# Toward a New Recovery Movement:

# Historical Reflections on Recovery, Treatment and Advocacy[1]

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## Preface

As a new recovery movement struggles to be born, many search for the midwife who can protect the Sources from whose loins this movement is emerging while helping this movement seek its own life and destiny. I believe history can serve as that midwife.

I have lived and worked in the worlds of addiction treatment and recovery for more than three decades--all of my adult life, and it was my experiences in these worlds that first incited my fascination with history and my discovery of history as the ultimate elder. For many years, I have sat at history's feet, listened to her stories, and tried to be an ardent student. The following pages are filled with my, admittedly inadequate, comprehension of the lessons that I believe history can offer this new recovery movement. These ideas were first presented at CSAT=s Recovery Community Support Program Conference in April, 2000 and are here expanded in the hopes of aiding recovery organizations across the country.

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*We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.*
BSandra Bloom, Creating Sanctuary

- Twenty-eight African-American ministers are meeting today to discuss using the combined resources of their churches to launch a local faith-based addiction recovery program aimed at salvaging the lives of individuals and families being destroyed by alcohol and other drugs. The ministers are deeply concerned that many members of their community have not done well in traditional treatment or mutual aid groups.
- The Circles of Recovery program (of White Bison, Inc. in Colorado Springs, Colorado) uses thirty tribal colleges to train individuals in recovery ("Firestarters") to seed cultures of recovery within Native American communities.
- The Connecticut Community for Addiction Recovery has organized recovering people and their families to help educate communities about recovery, to advocate for improved quality of addiction treatment, and to provide a wide range of recovery support services.
- Every Saturday, 20 young men in recovery from addiction wearing T-shirts that read, "Ambassadors of Recovery" clean up neighborhood parks, replace graffiti with uplifting art, and talk with neighborhood youngsters. They consider these service activities a way to make restitution for the wounds they afflicted on their community when they were addicted.

These local stories are part of a larger story: recovering people across the United States joining together to achieve goals that transcend their mutual support needs. Collectively, these communities without boundaries are expanding local recovery support services, advocating for the needs of addicted and recovering people, and finding creative ways to make amends and carry hope to others. The purpose of this paper is to acknowledge the existence of this new recovery movement, and to tap lessons from the history of addiction recovery, treatment and advocacy in America that might guide and protect this movement.

**1.0 Recovery Advocacy in America: A Brief Synopsis**

To begin, the history we will use to illuminate this new recovery movement is a deep one. For more than two centuries, recovering people and their families have been at the forefront of efforts to organize or sustain addiction-related mutual aid societies, religiously and medically-focused treatment institutions, and a wide variety of alcohol/drug-related advocacy groups in America.

The history of addiction mutual aid societies spans:

- X 18th century Native American recovery "circles"
- X 19th century alcoholic mutual aid societies (the Washingtonians, the fraternal temperance societies, the ribbon reform clubs, the Godwin Association, the Ollapod Club, the Keeley Leagues, and various moderation societies)
- X early 20th century alcoholic mutual aid societies (The United Order of Ex-Boozers, the Jacoby Club)
- X Alcoholics Anonymous, Al-Anon, Narcotics Anonymous and other 12-Step addiction recovery groups, and
- X a plethora of post-AA mutual aid societies (Alcoholics Victorious, Women for Sobriety, Secular Organization for Sobriety, and Moderation Management, to name only a few). (White, 2000 a,b,c).

There is a similarly long history of addiction treatment in the United States. Such treatment began within the private physician practices of the late 18th and early 19th centuries. By the late 19th century, there was a multi-branched treatment movement made up of:

- X religiously-oriented inebriate homes
- X medically-oriented inebriate asylums
- X for-profit private addiction cure institutes, and
- X bottled home cures for the alcohol, drug and tobacco "habits."

Following the virtual collapse of the specialized field of addiction treatment in the opening decades of the 20th century, treatment institutions again emerged during the middle decades of the 20th century (White, 1998).

Social, political and religious advocacy regarding alcohol other drug-related problems first focused on the problem of public intoxication (Austin, 1979; Lender and Martin, 1982). Advocacy efforts evolved into a concern about alcohol and other drug addictions in the 19th century (Levine, 1974), and culminated in parallel alcohol and other drug prohibition movements that reached a crescendo in the second decade of the 20th century (Sinclair, 1962; Musto, 1973). In the Post-Repeal years, alcohol and other drug (AOD)-related advocacy movements have varied greatly in the:

1) drugs they targeted,

2) population of users with whom they were most concerned,
3) particular drinking or drug using behavior that was their primary focus of attention, and
4) overall goals.

Such movements have included victim/survivor groups (MADD), drug prohibition and legalization movements, and a broad spectrum of prevention-oriented movements. Advocacy specifically related to addiction treatment and recovery began anew in the 1940s.

Between 1940 and 1970, a multi-factioned "modern alcoholism movement" sought and partially achieved a dramatic change in how the nation perceived alcoholism and the alcoholic. The grass roots nature of this movement dissipated as an alcoholism industry (and by extension, addiction industry) emerged and then became highly professionalized and commercialized. The 1990s witnessed a financial and ideological backlash against this industry and a new century opens with many believing that the ground gained in the mid-20th century is being lost in the face of a growing demedicalization, restimgatization and recriminalization of addiction.

The evidence of this shift can be seen in the:

X growing frequency and stridency of attacks on the disease concept of addiction and Alcoholics Anonymous,
X erosion of funding for addiction treatment,
X closure and/or dramatic downsizing of most hospital-based and (many) private addiction treatment units, and
X virtual explosion in the number of alcoholics and addicts who, once cared for in the public health arena, are now being controlled within the criminal justice arena.

In the midst of growing pessimism in the American culture about the prospects of recovery, there is a growing call for a new, grassroots recovery movement. This movement is re-raising questions about the potentials and pitfalls in the interrelationship between recovering people, mutual aid organizations, treatment institutions, and public education and social advocacy agencies.

## 2.0 Toward a Recovery Movement

**2.1 Alcoholism Movement, Treatment Movement, Recovery Movement** The modern alcoholism movement focused on educating the public and professionals on the nature of alcoholism and the character of the alcoholic. The treatment movement that grew out of it focused on creating, professionalizing and legitimizing medically- and psychologically-oriented care of the alcoholic and the addict. While each of these movements can claim successes, the dissipation of the first movement and a backlash against the second has left a vacuum that begs to be filled. *It is time for a recovery movement. The central message of this new movement is*

*not that "alcoholism is a disease" or that "treatment works" but rather that permanent recovery from alcohol and other drug-related problems is not only possible but a reality in the lives of hundreds of thousands of individuals and families.*

In our enduring debate over whether the roots of addiction lie in the medical arena (a problem of susceptibility) or the moral arena (a problem of culpability), we have lost touch with real solutions to addiction, the evidence of which is in the transformed lives of recovering and recovered people across America. Demonstrated solutions to alcohol and drug problems will do more to reduce the stigma attached to these conditions than will endless debates about the source of such problems. The question of the etiology and nature of addiction is a scientific question, not one resolved by social policy proclamation. The focus of this new movement is not on the source or nature of addiction, nor on the solutions that science may provide tomorrow. Instead, the focus is on the solutions that are possible at this moment if resources can be mobilized to effectuate them. *It is time we (the remnants of the existing alcoholism/treatment movements) redirected our energies from an emphasis on pathology to an emphasis on resilience and recovery.*

**2.2 Multiple Movements** There is accumulating evidence of two new emerging and potentially complimentary movements:

1) a recovery movement that is affirming the very real potential for permanent personal resolution of alcohol and other drug (AOD) problems, and
2) a public health movement that is offering solutions to AOD problems at the community and cultural levels.

While this paper focuses on the recovery movement, both movements are essential for the long-term prevention and management of AOD problems.

**2.3 Recovery Community and Recovery Movement** *The "recovery community" is a voluntary association of those impacted by AOD problems who come together for mutual support and joint action on AOD-related issues.* A "recovery community" exists only to the extent that multiple and diverse recovery communities reach beyond their own geographical and cultural boundaries to embrace a single identity. *The recovery movement is an organized effort to: 1) remove barriers to recovery for those still suffering from AOD problems, and 2) to improve the quality of life of those recovering from AOD problems.*

References to a recovery community and a recovery movement reflect a sense of identification that goes beyond one alcoholic sharing with another. It is the recognition of the existence of an invisible society without boundaries--a society in which citizenship is granted by

the status of shared experience and vulnerability. What the recovery movement offers through its leaders call for mutual aid, social communion, and political advocacy is a siren call of redemptive "we-ness" to those who have been shamed into isolation or cloistered within subterranean subcultures. The recovery movement offers an emboldened challenge to members of the recovering community who have achieved recovery from addiction and are passing as 'civilians' within the larger culture: "It is time we came out of hiding; it is time we announced our presence; it is time that our collective silence was broken." The expectation is not that all or even a majority of persons will go public with their recovery story, but that a sufficient number will choose to do so and that this choice will widen the doorway of entry to recovery for those who are still suffering.

**2.4 Movement Goals** *The internal goals of the recovery movement include:*

1) portraying alcoholism and addictions as problems for which there are viable and varied recovery solutions,
2) providing living role models that illustrate the diversity of those recovery solutions,
3) countering any public attempt to dehumanize, objectify and demonize those with AOD problems,
4) enhancing the variety, availability, and quality of local/regional treatment and recovery support services, and
5) removing environmental barriers to recovery, including the promotion of laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems.

The modern alcoholism movement focused on changing what people believed: their perceptions and attitudes toward alcoholics. Its focus was on reducing stigma. Movement leadership believed that improved care for the alcoholic would inevitably flow from the removal of such stigma. For the new recovery movement, reducing stigma may be best viewed as a peripheral by-product rather than a central goal of the movement. The goals instead would be best focused on what we want people (represented collectively as communities, states and the nation) to do. Such goals might include advocacy to:

X stop punishing and incarcerating people for what is essentially their status as addicts,
X create physical and psychological space in communities where recovery can occur,
X support research that will contribute to improved recovery outcomes,
remove barriers of discrimination against, and enhance opportunities for,

recovering people seeking to re-enter productive roles in their communities.

**2.5 Distinguishing Treatment and Recovery** There are enormous differences between professionally-directed treatment institutions and mutual aid societies, just as there are enormous differences in what constitutes "treatment" and what constitutes "recovery." A corollary of the proclamation that recovery is a reality is the recognition that professionally-directed addiction treatment may or may not be a factor in such recoveries and, where treatment does play a role, it is an important but quite time-proscribed part of the larger, more complex, and more enduring process of recovery. Treatment was birthed as an adjunct to recovery, but, as treatment grew in size and status, it defined recovery as an adjunct of itself. The original perspective needs to be recaptured. Treatment institutions need to once again become servants of the larger recovery process and the community in which that recovery is nested and sustained. *Treatment is best considered, not as the first line of response to addiction, but a final safety net to help heal the community's most incapacitated members. The first avenue for problem resolution should be structures that are natural, local, non-hierarchical and non-commercialized.*

*The interests and agendas of the recovery community and the treatment field overlap but are not the same*. Strong, highly organized constituencies of recovering people are not necessarily in the best interests of professionally-directed treatment institutions. Recovery constituencies are as likely to be critics as they are supporters of institution-based treatment. Members of recovery advocacy group, perhaps more than anyone, know the excesses and inadequacies of treatment institutions. Recovery advocacy groups will demand that the relationship between treatment professionals and their clients shift from its traditional hierarchical nature to that of a more respectful partnership in which clients have significantly enhanced rights and powers. Recovery advocacy groups will demand that the voices of addicted and recovering people be heard by treatment professionals and not discounted as "their diseases talking." These groups will advocate that treatment become more accessible, affordable, family-centered and effective, and they will confront exploitive or disrespectful treatment practices. The respective interests of the recovery movement and the treatment movement will also create tension over the question of whether resources should be allocated for treatment services or allocated for a broader range of recovery support services.

*Recovery support services are services aimed at removing barriers and opening natural pathways to addiction recovery.* Such services include transitional housing, recovery homes, day care to increase access to support meetings, sobriety-conducive employment, educational access, debt management and budget counseling, sober fellowship, as well as traditionally defined treatment services. The overall goals are to remove barriers to recovery and to create positive space (sober sanctuary) where recovery can grow. *Professionally-directed treatment services are*

*not the same as the broader umbrella of recovery support services. Indigenous people who lack professional training should not be involved in the former, while the latter may be best designed and delivered by the recovery community. Those providing treatment services and those providing recovery support services play different but complementary roles in the long-term recovery process.*

**2.6 Distinguishing Mutual Aid, Treatment and Advocacy** Mutual support, professional treatment and social advocacy constitute different but related functions. Mutual aid and treatment seek the transformation of the individual and the family, either within indigenous or professionalized support structures; advocacy seeks the transformation of the community environment.

The recovery community is one in which service is highly valued--one in which the stability of one's own sobriety is measured not by what one possesses but by what one gives away. Advocacy for recovering people is like making a 12th step call on a whole community or culture. It is a way to move recovery from the level of personal redemption to the level of social justice--a way of carrying experience, strength and hope to a whole community. The focus of advocacy is to assure that the cultural forces inhibiting addiction and promoting recovery outweigh those conditions within which addiction flourishes.

The functions of social advocacy and mutual aid rarely co-exist successfully within the same organization. Addiction recovery mutual aid societies have been mortally wounded by their involvement in operating treatment institutions or becoming ensnared in the political and, sometimes, religious conflict that often surrounds policy advocacy movements. The Washingtonians (1840s), the fraternal temperance societies (mid-1800s) and the reform clubs (1870s-1880s) are merely the earliest examples of the risk of such disruptive influences. When mutual aid groups get involved in broad public policy debates, they face two threats: 1) being torn apart by ideological schisms, and 2) being hijacked by larger, more powerful institutions or movements. *Co-mingling mutual aid and policy advocacy functions usually creates an organization that will either perform both functions poorly or sacrifice one function for the other. It is usually best to separate the service functions of mutual support, professionally-directed treatment, and social policy advocacy into separate agencies (or at least separate organizational units), but there are exceptions to this rule.*

**2.7 Cultural Revitalization** *For a besieged people (community), personal recovery may be inseparable from the broader issues of social policy advocacy and cultural revitalization.* Colonization, cultural dispossession and the resulting social, family, and personal disorganization heighten vulnerability for AOD problems. Cultural revitalization and cultural

repossession provide an antidote to such disorganization and a potential pathway out of addiction. Where viable, indigenous spiritual and healing practices and cultural prescriptions for abstinence need to be embraced within the larger umbrella of recovery support services. (See Williams, 1992 for a vivid example of such indigenous resources in one African-American community.)

*Within disempowered communities, addiction and recovery may need to be framed in their political, economic and cultural contexts.* Here, one's recovery is more than a personal act and may need to personally and culturally understood as such. Organizations advocating only a political framework of recovery (e.g., depictions of alcohol as a tool of genocide and recovery as a refusal to participate in that genocide), however, have rarely been able to sustain themselves over time, and their members themselves have been quite vulnerable to problems of addiction (See Hilliard and Cole, 1993). Disempowered communities require a balance between personal, political, religious, and professional frameworks of recovery, and the nature of that balance (which component is emphasized) may need to evolve over time. As groups/communities achieve revitalization, more personal and less politicized frameworks of recovery become prominent.

**2.8 Concepts that "Work"** *To be successful, the core concepts of recovery advocacy movements must "work" at personal, professional, community and cultural levels.* They must provide ideas, language, and ritualized experiences that are personally redemptive for those who devote their energies as the soldiers of this movement and to those who are still seeking a way out of their entrapment in alcohol and other drug-related problems. Recovery advocacy movements need to also work at a professional level by changing the way that professional caretakers perceive and respond to addiction and addicts, and by changing the value that society attaches to those who devote their lives to helping resolve such problems. Recovery advocacy movements need to also work at community and cultural levels to define who has ownership of alcohol and other drug problems and how such problems are to be managed. The historical intractability of alcohol and other drug problems suggest that cultural ownership of these problems is inherently unstable. (Room, 1978)

**2.9 New Kinetic Ideas** To alter public opinion, *successful movements condense complex ideas and needs into easily digestible slogans. Once these have achieved broad social acceptance, they may need to be de-constructed for the movement to move toward full maturity.* Where such maxims become concretized and reified, the movement sets itself up for a future ideological backlash. A most recent example of this can be seen in how the over-simplification and reificiation of the disease concept of alcoholism set the stage for a subsequent scientific

backlash against this idea. Dwight Anderson and Marty Mann, who defined the core ideas of the modern alcoholism movement in the early 1940s, characterized such ideas as "kinetic" for their potential ability to move people and incite change within major cultural institutions. Their kinetic ideas focused on the nature of alcoholism (as a treatable disease), the nature of the alcoholic (able to be helped and worthy of being helped), and the physical and social consequences of alcoholism (the status of alcoholism as a major public health problem) (Anderson, 1942; Mann, 1944). Developmentally, *it is time to shift the focus of this enduring advocacy movement from the nature of addiction to the reality of recovery.* The "kinetic" ideas for this new movement need to shift from a focus on pathology to a focus on the potential for recovery at the levels of the person, the family, the neighborhood and the community. This new focus will not be on the problems that alcohol and other drug use inflicts on a community but on the problems recovery removes from the community and what recovery positively contributes to the life of the community. The recovery movement will need to formulate and introduce a new set of kinetic ideas to guide its education and advocacy work. I believe that the following ideas will become central to this new movement.

1. *Addiction recovery is a reality*.
2. *There are many paths to recovery.*
3. *Recovery flourishes in supportive communities*.
4. *Recovery is a voluntary process*.
5. *Recovering and recovered people are part of the solution; recovery gives back what addiction has taken.*

***2.9.1. Addiction recovery is a reality*** for individuals, families, neighborhoods, and communities. The recovery movement will need to underscore this reality with faces, with stories, with numbers. It is time we introduced the community and the culture to hundreds of thousands of people in long-term recovery from addiction.

***2.9.2 There are many paths to recovery*** that are reflected in different structures and styles of recovery. In 1944, AA-cofounder Bill Wilson, responding to queries about why a story of "solo recovery" had appeared in the *A.A. Grapevine*, stated a simple but widely ignored truth: "the roads to recovery are many." (Wilson, 1944). These paths mirror the considerable diversity in the etiology, onset, course and outcome of alcohol and other drug problems. The recovery movement needs to celebrate the growing variety of structures and styles through which individuals are permanently resolving these problems.

The expanding varieties of recovery experiences are reflected in the growing diversity of

AA/NA and other Twelve Step group experience (Kurtz, 1999), the proliferation of mutual aid adjuncts and alternatives to AA/NA, a proliferation of religious and culture frameworks of recovery, as well as many emerging styles of "solo recovery."[4] The images that project from this movement into the wider society need to mirror the growing diversity of the culture of recovery. AA, NA, CA, WFS, SOS, RR and MM are a patchwork of organizations who differ markedly in their philosophies about the source and solution to AOD problems, but who share an enduring optimism about the potential for permanent resolution of such problems. Rather than fight with each other over THE right way to recover, it is time to acknowledge what anyone with any observational skills and common sense has known for a long time: *people with myriad patterns and circumstances surrounding their problematic relationships with alcohol and other drugs are finding diverse ways to initiate and sustain their resolution of these problems. It is time we celebrated the growing pluralism of the culture of recovery.*

**2.9.3** ***Recovery flourishes in supportive communities*** (that create space for recovery to grow). Major agendas for the recovery movement includes helping create space within communities where recovery can blossom and to then nourishing and celebrating these local recovery communities.

> *When we speak of "recovery community," these qualities take on added significance because of the shared wounds its members bring to their membership in this community. It is here that those who have never experienced sanctuary often discover a place where they feel physically and psychologically safe for the first time. Here one is accepted not in spite of ones imperfectness but because of the very nature of that imperfectness. It is here that, in discovering one's self in the stories of others, people discover both themselves and a "narrative community" whose members not only exchange their stories but possess a "shared story." Within such a community, one can find a deep sense of fit--a sense of finally discovering and connecting to the whole of which one is a part. The recovery community is a place where shared pain and hope can be woven by its members into life-saving stories whose mutual exchange is more akin to communion than communication.*[5] *This sanctuary of the estranged fills spiritual as well as physical space.*

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[4]"Solo recovery" (also described by this author as an "acultural style" of recovery, White, 1996) involves pursuing recovery from addiction without on-going relationships with formal addiction treatment, mutual aid structures, or significant support from other people in recovery.

[5]Kurtz, E. (1997a). Spirituality Workshop. Presented January 10-12, Little Rock, Arkansas; Kurtz, E. (1997b). Story, Memory and Identity. Presented at University of Chicago SSA Professional Development Program, October 31.

> *It is a place of refuge, refreshment and renewal. It is a place that defies commercialization--a place whose most important assets are not for sale*. (White, 2000d)

Recovery advocacy is not an advocacy for special treatment but an advocacy for justice: equitable access to health and social services and freedom from discrimination. Recovery flourishes in communities that value justice.

**2.9.4** ***Recovery is a voluntary process*.** Those addicted to alcohol and other drugs have all manners of coercive influences that challenge their continued AOD use. Natural coercion of the addict (the push forces that propel the addict toward a recovery process) come from the natural and accumulating consequences of addiction applied by those whose lives are impacted by the addict's behavior. *The world will deliver sufficient pain and threat to the door of the addict; the role of the recovery community is to deliver to the addict a message of experienced-based hope.* It is not the role of the recovery community to be the agent of such coercion. While treatment and exposure to mutual aid groups can be coerced, enduring recovery comes finally only through choice. Recovery involves the resurrection of the will and (for most people) a mobilization of resources beyond the self. The role of the recovery community is to create a welcoming sanctuary (a pull force) where the coerced can find, not an agent of punishment, but an agent of hope. Coerced recovery is an oxymoron; one cannot be forced to be free.

**2.9.5** ***Recovering and recovered people are part of the solution*** (to alcohol and other drug problems). *Recovery opens opportunities to give back what addiction has taken* (from individuals, families, neighborhoods, and communities). There is a profound sense of justice in the universe. If you disturb that balance, you take on a debt of obligation to restore it. Recovery takes a community's historical deficits and turns them into assets by challenging those in recovery to accept the mantles of restitution and service.

Recovering addicts repay their debt to the community through acts of restitution, by returning to productive roles in their families and workplaces, and by putting resources into the community rather than taking resources out of the community. The recovery movement offers the challenge of redemptive service: "You have been part of the problem; now be part of the solution!"

The service mantle offered by the recovery community can be actualized in many forms, but one potentially controversial form is that of breaking public silence and taking the act of advocacy public. The recovery movement offers a challenging invitation: "If you have found recovery, consider giving the community your story as an instrument of hope and healing. If you

have been blessed by resources that helped you find and sustain recovery, then join the fight to expand those resources for those who are still suffering." The key in this is personal choice: the right of each recovering person to determine if, when, and at what level of detail their recovery story is shared. Recovering people bring quite different individual circumstances to this question and affiliation with divergent support structures. The recovery movement will need to be exceptionally tolerant of individual choice regarding public disclosure of recovery decisions as it seeks its overall goal of creating hope for recovery and creating visible pathways of entry into recovery. Public self-disclosure of one's story is just one of a broad spectrum of gifts recovering people can offer to this movement.

**2.10 The Cost of Recovery** While there is legitimate concern about the skyrocketing costs of acute episodes of addiction treatment, "the vast majority of people in recovery manage the chronic and recurring nature of their disease at no cost to the taxpayer or the health care system" (Gertig, 1997). The successful management of long-term addiction recovery exacts fewer costs than the management of almost any other chronic disorder. The most important elements of sustained recovery--the commitment of self and the support from family, friends, and other recovering people--come without a price tag, and it is the nurturance and mobilization of those elements that are the primary mission of the new recovery movement.

**2.11 Redefining Recovery** The varieties of recovery experience call for this new movement to contemplate the very definition of recovery and sobriety. "Recovery" can entail a complete elimination of AOD use and AOD problems AND it can also entail a significant reduction in such use and problems. Recovery from addiction, like recovery from other serious medical disorders, can involve patterns of full or partial remission. AA recognized this continuum of outcomes from its inception; it was one of the first alcoholic mutual aid societies that did not threaten to expel members who relapsed. AA asked not for perfection but for progress; the requirement for membership was defined not as the achievement of permanent sobriety but a "desire to stop drinking." Recovery is the process of bringing alcohol and drug problems into a state of stable remission. From individual to individual, that process may require many diverse strategies and steps. As the recovery movement seeks to define the boundaries of recovery, it will need to address many potentially contentious issues: Can and should harm reduction activities play a contributing role (e.g., information. engagement) in this long-term process of recovery? Should individuals who have been long stabilized on methadone be welcomed with full status into this recovery community? The long term fate of this movement may hinge on its ability to tolerate differences and tolerate boundary ambiguity while forsaking calls to create a closed club whose exclusiveness would leave many suffering people refused

entry at its doorway. Somewhere in this movement's maturation, a message of unification needs to be extended that psychologically and socially links the growing number of recovery groups and solo flyers into a community of shared experience that can transcend differences and allow it to speak powerfully on one issue: the very real hope for permanent recovery from addiction. It is crucial that a way be found to transcend the internalized shame that turns members of stigmatized groups upon each other in frenzies of mutual scapegoating. The most serious battles fought by this movement are best waged, not with each other, but with more formidable forces in the culture that seek to objectify, demonize and sequester all those with AOD problems.

**2.12 Models of Change** The current generation of recovery advocacy groups are among the first to utilize theoretical models of social change to guide there development of strategies and tactics, e.g., Ghandi, King, Alinsky, Freire. It is this generation of recovery advocacy groups that will, through their unique histories, reveal whether such models enhance outcomes or whether it is better to have a model evolve out of a particular local, historical and cultural context.

**2.13 Core Activities**. Seven activities constitute the heart of the recovery movement:
1) *Recovery Needs Assessment* (identifying recovery obstacles, evaluating existing treatment/recovery support structures, identifying needed recovery support services).
2) *Recovery Education* (lay and professional).
3) *Resource Development* (philanthropy, fund-raising, grant-writing assistance, volunteer recruitment, participation in service planning/evaluation structures).
4) *Recovery Resource Mobilization* (community organizing; operating/supporting centralized information and referral services serving as client advocates).
5) *Policy Advocacy* (federal, state, and local political advocacy regarding legislation, regulation, programming, funding).
6) *Recovery Celebration* (enhancing identity and cohesion of recovery community, making recovery visible in the community, putting human faces on recovery via major media outlets).
7) *Research* (supporting a recovery research agenda: see later discussion).

**2.14 Toward Realistic Images** The modern alcoholism movement took the humor out of "drunk jokes," conveyed the terrible toll that alcoholism takes on individuals, families and communities, and altered the image of the alcoholic from that of a skid row derelict, to one's next door neighbor, or one's own family member. Perhaps the apex of this destigmatization campaign came the moment that First Lady Betty Ford told the nation about her treatment for

alcoholism and her continuing recovery. Her disclosure reflected a Camelot period in which people from all walks of life declared their recovery from alcoholism. But many of those images have disappeared as America has begun to restigmatize the alcoholic and the addict. Watching the instruments of popular media, one could rightly ask whether anyone goes to "rehab" other than celebrities caught in their latest indiscretion. Watching millionaire, celebrity athletes announcing their re-entry into a private treatment center following their latest failed drug test, one could rightly ask whether anyone every really recovers from addiction to alcohol or other drugs. The faces of barely sober addicts on television screens need to be replaced by the faces of people from all backgrounds who have survived addiction to live full lives. With no other disorder do we ask people in the earliest days of recovery to speak as if permanent recovery had already been achieved. It is not that the floundering, newly sober celebrity is not welcome in the culture of recovery; it is that portraying this person as the culture of recovery is a gross misrepresentation of reality. It is also a fact that thrusting individuals in the earliest stages of recovery into the limelight is to invite disaster for them as well as the movements they represent.

The focus needs to shift from the addiction, the addicted, and the barely sober, to those in sustained recovery. Attitudes toward cancer and people who experienced cancer weren't changed by portraying dramatic images of cancer's potential devastation--fact too painfully known by most citizens. Nor were such attitudes changed by having people survive their acute treatment experiences. Attitudes changed when, as a culture, we reached a critical mass of visible people who had recovered from cancer and went on to live full lives.

*Superficial lip service that alcoholism is a disease will not change how the culture views the alcoholic if the reality of recovery is not brought into the direct experience of the citizenry.* The 19th century ribbon reform club movements (noted for the practice of recovering people wearing a ribbon on their clothing) were not only for mutual identification and support but a means of conveying hope to a larger community that enduring recovery was not only possible but a living reality.

**2.15 Accurate, Hopeful Language** *One of the challenges of the recovery movement will be how to reduce the stigma attached to a condition and those who suffer from it with a cultural language that is heavily laden with the stigma.* The movement will need to enter into serious debate about how to refer to those suffering from alcohol and other drug problems and how to refer to those who no longer experience such problems. The vogue in recent years, that many have attacked as superficial political correctness, is to replace labeling individuals as conditions or things ("the disabled," "chronics") with a less objectifying and stigmatizing "first person" language ("persons with disabilities," "persons suffering from severe and persistent mental illness").

In the addiction recovery arena, two sets of language may be required--one for internal and one for external communications. Because mutual identification and linguistic candor are so much a part of the American culture of recovery, self-identification using the terms "alcoholic" or "addict" possess utility as tools of personal change that will continue well into the future. I would, however, recommend that, at the level of public discourse, the terms "alcoholic" and "addict" be replaced with first person language ("person experiencing alcohol (drug)-related problems") that is less objectifying and socially stigmatizing. This would also provide a way to escape the cultural confusion over exactly who is and is not an alcoholic, and by doing so shift the focus from the technical application of this label to a focus on the precise consequences of alcohol and other drug use on users and those closest to them. If we continue to use the language of "addicts" and "alcoholics" (as I am prone to do after more than 30 years in the addiction treatment/recovery worlds), we might at least consider referring to "alcoholics in recovery" and "alcoholics not yet in recovery"--a way to signal the reality of the former and optimism for the latter.

There are also potential benefits of using multiple terms at the level of public and professional discourse that could convey the developmental stages of addiction recovery and the continuum of remission patterns. The terms "seeking recovery," "in recovery" and "recovering" could continue to be used to depict individuals who are making concerted efforts to remove destructive patterns of alcohol and other drug use from their lives, while the term "recovered" could be used to depict those who have achieved an extended (perhaps 5 years)[6] period of symptom remission.

**2.16 Transforming Existing Social Institutions** *To be successful, advocacy movements must engage primary cultural institutions.* The change induced by such movements must extend itself into and be anchored within the heart of society rather than being a superficial and potentially transient appendage to it. Like the alcoholism movement that preceded it, this new recovery movement must generate many smaller movements to carry its message of hope for recovery to the very heart of the culture and into the realms of media, government, law, medicine, business, education, religion, and entertainment. The concept of "recovery community" must be extended to the creation of micro-communities within neighborhoods,

[6]The traditional time period to medically designate recovery from a potentially chronic disease.

schools, churches, workplaces, and the courts..

**2.17 Movement Scope** Eventually, the new recovery movement will need to organize at local, state/regional, and national levels. We must build this movement within local recovering communities while building connecting tissue and forging an inclusive identity across these communities. Given the enormous diversity of local groups, both in terms of their membership composition and their primary foci, the national movement must be able to embrace groups with widely varying philosophies and agendas. The question of whether it is better to energize an existing national organization with a compatible mission or create a new organization depends to a great extent on whether the existing organization can meet this challenge of inclusiveness.

## 3.0 Movement Pitfalls

Virtually every aspect of how an AOD-related advocacy movement is launched and sustained contains the seeds of that movement's success or demise. *The major pitfalls of AOD-related mutual aid and advocacy groups have included mission diversion, ill-conceived or ill-defined core ideas, ideological extremism, commercialization, professionalization, charismatic leadership, organizational isolation, external co-optation, premature and superficial success, and unmanageable growth or attrition.* What follows are some brief reflections on some of these pitfalls.

**3.1 Professionalization and Commercialization** *The twin threats of professionalization (preoccupation with power/status) and commercialization (preoccupation with money/property) have often proved fatal to advocacy movements.* The professionalization of helping systems can inadvertently undermine indigenous supports for recovery, shift the focus of a movement from experienced knowledge to second-hand knowledge, and shift the service relationship from one that is enduring and reciprocal to one that is time-limited, hierarchical, and commercialized. In this transition toward professionalization, the functions of the movement are essentially commodified and privatized, risking a shift in focus from service to others to financial gain and achievement of professional status. John Gough and John Hawkins, the two most famous recovering Americans of the 19th century, abandoned their roles as indigenous leaders of alcoholic mutual aid societies to pursue careers as paid temperance lecturers. The best antidote against this pitfall is to make sure that the bulk of resources go to support service activities rather than property or personnel. The primary focus of the movement should remain on *voluntary action*. When moral entrepreneurs evolve into business entrepreneurs, the social movement that they started evolves into an industry that may lose touch with its historical mission. One wonders about the emotions of Harold Hughes, who after leading the battle to create federal

funding for community-based alcoholism treatment, later lamented the emergence and explosive growth of an "alcohol and drug abuse industrial complex."

In the transition between social movement and industry, some movements become social/commercial phenomenon marked by celebrity speakers, books, journals, audiotapes, and innumerable movement icons. There is nothing inherently wrong with such trappings; they characterize the most successful of movements. But there is a danger that the soul of a movement can be corrupted by the crass commercialism that often marks the shift from movement to pop cultural phenomenon. The proliferation of such items in the 1980s led some to coin the term "recovery porn" to classify this genre of items whose intent was more one of making money than supporting recovery.

**3.2 Money and Movements** *It is better to have an unfunded or under-funded movement than to have a well-funded movement whose mission is corrupted by the source or level of that funding. It is better to have the inception of a movement postponed than to have that birth prematurely induced by money that deforms its subsequent development.* Strategies of financial support that work in the short run can sometimes undermine a movement in the long run. Movements can die from a lack of resources, but they can also die from the turmoil, restrictions, and diversions that resources can bring. To the new generation of grass roots advocacy organizations I would say:

> Carefully heed the adage 'he who pays the piper picks the tune'; find your own voice and sing only your own song. Be aware of seeking funding from any source that changes, no matter how subtly, your thinking, your vocabulary, your mission, or your methods. Find a way to use money temperately to achieve your mission; money has no value and becomes destructive when it takes your "eyes off the prize." If you evolve into funded treatment agencies, you will have failed by professional absorption.

What happened to the advocacy organizations of the 1960s and 1970s was that they evolved into funded treatment and prevention agencies. They ceased being volunteer-based advocacy organizations and became professionally-directed service organizations. Rather than serving as a support to and as the conscience of the emerging treatment system, they became part of that system. In fulfilling an important unmet need, in stepping in to fill that void, they abandoned their original mission. Their organizations survived but their advocacy missions did not, and it was that failure that left a void of need that set the stage for the current re-emergence of advocacy agencies in the addiction/recovery arenas. Some of the most successful social movements that were able to bring together diverse and multi-agendaed constituencies behind a single goal

fragmented at the very time the success of that movement was imminent. *Dividing the "spoils of success" is one of the most precarious times for any social movement.*

**3.3 Lost Stewardship** When movements get institutionalized, there is often a progressive erosion in stewardship practices. Resources devoted directly to the mission in early stages get absorbed into organizational infrastructure and personal and/or professional enhancement in later stages. *The principle of stewardship demands that we monitor the resources that flow into and out of recovery movement organizations to assure that resources that once passed through the organization into the community, do not begin to remain in the organization.* The best test of whether we have remained true to our founding mission is how we are expending our resources. Put simply, if you want to know the philosophy of a particular organization, don't read its vision or values statements, read its budget.

**3.4 Self-destruction by Implosion or Absorption** *The successes and potential vulnerabilities of mutual aid societies, treatment institutions, and social advocacy organizations often flow out of how they relate to the wider community.* The gravest dangers emerge from two excesses. The first is sustained isolation from the community, a stance that is often a precursor to cult-like extremism. Such isolation often results in stagnation and implosion, as can be seen in the histories of early (the New York State Inebriate Asylum) and modern (Synanon) treatment institutions. The opposite danger lies in such over-involvement in the community that the organization is vulnerable for colonization by more powerful forces. This risk of death by dilution, diffusion and co-optation can be seen in the histories of such groups as the Washingtonians and the Keeley Leagues.

Leaders of recovery advocacy movements need to cultivate the ability to anticipate and read changing cultural winds. *Effective recovery movement leaders carefully monitor changes in their operating environment and regularly ask, "What does this unfolding event and the culture's response to it reveal about the status of our mission and our methods?"*

**3.5 Premature Victory** (The Dangers of "Super Success") *There is danger that movements focusing on reducing stigma prematurely claim victory in the face of a positive media attention or sudden (but often superficial) shifts in public opinion. The fastest way to kill anything in America is to turn it into a superficial fad that dies from distortion and over-exposure.* The Washingtonians died, in part, from over-exposure, and one of the greatest threats to AA came in the 1970s and 1980s at the very time that the rehab/recovery fad was generating explosive growth in AA. The threat was that historical AA would be drowned in a sea of treatment psychobabble and commercialized recovery paraphernalia. *The most insidious death of*

*the recovery movement could occur if the essence of that movement died while the illusion of its continued existence remained. This would be an invisible death--a death by value dilution and corruption.*

Cosmetic change can pacify a movement and lead to claims of premature victory. Such superficial change (tokenism) often masks the absence of fundamental change.

Social change is like personal change in that it involves the twin challenges of initiating change and then sustaining that change over time. Social change, like personal recovery, requires a maintenance program in order to avoid regression and relapse. It has been interesting to watch recovering people whose own transformation spans years of false starts and regressions get involved in advocacy and become impatient and angry at the slow pace of change in their communities. *Conversion experiences are rarer for communities than they are for individuals; social change often involves the same slow stages of change that so often mark the process of personal recovery.*

**3.6 Mission Diffusion** *One of the most significant challenges of any advocacy movement is to maintain fidelity to its founding mission.* What looks like a natural extension of mission can turn out to be a fundamental diversion from mission. A movement initiated with a narrow agenda may absorb other agendas as it gains momentum; this agenda acquisition process can alter the character and future of the original movement. This is evident in the transformation of occupational alcoholism services into employee assistance services, then into behavioral risk management programs (the drug free workplace movement), and, more recently, into managed behavioral health and work life programs. These shifts created, not by intent but by consequence, a lost focus on recovery resources for addicted people. To avoid what will be innumerable temptations, *the recovery movement will have to find a way to clearly define and maintain its singleness of purposes and to avoid political and financial entanglements that could divert it from that purpose.* If these newly emerging advocacy organizations themselves become overly preoccupied with maintaining their own infrastructures or evolve into service agencies, they will have failed, as measured by fidelity to their founding mission.

**3.7 Methods and Mission** Social movements often go awry when their emerging methods conflict with their mission and core values. *The means used by movements to achieve their mission must be congruent with that mission.* Recovery movements must be, above all, grounded in recovery values: honesty, simplicity, humility, gratitude, and service.

**3.8 Stigma Close to Home** Organizations providing recovery support services will have to confront stigma from a most unexpected source--those who fund addiction-related services.

Representatives of funding organizations can exhibit such stigma via paternalistic judgements regarding what recovery-based organizations are capable of achieving. As the recovering community and its partners come together, the first task will be to explore how we act out the very stigma we are trying to remove in the larger society.

**3.9 Scapegoating: Inclusion/Exclusion** Movements organized by and for individuals from socially stigmatized groups are prone to create exclusionary class structures regarding movement participation. This phenomena represents a type of "Stockholm Syndrome" through which traumatized victims mimic the behaviors of those who have controlled their fate. Exclusion, scapegoating and extrusion of particular groups of individuals, and intra-movement schisms and warfare are all ways that oppressed groups avoid confronting more powerful forces in the larger social/cultural environment. The "modern alcoholism movement" of the 1940s-1960s was to a great extent a movement whose aim was to make alcoholism a respectable disease for those who had already achieved recovery, particularly the elite who, without the stain of alcoholism, could resume their positions of cultural entitlement. Pecking orders of status based on drug of choice, support structure affiliation, style of recovery, treatment modality, and degree of recovery (defined quantitatively and qualitatively) have all served to divide the recovery community, as have issues of gender, race, and social class. *Before the recovery movement can confront stigma in the larger society, it must confront how that same stigma gets acted out as a destructive force inside the movement. Developing an inclusive recovery movement requires skills in cross-cultural communication, conflict resolution processes, and safe sanctuaries where healing and cross-cultural communication and relationship-building can occur*.

**3.10 Those Left Behind** *Movements that are created to advocate on behalf of the most disempowered often leave these very individuals behind as the focus of the movement seeks wider social acceptance*. To alter the image of the alcoholic/addict, there is a danger that those who come closest to the demonized caricature will be left behind in the wake of the movement's success. In emphasizing that the skid row alcoholic was only 5% of alcoholics, the skid row alcoholic (and the poor alcoholic, in general) was excluded from most of the treatment and recovery support services that marked the expansion of such services in the late 1970s and 1980s. The recovery movement will also have to guard against the process of inversion: shifting its primary focus from the needs of the still suffering (those not yet in recovery) to the needs of the stable (those who are in recovery).

**3.11 Movement Coalitions** Successful social change movements bring together broad, multi-agenda coalitions who may support a single goal but then fragment into competing camps

as success nears or is achieved. The future fate of some movements are set in the earliest formation stage of the movement when coalitions are created by parties whose long-term interests are incompatible, e.g., MADD and SADD accepting financial support from the alcohol industry. What many groups did not realize was that what presented itself as an opportunity to push the movement forward turned out to a source of mission corruption and a source of damage to the movement's image and credibility. *Compatibility of primary interests is an essential principle in creating effective social movement coalitions.* Successful movements bring together multiple stakeholders with diverse agendas while guarding against attacks from persons and institutions whose interests are threatened by the new movement. *As local recovery advocacy movements emerge, defining friends and enemies of the movement is not always easy. It is best not to enter into alliances until one's own organizational identity (mission, core values) has solidified.*

**3.12 Developmental Stages** *There are predictable developmental stages in the life of AOD-related advocacy organizations.* The first challenges are for an organization or larger movement to get launched and then establish its niche within the alcohol and drug problems arena. At this point, the organization must compete with other AOD problem stakeholders in the marketplace of ideas and compete for resources and the public's attention. Fledgling movements must emulate the "little engine that could" by acting as if they are a movement until they become a movement.

Crucial developmental tasks during this period include the emergence of organizational leaders; the formulation of a viable organizational structure and decision-making processes; the codification of the mission, vision and core values; the emergence of core methods and activities; the creation of a resource development strategies; and the structuring or relationships with other organizations within and outside the AOD problem arena. The future success or failure of an organization is often shaped by how well these early tasks are managed.

To achieve maturity requires both time and the completion of other critical developmental tasks: resolving problems of charismatic leadership, addressing leadership development and succession, working out on-going questions regarding strategies and tactics, finding sufficient resources to sustain the organization and its core activities, and balancing the emotional needs of members with the demands for increased organizational efficiency. The most significant danger at this stage is the tendency of the movement to move toward professionalization and bureacratization. The risk is that the focus and passion that spawned the organization get lost in the shift in focus from why things are done and their effects to a preoccupation with how things are done.

Organizations and movements, like individuals, can die from old age. To sustain a

movement requires a structure of leadership development, membership recruitment, and continued resource development, but it also requires that the movement's core ideas and strategies get re-interpreted and sometimes redefined in light of changing political, economic, and social contexts. *The ebb and flow of energy within social movements is normal and can be actively managed with periodic renewal processes/rituals.*

**3.13 Movement Stages and Movement Roles** *Three overlapping roles can be found in the history of destigmatization movements: moral entrepreneurs, business entrepreneurs, and technocrats.* A movement's fate is dictated in part by which of these roles dominate at different stages of the movement. There are similarly different backgrounds and skills needed at different stages of social movements. The job of the moral entrepreneurs is to use their personal charisma to call the community's attention to unmet needs and to mobilize interested parties into a sustained movement to address these needs. The job of business entrepreneurs is to create viable, sustainable organizations and to codify their products and services. The job of the technocrats is to sustain this organization and refine its products and services over time. Some individuals will likely end up performing all three roles over the course of their involvement in the recovery movement. Technocrats fail at leading movements just as moral entrepreneurs often fail at sustaining organizations. The key is to match the right leadership role with each particular developmental stage of a social movement and to weather the personal and organizational strain during the transition from one stage to the next.

**3.14 Member Attrition** *Nearly all movements experience critical periods of member attrition through which oral history, core values, and key areas of technical knowledge are diluted or bled out of the organization.* Such crises suggest the need for ongoing membership recruitment that crosses generational lines and the need for archivist whose contribution to the movement is to prevent such valuable knowledge from being lost. Movement records provide an opportunity to honor the history of the movement as well as study and reinterpret key documents for their contemporary import.

**3.15 Counter-movements** *Movements that acquire visibility and influence often generate their own counter-movement*. Once movements become visible on the cultural horizon, they become a target of those institutions whose interests they threaten. The degree of success of any movement--the civil rights movement, the environmental movement, the gun control movement--cannot be fully ascertained until that movement has weathered the counter-movement that it generates. Counter-movements can gain energy and credibility by capitalizing on flawed elements of philosophy or strategy that occur early in a movement's history. For

example, the narrowly defined disease concept of alcoholism that produced a workable slogan for de-stigmatization campaign from the 1940s to the 1970s eventually triggered a scientific and clinical backlash against this very concept in the 1980s and 1990s. Tomorrow's attacks upon a movement from without are often the shadow of today's misuse of ideas, people and resources within the movement. It would have been hard during the very height of the destigmatization of alcoholism in the U.S. in the 1970s, to have envisioned the ideological and economic backlash against treatment and recovery that would begin in the following decade. *Counter-movements germinate within the soil of a movement's excesses.*

**3.16 Defining Moments** There are defining moments in all social movements. It is the decisions made in the heat of these moments that determine the fate and character of the movement. Some of these moments are recognizable as they unfold; others are recognizable only in retrospect and can consume hours of "What if?" discussions. *Recovery and advocacy movements succeed or fail by either capitalizing on or failing to recognize such narrow windows of threat or opportunity.*

**4.0 The Recovery Research Agenda**

**4.1 Technological Advances** *There are critical stages in most successful social movements that require breakthroughs in technology for the movement to proceed.* The goal of expanding reimbursement for alcoholism treatment could not have been successful without: 1) acceptable diagnostic criteria, 2) replicable treatment models, 3) alcoholism treatment program accreditation procedures, and 4) alcoholism counselor credentialing procedures. The emerging recovery movement will reach a point where it cannot proceed without a foundation of scientific research on recovery itself. (An effective use of federal, state, and private philanthropic dollars would be to support the development of this critical technology.)

**4.2 The Recovery Research Agenda** The question of "how do we get persons suffering from alcohol and other drug problems into treatment?" needs to be reframed to the question of "how we get them into recovery?" The answers to these two questions are not necessarily the same. *The future of the recovery movement does not hinge solely on recent or future scientific data on the etiology of AOD problems/addictions. It hinges on the emergence of a science of recovery extracted from the lives of those who have achieved such recovery*. Scientific breakthroughs on the etiology of addiction are relevant only to the extent that they provide clues to the prevention of addiction and clues to successful recovery pathways and strategies.

We know a great deal about addiction and that body of knowledge grows daily, but we know very little about recovery. We have elaborate systems to measure the incidence and

prevalence of AOD use, and AOD problems, but virtually no comparable systems that can tell us the number or characteristics of those who have found enduring solutions to these problems. We study the status of people a few months or a few years following a treatment episode, while we know virtually nothing about people whose recovery is measured not in weeks or months but in decades.

Treatment studies are not recovery studies; studying recovery by studying treatment is like studying human life by studying only birth. Our studies of addiction have produced only humble results. *Perhaps it is time we expanded our focus beyond the study of the addiction problem and the effects of various treatments to include studies of the broader recovery solutions.* The shift being called for is one that moves the focus of our attention from one of the study of risk/pathology to one of recovery/resilience/possibility. A recovery research agenda would include attempts to answer such basic questions as:

- X How many recovering and recovered people are there in the U.S.?
- X How do the characteristics of those who are in recovery differ from the characteristics of those people with AOD problems who are not in recovery?
- X What are the processes, strategies, support structures, environmental contexts, and precipitating events that characterize such recovery?
- X How do recovery pathways and styles vary by age of onset of use/recovery, duration of use/recovery, gender, ethnicity, education, class, living environment, sexual orientation, religious affiliation, disability and primary drug of choice?
- X What resources play the most critical roles in successful recovery from AOD problems?
- X What are the variety of patterns represented in the recovery process, e.g., patterns of full remission, types and styles of partial remission?
- X Are the rituals and structures that support long term recovery different than those that support early recovery?
- X How do the mechanisms that support solo recovery differ from recovery that is mutually supported?
- X How do different recovery structures and styles differ qualitatively, via Wilson's concept of "emotional sobriety?"
- X What events or circumstances contribute to relapse by those who have achieved long (more than 5 years) of symptom remission?
- X What activities (across recovery styles/structures) are most predictive of symptom remission?
- X Do "harm reduction" interventions constitute a pathway of entry (an early

developmental stage) of recovery or do they postpone or divert recovery decisions?

There is much that could be gained by pursuing a recovery research agenda. We have multiple taxonomies of alcoholism/addiction but virtually no taxonomy that depicts the variety of subgroups who have successfully achieved long term recovery. Who are these people and what subgroups make up this growing "recovery community?" Do different subgroups use different support structures and mechanism of self-governance to sustain their sobriety?

*It is time the recovery community created an activist-based, solution-focused research agenda: an agenda that seeks not merely understanding but one that seeks knowledge that can make a difference in the lives of individuals, families and communities.* Support for recovery research could be made contingent upon whether the findings of a proposed study will help initiate, sustain, or enhance the quality of recovery.

## 5.0 Leadership

**5.1 Source of Movement Leadership** *The leadership of the recovery movement must come from the recovery community and the movement's agenda must be those of recovering people and their families.* Great care must be taken in avoiding the problem of double agentry--individuals speaking openly as recovering people while their voices actually represent hidden professional or institutional interests. The movement must guard against those who will seek to colonize this movement to further their own personal, professional, and proprietary interests. Federal/state alcohol and drug authorities, treatment institutions, and treatment professionals may be supporters, members, and partners within this movement, but the leadership must come from within the indigenous recovery community. Where few indigenous resources exist, local treatment agencies/professionals can play a role in nurturing the development of such resources, but it is the recovery community itself that must eventually assume the central role in recovery advocacy and in the design, delivery and evaluation of key recovery support services.

**5.2 The Problem of Centralized, Charismatic Leadership** There is a unique paradox related to the issues of leadership of advocacy movements. *Advocacy movements need strong leadership and yet can be wounded by that very style of leadership.* The centralization of power and decision making in a single leader (and his/her inner circle) can, over time, magnify even minor character flaws into major sources of personal/organizational vulnerability. The best antidote to such vulnerability is a style of leadership that is democratic (facilitative rather than directive) and regularly rotated, or tandem leadership in which two or more leaders serve jointly, each tempering the potential excesses of the others. (An historical example of tandem leadership

in the early stages of a movement can be found in the relationship between AA's co-founders.)

**5.3 Personal Price of Leadership** The recovery movement is greater than its leaders, and it is that higher value which compels these leaders to honorably represent the movement and to not wound the movement through personal excesses or indiscretions. *What advocacy movements demand of their most visible leaders is not perfection but continual vigilance and a reasonable congruence between the life lived and the implicit and explicit values of the movement.* The weight of this mantle of leadership can be a considerable one.

**5.4 The Vulnerability of Leaders (The Curse of Icarus)** *When a whole movement is linked to the reputation of a single man or woman, whose reputation is then publicly wounded, such wounding can prevent the full emergence of a movement or, once emerged, lead to the premature diminishment or death of that movement.* Men and women who have conquered all manner of addicts can become intoxicated with their leadership positions and the holiness of their new cause. It is not unusual for such individuals in the throes of such intoxication to fly to close to the sun and then plummet to their demise, sometimes taking their movement with them. As the recovery movement builds, those who successfully led smaller groups may be thrust into larger arenas in which even minor character defects can be magnified into potentially fatal flaws. This can be particularly true for individuals in early recovery for whom the spotlight constitutes a most dangerous place. This capacity for excess can be tempered by rotating leadership, by openly recognizing such risks, and by building support systems that can help keep our leaders grounded.

**5.5 Media and Leadership** The media that feeds on today's story of our leader's dramatic redemption will tomorrow circle like vultures at the first sign of a fall from grace. *Over-telling the redemption story can set one up for such a later fall from grace.*

**5.6 Leadership Development and Succession** *Mutual aid, advocacy and treatment organizations can die due to their failure to adequately address the issue of leadership development and leadership succession.* Continuing membership recruitment across generational lines and rotating leadership practices are the two most successful strategies to sustain social movements.

## 6.0 Pleasures and Pitfalls of Movement Participation

**6.1 The Nobility of Service** Many people wake up in the early or middle stages of recovery with a sudden realization that they are alive and free from the obsession and physical appetite of addiction. This realization is also accompanied by what might be called survival guilt. Such breakthroughs of awareness can raise penetrating question about why one was saved when so many others were not. It is within such introspection, that one can feel the stirrings of "calling"--a sense that one was saved for some special purpose that must now be pursued. *For more than two centuries, recovering people have pursued this calling within the arenas of advocacy and service.*

**6.2 Movement Participation** *Successful social movements recognize and respect the fact that members bring different capacities regarding the duration and intensity of movement participation*. Successful movements create within their evolving membership a blend of short-term, task-oriented involvement and long-term commitment, like a track team with runners specializing in different distances. The future of any advocacy group is threatened by a membership of all short-distance runners.

**6.3 Message and Messenger** For recovering people to take on the role of advocate is not an act of ego; it is an act of service and an act of restitution. To those who would claim to be too imperfect an instrument to serve in such a movement, I would argue that *the greatest social movements have often been sparked and sustained by the small acts of imperfect and often unknown individuals.* If a recovery movement waited for those with perfect credentials, that movement would not be born, and if it was, could not succeed with such credentials.

*The message of recovery has always been able to transcend the imperfections of its messengers.* In fact, it is that "spirituality of imperfection," as Ernest Kurtz has christened it, that makes the recovery movement unique. It was this very movement that pioneered the concept of the "wounded healer"--the idea that acceptance of imperfection was the foundation of recovery, and that what imperfect people could not achieve alone they could achieve together. In every community and in the country as a whole, there are growing vacuums of need calling to be filled not by perfect servants but by willing servants--servants whose human imperfections can be transcended by collective action and the import of the recovery movement's cause.

**6.4 Movement Demands/Strains** Participation in recovery advocacy is not without its personal risks. *The passion required to elicit and sustain a social movement (whether local or national) can elicit a wide range of excessive behaviors.* Personal participation can be wearing

within any movement that at a personal level deals with such life and death issues and that at a cultural level confronts so much stigma and prejudice and absorbs so much overt and latent conflict. There is a vulnerability for excess among all who pursue roles in this movement.

**6.5 The Primacy of Personal Recovery** While the creation and sustenance of addiction treatment programs and public education/advocacy campaigns may be fueled by the passion of recovering people, *pursuing avocations/vocations in addiction treatment or community education and advocacy does not constitute a viable strategy for personal recovery*. The history of addiction in America is strewn with the bodies of those who believed otherwise. When helping, educating, and advocating for others is used as or replaces a personal program of recovery, there is a considerable risk of relapse. People involved in these activities must find a way to sustain themselves (and their personal recovery).

There are four daily rituals that have long marked the essence of addiction recovery and that have also characterized the lives of those who have sustained themselves for years of service work within mutual aid societies, professionally-directed treatment, and advocacy organizations/movements. These core activities include: 1) centering rituals, 2) mirroring rituals, 3) acts of personal responsibility, and 4) unpaid acts of unrelated service.

**6.5.1 Centering Rituals** are times and activities allotted to keep oneself focused or to get oneself refocused. These are daily rituals, usually performed alone, that allow us to renew that center of ourselves out of which our advocacy and service work flows. These rituals vary from person to person but often include reflection, refreshment, and renewal, whether it be through reading literature that pulls us toward our aspirational values or through quiet thought or prayer.

**6.5.2 Mirroring Rituals** are rituals through which we interact with others who share our core values. These rituals provide opportunities for public re-commitment, fellowship, support and laughter.

**6.5.3 Acts of Personal Responsibility** are those rituals through which we act out the healing power of recovery upon our own selves and those closest to us. It is making sure that in caring for others, we don't neglect our own needs. This caretaking extends beyond one's own physical, emotional and spiritual needs and extends to our intimate circle. One of the best pieces of advice I was ever given is captured in the following words: "One must be careful in carrying light to the community that one's own home is not left in darkness."

**6.5.4 Unpaid Acts of Unrelated Service** Performing unpaid acts of service unrelated to our primary cause is a way to freshly re-experience the commitment that drew us to this work. It is a way to connect with like-minded people in other arenas and to re-affirm our core identity and our core values.

**6.6 The Potential Enormity of an Individual Life** Many things compete for our time and our energy, including many seemingly intractable problems facing our community, our country and our world. In the face of such challenges, how does one find or sustain the motivation that social movement advocacy demands? To make such a commitment requires getting beyond the belief in the meaninglessness of one's own potential minor contributions. *A theme that exists within the history of all great social movements is the potential enormity of a single life.* Consider what the actions of a single woman--Rosa Parks--meant to the American civil rights movement. Consider how the treatment of the mentally ill would be different today if there had been no Dorthea Dix. Consider whether a new recovery movement would even be possible today without the foundation laid by people like Marty Mann and Harold Hughes. It is only in retrospect that we understand how the actions of a single individual can spark or move forward a whole social movement. *The past history of recovery in America is a rich one; you can be an observer of that continuing history or accept the invitation to become an active part in it.*

## 7.0 Summary

There is a rich history of addiction recovery and advocacy dating back more than 250 years in America. The lessons buried within this history transcend the stories of the individual leaders, groups and communities. *These lessons of history can provide a source of technical guidance, a source of individual and organizational protection, a source of refreshment and renewal, and, most importantly, a source of unquenchable hope. We would be well advised to sit at history's feet and absorb the lessons of her stories. Perhaps if we listen carefully, she will not have to repeat herself.*

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