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Recovery from Addiction and Recovery from Mental Illness: Shared and Contrasting Lessons

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A qualitative shift is occurring in the conceptual foundation and design of behavioral health services. Grassroots advocacy movements and a growing body of longitudinal research are challenging mental health and addiction treatment service providers to re-focus their services toward the goal and processes of long-term recovery. In the mental health field, the "ex-patients' survivor" movement of the 1970s (Chamberlin, 1978) was followed by new "consumer" voices in the 1980s (Deegan, 1988; Unzicker, 1989) and the christening of the 1990s as the "decade of recovery" (Anthony, 1993). Dramatic changes in the conceptual underpinnings of mental health treatment were spurred by research studies confirming that between half and two-thirds of people with serious mental illness achieve substantial recovery (Harding, 1989; Harding, Brooks, Ashikaga, Strauss & Breier, 1987; Harding, Zubin, & Strauss, 1992; Strauss, Gagne, & Koehler, 1985). Today, well-organized ex-patient/consumer/survivor groups and visionary professionals are moving beyond the call for "recovery-oriented" systems of care to actually creating such systems (Anthony, 2000).

The addiction treatment field is being similarly challenged by a "New Recovery Advocacy Movement" led by recovering people and their families (White, 2000b; 2001b). These recovery advocates and their professional allies are demanding that addiction treatment be reconnected to the larger and more enduring process of recovery, and that treatment shift from serial episodes of unconnected acute interventions to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, in press).

The consumer and professional renewal movements within the mental health and addiction treatment fields have much that they can learn from one another. Both movements are trying to shift from a focus on symptom suppression to global health and development. Both are trying to balance the preoccupation with managing social costs with more qualitative measures of service outcomes, e.g., post-treatment meaningfulness and quality of life. And yet, each field brings areas of marked contrast. Such similarities and differences suggest the potential for positive synergy between the two fields. In this article, the authors will

explore lessons from the addictions field regarding the recovery experience, recovery mutual aid groups, and recovery advocacy movements. Our focus will be on those lessons that may have relevance to personal recovery and political advocacy movements organized by and on behalf of people who have experienced psychiatric disability.

The Recovery Experience

A common theme noted throughout this book, and a theme that is central to the consumer/ex-patient/survivor movement, is that recovery from mental illness must be defined as a complex, dynamic, and enduring process rather than a biological end-state described by an absence of symptoms. Recovery is, in its essence, a lived experience of moving through and beyond the limitations of one's disorder. Viewing recovery in terms of an ongoing and highly personalized experience, rather than a biomedical disease, is a new and radical concept in the mental health field and one that requires a paradigm shift in how we think, how we design service systems, and how we conduct clinical research. In reviewing what has been learned about recovery in the addictions and mental health fields, we find the following findings most suggestive.

Recovery is the process of healing the effects of a) one's illness and its consequences, b) the social stigma attached to the illness, and c) the iatrogenic effects of treatment interventions (Spaniol, Gagne & Koehler, 2002). Recovery implies a process of retrieval (regaining what was lost due to one's illness and its treatment) and a process of discovery (moving beyond the illness and its limitations).

Treatment and recovery are not the same. Treatment encompasses the way professionals intervene to stabilize or alter the course of an illness; recovery is the personal experience of the individual as he or she moves out of illness into health and wholeness. Recovery is the experiential shift from despair to hope, alienation to purpose, isolation to relationship, withdrawal to involvement, and from passive adjustment to active coping (Ridgway, 2001). Recovery can occur within or outside the context of professionally directed treatment, and where professional treatment is involved, it may, depending on its orientation and methods, play a facilitative, insignificant, or inhibiting role in the recovery process. Recovery can be claimed only by the person in recovery, and that ownership includes the right to take risks, make mistakes and learn from one's experiences (Deegan, 1992).

Recovery exists on a continuum of improved health and functioning. The mental health field has long affirmed the concept of partial recovery (some residual disability with reduced social costs and improved health and functioning) but, until recently, has lacked a vision of full recovery from severe mental illness (minimal residual disability and resumption of pre-illness levels of health and functioning). In contrast, the addiction treatment field has had an unequivocal goal of full recovery (sustained abstinence and increased emotional and relational health) but has lacked an operational concept of partial recovery (reduced frequency and intensity of alcohol and other drug use and related problems and increased quality of life). It may be time for both fields to recognize within the growing genre of recovery narratives the existence of what might be called transcendent recovery (minimal residual disability and the achievement of health, functioning and quality of life superior to that which existed before the onset of illness). The concept of transcendent recovery acknowledges the existence of people who, following the experience of addiction and/or mental illness, get "better than well," not in spite of the illness but because of the experiences and insight that emerged within their recovery processes (Young & Ensing, 1999). It is within this experience of transcendent recovery that some people reframe their illness from a curse to a condition that brought unexpected gifts to their life.

The potential for recovery and the quality of recovery are determined by the synergy between recovery debits (personal and environmental factors that inhibit and

limit recovery) and recovery capital (internal and external resources that serve to initiate, sustain and expand recovery) (Granfield & Cloud, 1999). In what is likely to be a milestone study, Onken and colleagues (2002) explore the interaction of recovery facilitating and inhibiting factors drawn from the experiences of individuals in recovery from mental illness. They conclude that such factors exist at multiple, interacting levels: characteristics of the individual (e.g., the presence or lack of hope, resourcefulness, self-reliance, recovery self-management skills); characteristics of the environment (e.g., the presence or lack of safety-enhancing material resources--housing, transportation, healthcare, and a means of communication); and characteristics of the interaction between the individual and the environment (e.g., the presence or lack of meaningful relationships and activities, choices, empowering service and peer relationships). *There are many pathways to and varieties of recovery experience* (Humphreys, Moos & Finney, 1995; Vaillant, 1983). The course and outcome of alcohol and other drug problems vary across transient and persistent patterns. The former are amenable to self-resolution or brief professional intervention, while the latter often require sustained professional- and peer-based supports (Kandel & Raveis, 1989). Those with a more prolonged course often differ in the presence of greater personal vulnerability (e.g., family history, lower age of onset), greater problem severity, interlocked co-occurring problems, and low family and social supports. Recovery styles span natural recovery (without the aid of professional or peer support), peer-assisted recovery (mutual aid involvement) and professionally-assisted recovery (professional treatment). While there is a growing body of research on natural recovery from addiction (Granfield & Cloud, 1999), the absence of comparable data in the mental health field raises two important questions: 1) What is the prevalence of natural recovery among people with different types of mental illness? 2) How do those who experience natural recovery differ from those most frequently

treated by mental health agencies?

There are variations in recovery style based on the extent to which one's disorder becomes a central part of one's identity, and one's degree of affiliation with a larger community of recovering people. There are acultural styles of recovery (no affiliation with other recovering people), bicultural styles of recovery (affiliation with recovering people and people without addiction/recovery backgrounds), and culturally enmeshed styles of recovery (emersion in a culture of recovery) (White, 1996). People in recovery display highly variable but viable styles of relationship to professionally-directed treatment, peer-driven support services and mutual aid societies. The addictions field is slowly (and painfully) learning to work within this variability of styles rather than attempting to program all recovery experiences through narrow vision of how recovery must be achieved and sustained. A cartography of pathways and styles of recovery from mental illness has yet to be drawn.

The role of self is essential to understanding the recovery process; the self, not the service professional, is the "agent of recovery" (Davidson & Strauss, 1992; Spaniol, Gagne, & Koehler, 2002). Recovering people are more than passive recipients of recovery. While they may draw on the clinical technologies of professional helpers and the "experience, strength and hope" of others in recovery, each recovering person must ultimately become the architect and engineer of his or her own recovery. Recovery involves a reconstruction of personal identity, a reformulation of the relationship between self and illness, and a reconstruction of one's relationship with the world. These dimensions are often evident in the three-part story style of people in recovery: 1) the way it was (depiction of the onset and course of the illness), 2) what happened (the experience of recovery initiation), and 3) what it is like now (depiction of life in recovery).

The initiation of recovery may be marked by processes of transformational or incremental change. The former, which has been christened "quantum change," involves

sudden, recovery-inducing experiences that are dramatic, unplanned, positive and enduring (Miller & C' de Baca, 2001). While quantum change has long been noted within the history of addiction recovery (White, 1998), the authors are aware of no studies exploring the role of quantum change experiences in initiating recovery from severe mental illness. In contrast, there are several studies that have explored the developmental stages of long-term recovery from addiction (Brown, 1985; Prochaska, DiClimente, & Norcross, 1992) and from mental illness (Davidson & Strauss, 1992; Jacobson, 2001; Morse, 1997; Ridgeway, 2001; Strauss & Carpenter, 1981; Weaver-Randall, 2002; Young & Ensing, 1999). These stage models of recovery depict a process of recovery initiation (acceptance of one's illness, hope and resolution for change, first steps toward self-management), a process of stabilization (ownership and active management of one's own recovery), a mastery of rituals of daily living (increased comfort and confidence, self-monitoring and active efforts to prevent relapse, deepened insight about self in relationship to illness) and a sustained movement toward health and a wholeness (increased quality of life via greater independence, self-acceptance, a safe and pleasant living environment, satisfying relationships, and meaningful activities). Several points are noteworthy about these models. First, those factors required to initiate recovery are often quite different than the factors that later serve to maintain and enrich recovery (Humphreys, Moos & Finney, 1995). This suggests that interventions helpful at one stage of recovery may be ineffective or even harmful at other stages. For example, continuing to provide "care taker" functions within an assertive community treatment model could well have iatrogenic effects upon individuals who are developmentally ready to take ownership of their own recovery. The extent to which these developmental stages of recovery differ by type, severity and duration of illness and across developmental age, gender, and culture is an important research agenda.

There are critical points (developmental opportunities) that arise within the prolonged course of a disorder that constitute doorways of entry into recovery or opportunities to move from one stage of recovery to another (Young & Ensing, 1999). These milestones can mark a shift either toward greater problem severity or the initiation or qualitative strengthening of recovery. When such transitional experiences initiate or deepen recovery, they are nearly always characterized by a synergy of pain and hope. This birth of hope that is such a central theme in recovery narratives almost always occurs in the context of relationships and resources beyond the self, and often occurs through encounters with the "experience, strength and hope" of others in recovery. Historically, the addiction field believed that recovery initiation was grounded in the experience of pain ("hitting bottom"), but there is growing recognition that the deepest despair incites recovery only in the presence of hope. It is often at the point of this synergy of pain and hope that people suffering from addiction and/or mental illness, like the mythical Phoenix, rise from the ashes of their own self-destruction (Johnson, 1993; White, 1996).

Recovery occurs at a different pace across a number of zones: physical, intellectual, emotional, relational, personal (rituals of daily living), and spiritual. Progress in one zone can help prime and sustain positive change in other zones.

Spirituality is a potentially important but often ill-understood ingredient of the recovery process (Sullivan, 1994). The role of spirituality to provide hope, to neutralize stigma and shame, and to bolster strength and courage are frequently noted in recovery narratives (White, 1996; Young & Ensing, 1999). The addictions field has a long history of emphasizing the role of spirituality in the recovery process -- so much so that purely secular frameworks of recovery are lauded as innovations. Mental health professionals are just beginning to explore the role of spirituality in recovery. What the addictions field is slowly learning is that, like many aspects of recovery, spirituality is a highly personal experience and a choice, not

something to be codified within a "program."

People recovering from two or more co-occurring problems may address these interacting processes simultaneously (dual recovery) or sequentially (serial recovery). People may be at different stages or levels of motivation for addressing various problems that they are experiencing. The same person can experience differential rates of recovery from multiple disorders/experiences, e.g., mental illness, addiction, traumatic victimization and loss.

The relationship between medication and recovery is a complex and potentially stage-dependent one. The addiction and mental health fields have histories that underscore the value as well as the potential iatrogenic effects of medications on the recovery process. The mental health field has had a bias towards medication, including medications with severe and debilitating side effects (e.g., Cohen, 1994; Cohen & McCubbin, 1990; Valenstien, 1998). The addictions field has had a bias against medication, even when those medications have had overwhelming research support for their safety and efficacy, e.g., methadone. The narratives of recovering people emphasize that medication can facilitate or hinder recovery and that symptom elimination or minimization via medication, in and of itself, does not constitute recovery. The future promises more effective medications and a widening menu of alternatives and adjuncts to medication.

Both illness and recovery require substantial adaptational energy of one's family and social network (Brown, 1994; Brown & Lewis, 1999). The responses of family members to illness and disability and to stages of recovery represent normal rather than pathological reactions. Family recovery is the process of finding the best ways to adapt to the presence and then the absence of illness as an organizing motif within the family system. There may be developmental stages of family recovery that parallel the stages of personal recovery. It has been suggested that family members make these adaptations in their own style and at their own pace (Spaniol & Zipple, 1994). There is a marked absence of research on how family members of persons with severe mental illness and the family as a whole recovers from the impact of mental illness and its associated stigma. In the addictions field, interest in this area evolved from the concept of co-alcoholism, into offering "family programs", to the emergence, corruption (by over-extension) and commercialization of the concept of co-dependence. The latter stage created an ideological backlash that has diminished interest in this area by clinicians and researchers.

Recovery involves transcending the stigma that has been attached to addiction and/or mental illness. Stigma within the larger culture creates conceptual (how one sees oneself) and concrete (discrimination resulting from how one is seen by others) barriers to recovery. Stigma-shaped practices within treatment systems have also served to depersonalize and dehumanize. Deegan (1990) has collectively christened such practices as "spirit-breaking." Confronting and exorcising stigma within oneself (self-healing) and within one's environment (political advocacy) are frequent dimensions of the recovery process.

Language is important to personal recovery (Spaniol & Cattaneo, 1997; White, 2001). Words are the conceptual building blocks of recovery. The ability of recovering people to coin or select words that accurately and respectfully portray their experiences and aspirations is a crucial dimension of the personal recovery experience. Words have long been used to objectify and demonize people experiencing mental illness and substance use disorders. In recovery, alternative words become instruments of personal and collective liberation. Crafting language is about personal and social change, not political correctness.

Recovering people can become their own recovery experts (Deegan, 1992). Recovering people have also served within the "wounded healer" tradition for more than two centuries, with such service work providing a boon to others and a source of strength within their own recovery processes

(White, 2000a). A few important lessons from this tradition within the addictions field may be important for the rising "prosumer" movement in the mental health field.

- Paid service work is not a program of personal recovery and, for some individuals, can pose a significant obstacle to recovery.
- People in recovery can work as prosumers in circumstances that are empowering to their recoveries (e.g., treated with respect, held accountable, and provided salaries commensurate with their work) or work in circumstances that are disempowering (e.g., treated as "senior clients", hired as token consumers via minimal or lack of comparable performance expectations, exploited financially via low pay and excessive and undesirable hours, and abandoned and discarded in the face of relapse).
- People in recovery can become so "professionalized" that assets drawn from their own recovery experiences are lost.
- There is a danger that recruiting people from recovery networks into paid service jobs could undermine the service ethic within those networks. It is very important that distinctions be made between services for which one is paid and service work that is done as part of one's personal recovery process.
- While those who hold dual roles as "consumers" and service providers may serve as "translators" (interpreting and synthesizing the multiple voices within the mental health recovery advocacy movement) (Frese, 1998), the experiences of consumer-providers may not be representative of the larger community of recovering people,

and the consumer-provider must avoid the problem of "double-agentry"—representing themselves as the voice of consumers while consciously or unconsciously representing their own financial interests and/or the institutional interests of service providers.

- People in recovery hired into service roles can benefit from special training and supervision on managing issues related to this duality of roles. (See expanded discussion below.)

Recovery Mutual Aid Groups: A Brief History

Peer-based systems of mutual support for addiction recovery predate the professionalized field of addiction treatment and their continued importance in long-term recovery support is a unique aspect of the addictions field. Such systems of mutual aid (reciprocal support as a solution to a shared problem) are distinguished from "self-help" approaches (efforts made by individuals to solve their own problems) (Ogborne, 1996). What addiction recovery mutual aid societies have provided is an esteem-salvaging framework for understanding illness, a cognitive and emotional roadmap of recovery, a strategy for reframing and countering stigma, and social support and fellowship. In this section, we will explore what the mental health field can learn from the addiction recovery mutual aid societies.

There is a long and rich history of addiction recovery mutual aid societies in America. Eighteenth century Native American recovery "circles" and other abstinence-based cultural and religious revitalization movements mark the beginning of peer-based models of alcoholism recovery. These were followed in the nineteenth century by mutual aid societies that emerged as part of the "rescue work" of the American temperance movement. The largest and most geographically dispersed of such societies included the Washingtonian Temperance

Societies (1840s), the fraternal temperance societies (1840s-1870s), and the ribbon reform clubs (1870s). There were also mutual aid societies that sprouted within inebriate asylums (Ollapod Club), inebriate homes (Godwin Association), the addiction cure institutes (Keeley Leagues), urban rescue missions (the United Order of Ex-Boozers; Drunkard's Club), and early twentieth century alcoholism clinics (Jacoby Club) (White, 2001a).

The founding of Alcoholics Anonymous (A.A.) in 1935 marks the beginning of modern addiction recovery mutual aid societies. A.A. has become the standard by which all mutual aid groups are measured because of its size (2.2 million members and more than 100,000 groups worldwide; 1.1 million members in the United States alone), its geographical dispersion (more than 175 countries) and its longevity (more than 65 years) (http://www.alcoholics-anonymous.org). As A.A. grew, its Twelve Step program was adapted for family members (Al-Anon-1951), for persons addicted to drugs other than alcohol (Narcotics Anonymous-1947-1953; Cocaine Anonymous-1982), and for persons suffering from addiction and other problems (Dual Disorders Anonymous-1982; Dual Recovery Anonymous-1989). There were also a growing number of religious adjuncts to A.A. (Alcoholics Victorious-1948; the Calix Society-1949; Jewish Alcoholics, Chemically Dependent People and Significant Others-1979) and alternatives to A.A. (Women for Sobriety-1975; Secular Organization for Sobriety-1985; Rational Recovery-1986; LifeRing Secular Recovery-1999; Teen-Anon, 1999, Moderation Management-1994) (White, in press). All of this offers testimony to the growing varieties of recovery experience within and outside of Alcoholics Anonymous.

Addiction recovery mutual aid societies constitute an important historical backdrop to modern mutual aid societies in the mental health field, e.g., Recovery, Inc.-1937; GROW, Inc.-1957; Emotions Anonymous-1971; National Alliance for the Mentally Ill (NAMI)-1979; Anxiety Disorders Association of America-1980; Schizophrenics Anonymous-1985; National Depressive and Manic-Depressive Association-1986; and Obsessive-Compulsive Foundation, Inc.-1986.[1] Because of the longer history, larger membership, and greater geographical dissemination of addiction recovery mutual aid groups, we thought that some of what has been learned in these groups might be helpful to existing and new recovery mutual aid groups in the mental health field. Seen as a whole, the addiction recovery mutual aid societies offer ten lessons about the promises and perils of peer-based models of recovery support (from White, 2001a, unless otherwise noted).

1. *Addiction recovery for historically disempowered peoples (groups that have suffered physical/cultural assault, enslavement, economic exploitation and oppression) must be offered within a framework of hope for a community as well as the individual and family.* Such frameworks have been particularly evident with Native American and African American communities who still suffer the effects of such oppression (e.g, African Americans represent 15% of illicit drug users, but more than 60% of drug-offenders entering prison; 1 in 20 African American men over age 18 is under the control of the criminal justice system, US Department of Justice, 2000; substance-involved African American women are 10 times more likely to be reported to child welfare agencies for prenatal drug exposure than their White counterparts, Neuspiel, 1996). In such communities, abstinence-based cultural and religious revitalization movements have long provided a shared pathway of addiction recovery and community survival and renewal (Coyhis & White, 2002; Williams & Laird, 1992). When Native American leaders proclaim that "the community is the

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[1] The functions of mutual aid and advocacy are much more likely to be blended within the same organization within the mental health field.

treatment center," they point out the inextricable link between personal recovery and the broader health of the community in which that recovery is nested (*The Red Road to Wellbriety,* 2002). Such proclamations simultaneously provide hope to individuals and hope for the future of a people.

2. Recovery mutual aid societies are vulnerable to colonization by more powerful forces within their operating environments, particular domination by larger social or professional movements. A.A., for example, was deluged with groups wanting to join and use A.A. to address a wide variety of problems other than alcoholism. A.A. took the position that other groups could adapt the Twelve Steps and Traditions for their own use but could not become a member of A.A. unless they met A.A. membership criteria ("a desire to stop drinking"). The most resilient of the recovery mutual aid societies are ones that maintain their indigenous leadership and "closed" meeting structure. Successful recovery mutual aid societies must also carefully construct their relationship with professionally-directed treatment agencies. The historical relationship between mutual aid societies and treatment institutions is a complex one. Treatment institutions have emerged from mutual aid organizations, e.g., the nineteenth century Washingtonian Homes. Treatment institutions have co-opted and corrupted mutual aid organizations; e.g., the attempt to manipulate the Keeley Leagues to market the proprietary services of the Keeley Institutes. Treatment institutions have also created partnerships with mutual aid societies in which boundaries were clear and respected; e.g., the relationship between A.A. and local hospitals in the 1940s and 1950s. The long history of strain between mutual aid societies and professional treatment agencies has centered on: 1) poorly defined boundaries between mutual aid and professional treatment, particularly when people in recovery are hired to do the latter, 2) differences in philosophies and helping practices, and 3) the near universal attempt by professional agencies to colonize or at least control mutual aid movements.

This tension has pervaded the history of mutual aid movements in the United States as well as the Alcoholic Treatment Clubs in Italy (Patussi, Tumino, & Poldrugo, 1996) and the Abstainer Clubs in Poland (Świątkiewicz, 1992). Professionals have played important roles in the birth of many mutual aid societies, but have also played a role in conflict that has led to the demise of such groups.

3. Professionalism, money, property, publicity, and religious/political conflict are potential forces of dissension that can threaten the survival of local mutual aid societies. Money and professionalism are particularly problematic. Addiction mutual aid programs -- from the Washingtonians in the U.S. (White, 1998) to the Links Societies in Sweden (Kurube, 1992) -- have experienced strife when their members assumed paid helping roles. In Germany, for example, recovery activists condemn paid service work on the grounds that it creates status hierarchies within the recovery community (Appel, 1996). Guidelines governing how such dual roles can be maintained have helped manage these potential problems (*A.A. Guidelines*, ND). Maintaining ideological and financial autonomy seems to be crucial to the survival and health of mutual aid societies Outside funding has often turned out to be a mechanism of control and cooptation, and mutual aid groups have a long history of death via ideological (political and religious) schisms. Conflict over money, religion and politics within the early history of A.A. led A.A. to pledge itself to corporate poverty, self-sufficiency and neutrality on all outside issues. Based on A.A.'s example, American mutual aid societies have, until recently, tended to be financially self-supporting and neutral on questions of political or religious doctrine, whereas such societies in Europe are much more likely to be financially supported by the state (e.g., the abstainer clubs in Poland) and to be linked to particular political movements (e.g. the New Left influence on mutual aid groups in Germany) (Room, 1998). The recent growth of faith-based recovery ministries, church-based mutual aid recovery groups, and the funding

of these ministries by federal, state and local governments marks a new chapter in the history of mutual aid in America; these groups constitute a living experiment whose processes and fate warrant close examination.

4. The centerpiece of all successful recovery mutual aid groups is the process of sharing "experience, strength and hope." The glue of such societies is mutual identification and mentorship within relationships that are time-sustained, non-hierarchical, and non-commercialized. Recovery mutual aid groups constitute a community of shared vulnerability whose members draw resilience and power from the safety of this sanctuary to do things within their lives in consort that they could not do alone. These communities of recovery also constitute cultures of resilience and recovery (with their own language, values, rituals, and symbols) that for many constitutes alternative to the cultures of pathology and dependence within which they have been enmeshed. It is here that the most personal and intimate experiences of healing are wed to an intuitive understanding of the social ecology of recovery.

5. A major challenge of mutual aid societies is transcending the foibles and deaths of their founding, charismatic leaders. The Ribbon Reform Clubs that thrived across America in the 1870s and 1880s as local sobriety-based support fellowships collapsed as their charismatic leaders aged, suffered infirmities, and died. Successful mutual aid societies emphasize leadership development and rotation. For example, in A.A. groups, there are no elected officers and the meetings are chaired by a variety of members rather than by a single leader.

6. *The most resilient of the mutual aid societies utilize a highly decentralized cell structure; the essential organizational unit is the small, local group that provides its members a venue for mutual identification and support.* Such de-centralization allows forces of potential disruption (e.g., explosive growth, personality conflicts, ideological schisms) to serve as mechanisms of growth via the spawning of new groups rather than member attrition.

7. All addiction recovery mutual aid societies have had to decide how its members should respond to social stigma, e.g., from encouraging bold visibility (public declarations of one's addiction and recovery) to hiding one's stigmatized status via assurances of secrecy and anonymity. In cultures in which addiction or mental illness is highly stigmatized, mutual aid societies have provided a variety of vehicles through which its members could salvage their "spoiled identities." The Keeley Leagues of the 1890s defined recovery as sign of manhood, boldly challenged members to write letters to local newspapers proclaiming their recoveries, and proudly wore the Keeley League pin on their clothing. In contrast, other societies have promised their members confidentiality and discouraged or prohibited public disclosures of their affiliation. Where some societies integrate recovery and advocacy, others become secret societies. An interesting question is the extent to which such secrecy actually serves to perpetuate stigma. One is forced to wonder: What would the effect have been on public attitudes and public policies if hundreds of thousands of persons in recovery from addiction or mental illness had publicly proclaimed their recovery over the past decades? Strategies that protect members from stigma at an individual level may inadvertently help perpetuate that very stigma at a societal level. Some recovery advocates argue that living in silence and secrecy in terms of one's recovery status perpetuates stigma by withholding faces and voices of successful recovery and placing in the national consciousness images only of those who fail to recover.

8. Successful recovery mutual aid societies must have both a "program" or operational framework of recovery (e.g., A.A.'s Twelve Steps) and a set of core values (e.g., A.A.'s Twelve Traditions) to manage forces that can threaten the life of the organization. These forces include those earlier noted (ideology, professionalism, publicity, and money) as well as personality conflicts and sexual attraction or behavior

among members. Successful mutual aid societies develop values ("group conscience") and rituals to minimize interpersonal conflict (e.g., A.A.'s emphasis on "principles before personalities") and protect vulnerable members from potential exploitation by other members (e.g., the sexual exploitation of new members pejoratively referred to in A.A. as "Thirteenth Stepping").

9.   The length of expected member involvement in a mutual aid society must reflect both the time span of needed recovery support of its members and what will be required to maintain the life of the organization. Lifelong mutual aid participation may not be a requirement for effective self-management of recovery, but a core of individuals committed to such participation may be crucial to the survival of any recovery mutual aid society.

10. Recovery mutual aid societies can peacefully co-exist, collectively offering a menu of pathways of recovery, or they can enter into competition and conflict in an effort to define the "right" pathway of recovery. The former is illustrated by the co-existence of many recovery support societies in Germany (Appel, 1996); the latter is illustrated by the acrimony that has sometimes characterized the relationship between members of A.A. and members of secular and religious alternatives to A.A. (White, 1998). Recovery pluralism is evident in the number of people who simultaneously participate in more than one mutual aid society or who move from one society to another during different stages of their recovery careers (Appel, 1996; Humphreys & Klaw, 2001).

While the above lessons are deeply imbedded within the history of addiction recovery mutual aid societies, they may not universally apply to the organizational processes of shared recovery from mental illness. In applying these lessons to the mental health field, the following question seems apt: What is qualitatively different about mental illness and recovery from mental illness that would influence the ideal structure and process of mutual aid groups? A definitive history of such groups that answers that question has yet to be written.

Recovery Advocacy Movements

There are substantial differences between peer-based recovery movements and recovery advocacy movements. The former focus on the needs of the individual for mutual support of long-term recovery; the latter focus on promoting pro-recovery attitudes, social policies, and recovery-oriented systems of care. The target of advocacy movements, while providing a voice to the experiences and needs of people in recovery that may have therapeutic effects, is primarily the social and political environment rather than the individual. Recovery advocacy provides a means through which people in recovery can confront stigma and its resulting social and institutional obstacles to recovery and shape service systems that reflect their own aspirations and needs. In this section, we will explore the history of recovery advocacy in the addictions field with a particular eye on what this history may offer regarding recovery advocacy within the mental health field.

There is a long history of recovery advocacy in both the addiction and mental health fields. The former range from 19th century patient clubs to the local alcoholism councils of the mid-twentieth century (White, 1998), and the latter span early patient advocates (Elizabeth Packard, Elizabeth Stone, and Clifford Beers) to the rise of an ex-patients' movement in the 1970s (Chamberlin, 1984, 1990, 1995; Frese, 1998; Kaufmann, 1999; McLean, 1995). The re-stigmatization and re-criminalization of the status of addiction in the United States in the 1980s and 1990s has spurred the rise of a New Recovery Advocacy Movement (White, 2000b). In this section, we will describe this movement and compare it to the ex-patient/consumer/survivor movement within the mental health field.

Representative   organizations. Organizationally, the New Recovery Advocacy Movement is made up of 1) local affiliates of the National Council of Alcoholism and Drug Dependence (NCADD) who are trying to recapture their advocacy

roots, 2) grantees of the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP), 3) faith-based recovery ministries, 4) abstinence-based cultural revitalization movements in communities of color, and 5) survivor organizations (family members who have lost a loved one to addiction). These organizations are loosely linked through their involvement in various recovery advocacy conferences and the National Faces and Voices of Recovery Campaign (www.facesandvoicesofrecovery.org). These organizations are the historical counterparts to the National Association of Mental Patients (later the National Association of Psychiatric Survivors), the National Mental Health Consumers' Union, and the earlier noted mutual aid societies (e.g., NAMI) that also function as advocacy organizations.

Membership constituency. While membership in mental health advocacy organizations such as NAMI and local Mental Health Associations has until recently been dominated by family members and professionals, the addiction recovery advocacy movement has been dominated by persons in recovery from addiction. As each of these respective movements mature, its constituencies are expanding, with persons in recovery from mental illness now emerging as a powerful force within the mental health advocacy movement and family members becoming increasingly involved in the New (addiction) Recovery Advocacy Movement.

Membership recruitment. The greatest barrier to recruitment in both the addiction and mental health recovery advocacy movements is fear of the stigma associated with public disclosure of one's recovery status. The addictions field has an added concern about clarifying the potential conflict between the requirement for anonymity within AA and NA and encouragement by advocacy groups to step forward to put a face and a voice on recovery (White, 2000b). Those RCSP grantees, who have worked to organize the (addiction) recovery community over the past five years, have found that considerable groundwork must be laid before significant numbers of people in recovery join or participate in recovery advocacy activities.

Movement goals. The goals of the New Recovery Advocacy Movement are to: 1) portray alcoholism and addictions as problems for which there are viable and varied recovery solutions, 2) provide role models that illustrate the diversity of those recovery solutions, 3) counter attempts to dehumanize, objectify and demonize those with alcohol- and other drug-related problems, 4) enhance the variety, availability, and quality of local/regional treatment and recovery support services, 5) remove environmental barriers to recovery, and 6) promote pro-recovery laws and social policies.

Core values. The values of recovery advocacy organizations are reflected in the core values adopted by the board of Recovery Communities United (RCU) in Chicago:
1) primacy of personal recovery (reminding ourselves that service work alone is not a viable program of addiction recovery),
2) authenticity of voice and representation (empowering recovering people and their family members to express their own needs and aspirations),
3) varieties of recovery experience (respecting varied pathways, styles and stages of recovery),
4) diversity and inclusion (representation of all people in recovery across the boundaries of age, gender, ethnicity, sexual orientation, and problem severity),
5) hope-based interventions (providing "living proof" of the reality of long-term recovery to those in need of recovery, to service professionals, and to the larger community),
6) resilience and recovery (focusing on the strengths of individuals, families and communities),
7) collaboration (community-building between recovering people/families, treatment providers, indigenous healers/institutions, and researchers),
8) recovery community development (building the service and leadership

capacity of recovery community rather than competing, replacing, or otherwise undermining the natural leadership and service ethic of that community), and

9) ethics of mutual support (elevating our ethical sensitivities and decision-making skills within the arena of recovery support services).

Kinetic ideas. In 1942, Dwight Anderson coined a set of "kinetic" ideas (ideas capable of shifting people's attitudes and actions) that were later integrated into the campaign of the National Committee for Education on Alcoholism -- the precursor to today's National Council on Alcoholism and Drug Dependence (Anderson, 1942; Mann, 1944). These ideas were intended to reframe the nature of the problem ("Alcoholism is a disease"), change the perception of those with the problem ("the alcoholics is a sick person"), and posit hope for the problem ("the alcoholic can be helped and is worthy of being helped"). These ideas laid the ideological foundation for modern addiction treatment. A reformulated set of kinetic ideas is emerging within the New Recovery Advocacy Movement. Each idea is designed as an antidote to a prevailing idea within the culture. In response to renewed cultural pessimism about the prospects of recovery, the NRAM is declaring that recovery is a living reality in the lives of hundreds of thousands of individuals, families and communities. Internally, this movement is calling for a vanguard of recovering people to step forward publicly to offer "living proof" of the transformative power of recovery. In response to the idea that there is only one way to recover, the NRAM is declaring that there are many pathways of recovery. In response to a treatment system that has become increasingly coercive, the NRAM is declaring that recovery is a voluntary process. In response to the re-stigmatization and re-criminalization of the status of addiction, the NRAM is declaring that recovery flourishes in supportive communities (White, 2000b). Local recovery advocates across the country are enlisting the support of local policy makers to help create the physical, psychological and social space where the seeds of recovery can be sown and nurtured into maturity. The new recovery advocacy movement is offering its members as evidence that recovery gives back what addiction has taken from individuals, families and communities and that recovering and recovered people are part of the solution (to alcohol and other drug problems).

Core strategies. There are eight strategies that make up the action agenda of (addiction) recovery advocacy organizations.

1. Recovery organization: developing leadership within communities of recovery so that these groups can declare their existence, express their collective voice, and provide a venue for community service.

2. Recovery representation: assuring that the voices of recovering people and their families are included in all venues that address severe and persistent alcohol and other drug problems.

3. Recovery needs assessment: identifying obstacles to recovery, evaluating existing service structures, and prioritizing needed recovery support services.

4. Recovery education: educating lay and professional audiences on the varieties, stages and styles of addiction recovery.

5. Resource development: cultivating volunteerism within the recovery community and expanding philanthropic and public support for recovery support resources.

6. Policy advocacy: championing (through negotiation and social action) stigma-reduction and pro-recovery policies at federal, state, and local levels.

7. Recovery celebration: enhancing the identity and cohesion of local recovery communities, making recovery visible within the larger community, and putting faces and voices on recovery via major media outlets.

8. Recovery research: support of studies to illuminate the strategies, structures and processes associated with long-term recovery.

The experiences of the local organizations that make up the New Recovery Advocacy Movement offer some lessons for their

counterparts within the mental health field.***

First, the specialization and fragmentation of recovery advocacy movements is almost inevitable given the diversity of experiences and varying needs of recovering people and their families, the competition for public attention and limited financial resources, and the threats such movements pose to established mutual aid groups, service professions and service institutions (Kaufmann, 1999). Schisms within advocacy movements reflect different views of addiction and mental illness, different languages used to characterize these conditions, and sometimes radically different visions about the desired alternative to the existing service system. Battles between various advocacy factions may also reflect internalized stigma and the avoidance of confrontation with more powerful forces outside the movement. Such displacement has a long history among social movements of disempowered peoples.

The problems of organizational leadership and structure that have long-plagued recovery mutual aid societies also pose a threat to recovery advocacy organizations. Charismatic leadership and hierarchical structures can undermine the egalitarian, democratic values of these movements and alienate leaders from grassroots constituencies (McLean, 1995). Minimalist approaches to organization and rotating leadership constitute viable antidotes to such tendencies.

Advocacy organizations that evolve into alternative service organizations are vulnerable to losing their advocacy focus as they get caught up with funding requirements and the demands of running a service organization. This happened to many local Councils on Alcoholism in the 1960's and 1970's when funding became available for community-based alcoholism treatment. Advocacy groups that pose a threat to the status and financial interests of service professionals and treatment institutions are often colonized by these institutions via recruitment of leaders into paid roles, pitting moderate groups against more radical groups, and by the theft, dilution and distortion of the language and core concepts of advocacy groups (McLean, 1995).

There is a trend in both the mental health and the addictions field to hire consumers within mainstream service agencies and/or to develop consumer-controlled and operated agencies that provide a wide spectrum of recovery support services. These agencies vary in their philosophies, with some serving as adjuncts to professional treatment and others competing as alternatives to professional treatment. These roles and agencies constitute the emerging service frontier of the mental health and addictions fields and will force a rethinking of many areas of service philosophy, design and delivery. No area within this re-evaluation is likely to be more difficult than the issue of appropriate, ethical boundaries in the relationship between service providers, whether paid or volunteer, and service consumers. Both fields will need to invest substantial energy in redefining such standards as relationship hierarchies collapse and as the line between service provider and service consumer becomes less distinguishable.

Summary

In this chapter, we have tried to explore what has been learned within the addictions and mental health fields about the recovery experience, the role and threats to recovery mutual aid societies, and the nature of recovery advocacy organizations. There are many shared characteristics and themes in recovery from addiction and from mental illness: definitional controversies; the role of self as the "agent of recovery"; levels of recovery (partial, full and transcendent); the variability of pathways, styles and stages of recovery; the roles of recovery debits and recovery capital; the sequencing of change across multiple zones of recovery (physical, intellectual, emotional, relational, rituals of daily life, and spiritual); and the adaptation demands on the family to both illness and recovery. Service work has a distinguished role within the history of recovery, but there are pitfalls as well as promises in the professionalization of such service activities.

Such professionalization must be actively managed to reduce potential harm to the prosumer, other service consumers, the service organization, and local recovery mutual aid and recovery advocacy organizations.

Lessons from the history of addiction recovery mutual aid societies that have salience for other mutual aid groups include the potentially destructive influences of colonization, professionalization, money, property, publicity, and religious/political conflict. The most successful and enduring mutual aid societies maintain their singularity of purpose and closed meeting structure; utilize a flattened, de-centralized organizational structure, regularly rotate leadership at the national and local levels; craft a preferred style of responding to social stigma; and create both a framework ("program") of personal recovery and a set of core values to protect the organization and enhance its future viability.

Recovery advocacy organizations in the addictions and mental health fields share many characteristics (and some subtle differences) in the evolving characteristics of their membership, organizational goals, core values, central ideas, and core strategies. As the addictions and mental health fields are being again pushed toward greater collaboration and integration, the recovery concept seems to be a bridge of shared experience and a vision through which these fields can reach out to one another. Particularly promising are states like Connecticut where human service policy leaders are re-shaping both the addiction and mental health service systems around this recovery vision. We close this investigation believing that there is great potential for positive synergy between these two fields whose histories have been so closely related for more than two centuries, and that the recovery concept may provide a framework for such synergy.

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