Background Paper:
Recovery Themes

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Introduction

This paper has been prepared as part of the background material for the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) Planning Group which will meet on June 13-14, 2005 to prepare for a CSAT National Recovery Summit scheduled for September 28-29, 2005. The Recovery Summit will gather approximately 100 leaders from the addiction treatment and recovery communities who will seek to:

1. Reach a shared understanding of principles of recovery from addiction[1] to alcohol and/or other drugs,
2. Identify domains and associated markers that lend themselves to measuring recovery, and
3. Recommend next steps for moving addiction treatment systems beyond a pathology-based focus on the remission of symptoms to a focus on wellness.

The purpose of this paper is to assist the Planning Group in its considerations of how best to facilitate the National Recovery Summit's achievement of the first goal—a shared understanding of principles of recovery.[2]

A substantial body of clinical and research literature exists on addiction, pre-treatment and treatment activities, relapse prevention, and early recovery (the stage most often measured in treatment outcome studies). Considerably less can be found on middle-stage and ongoing recovery. However, a large body of literature, prepared by individuals in recovery and

[1] As used in this paper, the term *addiction* includes alcoholism, and *addict* includes the alcoholic. These terms are widely used by people associated with different schools of thought, including those who reject disease-based concepts and terminology. The authors recognize and respect the preference of many to adopt less stigmatizing and more "person first" terminology, such as "persons with substance use disorders."
[2] Materials related to Goals 2 and 3 will also be provided to assist the Planning Group.

members of mutual-aid groups, lays out experientially derived processes and methods for achieving and sustaining recovery.

In addition, numerous perspectives on addiction recovery and treatment models for medically assisted recovery have been advanced by leaders in a wide array of professions—ranging from clinicians and social workers to brain researchers and other scientists. Much information, particularly about early recovery, has been generated by treatment practitioners, evaluators, and systems professionals. Also, researchers are beginning to accumulate information about successful recovery strategies that involve neither formal treatment nor mutual-aid support.

The perspectives and models of recovery presented in professional and lay literature have emerged from a wide variety of social, cultural, and life-cycle contexts and represent many different voices. Multiple voices and perspectives do not lend themselves easily to the development of shared definitions or a unified theory. Yet, in practice, a pragmatic streak of eclecticism exists, with peers, practitioners, researchers, and theoreticians frequently drawing from what appear to be promising practices and wisdom representing various doctrines, methods, and styles of recovery.

The authors have also adopted an eclectic approach in preparing this background paper on recovery. Such an approach is consistent with a major theme that emerges from the literature: Like addiction, recovery is a complex and dynamic process. Race, class, ethnicity, gender, sexual orientation, family history, life-cycle stage, environment, and culture combine with the individual's unique experiences, strengths, values, needs, and desires to form an ecological context within which recovery takes place. This means invariably that recovery is experienced differently by different people, depending on who they are and the circumstances and environment in which they live.[3]

[3] A systematic exploration of the commonalities and differences in recovery thinking associated with the person (e.g., age, gender, sexual orientation, co-existing disorders and conditions) and his or her environment (e.g., culture, ethnicity, family, class, criminal justice involvement, housing status) is beyond the scope of this paper. Nevertheless, the importance of developing recovery principles that accommodate these differences cannot be overstated.

Although no universally accepted definition of recovery exists, recovery can be understood to be a process of change that takes place between the individual and his or her relationship to alcohol and/or other drugs, that typically is experienced in many dimensions of life.[4] This understanding forms the basis for this paper, which is presented in three sections. Section 1., The Architecture of Change, identifies a number of themes that occur in the literature relating to the nature of change during the recovery process. Section 2., Recovery Across Body, Mind, Relationships, and Spirit, is an in-depth exploration of one overarching theme that emerges from the literature—the holistic nature of physical, mental, social, and spiritual changes experienced by an individual throughout recovery. The paper concludes by highlighting some of the tensions and unresolved issues that exist in any discussion of themes on recovery in Section 3., Illustrative Questions for Discussion and Dialogue.

Themes found in the literature are not, themselves, principles of recovery, but they can inform the search for principles in several ways. In some cases, a theme may point the way to a clear consensus on a matter that will likely be widely accepted as a shared principle without much discussion. In other cases, themes can reveal tensions between and among differing viewpoints. In these cases, discussion and dialogue can help to bridge the gap between views, honoring the truth of each in the development of shared principles. Alternatively, discussion and dialogue can shed new light on hard questions, moving the addiction and recovery field forward in its thinking. This paper is presented in the spirit of advancing such a discussion and dialogue.

Section 1. The Architecture of Change

This section is a distillation of a number of themes from the literature relating to the nature of change in the recovery process. These themes reflect many varieties of individual experience and at times display seemingly contradictory qualities or phases. These contradictions are

[4] This change in relationship is defined in abstinence-based models as stopping all use. For those who approach the question from a disease perspective, diagnostic criteria may play a role in defining the changed relationship. DSM-IV, for example, provides diagnostic criteria for levels of substance use disorders. Based on these criteria, "Recovery from DSM-IV Alcohol Dependence: United States, 2001-2002," a study released by NIAAA in January 2005 based on data from the 2001-2002 *National Epidemiologic Survey on Alcohol and Related Conditions* defined people as being in recovery who were classified as in partial remission, asymptomatic risk drinkers (who demonstrated a pattern of drinking that put them at risk of relapse), low-risk drinkers, and abstainers.

often reconciled over time. Therefore, respect for differences and an appreciation for paradox are needed in the search for shared principles of recovery.

Many Ecologies of Change. Each individual lives within an ecological system that is composed of personal, social**,** cultural, and environmental factors and influences. The base of this constellation of factors lies in one's origins (e.g., family, race, ethnicity, and gender), upon which are superimposed current realities of status (e.g., economic, educational, health, criminal justice, mental health); quality of "place" (i.e., where one lives, works, and finds community); and belief and value systems. These factors and influences can be major determinants of the individual's threshold for change, and, depending on their context, can function either as bridges or barriers to recovery. One way to view the ecology of change for a given individual is to look at his or her recovery capital, a concept first introduced by Granfield and Cloud, which refers to the sum total of social, psychological, and human capital that can be drawn upon for support.

Many Pathways of Change. The variety of recovery experience reflects the complex dimensions of function affected, as well as the unique strengths, values, needs, and desires that each recovering person brings to the process. As White notes, the expanding varieties of recovery experience are reflected in the growing diversity of mutual-aid groups; the proliferation of religious and cultural frameworks for recovery; the growth of medically assisted recovery; and increasing recognition of natural recovery.

Holistic Change. People from many varieties of recovery experience have a shared understanding that initiating and maintaining a changed relationship with alcohol and/or other drugs is not a simple matter of making a single change in behavior. Rather, it is a holistic process, involving many of life's domains—one's physical self (including the brain), how one thinks and processes emotions and feelings, one's relationships, and, for many, one's spiritual life. Each of these domains is addressed more fully in Section 2 of this paper.

Incremental/Transformative Change. People experience and/or analyze the recovery process in different ways. Some describe their recovery as occurring in small, incremental steps while others experience it as transformative, with major changes occurring suddenly.

Often it is portrayed as both. In 12-Step programs, for example, the newcomer is cautioned to take it “one day at a time,” but also learns that "the Promises," with their vision of a transformed self, will come into being over time. A strong sub theme is the concept of identity transformation, with important variations thought to exist along gender, cultural, and life-cycle parameters. With respect to identity, debate exists about the positives and negatives of accepting the label of alcoholic or addict. Identity transformation often is linked closely to the power of shared story, which is often a major strategy for recovery initiation and maintenance.

Nonlinear Change. Like other changes in life, recovery is not a linear process; it is often depicted graphically as a spiral, with movement in both directions on the spiral. Although the field has no shared definition of relapse, a number of models and strategies, such as those put forth by Marlatt and Gorski, exist for preventing it and for minimizing the consequences when relapse occurs. Relapse also has been viewed as a learning opportunity in the context of managing a chronic condition, as McLellan and others have pointed out. As a practical matter, however, a person who relapses may find his or her access to treatment and other recovery support services terminated, and also may feel shamed within his or her mutual-aid community.

Developmental Models of Change. A person who is one day sober is not in the same place as a person with 30 days, one year, or 10 years of sobriety. This reflects the number and degree of changes that take place over time in various aspects of the recovering person’s life and continued human development. A number of thinkers, including Larsen, Brown, DiClemente, and Picucci, have developed various staged or developmental models of recovery to describe this process. Among these models, the stages of change model has been most thoroughly researched and is well known in the treatment world, though less so in the recovery community. These models reflect a sense that, despite the multiple pathways, dimensions, and zigs and zags that characterize the many types of recovery experience, recovery generally follows predictable stages. These stages are marked by common milestones and seen as opportunities to build on changes that occurred in earlier stages in the process. Moving to a new stage has inherent risks, especially when people are asked to accomplish goals that they may not be ready for.

The existence of numerous models of human development across the life span should be noted. Where any given person is in the life cycle—e.g, adolescence; early, middle, or late adulthood; or old age—will affect his or her recovery process.

Safety as a Foundation for Change. The need to feel safe in the recovery process underlies the various structures of confidentiality and anonymity that pervade formal and informal treatment and recovery support systems. In recent years, this theme has acquired broader significance within the context of the early recovery needs of people who are survivors of violence and/or trauma, homeless, or living in unsafe environments.

Motivation: Pain and Hope as Foundations for Change. Most peer and professional recovery support approaches agree that motivation plays a central role in recovery. According to traditional 12-Step and treatment thinking, the motivation to change emerges from the pain of "hitting bottom." Pain often increases, and motivation may be enhanced, when others stop enabling the individual or when one's family and associates conduct an intervention. More recently, among increasingly disempowered persons, as well as those with co-occurring disorders, the opportunity to take part in empowering activities has been identified as a necessary precursor to the development of motivation. What is needed before some persons can develop the motivation to initiate recovery is not more pain, but hope.

Power and Powerlessness in the Change Process. One of the many paradoxes for persons in recovery is the need to strike a delicate balance between accepting, on the one hand, that one is powerless over alcohol and drugs while, on the other, developing the strength needed to overcome addiction. In the context of Alcoholics Anonymous, its offshoots, and many faith-based approaches to recovery, resolving this paradox requires surrender to a Higher Power. There is a great body of literature, most notably by Tiebout and Kurtz, on the psychological and spiritual significance of surrender and admission of powerlessness.

As noted by Williams, Kasl, Covington, and Kirkpatrick, some groups of people in recovery, including many women and Americans of color who see themselves as oppressed and disempowered, perceive the admission of powerlessness and surrender as a further undermining of their hope for recovery. In order to achieve recovery, many of them—as well

as others who have resisted either the admission of powerlessness or the spiritual aspects of surrender—have taken the opposite route: laying claim to power. Thus, some people gain control over the use of substances, not by accepting notions of their powerlessness, but by devoting energies to establishing their own internal power. Through this process, they develop the resilience and self-esteem needed to implement and sustain recovery. Countless millions of people in recovery around the world have embraced one or the other of these notions, sometimes (but not always) rejecting the other. Many have integrated both.

Intentionality and Choice in the Change Process. Intentionality means choosing to undertake the hard work of recovery by taking personal responsibility to safeguard and protect one's own recovery despite the many perceived obstacles ahead. For most people, recovery is an intentional process, with the individual playing an active role in initiating and, eventually, sustaining recovery within a web of self-selected supports that include a sense of place, community, and relationships with others. Intentionality assumes that the individual is ready, willing, and able to make these choices.

Paradoxically, the process of recovery often begins at a place where the individual may, in fact, be faced with limited choices and limited confidence in his or her ability to make those choices. The constriction of choice can take many forms: external pressures that oppose continued use of drugs and/or alcohol, such as the threat of imprisonment and correctional sanctions or fears of job loss; child-welfare pressures; family or community norms that may oppose or support continued use; lack of meaningful or personally acceptable treatment or recovery support options; and hopelessness, to name just a few.

Section 2. Recovery Across Body, Mind, Relationships, and Spirit

Both the literature and the practices of people seeking to achieve or sustain recovery clearly demonstrate that recovery is a process of change that involves the whole person, with all of his or her strengths, weaknesses, desires, goals, and values. Physical changes in the *body* (including the brain) are coupled, in the *mind***,** with changes in thinking patterns and acquiring new methods of dealing with emotions. Change also commonly occurs in a person's *relationships* with other people and his or her community. For many people, the process of change in recovery has a strong *spiritual* component.

These four domains of holistic health—body, mind, relationships, and spirit—parallel the biopsychosocial model of addiction. These domains are interactive, and change in one can influence change in another. Each is a place where recovery can begin and where recovery can be either strengthened or stymied. Different recovering individuals assess and balance the various changes differently, based on individual needs and preferences and the personal ecology in which recovery occurs, all of which change over time as recovery progresses.

A. Body

Brain and Central Nervous System. Researchers for the National Institute of Drug Abuse (NIDA) and in research centers around the world increasingly see addiction as a complex and chronic brain disorder that cannot be isolated from its behavioral and social components. Like Alzheimer's, Parkinson's, schizophrenia, and depression, addiction has behavioral and social dimensions. Research is yielding medical avenues to help assist recovery for some individuals.

In early recovery individuals often face a number of problems centered in the brain, such as detoxification, cravings, the response to events and environmental conditions that trigger cravings, and the reestablishment of brain and central nervous system functions affected by addiction. The confusion and befuddlement of very early recovery can fade away, but some brain effects are thought to be long lasting and may persist throughout recovery. Individuals with co-occurring mental and addictive disorders may experience change related to each disorder.

Physical Health. Individuals in early recovery often become concerned with their general health, which may have been neglected, sometimes for many years. Common problems include liver disease, anemia and other nutritional deficiencies resulting from poor dietary habits, neuropathy, HIV infection, hepatitis C, herpes, and sexually transmitted and other infectious diseases, including tuberculosis. Dental problems also are common. For those who have been living in the cramped and crowded conditions of shelters, jails, or prisons, multiple-drug-resistant tuberculosis and other infectious diseases can be a major problem, not just for the individuals directly affected but also for the communities to which they return.

Ideally, these conditions are identified early in recovery through a physical examination. Feelings of shame and a desire to avoid disapproval may prevent many from disclosing their addictive and recovery status to the physician or other health care provider. This is unfortunate, because full disclosure of past addiction history is necessary in order for the health care provider to recommend appropriate diagnostic tests, and to help minimize the adverse health conditions that often accompany addiction. Sometimes, medical problems emerge in later stages of recovery. Hepatitis C, in particular, is often discovered only after an individual is well along in recovery.

The presence of disorders that cause chronic or acute pain can present a significant challenge to the person in recovery since many pain-killing medications contain mood-altering drugs. This is a particular challenge for individuals who have been addicted to opiates such as heroin and who utilize an opioid-based form of recovery assistance, such as methadone. For example, practitioners unfamiliar with the recovering person's history might provide opiates or opioid medication for acute pain, unwittingly triggering relapse.

It is a good idea to work closely with a pain management specialist knowledgeable about addiction who can consider nonpsychoactive medications and techniques and establish a baseline for dosage purposes. Such assistance may not be readily available, however.

As recovery progresses, many people become involved in a proactive health regimen that includes healthy eating, exercise, and rest. Many recovering individuals find alternative health interventions, ranging from brain wave biofeedback to yoga and acupuncture, helpful in sustaining long-term recovery.

B. The Mind

At a minimum, the person in early recovery has to learn how to overcome the strong cravings common in early recovery and how to identify and avoid the triggers that can prompt relapse. He or she will need to accomplish the challenging task of learning to identify the cycle of environmental cues, thoughts, emotions, and behavior that act as triggers, and develop coping strategies. This task must be undertaken during a period which is frequently emotionally turbulent. Painful feelings associated with acknowledging the harm one may have done to

others, or suffered at the hands of others, can be particularly strong, especially when powerful cravings are present, and the person in recovery will need to develop new strategies to cope with these powerful feelings, as well.

Many people discover hidden strengths and resilience as they face these challenges. Some discover problem-solving skills (including insight and resourcefulness), or a sense of purpose and future (such as goal-directedness and an innate optimism and persistence). Others may have strong social competencies (such as good communication skills or a sense of humor) that will make it easier for them to find allies to support them. Many others may need support in building these skill sets.

The person in early recovery can be helped by many strategies and techniques for learning new behaviors. Cognitive restructuring can be achieved in numerous ways, including cognitive behavioral therapy (CBT), social skills training, and participation in the rituals and processes of mutual aid groups. Other key components in sustaining one's recovery are learning to identify personal stressors; developing a personal approach to stress management, self-care, and self-efficacy; and practicing these skills each day.

Other common and important tasks during early stages of recovery are addressing powerful feelings of grief, loss, shame, and guilt about the past and facing one's fears and apprehensions about the future. When these feelings are not dealt with, they can linger, adversely affecting relationships and self-esteem, as well as hampering the ability to accomplish the tasks of daily life and develop or regain a sense of competence. A strong sense of competence helps to facilitate the development of effective cognitive processes and increases performance in a variety of areas of life.

Another important task of ongoing recovery is to develop a healthy sense of autonomy in order to establish and maintain personal boundaries and to establish healthy relationships. Learning to resolve the tension between the desire for closeness and establishing appropriate distance is necessary to preserving personal relationships and establishing and maintaining new ones. For some, this can include cultivating quality nonsexual relationships with persons of the opposite gender, perhaps for the first time in their lives.

As recovery continues to progress, priorities often shift to achieving important, but less urgent, goals. This change in focus may come about naturally, as confidence in one's ability to sustain recovery grows. Educational or career development goals may emerge, as well as a desire to address unresolved family issues.

C. Intimate and Social Relationships

The task of building a network of social support is perhaps the most challenging part of recovery work. At the center of the web is a person in early recovery whose own sense of self-worth may be fragile, and who may be overwhelmed by demands to reprocess, and sometimes reconfigure, the internal dynamics related to his or her most important relationships. He or she may have many social skills and healthy relationships to fall back upon, or may have few. As one moves out from the center to family and other intimate relationships, peers, community, and culture, he or she will find many resources that support recovery. At the same time, the individual will encounter others that undermine recovery, and will be put to the task of distinguishing between them and deciding which fit comfortably with his or her newly recovering self.

Reconnecting with and sometimes disconnecting from friends, acquaintances, and colleagues are important goals. Making decisions about reconnecting and coming to terms with necessary separations constitute challenges because bonds of love and deep human needs are often involved. For the same reasons, cultivating strong and healthy new relationships is rewarding and contributes to a recovery that endures. One mark of mature recovery is completion of these processes.

Family and Other Intimate Relationships. Some approaches to recovery focus on the family either as a resource to help initiate or support the individual’s recovery process or to support the family’s own needs for healing. For some individuals, family or other intimate relationships may have contributed to the development of addiction or may play a subversive role in recovery. In many cases, individuals will work to assess these relationships and will struggle at re-establishing or severing these important ties.

Assessing the current status of relationships, and one's role within them, can be emotionally charged. Attempting to let go of relationships that are harmful, powerful feelings of grief and loss can occur. When attempting to re-establish former relationships, the individual often faces anger and resentment from others because of disappointments and hurts they experienced as a result of his or her addictive behaviors. Recovering persons also often are challenged to "prove" that they are now responsible and trustworthy.

Sometimes work to heal the family, as well as the recovering individual, is done in an addiction treatment setting. Healing also may occur later in the recovery process, either with professional assistance (for those who can afford it) or with the help of peer support and advocacy groups. Sometimes it is done without any formal assistance.

Peers. Many people in early recovery shift from the self-imposed isolation of addiction to a desire for connection with other people. Assessing the current status of relationships with peers is often necessary. This frequently results in a severing of relationships with peers who are using. For many, mutual-aid groups offer an opportunity to share their experience with others who are also restructuring relationships (or have already done so), observe social role modeling, take on responsibilities that enable them to develop skills, and learn from the sharing of stories with others. Mutual-aid groups offer affiliation with, and an ability to contribute to, a community of peers who have shown demonstrable strength, and even good humor, in the face of adversity. The support from others provided in these groups can strengthen hope and a belief that recovery is achievable. However, some people in recovery do not participate in these groups, whether because they feel they do not need peer support; the mutual-aid groups available to them seem inconsistent with their values, life expectations, or worldview; or they have poor social skills and difficulties interacting within a group.

Treatment Providers. Professional treatment providers can help the person in early recovery develop needed social and other life skills that contribute to effective socialization. However, treatment episodes are often brief, and focus primarily on the tasks of stabilization. Continuing care and emerging techniques (such as post-treatment brief telephone "check-ins") can sometimes extend the ability of the treatment provider to play this supportive role

during early recovery. Of course, many people cannot or do not avail themselves of treatment opportunities.

Community and Culture. The recovering person and his or her network of family, professional, and peer supports are nested within the larger community. This community may provide supports that nurture recovery, as well as conditions that foster relapse. At a minimum, the recovering person is likely to encounter stigma and discrimination in the community. Persons with co-occurring conditions (e.g., mental disorders) or characteristics (e.g., ex-offender status) often struggle with compounded stigma and discrimination.

Sometimes people look to the strengths of their culture as a source of support for recovery. For example, for Native Americans, *The Red Road to Wellbriety* integrates the wisdom of elders, traditional values, healing practices as depicted on the Medicine Wheel, and the insights of 12-Step fellowships within a community-based recovery support system. Important political and cultural trends within the larger community? such as the Civil Rights and racial pride movements, feminism, and more recently, the growth of Christian evangelism? are often reflected in recovery thinking as well. Typically, these cultural revitalization and social justice movements are concerned with healing the individual, the community, and society as a whole.

Life Tasks and Roles. Some persons in early recovery may need to learn new skills to survive in the larger society. They may need help in becoming employable, finding work, assuming the role of employee, finding suitable housing, and even acquiring basic skills such as learning how to prepare a meal. Many need to learn, or relearn, how to socialize without alcohol or other drugs as a social lubricant. Some will be challenged to develop a healthy sexual life that is not intimately connected to alcohol and/or drug use.

Liberated from their addiction, some individuals feel propelled to rediscover learning. Not only adolescents and young people, but also older people whose education may have been interrupted by their substance use, often return to school to complete their education and go on to pursue more advanced education and other professional goals. Others become interested in simply expanding their personal knowledge. Many take up expected family roles—son or daughter, spouse or partner, parent or grandparent—that they formerly ignored.

Some do this within their pre-recovery family structures, while others do so within new family arrangements or in other constructions of interpersonal relationships.

Success at an expanding array of life tasks and the assumption of new or enhanced roles in the community—as they are identified and defined by the person in recovery over time—both derive from and contribute to sustained recovery. Those without emotional and financial resources or social supports and skills to accomplish new or enhanced tasks and roles may need a great deal of support from others to achieve their goals.

D. Spirit

Spirituality and spiritual development receive a great deal of attention in both lay and professional recovery literature. Many recovering persons, as well as researchers and clinicians, view spiritual development as a catalyst that can drive and give meaning to the changes in body, mind, and social relationships that characterize recovery. Many other recovering people, however, cannot accept what they see as a religious aspect of traditional approaches to recovery. In addition, the topic is difficult to write about because it is personal in nature. Everyone "knows" what spirituality means, but it means different things to different people. Even so, one researcher, Ringwald, recently arrived at a definition that seems to embrace many other definitions: "[Spirituality is] an ongoing internal process of change that results in a transformation of the recovering person's attitudes, values, beliefs and practices."

The traditional understanding about spirituality in addiction recovery, which comes from 12-Step fellowships, suggests that spiritual change begins when the person seeking recovery realizes that he or she is imperfect, can not achieve recovery alone, and seeks help from an outside source. People taking the traditional spiritual route find that recovery can flourish through a connection to others, an affiliation with community, and a reliance on something greater than oneself, defined in a variety of ways, including "higher power" and God. Spiritually based programs give people in recovery a safe place to nurture the ongoing processes of healing, self-reflection, character building, and developing new attitudes and behaviors. A major component of spirituality is the ability to forgive and be forgiven for the range of things that went awry during addiction. The ethical principle of mutuality, or a spirit

of "giving back," also is associated with spiritual recovery approaches, and functions as a support for one's own recovery as well as the recovery of others.

Faith-based programs have brought new dimensions of spirituality into the recovery community. Increasing numbers of people are entering recovery through faith-based programs that are shaping new approaches to recovery by drawing directly from Judeo-Christian traditions in a way that publicly funded programs (where the majority of treatment has been provided in the United States) historically could not. These programs meet the person seeking recovery with the message that every human being is created in the image of God and is unconditionally loved by the creator. People entering the recovery community from these programs bring notions of God's love as the empowering force that enables them to make the changes required to recover.

While 12-Step fellowships and faith-based organizations are the best-known venues for spiritual approaches to recovery, spirituality and cultural revitalization movements are often intertwined. For example, to help those who are not well served by non-Native treatment and recovery supports, the Native American community has embraced traditional spiritual healing and ceremonial practices including drumming, sweat lodges, talking circles, chanting, pipe ceremonies, smudging, and other rituals. In this tradition, true healing takes place within the context of the community, and the process of recovery is a quest for harmony and wholeness within the context of the self, the family, and the tribe.

Section 3: Illustrative Questions for Discussion and Dialogue

As is apparent in the foregoing sections of this paper, the literature on recovery reveals areas of both consensus and divergence. As the Planning Group moves forward with its design of the National Recovery Summit, it may want to look at some of the "hard questions" that are raised by the themes of recovery recounted in this paper, and consider how to address them in ways that promote agreement rather than discord. The following examples are suggestive and meant to assist the Planning Group by stimulating discussion related to the development of shared principles about recovery:

- Some key concepts in recovery thinking are often expressed in ways that appear to be polar opposites. For example, some say that the key to recovery is admission of powerlessness; others say the key is empowerment. The pain and fear of negative consequences, on the one hand, are described as key motivators; on the other hand, hope and empowerment are described as the essential elements. How do we develop principles of recovery that recognize and reconcile such seemingly dichotomous perspectives?

- In mental health recovery, as in many other areas of health, choice is seen as a fundamental driver of recovery, conferring dignity on the individual and underscoring his or her right to live a self-directed life. The freedom to make meaningful choices is seen as essential to the healing process. A person approaching recovery from addiction, on the other hand, is often doing so in a context where his or her past choices are seen as deeply flawed and his or her ability to make sound current choices is viewed with suspicion. Moreover, the person may be facing an enormous array of social and criminal sanctions if he or she doesn't comply with other people's judgment about what constitutes good choices. How do we develop a principle relating to choice that takes these realities into account?

- Some Americans are attaining recovery via community- and culturally specific routes that focus first on healing the community (and sometimes the family). Does it fairly represent what we know about recovery—or what we hope to achieve by moving to a recovery-based paradigm—to develop recovery principles that are predominantly focused on the individual? If not, how could we expand the scope of these principles to include families and the community? How would these expanded parameters play out in our current systems?

- Wellness-based models typically incorporate strength-based planning and notions of resilience. How do these constructs fit within a recovery paradigm?

- Recovery is ultimately defined by most individuals as having a meaningful life that is consonant with their personal value system and includes values that derive

from their religious and spiritual beliefs and their culture. How do we develop principles that acknowledge the power of these values?

- It is commonly said that recovery is not a linear or one-step process—that there is important "pre-recovery" work preceding a decision to initiate recovery and important continuing work after recovery has been established, and that relapse is a normal part of the process and can be a learning experience. What would a system look like that offered meaningful support at all stages, including pre-recovery, continuing recovery, and relapse?

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