Recovery as an Ethical Ideal

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“Fall down seven times; stand up eight times”

Japanese proverb

The paper explores the varied implications of cure, healing, and recovery and considers why recovery is often the preferred characterization in relation to a medicalized drug dependency. The positive as well as the negative dimensions of recovery are noted; the ethical challenges of the primarily proccessual associations of recovery are investigated; and some policy implications are indicated.

Keywords AA; abstinence; achievement; addiction; cure; dependence; drugs; healing; lapse; normative concept; palliation; outcome; overcome; process; recover; recovery; relapse; remission; resilience; restoration; stakeholders; tasks; 12-step programs; vulnerability

Introduction

Especially in 12-step circles, but even more broadly, recovery is said to be an ethically desirable—at least acceptable—goal for those who are dependent on drugs, whether licit or illicit. The choice of vocabulary may be significant. For the most part we are socialized into searching for cures. If so, why do we settle for the vocabulary of recovery in the context of drug use? Is it simply a matter of historical happenstance? Part of an enduring slogan? Is it a choice of words with no more than a stylistic significance? And, if it is intentional, is it ethically appropriate? In this paper, I offer a preliminary exploration of the languages of recovery and seek to articulate and explore some of the ethical questions generated by this exploration.

My concern with the ethical dimensions of recovery is deliberate. We might choose to look at its economic, political, legal, psychological, sociological, or religious dimensions, but there is something particularly foundational about an ethical inquiry, for ethical categories constitute the basic currency of human intercourse. There is no more fundamental way in which we can relate to each other than those we characterize as ethical, for it is through such characterizations that we address each other as objects of dignity, autonomous

1The category of “drugs” is somewhat amorphous and socially contested, and in fact I use it here not simply to refer to those psychoactive substances commonly referred to as drugs but also as a dummy for other dependencies (associated with, say, gambling and eating) from which people often seek recovery.
beings, warranting respect and care and possessing a good for whose flourishing we are responsible. It is, moreover, by means of such ethical categories that we also pass judgment on the varied economic, political, legal, cultural, spiritual, and other arrangements under which our lives are lived. How those other arrangements impact on our dignity, autonomy, and flourishing is of critical import.

But who is the “we” to whom “we philosophers” so unselfconsciously appeal? It is, to some extent, a figment of philosophical imagination, like the lawyers’ “reasonable man.” It is the hypothetical reflective person who is presumed to know and care enough to deliberate in an informed way and to be able to assent to or dissent from what is proposed. This archetypal human always exists in a somewhat impure form, colored by—and perhaps tainted by the distortions of—particular cultural, scientific, or theoretical ideas. But because he does exist in some form, it is always open to him/her to question whether the we of “we” really is so. The reader is thus forewarned.

The Languages of Recovery

Recovery is but one of a number of cognate concepts that may be 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 employing the vocabulary of recovery? Does it refer to a process or outcome (or both), to the restoration of a physical, psychological, spiritual, or social status (or all four)? Does it require abstinence? Is it more suitably applied to drug users than to those who suffer from and/or manifest other infirmities?

Cure

In ordinary medical contexts it has been traditional to seek for cures—whether for cancer, the common cold, or fever. Although the language of cure can refer to a process (thus we speak of a curative process), the main focus in cure is on the idea of vanquishment—the complete overcoming, indeed elimination, of a source of disease, illness, or malady. The focus of a cure may be either an individual organism that is ailing or, more broadly, the elimination of a disease or ailment that has constituted a social as well as individual blight. In speaking of such overcomings, 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, primarily on the individual but often also the effects that it had on others, individually, collectively, and institutionally. Those who are cured are usually presumed to be restored to a status quo ante (or preexisting condition of well-being). Or, given that a person may be born with a certain disease, it may not be some preexisting condition of well-being that is restored but liberation from a malady and conformity to some expectational standard. 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.

2Not all philosophers are so unselfconscious. An illuminating discussion can be found in M. B. Foster (1957).

3There is a large literature that focuses on the conceptualization of disease and concepts that are related to it and whether they should be construed functionally, normatively, statistically, or in some other way, and although that debate has important implications for how we categorize drug dependence and characterize that categorization, I shall not pursue those issues here.

4This may not always be true of a person’s social status, which can be permanently affected by the preexisting condition.
Recovery as an Ethical Ideal

Healing

The idea of *healing*, though more processual than that of cure (for we speak more often of a healing process), also tends to look forward to its outcome—namely, being healed. Those who are healed are made hale or whole. True, the healed fracture or wound may leave a residual weakness or tenderness, and we may therefore be reticent about using the vocabulary of cure; still, to the extent that we speak of someone as being completely healed, the implication, as with cure, will be that something like a preexisting condition of well-being has been restored or a disease/illness removed.\(^5\)

Though we may wish for cures or complete healing, such aspirations are not always realized and sometimes may not even be reasonable. Remarkably resilient though humans are, they cannot always erase the effects of whatever it is that afflicts them. Though the physical effects may be removed, some psychical and social effects may remain. Or though the social and psychological effects may vanish, some physical effects may remain. Restoration is usually multidimensional, and the various dimensions do not always coincide.

In the case of disorders that standardly include social components or “triggers,” their management at one level (say, detoxification or mental stabilization) may still leave their subjects diminished as well as feeling and/or being vulnerable because the relevant social and other factors have not been addressed. If the disorder has disrupted social relations or economic well-being or has been generated by a harmful environment, attention to its “medical” aspects may be insufficient to return the person to health.\(^6\) This may be true even of standard “physical” diseases, where the social factors (such as unsanitary conditions and poverty) that initially exposed one to disease are not addressed along with its bodily effects.

Sometimes healing may be only partial, and remission may be only temporary, and at other times all that we may be able to provide is palliation of some kind. Not every preexisting condition of well-being can be restored. Maladies or illness may leave us permanently compromised or at least weakened—more vulnerable, perhaps, to new attacks.

Even in traditional medicine, with its heavy focus on bodily integrity and functionality, 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 and failed aspirations. 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.\(^7\) Less may be not only inevitable but also acceptable. Where the latter is so, it is often because the focus has shifted to a quality of life model for treatment and the delivery of care. That model gives a critical place to the patient’s own sense of the worthwhileness of the life that various treatment options can provide as well as his or her current satisfaction with life.

To the extent that we accommodate the psychic and social dimensions of disease and illness, it manifests a welcome holistic appreciation of human maladies/illnesses. It may, though, still be best to think of a layered continuum, with varying levels of organic, psychological, spiritual, and social involvement. Some organic problems (such as hypertension)\(^5\) in addition, of course, it is somewhat more natural to speak of an “organ” being healed and of a disease being cured. Nevertheless, healing is more frequently associated with a “residue” than a cure.\(^6\) The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

\(^7\) Of course, cure and healing may be out of our reach for other reasons, such as the availability of and accessibility to resources. “Availability” and “accessibility” may be a function of micro and macro social, political, and catastrophic “big events,” and economic, religious, and geographical factors. Overcoming such factors may sometimes have to await major social change.
may be asymptomatic and manifest themselves as real, anticipated, or supposed vulnerabilities or susceptibilities rather than as experiences of psychological stress or social tension. Others, even if not seriously disabling at a physical level (for example, certain physical conditions or deformities such as rosacea, baldness, and hermaphroditism), may have significant psychosocial implications. And yet others (such as gambling and sexual “addictions”) may operate primarily at the sociopsychological level.

If the vocabularies of cure and healing are now recognized to be sometimes problematic in relation to maladies that are primarily organic, they are even more problematic in the case of ailments that have substantial psychological components. Although it has often been noted that organic problems also tend to have significant psychological and often social components insofar as pain, suffering, and deformation are experienced by their subjects, nevertheless, in their case, if the physical preexisting condition can be restored, the psychological and social status quo ante can often be restored as well.

Recovery

Talk of recovery also has a long history in medical contexts (and the Oxford English Dictionary records such usages even in the 16th century), but the term 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 12-step programs (whether focused on alcohol, heroin, or cocaine). But the vocabulary of recovery is not exclusive to such programs, and even some programs that operate outside of and in some sort of competition with standard 12-step programs (such as “Methadone Is Recovery”) use the same vocabulary (National Alliance of Methadone Advocates, n.d.). In recent years “recovery” has universalized itself as a preferred characterization of the overcoming of drug dependency (Laudet, in press), usually in association with abstinence, though there is an ongoing debate concerning its applicability to alternative pathways.

That the vocabulary of recovery was used by AA—and has become pervasive—is probably significant. First of all, we use “recovery” more naturally in relation to what we construe as illness and disease than in relation to moral failure or other character deficits. In the case of the latter, the vocabulary is more likely to be that of redemption, correction, reformation, reclamation, or, to use a nicely ambiguous term, rehabilitation. Although alcoholism and similar diagnosed dependencies have often been conceptualized as being diseases or illnesses by those committed to the success of 12-step programs, it was not until DSM-IV (1994) that such dependencies were formally medicalized as chronic substance use disorders (SUDs) from which one might at least recover (American Psychiatric Association, 1994). The language of recovery thus stands in some sort of contrast to moralized conceptions of dependency (weakness of will, lack of discipline) that have been accorded to some drug use and other potential addictions such as gambling and sex.

Second, as with cure, recovery can occur spontaneously. The viral infection 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; and the cancer may (perhaps miraculously) disappear. Treatments—both informal and formal—might not be necessary. Like the allergic reaction to a food that eventually disappears or moderates, the need, ongoing desire, or “craving” for a particular substance may also diminish or go away completely. Some have claimed...
Recovery as an Ethical Ideal

that one can grow or mature out of the dependency (Winick, 1962) or “naturally” recover (Klingemann and Sobell, 2001) or that one’s psychological “organization” can undergo a gradual or sudden reordering that dispenses with the need for its maintenance by means of particular drugs. Not all therapies are constituted by treatments. Although our vocabulary is fluid, treatments tend to be formalized and other-directed, planned and professionalized, and tradition-based interventions, whereas therapies are less formalized remedial courses of action that may be self-administered. The therapeutic value of a mutual self-help 12-step program is generally not viewed as a treatment but simply as a social and environmental option that can enable a temporary or permanent recovery from an active dependency 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 value-laden assumptions.

Dimensions of Recovery

Those who speak of recovery do not necessarily have a single or simple idea in mind. It has several dimensions.

Recovery as a Desirable/Valued Goal

Recovery is generally a term of approbation: It characterizes something believed to be desirable. It implies not merely reversion to a former state but a former state that is seen to be desirable. Or in the event of an unacceptable former state, it implies the creation of personal conditions that are viewed as being acceptable. Recovery is generally contrasted 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. Nevertheless, as we will later observe, there may be a complex dialectic between recovery and (re)lapse. They do not constitute simple opposites: though relapse may thwart recovery, recovery may accommodate (re)lapse.

When used in the context of drug dependency, the vocabulary of recovery is applied to those whose dependency is viewed as a burden—presumably a burden to those who are dependent as well as to others. Where no burden is perceived no recovery is likely to be contemplated or sought. In such cases, it will be thought that there is nothing to recover from. 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 it is brought to the attention of and recognized by others. Although it is theoretically possible for others to count as recovery what is not seen as needed by its subject, recovery is not likely to occur (at least in the drug field) where no burden is recognized.

In the field of medicinal drugs, 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 its early contributors, particularly Dr. William Silkworth, viewed alcoholism as an “allergy” that one would not grow out of. It is not, however, part of what we understand by an allergy that one cannot grow out of it. Chronicity may not be “curable” but, to the extent that one can grow out of it, need not be permanent. See Kurtz (2002).

Without wishing to downplay the physiological and psychic effects that drug dependencies may have, we should not forget the extent to which the burdensomeness of drug use may be socially exacerbated through prohibitions, social opprobrium, and so forth. Just as disease is, to some extent, a social construct (and not a simple reflection of “scientific” functionality) so too is recovery. Independently of their impact on human systems, we may make the use of certain substances burdensome to those who use them.
of some deficiency, impairment, or vulnerability (say, diabetes or elevated blood pressure), is dependent on some supplemental or prophylactic drug may not be in need of recovery. Rather, the substance on which that person now depends may be part of the person’s recovery from the disorder for which it is taken. Even the person who is dependent on some narcotic drug may not consider recovery (from its use) as called for or needed, if access to it is unburdensome along with other risks being minimal. Those suffering from chronic pain may become dependent on oxycodone but not find that dependence unduly burdensome if the tablets are readily available and if the side effects are minimal. Indeed, any person for whom a particular kind of dependency has become a precondition of normal or optimal functioning is not likely to consider himself or herself in need of recovery. And neither will we consider that recovery is necessary, if the long-term psychosocial costs are not viewed as significant by the dependent individual or by others who may have particular stakes or agendas. A need for recovery, in other words, will be contextualized.

The general point here is that 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. Moreover there are many social dependencies that are integral to our well-being—friendships and intimate relationships as well as broader connections of trust and cooperative reliance. Interdependence is generally a condition of our normal functioning.

Recovery tends to be contextualized in other ways as well. Do we speak of recovery from nicotine addiction, caffeine addiction, or even food addiction? Not usually: at least we would generally not think of giving up cigarettes, coffee, or excessive eating as recovery from these, unless they were incorporated into a 12-step or other program. Otherwise we speak of overcoming or getting over them. Although “recovery” is used much more broadly than in the context of dependencies, we might wonder whether, when associated with drugs (and some other dependencies), the vocabulary is freighted with certain presumptions about those dependencies that need to be explored. Does, for example, the vocabulary suggest the kind of chronicity or ongoing susceptibility (or, more likely, danger) that needs to be checked by continuing attendance at 12-step program meetings or involvement in other programs? If so, is that a reasonable presumption? Or given that the language of recovery is not restricted to 12-step therapies, does it reflect a particular kind of burdensomeness that has come to be associated with the dependency? Do we need to “recover” only from those dependencies that interfere with what our society considers to constitute “normal” functioning? We will return to some of these questions later.

Beyond the question of desirability, what does recovery—in the context of dependency on drugs such as alcohol, heroin, and cocaine—consist of? We can think of recovery as having negative and positive dimensions (or, better, as manifesting itself on a complex and probably nonlinear and multidimensional continuum from negative through positive factors). We can also think of it as a process or outcome.

**Negative and Positive**

It may be helpful to think of recovery as from and to, that is, as having negative and positive features. Negatively, recovery may be considered simply as the removal or surmounting 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. Overcoming

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11 Either way, it might be claimed, we problematically mystify and empower them, whereas the emphasis ought to be on our own empowerment.
a dependency need not imply abstinence, though many who have been dependent on drugs consider abstinence a practical condition of overcoming dependency (Laudet, in press). More importantly, as already noted earlier, unless the dependency is seen as burdensome in some way, by the person, significant others, or other stakeholders, its removal is not likely to be characterized as recovery.

The fact that, strictly speaking, recovery from drug dependency may not require removal of the dependency but only a removal of its burdensomeness is one of the claims associated with the “Methadone Is Recovery” movement. It is argued that methadone use is less burdensome than heroin use (and that, no doubt, is partly because heroin use has been made illicit, driving up prices, fostering a surreptitious lifestyle, exposing one to heroin of questionable quality or the viral risks associated with shared injection paraphernalia). No doubt it is also one of the claims of those who press for decriminalization or legalization: they consider that much of the burdensomeness of illicit drug use and dependence is a function of the social (and particularly legal) strictures we place on its use. In practice, though, at least for many who are dependent on particular drugs, alleviation of their burdensomeness will be causally associated with surmounting their dependence.

A more problematic obscurity—one to which we will return—concerns an ambiguity in the idea of overcoming drug dependency. We can understand that recovering alcoholics will (usually) be understood to have surmounted their burdened dependence on alcohol. But what about their consumption of other drugs? The smoke haze and litter of coffee cups outside Alcoholics Anonymous (AA) meetings (or at least the meetings of the one that meets near where I live) suggests that recovering alcoholics often either remain or become heavily addicted to or dependent on nicotine and caffeine. So the recovery here is specific to a particular drug and not to “drugs” generally or to an abstinent or a harm reduction-based lifestyle, however might we cash out these accordion-like terms. Nor is it even recovery from “harmful” drugs, since “heavy smoking” is likely to lead to disabling emphysema, quite apart from deleterious effects that passive smoking may have on others. If anything, it is recovery from the day-to-day disruptiveness of the dependency associated with certain drugs (a disruptiveness, of course, that is often partly constituted by their illegality and the underground/criminal activity that then becomes associated with obtaining them).

Even more problematic is the case of former heroin users who are involved in “methadone maintenance” programs. Although “NA [Narcotics Anonymous] as a whole has no opinion on outside issues, including prescribed medications” (Narcotics Anonymous, n.d.), a phrasing that may be interpreted to include methadone maintenance, many individual

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12We should not leave unnoted the economic burdens that might be associated with substitution treatments, such as buprenorphine, and the ethical dimensions of deciding whether to use it or methadone.

13Ironically, it was emphysema that was largely responsible for the death of Bill Wilson, AA’s cofounder. See Cheever (2004).

14This “opioid agonist replacement therapy” substitutes for heroin an alternative opiate that is claimed to have less disruptive euphoric, sedative, and analgesic effects, thus enabling a person to engage more effectively in everyday activities. In addition, because it is said to be less addictive, it is said to enable a person to be more effectively weaned off drug (opiate) dependency. Whether these claims are factually correct or significantly infused with social and political agendas is another matter. Methadone too has become a “street drug.” The relatively recent vocabulary of “methadone maintenance” may suggest that it is an interim therapeutic measure, like being maintained on a respirator until one is able to breathe by oneself. See, for example, some of the treatment options discussed in Terry and Pellens (1928). However, for some advocates of methadone maintenance the analogy has been to insulin maintenance for those people living with diabetes, and who do not anticipate being weaned off it. We might wonder about the legitimacy of the latter analogy.
12-step NA program meetings will exclude from their active midst those who, though off heroin, are being “maintained” on methadone. The methadone user is seen as cheating and not really “in recovery,” for the latter requires the effort of abstinence. The 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 at best a precondition of recovery and not a full understanding of it. That is, recovery is not simply from but to; it is a positive and not merely a negative achievement. Dependencies become burdensome because they impact adversely on a person’s quality of life—either by consuming precious resources that would be devoted to needed and valued ends or by diminishing and/or compromising the personal powers that are the ingredients in a satisfactory or good life. The removal of one burden does not ipso facto ensure the removal of others. In a recovery worthy of the name, there must also be some more positive achievement—something that includes a level of economic, psychic, and social well-being, not that the process will necessarily be a smooth or untroubled one. Recovery is not linear but complex, dynamic, multifaceted, and ongoing. It may not exclude lapses. Indeed, a great deal of our learning and relearning is a matter of trial and error, of failing and retrying. Thus, learning to overcome the ravages of a complex dependency, with its social, economic, physiological, and spiritual/ethical impacts, is likely to involve missteps and setbacks, especially if the dependency has been one of longstanding.

Some drug users and others question whether recovery requires the overcoming of dependency rather than simply its routinization. Recovery, they argue, is not sobriety or abstinence so much as the restoration of safety, security, order, and routine, and to the extent that they can be returned without dependency being overcome, significant recovery will have taken place. They may not even think that recovery is generally required, except from a socially induced burdensomeness. Some advocates of methadone programs argue that one of their virtues is that they provide a structure for those who are opioid-dependent and enable them to resume an orderly, predictable life. We may grant the point in theory while seeing its realization in practice being problematic for an individual if certain critical internal and external conditions are not available or accessible. As long as heroin remains illicit, treatment with methadone may facilitate recovery. Whether this would be the case were all drugs freely available is less clear. To the extent that the disruptive and damaging aspects of drug dependence are contingent on social policy, we might separate recovery from an overcoming of dependence. To the extent that the substance in question has pharmacological properties that become burdensome, we will want to yoke recovery (at least in part) to an overcoming of dependence.

As noted, although recovery often anticipates the removal of a condition, it 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 preexisting condition, if

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15 A question: how does this differ from the case of the person whose deficiency requires dependence on drugs that are so costly that they allow for nothing much more than survival? In the latter case we might argue that it is the drug itself that is the source 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 consequence 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.

16 Libertarians often tend to associate (most of) the burdensomeness of the so-called problem drugs to the restrictions we place on accessing them. See Szasz (1996).
the preexisting condition were not desirable. Indeed, given that a preexisting condition may have been a salient element in bringing about the dependency in question (say, being socially marginalized or emotionally fragile), abstinence may leave the person, apart from unstable, not much better off than was the case during the period of dependency. In some cases, a fragile person may even be worse off because the drugs kept him or her from “the edge.” The dependency, though burdensome in its own ways, may have masked another burden and thus been a form of relief or alleviation. It is important, therefore, to see recovery in positive as well as negative terms (assuming, somewhat controversially, a negative dimension to it).

Recovery may not involve a restoration of a preexisting condition for the additional reason that things lost as a result of addiction may not always be recoverable. One loses a spouse, a job, and 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. There may of course also be social residues—one’s being labeled an (ex-) addict albeit “in recovery.” Some of the same is also seen (though less disparagingly) in the label often born by cancer “survivors.” Unlike “addicts” (or, sometimes, “ex-addicts”), however, cancer survivors are not usually seen as being at some fault (being weak and reckless, for example) for their situation. The social prejudices associated with drug dependency will not go quickly away, baseless though they may be.17

The positive sense of recovery may be primary, even though some of those concerned with recovery—most often critics of drug use—focus more on what is assumed to be its precondition, abstinence from drugs. Were it possible—as it might sometimes be—to secure the positive elements of recovery without needing its standard precondition, it would still be reasonable to speak of the person as having achieved a significant level and/or quality of recovery (here, from the social effects of the drug rather than from the drug itself). The idea of a progressive and ongoing recovery may be empowering to those who must wrestle with what is often a long-term and multilayered process of restoration and renewal. If a person can see the process of recovery as one that will become increasingly easy, even though exceedingly difficult in the instant, it may assist in the process of resistance. The idea of a multistaged and multilevel recovery is no doubt also a factor that informs those who support methadone programs.

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 related to or be treated as recovering. It is only an ethical problem, however, not necessarily an ethical failing, though 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 12-step programs relapse into heroin use (assuming, for the purposes of the argument, that this is intrinsically undesirable) than those who enter abstinence-based NA 12-step programs.18 It might then be argued that the work of the latter would be compromised if equal status were given to those who

17Whatever one thinks about the language of “addiction,” it is always problematic to turn an adjectival characterization of a person into a noun that now becomes the predominant focus—such as “homosexual,” “criminal,” “ex-felon,” or “Jew.” It is not merely the refocusing from part to whole, however; the substantival forms often tap into deeply ingrained social stereotypes/prejudices which are then communicated and experienced as dehumanizing.

18I find the data unclear. Apart from anything else, it is unclear whether the groups are interchangeable. A significant number of those who responded well to a methadone treatment program may not have responded well to a twelve-step program and vice versa.
are being maintained on methadone. For those who believed that abstinence is necessary
would be given the message that an equally acceptable alternative route to recovery was
available to them. Proclaiming the virtues of methadone maintenance might thus be seen as
counterproductive by those who wish to provide maximal support for people who struggle
to maintain an abstinence-based recovery.19

Process and Outcome

What about the process–outcome distinction? Following the publication of Gilbert Ryle’s
influential book, *The Concept of Mind*, in which he distinguished the words “task” and
“achievement,” there has been lively philosophical debate concerning processes and out-
comes and their logical relations (Ryle, 1949, pp. 150–153).20 What Ryle had primarily in
mind was a distinction between words that characterized tasks and words that characterized
achievements—words such as run and win or treat and cure. Running and treating are tasks
or performances, but winning and curing are achievements or successes. In winning and
curing something is brought about over and above whatever is involved in the performance
(of running and treating, respectively). In addition, he claimed, we can talk about tasks in
ways that would be inappropriate, were we to attribute them to achievements. Thus we
can characterize the performance of tasks as, say, assiduous or careful, but the achieve-
ments cannot be so characterized. As well as distinct task and achievement terms, Ryle also
recognized that some terms could be used in both the task and achievement senses. Ryle
used “observe” as an example, but we might more relevantly consider “recover.” There is,
grammatically, a continuous present tense of recover—like in “I am recovering from drug
addiction,” in which there is no implication that the person “has recovered from drug ad-
diction.” But as well there is a use of recover in which if one is said to have recovered from
a drug addiction, then one’s claim is conceptually mistake-proof. Recovery there refers to
something accomplished or achieved.

Our choice of vocabulary has some significance. As noted earlier, the focus in the
language of cure tends to be on outcomes, even though one may not only be cured as an
outcome but be in the process of being cured. As in the case of remission, so too 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. Recovery is seen as a process that may not
result in achievement and not just as a process that succeeds. Although the logic of recovery
is such that one may speak of recovery as a matter of degree—and even of a distinction
between “partial” and “full” recovery (Dawson et al., 2005)—there is a tendency in the
informal drug user treatment literature to see recovery as being partial rather than as being
full, as being an ongoing process rather than as being a final outcome. Outcome-oriented
researchers however, tend to operationalize recovery in terms of defined period of abstinence
(say, 1 year), a tendency that sits somewhat awkwardly with the idea of chronicity.

Thus, those for whom drug dependency has become burdensome and who have sought
to overcome it are usually said to be “in recovery.” Their recovery is not viewed as an
outcome but as an ongoing process. Like someone whose cancer is in remission, their
recovery is not construed as a “done deal” but as a contingent state of affairs that, without

19 The focus on abstinence is sometimes used discriminatorily. In US disability law, a diagnosed
“alcoholic” does not have to be abstinent in order to qualify for publicly funded vocational rehabilit-
ation programs whereas those who suffer from illicit substance use disorders do. See Magura and

20 For a perceptive critique, see Marshall (1975).
positive measures, could lead to relapse. Indeed, given the conceptualization of SUDs as chronic, those in recovery may be seen as being under permanent threat of relapse or, at the very least, of a lesser “lapse.” The idea of total or complete recovery is marginalized if not excluded. “Full” recovery will include the restoration or re-creation of normal psychosocial functioning but, like remission, will not signal a cure.  

Although those involved in 12-step programs frequently refer to themselves as being “in recovery,” where this refers to an ongoing process, the early AA literature interestingly referred to recovery in the past tense—as something that could be and had been achieved. Indeed, The Big Book (Alcoholics Anonymous World Services, 2001) is subtitled The Story of How Many Thousands of Men and Women Have Recovered From Alcoholism. It is not spoken of as though one was “in remission” in which the progress of a disease was held merely at bay but as something that could be and had been dealt with, with some degree of finality. The assumption—now empirically supported—was that as time went on one would find it easier not to lapse or relapse (Dennis, Scott, Funk, and Foss, 2005; Scott, Foss, and Dennis, 2005).

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. It suggested not only that control had been regained, but that it was also secure. But that, it might be argued, does not mesh with the experience of most who have found themselves dependent on drugs. Because dependence has a significant psychological component, the tendency is chronic, and the process of recovery is usually particularly fraught. A heroin dependent person who has not used the drug for a month is thus said to be in recovery rather than to have recovered. Then, might a person who has not touched the drug for 10 years and who feels no strong urge to do so wish to speak of himself or herself as having recovered? Within the current 12-step community, however, the notion of “finality” tends to be avoided (as in the expression, “My name is . . . , and I am an alcoholic . . . ”) and the preferred language is that of “in long-term recovery” (Faces and Voices of Recovery). What is accepted as the chronicity of SUDs along with stories of relapse sound a permanent warning against the lowering of one’s guard. Insofar as there is achievement, it is the achievement of remission, not of cure.

Thus, 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 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 thought or spoken of as “suffering” from drug addiction. The accepted presumption here is that addiction is a chronic and permanent condition, one that may be brought under control but not one from which one may be cured or fully recover (McLellan, Lewis, O’Brien, and Kleber, 2000). One is, as it were, marked or at least susceptible for life. Similar to remission from 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 but also predisposed to a certain response to the drug in question and must therefore continue to take special steps to ensure that they do not fall under its sway.  

Even if a former drug user no longer feels drawn to the use of the particular drug, his or her susceptibility is presumed to remain, along with ongoing psychosocial

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21Strictly speaking, a chronic condition simply persists over a significant period of time, but in medical contexts it tends to carry the added implication that it cannot be cured (only alleviated). We should be careful, however, not to harden what is at best a contingent distinction (acute/chronic) into an absolute one, especially given the tendency for derogatory socializations such as “once an addict/alcoholic, always an addict/alcoholic.”

22The concepts of vulnerability, predisposition, and susceptibility are hardly perspicuous, and their various dimensions—physiological, social, and psychological—need to be articulated and evaluated.
threats to the stability that has been gained. Unlike other folk, who may be able to consume alcohol or other drugs in an unproblematic way, it is claimed that the formerly dependent user must abstain altogether from its use. And so the person who is in recovery is therefore seen as someone who cannot quite rejoin the ordinary social world of drug consumption but must maintain a special diligence with respect to his or her posited chronic, vulnerable situation. However, a historical review of drug use and of social responses to it should make us a little wary of mystifying the power of drugs and slightly skeptical about a culture of disempowerment of drug users (Brecher and Editors of Consumer Reports Magazine, 1972). Drugs, their effects, and their users are more complex than the social stereotypes that mark our public responses. Although I do not question the good that has been and continues to be associated with both the processes and the outcomes of 12-step programs, I wonder whether they too readily accept and perhaps contribute to stereotypes and the “principles of faith” that we have about the chronicity of drug dependence.23

An ethical question that arises here is whether, in some parts of the drug user recovery world, there may be an implicit—albeit less problematic—kind of dependency in which those who are “in recovery” are now made questionably dependent on the 12-step program/community they have joined. That is, they are led to believe that their continuing recovery requires that they maintain social links with fellow recoverers via ongoing attendance at 12-step program meetings, faithful following of the steps, and the maintenance of a self-image of someone who is powerless before a drug at the same time as the broader culture celebrates the value of predictability and control. Should such a dependency exist, it need not be a deeply problematic one, for 12-step program meetings can provide an important locus and focus of community. Nevertheless, the question should be asked, just as one might want to ask it of the person who remains within a religious community because, “without God, everything is permitted.”

As I’ve suggested, I raise the question more as a question than as a judgment. Clearly the answer is contingent on certain broadly empirical data about dependency—about its nature, necessary conditions, causes, and, to the extent that it is possible, ways in which it may be addressed.24 If, for example, a particular dependency can be strongly associated with a genetically identifiable condition, then, minus certain other factors, someone possessing that condition would have good reason to remain vigilant with respect to the substance to which he or she is vulnerable.25

The ethical question may also point to a certain kind of empirical uncertainty or ignorance—a gap in our knowledge. 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 those dependencies are sufficiently great to make it advisable to continue with “accepted” processes of recovery (such as abstinence, continued attendance at 12-step program meetings, working the “steps,” staying away from old associates, and so forth) as elements within that recovery. In other words, the “promulgation” of certain processes of recovery may be seen as a precautionary device.

23Given that dependency is partly a function of social setting and not simply of physiological (or genetic) predisposition, it is not unreasonable to think that changes in personal skills and social situations might enable people who have experienced periods of dependency on drugs to use them in moderation. I say this without questioning the general practical wisdom of 12-step living.

24There is, of course, then the further issue of transferring such knowledge into actual programs—partly an economic and political problem, partly a reflection of the social communication gaps among researchers, policy makers, and practitioners.

25The reference to “certain other factors” might countenance (future) possibilities such as genetic manipulation or other forms of counteraction that would eliminate the predisposition.
Perhaps the person could drink in moderation but, if we were wrong about it, the consequences would be such as to make it inadvisable. Nevertheless, that judgment presumes a level of risk that would mandate erring on the side of caution. Is that a reasonable presumption? It may be, but it works with an understanding of the consequences of both use and dependency that in some cases (of unknown proportion) may be a function of social responses to drug use as much as to drug use itself (or, perhaps more accurately, to drug use in other social contexts). Why is it that certain “addictive drugs” cause fewer problems when used in medical contexts than when used in some other social contexts? Even when iatrogenic addiction occurs, it tends to follow a very different course from that associated with the same drugs when used illicitly.

Recovery and (Re)Lapse

Is recovery compatible with relapse? At first blush it would appear not. We have already noted the different normative implications of recovery and relapse. Recovery is seen as good and relapse (although often anticipated) as bad. Those who relapse are often said to be those whose efforts at recovery have failed. It may, however, be more complicated than this. Not every recovery is smooth. Recoveries may have different patterns. Setbacks need not doom one but are often expected occurrences along the path to recovery, given what we know about causes and treatment. Someone who is recovering from an operation may encounter, as a common part of the process of recovery, a series of setbacks. The immune system may be compromised; an infection may develop; a wound may reopen; or tissue rejection may begin to occur. The patient may have a bad reaction to one of the drugs that is used. Such occurrences are not only setbacks to the process of recovery but they may also be setbacks in an ongoing process of recovery.

One might reasonably argue that if setbacks can occur as part of the process of recovery from a physical ailment, they will almost certainly occur more often when the malady from which a person is recovering has a strong sociopsychological component. We have a fair bit of evidence that those who are dependent on drugs, both licit and illicit, frequently lapse, even on the path to recovery (Scott et al., 2005). Therefore, should such lapses be integrated into the recovery process rather than being seen as failures in recovery? This is a critical issue, both ethically and for the formation of social policy. Failures undoubtedly occur. But at what point should a lapse or series of lapses be taken to signal failure rather than a “hiccup” in the process of recovery? Might such lapses be the context in which a robust and resilient recovery can take place? Such questions cannot be ignored.

Lapses or (relapses) may be attributable to a variety of factors. One factor will have to do with the nature of the dependency—with its interlocking, physical, psychological, and social factors. If one or the other of these factors is not addressed, it may disrupt progress with respect to the others. Both dependency and recovery are multifactorial. Time spent in a detoxification unit will be wasted if other issues are not addressed. It will not even make someone temporarily abstinent. Often, by the time people accept treatment or the therapeutic options of a 12-step program, they have aggravated whatever originally prompted them into dependency, and will quickly lapse if these are not attended to. They will have lost housing and employment, financial and family support, and moreover, they are likely to have health and psychological problems and a criminal record and suffer from various social and welfare disqualifications (particularly if illicit drug use was involved). Abstinence is only a tiny step if other issues are not also being addressed.

But another important partial explanation of relapse can be provided by the kinds and quality of care that are provided in each case, and those are functions of the social investment
that we are prepared to make in the recovery process. Even at the level of standard health care, some advanced countries, such as the United States, which does not have a tradition of universal health care, have a poor record of publicly available treatment. The situation is worse for disorders that have a strong psychosocial component. Many mental disorders (such as anorexia and Alzheimer’s disease) have only recently been covered by benefit programs—and often inadequately). But in the case of psychosocially related disorders that attract widespread social condemnation—even criminalization—adequate resources and support are less likely to be available. If, moreover, as it is now usually argued, drug dependence is a chronic disorder, which most treatment options cover only in its acute manifestations, it is only to be expected that lapses and relapses will occur. As a society, we accompany strong calls for “recovery” with minimal resources, often treating the problem as though it were basically a function of will or character. We ignore the fact that an unencumbered will is precisely what is lacking.

So, then, might recovery be compatible with (some) lapses? When we look back on individual cases—the cases of those who have shown strong evidence of recovery—we can almost always answer the question affirmatively. Recovery is compatible with lapses. Not all lapses, however, will be compatible with recovery. If, after a reasonable amount of time, lapses have not become less frequent or less serious, we will be inclined to say that there has been no recovery, only relapse. That of course prompts a question about what a “reasonable amount of time” is, especially given the chronicity of dependency. The venerable Solon argued that we should call no one happy until he was dead, the assumption being that a bad death would undercut the judgment of happy life. Should we then withhold the judgment that a lapse is not part of a recovery until (perhaps) death resolves the issue? I suspect not. We should consider lapses as being a part of a recovery when they can be seen as part of a pattern in which they become increasingly rare and/or less serious. If they do not conform to such a pattern, we might then be more inclined to speak of failed attempts at recovery. But we have no right to expect recovery if the resources that might reasonably be expected to treat a disorder possessing significant chronicity are not (made) available or are not easily accessible. What that means in practice is that at the time of its occurrence we may not know whether to see a particular relapse as an element within a process of recovery or as a failure in recovery. How we choose to categorize such a lapse will have important ethical implications. If it is seen as failure we may “give up on” the person, even with a sense that the person has failed us. It may be a self-fulfilling conceptualization: the fear of failure may precipitate it. If, however, lapses are seen instead as a frequent part of a process of recovery, we may treat them as calls for additional or more innovative efforts. Our response to such lapses may thus say more about our social attitudes than about those who have experienced setbacks to their recovery.

There may be strong ethical reasons for construing “recovery” broadly enough to encompass some continued drug use as well as lapses under an ongoing process that will include, for the drug user, the recovery of hope, optimism, a sense of empowerment and control, the restoration or establishment of productive relations and employment, and so forth. Casting recovery so narrowly that it requires resolute abstinence as its precondition will be to ignore its posited chronicity and the vicissitudes of the struggle that recovery usually involves, and it may deny those who wish to recover the opportunities and access that may be important to their ultimate success. This does not gainsay the practical value that a goal of abstinence may have for persons seeking recovery. But if abstinence is made a precondition of recovery then lapses will not be included in a process of recovery.

What may be needed here is a reasonably sophisticated meta-analysis of generalized data that we have on recovery—not merely to track relapse and recovery but also to explore
the variety of causal factors and environmental conditions involved. Such a study would then give rise to more nuanced research into more effective strategies for detecting readiness for recovery, including motivational factors and their preconditions, causes of relapse and effective responses thereto, as well as various endogenous and exogenous “risk factors” supposedly associated with diverse recovery strategies.

**Recovery as an Ethical Ideal**

What is it to speak of recovery as an ethical ideal that we might wish to promote? Ideals may be of various kinds: they may be economic, scientific, legal, 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, as things to strive for though not always accomplished. Thus simplicity as a scientific ideal may lead one to search for explanations that minimize conceptual baggage. Comprehensiveness as a spiritual ideal will lead one to search for holistic meanings. Ethical ideals like honesty or “Do no harm” will function to order our actions. Though distinguishable, these different kinds of adjectival ideal may be congruent or divergent. What we seek to achieve as fairness in ethics, politics, and law may be closely related—and indeed, we may strive to make them perfectly congruent. But the requirements of different domains—the need for bright lines and closure in law or the need to accommodate limited resources and diverse decision makers in politics—may result in divergences.

**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 aspire to the restoration or creation of productive human relationships. Although the moderate use of certain drugs (usually those that are socially accepted and have a long history of being characterized as “recreational drugs”) may sometimes enhance sociality, loosening inhibitions that keep people from engaging with each other in open ways, those who experience or “suffer from” dependency on or addiction to alcohol or narcotics will generally find that their social relations become fragile and impaired. Drug use and social withdrawal or forms of antisocial behavior are often correlated. The crack-addicted mother may tend to neglect her children—not that the crack abstinent mother will necessarily provide healthy mothering and nurture (the issue being one of relative capacity and probability). The alcoholic father will be more likely to fail to provide for his family or become abusive toward his spouse. The heroin addict may be an unreliable employee or friend. We are talking,  

26Perhaps we should think here not of certain drugs as, per se, “recreational” but less tendentiously of “recreational drug use,” that accommodates a wider range of substances (albeit under certain conditions).

27I am of course leaving out of the equation certain social policies that serve to exacerbate the human problems. Nevertheless, I am assuming that even with different policies these dependencies would often be disruptive of socially satisfying relations.

28However, we should not disregard the limited but real helping community that sometimes develops among drug users. A small number of harm reduction based needle exchange programs in the USA, the UK, and Australia have recently begun to train active-injecting drug users in the use of naloxone—which is given to them in packages with syringes—as immediate first aid for someone having an opiate overdose. As a result, lives have been saved.
of course, only about probabilities, although societal attitudes and policies often serve to increase them. In the context of drug dependency, then, recovery will constitute an ethical ideal insofar as it helps to reinstate the person in recovery within the realm of satisfying and productive social exchanges. Of course, recovery per se may not be enough. A person in recovery may still experience and/or manifest serious relational problems that are quite independent of drug use. Not all relational failures are precipitated or even worsened by drug use, and it is possible—though probably not common—that recovery may open the door to other failings.

Second, although the primary domain of the ethical is that of the interpersonal, it is also concerned with what might be called strength or excellence of character—with the stable 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 are often considered to have ceded some measure of control over their lives—though whether that is actually so is a matter of some debate. The conventional wisdom, however, no doubt true in some cases, is that their autonomy is compromised, and with that, their dignity is often 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—some drug dependency is frequently associated with a loss of dignity on the part of the drug user, as decisions are increasingly determined by the need for the drug in question. No doubt 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 distort one’s appreciation of outside stimuli and of the ongoing requirements of the business of living. Neither the opium den nor the passed out drunk or “stoned” student represents a particularly engaging expression of human life. Recovery, then, to the extent that it involves a recovery of control over one’s inner domain, one’s presentation and self-presentation, constitutes an ethical ideal. It is usually a step on the way to becoming a free being.

Conclusion

How we construe recovery is not a simple matter of scientific definition but also a matter of social choice—ideally, the choice of reasonable people who are able to accommodate the interests of various stakeholders. In important respects, recovery is a normative concept, and the ways in which it is currently construed by social decision makers have colored—often cruelly, dehumanizingly, and discriminatorily—our policies and investments with respect to regulation, resourcing, treatment, and mutual self-help therapies and have affected our attitudes to those who often struggle with the effects of psychoactive substances on which they have become dependent. Indeed, we have for the most part given only an afterthought to recovery, focusing instead on what is deemed to be the social unacceptability and disruptiveness of “drugs,” their users, and “addiction.” We have warred without considering what makes for peace. And we have warred on a population, not on drugs.

For the most part, our society has focused its attention inappropriately, defining “the problem” and its solutions too narrowly, too tribally, with the result that we have...
differentiated ourselves from “the others” in our midst, thanking God that we are not as
they. It would be not only be more humane but also more in keeping with the egalitarian
recognition that we are all vulnerable in certain ways if we use “recovery” from SUDs
to refer not simply and maybe not even necessarily to the requirement of abstinence and
sobriety but more centrally to an overall positive trajectory in which a person can gain
increasing influence over the key elements of his or her life. True, that may often involve
or require sobriety and abstinence, but, because the path to recovery is often fraught with
lapses, we would do well not to build it into our understanding of recovery as its primary
focus.

As a matter of social policy, it becomes increasingly important that we not only abandon
our almost undifferentiated concern with “drugs”—even with the distinction between “licit”
and “illicit” drugs—but also instead integrate into our social policies the knowledge we have
of the ways in which different psychoactive substances act and the contexts in which they
have their varied effects and the problems that may sometimes ensue and develop responses
to those problems that are both realistic and humane.30 However soft the distinction is
between acute and chronic illnesses, drug dependencies more often tend to be placed at the
chronic pole, and we have an ethical obligation to develop social, treatment, and resource
responses that acknowledge this reality. It is not good enough—in effect—to say to a person
who has lapsed, “You’ve blown your chances; you’re out!” when the problem is because of
its nature one that persists.31

RÉSUMÉ

La Désintoxication en tant qu’Idéale Morale

Cet article explore les implications des termes ‘remède,’ ‘guérison’ et ‘récupération’ pour les
personnes atteintes de toxicomanie et s’interroge sur le fait que la récupération est souvent
le terme privilégié dans les cas de dépendance médicalisée. Les aspects aussi bien négatifs
que positifs de la récupération sont soulignés, les défis éthiques de nature principalement
procédurale sont examinés et les aspects liés à la politique sont signalés.

RESUMEN

La Recuperación como ideal ético

Este ensayo explora las implicaciones variadas de la cura, curación, y recuperación, y
considera la razón de por qué la recuperación es muchas veces la caracterización preferida
en relación a la dependencia medicalizada de la droga. Se notan tanto las dimensiones
positivas como las negativas de la recuperación, se investigan los desafíos éticos y las
asociaciones principalmente de proceso de la recuperación, y se indican unas implicaciones
para la política.

30The US. Supreme Court notwithstanding (United States v. Oakland Cannabis Buyers’ Coop-
erative et al., 532 U.S. 483 [2001]), it is unconscionable that our exaggerated social response to
marijuana should flow over into our policies regarding its medical use.

31I am grateful to Stanley Einstein and Alexandre Laudet for provocative comments on a draft of
this essay. Like all good editors, not only have they prompted better answers but also more questions
than those for which I have answers. Andrew Long provided valuable research assistance.
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Glossary

Burdensomeness: The onerousness attaching to a form of behavior or condition. In the present context, it refers to the negative value that drug use has come to have primarily for the user, though it may be extended to encompass its onerousness for others.

Drug dependence: Variously understood, often pejoratively, and sometimes distinguished from “habituation” and “addiction,” it is here understood broadly as an almost uncontrollable need to engage in some activity (not necessarily involving a psychoactive substance), even at a risk of significant harm to oneself.

Normative concept: Usually contrasted with descriptive concept, a normative one can be explicated only by reference to certain embedded values. They need not be—though often are—ethical values.

Recovery: A process or outcome in which a disabling burden is overcome and an affirmative state of being or wellness is established.

Sexual “addictions”: A significant inability to control sexual desire, whether expressed in sexual contact, viewing pornography, or other forms of sexual expression.

A 12-step program: Generic name for a set of self-help understandings and mutual practices based on those originally developed for AA.

References


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