Abstract: The paper explores the varied implications of cure, healing, and recovery from substance use and considers why recovery is the preferred characterization in relation to a medicalized drug dependency. The positive as well as negative associations of recovery are noted, and the ethical implications of the primarily processual dimensions of recovery are investigated.

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Recovery as an Ethical Ideal
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Recovery is often said to be an acceptable – even desirable – goal for those who are dependent on drugs. The choice of vocabulary may be significant. For the most part we are socialized into searching for cures. Why do we settle for recovery? Is it simply a matter of historical happenstance? An insignificant choice of words? And, if intentional, is it ethically appropriate? In this paper we will explore the languages of recovery and seek to address some of the ethical questions to which this exploration gives rise.

The languages of recovery

Recovery is but one of a number of cognate concepts associated with the surmounting of drug dependence. We – as others sometimes do – might also speak of cure, healing, and remission, along with therapy, and treatment. What is the significance, if any, of using the vocabulary of recovery?

In ordinary medical contexts it has been traditional to seek for cures – whether for cancer, the common cold, or a fever. Although the language of cure can refer to a process, the main focus is on the idea of vanquishment – the complete overcoming, indeed elimination, of a source of disease, illness, or malady. More is involved than palliation or remission. As an outcome, not only does the vocabulary of cure suggest the removal of a disease source but also the removal of its effects. Those who are cured are usually presumed to be restored to a status quo ante. Or, given that a person may be born with a certain disease, it may not be some status quo ante that is restored, but liberation from a malady. To the extent that our focus is on cure, it is primarily on a certain outcome, a state in which it is as if the malady had never afflicted its victim.

The idea of healing, though somewhat more processual than that of cure, also tends to focus heavily on an outcome. Those who are healed are made hale or whole. True, the healed fracture or wound may leave a residual weakness or tenderness, but to the extent that we speak of someone as being completely healed, the implication, as with cure, is that something like a status quo ante has been restored or a disease/illness removed.

Though we may wish for cures or complete healing, such aspirations may not always be reasonable. Remarkably resilient though we are, we cannot always erase the effects of whatever it is that afflicts us. Sometimes healing may be only partial, remission may be only temporary, and at other times all we may be able to provide is palliation of some kind. Not every status quo ante can be restored. Maladies may leave us permanently compromised or at least weakened.

Even in traditional medicine, with its heavy focus on bodily functionality and integrity, it has been increasingly recognized that the search for a cure or healing may sometimes set the bar too high – or at least place it where it should not be. The language of cure, and even of healing, may be a recipe for frustration. As desirable as cures may be, they may ask more of us than we can or can reasonably be expected to provide, and not just because we are technically limited but because our bodies – or
persons – are not made for that level of either resilience or malleability. Less may be not only inevitable but also acceptable.

If the language of cure and healing is now recognized sometimes to be problematic in relation to maladies that are primarily organic, it is even more problematic in the case of ailments that have strong psychological components. One might of course wish to argue that even organic problems tend to have significant psychological and often social components insofar as pain, suffering, and deformation are experienced by their subjects.

To the extent that we accommodate the psychic and social dimensions of disease and illness, it betokens a welcome holistic appreciation of human maladies. It may, though, still be best to think of a continuum, with varying levels of organic, psychological, and social involvement. Some organic problems (such as hypertension) may be symptomless, and manifest themselves as vulnerabilities rather than as an experience of psychological stress or social tension. Others, even if not seriously disabling at a physical level (such as certain physical deformities), may have significant psychosocial effects. And yet others (such as gambling and sexual addictions) may operate primarily at the sociopsychological level.

Talk of recovery also has a long history in medical contexts (the Oxford English Dictionary records such usages in the sixteenth century), but the terms has come to have a central place in the treatment and response to psychological ailments and drug dependencies. The preface to the first (1939) edition of Alcoholics Anonymous makes use of the vocabulary of recovery, and since then it has become a fixture in the literature of various twelve-step programs (whether focused on alcohol, narcotics, or cocaine).

The vocabulary of recovery is not, however, exclusive to such programs, and some programs that operate outside of and even in some sort of competition with such programs (such as Methadone is Recovery) use the same vocabulary.

Like cures, recovery can occur spontaneously. The fever that plagued one may run its course, the fracture may heal without any more assistance than that naturally provided by the desire to avoid pain, the cancer may (miraculously?) disappear. Treatments – both informal and formal – might not be necessary. Like the allergic reaction that eventually disappears, so too may the need or ongoing desire for a particular substance. It may be that one almost “grows out of” the dependency or that one’s psychic furniture undergoes a gradual or sudden reorganization that dispenses with the need for its maintenance by means of particular drugs. Not all therapies are constituted by treatments. The therapeutic value of a twelve step program is not a treatment but simply a social and environmental option that can enable recovery to take place.

Whether treatment should be undertaken or recommended, or whether other therapeutic options should be sought or explored or engaged in, is largely an empirical matter, albeit one that is often likely to be infused with various value-laden assumptions.

*Dimensions of recovery*
Those who speak of recovery do not necessarily have a single or simple idea in mind. Several elements are usually implied.

*Recovery as a desirable goal.* Recovery is generally a term of approbation – it characterizes something believed to be desirable. It is not merely reversion to a former state (albeit not necessarily a status quo ante), but to a former state that is seen to be desirable. It usually contrasts with relapse, in which reversion to an undesirable former state is indicated. One relapses into crime, illness, or drug use, whereas one recovers one’s good name, health, or autonomy.

When used in the context of drug dependency, the vocabulary of recovery is used of those whose dependency is viewed as a burden – presumably as a burden by those who are dependent as well as by others. Where no burden is perceived no recovery is likely to be either contemplated or sought. Sometimes the need for recovery is identified only by others; at other times it is only when the dependent person perceives the burden and need for his or her own recovery that the need is brought to the attention of and recognized by others.

Even in the drug field, a particular dependency need not be seen as something from which one needs to recover, even if, at a certain level, it is burdensome. A person who, as a result of some deficiency, is dependent on some supplemental drug, may not be in need of recovery. Indeed, the substance on which that person is now dependent may be seen as part of that recovery. Even the person who has become dependent on some narcotic drug may not consider recovery (from the drug) as something called for or needed, if access to it is unburdensome and other risks are minimal. The person for whom a particular kind of dependency has become a precondition of normal or optimal functioning may not consider him-or herself in need of recovery. And neither may we consider that recovery is necessary, if the long-term psychosocial costs are not viewed as significant.

What does recovery – in the context of dependency on drugs such as alcohol, heroin, and cocaine – consist in? We can think of recovery in either negative or positive terms (or perhaps on a continuum of negative through positive). We can also think of it as a process or outcome (or as on a continuum from process through outcome).

*Negative and positive.* Negatively, recovery may be considered simply as the removal of a burden or blight – or, as in the case of drug dependency, as an overcoming of that dependency. But there is some vagueness and ambiguity involved in this assertion. As noted above, unless the dependency is seen as burdensome in some way, the removal of the dependency is not likely to be characterized as recovery. Dependency as such need not be burdensome. We are dependent on food and oxygen, and though the removal of those dependencies might open up options for us that we would not otherwise have had, they are not viewed as burdens to be borne or overcome.

A more problematic obscurity – one to which we will return – concerns the ambiguity in the idea of overcoming drug dependency. We can understand that recovering alcoholics will (usually) be understood to have overcome their dependence on alcohol. But what about other drugs? The smoke haze and litter of coffee cups outside Alcoholics Anonymous (AA) meetings (or at least the one that meets near where I
live) suggests that recovering alcoholics often either remain or become heavily addicted to nicotine and caffeine. So the recovery here is specific to a particular drug – not to “drugs” generally, however we might cash out that accordion-like term.

A more problematic case concerns former heroin users who are involved in methadone maintenance programs. Many individual twelve-step Narcotics Anonymous (NA) program meetings will exclude from their active midst those who, though off heroin, are being maintained on methadone. Such people are not considered to be in recovery for the purposes of the particular NA group. Those same people, however, might be welcome to speak at an AA group meeting if alcohol is also among the dependencies they have managed to surmount.

But most who write on the subject think that the overcoming of a dependency captures only a precondition of recovery and not a full understanding of it. Dependencies become burdensome because they impact negatively on one’s quality of life – either by consuming precious resources that would be devoted to needed and valued ends\(^1\) or by diminishing and/or compromising the personal powers that are ingredients in a satisfactory life. The removal of one burden does not ipso facto presage the removal of others. There must be some more positive achievement as a result – something that includes a level of economic, psychic, and social well-being. Recovery is more than mere remission.

Recovery then, even though it often presupposes the removal of a condition, almost always includes the idea of restoration – or at least the enablement of some positive state of affairs. In this respect, recovery may be more than a restoration of a status quo ante, if the ante was not desirable. Indeed, given that a status quo ante may have been salient element in bringing about the dependency in question, it may leave the person not much better off than was the case during the period of dependency. In fact, the dependency, though burdensome in its own ways, may have also masked another burden and thus been seen as a form of relief or alleviation. It is important, therefore, to see recovery in positive as well as negative terms.

Recovery may not involve a restoration of the status quo ante for the additional reason that things lost as a result of addiction may not always be recoverable. One loses a particular spouse, a particular job, and particular friends, and though recovery may be associated with new and productive relationships they will not necessarily be the same as or equivalent to those that were lost.

The positive sense of recovery may be primary, even though those concerned with recovery sometimes focus more on what is assumed to be its precondition – for example, abstinence from drugs. Were it possible – as it might sometimes be – to secure the positive elements of recovery without needing its standard precondition, it

\(^1\) A question: How does this differ from the case of the person whose deficiency requires dependence on drugs that are so costly that allow for nothing much more than survival? In the latter case we might argue that it is the drug itself that is the sources of the economic disenablement, whereas in the former case, the economically disenablement is generated by something external to the drug for which the drug provides an antidote. But this won’t quite do, because the drug is usually economically disenabling only because it has been prohibited with the result that the economic costs of obtaining it have been multiplied. Otherwise access would be more like access to cigarettes, expensive, perhaps, but not usually so economically disenabling as to be crippling.
would be reasonable to speak of the person as having achieved a significant level of recovery (here, from the effects of the drug rather than the drug itself).

To the extent that recovery is considered primarily in terms of certain positive gains, an ethical problem is involved if the boundaries of recovery are drawn too narrowly, so that those who continue to have certain specified dependencies cannot be seen or treated as recovering. It is only an ethical problem, though, not necessarily a failing, and it is not a problem that has a simple resolution. One reason why it has no simple resolution is that it can be approached either as a matter of individual judgment and attitude or as a matter of institutional or collective policy. Suppose that a significantly greater percentage of those who enter methadone maintenance programs relapse into heroin use than those who enter abstinence-based twelve-step programs. It might then be argued that the work of the latter would be compromised were equal status to be given to those who are on methadone. Proclaiming the virtues of methadone maintenance might be seen as counterproductive by those who wish to provide maximal support for people who struggle to maintain an abstinence-based recovery.

Process and outcome. [This section needs major work] What about the process-outcome distinction? In his justly celebrated volume, The Concept of Mind, Gilbert Ryle distinguished what he spoke of as task and achievement words. What Ryle had primarily in mind were words that denoted tasks and words that denoted achievements—words such as run and finish, or, as it became popular to debate in the philosophy of education literature, teach and learn. But what is also clear is that many of the terms in our language may be used to characterize both tasks and achievements. And even Ryle’s distinctions were questioned.

To say that John taught Mary is to say that in relation to Mary John engaged in a certain activity—he taught her. But to say that John taught Mary is often—though not always—to imply that Mary learned something from John. That is, a certain outcome ensued. If Mary learned nothing from John did he teach her or only try to teach her? Well, it depends of course whether one is focusing on the formalities of the relationship (Mary was in the class that John taught) or on an implication of that formal relationship, namely that of teacher and learner in which what was taught was learned.

In the considerable debate that has taken place since Ryle’s discussion—particularly in the philosophy of education—there has been some dispute between those who have claimed that teaching can go on in the absence of learning and those who argue that the outcome sense of teaching is in some sense logically prior to its task or process sense. We have to know what is constituted by successful teaching (namely, learning) before we can make any good sense of the task of teaching.

As noted earlier, the focus in the language of cure tends to be very much on that of outcome, though of course one may be in the process of being cured and not only be cured as an outcome. In the case of recovery, the focus is often as much on the process as on a particular outcome. The dimension of “finality” is often underplayed.

Those for whom dependency has become burdensome and have sought to overcome it are often said to be “in recovery.” Recovery is viewed not simply as an outcome but as a process. Like someone whose cancer is in remission, recovery is not construed as
a “done deal” but rather as a contingent state of affairs that, without positive measures, could lead to relapse.

Although those involved in twelve-step programs frequently refer to themselves as being “in recovery,” where this refers to an ongoing process, the early AA literature tends to refer to recovery in the past tense – as something that can and has been achieved. It is not spoken of as though one is “in remission” in which the progress of a disease is held merely at bay but as something that can and has been dealt with with some degree of finality. (The assumption is that as time goes on one will find it easier not to relapse.)

What is going on here? First off, the language of achievement is generally intended to indicate a level of stability that has been attained by the person who was dependent. Insofar as dependence has a significant psychological component, the process of recovery may be a particularly fraught one. A heroin dependent person who has not used the drug for a month may be said to be in recovery rather than to be (or have) recovered. A person who has not touched the drug for ten years however, and who feels no strong urge to do so, might well wish to speak of him- or herself as having recovered.

Nevertheless, even those who have not ingested drugs for a long period and who have no great urge to do so may wish to speak of themselves as “in recovery.” What I think this reflects is a particular conceptualization of drug dependency, at least in the more radical form in which the person who is drug dependent is spoken of as suffering from drug addiction. The presumption here – which may well be correct – is that addiction is a chronic condition, one that may be brought under control but not entirely removed. Like remission with respect to cancer, which implies the ongoing presence of cancer cells but suggests that they are being held in check, those who are in recovery remain not merely vulnerable to but predisposed to a certain response to the drug in question and must therefore take some special steps to ensure that they are do not fall under its sway again. Unlike other folk, who may be able to consume alcohol or other drugs in an unproblematic way, they must abstain altogether from its use.

The person who is in recovery therefore is someone who does not quite rejoin the ordinary social world of alcohol or drug consumption but who must maintain a certain special diligence with respect to his or her situation.

An ethical question that arises here is whether there may be implicit in the drug user recovery world a different – though much less problematic kind of dependency, in which those who are “in recovery” are now made dependent in a different way – led to believe that their recovery is dependent on maintaining their social links with fellow recoverers via ongoing attendance at twelve-step meetings and so forth.

I raise the question simply as a question and not as a judgment. Clearly the answer is contingent on certain broadly empirical data about dependency – about its causes and ways in which it may be overcome. If, for example, a particular dependency can be associated with a genetically identifiable condition, then, absent certain other factors, someone possessing that condition would have good reason to remain vigilant with respect to the substance to which he or she was particularly vulnerable. The “certain
“other factors” might refer to such possibilities as genetic manipulation or counteraction that would cancel out the predisposition.

It may also refer to a certain kind of empirical uncertainty or ignorance – an epistemic lack. If we are unsure of the empirical mechanisms of addiction or, if knowledgeable in certain respects, unsure of the mechanisms with respect to a particular person, we may believe that the burdens of addiction are sufficiently great to make it advisable to continue with certain processes of recovery as elements within that recovery. In other words maintenance the processes of recovery may be seen as a precautionary device. Perhaps the person could drink in moderation but, if we are wrong about that, the consequences make it inadvisable to take the risk.

Recovery and relapse

Is recovery compatible with relapse? At first blush it would not appear to be so. We have already noted their different normative implications. Recover is seen as a good, relapse as an evil. Those who relapse are often said to be those whose efforts at recovery have failed. But it may be a bit more complicated than this. Not every recovery is smooth. Recoveries may have different patterns. Setbacks need not be Sisyphean, but expected occurrences along the path to recovery, given what we know about aetiology and treatment. Someone who is recovering from an operation may encounter, as a common part of the process of recovery, a series of setbacks. An infection may develop, a wound may reopen, rejection may begin to occur. The patient may have a bad reaction to one of the drugs that is used. These are setbacks to the process of recovery but also setbacks in an ongoing process of recovery.

One might argue that if setbacks can occur as part of the process of recovery from a physical ailment, they are almost certainly more likely to occur when the malady from which a person is recovering has a strong psychological component. We do indeed have a fair bit of evidence that those who addicted to certain substances frequently relapse, even on the path to recovery. [empirical data? Reference?]

This may be attributable to a variety of factors. Obviously one will have to do with the nature of much dependency – its interlocking, physical, psychological and social factors. But partial explanation might also be provided by the kinds or quality of care that is provided in each case, that is, often, the social investment we make in the recovery process.

So might recovery also be compatible with (some) relapse? With hindsight I think we may be able to provide an affirmative answer – but probably only with hindsight. Because if the relapse is not followed by recovery within a reasonable amount of time, and with a reasonable investment of resources, or a reasonable pursuit of alternative options, we might be more inclined to speak of failed attempts at recovery that failed. What that means, of course, is that at the time of its occurrence we may not know whether to see a particular instance of a relapse as an element within a process of recovery or as a failure in recovery. How we choose to categorize it will have important ethical implications. If seen as failure we may give up on the person, but if seen as a not unsurprising part of a process of recovery, we may see it as calling for additional or more innovative efforts. It may say something about our social attitudes toward a particular group of people that we choose one option over the other.
What may be needed here is a reasonably sophisticated meta-analysis of data we have on recovery – not merely to track relapse and recovery but also to explore the causal factors involved. This would then give rise to more nuanced research into more effective strategies for detecting readiness for recovery, causes of relapse and effective responses thereto, and various risk factors associated with diverse recovery strategies.

Recovery as an ethical ideal

What is it to speak of recovery as an ethical ideal? Ideals may be of various kinds – they may be economic, scientific, aesthetic, political, or spiritual, to give a few examples. What it means to speak of an adjectival ideal is that the aspirations embodied in the ideal are embedded in the norms of a particular kind of human activity, be it that of an economic, scientific, aesthetic or spiritual kind. Though distinguishable, different kinds of adjectival ideal may congruent or divergent.

Conceived of as an ethical ideal recovery will tend to have a double reference.

First, as with most ethical ideals, it will have regard to a certain quality of relationship between and among people. In the context of recovery from drug dependency, recovery will include the restoration of productive human relationships. Although the moderate use of certain drugs may sometimes enhance sociality, loosening inhibitions that keep people from engaging with each other in open ways, those who suffer from dependency on or addiction to alcohol or narcotics generally find that their social relations become impaired. Drug use and social withdrawal or forms of anti-social behaviour are often correlated. The crack-addicted mother will neglect her children. The alcoholic father will often fail to provide for his family or will be abusive toward his spouse. The heroin addict may be an unreliable employee or friend. Recovery, then, will constitute an ethical ideal insofar as it helps to reinstate the person in recovery within the realm of productive social exchanges.

Secondly, although the primary domain of the ethical is that of the interpersonal, it is also concerned with what might be called excellence of character – with the possession of virtues, dispositions and powers of certain kinds. Though these will generally have a social expression they also have an important individual dimension. Those dependent on certain kinds of drugs have ceded a certain measure of control over their lives. Their autonomy is compromised and, often, their dignity is also impaired. Insofar as our dignity is partly a function of our capacity to act responsibly – to control the terms of our lives and retain charge of our decisions – drug dependency is often associated with a loss of dignity as decisions are increasingly determined by the need for the drug in question. True, the lack of dignity is sometimes – and perhaps often – exacerbated by the social proscription of the drug in question and the need therefore to do what must be done to get it in straitened circumstances. But even in cases in which a particular drug is freely available, its effect may be to dull one’s responsiveness to outside stimuli and the ongoing

2 I am of course leaving out of the equation certain social policies that may exacerbate the human problems. Nevertheless, I am assuming that even with different policies these dependencies would often be socially disruptive.
requirements of the business of living. Neither the opium den, passed-out drunk, nor stoned student represents a particularly engaging expression of human life.

Additional notes

Recovery is a matter of degree. A person in the early stages of recovery may find it difficult to exercise control over the terms of her life, though there is some reason to think that the longer a person can stick it out the easier it becomes to resist the psychological and/or physiological pressures to relapse.

Recovery need not involve abstinence from drugs, or even the overcoming of all dependence, though one might see recovery in such cases as only partial. A person who enters into a methadone treatment program might be said to be “recovering,” simply because the effects of methadone are less destructive or disruptive than those of heroin. Ideally, one might wish to be free from dependence on methadone as well, though since recovery is a matter of degree, continued dependence on it is not incompatible with some degree of recovery. It is not uncommon for those recovering from alcohol dependence to be heavy smokers. That too may be less than ideal, especially given the potentially harmful effects of tobacco; nevertheless, partial recovery is involved insofar as the effects of alcohol dependency are avoided and the nicotine dependence is not as burdensome. We would not, however, speak of recovery if the person previously dependent on heroin now becomes dependent on crack cocaine, for the crack cocaine can be as consuming and burdensome as the heroin.