

**The Rhetoric of Recovery Advocacy:  
An Essay On the Power of Language<sup>1 2 3</sup>**

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<sup>3</sup>The historical references in this article are drawn primarily from: White, W. (In Press) The Lessons of Language: Historical Perspectives on the Rhetoric of Addiction. In: Tracy, S. and Acker, C. *Altering American Consciousness: Essays on the History of Alcohol and Drug Use in the United States, 1800-1997*. Amherst, MA: University of Massachusetts Press.

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**The Rhetoric of Recovery Advocacy:  
An Essay on the Power of Language<sup>5</sup>**

William L. White

*The difference between the right word and the almost right word is the difference between lightning and the lightning bug. –Mark Twain*

*To kill a dog you must call him crazy. –Ethiopian Proverb*

*Words are important. If you want to care for something, you call it a “flower;” if you want to kill something, you call it a “weed.” –Don Coyhis*

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<sup>5</sup>This paper is written to those within the New Recovery Movement. When I speak of “we” or “our,” it refers to members of this movement: those recovering and recovered, the family members sharing this recovery process, and those I will later define as “friends of recovery.”

In an earlier communication,<sup>6</sup> I described the rise of a New Recovery Movement<sup>7</sup> and identified lessons that could guide this movement that were drawn from the history of earlier addiction mutual aid societies and recovery advocacy organizations. If successful, the New Recovery Movement will create a fully developed recovery advocacy culture—a culture with its own history, institutions, folk heroes, “kinetic” ideas, core values, key roles, images, symbols, language, art, music and rituals. It will use the collective elements of this culture to extend its influence into the larger society in which it is nested. It is, in part, through “seeding” the larger society with these elements that advocacy movements achieve the changes that they are seeking. This paper will explore how one element of the recovery advocacy culture, that of language, can be used as a tool of self-transformation, constituency mobilization, and social and political change.

To begin this discussion, we should acknowledge that the childhood adage, “sticks and stones can break my bones, but names can never hurt me,” is patently untrue. Words, and the meanings with which they are imbued can achieve accuracy and relevance or they can transmit dangerous stereotypes and half-truths. They can empower or disempower, humanize or objectify, engender compassion or elicit malignant fear and hatred. Words can inspire us or deflate us, comfort us or wound us. They can bring us together or render us enemies. Put simply, our lives are profoundly shaped by the words we apply to ourselves and those that come to us from others. The shaping/transforming/deforming power of labels is particularly compelling: Educators have long noted the self-fulfilling power of labeling children.

For more than two centuries, addicted and recovering people in America have been the object of language created by others. People experiencing severe and persistent alcohol and other drug problems have inherited a language not of their own making that has been ill-suited to accurately portray their experience to others or to serve as a catalyst for personal change.

When historically stigmatized peoples create social movements to free themselves from their “stained identities” and to alter the social conditions within which they are stigmatized, they

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<sup>6</sup>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. Contracted paper distributed to all of the Center for Substance Abuse Treatment’s RCSP grantees. Posted at [www.defeataddiction.org](http://www.defeataddiction.org)

<sup>7</sup>The New Recovery Movement is a term that describes the collective efforts of grassroots recovery advocacy organizations whose goals 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 attempts to dehumanize, objectify and demonize those with alcohol and other drug (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 experiencing AOD problems. This movement is not a “thing”: there is no national headquarters, no president or vice-president to call. There are only a growing number of recovery advocacy groups that have begun to discover each other and to think of themselves as a “we.”

often begin with processes of renaming, story reconstruction and story telling that are designed to alter their perceptions of themselves individually and collectively.<sup>8</sup> Such processes identify and diminish the effects of internalized stigma (shame, hopelessness, helplessness, passivity) and make individual and collective action possible. In this emergence, stigmatized peoples reject labels applied to them by others and replace this language with words of their own choice or creation.

Focusing on the subtle meaning of words—rejecting some while embracing others—is far more than a matter of shallow political correctness. It is about changing the way addicted and recovering people see themselves and are seen by others. It is about changing the language that affects social policies and is in turn affected by those policies. Changing language is a way to personally and culturally close one chapter in history and open another.

The New Recovery Movement is faced with several choices. It can continue to stigmatize its members by using a poisoned language incongruent with its mission and core values. The Movement can try to rehabilitate the existing language by reframing it or squeezing as much poison out of it as possible, or the New Recovery Movement can coin and promulgate a new pro-recovery vocabulary.

What I hope to do in this brief essay is to offer some historical and personal reflections on the words that have been the central tools in conceptualizing both alcohol and other drug-related problems and their resolution. My goal is to stimulate discussion about the layers of potential meaning that fill much of this language. For the New Recovery Movement to be “new,” it will need a fresh and dynamic language to free it from the echoes of the past. In this essay, I will call for the abandonment of some long-used words, the careful re-examination of other words, and the elevation of yet other words to the center of the New Recovery Movement.

Recovering people need a pro-recovery language to interpret their own experience, to communicate with each other, and to give the larger culture more accurate and respectful words to depict the nature of severe and persistent AOD problems and how those problems may be resolved. By claiming the right to speak publicly and to frame their experience in their own language, recovering people are politicizing (in the best sense of this term) what up until now have been their own private experiences. Words have been used to wound addicted and recovering people—to declare their status as outcasts. Words can also be used to heal addicted and recovering people and invite them into fellowship with each other and the larger society.

### **Words/Concepts We Need to Abandon**

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<sup>8</sup>This renaming is evolutionary through the life of such movements, e.g., the most degrading of epithets gave way to Negro, then Black, then African American, and the more recent and embracing People of Color. The New Recovery Movement will likely go through similar processes of language evolution.

*These words are razors to my wounded heart.*  
–William Shakespeare

Communities of color have shed (or reframed) other-applied names and re-christened themselves as they came of age and matured as communities. For isolated individuals to come together as a group, they must come to see and define that which characterizes them as a distinct people. When those distinguishing qualities have been defined by others in terms of disrespect and disrepute, these terms must be cast away and new labels elicited from their collective aspirations. All modern rights and liberation movements have understood this need to shape their own language and images. The New Recovery Movement, as it moves towards its own self-examination and coming of age, will, like the movements before it, confront this issue of language. As a contribution to this work, I would like to recommend that several words/phrases be cast aside by the New Recovery Movement.

## **Abuse**

Of all the words that have entered the addiction/treatment vocabulary, “abuse” is one of the most ill-chosen and, as Mark Keller once characterized it, pernicious. First of all, to suggest that the addict mistreats the object of his or her deepest affection is a ridiculous notion. Alcoholics do not “abuse” alcohol (mixing Jack Daniels with fruit punch does come to mind here) nor do addicts “abuse” drugs. Addicts, more than anyone, treat these potions with the greatest devotion and respect.

In addition to being technically incorrect, references to alcohol/drug/substance “abuse” drip with centuries of religious and moral censure. In 1673 Increase Mather in his sermon, “Woe to Drunkards” proclaimed that alcohol was the “good creature of God” but that the “abuse of drink” was “from Satan.”<sup>9</sup> Terms such as *alcohol abuse*, *drug abuse*, *substance abuse* all spring from religious and moral conceptions of the roots of severe alcohol and other drug problems. They define the locus of the problem in the willful choices of the individual, denying how that power can be compromised, denying the power of the drug, and denying the culpability of those whose financial interests are served by promoting and increasing the frequency and quantity of drug consumption.

*Abuse* has long implied the willful commission of an abhorrent (wrong and sinful) act involving forbidden pleasure, e.g., the historical condemnation of masturbation as *self-abuse*.<sup>10</sup> The term has also come to characterize those of violent and contemptible character—those who abuse their partners, their children or animals. It was the very weight of this history that led the

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<sup>9</sup>Lender, M. (1973). Drunkenness as an Offense in Early New England: A Study of ‘Puritan’ Attitudes. *Quarterly Journal of Studies on Alcohol*, p 353.

<sup>10</sup>Renaud, J. (1989). Substance Abuse is Language Abuse. *The Counselor*, July/August 7(4):26-27. Others who have argued against the application of “abuse” to severe and persistent alcohol and other drug problems include James Royce, Mel Schulstad, Neil Scott, and the Society of Americans for Recovery.

National Commission on Marihuana and Drug Abuse to criticize the term “drug abuse” in 1973. The Commission suggested that “continued use of this term with its emotional overtones, will serve only to perpetuate confused public attitudes about drug using behavior.” The term gained even greater prominence following the Commission’s report.

To refer to people who are addicted as alcohol, drug or substance *abusers* misstates the nature of their condition and calls for their social rejection, sequestration and punishment. There is no other medical condition to which the term “abuse” is applied. If we truly believe that addiction is a serious health problem, then why do we continue to have departments and centers of substance abuse? The terms *abuse* and *abuser* should be now and forever be abandoned in discussions of people with severe and persistent alcohol and other drug-related problems.

### **“Self-help”**

It is common to refer to Alcoholics Anonymous, Narcotics Anonymous, Women for Sobriety and other such organizations as “self-help” groups or refer to a broader “self-help” movement. Ernest Kurtz and William Miller have quite insightfully noted that such designation conveys a “pulling-oneself-up-by-the-bootstraps” image of addiction recovery. They noted, in contrast to this image, that people who seek help from such groups usually do so as an acknowledgment that all attempts at self-help have failed.<sup>11</sup> Recovery in many support groups is not “self-help” but the utilization of resources and relationships beyond the self. As such, the New Recovery Movement organizations could more correctly depict these groups as “recovery support” or “mutual aid” groups.

### **“Untreated Alcoholics” / “Untreated Addicts”**

In the lobbying for parity (the funding of addiction treatment on par with other medical disorders), one endlessly hears about the personal and social costs of “untreated addiction” and about the number of “untreated alcoholics” and “untreated addicts” that are now denied access to treatment. While such language well-serves the parity argument, it implies that the pathway into recovery inextricably requires passage through professionally-directed treatment. This is simply not true. Referring to people still suffering from addiction as “people not yet in recovery” is a far more accurate and preferable term than depicting such people as “untreated.”

### **“Consumer”**

The term, *consumer*, when used as a synonym for recovered and recovering people, is a misnomer. Like “untreated alcoholics” or “untreated addicts,” the term implies that all people in recovery have been, or need to be, consumers of treatment services. By speaking of “consumer representation,” the language narrows participation in policy development to people who have

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<sup>11</sup>Miller, W. and 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*, pp.159-166 (March).

participated in treatment rather than to the larger pool of addicted and recovering/recovered people. Those who seek treatment and those who do not seek treatment constitute different populations of people, making it impossible for the former to speak for the experiences and needs of the latter. (If, for example, we want to ascertain how to reach those who need but have never utilized treatment services, we should conduct focus groups with them rather than ask the most successful treatment graduates how to reach that group.) The focus should be not on “consumer representation” but on “constituency representation” or “recovery representation” and all that the latter terms imply by way of diversity.

### **The Language of Self-Pity**

Any new movement must define itself within the times and social context in which it finds itself. Over the past half-century, Americans have experienced social movement after social movement—each vying for attention, each claiming an emotional debt, each seeking redress for past wrongs. As a result, America is today suffering from compassion fatigue. Its tolerance for old and new demands is so low that any new movement risks inciting a rapid backlash of derision that could hurt the very cause it seeks to promote. Great care must thus be taken in using the rhetoric and methods of earlier movements.

America has lived through the “me decade” of the 1980s and the security of widespread prosperity of the 1990s, but a new century is opening with many themes worth noting: heightened financial insecurity, a growing sense of depersonalization and diminished sense of control over most aspects of our lives, and a diminishment of respect for professions that historically protected the vulnerable (physicians, clergy, lawyers, etc.). The New Recovery Movement must position itself in this cultural stew.

Any language that even hints at self-pity will doom the legitimate aims of this movement. While the New Recovery Movement, like its predecessors, is, at least in part, a rights movement, this is not the moment to push such issues to the fore. What is needed are themes that strike strong emotional cords in the culture at large. What will get America’s attention is not a call for sympathy or redress of past and present insults to addicted and/or recovering people, but articulating themes of gratitude, responsibility and service. (See later discussions). What will grab the attention of the culture is a movement whose members are coming together not in supplication but in service; not asking for something, but offering something; not advocating for themselves, but for others; not acting as individuals, but in communion; and not seeking solutions through formal institutions but through the community itself.

### **Words/Concepts We Need to Discuss and Debate**

While some words may need to be changed, others need to be carefully analyzed and discussed. A few of my nominations in this category are: alcoholic/addict, disease, “treatment works,” stigma, recovered/recovering, relapse, and enable.

#### **Alcoholic/Addict**

How shall we refer to this condition in which people in spite of their best intentions continue to consume psychoactive drugs at a frequency and intensity that destroys them and those around them? How shall we refer to people with severe and persistent alcohol and other drug-related problems? To sort out the kind of language that will best serve the New Recovery Movement requires that we raise an important point: Language that has a high degree of meaningfulness and usefulness in intra-group communication might have unforeseen, harmful consequences in extra-group communication. Positioned on the boundary between the recovery world and the civilian world, the New Recovery Movement may need to use one language when it turns inward and another language when it turns outward to communicate with the larger society.<sup>12</sup>

The terms *alcoholic* and *addict* have provided people with severe and persistent alcoholic and drug problems an important set of tools to understand the specific nature of their problem, to take ownership of that problem, and to understand where they should seek help for that problem. The words have been an important part of addict-physician and addict-addict communication for more than a century. The terms *alcoholic* and *addict* are foundational terms in Alcoholics Anonymous and Narcotics Anonymous and in many addiction treatment programs, even though *alcoholism* and *alcoholic* are no longer used as official diagnoses. The words have had, and will continue to have, value in helping individuals understand aspects of their experience and their own personhood that would otherwise be inexplicable and to use this understanding to resolve their alcohol- and drug-related problems.

These same terms used in common discourse outside therapeutic and recovery circles have done something of a disservice. They have contributed to the tendency to define all alcohol- and drug-related problems within the rubric of the clinical entities of alcoholism and addiction. Because of the moral stigma attached to these severe conditions, the labels have themselves become an obstacle to people seeking resolution of AOD problems in a timely manner. When people experience problems with alcohol and other drugs, they and those around them seem to be fixated on the question, “Am I (or, Is \_\_\_) an alcoholic.” It is only natural that such a stigmatized label would be resisted. The focus in this situation shifts from the problem to the fear of the label and its stigmatizing consequences. Embracing large numbers of people within the rubric of “alcoholic” or “addict” also conveys the impression that these individuals are the same. Referring to people by their shared medical diagnosis assumes any important differences have been lost to the homogenizing influence of their disorder. “Disease first” language, as opposed to “people first” language, obliterates individual differences and depersonalizes those to whom the label is applied.

Popular terms for people with severe and persistent alcohol/drug problems have for the past two centuries included *drunkard*, *sot*, *soaker*, *hard case*, *wino*, *rum-sucker*, *junkie*, *dope fiend*, *speed freak*, *acid/pot head*, and a wide variety of clinical terms: *oinomaniac*, *dipsomaniac*, *inebriate*, and *narcomaniac*, among the more colorful. I believe that use of the terms *alcoholic* and *addict* and other euphemisms will continue well into the future in alcoholic-alcoholic and addict-addict communications. Such communication reflects the way that stigmatized groups

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<sup>12</sup>I am indebted to Ron Roizen for introducing me to this notion.

can take a clinical term (or social epithet) and transform it into something positive—positive in terms of facilitating change and positive in terms of intra-group identification.

Members of the New Recovery Movement need to discuss whether it is time to drop such objectifying labels in communications to the public in preference for a more respectful and less stigmatizing “people first” language. The terms *alcoholic* and *addict* could be relegated to intragroup communication while being replaced in public communications with the phrase “person/people experiencing an alcohol/drug problem.” Such a stance might deflect the arcane arguments over whether someone is or is not this something called an “alcoholic” or “addict” to the much more concrete and verifiable question of whether alcohol and other drugs are creating problems in his or her life.

I believe this shift from labeling someone a thing to describing what a person is experiencing is worthy of serious consideration. The former implies an unchangeable status; the latter a circumstance that can be time-limited and potentially resolvable. People first language emphasizes the person before the disorder. This recommended language also implies that not all problems related to alcohol and other drugs are problems of alcoholism or addiction. It is more respectful and less stigmatizing and it suggests that if a person’s alcohol or drug consumption is creating problems, then he or she should do something about it, regardless of whether the labels alcoholism/alcoholic or addiction/addict apply. It may be time recovering people joined other historically stigmatized groups in rejecting “labeling language” and embracing a “people first” language in their public communications. The challenge will be to find words that are accurate and respectful while still facilitating ease of communication.

### **“Disease” / “Disease Concept”**

The proclamation that “alcoholism is a disease”<sup>13</sup> was the foundation of the modern alcoholism movement and became the dominant mantra in the emergence of a modern field of addiction treatment. In the last two decades of the 20<sup>th</sup> century, debates surrounding the conceptualization of addiction as a disease have reached a crescendo of controversy and professional acrimony.<sup>14</sup> Historical momentum places the “disease concept” at the feet of the New Recovery Movement. It is both inevitable and desirable that the potential role and relative value of this idea be thoroughly discussed and debated within the New Recovery Movement.

There are at least three potential choices. First, the New Recovery Movement could, like the movements that preceded it, make an addiction disease proclamation one of its core ideas. Second, the New Recovery Movement could reject this concept as untenable and seek alternative ways to portray alcohol and other drug problems. Third, the New Recovery Movement could, like A.A., declare a stance of neutrality in the addiction disease debate. There are several arguments that make the third of these options worthy of consideration.

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<sup>13</sup>Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol*, 5(2):354.

<sup>14</sup>White, W. (In Press) Addiction Disease Concept: Advocates and Critics. *Counselor*.

While many A.A. members speak of alcoholism as a “disease”<sup>15</sup> or in other medical metaphors, they do so not so much as a declaration of A.A. policy or of science but as sense-making (“It explains many things for which we cannot otherwise account.”)<sup>16</sup> The contemporary use of such medicalized language does not reflect the heart of A.A.’s view of alcoholism as represented in its basic texts. Ernest Kurtz, author of *Not-God: A History of Alcoholics Anonymous*, challenges the frequent attribution of the disease concept to A.A.

*On the basic question, the data are clear: Contrary to common opinion, Alcoholics Anonymous neither originated nor promulgated what has come to be called the disease concept of alcoholism. Yet its members did have a large role in spreading and popularizing that understanding.*<sup>17</sup>

When A.A. Cofounder Bill Wilson was asked in 1961 whether alcoholism was a disease, he replied:

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<sup>15</sup> References to “disease” are more likely to reflect the culture of addiction treatment than the culture of A.A.. (See Kurtz, 2000 footnoted below)

<sup>16</sup>*Alcoholics Anonymous*, 1976, p. xxiv

<sup>17</sup>Kurtz, E. (2000) Alcoholics Anonymous and the Disease Concept of Alcoholism. Unpublished manuscript prepared for the Behavioral Health Recovery Management Project, p. 2.

*We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore we did not wish to get in wrong with the medical profession by pronouncing alcoholism a disease entity. Therefore we always called it an illness, or a malady – a far safer term for us to use.*<sup>18</sup>

Wilson's point here is that A.A.'s focus was not on the debate about the nature of alcoholism, but on the affirmation that there was solution to alcoholism. This is a stance worthy of consideration.

The New Recovery Movement must be able to embrace people across multiple cultural contexts who developed alcohol and other drug-related problems through varied paths and which unfolded in varied patterns. The arms of the New Recovery Movement must be wide enough to embrace widely divergent metaphors which may be used to understand and resolve AOD problems. What the New Recovery Movement brings so uniquely to these problems is an unequivocal message of hope that they can be solved.

It is not up to recovering people to declare whether addiction is or is not a disease: Such matters are not determined by a vote of the afflicted. Whether severe and persistent alcohol and other drug problems constitute a "disease" is a question for medical science and medical practitioners. What recovering people can bring to this problem is LIVING PROOF of: 1) the reality of recovery, 2) the diversity of patterns of recovery, and 3) the variety of methods used to achieve recovery. While all manner of specialists can claim expertise on addiction, recovering people stand alone in terms of their collective knowledge of how recovery can be initiated and sustained.

Those who advocate placing "disease" language at the forefront of the New Recovery Movement often claim that THE biological cause of addiction will be soon found and that the New Recovery Movement should lay the social groundwork for that discovery. I have long dreamed of this discovery, and yet I have come to think that this very discovery could have unanticipated and profoundly negative consequences as well as great potential benefit. Let me give two examples. First, in the current social climate, the discovery of anything claimed to be THE primary biological factor in addiction (and its accompanying biological markers) could lead to new forms of invasiveness and discrimination relating to everything from occupational opportunities to access to health and life insurance. Second, what might it mean to people already in recovery from AOD problems who were to discover that they did not possess this newly discovered X factor but who have used a disease metaphor to anchor their recovery? The New Recovery Movement would be well advised to base its core ideas not on a narrowly defined depiction of the source or nature of addiction, but on the broad solutions that exist for its resolution.

The New Recovery Movement can still take a stance on the important question, "Who shall have cultural ownership of severe and persistent alcohol and other drug problems?" The

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<sup>18</sup>Quoted in Kurtz, 2000.

answer to that question determines whether persons suffering from such problems sit before physicians, psychiatrists, social workers, clergy, or judges. “Disease” language conveys is placement of AOD problems in the medical and public health arena, but it invites a whole series of technical debates about whether such problems (or which of these problems) are really a “disease.” A “health problems” language has the advantage of opening the doors of the health care system for needed services without the accompanying disease debate controversy. Nearly everyone would agree that sustained, excessive AOD use is a serious health problem while many of those same individuals would argue that these problems do not constitute diseases. The New Recovery Movement would be well-advised to avoid the distractions of the “disease” debate and maintain their focus in one area: recovery solutions!

While the New Recovery Movement avoids the technical debates surrounding the disease concept, it can still demand that severe and persistent alcohol and other drug problems be described and discussed using the language of public health and not a military language that, when misapplied to the containment of health problems, contributes to “ex-communicating and stigmatizing the ill.”<sup>19</sup> If it chooses to incorporate the proclamation that addiction is a disease in its pronouncements, then it should define the nature of this disease in a manner that is scientifically defensible.<sup>20</sup>

### **“Treatment Works”**

“Treatment Works” is an example of a phrase whose purpose is noble—countering cultural pessimism about the prospects of long term recovery—but whose effect is potentially disempowering to addicted and recovering people. The slogan implies that interventions *done to* people with AOD problems (as one would surgically remove a malignant tumor) are responsible for freeing their entrapment. It places the locus of responsibility and accountability for recovery not on the individual with an AOD problem but in the hands of the expert professional and the treatment institution. It detracts from the range of recovery tasks that are not in control of the professional and which are the responsibility of the individual and the wider community. The slogan, by exaggerating the power of treatment, fails to acknowledge the role of resources and relationships outside the scope of the treatment institution in the recovery process.

Compare the institutional slogan “Treatment Works” with recovery advocacy group slogans such as “Recovery is a reality” or “Recovery: LIVING PROOF.” All convey optimism, but the former places the focus on the professional expert, while the latter two place the focus on the experience of the recovering person. The New Recovery Movement is placing the locus of

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<sup>19</sup>Sontag, S. (1989) *AIDS and Its Metaphors*. New York: Farrar, Straus, and Giroux.

<sup>20</sup>See White, W. (2001) A Disease Concept for the 21<sup>st</sup> Century. *Counselor*. Accepted for publication.

control for recovery within the recovering person and that person's ability to embrace resources within and beyond themselves to support that recovery. Treatment is viewed not as the instrument of recovery but as a potentially helpful, but often insufficient, ingredient in the recovery process.

## **Stigma**

Reducing the stigma associated with addiction/recovery is emerging as a central focus of the New Recovery Movement. There is something about this focus that disturbs me, perhaps an inkling that this focus is slightly askew. I worry that the focus on stigma may direct movement resources to narrowly on public opinion as opposed to the broader arenas of public policy and law. While the New Recovery Movement will have many facets, it must be as much a rights movement as a movement that simply seeks to change the social acceptance of addicted and recovering people. Our focus on stigma must be focused on the way that stigma is manifested in discriminatory laws, policies and practices.

Perhaps this is a chicken or egg question. When politicians demonize addicts and propose draconian measures for their sequestration and punishment, are these actions an expression of personal belief or Machiavellian political manipulation? When prison guard unions testify against proposals that would divert addicts from prison to community-based treatment, is this action an expression of their collective perception of addicts or an expression of their need for a continued supply of raw materials (consisting mostly of poor young men-of-color) to support their own careers and the prison as an economic institution? When insurance companies promulgate exclusionary policies against recovering people, are these actions an expression of attitudes or economics? The New Recovery Movement must, like all social movements, define as concretely as possible what the movement is seeking to change. The fate of such movements often hinges on the accuracy of that definition. In our approach to stigma, we must ask how a condition that had achieved the status of a medical disease is being again defined in terms of immorality. How could this country take generations to cast aside the "immoral model" of addiction only to decades later re-embrace this very notion? There is more afoot here than simply an evolution of public opinion. That complexity must be understood.

## **Enable**

In the addiction treatment/recovery arena, the act of "enabling" has come to mean any intervention that, with the intention of helping the alcoholic/addict, inadvertently results in harm. It is thought that actions that protect the person not yet in recovery from the consequences of his or her drinking/drugging, increase the likelihood of continued addiction. The concept led family members and counselors alike to fear accusations that they were "enabling" or had become "enablers." That fear escalated even further in the late 1980s. At the peak popularity of "codependency," the most basic acts of human kindness toward others were framed not as evidence of compassion but of psychopathology.

While the term *enable* has been useful in distinguishing helpful from harmful styles of support, the use of the term in this way destroyed the original meaning of "enable" (as used in the

social work field). That value needs to be rediscovered within the New Recovery Movement. The field of social work has long used the term “enable” to convey a particular type of helping relationship in which the empathy, emotional authenticity, and encouragement of the helper empowered those being helped to do things for themselves that they had been unable to achieve by themselves. Perhaps it is time to rehabilitate the word “enable” (or select an alternative word such as *empower* which, while overused, comes close to the desired meaning) that can help us recapture the vibrancy and usefulness of the original meaning of this concept.

## Relapse

I’m not sure about the word relapse. Something in the emotional baggage of the word troubles me. In the research world, the word is plagued by innumerable definitions that range from any use of alcohol or substitute drugs to a return of alcohol and other drug-related problems, the latter implying that relapse arrives not with drinking but with its consequences. Some within the New Recovery Movement are pressing to replace references to “relapse” with the term “reoccurrence” on the grounds that the latter more closely parallels the language used with other chronic diseases and is less morally judging than the term relapse. This is one we need to include in our audit of language in the New Recovery Movement.

## Recovering/Recovered

Consensus on how to refer to people that were once addicted but are no longer addicted has never been reached. Such people have been referred to as *redeemed (or repentant) drunkard, reformed drunkard, dry drunkard, dry (former) alcoholic, arrested alcoholic, sobriate, ex-addict, ex-alcoholic* (the latter being the only word removed from the first edition of the book *Alcoholics Anonymous*<sup>21</sup>). They have been described as *sober, on the wagon, drug-free, clean, straight, abstinent, cured, recovered, and recovering*. Modern debate has focused on the last two of these terms. While *recovering* conveys the dynamic, developmental process of addiction recovery, *recovered* provides a means of designating those who have achieved stable sobriety and better conveys the real hope of for a permanent resolution of addiction.<sup>22</sup> James Royce criticized the use of “recovering” in 1986 on the grounds that the term implied that the alcoholic was still sick years after he or she had stopped drinking.<sup>23</sup> He believed “recovering” should be used to designate only the earliest stages of alcoholism remission. Testimony to just how far back this concern over language goes can be found in Harrison’s 1860 report that the Washingtonian Society of Boston “fitted up rooms under their hall for the temporary accommodation of reformed, or rather, reforming, men.”<sup>24</sup>

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<sup>21</sup>Kurtz, E. (1999). *The Collected Ernie Kurtz*. Wheeling, WV: The Bishop of Books..

<sup>22</sup>Blume, S. (1977). Role of the Recovered Alcoholic in the Treatment of Alcoholism. In: *The Biology of Alcoholism, Vol. 5, Treatment and Rehabilitation of the Chronic Alcoholic*, Ch. 12, p 546, Eds. Kissin, B. and Beglieter, H. New York: Plenum Press.

<sup>23</sup>Royce, J. (1986). Recovered Vs. Recovering: What’s the Difference? *The U.S. Journal*

I think this is another area in which one language could be used inside recovery circles while another language could be used to speak publicly. 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. This usage would be congruent with how we speak of people responding to other chronic conditions and illnesses. The language assumes both commitment and progress rather than a complete absence of symptoms. In a similar manner, the term “recovered” could be used to depict those who have achieved an extended period of symptom remission. The period used to designate people recovered from other chronic disorders is usually five years without active symptoms.

Arthur Frank, noting the propensity to call those who have lived through life-threatening illnesses “survivors,” casts his vote for the term “witnesses”—the latter suggesting the responsibility to tell others what happened.<sup>25</sup> Perhaps there is a day in the future when, with diminished stigma, all recovering and recovered people will have the choice to be *recovery witness*. What would be the impact upon this country if it were to experience thousands of voices of recovering people, with the influence of each witness spreading outward like the spreading ripples of a rock thrown into water?

### **Anonymity and Passing**

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March, p.7.

<sup>24</sup> Harrison, D. (1860). *A Voice From the Washingtonian Home*. Boston: Redding & Company.

<sup>25</sup> Arthur Frank (1995). *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press.

Few issues have been as contentious in the early history of the New Recovery Movement as the meaning of anonymity. Many recovering individuals in Twelve Step groups were offended by invitations to step forward to “put a face on recovery” on the grounds that such declaration would violate the traditions of A.A., N.A. or other Twelve Step Groups.

Historically, anonymity served three functions in A.A.: 1) It protected individuals from the harm that can ensue from a stigmatized condition, 2) it protected the fellowship of Alcoholics Anonymous from the potentially discrediting behavior of its members, and 3) it served as a spiritual exercise—an antidote to narcissism and grandiosity. These functions were so important that anonymity was codified in A.A.’s Twelve Traditions. I have argued elsewhere that the traditions of Alcoholics Anonymous are the primary reason that A.A. survived when all of its predecessors self-destructed.<sup>26</sup> Given this, any potential compromise of that source of resiliency should be closely examined. There are three of the Twelve Traditions that have particular relevance to the New Recovery Movement.

Tradition Six states that “An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.”<sup>27</sup> A.A./N.A.’s name should thus not be drawn into any aspect of the New Recovery Movement. No A.A./N.A. group or no A.A./N.A. member should be asked to participate in or support any recovery advocacy organization as a group or individual representing A.A./N.A..

Tradition Ten states that “Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.”<sup>28</sup> Recovery advocacy, by definition, involves itself in public policy issues, some of which involve those very controversies. That means that the name of A.A./N.A. should never be brought into those advocacy efforts.

Tradition Eleven states that “Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.”<sup>29</sup> This means that no one in the New Recovery Movement who is a member of A.A./N.A. should reveal that affiliation “at the level of press, radio and films.” That does not mean that a person in A.A./N.A. cannot publicly identify themselves as a person who has recovered or is recovering from alcoholism/addiction (as long as no A.A./N.A. affiliation is noted at the media level.)

Keeping one’s recovery status silent at ALL levels is not respectful of recovery fellowship traditions. (It may even violate the Tradition Five which states: “Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.”) Silence at all levels is not anonymity but what sociologists call “passing”—hiding one’s stigmatized status by failing

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<sup>26</sup>White, W. (2001). Pre-A.A. Alcoholic Mutual Aid Societies. *Alcoholism Treatment Quarterly*. In Press.

<sup>27</sup>*Twelve Steps and Twelve Traditions* (1981). NY: Alcoholics Anonymous World Service, Inc.

<sup>28</sup>Ibid.

<sup>29</sup>Ibid

to disclose one's link to a stigmatized condition or group and, in effect, passing as a "normal"<sup>30</sup> (or what some people in recovery refer to as a "civilian"). Erving Goffman, in arguably the most famous essay on stigma ever written, noted the toll stigma takes on the stigmatized. He reported how the autobiographies of such people often describe finally reaching a "state of grace" where they no longer felt a need to pass and were able to accept themselves as whole persons.<sup>31</sup>

Senator Harold Hughes, two years before he died, spoke out on the effect "passing" had on others.

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<sup>30</sup>Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster, Inc.

<sup>31</sup>*Ibid*, p. 102.

*We in recovery have been part of the problem. We have both accepted and perpetuated the stigma that kept us from getting help and that has killed millions of addiction disease victims. By hiding our recovery, we have sustained the most harmful myth about addiction disease: that it is hopeless. And without the examples of recovering people, it's easy for the public to continue thinking that victims of addiction disease are moral degenerates—and that those who recover are the morally enlightened exceptions. We are the lucky ones—the ones who got well. And it is our responsibility to change the terms of the debate, for the sake of those who still suffer<sup>32</sup>.*

The New Recovery Movement is calling people to respect the recovery fellowship tradition of anonymity, but to carefully consider the costs of “passing” (refusing to acknowledge, not their AA affiliation but, their recovery status) on their own emotional health and its effect on those still suffering from alcohol and other drug problems. The New Recovery Movement is declaring that it is time for a vanguard of recovering people to stand up and announce their presence in this culture—NOT as members of any identified recovery fellowship, but as members of a larger recovery community. This invitation explicitly includes family members in recovery. Even those of us who have lost loved ones to addiction must become more than saddened spectators of such loss. We must find a way to tell our lost person’s story wrapped within our own story. We must witness for them as well as ourselves.

### **New Recovery (Advocacy) Movement**

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<sup>32</sup>Hughes, H. (1994-1995) Coming out of the Closet to Fight Abuse. SOAR USA Bulletin Fall/Winter. Posted at <http://www.aaw.com/library/soar1.html>

In a 1998 published interview with Bill Moyers, I described the cyclical nature of policies and programs in the addictions arena and predicted the rise of a new recovery movement in the future.<sup>33</sup> When grass roots recovery advocacy organizations began to appear in the next few years (far quicker than I had anticipated), it was only natural to refer to these groups collectively as the “New Recovery Movement.” If these local groups do flower into a sustainable movement, the day will come when they will need to consider how to refer to their collective efforts. For now, the “New Recovery Movement” designation can be used (but should be kept on probation) until it is either blessed by these local groups or until a better term comes along. To avoid confusion, references to the “New Recovery Movement” would best be accompanied by the stipulation that what makes this movement “new” is its shift in focus from mutual aid to a focus on creating pro-recovery community attitudes and policies and on expanding the range and quality of local recovery support resources. Participants in the New Recovery Movement are not there for personal change for themselves or others: most have other venues where such personal work is done. Clarifying that the locus of intervention for this movement is not the individual but the community may help distinguish it from other recovery-related organizations, e.g., mutual aid groups, treatment agencies. In contrast to both treatment and mutual aid, the focus on the New Recovery Movement is on the ecology of recovery. It calls upon recovering people to move beyond their personal service work and become recovery activists. To reflect this emphasis and to avoid confusion, it may be helpful to shift to the use of “New Recovery Advocacy Movement.”

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<sup>33</sup>See [www.pbs.org/wnet/closetohome/home.html](http://www.pbs.org/wnet/closetohome/home.html) (Click Policy: The Politics of Addiction/Interview)

## Words/Concepts We Need to Elevate and Celebrate

*We've only just begun to fashion a vocabulary to deal with the "silences" of our lives.* –Toni Cade Bambara

The New Recovery Advocacy Movement will need to develop a core lexicon that distinguishes itself both from mutual aid societies, from professionally directed addiction treatment and from earlier addiction-related advocacy movements. Some of the following words and phrases are worthy of nomination to a visible status in that lexicon: recovery, recovery community (or communities of recovery), advocacy, sustainability, recovery support services, recovery coach, recovery pathways/styles, Presenting the Faces and Voices of Recovery / Living Proof, recovery friends.

### Recovery

If there is a word and concept that should be at the center of the New Recovery Advocacy Movement, it is unquestionably that of *recovery*. Embracing this concept is more important and a more difficult process than might be initially thought.

Elevating the concept of recovery is important because it reflects a shift from a pathology paradigm to a resiliency paradigm. It is a way of declaring that it is time for “addiction treatment” agencies to become “recovery agencies.” This means that treatment agencies need to shed their models of acute intervention in which severe and persistent alcohol and other drug problems are treated as if they were a broken arm or a bacterial infection. It is time the focus shifted from brief episodes of acute intervention to models that reflect an understanding of, and focus upon, the long term recovery process. The problem right now is not just that treatment resources are declining; it is that the number of treatment episodes far exceeds the number of people entering long term recovery.

As the leaders of this New Recovery Advocacy Movement interface with policy and treatment specialists, they will be tempted to be pacified with superficial changes in rhetoric, token representation, and a few minuscule grants or specialty positions. The goal of the New Recovery Advocacy Movement as it relates to the field of professionally-directed treatment is nothing short of radical changes in:

- the goals to which those services are directed;
- how, when and by whom those services are delivered and evaluated; and
- the settings in which such services are delivered.

It is incredible when one thinks about it that the word *recovery* does not appear in any of the major arenas of the field's activities (e.g., prevention, early intervention, treatment) nor in the names of the field's major governmental and professional organizations. (What, for example, would be the implications of changing the name of the Center for Substance Abuse Treatment to the Center for Addiction Recovery?) What the New Recovery Advocacy Movement is saying is that the time for a major and sustained focus on RECOVERY is long overdue.

Having now made the case for elevating recovery as a word and concept, it is important to acknowledge a few of the challenges that lie ahead. The most nettlesome may be that of defining the precise meaning and boundaries of the concept of recovery.

There are several options available. First, the New Recovery Advocacy Movement could limit the use of this term to the resolution of severe and persistent alcohol and other drug problems. But even here we must struggle to define what we mean by “resolution.” The resolution of chronic problems, and particularly chronic diseases, often demonstrate a high degree of variability of outcome that include both full and partial recoveries. Achieving consensus on the meaning of full remission, defined by Milam and Ketcham as “a return to normal functioning based on total continuous abstinence from alcohol and substitute drugs,”<sup>34</sup> could itself be troublesome for some if, for example, nicotine were to be included in the category of substitute drugs. Such a definition would deprive a lot of “old-timers” of their recovery status and tenure. Particularly difficult will be the question of whether recovery ought to be defined in terms of optimal global functioning—a measure that could include a movement from problematic to non-problematic drug use by some individuals. Our stance on this question will be determined, in part, by whether the term recovery will be applied to the resolution of the whole spectrum of alcohol and other drug related problems or to the more narrowly defined clinical categories of drug addiction/dependence. If our choice is the former, then we will need to carefully define what we mean by “problem” and “resolution.”

A second option is for the New Recovery Advocacy Movement to apply the term recovery to the sustained absence of severe and persistent compulsive behavior (other than that involved in the clinical entity, obsessive compulsive disorder). This would expand the New Recovery Advocacy Movement into the arenas of what have come to be called “process addictions” (toxic relationships with food, work, sex, money, etc.) An even more encompassing definition would include all people who have survived a life-threatening disorder or condition—a definition that would dramatically expand the boundaries of the New Recovery Advocacy Movement.

Defining the boundaries of “recovery” is not an inconsequential process. Not only is this boundary important, but the timing of this boundary and how it evolves over time is also important. To start with, too broad a definition or the too rapid expansion of that definition could mortally wound this movement via loss of mission and dissolution. It may be important to maintain the identity of this New Recovery Advocacy Movement in terms of recovery from chemical additions at the same time the organizations and members of the New Recovery Advocacy Movement will need to be open to project-specific collaborations with parallel movements. Perhaps most important is that such definitions and evolutions come from inside the movement rather than from external ideological, institutional or financial influences. Eventually, the New Recovery Advocacy Movement will need to link itself to a larger body of people recovering from life-depleting and life-threatening illnesses and conditions.

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<sup>34</sup>Milam, J. and Ketcham, K. (1989). *Under the Influence: A Guide to the Myths and Realities of Alcoholism*. New York: Bantam Books.

In that same spirit of linking and expanding, the line between active addiction and recovery may, in the end, need to be understood as not a line (as I all too often am prone to portray it) but a very long process. One of the reviewers of an early draft of this paper eloquently detailed this broader perspective:

*...our working definition of recovery is the choice of life over death. Anything that manifests the will to live can be defined as recovery in this scheme...Active alcohol and drug use was for me a way out of pain—an alternative to suicide...For me, addiction was probably the only answer...It was my way of saying yes to life over death. It was in itself a way of grasping for recovery. In this way, addiction and recovery are not separated by a hard and fast line, but constitute a continuum...Acknowledging this helps to unite those who need recovery with those who are in recovery (as you define it in the article).*

The above comments offer much food for thought as this new movement tries to articulate the need for a continuum of local recovery support services. By raising the possibility that recovery begins with experiences during active addiction,<sup>35</sup> new types of interventions may be developed through which people may enter conscious, active recovery at earlier and earlier stages of change.

### **Recovery Community/Communities of Recovery**

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<sup>35</sup>This notion is completely congruent with the growing body of “stages of change” research and empirically-based “developmental models of recovery.”

In an earlier paper, I defined the “recovery community” as “a voluntary association of those impacted by AOD problems who come together for mutual support and joint action on AOD-related issues.” The members of this community include those in personal recovery from addiction, family members impacted by AOD problems, professionals whose identification with this community transcends their paychecks, and other people of good will concerned about AOD problems. What binds this community together is their history of shared experience and their willingness to move beyond mutual fellowship to social and political advocacy on recovery-related issues. Yet using “community” in the singular implies something of an homogenous group of people and shared interests. A “recovery community” exists only to the extent that multiple and diverse recovery communities reach beyond their own geographical and cultural boundaries to embrace such an identity. Ernest Kurtz has suggested that the phrase “communities of recovery” may more precisely describe the actual nature of the recovery advocacy constituencies.<sup>36</sup> I think this suggestion is one worthy of consideration. Reminding ourselves that we are many communities bound together only by shared experience and a shared vision may counter efforts to foist an overly centralized and hierarchical structure upon this evolving movement.

## **Advocacy**

The second word/concept (other than recovery) most central to the New Recovery Advocacy Movement is *advocacy*. That word and function must be kept to the forefront or this movement could suffer the fate of its predecessors. The advocacy function of many local mid-20th century alcoholism councils was lost as such groups evolved into the boards of treatment agencies during the flood of new federal and state monies. Every publication regarding the New Recovery Advocacy Movement should begin with a declaration/reminder of what recovery advocacy is and is not.

Advocacy is about changing the cultural perception and attitudes that underlie ill-conceived policies and practices directed toward addicted and recovering people. Advocacy is about confronting the political, economic and institutional interests that benefit from such policies and practices. Advocacy is about conveying alternative perceptions and beliefs and generating the influence to change ineffective and harmful policies and practices. Advocacy is about turning personal stories into social action; it is about turning recovery outwards. Advocacy is about acquiring and using power to change the ecology of addiction and recovery. If the New Recovery Advocacy Movement is truly an advocacy movement, then it will be at its heart a movement about the expansion of recovery resources in communities across the country.

There are two things advocacy is NOT. First, advocacy is not mutual aid. If recovery advocacy organizations are mistakenly thought to be mutual aid societies, both the organizations and their members are at risk of harm. Participation in the New Recovery Advocacy Movement is founded on the primacy of personal recovery, but involvement in this movement must be focused on recovery ADVOCACY, not mutual aid. Advocacy is not a personal recovery

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<sup>36</sup>Personal Communication, December, 2000.

program! (The history of recovery advocacy is strewn with the bodies of those who believed advocacy work would by itself keep them sober.)

Second, advocacy is not about entering into competition with mutual aid groups or treatment agencies in the provision of direct services to those seeking recovery. Advocacy is about environmental change—changes in cultural perceptions and beliefs, changes in social policies, changes in laws, changes in institutional practices. New Recovery Advocacy Movement organizations must keep their eyes on the primacy of this advocacy function. Their primary responsibility is to advocate for and help organize and support needed treatment and recovery support services, not to operate/deliver those services. When community organizers take on such operational functions, their viability as organizers is usually lost. Some New Recovery Advocacy Movement organizations have and will continue to involve themselves in recovery support services, but great care must be taken to assure that these service functions do not devour the advocacy agenda. If advocacy gets pushed into the shadows and lost to the demands of direct service, the New Recovery Advocacy Movement will be absorbed into America's ever-growing system of health and human services and die. The purpose of advocacy is to influence that system, to hold that system accountable for its practices and the stewardship of its resources, and to help organize indigenous resources that transcend that system.

As important as this concept is, use of the word advocacy does come with its own problems. Several local recovery advocacy organizations have been denied their status as a 501C3 agency because of use of the word advocacy in their application. Because advocacy is often interpreted exclusively in terms of lobbying, emphasis upon this function may deny some organizations their tax-exempt status. While terms like “public education” and “policy education” may help avoid such difficulty, this dilemma provides an example of how the quest for financial resources begins to suddenly or incrementally alter the very essence of how a movement defines itself.

## **Sustainability**

The success of the New Recovery Advocacy Movement requires not only unwavering focus on recovery advocacy, but a way to sustain this work over an extended period of time. The word/concept of sustainability will need to remain at the center of consciousness of New Recovery Advocacy Movement organizations. Such sustainability will require: 1) procuring financial resources to support the minimal level of infrastructure required to sustain New Recovery Advocacy Movement activities, 2) recruiting and developing local New Recovery Advocacy Movement leaders, and 3) developing local membership cadres committed to the enduring work of the this Movement.

**An Important Debate:** Before discussing the financial sustainability of recovery advocacy organizations, it is important to first ask what kind of financial resources such organizations require. The answers will vary in what will be a lively and important debate on this question, and these variations will come out of both differences in philosophy and differences in community and cultural contexts. The question is a crucial one. The fate of recovery advocacy organizations can be doomed by too little money, too

much money, ill-timed money, poisoned (mission-corrupting) money, and dependence upon money from a single source. My own bias is towards a minimalist approach to infrastructure for this movement. The success of this movement will be measured not by the size of the budgets of its organizational members but by the degree of changes in community attitudes and increases in recovery resources that they are able to generate in local communities. It is my hope that the core of this movement must remain focused on the power of voluntary service. It is very important that paid positions not further undermine the service ethic of local recovering communities.

**Financial Sustainability:** Many New Recovery Advocacy Movement organizations will be seeded with membership contributions, funds from philanthropic foundations, or from federal, state, or local agencies concerned with alcohol and other drug-related problems. While these funds can be supplemented by a wide variety of fund-raising activities, it is a rare organization that will be able to fully sustain both its infrastructure and its core advocacy work in the larger community without a stable stream of funding, no matter how small that funding may be.

Federal, state, and local funding agencies provide continued support for prevention and treatment services but expect the functions of advocacy and community resource development to be self-sustaining after a year or two of seed money. This policy is fundamentally flawed in both design and execution. The design flaw is in refusing to fund the very functions that can enhance treatment outcomes while continuing to fund serial episodes of acute treatment that often fail because of the barriers to, and lack of resources to support, recovery in the natural community environment following discharge from treatment. The execution flaw is that advocacy organizations are forced to transform themselves into service organizations in order to financially survive. Ironically, these organizations then suffer poor service outcomes because of the lack of the very resources for which they were originally advocating.

It is time that the functions of recovery advocacy and community recovery resource development were recognized as being on par with prevention and treatment and were provided at least modest streams of funding to sustain them over time.<sup>37</sup> Pouring money into treatment that initiates recovery without the indigenous community supports to sustain those recoveries represents extremely poor stewardship of funding resources. It is not enough to create temporary sanctuaries in which people can initiate brief experiments in sobriety; that physical and psychological sanctuary must be extended into the wider community where the most fragile, treatment-initiated sobrieties will either be devoured or nurtured into maturity. It makes no sense to provide ongoing financial resources to support recovery initiation while providing no ongoing financial resources to support recovery stabilization and maintenance. This is analogous to providing half the dose of antibiotics required to fully suppress a n infection or conducting heart bypass

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<sup>37</sup>There are actually historical precedents for such funding that span NIAAA funding of NCA to organize state and local advocacy organizations to CSAT's current Recovery Community Support Program.

surgery with no prescriptions and support for managing such post-hospitalization behavioral risk factors as diet, exercise and contraindicated drug use.

Rectifying this situation will require that funding agencies find ways to shift from a treatment paradigm to a recovery paradigm. Recovery services (recovery advocacy, recovery resource development, and recovery support services) need to be financially supported on a continuing basis on par with prevention and treatment. Professional treatment needs to be seen again in proper perspective as one potentially helpful, but not always necessary or by itself sufficient, step in the larger and more enduring process of recovery.

**Leadership Sustainability:** The New Recovery Advocacy Movement in the opening of 2001 represents a unique phenomenon in that it is a movement spreading with no national leadership or centralized national structure. The grassroots quality of the New Recovery Advocacy Movement is at this moment one of its greatest strengths. A time will come when national leaders will be needed (at least individuals who can act in this role on an ad hoc basis), but these should be drawn from those who have been seasoned in local leadership roles. Local leaders have assumed these roles through a combination of being called, being chosen (by the local recovery community) or just plain happenstance. The New Recovery Advocacy Movement will need to develop a vision and a strategy for how its future leaders will be recruited, developed, and supported over time.

**Cadre Sustainability:** The impact of the New Recovery Advocacy Movement will not be determined by the size of its formal membership. In contrast to mutual aid groups whose influence is measured by the number of individual members, 100 local recovery advocacy organizations each with a small core of committed members could change how this country perceives and responds to those with severe and persistent alcohol and other drug problems. The challenge will be to develop these local cadres of committed individuals and to manage the health of such cadres over an extended period of time. Such sustainability will require strategies of mutual support, not for recovery (that must come from other sources such as mutual aid groups), but for the emotional wear and tear inherent in advocacy work.

The primacy of sustainability is to the New Recovery Advocacy Movement organization what the primacy of recovery is to the New Recovery Advocacy Movement member. Recovery advocacy, like recovery itself, is an enduring marathon, not a sprint.

### **Recovery Support Services / Recovery Coach**

Professionally-directed treatment rose in the mid-20th century as an adjunct to the recovery process, but as the treatment field grew to enormous proportions, it tended to define recovery as an adjunct to itself. Getting treatment was important; on-going recovery management was relegated to the status of an afterthought called “aftercare,” or more recently “continuing care.” This imbalance can be corrected by integrating treatment within a larger

umbrella of recovery support services.

Recovery support services are actions designed to:

1. eliminate personal and environmental obstacles to recovery (including obstacles to participation in pro-recovery activities)
2. elicit positive motivation for personal change in persons experiencing alcohol and other drug-related problems,
3. link those wishing to recovery to both professional and indigenous community recovery resources, and
4. sustain a supportive, cheerleading, problem-solving relationship with persons in pre-recovery and early recovery, with a particular emphasis on guiding the individual through the pre-action stages of change and helping solidify the maintenance stage of change.

Who will provide these new recovery support services that now either don't exist or are scattered piecemeal across the roles of counselor, counselor aides, detox technicians, case managers, outreach workers or volunteers? Actually this function once existed, but disappeared when the role of addiction counselor was professionalized. The focus of the earliest roles I filled within alcoholism programs of the 1960s and early 1970s was not on counseling or psychotherapy, but on developing and mobilizing indigenous recovery resource on behalf of individuals seeking help for alcohol and other drug problems. My experience was not unique. J. David Else has described the way in which he was indoctrinated at the Gateway Rehabilitation Center in 1970:

*Your job is not to cure or fix people. Healing is our goal and healing comes from the community. Your role is to build and enhance the community here.*<sup>38</sup>

When the role of the modern alcoholism counselor was first formulated, the focus of the role was not therapy. Robert Wayner, one of the founding members of the National Association of Alcoholism Counselors and Trainers explains:

*Our original idea was to have counselors train people in communities to deal with the growing alcoholism problem. The training we taught was not based on clinical skills; it was based on a community development model...*<sup>39</sup>

In the rush to professionalize, the focus shifted from resources and relationships in the alcoholic's natural environment that could help initiate and sustain recovery to the alcoholic's cells, thoughts and feelings. The dominant influence shifted from the discipline of community

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<sup>38</sup>Else, J.D. (1999). Recovering Recovery. *Journal of Ministry in Addiction & Recovery*, 6(2):11-23.

<sup>39</sup>NAADAC: 20 Years of Leadership. (1992). *The Counselor*, 10(3):15-27.

development to the discipline of psychotherapy.<sup>40</sup> The New Recovery Advocacy Movement seeks a shift in focus from the unique pathology of the addicted individual to the social ecology of addiction and addiction recovery.

While recovery support functions could be integrated into many roles within the addiction treatment “continuum of care,” it may be easiest to simply create the new role of *recovery coaches* (or what some are calling *recovery guides* or *recovery support specialists*) and integrate these specialists into the many service settings in which alcoholics and addicts are encountered. The focus of the recovery coach role must be one of tapping the service ethic of the indigenous community—not on replacing that ethic with paid service activity. The focus must be on recovery resource development and linkage rather than on traditionally delivered direct service.

There will be many questions to address in the formulation and implementation of this new role.

- How shall this role be defined and delineated from existing services roles?
- How will this role be effectively integrated into a larger interdisciplinary service delivery team?
- What qualifications and competencies will be required to fill this role?
- How will “folk (experienced, firsthand, internal) knowledge” be valued in comparison to “formal (acquired, secondhand, external) knowledge.” How should the financial compensation of the recovery coach compare to other service roles? Will the level of compensation allow us to recruit and retain the best recovery coaches?
- What standards of ethical conduct and boundary management should guide the relationship between the recovery coach and those they support?

All of these questions require serious and sustained discussion within the New Recovery Advocacy Movement and the larger addiction/recovery service arena. It will be important for the New Recovery Advocacy Movement to keep these positions/functions from being overly professionalized. The goal is not to speed the professionalization of this role, but to actually slow such processes and maintain the role’s dynamic quality.

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<sup>40</sup>For an elaboration of this discussion, see White, W. (2001). A Lost Vision: Addiction Counseling as Community Organization. *Alcoholism Treatment Quarterly*. In Press.

There is a danger that accompanies the growing recognition of the need for recovery support services. If the treatment field does not find a way to develop adequate recovery support services, these services may emerge as a separate system developed out of recovery advocacy organizations. The danger here is a separation between recovery support services and treatment services similar to the split that has long existed between the treatment and prevention fields.<sup>41</sup> That split would not benefit the people both treatment and recovery advocacy organizations are pledged to serve and could result in recovery advocacy organizations competing with treatment agencies for a shrinking pool of funding.

### **Recovery-oriented Systems of Care**

One function of the New Recovery Advocacy Movement will be to influence professionally-directed addiction treatment toward a more recovery-oriented system of care. Briefly, this will entail such changes as:

- the Integration of medical/psychotherapy model of treatment with community development models of recovery
- an aggressive approach to eliminating personal and environmental obstacles to recovery (“recovery priming”)
- the reconceptualization of treatment from that of the first line of response to addiction to a last resort—a safety net for those requiring resources beyond indigenous recovery support systems, e.g, family and extended family, the church, mutual aid groups

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<sup>41</sup>I would like to acknowledge Don Malec of Recovery Communities United in Chicago for first asking me to think about this potential danger.

- a shift from time-limited acute interventions to long-term recovery management—a shift from treatment planning to recovery planning<sup>42</sup> --and the abandonment of such concepts as *discharge* and *aftercare*
- a shift in locus of service delivery from the treatment institution to the natural environment of the client, and
- a shift from a hierarchical (expert-patient) helping model to a partnership (sustained recovery management) model.<sup>43</sup>

## Recovery Pathways/Style

Anatole Broyard once observed that “every seriously ill person needs to develop a style for their illness,”<sup>44</sup> and I would add, “a style for their recovery.” If we carefully listen to the stories of recovered and recovering people, we will find a staggering diversity of such styles of addiction and recovery. We have yet to coin the words to depict such variations. If we are truly serious about recognizing and celebrating the growing pluralism of the culture of recovery, then we need to evolve a language that depicts such diversity. One area of substantial variation involves whether (and the degree to which) addiction and recovery are pursued as solo or shared experiences. I have earlier described acultural (addiction isolated from other addicts), bicultural (dual membership in the culture of addiction and the larger society) and culturally enmeshed (a life consumed by and within the culture of addiction) styles of addiction and counterpart styles of recovery.<sup>45</sup> But a simpler language is needed to describe such variations. Here are some possibilities.

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<sup>42</sup>See Borkman, T. (1997). Is Recovery Planning Any Different from Treatment Planning. *Journal of Substance Abuse Treatment*, 15(1):37-42.

<sup>43</sup>See Eisler, R. (1987). *The Chalice and the Blade*. San Francisco: Harper Collins Publishers.

<sup>44</sup>Broyard, A. (1992). *Intoxicated by My Illness*. New York: Fawcett Columbine

<sup>45</sup>White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, Minnesota: Hazelden.

1. *Affiliated recovery* is a phrase that depicts the traditional pathway of initiating and sustaining recovery within an organized recovery mutual aid society. Affiliated recovery would include those individuals who are recovering within the framework of AA/NA or in such 12-step alternatives as Secular Organization for Sobriety or LifeRing. The term would also apply to those individuals who are recovering via participation either in specialized addiction ministries or broader religious pathways of recovery in which addiction is framed as a sin and recovery is defined in terms of redemption and living within a sober, faith-based community.

2. *Virtual recovery* or *cyber-recovery* is a phrase that describes people who have initiated or sustained their recovery from addiction through internet discussion and support groups, without face-to-face contact with other people in recovery.

3. *Disengaged recovery* is a term that depicts people who initiated their recovery within a professionalized treatment context or a recovery mutual aid group, perhaps even sustained that recovery for an extended period of time within that professional or mutual aid structure, but then disengaged from active participation while continuing to maintain their sobriety and emotional health through other methods. Such eventual disengagement is anticipated and encouraged in some groups (e.g., Women for Sobriety). It also occurs in traditional Twelve Step recovery groups much more frequently than publicly acknowledged, but this style of recovery has not been “blessed” by the Twelve Step community.<sup>46</sup>

4. *Solo recovery* is a term that describes people who recover from severe alcohol and other drug problems without the aid of either professionally-directed treatment or participation in recovery support groups. Terms such as *maturing out*, *natural recovery*, *spontaneous remission*, *auto-remission*, and *untreated recovery* have been used in the addiction research community to

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<sup>46</sup>Given that open acknowledgment of this phenomenon is likely to stir controversy and powerful resistance in some circles, I will briefly elaborate. I believe that sustained participation in mutual aid groups is an essential sobriety maintenance function for many people, that such sustained participation is a framework for spiritual fulfillment and meaningful social fellowship for many people, and that the survival of mutual aid groups as viable organizations requires a cadre of leaders and elders committed to sustained involvement. This does not alter the fact that many people with severe and persistent alcohol and other drug problems can and do achieve sustained recovery without life-long participation in such groups. This is also a way of stating my belief that the impact of AA and NA on America’s alcohol- and other drug-related problems far exceeds the impact reflected in the number of active members at any point in time.

depict this phenomenon. The acknowledgment of solo recovery is an important step in celebrating the growing pluralism of the culture of recovery in the United States, but it is likely that this term will give way to other yet to be coined terms. The reason is that studies of natural recovery confirm that most people who recover from addiction without the aid of treatment or support groups do so with significant family and social support for their personal recovery. One of the challenges of involving people in solo recovery in the New Recovery Advocacy Movement is that many such individuals shed alcohol and other drug problems without incorporating addiction or recovery into their personal identity and story. It will require visible accounts of solo recovery for such individuals to self-identify themselves and consider participation in this movement.

5. *Manual-guided recovery* is a term reflecting a mid-point between affiliated and solo recovery. Here the individual seeks outside assistance in the form of a written manual that provides a highly proceduralized approach to altering his or her relationship with alcohol and other drugs without face-to-face contact with others in recovery. As more of these manuals move on to the Internet, the paths of virtual recovery and manual-guided recovery are likely to merge.

There may be better words to depict the unspoken realities and diversities of these recovery pathways. As the diversity of recovery paths becomes more fully charted and culturally known, we will evolve new terms to depict this diversity at the same time the need for such designation will likely diminish. Once charted and known, what will become increasingly important to the New Recovery Advocacy Movement is that people ARE in recovery, not how that recovery was achieved or is being sustained.

### **“Presenting the Faces and Voices of Recovery” / “Living Proof”**

It is only when we reach a critical mass of people in America who personally know someone in stable recovery that attitudes toward addiction and the possibility of recovery will change. This is how attitudes toward a number of illnesses changed. The death sentence connotations of cancer, for example, changed only when known survivors of cancer reached a point of critical mass in the culture. The problem with addiction recovery is this: Most people already know someone in stable recovery from addiction but they don't know of this individual's recovery status because it has been withheld. It is when that status becomes known that people have to confront their own stereotypes about addiction and recovery. That's why “coming out” or “going public” (declaring one's stigmatized identity) is a political act. What the New Recovery Advocacy Movement is advocating is “reverse passing”—the creation of a cadre of people declaring their recovery status who could continue to “pass” if they chose to. One wonders what it would mean to those actively addicted and to the citizens of this country to witness people in incomprehensible numbers marching in Washington to proclaim their stable and enduring recovery from addiction.

The strategy of “Putting a Face on Recovery” and offering “Living Proof” is a sound one, but the question is how do we launch and sustain this campaign without doing harm to those at the forefront of this campaign? That harm is real and can come in the form of social, political, and financial discrimination. Given such potential harm, it is best to launch this campaign in phases, beginning with those who face the least harm to those who face potentially greater harm.

This way, the success of the early campaign can serve to lesson the harm to those whose disclosures follow in the months and years after this first wave. The New Recovery Advocacy Movement does not need, is not asking, nor would desire, that all recovering people disclose their recovery status. What is needed is a vanguard of recovering people from all walks of life to challenge the stereotypes about addiction and recovery and to challenge the most objective forms of prejudice and discrimination. This vanguard will be to the New Recovery Advocacy Movement what the Freedom Riders were to the Civil Rights Movement.

In calling for such a vanguard, we should be fully cognizant of the price members of this vanguard may pay for their disclosure and build in supports to counter such effects. Erving Goffman in his classic work, *Stigma*, notes the potential price of forsaking anonymity:

*The problems associated with militancy are well know. When the ultimate political objective is to remove stigma from differentness, the individual may find that his very efforts can politicize his own life, rendering it even more different from the normal life initially denied him—even though the next generation of his fellows may greatly profit from his efforts by being more accepted.*<sup>47</sup>

We do not want the recovery community to become a community of pariahs who, once identified, face greater social sequestration and discrimination. We need to identify the exact ways in which recovering people could be harmed by “coming out”<sup>48</sup> and communicate those risks to those inside the New Recovery Advocacy Movement at the same time we seek to alter those very conditions. By phasing the process of “going public” from those with least to those with greater risks in disclosing, it might be possible to reduce and manage such harm. The New Recovery Advocacy Movement can recruit this vanguard while fully respecting the timing of participation in this effort as well as the decision to withhold public disclosure of recovery where to do so would be injurious to individuals or their families. There is much we could learn on this issue by studying the history of the gay, lesbian, bi-sexual and transgender rights movement.

New Recovery Advocacy Movement organizations might consider altering the phrase “Putting a face on recovery,” to “Presenting the faces and voices of recovery.” This shift emphasizes two things. First, there need to be many faces put on recovery to convey the growing size of communities of recovery, and there need to be many faces to reduce the individual vulnerability of going public. This vulnerability stems both from social/occupational/economic injury that could accompany disclosure and the challenge to, in the words of Bill Wilson, “keep

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<sup>47</sup>Goffman, I. (1963). *Stigma: Notes on the Management of a Spoiled Identity*. New York: Simon and Schuster, p. 114.

<sup>48</sup>Such injury could include job discrimination related to hiring, advancement, discharge particularly in positions calling for either high moral character (clergy, teachers, political appointments, etc.) or security clearances; financial harm due to lost clients; discrimination in divorce, child custody, or adoption hearings; decreased access to or increased costs of health and life insurance; embarrassment or social ostracism of family members; etc.

those fool egos of ours from running hog wild...”<sup>49</sup> The vulnerability of a recovering person is magnified when they stand alone under a media spotlight; the strength of recovering people is enhanced when they stand together in such numbers that no spotlight can focus on one face or fully encircle them. This might be called the power of the plural that has long marked addiction recovery: the discovery that what cannot be achieved alone can be achieved together.

## **Story**

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<sup>49</sup>Quoted in: Bill Wilson’s New York Times Obituary.  
[http://www.aahistory.com/aa/Bills\\_obit.gif](http://www.aahistory.com/aa/Bills_obit.gif)

If there is anything at the heart of the recovery process it is surely the processes of story reconstruction and story telling. Arthur Frank has eloquently detailed the way in which “seriously ill people need to become storytellers in order to recover the voices that illness and its treatment often take away.”<sup>50</sup> Many recovering people experience a need to “reclaim their voice” because that voice was culturally suppressed or abdicated. Those addicted and those recovering from addiction have had multitudes of professional specialties and social and religious reformers speaking about them and on their behalf, but rarely have their first-person voices been heard without the filter of professional/moral interpretation. The New Recovery Advocacy Movement is in part a declaration that recovering people should be speaking for themselves—should be playing a part in shaping the knowledge base of addiction medicine and addiction counseling as well as having a role in shaping social policies that affect the lives of addicted and recovering people. It is in the transition from personal recovery to social/political advocacy that recovering people discover the “connection between telling their stories and changing the world.”<sup>51</sup>

The New Recovery Advocacy Movement, in calling on recovering people to “put a face on recovery” and offer “living proof” of recovery, is inviting a contingent of recovering people to tell their story to a new audience—not to themselves, to treatment professionals, or each other, but to the larger social community. And yet it will be important for members of the New Recovery Advocacy Movement to discuss how this public story should differ from the one shared in the counselor’s office, in face-to-face mutual aid meetings, and in online support groups. At local and national levels, we need to ask ourselves the following questions:

1. What message do we want these stories to convey?
2. How can that message be best presented?
3. Who can best present this message?

When we move from mutual aid to recovery education/advocacy, we will need to redefine the meaning of “telling our story.” We will need to stay message focused and avoid the temptation of overly dramatizing addiction and overly romanticizing recovery.

The New Recovery Advocacy Movement needs to convey a new language, new ideas, and new images about addiction recovery. We need to replace the flailing efforts of the cornered celebrity-addict to verbally extricate himself or herself from their latest public indiscretion with the more reasoned voices of those speaking not from a position of crisis but from a platform of stable and enduring recovery. The purpose of this storytelling is not emotional catharsis or anchoring one’s own recovery. Instead, it is to: 1) send a message of hope to those still impacted

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<sup>50</sup>Frank, A. (1995) *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press, p. xii.

<sup>51</sup>I would like to acknowledge John Magisano for calling this point to my attention.

by AOD problems, 2) place AOD problems in their larger context, and 3) form an emotional bridge between those in recovery and those who have never experienced AOD-related problems. The second of these goals requires depicting how society, through its misconceptions, misinformed policies, and inadequate resources has amplified the problems of addiction and inadvertently erected barriers to recovery. The third goal is to demystify addiction and recovery—to place addiction within the rubric of having experienced brokenness and separation from others. By placing addiction and recovery within the larger rubrics of adversity and the struggle to heal and be whole again, the separation—the “We-They” thinking—between addicted and recovering people and the larger community is bridged. The point of telling recovery stories publically is not what it does therapeutically for the storyteller, but what it does to and for the listeners.

### **Responsibility, Gratitude, Service**

I noted earlier that the New Recovery Advocacy Movement must find a fresh approach to enlist public support. While there are many rights issues that fall within the umbrella of this movement, I don't think appeals to injustices and rights will work with a citizenry that is losing its capacity to attend to new claims in this area. But there is a way that the New Recovery Advocacy Movement can present itself in a way that taps the core values of communities of recovery and, by doing so, bring something that is desperately needed in the larger culture. The emerging New Recovery Advocacy Movement is as much a responsibility movement as a rights movement. The message is a fresh one.

*Through our addiction, we have wounded ourselves, our families and our communities. In gratitude for the gift of recovery, we declare our responsibility to manage our own recovery, to make restitution for the injuries we have inflicted, to carry a message of hope to others, and to contribute to the larger health of the community.*

The New Recovery Advocacy Movement would be well served by elevating the values of responsibility, accountability (restitution), and service and assuring that these values are expressed only on a voluntary basis.<sup>52</sup>

### **Friends of Recovery**

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<sup>52</sup>My emphasis on voluntary service is to head off any effort to enlist members in this movement through the vehicle of court-ordered community service.

Every movement to liberate or improve the lives of disempowered people brings people into the movement who are not members of this group, e.g., Whites playing supportive roles in the civil rights movement, men playing supportive roles in the women's movement. Some individuals are given "honorary" membership as "one of us" because of their empathy, their understanding, their commitment and their contributions to the movement. Some are so absorbed into the group that they lose nearly all aspects of their non-member status. Such people are in evidence in most earlier recovery mutual aid and recovery advocacy movements. How are these special friends to be designated? Sociologists have referred to such people as "the wise"<sup>53</sup> while others have sometimes referred to them as "fellow-travelers." Perhaps such people could be referred to simply as "friends of recovery." The use of "friend" in this manner dates at least as far back as the Washingtonian revival of the 1840s.<sup>54</sup> The New Recovery Advocacy Movement will need and will have many such *friends of recovery*. I noted in an earlier paper that the leadership of this New Recovery Advocacy Movement should be authentic, and what I meant was that the leadership should come from those in recovery and their families. But technically, what is most important is that recovering people and their families choose their own leaders and that those leaders remain responsive to this constituency. There are places and circumstances where that leader will be a friend of recovery who is chosen by and represents the needs of the local recovery community.

### Summary

There will be many strategies and tactics of the New Recovery Advocacy Movement. Language will be one method of altering the consciousness of those who make up this movement and altering the attitudes and beliefs in the community. As this New Recovery Advocacy Movement emerges, we must carefully assess and shape this language and then let that chosen language evolve as the Movement matures.

Somewhere in this movement's maturation, a message of unification must be forged that psychologically and socially links the growing number of recovery groups and solo flyers into communities of shared experience that can transcend their internal differences to speak powerfully on one issue: the hope and reality of permanent recovery from addiction. We need to find common ground of solidarity among those who were once afflicted but are today well and free. We must find a common recovery advocacy language that transcends the differences we have as groups and individuals. The most serious struggles need to be waged not with each other but with the more formidable forces in our communities and our culture that seek to objectify and demonize those who have experienced alcohol- and other drug-related problems.

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<sup>53</sup>Goffman, 1963.

<sup>54</sup>Blumberg, L. with Pittman, W. (1991). *Beware the First Drink!* Seattle: WA: Glen Abbey Books.

