substance use disorder in the U.S. seek professional treatment in a given year (SAMHSA, 2003), and only 25% of individuals with such disorders will receive treatment in their lifetime (Dawson et al., 2005).
- Addiction treatment in the United States is not a homogenous entity, but a network of service organizations with diverse philosophies and techniques that vary significantly in their effectiveness (Wilbourne & Miller, 2003).
- Those who seek professional treatment are characterized by high personal vulnerability (e.g., family history of AOD problems, lowered age of onset of use, traumatic victimization), greater problem severity and complexity, weaker social supports, fewer occupational opportunities, and less success (Polich, Armour, & Braiker, 1980; Room, 1989; Weisner, 1993; Tucker & Gladsjo, 1993; Cunningham et al., 1995).
- Recovery outcomes are compromised by high treatment attrition rates (more than 50%) (SAMHSA, 2002) and doses of treatment services (measured in days of care or number of sessions) that often fall below standards recommended for optimal effects (NIDA, 1999).
- Individuals may have experienced professional treatment, but such treatment may not have played a role in their later achievement of stable recovery.

In spite of such limitations, the vast majority of persons who suffer from substance dependence (in contrast to less severe AOD-related problems) enter recovery through the vehicle of professionally directed treatment (Cunningham 1999a,b, 2000). But this link is not as direct as one might think. Recent studies have shown that a significant portion of people with the most severe substance use disorders achieve stable recovery only after multiple treatment episodes spread over a number of years (Anglin, Hser, & Grella, 1997; Hser, Grella, Chou, & Anglin, 1998; Dennis, Scott, & Hristova, 2002), suggesting a possible cumulative effect of such interventions.

Peer-assisted recovery involves the use of structured recovery mutual aid groups to initiate and/or maintain recovery from AOD problems. Addiction recovery mutual aid structures of many varieties exist in the United States (see discussion below). Alcoholics Anonymous is the most widely used community resource for the resolution of alcohol-related problems (Room, 1989; Weisner, Greenfield, & Room, 1995), with 3.1% of U.S. citizens reporting having attended A.A. meetings sometime in their life for an alcohol problem and 1.5% reporting attendance at A.A. meetings for an alcohol problem in the past year (Room & Greenfield, 1993). Mutual aid involvement, as measured by studies of A.A., can play a significant role in the movement from addiction to recovery (Timko, Moos, Finney, & Moos, 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Emrick, Tonigan, Montgomery, & Little, 1993; Tucker, Vuchinich, & Gladsjo, 1994; Morgenstern, Labouvie, McCray, Kahler, & Frey, 1997; Humphreys, Wing, McCarty, Chappel, & Galant, 2004). This positive effect extends to:

- adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000; Kelly, Myers, & Brown, 2002),
- women and cultural minorities (Denzin, 1987; Caetano, 1993; Humphreys, Mavis, & Stoffelmayr, 1994; Kessler, Mickelson, & Zhoa, 1997; Bischof, Rumpf, Hapke, Meyer, & John, 2000; Winzelberg & Humphreys, 1999),
- persons experiencing substance use and psychiatric disorders (Meissen, Powell, Wituk, Girrens, & Artega, 1999; Ouimette, Humphreys, Moos, Finney, Cronkite, & Federman, 2001),

- persons using medications to support their recovery (Rychtarik, Connors, Demen, & Stasiewicz, 2000), and
- agnostics and atheists (Winzelberg & Humphreys, 1999; Weiss, Griffin, Gallop, Onken, Gastfriend, Daley, Crits-Christoph, Bishop, & Barber, 2000).

For those seeking support from recovery mutual aid groups, there is a dose effect related to meeting participation. The probability of stable remission rises in tandem with the number of meetings attended in the first three years of recovery (Hoffmann, Harrison, & Belille, 1983; Pisani, Fawcett, Clark, & McGuire, 1993; Humphreys, Moos, & Cohen, 1997; Chappel, 1993). Recovery prospects also rise with the intensity of mutual aid involvement, as measured by active application of program concepts, meeting participation (speaking, interacting, leading), participation in pre- and post-meeting rituals, use of mutual aid networks for fellowship and leisure, reading program literature, being sponsored, sponsoring others, and involvement in other service work (Sheeren, 1988; Cross, Morgan, Moonye, Martin, & Rafter, 1990; Johnson & Herringer, 1993; Emrick et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, & Cohen, 1997). This intensity of participation effect also applies to adolescents (Margolis, Kilpatrick, & Mooney, 2000).

Peer-assisted recovery is also reflected in the growing recovery home movement (most visibly in the Oxford Houses) (Jason, Davis, Ferrari, & Bishop, 2001) and the rapid growth of non-clinical, peer-based recovery support services (White, 2004c).

Natural recovery, treatment-assisted recovery, and peer-assisted styles of recovery are not mutually exclusive. A.A.'s 2004 membership survey reveals that 64% of A.A. members received some type of treatment or counseling prior to joining A.A. and that 65% received professional treatment or counseling after they entered A.A. (Alcoholics Anonymous, 2005). In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to" alcohol and other drugs, 25% reported initiating and sustaining recovery without treatment or mutual aid (Faces & Voices of Recovery, 2001).

RECOVERY INITIATION FRAMEWORKS (RELIGIOUS, SPIRITUAL, SECULAR)

There are considerable differences in recovery styles based on the presence or absence of religion or spirituality as an important dimension of the recovery process. There are *religious frameworks of recovery* (sometimes referred to as *faith-based*) in which severe alcohol and other drug problems are resolved within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship, and support of a community of shared faith. Within various religious traditions, the abandonment of addiction is viewed as a byproduct of the experience of religious conversion/affiliation and the reconstruction of a faith-based personal identity and lifestyle. In this framework, recovery is a divine gift of grace rather than something that one does. Religion is viewed, not as an enriching dimension of recovery, but as the catalytic agent that initiates and sustains recovery (White & Whiters, 2005). Religious pathways of recovery are marked by:

- a religious rationale for the roots of addiction (e.g., the Islamic interpretation of alcoholism as a fruit of the tree of *Jahiliyyah* (ignorance/idolatry) (Badri, 1976);
- a mytho-magical personification and demonization of drugs and the addiction process, e.g., the Islamic interpretation of drink and drunkenness as an "infamy of Satan's handiwork" (Badri, 1976, pp. 3-5);
- a religious rationale for restraint and temperance (e.g., the body as the temple of God) (Bible, 1 Cr 3:16-17; Miller, 1995);

- rituals of confession, restitution, and forgiveness as tools of psychological reconstruction;
- the use of prayer, reading, and service to others (e.g., witnessing) as daily rituals of recovery; and
- enmeshment in a community of faith that meets needs once met within the culture of addiction.

Religious and spiritual frameworks of recovery can closely co-exist. For example, there are societies that help A.A. members who share a particular religious orientation pursue work on A.A.'s Step Eleven: "Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out." Two of the oldest Eleventh Step groups are the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS). Eleventh Step groups usually serve as adjuncts rather than alternatives to A.A. participation (White, 1998).

Spiritual frameworks of recovery overlap with religious pathways of recovery in the sense that both flow out of the human condition of wounded imperfection (what William James, 1902, referred to as "torn-to-pieces-hood"), involve experiences of connection with resources within and beyond the self, and involve a core set of values (e.g., humility, gratitude, and forgiveness) (Kurtz & Ketcham, 1992). Spiritual frameworks of recovery such as Alcoholics Anonymous focus on defects of character (self-centeredness, selfishness, dishonesty, resentment, anger, preoccupation with power and control) as the root of addiction, and provide a means of reaching both into oneself (e.g., self-inventory, developing the traits of honesty, humility, and tolerance) and outside oneself (reliance on a Higher Power, prayer, confession, acts of restitution, acts of service, participation in a community of shared experience) (Miller & Kurtz, 1994; Green, Fullilove, & Fullilove, 1998). Spirituality as a framework of recovery involves the embrace of paradox (e.g., "sober alcoholic"), gaining a degree of control by admitting one's powerlessness, and becoming whole by accepting one's imperfection (Kurtz, 1999). Spirituality as a medium of recovery is rooted in the understanding that: 1) human beings are born with a vacuum inside themselves that craves to be filled with meaning, 2) we can artificially and temporarily fulfill this need through the medium of drug intoxication, and 3) more authentic and lasting frameworks of meaning can displace the craving for intoxication. Religious and spiritual frameworks can overlap (e.g., religion as a vehicle of spirituality) or exist as distinct experiences (spirituality without religion, religion without spirituality). One of A.A.'s innovations was its emancipation of spirituality from its explicitly religious roots.

Secular recovery is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or rituals (prayer). Secular recovery rests on the belief in the ability of each individual to rationally direct his or her own self-change processes. Secular recovery groups view the roots of addiction more in terms of irrational beliefs about oneself and the world and ineffective coping strategies than in terms of biology, morality, character, or sin. Secular frameworks of recovery such as Secular Organization for Sobriety and LifeRing Secular Recovery reinforce the "Big Decision" or "Sobriety Priority" ("not using no matter what") through a variety of cognitive and behavioral self-change techniques. Where spiritual and religious frameworks of recovery involve a transcendence of self, secular frameworks of recovery involve an assertion of self (White & Nicolaus, 2005). Where spiritual frameworks of recovery emphasize wisdom (emphasis on experience, search for meaning, freedom rooted in the acceptance of limitation, self-transcendence by connection to a greater whole, strength flowing from limitation), secular frameworks of recovery emphasize knowledge (emphasis on scientific evidence, an assertion of control, self-mastery through knowledge of self and knowledge of one's

problem, and strength flowing from personal competence).

All three recovery initiation frameworks share what Morgan (1995a) has described as a 1) re-visioning of self, 2) a re-visioning of one's life-context, and 3) a restructuring of life-stance and lifestyle. All three frameworks share a three-part story-style in which people in recovery report "in a general way what we used to be like, what happened, and what we are like now" (Alcoholics Anonymous, 1939, p. 70). And yet listening to these tales of "rescue and renewal" (Morgan, 1995b), one finds critical differences in the instrument of recovery (the grace/gift of having been changed versus personal ownership of that change), different metaphors and rituals used to initiate and sustain recovery, and different views of the role of a community of shared experience in the recovery process.

RECOVERY INITIATION STYLES

There are three styles of recovery initiation: *quantum change*, conscious *incremental change,* and a less conscious process that sociologists refer to as *drift*.

Quantum change, also referred to as *transformational change*, is distinguished by its vividness (emotional intensity), suddenness (lack of intentionality), positiveness, and permanence of effect (Miller and C'de Baca, 2001). Quantum change can occur as a breakthrough of self-perception or insight (an epiphany) or as a mystical or religious experience. Both experiences produce fundamental alterations in one's perception of self and the world. The liberation from alcohol and other drug problems and related changes flow from these core alterations of identity and values. Quantum change is sometimes experienced as a Damascus-type[3] conversion (religious, spiritual, or secular in nature) that precisely and forever demarks addiction and recovery. Such recovery conversion experiences are rooted in calamity — often referred to as "hitting bottom." Recovery-catalyzing breakthroughs have been described in the research literature as an "existential crisis" (Coleman, 1978), a "naked lunch experience" (Jorquez, 1993), a "rock bottom experience" (Maddux and Desmond, 1980), a "brief developmental window of opportunity" (White, 1996), a "crossroads" (Klingemann, 1991, 1992), an "epistemological shift" (Shaffer and Jones, 1989), and a "radical reorientation" (Frykholm, 1985). Quantum change as a pathway of addiction recovery has a long history and is often the ignition point of historically important abstinence-based healing and religious/cultural revitalization movements (White, 2004b). Quantum change occurs in religious, spiritual, and secular forms. Illustrative of this experience is the report of Samuel Hadley, whose religious conversion at the Water Street Mission in New York City marked the beginning of a lifetime of service to God and other alcoholics.

> *Although up to that moment my soul had been filled with indescribable gloom, I felt the glorious brightness of the noonday sun shine into my heart. I felt I was a free man….From that moment till now I have never wanted a drink of whiskey, and I have never seen money enough to make me take one. I promised God that night that if he would take away the appetite for strong drink, I would work for him all my life. He has done his part, and I have been trying to do mine* (Quoted in James, 1902, p. 203).

While there is a tendency to grant a special quality to these recovery conversion experiences, Bill Wilson cautioned against such glorification.

> *There is a very natural tendency to set apart those experiences or awakenings which happen to be sudden, spectacular*

[3] The reference to Damascus refers to the Biblical account of the transformation of Saul of Tarsus, the orthodox Jew and prosecutor of Christians, into St. Paul, the Christian missionary, on the road from Jerusalem to Damascus.

or vision-producing….But as I now look back on this tremendous event [his own transformative change experience]*….it now seems clear that the only special feature was its electric suddenness and the overwhelming and immediate conviction that it carried to me. In all other respects, however, I am sure that my own experience was not different than that received by every AA member who has strenuously practiced our recovery program* (Wilson, 1962).

In contrast to the lightning strike of quantum change, incremental recovery involves a time-encompassing and stage-dependent process of metamorphosis. Researchers have described many stage models of addiction recovery, including:

- Frykholm's (1985) 3-stage model (ambivalence, lengthening periods of abstinence, and emancipation);
- Biernacki's (1986) four-stage model (a resolution to quit either through drift, rational decision, or "rock bottom" experience; a detachment from the physical and social worlds of addiction; managing cravings and impulses and staying clean (abstinent); and becoming ordinary);
- Waldorf's (1983, 1990) six-stage model (going through changes; forming a resolve; cessation experiments; becoming an ex-addict; learning to be "ordinary"; filling the physical, psychological, social, lifestyle void with family work, religion, politics, and mutual aid);
- Brown's (1985) four-stage model (drinking, transition, early recovery, and ongoing recovery);
- Shaffer and Jones' three-stage model (experiencing turning points, active quitting, and relapse prevention);
- Klingemann's (1991) three-stage model (motivation, action, maintenance); and
- Prochaska and colleagues' (1992) six-stage model (precontemplation, contemplation, planning, action, maintenance, and termination).

Stage models suggest that the process of recovery begins before AOD use is moderated or terminated and that, while linear movement through particular stages is possible, the more common experience is a recycling through these stages before permanent recovery is achieved. The repeated sequence that predates recovery stability might be constructed as follows: escalating AOD-related pain (I need to recover), the desire to change (I want to recover), belief in possibility of change (I can recover), commitment (I am going to recover), experiments in abstinence (I am recovering), and movement from sobriety experiments to sobriety identity (I am an ex-addict; I am a recovered/recovering alcoholic/addict; I no longer use or misuse alcohol or other drugs). Stages of change models are very popular among addiction professionals, but have come under attack for the lack of empirical evidence supporting them (Sutton, 2001; West, 2005).

Quantum change and incremental change have been described as two discrete phenomena, but we have listened to recovery stories in our travels that have dimensions of both. For example, we have seen individuals who repeatedly cycled through preparatory stages of recovery (what we have here referred to as recovery priming) but whose point of recovery stabilization was marked by a profound, life-altering quantum change experience.

The third style of recovery initiation is one of *drift* — the gradual cessation/reduction of AOD use and related problems as a matter of circumstance rather than choice. Here the addict simply "goes with the flow," only to find in retrospect that events and circumstances lead away from drugs and the culture in which his or her drug use was nested (see Waldorf, 1983; Biernacki, 1986, 1990; Granfield & Cloud, 1999). Developmental maturation and environmental change can elicit changes in alcohol and other drug use in some individuals in ways that do not follow the conscious, self-engineered styles of change depicted in stages of change models. For example, some studies of female heroin

addicts depict recovery, not as a central goal, but as an inadvertent outcome of severing contact with former drug-using environments and relationships (Gerstein, Judd, & Rovner, 1979). Some individuals drift out of addiction through processes similar to the processes by which they drifted into addiction, including finding an intense alternative pursuit that gives new meaning to one's life (Cloud & Granfield, 2001).

RECOVERY IDENTITY

Recovery styles also reflect different *recovery identity* patterns — variations in the extent to which AOD problems and the recovery process influence one's identity, and the degree to which one identifies with other people who share this recovery process. There are those with recovery-neutral identities (persons who have resolved severe AOD problems but who do not self-identify as "alcoholics," "addicts," or "persons in recovery"), those with recovery-positive identities (those for whom the status of recovery from addiction has become an important part of their personal identities), and those with recovery-negative identities (those whose addiction/recovery status is self-acknowledged but not shared with others due to a sense of personal shame derived from this status).

These identities, rather than being mutually exclusive, can constitute different points in a prolonged recovery career. For example, we have witnessed such evolution in the modern history of recovering people working as addiction counselors. Early addiction counselors boldly proclaimed their recovery status as their primary credential, but began withholding that recovery status in the 1980s and 1990s behind their accumulating credentials and the restigmatization of AOD problems. In the face of a new recovery advocacy movement calling upon recovering people to put a face and voice on recovery, many of those same addiction counselors are again going public with their recovery status. In our experience, evolution in identity is the norm in addiction recovery.

RECOVERY RELATIONSHIPS

There are acultural *styles of recovery* in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery and without identification with a larger *recovery community* or *culture of recovery* (a social network of recovering people with their own recovery-based history, language, rituals, symbols, literature, and values). This is not to say that this style of recovery is void of social support, but that support usually comes from one's inner family and social circle rather than from a larger community of recovering people. Gerry Spense, the noted trial lawyer, describes this style of recovery:

> *We (Gerry and his new wife) sort of became each other's A.A. We quit together, and we hung on to each other. Although I have never attended an Alcoholics Anonymous session, we must have had the kind of experience that people have there.* (Quoted in *Wholey, 1984, p. 106.)*

In contrast, there are *bicultural styles of recovery,* in which individuals sustain their recovery through simultaneous involvement in a culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). There are also *enmeshed styles of recovery,* in which one initiates and maintains recovery in almost complete sequestration within a culture of recovery (White, 1996).

These styles are not mutually exclusive and can change over the course of recovery, with some individuals exhibiting very enmeshed styles of early recovery, only to migrate toward a bicultural or acultural style of recovery later in their lives. Some individuals use recovery mutual aid groups for recovery initiation and maintenance, where others seem to initiate recovery through such resources, but then sustain that recovery through their own personal, family, and social resources. Some continue Twelve Step or other recovery maintenance practices without meeting participation,

while others find other sources of long-term recovery support (Tonigan, Miller, Chavez, Porter, Worth, Westphal, Carroll, Repa, Martin, & Tracy, 2002). A relatively recent phenomenon is the advent of *virtual (Internet) recovery* — the achievement or maintenance of recovery through Internet support groups, with little or no participation in face-to-face support meetings. Web-based recovery support services include email and instant messaging systems, newsgroups, bulletin boards, chat rooms, self-assessment instruments, and recovery coaching (Walters, Hester, Chiauzzi, & Miller, 2005). The Internet seems to elicit a much higher degree of participation among women and individuals in high-status occupations than do either professional treatment or face-to-face recovery mutual aid groups (Hall & Tidwell, 2003).

Communities of recovery is a phrase coined by Ernest Kurtz to convey the existence of multiple recovery communities. Addiction treatment professionals should refer people to these communities with the goal of achieving reciprocity of fit between the individual and the group. Style differences based on the evolution in how one relates (or does not relate) to these communities of recovery are part of what could be described as one's *recovery career*. The concept of *career* has been applied to the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Timko, Moos, Finney, Moos, & Kaplowitz, 1999; Dennis, Scott, Funk, & Foss, 2005). *Recovery career* is an extension of this application and refers to the evolving stages of recovery stability and one's identity and recovery support relationships over time.

VARIETIES OF TWELVE-STEP EXPERIENCE

Peer-based support groups constitute a major resource for the resolution of alcohol and other drug problems (Room & Greenfield, 1993; Kessler, Mickelson, & Zhoa, 1997; Kissin, McLeod, & McKay, 2003). Such groups are attractive, are geographically accessible and affordable, require no formal admission procedures, and place no limits on length of participation (Humphreys, et al., 2004). Twelve-Step groups began with the founding of Alcoholics Anonymous in 1935. Although there were dozens of recovery mutual aid societies that pre-dated A.A. (White, 2001), A.A. continues to be the standard by which other mutual aid groups are measured due to its size (2.1 million members in 100,766 groups), geographical growth (150 countries), and longevity (Kurtz & White, 2003). Varieties of A.A. experience were evident from its inception (e.g., differences between A.A. in Akron and New York City) and have grown throughout A.A.'s history.

Varieties of A.A. experience are reflected in the diversity of A.A. meeting formats (e.g., open vs. closed meetings, speaker meetings vs. discussion meetings), in the trend to organize A.A. around special populations and special needs, and in the wide variance of styles of "working" the A.A. program. Local A.A. meeting lists reflect such specialization, e.g., meetings organized by age (young people's meetings, old-timers meetings), gender (women-only and men-only meetings), sexual orientation (lesbian, gay, bisexual, transgender), language (Spanish, Polish, no profanity), profession (physicians, lawyers, airline pilots), social status (off-the-books meetings for celebrities and those in high-status positions), relationship status (single, couples), co-occurring problems (psychiatric illness, HIV/AIDS), and smoking status (non-smoking), to name just a few. There are differences in A.A. that transcend filtering the A.A. program through particular types of categorical/cultural experience. Significant differences can be found in A.A. meetings related to such factors as degree of religious orientation (from efforts to Christianize A.A. to A.A. groups for atheists and agnostics), meeting rituals, pre- and post meeting activities; and basic interpretations of the nature of the A.A. program (Kurtz & White, 2003). Such varieties multiply exponentially when one examines the range of adaptations of A.A.'s Twelve Steps to other drug problems (e.g., Narcotics Anonymous, Cocaine Anonymous, Marijuana

Anonymous, Pills Anonymous, Methadone Anonymous) and to co-occurring problems (e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery).

The explosive growth of A.A. in the 1970s and 1980s and the growing influence of the addiction treatment industry and the criminal justice system upon A.A. (via mandated A.A. attendance) led to concerns among A.A. old-timers that the core of A.A.'s program was being corrupted. This concern led to efforts to define and recapture the historical A.A. A.A. historian Ernest Kurtz (1999, pp. 131-138) proposed five criteria to distinguish "real A.A." from meetings that had taken on the flavor of treatment groups: 1) A.A. vocabulary (defects of character, self-inventory, Higher Power) rather than treatment vocabulary; 2) humor and the appreciation of paradox; 3) a story style that "describes in a general way what we used to be like, what happened, and what we are like now"; 4) respect for and adherence to A.A. traditions; and 5) a conviction by those attending meetings that they NEED rather than WANT to be there.

The growing varieties of A.A. experience triggered efforts in the scientific community to define the "active ingredients" of A.A. These scientists, confronted with the large menu of concepts and activities that make up the A.A. experience, attempted to define which aspects of the A.A. experience were the most potent in altering the course of alcoholism and strengthening the recovery experience. To-date, these studies have focused on such mechanisms as motivational enhancement, development of Twelve-Step cognitions (e.g., commitment to abstinence and continued A.A. participation), recovery coaching (advice), mastery of behavioral prescriptions for coping, exposure to recovery role models, enhanced self-efficacy, changes in friendship networks, and the therapeutic benefits of helping others (Morgenstern, et al., 1997; Humphreys, Mankowski, Moos, & Finney, 1999; Pagano, Friend, Tonigan, & Stout, 2004). Scientists have also plotted a continuum of response to Twelve-Step involvement across three populations: optimal responders, nonresponders, and partial responders (Morgenstern, Kahler, Frey, & Labouvie, 1996).

Other areas of diverse experience within Twelve-Step groups include patterns of co-attendance of Twelve Step and other groups, e.g., attending A.A. and Al-Anon, A.A. and N.A., A.A. and Women for Sobriety; patterns of primary affiliation (e.g., shifting primary allegiance from N.A. to A.A.); patterns of intensity of participation (frequency of meeting attendance and other Twelve-Step practices); and duration of participation over time (e.g., decreasing involvement or disengagement from regular involvement in meetings and rituals).

STILL OTHER VARIETIES

The existence of those who did not respond or only partially responded to spiritually oriented Twelve-Step programs set the stage for the emergence of explicitly religious and secular frameworks of peer-based recovery support (Humphreys, 2004). Religious recovery support groups include (with their founding dates where available) Alcoholics Victorious (1948), Teen Challenge (1961), Alcoholics for Christ (1976), Overcomers Outreach (1977), Liontamers Anonymous (1980), Mountain Movers, High Ground, Free N' One, Victorious Lady, Celebrate Recovery, Millati Islami, and innumerable local recovery-support ministries. As noted earlier, these groups share a religious interpretation of the roots of addiction (e.g., as a sin of the flesh, idolatry, or demonic possession), recovery founded on total surrender to a religious deity, a religiously based reconstruction of personal identity and values, and immersion in a faith-based community (White & Whiters, 2005).

Secular recovery support groups (with their founding dates) include Women for Sobriety (WFS) (1975), Secular Sobriety Groups (later renamed Secular Organization for Sobriety — Save Our Selves (SOS) (1985), Rational Recovery (RR) (1986), Men for Sobriety (MFS) (1988), Moderation Management (MM) (1994), SMART Recovery® (1994), and LifeRing Secular Recovery (LSR) (1999). Secular groups are

distinguished by their meeting locations (homes and religiously neutral sites); lack of reference to religious deities; discouragement of self-labeling ("alcoholic" and "addict"); emphasis on personal empowerment and self-reliance; openness to crosstalk (direct feedback and advice between members); lack of formal sponsorship; encouragement to complete a recovery process and move on to a full, meaningful life (rather than sustain meeting participation for life); and use of volunteer professional advisors (persons not in personal recovery) to facilitate and speak at meetings (White & Nicolaus, 2005).

Individuals who participate in Twelve-Step alternatives may do so exclusively, concurrently with A.A. meetings, or sequentially (using one framework to initiate recovery and another framework to maintain and enrich that recovery over time (Kaskutas, 1992; Connors, Dermen & Duerr, 1992; White & Nicolaus, 2005).

RECOVERY DURABILITY

Interest has grown over the past decade in the prospects and processes involved in long-term recovery stabilization (Morgan, 1995; Chappel, 1993), as it has become clear that short periods of sobriety or decelerated AOD use are not predictive of sustained recovery. Some researchers have claimed that stable remission can be predicted by as little as six months of sobriety (Armor, Polich, & Stambul, 1978). Vaillant (1983), in a prospective study of alcoholic men, found that the stability and durability of addiction recovery increases with length of sobriety, with no relapses in his study among those who had achieved six or more years of continuous sobriety. A growing number of studies are suggesting that the point at which most recoveries from alcohol dependence become fully stabilized is between four and five years of continuous remission (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, O'Donnel, & De Soto, 1989; Dawson, 1996; Jin, Rourke, Patterson, Taylor & Grant, 1998). Once attained, recovery from alcohol dependence is more stable for those with late-onset alcohol problems compared to those with early-onset alcohol problems (Schutte, Brennan & Moos, 1994).

Studies of heroin addicts further confirm the fragility of short periods of abstinence. Follow-up studies have demonstrated that only 42% percent of those abstaining from opiates in the community at two-year follow-up were still abstinent at five-year follow-up (Duvall, Lock, & Brill, 1963). One third of those who achieve three years of abstinence eventually relapse (Maddux & Desmond, 1981), and one quarter of heroin addicts with five or more years of abstinence later return to heroin use (Hser, Hoffman, Grella, & Anglin, 2001).

While recovery stability seems to vary somewhat across drugs used, the principle that recovery becomes more stable over time seems to apply to all patterns of addiction. In a 2001 national survey of people who self-identified as "in recovery" or "formerly addicted to alcohol or other drugs," half reported being in stable recovery more than five years, and 34% reported having achieved stable recovery lasting ten or more years (Faces & Voices of Recovery, 2001). The average length of continuous sobriety reported in the latest membership survey of Alcoholics Anonymous was 8 years, with 36% of A.A. members reporting continuous sobriety of more than 10 years (*A.A. Grapevine*, July, 2005).

Persons who achieve full, uninterrupted recovery for five years, like persons who have achieved similar patterns of symptom remission from other primary health disorders, can be described as *recovered*. In general, this means that the risk of future lifetime relapse has approached the level of addiction risk for persons without a history of prior addiction. Those who achieve full symptom remission for less than five years or who have achieved partial recovery (marked reduction of AOD use and related consequences) can best be described as *in recovery* or *recovering*. Use of the term *recovering* in later years (after five years) of recovery reminds the individual that recovery is an enduring process requiring sustained vigilance and recovery maintenance. However, such use, by

inadvertently conveying the lack of a permanent solution for severe AOD problems, may contribute to the stigma and pessimism attached to these problems.

RECOVERY TERMINATION

One of the recent controversies related to recovery from addiction involves the question of whether addiction recovery is ever fully completed. The stage models of recovery summarized earlier collectively portray four broad stages of recovery: 1) *recovery priming* (experiences that open a doorway of entry into recovery), 2) *recovery initiation* (discovering a workable strategy of problem stabilization), 3) *recovery maintenance* (achieving recovery stability and sustaining and refining broader strategies of problem resolution with a continued focus on the recovery process), and 4) *recovery termination* (achievement of global health with diminished preoccupation with recovery). This last stage, referred to as *Stage II Recovery* ("rebuilding the life that was saved in Stage I") (Larsen, 1985, p. 15), transcends the early concern with the addictive behavior and focuses on a reconstruction of personal character, identity, beliefs, and interpersonal relationships. This stage is also referred to as *completed recovery* or the *real thirteenth step*[4] — an "advanced state" of recovery marked by global health and a heightened capacity for intimacy, serenity, self-acceptance, and public service (Picucci, 2002; Tessina, 1991).

IMPLICATIONS FOR THE PROFESSIONAL TREATMENT OF AOD PROBLEMS

This review contains critical understandings that could help shape recovery-oriented systems of care. Some of the most important of these include the following.

Paradigmatic Shift: There will be increasing calls to shift addiction treatment and addiction counseling from a problem-focused or intervention-focused paradigm to a recovery paradigm. This will shift the emphasis of treatment from one of brief biopsychoscial stabilization to one of sustained recovery management (pre-recovery engagement; recovery initiation; sustained monitoring; stage-appropriate recovery education and coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention) (White, Boyle & Loveland, 2003).

Recovery Definition and Scope: The shift to a recovery paradigm will require considerable discussion between the professional addictions field and diverse communities of recovery about the very definition of recovery. These discussions will be contentious, but we would make the following predictions:

1. Abstinence will shift from its status as a *goal* and definitional requirement of recovery to the status of *one method* of achieving recovery (and the preferred method for those with the most severe AOD problems). The goal will shift to the resolution of AOD problems by any means possible — a goal that will legitimize moderated outcomes for those with less severe AOD problems.

2. The focal point of recovery (changes in one's primary drug relationship) will broaden to include a healthy relationship or non-relationship with all psychoactive drugs and the achievement of global health. Addiction treatment programs will increasingly be held accountable for multiple recovery outcomes, e.g., changes in primary and secondary drug use as well as changes in physical, emotional, family/relational, and occupational/academic health and functioning. There will be a shift in focus from what recovery

[4] The thirteenth step is a euphemism for romantic involvement between AA members and, more specifically, the sexual overture by an older AA member to a newly sobered AA member.

eliminates (AOD use and related problems) to what recovery adds to individuals, families, and communities (global health, occupational and academic productivity, active citizenship) (http://www.samhsa.gov/Matrix/SAP_treatment.aspx).

3. Re-elevating the concept of *family recovery* will exert pressure for new technologies of family assessment, intervention, and sustained monitoring as well as impetus for a family-oriented recovery research agenda.

4. The concept of *partial recovery* will receive greater elucidation and legitimacy within the addictions treatment field, and cases of *enriched recovery* (dramatically elevated health, functioning, and community service) will be documented and culturally elevated to help ameliorate the social stigma that continues to be attached to AOD problems.

Recovery Capital: The pathology and intervention paradigms that have guided addiction treatment have shaped assessment and placement protocol so that they focus almost exclusively on problem severity and complexity. The resiliency/recovery paradigm calls for measuring recovery capital; distinguishing the role of recovery capital in *natural*, *treatment-assisted*, and *peer-assisted* recoveries; and giving prominence to an individual's/family's recovery capital within the process of clinical decision-making. The most important implication of the concept of recovery capital is the premise that not all individuals experiencing AOD problems need professional treatment. Individuals with lower problem severity and high recovery capital can be encouraged to explore natural and peer-based resources as less restrictive, less expensive, and less stigma-laden alternatives to addiction treatment. Monitoring responses to such resources can be used to determine if and when professional services are necessary.

Medication-Assisted Recovery: Tension is growing between an anti-medication bias within the field of addiction treatment (and within American communities of recovery and the larger American culture), the growing availability of a wide variety of pharmacological adjuncts in the treatment of addiction, and the growth in scientific evidence supporting their effectiveness. We anticipate a day when the legitimacy of such pharmacological adjuncts will be widely recognized in professional and recovery communities and integrated within the large spectrum of treatment and recovery support services. If such legitimacy is not achieved, we would anticipate a schism within the field in which more scientifically and medically based treatments split off into a separate field within primary medicine. We would consider this further splitting of body from mind and soul a tragic event in the history of the field.

Recovery Frameworks: Religious, spiritual, and secular frameworks of recovery must be more completely charted and evaluated, with a particular focus on their applicability to particular cultural and clinical populations. For example, researchers have extensively studied (some would say over-studied) AOD problems in Native American and African American communities, but no comparable quantity of literature exists on the varieties of recovery experience within these communities. How many African Americans initiate and sustain recovery through the historical Black church? How many African Americans initiate recovery through A.A. or N.A. and then migrate into the Black church to sustain their recoveries? How many Native Americans use indigenous cultural or religious revitalization movements as a framework for long-term sobriety? In the same vein, how do members of secular frameworks of recovery differ from those in religious or Twelve-Step frameworks of recovery? What mechanisms of change are shared across religious, spiritual, and secular frameworks of recovery; and what

mechanisms of change distinguish such frameworks from each other? Definitive, scientifically researched answers to such questions do not yet exist.

Recovery Styles: Variations in how recovery is initiated and how recovery shapes personal identity and interpersonal relationships illustrate the diversity of experiences that constitute recovery from AOD problems. Further documentation of such styles and their relative prevalence across cultural and clinical subpopulations is needed to guide the delivery of treatment and recovery support services. The elucidation of recovery styles is part of a larger recovery research agenda that is currently gaining prominence.

Varieties of Recovery Mutual Support Societies: The numerical expansion and growing diversity of peer-based recovery support groups suggests the need for all addictions professionals to become students of such groups, develop relationships with these groups, provide clients information about such groups, and develop a style of active linkage to these groups. The diversity of recovery support groups has prompted calls for matching individual clients to particular groups by such factors as age, gender, socioeconomic status, drug of choice, smoking status, and attitudes toward religion and spirituality (Forman, 2002; White & Nicolaus, 2005). Celebration of the growing diversity of recovery pathways and a philosophy of choice permeate the philosophies of the best treatment programs. Recent reviews of treatment effectiveness have linked this philosophy of choice to enhanced motivation and treatment outcomes (Hester & Miller, 2003). All recovery support structures, like all treatments, will have optimal responders, partial responders, and non-responders. This calls for continued monitoring and support to get the best possible fit between each individual and a particular method of treatment or recovery support. Combinations of natural resources, peer recovery networks, and professional treatment may generate amplified recovery outcomes for those individuals and families with the greatest problem severity and complexity.

SUMMARY AND CONCLUSIONS

The extension of the pathology and intervention paradigms toward a recovery paradigm will generate significant new understandings about the varieties of recovery experience. However, our understanding of those varieties is in its infancy. It is time the recognition of multiple pathways and styles of recovery moved beyond the level of superficial rhetoric. It is time the field aggressively pursued a recovery research agenda. It is time that the recognition of multiple pathways and styles of recovery fully permeated the philosophies and clinical protocols of all organizations providing addiction treatment and recovery support services.

REFERENCES AND RECOMMENDED READING

Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism. (1939). New York: Works Publishing Company.

Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism. (1976) New York: A.A. World Services, Inc.

Alcoholics Anonymous (2005). Survey profiles today's AA members. *About AA: A Newsletter for Professionals*, Fall, p. 1.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Anglin, M. D., Almong, I. J., Fisher, D. G. & Peters, K. R. (1989). Alcohol use by heroin addicts: Evidence for an inverse relationship. A study of methadone maintenance and drug free treatment samples. *American Journal of Drug and Alcohol Abuse*, 15(2), 191-207.

Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. *Psychology of Addictive Behaviors*, 11(4), 308-323.

Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. *Psychology of Addictive Behaviors*, 11, 308-323.

Anthony, J. C., & Helzer, J. E. (1991). Syndromes of drug abuse and dependence. In L. N. Robins, & D. A. Regier. (Eds.). *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (pp. 116-154). New York, NY: The Free Press. Armor, D. J. and Meshkoff, J. E. (1983). Remission among treated and untreated alcoholics. In N. K. Mello. (Ed.), *Advances in Substance Abuse: Behavioral and Biological Research: Volume 3* (pp. 239-269). CN: JAI Press.

Armor, D. J., Polich,J. M., & Stambul, H. B. (1978). *Alcoholism and Treatment.* New York: Wiley.

Bacchus, L, Strang, J, and Watson, P. (2000). Pathways to abstinence: Two-Year follow-up data on 60 abstinent former opiate addicts who had been turned away from treatment. *European Addiction Research*, 6(3), 141-147.

Badri, M. B. (1976). *Islam and alcoholism*. Tacoma Park, MD: Muslim Students Association of the U.S. and Canada.

Behar, D., Winokur, G. & Berg, C. J. (1984). Depression in the abstinent alcoholic. *American Journal of Psychiatry*, 141(9), 1105-1107.

Bien, T. & Barge, R. (1990). Smoking and drinking: A review of the literature. *International Journal of the Addictions*, 25(12), 1429-1454.

Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery without Treatment*. Philadelphia, PA: Temple University Press.

Bischof, G., Rumpf, H., Hapke, U., Meyer, C. & John, U. (2000). Gender differences in natural recovery from alcohol dependence. *Journal of Studies on Alcohol*, 61(6), 783-786.

Borkman, T. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, 15(1), 37-42.

Brown, S. (1985). *Treating the Alcoholic: A Developmental Model of Recovery.* New York: Wiley.

Brown, S., & Lewis, B. (1999). *The Alcoholic Family in Recovery: A Developmental Model.* New York, NY: Guilford.

Burman, S. (1997). The challenge of sobriety: Natural recovery without treatment and self-help programs. *Journal of Substance Abuse*, 9, 41-61.

Caetano, R. (1993). Ethnic minority groups and Alcoholics Anonymous: A review. In B. McCrady and W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp.209-231). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Caldwell, P. E., & Cutter, H. S. G. (1998). Alcoholics Anonymous affiliation during early recovery. *Journal of Substance Abuse Treatment*, 15(3), 221-228.

Carmelli, D. & Swan, G. (1993). The relationship between quitting smoking and changes in drinking in World War II veteran twins. *Journal of Substance Abuse*, 3(5), 103-116.

Chapman, R. E. (1987). Personality characteristics of alcoholics in long-term recovery. *Dissertation Abstracts International*, 48(2), 338-A.

Chappel, J. N. (1993). Long-term recovery from alcoholism. *Psychiatric Clinics of North America*, 16(1), 177-187.

Cloud, W. & Granfield, R. (1994). Terminating addiction naturally: Post-addict identity and the avoidance of treatment. *Clinical Sociology Review*, 12:159-174.

Cloud, W. & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, 1(1), 83-104.

Cohen, P. & Sas, A. (1994). Cocaine use in Amsterdam in non-deviant subcultures. *Addiction Research*, 2(1), 71-94.

Coleman, J. (1978) *A theory of narcotic abstinence*. Paper presented at the 1978 Conference of the Society for the Study of Social Problems, San Francisco, California.

Connors, G. J., Dermen, K. H. & Duerr, M. (1992). SOS membership survey: Preliminary results. In J. Christopher (Ed.), *SOS Sobriety* (pp. 61-65). Buffalo, NY: Prometheus Books,

Copeland, J. (1988). A qualitative study of self-managed change in substance dependence among women. *Contemporary Drug Problems*, 25(2), 321-345.

Courtwright, D. (2001). *Forces of Habit: Drugs and the Making of the Modern World.* Cambridge: Harvard University Press.

Coyhis, D. (1999). T*he Wellbriety Journey: Nine Talks by Don Coyhis.* Colorado Springs, CO: White Bison, Inc.

Coyhis, D. (2000). Culturally specific addiction recovery for Native Americans. In: Krestan, J. (Ed.), *Bridges to Recovery* (pp. 77-114). New York: The Free Press.

Cross, G., Morgan, C., Moonye, A., Martin, C., & Rafter, J. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism Clinical and Experimental Research*, 14(2), 169-173.

Cunningham, J. A. (1999a). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*, 60(4), 463-466.

Cunningham, J. A. (1999b). Untreated remissions from drug use: The predominant pathway. *Addictive Behaviors*, 24(2), 267-270.

Cunningham, J. A. (2000). Remissions from drug dependence: Is treatment a prerequisite? *Drug and Alcohol Dependence*, 59(3), 211-213.

Cunningham, J. A., Lin, E., Ross, H. E., & Walsh, G. W. (2000). Factors associated with untreated remissions from alcohol abuse or dependence. *Addictive Behaviors*, 25(2), 317-321.

Cunningham, J., Sobell, L. Sobell, M. & Kapur, G. (1995) Resolution from alcohol problems with and without treatment: Reasons for change. *Journal of Substance Abuse*, 7(3), 365-372.

Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20(4), 771-779.

Dawson, S. A., Grant, B. F., Stinson, F. S., Chou, P. S. Huang, B. & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction*, 100(3), 281-292.

Dennis, M. L., Scott, C. K, & Hristova, L. (2002). The duration and correlates of substance abuse treatment careers among people entering publicly funded treatment in Chicago [Abstract], *Drug and Alcohol Dependence*, 66(Suppl. 2), 44.

Dennis, M.L., Scott, C.K., Funk, R. & Foss, M.A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, 28, S51-S62.

Denzin, N. K. (1987). *The Recovering Alcoholic*. Newbury Park, CA: Sage.

De Soto, C. B., O'Donnell, W. E., Allred, L. J. & Lopes, C. E. (1985). Symptomatology in alcoholics at various stages of abstinence. *Alcoholism Clinical and Experimental Research,* 9(6), 505-512.

De Soto, C. B., O'Donnel, W. E. & De Soto, J. L. (1989). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research*, 13(5), 693-697.

Dickens, B.M., Doob, A.N., Warwick, O.H., & Winegard, W.C. (1982). *Report of the Committee of Inquiry into Allegations Concerning Drs. Linda and Mark Sobell*. Toronto, Canada: Addiction Research Foundation.

Downey, L., Rosengren, D. B., & Donovan, D. M. (2000). To thine own self be true: Self-concept and motivation for abstinence among substance abusers. *Addictive Behaviors*, 25(5), 743-757.

Duvall, H. J., Lock, B. Z. & Brill, L. (1963). Follow-up study of narcotic drug addicts five years after hospitalization. *Public Health Reports*, 78(3), 185-193.

Edwards, G. (1984). Drinking in longitudinal perspective: Career and natural history. *British Journal of Addiction*, 79, 175-183.

Edwards, G., Duckitt, A., Oppenheimer, E., Sheehan, M. & Taylor, C. (1983). What happens to alcoholics? *The Lancet*, 2(8344), 269-271.

Elise, D. (1999) Recovering recovery. *Journal of Ministry in Addiction And Recovery*, 6(2),11-23.

Emrick, D. C., Tonigan, J. S., Montgomery, H. & Little, L. (1993). Alcoholics Annonymous: What is currently known? In B. McCrady and W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp. 41-78). Brunswick, NJ: Rutgers Center of Alcohol Studies.

Faces & Voices of Recovery (2001). *The Road to Recovery: A Landmark National Study on the Public Perceptions of Alcoholism and Barriers to Treatment.* San Francisco, CA: Peter D. Hart Research Associates, Inc./The Recovery Institute.

Fillmore, K. M., Hartka, E., Johnstone, B. M., Speiglman, R., & Temple, M. T. (1988). *Spontaneous Remission of Alcohol Problems: A Critical Review*. Washington, D.C.: Institute of Medicine.

Finney, J. & Moos, R. (1981). Characteristics and prognosis of alcoholics who become moderate drinkers and abstainers after treatment. *Journal of Studies on Alcohol*, 42(1), 94-105.

Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, 25(1), 93-116.

Fiorentine, R., & Hillhouse, M. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment*, 18(1), 65-74.

Forman, R.F. (2002). One AA meeting doesn't fit all: 6 keys to prescribing 12-step programs. *Psychiatry Online*, 1(10), 1-6.

Frykholm, B. (1985). The drug career. *Journal of Drug Issues*, 15(3), 333-346.

Gerard, D., Sanger, G. & Wile, R. (1962). The abstinent alcoholic. *Archives of General Psychiatry*, 6, 83-95.

Gerstein, D., Judd, L.L., & Rovner, S.A. (1979) Career dynamics of female heroin addicts. *American Journal of Drug and Alcohol Abuse*, 6(1), 1-23.

Goldman, M. S. (1983). Cognitive impairment in chronic alcoholics: Some causes for optimism. *American Psychologist*, 38(10), 1045-1054.

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction without Treatment*. New York, NY: New York University Press.

Green, L. L., Fullilove, M. T. & Fullilove, R. E. (1998). Stories of spiritual awakening: The nature of spirituality in recovery. *Journal of Substance Abuse Treatment*, 15(4), 325-331.

Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, 24(2), 161-167.

Harding, W. M., Zinberg, N. E., Stelmack, S. M. & Michael, B. (1980). Formerly-addicted-now-controlled opiate users. *International Journal of the Addictions* 15(1), 47-60.

Havassy, B. E., Hall, S. M., & Wasserman, D. A. (1991). Social support and relapse: Commonalities among alcoholics, opiate users, and cigarette smokers. *Addictive Behaviors*, 16(5), 235-246.

Helzer, J. E., Burnam, A. & McEvoy, L. T. (1991). Alcohol abuse and dependence. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (pp. 81-115). New York: The Free Press.

Hester, R. K., & Miller, W. R. (Eds.) (2003). *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (3rd ed.). Boston, MA: Allyn & Bacon.

High Bottom. (1949). *A.A. Grapevine*, October.

Hoffman, A. & Slade, J. (1993). Following the pioneers: Addressing tobacco in chemical dependency treatment. *Journal of Substance Abuse Treatment*, 10(2), 153-160.

Hoffmann, N., Harrison, P. & Belille, C. (1983). Alcoholics Anonymous after treatment: Attendance and abstinence. *International Journal of the Addictions*, 18(3), 311-318.

Hser, Y. (2000). Substance Abuse and Aging Project: Drug Use Careers: Recovery and Mortality. Retrieved on March 24, 2005 from http://www.oas.samhsa.gov/aging/chap3.htm.

Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment*, 14(3), 1-16.

Hser, Y., Grella, C., Chou, C. & Anglin, M.D. (1998) Relationship between drug treatment careers and outcomes: Findings from the National Drug Abuse Treatment Outcome Study. *Evaluation Review.* 22(4):496-519.

Hser, Y., Hoffman, V., Grella, C. & Anglin, D. (2001) A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58(5), 503-508.

Hughes, J.R. (1996). Treating smokers with current or past alcohol dependence. *American Journal of Health Behavior*, 20(5), 286-290.

Hughes, J. R. (1995). Clinical implications of the association between smoking and alcoholism. In J. B. Fertig & J. P. Allen (Eds.), *Alcohol and Tobacco: From Basic Science to Clinical Practice*. (NIAAA Research Monograph No. 30, NIH Publication No 95-3931, pp. 171-185). Washington, Government Printing Office.

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Humphreys, K., Mankowski, E., Moos, R. & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, 21(1), 54-60.

Humphreys, K., Mavis, B. E., & Stoffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, 11, 165-180.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58(3), 231-238.

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., et al, (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 151-158.

James, W. (1902, 1982). *The Varieties of Religious Experience*. New York: Penguin.

Jason, L.A., Davis, M.I., Ferrari, J.R. And Bishop, P. D. (2001) Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, 31(1):1-27.

Jin, H., Rourke, S. B., Patterson, T. L., Taylor, M. J. & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol*, 59(6), 640-646.

Johnson, E. & Herringer, L. (1993). A note on the utilization of common support activities and relapse following substance abuse treatment. *Journal of Psychology*, 127(1), 73-78.

Jordan, C. M. & Oei, T. P. S. (1989). Help-seeking behavior in problem drinkers: A review. *British Journal of Addiction,* 84, 979-988.

Jorquez, J. (1983). The retirement phase of heroin using careers. *Journal of Drug Issues,* 18(3), 343-365.

Kandel, D. B. & Raveis, V. H. (1989). Cessation of drug use in young adulthood. *Archives of General Psychiatry*, 46(2), 109-116.

Kaskutas, L. (1992). Beliefs on the source of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems*, 19(4), 631-648.

Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63(3), 293-304.

Kessler, R. C., Mickelson, K. D. & Zhoa, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy*, 27(3), 27-45.

Kessler R. C., Nelson, C. B., McGonagle, K. A., Edlund, M. J., Frank, R. G., & Leaf, P. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*, 66(1), 17-31.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life*. New York: Ballantine Books.

Kishline, A. (1994). *Moderate Drinking*. Tucson, Arizona: See Sharp Press.

Kissin, W., McLeod, C. & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, 26, 311-323.

Klingemann, H. K. H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of the Addictions,* 86(6), 727-744.

Klingemann, H. K. H. (1992). Coping and maintenance strategies of spontaneous remitters from problem use of alcohol and heroin in Switzerland. *International Journal of the Addictions*, 27(12), 1359-1388.

Kreek, M. & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment*, 23(2), 93-105.

Kurtines, W. M., Ball, L. R.& Wood, G. H. (1978). Personality characteristics of long-term recovered alcoholics: a comparative analysis. *Journal of Consulting and Clinical Psychology*, 46(5), 971-977.

Kurtz, E. (1999). *The Collected Ernie Kurtz.* Wheeling, WV: The Bishop of Books.

Kurtz, E. & Ketchum, K. (1992). *The Spirituality of Imperfection: Modern Wisdom from Classic Stories*. New York: Bantam Books.

Kurtz, E. & White, W. (2003). Alcoholics Anonymous. In J .Blocker and I. Tyrell (Eds.), *Alcohol and Temperance in Modern History* (pp. 27-31). Santa Barbara, CA: ABC-CLIO.

Larimer, M. E. & Kilmer, J. R. (2000). Natural history. In G. Zernig, A. Saria, M. Kurz, & S. S. O'Malley, (Eds.), *Handbook of Alcoholism* (pp. 13-28). Boca Raton, FL: CRC Press.

Larsen, E. (1985). *Stage II Recovery: Life Beyond Addiction*. New York, NY: HarperCollins Publishers.

Lender, M & Martin, J. (1982). *Drinking in America*. NY: The Free Press.

Levy, B. S. (1972) Five years later: A follow-up study of 50 narcotic addicts. *American Journal of Psychiatry*, 128(7), 102-106.

Maddux, J. & Desmond, D. (1986). Relapse and recovery in substance abuse careers. In F. Tims & C. Leukefeld, (Eds.), *Relapse and Recovery in Drug Abuse. (NIDA Monograph Series* 72, pp. 49-72).

Maddux, J. F. & Desmond, D. P. (1980). New light on the maturing out

hypothesis in opioid dependence. *Bulletin on Narcotics*, 32(1),15-25.

Maddux, J. F. & Desmond, D. P. (1981). *Careers of Opioid Users*. New York: Praeger.

Maddux, J. F. & Desmond, D. P. (1992). Ten-year follow-up after admission to methadone. *American Journal of Drug and Alcohol Abuse*, 18(3),289-303.

Margolis, R., Kilpatrick, A., & Mooney, B. (2000). A retrospective look at long-term adolescent recovery: Clinicians talk to researchers. *Journal of Psychoactive Drugs*, 32(1), 117-125.

McMurran, M. (1994). The Psychology of Addiction. Washington, D.C.: Taylor and Francis.

Meissen, G., Powell, T. J., Wituk, S. A., Girrens, K. & Artega, S. (1999). Attitudes of AA contact persons toward group participation by person with mental illness. *Psychiatric Services,* 50(8), 1079-1081.

Mental sobriety means spotting danger signals. (1946). *AA Grapevine*, March.

Miller, W. R. (1995). Toward a Biblical perspective on drug use. *Journal of Ministry in Addiction & Recovery*, 2(2), 77-86.

Miller, W. & C'de Baca, J. (2001). *Quantum Change: When Epiphanies and Sudden Insights Transform Ordinary Lives*. New York, NY: Guilford Press.

Miller, W. & Kurtz, E. (1994). Models of alcoholism used in treatment: contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, 55(2), 159-166.

Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol*, 62(2), 211-220.

Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment*, 12(4), 241-246.

Moos, H., Finney, M., & Cronkite, R.C. (1990). *Alcoholism treatment: Context, process and outcome.* New York: Oxford University Press.

Morgan, O.J. (1995a). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly*, 12(1), 59-71.

Morgan, O.J. (1995b). Recovery-sensitive counseling in the treatment of alcoholism. *Alcoholism Treatment Quarterly*, 13(4), 63-73.

Morgenstern, J., Kahler, C. W., Frey, R. M. & Labouvie, E. (1996). Modeling therapeutic response to 12-step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, 8(1), 45-59.

Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65, 768-777.

Murphy, S. and Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs*, 24(3), 257-264.

Musto, D. (1999). *The American Disease: Origins of Narcotic Control*. New York: Oxford University Press.

Myers, M. & Brown, S. (1990). *Cigarette smoking and health in adolescent substance abusers.* Paper presented at the Society of Behavioral Medicine, Chicago, IL.

Narcotics Anonymous. (1988). Van Nuys, CA: NA World Service Office, Inc.

Nathan, P. & Skinstad, A. (1987). Outcomes of treatment for alcohol problems: Current methods, problems and results. *Journal of Consulting and Clinical Psychology*. 55(3), 332-340.

National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association*,

280(22):1936-1943. (See http://odp.od.nih.gov/consensus/cons/108/108_statement.htm)

National Institute on Drug Abuse. (1999). *Principles of Drug Addiction Treatment* (NIH Publication No. 00-4180). Rockville, MD: NIDA.

Ojesjo, L. (1981). Long-term outcome in alcohol abuse and alcoholism among males in Lundby general population, Sweden. *British Journal of Addiction*, 76, 391-400.

Ouimette, P., Humphreys, K., Moos, R., Finney, J. Cronkite, R. & Federman, B. (2001). Self-help participation among substance use disorder patients with posttraumatic stress disorder. *Journal of Substance Abuse Treatment*, 20(1), 25-32.

Pagano, M. E., Friend, K. B., Tonigan, J. S., & Stout, R. L. (2004). Helping other alcoholics in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol,* 65(6), 766-773.

Pendery, M., Maltzman, I., West, L. (1982). Controlled drinking by alcoholics? New findings and a reevaluation of a major affirmative study. *Science*, 217, 169-175.

Picucci, M. (2002). An Interview with Dr. Michael Picucci; *Terms and Definitions*.

Pisani, V. D., Fawcett, J., Clark, D. C., & McGuire, M. (1993). The relative contributions of medication adherence and AA meeting attendance to abstinent outcome of chronic alcoholics. *Journal of Studies on Alcohol*, 54,115-119.

Polich, J. M., Armor, D. J., & Braiker, H. B. (1980). *The Course of Alcoholism: Four Years after Treatment.* New York: Wiley.

Prochaska, J., DiClimente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102-1114.

The Red Road to Wellbriety. (2002). Colorado Springs, CO: White Bison, Inc.

Room, R. (1989) The U.S. general population's experiences of responding to alcohol problems. *British Journal of Addiction*, 84(11), 1291-1304.

Room, R. & Greenfield, T. (1993). Alcoholics Anonymous, other 12-step movements, and psychotherapy in the U.S. Population, 1990. *Addiction*, 88(4), 555-562.

Rosenberg, H. (1993). Prediction of controlled drinking by alcoholics and problem drinkers. *Psychological Bulletin*, 113(1), 129-139.

Rouhbakhsh, P., Lewis, V., & Allen-Byrd, L. (2004). Recovering Alcoholic Families: When is normal not normal and when is not normal healthy? *Alcoholism Treatment Quarterly*, 22(2), 35-53.

Rychtarik, R. G., Connors, G. J., Demen, K. H. & Stasiewicz, P. R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, 61(1), 134-138.

Schutte, K., Brennan, P. & Moos, R. (1994). Remission of late-life drinking problems: A 4-year follow-up. *Alcoholism: Clinical and Experimental Research*, 18(4), 835-844.

Schutte, K. K., Nichols, K. A., Brennan, P. L., & Moos, R. H. (2001). Successful remission of late-life drinking problems. *Journal of Studies on Alcohol*, 64(3), 367-374.

Scott, C.K., Foss, M.A. & Dennis, M.L. (2005). Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, 28, S63-S72.

Selby, M., Quiroga, Ireland, S, Malow, R. & Azrin, R. (1995). Neuropsychological recovery in alcoholics and cocaine users. In L. Harris (Ed.), *Problems of Drug Dependence, 1994: Proceedings of the 56th Annual Scientific Meeting, the College on Problems of Drug Dependence, Inc.* Volume 2 (NIDA Research

Monograph 153). Rockville, MD: National Institute on Drug Abuse.

Shaffer, H. J. & Jones, S. B. (1989). *Quitting Cocaine: The Struggle against Impulse*. Lexington, MA: Lexington Books.

Sheeren, M. (1988). The relationship between relapse and involvement in Alcoholics Anonymous. *Journal of Studies on Alcohol*, 49(1), 104-106.

Simpson, D. D. & Sells, S. B. (1990). *Opioid Addiction and Treatment: A 12-year Follow-up*. Malabar, FL.: Krieger.

Sobell, M.B. & Sobell, L.C. (1973). Indivdiualized behavior therapy for alcoholics. *Behavior Therapy*, 4, 49-72.

Sobell, M.B. & Sobell, L.C. (1976). Second year treatment outcome of alcoholics treatment by individualized behavior therapy: Results. *Behavior Research and Therapy*, 14, 195-215.

Sobell, M.B. & Sobell, L.C. (1978). *Behavioral Treatment of Alcohol Problems*. New York: Plenum.

Sobell, M. B., Sobell, L. C. & Toneatto, T. (1991). Recovery from alcohol problems without treatment. In N. Heather, W. R. Miller and J. Greeley (Eds.) *Self Control and the Addictive Behaviors* (pp. 198-242). New York: Maxwell Macmillan. Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. American Journal of Public Health, 86(7), 966-972.

Sobell, L. C., Ellingstad, T., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addiction*, 95(5), 749-764.

Sobell, L.C., Sobell, M.C., Toneatto, T., & Leo, G.I. (1993). What triggers the resolution of alcohol problems without treatment? *Alcoholism: Clinical and Experimental Research*, 17, 217-224.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2002). *Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services.* (DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2003). *Results from the 2002 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NHSDA Series H-22, DHHS Publication No. SMA 033836). Rockville, MD.

Sutton, S. (2001). Back to the drawing board? A review of the applications of the transtheoretical model of substance use. *Addiction*, 96, 175-186.

Tessina, T. (1991). *The Real Thirteenth Step: Discovering Confidence, Self-reliance and Autonomy beyond the 12-Step Programs.* Los Angeles, CA: Jeremy P. Tarcher, Inc.

Timko, C., Moos, R., Finney, J. & Moos, B. (1994). Outcome of treatment for alcohol abuse and involvement in Alcoholics Anonymous among previously untreated drinkers. *The Journal of Mental Health Administration*, 21(2), 145-160.

Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, 60(4), 437-447.

Toneatto, A., Sobell, L. C., Sobell, M. B., & Rubel, E. (1999). Natural recovery from cocaine dependence. *Psychology of Addictive Behaviors*, 13(4), 259-268.

Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V, Carroll, L., Repa, K., Martin, A & Tracy, L. A. (2002). *AA participation 10 years after Project MATCH treatment: Preliminary findings*. Poster presentation, Research

Society on Alcoholism, San Francisco, July.

Trachtenberg, R.L. (1984). *Report of the Steering Group to the administrator Alcohol, Drug Abuse and Mental Health Administration regarding its attempt to investigate allegations of scientific misconduct concerning Drs. Mark and Linda Sobell*. Alcohol, Drug Abuse and Mental Health Administration. Rockville, MD.

Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol*, 42, 626-641.

Tuchman, B. (1981). *Practicing History*. New York: Alfred A. Knopf.

Tucker, J. A., & Gladsjo, J. A. (1993). Help-seeking and recovery by problem drinkers: Characteristics of drinkers who attended Alcoholics Anonymous or formal treatment or who recovered without assistance. *Addictive Behaviors*, 18(5), 529-542.

Tucker, J. A., Vuchinich, R. E. & Gladsjo, J. A. (1994). Environmental events surrounding natural recovery from alcohol-related problems. *Journal of Studies on Alcohol*, 55(4), 401-411.

Vaillant, G. (1983). *The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery*. Cambridge, MA: Harvard University Press.

Vaillant, G. (2003). 60 year follow-up of alcoholic men. *Addiction*, 98(8), 1043-1051.

Vaillant, G. E. (1979). Paths out of alcoholism. In *Evaluation of the Alcoholic: Implications for Research, Theory and Treatment* (Research Monograph No. 5, pp. 383-394). Rockville, MD: National Institute of Alcohol Abuse and Alcoholism.

Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry*, 53(3). 243-249.

Volpicelli, J. & Szalavitz, M. (2000). *Recovery Options*. New York: Wiley.

Waldorf, D. (1983). Natural recovery from opiate addiction: Some social-psychological processes of untreated recovery. *Journal of Drug Issues*, 13(2), 237-80.

Waldorf, D., Reinarman,C. & Murphy, S. (1991). *Cocaine Changes: The Experience of Using and Quitting*. Philadelphia, PA: Temple University.

Walters, S., Hester, R., Chiauzzi, E. & Miller, E. (2005). Demon rum: High-tech solutions to an age-old problem. *Alcoholism: Clinical & Experimental Research*, 29(2), 270-277.

Weiss, R.D., Griffin, M.L., Gallop, R., Onken, L., Gastfriend, D.R., Daley, D., Crits-Christoph, P., Bishop, S. & Barber, J. (2000). Self-help group attendance and participation among cocaine dependent patients. *Drug and Alcohol Dependence* 60(2), 169-177.

Weisner, C. (1993). Toward an alcohol treatment entry model: A comparison of problem drinkers in the general population and in treatment. *Alcoholism Clinical and Experimental Research*, 17(4), 746-752.

Weisner, C, Greenfield, T & Room, R. (1995). Trends in the treatment of alcohol problems in the U.S. population. *American Journal of Public Health*, 85(1), 55-60.

West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, 100, 1036-1039.

White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals* (2nd ed.). Center City, MN: Hazelden.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, April 3-5, 2000. Retrieved July 31, 2004 from http://www.facesandvoicesofrecovery.org/pdf/toward_new_recovery.pdf.

White, W. (2001) Pre-AA Alcoholic Mutual Aid Societies. *Alcoholism Treatment Quarterly* 19(1), 1-21.

White, W. (2004a). Recovery: The next frontier. *Counselor*, 5(1), 18-21.

White, W. (2004b). Transformational Change: A Historical Review. IN SESSION: *Journal of Clinical Psychology*, 60(5), 461-470.

White, W. (2004c). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Retrieved on September 19, 2005 from http://www.facesandvoicesofrecovery.org/pdf/peer-based_recovery.pdf

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.

White, W., Boyle, M. & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, 20(3/4),107-130.

White, W. & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor*, 4(5), 58-63.

White, W. & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, 6(4), 58-61.

White, W. & Scott, C. (Draft Manuscript) Addiction recovery: Its definition and conceptual boundaries.

White, W. & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor*, 6(5), 58-62.

Wholey, D. (1984). *The Courage to Change: Personal Conversations about Alcoholism with Dennis Wholey*. New York: Warner Books.

Wilbourne, P., & Miller, W. (2003). Treatment of alcoholism: Older and wiser? *Alcoholism Treatment Quarterly*, 20(3/4), 41-59.

Willie, R. (1978). Preliminary communication--cessation of opiate dependence: processes involved in achieving abstinence. *British Journal of Addiction*, 73(4), 381-384.

Wilson, B. (1944). Bill's comments on Wylie ideas, hunches. *A.A. Grapevine*, 1(4), 4.

Wilson, B. (1958). The next frontier: Emotional sobriety. *A.A. Grapevine*, January, 2-5.

Wilson, B. (1962). Spiritual Experiences. *A.A. Grapevine*, July, 2-3.

Winick, C. (1962). Maturing out of narcotic addiction. *U.N. Bulletin on Narcotics*, 14,1-7 (January-March).

Winick, C. (1964). The life cycle of the narcotic addict and of addiction. *U.N. Bulletin on Narcotics*, 16(1),1-11.

Winzelberg, A. & Humphreys, K. (1999). Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Counseling and Clinical Psychology*, 67(5), 790-794.

Workgroup on Substance Abuse Self-Help Organizations (2003). *Self-Help Organizations for Alcohol and Other Drug Problems: Towards Evidence-based Practice and Policy.* (February 2003 Technical Report). SAMHSA.

Zweben, J. E. (1996). Psychiatric problems among alcohol and other drug dependent women. *Journal of Psychoactive Drugs*, 28(4), 345-366.

Zweben, J.E. (1986). Recovery oriented psychotherapy. *Journal of Substance Abuse Treatment*, 3, 255-262.

Acknowledgement: Financial support for the preparation of this paper was provided by the Great Lakes Addiction Technology Transfer Center (ATTC), which is funded by the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT). The ideas expressed here are those of the authors and should not be interpreted as reflecting the opinions or policies of the Great Lakes ATTC and SAMHSA. The authors would like to extend their appreciation to Earl Harrison, whose comments and suggestions on our first draft of this paper were particularly helpful.