In it for the Long Haul: Recovery Capital, Addiction Theory and the Inter-Generational Transmission of Addictive Behaviour

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Introduction

In recent years, there appears to have been a growing interest both in a wider view of addiction and its treatment in general and of the issue of recovery in particular (Betty Ford Concensus Panel, 2007; Scottish Govt., 2008; HM Govt., 2008). In part this rebirth of interest in recovery appears to have been driven by a media-led dissatisfaction with the perceived failures of the substitute prescribing policy of the previous two decades (Ashton, 2007). In part also, though, it appears to owe much to a largely grassroots led movement to redefine the nature and direction of the treatment process (Day et al, 2005).

This chapter briefly charts the early history of the recovery movement and outlines its beliefs. Most of these groups were self-help mutual-aid groups with little or no input from the mainstream treatment providers who were largely content to leave the state response to excessive alcohol use to the relevant criminal justice systems (Yates and Malloch, 2010; Yates and McIvor, 2003; Berridge, 1999; Peele, 1995).

It was not until the middle of the Twentieth Century that the scientific and academic community began to seriously explore the theoretical frameworks of addictive behaviour. Prior to that time, there was a general acceptance of the broad position within the various temperance movements that the addictive element was firmly located within the substance: the Devil was in the bottle (Berridge, 1999; Peele, 1995; Roizen, 2004). With the development of competing theoretical models of addiction came the associated treatment and, though more gradually, changes in public perception and attitude (Room, 2003; Roizen, 1987). The history of addiction theory and its implications for treatment are outlined here and in the latter part of this chapter, the relevance of these two associated histories for the modern recovery movement is set out.

The Early Recovery Movement

Some of the earliest examples of self-help mutual-aid fellowships appeared amongst the Native American population (White, 2000). Both Kenekuk, the so-called Kickapoo prophet and Handsome Lake, a Seneca chief[1], founded popular movements in the Eighteenth Century (White, 2000), built around the concept of recovery and sobriety but extending across much of the cultural life of their tribe (Parker, 2008; Herring, 1877; White and Whiters, 2005). Both Kenekuk and Handsome Lake were

[1] The Seneca people were one of the six tribes which constituted the Iroquois Nation

reformed drinkers. Both saw sobriety as a first step in restoring cultural integrity and 'upright living' to a people humiliated and disenfranchised by decades of white aggression and deceit.

Handsome Lake did much to restore the broken Iroquois Nation and rebuild the confederation as a respected force in Native American politics. His Gaiwiio (Good Message) runs to many pages and was (and still is) learnt by heart by many of his followers (Sturtevant and Trigger, 1978).

Both of these early movements, coming over 150 years before the establishment of Alcoholics Anonymous, recognised that simply stopping drinking was only a small part of the solution. What was required was a significant change in belief and behaviour. Kenekuk railed against the high prevalence of domestic violence amongst the Kickapoo and Handsome Lake argued that the work of a sober Indian was to organise and restore the dignity and cultural self-belief of the red man (Smith, 1985; White, 2000; Parker, 2008).

Similarly, the Washingtonian movement which flourished across America in the mid-Nineteenth Century argued that a reformed drunkard had a crucial duty to become the family's main breadwinner. The Washingtonians (more formally entitled the Washington Temperance Society), a recovery movement founded in 1840 by a group of former drinkers, eschewed religious doctrine and allowed only "reformed drunkards" to speak at their meetings (Maxwell, 1950; Peele, 1995). The Washingtonian meetings followed a format remarkably similar to that adopted by the Alcoholics Anonymous fellowship almost a hundred years later. T. S. Arthur (1848), in a temperance tract published some eight years after their formation, paints a vivid picture of his attendance at Washingtonian meetings in Philadelphia and offers a series of somewhat romanticised vignettes of the lives and tribulations of some of its members. Even within this short space of time, the Washingtonians were holding regular meetings in most East-coast cities in America and had already established a number of lodging houses for the respite of their fallen members. On the anniversary of the 110th anniversary of the birth of George Washington, Abraham Lincoln chose the meeting of the Springfield Washingtonians to deliver his memorial address (Basler, 1953). At its peak, the Washintonians numbered between 300,000 and 600,000 (reports vary wildly) and could boast at least 150,000 members in long-term recovery (Maxwell, 1950; Peele, 1995; White, 2001).

Although the organisation allowed only those in recovery to speak at their meetings, both membership and attendance was open to all. As a result, membership appears to have been swelled by an influx of temperance campaigners and religious proselytisers. This resulted in a series of damaging and, ultimately fatal, internal schisms with some members insisting that the organisation be more active in the prohibition campaign, more meaningfully connected to the established church and even, more active in the anti-slavery movement. For some twenty years, the Washintonians flourished, founding new branches across America but by the 1860s, the internal feuds caused the organisation to implode. Some of its sober houses continued, often under the management of other temperance organisations, the sober house in Chicago became the Washington Hospital and continued to offer alcohol treatment up until the 1980s. But mostly, the organisation simply crumbled. Members left to join other related organisations and, by the 1940s, the dissolution was

so complete that the founders of Alcoholics Anonymous claimed never to have heard of it (Peele, 1995).

In the early years of the Twentieth Century, the Emmanuel Movement, based in the Emmanuel Baptist Church in Boston, began to achieve significant attention for their blend of spirituality, medicine and a kind of basic psychotherapy. The movement attracted serious criticism from Freud, during his brief visit to the United States in 1909. Freud was, perhaps understandably, particularly scathing about the limited medical qualifications of the movement's main protagonists (Dubiel, 2004). Despite Freud's scepticism and that of many other medical professionals the movement grew and in 1909, Ernest Jacoby began to organize weekly meetings at Emmanuel Church. More meetings began to be established as Jacoby Clubs, ("A Club for Men to Help Themselves by Helping Others") and Jacoby Clubs and their weekly meetings flourished (McCarthy, 1984). In Boston, the Jacoby Club provided meeting space for one of the earliest AA groups but the two organisations remained separate and the Jacoby Clubs gradually lost out to their newer, more vigorous fellow traveller (White, 2000; Dubiel, 2004).

What seems striking about these early recovery groups is the similarity of their insistance that stopping drinking alone was not enough to sustain recovery. What was required was a much more radical alteration in the former addict's thinking about themselves and how they behaved towards others and the company they kept. In this, they foreshadowed the central tenets of the Black Power movement – similarly led by a reformed criminal and multi-drug user, Malcolm X – in the 1960s (White and Whiters, 2005). Malcolm X argued that stopping using drugs and drinking and stopping offending was not enough. Members of the movement were exhorted to be "black and proud" (Johnson, 1986).

The Alcoholocs Anonymous (AA) fellowship has been one of the most successful mutual-aid groups and has spawned a number of parallel organisations including Narcotics Anonymous, Gamblers Anonymous and Cocaine Anonymous. They too have, from their earliest writings, discussed the concept of the "dry drunk": the former drinker who continues to behave in ways which are unacceptable and which were the hallmark of their former drinking career (Mäkelä et al., 1996).

Largely informed by the work of therapeutic community (TC) pioneer, Charles Dederich at the experimental commune, Synanon and bolstered by the 'second generation of therapeutic communities on the East coast of America (Rawlings and Yates, 2001; Broekaert et al., 2006), the residential self-help community, modelled on AA practices, rapidly gained a foothold in Europe in the early 1970s. In Europe, this development was melded with the existing therapeutic community practice in psychiatry pioneered by Jones, Laing, Clark and others and grafted onto a century long tradition of caring for (and addressing the needs of) "maladjusted" children (Rawlings and Yates, 2001). Even with this rich history however, the notion that a community of addicts could manage and control the elements of their own recovery, was initially greeted with scepticism within mainstream addiction treatment (Yates, 2003; Broekaert et al., 2006). Perhaps one of the most telling clues to the origins of the TC movement lay in its insistence on the AA concept of the 'dry drunk'. Early in the history of Synanon, Dederich argued that Synanon was emphatically not a treatment service, rather, he said, it was a school where people learned to "live right".

Subsequently, De Leon, one of the foremost evaluators of the TC and undoubtedly its foremost chronicler, argued that the notion of 'right living' lay at the heart of the TC approach (De Leon, 2000). The TC, he suggested was more school than hospital and could better be viewed as a learning environment where individuals learned (or relearned) correct behaviour. Abstinence was not a goal, necessarily, rather a serendipitous outcome of overall behaviour change.

Addiction Theory

Peele (1995) has noted that the vigorous promotion of alcoholism as a chronic, relapsing disease by the scientific medical community in the 1950s and 1960s (Jellinek, 1952; Jellinek, 1960; Glatt, 1952; Keller, 1962) has effectively embedded the notion of addiction, in both the public consciousness and (to a lesser, though significant extent) within the academic discourse, as an incurable condition which can, at best, be managed and contained. Room (1983) has charted the opposition to this position by sociological researchers and proponents of the behaviourist schools, but, although these arguments gained significant ground during the 1970s and early 1980s, the increasing focus, during the past two decades, upon infection control and crime reduction has resulted in a general return to a medical model of addiction treatment predicated upon the management of the problem and containment of its physiological and criminological sequalae.

The notion of a disease, which robs those afflicted with it, of their individual will, is embedded in a cultural context where individuality and liberty is a paramount aspiration and where appropriate behaviour is an individual personal responsibility. This, of course, is precisely the cultural matrix which developed with the industrialization of previously rural communities, where controls had tended to be vested more explicitly within the family or 'tribe' than in the individual.

These concepts have proved to be of an enduring nature. The current definition of addiction or dependence, as set out in the *International Classification of Diseases* (ICD-10) (World Health Organisation, 1992), neatly sets out this diagnostic requirement as, "Impaired capacity to control substance-taking behaviour in terms of onset, termination or level of use". ICD-10 lists a number of other manifestations of addiction[2], including a preoccupation with the substance of choice, which disregards other important concerns or alternatives. Room (2003) argues that this definition again, is culturally specific, relating to a social structure in which time has become a commodity in itself, "a cultural frame in which time is… used or spent rather than simply experienced" (Room, 2003, 226).

Thus, the discovery of addiction (and, consequently, of 'recovery') came during a period of extraordinary social upheaval and change. In America, in particular, the period was also associated with additional changes in established communities as existing residents moved out to explore and settle new territories and were replaced by significant numbers of immigrants from Europe. In the period between 1785 and 1835, the population of the United States almost doubled (Peele, 1995). In the newly settled territories, drinking houses were largely rudimentary, frequented by prostitutes and gamblers, and generally structured to encourage drunkenness and heavy, drink-

[2] The WHO uses the term 'dependence' – currently, the preferred terminology.

related spending; a far cry from the community-oriented taverns in the close-knit communities most settlers had left behind. In the cities and established communities, the new immigrants brought with them European drinking practices, which were often frowned upon and largely misunderstood.

The publication of Jellinek's (1952) work on phases of alcoholism and its subsequent incorporation into World Health Organisation guidelines (Room, 1983), significantly influenced discussions on the nature of addiction and recovery for most of the 1950s and 1960s. This disease model of addiction was not without its critics. Trice and Wahl (1958) tested Jellinek's hypothesis and concluded, "if the concept of a disease process in alcoholism is valid, only the earliest or the most advanced stages are reliably indicated." Similarly, the presentation of alcoholism as an *irreversible* disease, has been subjected to much debate and criticism.

Davies (1962) provided an early challenge to this notion with a paper in the *Quarterly Journal of Studies on Alcohol,* which noted the capacity of many of his patients to return to normal drinking patterns. Commentaries in subsequent issues - on both his findings and his diagnostic methodology - was heated but largely scholarly. Not so the response to the Rand Report, *Alcoholism and Treatment* (Armor, Polich and Stambul, 1976). The controversy which surrounded the publication of this report, with its finding that not only was a reversion to controlled drinking possible but that it was the most likely successful outcome, sparked a public argument which refused to die down. Room (1983) has noted that some studies of controlled drinking had their funding withdrawn at this time and that the debate became at times, extremely emotive. The authors were accused of providing struggling abstainers with a "scientific excuse for drinking" (Room, 1983) and numerous commentators predicted dire consequences as a result of its publication (Roizen, 1987). However, as Roizen points out, subsequent studies (Hingson, Scotch and Goldman, 1977) indicated that this apprehension had been misplaced and the publication of the report – and its interpretation in the media - had had little or no impact on drinking behaviour.

By this time also, the notion of addiction as a disease was being increasingly challenged; particularly by sociological and psychological theorists. As social concern switched for being largely dominated by alcohol misuse and began to respond to increasing use of illicit drugs, particularly heroin and cocaine, the emergence of theories based upon psychodynamic, socio-cultural and behaviourist traditions multiplied inexorably.

Khantzian (1974a; 1974b), Wurmser (1974) and others suggested that the origins of addiction might lie in deep-rooted childhood trauma. Psychoanalytic and psychodynamic theorists have been prominent in developing theories of drug dependence based on personality factors. Early psychoanalytic theories suggested that alcohol abuse reflected an individual who was experiencing severe conflict concerning dependence which was expressed by oral fixation. Over the years, these theories have ranged from suggestions that drug dependence reflects low self-esteem to sex-role conflicts, or feelings of powerlessness which are masking a need for control (Blane and Leonard, 1987). Wurmser, writes that "actual, overwhelming, early trauma" creates "neurotic conflict." In this model, a harsh superego creates intense feelings of rage, fear, guilt, and anxiety. The use of drugs is a way of escaping these feelings.

Others (Ellis and Harper, 1975) proposed a behavioural origin to the addiction phenomenon based largely upon the work of Skinner and Pavlov. Addiction was, they argued, a learned behaviour which could, in turn be unlearned or, perhaps more accurately, replaced with less self-destructive behaviours. These theories, in their turn, spawned a raft of cognitively based interventions still in use today, including motivational interviewing (Miller and Rollnick, 1991) and relapse prevention (Marlatt and Gordon, 1985).

Perhaps the greatest leap forward in understanding addiction, came with the work of theorists such as Engel (1980), Robbins (Robbins, Robbins and Stern, 1970) and Zinberg (1984) through the development of models of addiction – most often described as biopsychosocial – which are multi-dimensional.

Bio-psychosocial theories of addiction argue that the addiction experience is impacted upon by three distinct factors. These factors – Zinberg's 'drug, set and setting' - are the chemical interaction and any biological or genetic predisposition to intoxication; the individual's psychological and spiritual state; and the environment in which he or she exists. This three-part model has been hugely influential in the drug treatment field in the past thirty years. Some practitioners have argued that the model provides an essential framework for assessment and treatment planning (Yates, 1985) and most validated instruments, such as the Maudsley Addiction Profile, the Addiction Severity Index and the Client Treatment Matching Protocol would appear to owe their genesis to this layered and individualistic approach to the problem.

Subsequently, a number of practitioner authors (Yates, 1979; Madden, 1977; Yates, 1984) argued that the model was not only a tool for understanding addiction but could also be used to assess problems and plan treatment interventions. Yates (1979, 1984) developed an assessment model which set out the various questions which would need to be asked to ascertain the balance of difficulties experienced by the individual in each of the three domains. Thus, if the level of drug-taking was relatively low and of short duration whilst self esteem and the availability of non-using friends and relatives was correspondingly high, then a fairly low intensity intervention would be required. Madden (1977) similarly argued that the three domains outlined by Zinberg could be used in an understanding of the 'treatment strengths' with which the addict came to their first appointment.

Addiction Theory and Long-Term Recovery

Addiction theory matters not simply because it underpins the approaches used in drug treatment interventions[3] but because it also has implications for recovery and for the long-term sustainment of recovery.

[3] At least, this should be the case. Paradoxically, it can be argued that many substitute prescribing agencies, whilst espousing a bio-psychosocial approach, actually operate as if their central principle was the disease model. Equally, 12-step fellowships, despite arguing for the disease model, in practice place as much, or more emphasis on securing changes in personal self-perception and the socio-cultural environment.

If indeed, addiction is a result of a fluid interaction between the biological propensity, the environmental setting and the self-esteem and self-belief of the individual, then clearly, an intervention must address all three elements if it is to be successful. Treatment interventions which are limited to a concentration on the addicts consumption of substances will at best, deliver a level of stability. At the worst, they will attempt abstinent recovery for which the individual will – without radical changes to his/her environment and their own self-esteem – be both ill-prepared and ill-equipped.

The tem, social capital, is generally used by sociologists to describe the connections within and between social networks. The term was probably first used by the American schools inspector, Lyda Hanifan. Introducing the term in a 1916 report on rural schools in Virginnia, Hanifan explained:

> "I do not refer to real estate, or to personal property or to cold cash, but rather to that in life which tends to make these tangible substances count for most in the daily lives of people, namely, goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families who make up a social unit… "
> (Hanifan, 1916, 130)

Sheldon and MacDonald (2009) note that Hanifan's notion of 'social capital' was rooted in a belief in self-help and peer support. Hanifan himself was content to conclude that: "It was not what they [professionals] did for the people that counts in what was achieved; it was what they led the people to do for themselves that was really important" (Hanifan, 1916, 138). Whatever its origins, it is clear that the term has become a shorthand for all that is good about community spirit in the related fields of sociology, social policy and social work.

More recently, writers on recovery, such as White and Cloud (2008) and Best and Laudet (2010), have taken this idea and coined the term 'recovery capital' to describe changes they have observed in the resilience and robustness of people's social and emotional circumstances in long-term, abstinent recovery. There are, they argue, dramatic improvements in self-esteem, civic and social engagement, physical and psychological health and overall well-being. These changes, they argue are fundamental to the successful outcome of any abstinence-based recovery journey (Best et al., 2010).

> "The best predictor of the likelihood of sustained recovery is the extent of 'recovery capital' or the personal and psychological resources a person has, the social supports that are available to them and the basic foundations of life quality, i.e. a safe place to live, meaningful activities and a role in their community (however this is defined)."
>
> (Best et al., 2010, 8)

Cloud and Granfield (2009) have recently suggested that this concept can be further refined as four individual, though overlapping, catagories: social, physical, human and cultural. Best and Laudet (2010) endorse this view but note that of these, the social, human and cultural capital 'reserves' are probably of the most significance, particularly in group or community settings:

> "Although the focus here is primarily on individual factors, it is the meshing of three of these components – social, human and cultural capital – that may be particularly important in assessing recovery capital at a group or social level."
>
> (Best and Laudet, 2010, 4)

But significantly, these categories bear a striking resemblence to Zinberg's 'drug, set and setting' (and to Madden's 'the seed, the soil and the atmosphere', op cit.; and Yates' effect, expectation and situation', op cit.). In all of these analyses, it is argued that changes in these three central areas are vital for both a comprehensive assessment and the development of a person-appropriate treatment plan. What was not examined in any systematic way in these earlier writings was the use of this model to measure long-term improvements in individual resilience and social reintegration. What is argued here is that the use of the bio-psychosocial model in all phases of the recovery journey would provide a coherence to the role of various interventions throughout the process and enable drug treatment practitioners – even those who remain sceptical of the so-called 'recovery agenda' – to view their role in the process from within an accepted scientific framework.

Conclusion

Numerous authors (Best et al., 2000a; White and Whiters, 2005; White, 2009; Yates and Malloch, 2010) have commented upon the apparent antipathy, even occasionally outright hostility, of mainstream treatment practitioners to the 'unscientific' nature and ungrounded optimism of the self-help recovery movement (Best et al. 2000a; Yates and Malloch, 2010). In order for this scepticism to be modified, the recovery movement in all it's forms (spiritual healing communities, 12-step groups, therapeutic communities etc.) will need to demonstrate an openness to research and innovation and a willingness to debate their role and responsibility within the wider sphere.

Why this seems important is not only because of issues of individual well-being but about the wider issue of intergenerational transmission of addiction and it's associated problems: low educational achievement, unemployment, offending behaviour, teenage pregnancy, physical and mental ill-health. Numerous authors have noted this phenomenon (Peele and Brodsky, 1975; Peele, 1985; Best et al., 2010; Gilman and Yates, 2011) and argued that improvement in this area is the ultimate prize for treatment intervention. Whilst some have argued that this apparent inheritance of problematic behaviour may have it's roots in genetics (Goodwin, 1990), the argument for a mixture of the biological, social and psychological (echoing the bio-psychosocial model) seems particularly compelling. Since long-term, abstinence-oriented recovery appears to require significant improvements in all three domains it seems appropriate to explore whether such recovery journeys have an impact upon parenting and subsequent behaviour in drug-affected families.

Andreas and O'Farrell (2009) have noted improvements in behaviour and attitude amongst the children of parents in long-term engagement with mutual-aid fellowships. Similarly, in a large Australian study, Callan and Jackson (1985) reported significantly better behaviour and well-being of children in families where

one or both parents had achieved long-term recovery than amongst children where parental drug use was continuing.

Conversely, numerous studies have shown that whilst long-term substitute prescribing, concentrating as it does, on the biological elements of the addiction experience, whilst having a significant impact upon illicit drug use and its consequent criminality and joblessness, seems largely unable to completely eradicate these behaviours in the majority of individuals (Best et al., 1998; Best et al., 1999; Best and Ridge, 2000b; Best and Ridge, 2003). Illicit drug use and criminality appears to continue at a reduced level in most thus prescribed (Eley-Morris et al., 2002; Eley et al., 2002; Yates et al., 2005; McIvor et al., 2006).

Thus, whilst long-term substitute prescribing might seem to offer the greatest gains – in terms of treatment expenditure – over the short-term, it would appear that long-term abstinence-oriented recovery is likely to deliver the most significant gains when examine over a more significant period.

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