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Published online: 06 Oct 2014.

To cite this article: Izaak L. Williams (2014) Drug Treatment Graduation Ceremonies: It's Time to Put This Long-Cherished Tradition to Rest, Alcoholism Treatment Quarterly, 32:4, 445-457

To link to this article: http://dx.doi.org/10.1080/07347324.2014.952995

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PERSPECTIVES

Drug Treatment Graduation Ceremonies: It’s Time to Put This Long-Cherished Tradition to Rest

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Over past decades, graduation ceremonies have become a prominent, long-standing, traditional centerpiece of substance use disorder treatment programs and settings. In total, graduations provide clients with a platform to look back at their time in treatment, consider the things they’ll take away from that experience, and voice the particularities of their own personhood (“my addict personality” or “parts of the old me”) that they wish to symbolically bury and “leave behind.” As such, graduation ceremonies are celebratory in nature and socially reinforce milestones, accomplishments, and memories of clients’ journeys in treatment recovery. However, lack of survey data on client and professional perceptions of graduation ceremonies, in combination with the virtually nonexistent body of evidence on how they affect the recovery process, raise provocative and potent questions about how this tradition has perpetuated itself throughout treatment practices. This article explores the place and orientation of graduation ceremonies as part of the therapeutic context of treatment and recovery. Challenging the apparent taboo against questioning such ceremonies permits new suggestions for how treatment staff and clients might proceed with graduation ceremonies in the future.

KEYWORDS Graduation ceremonies, recovery management, drug treatment, substance abuse, performance measures, acute care, commencement

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Today, graduation ceremonies are a near-universal centerpiece of substance use disorder treatment, a tradition often considered sacrosanct. Despite the ubiquity of this attitude, however, I can confidently state the belief in the efficacy of graduation ceremonies is anything but universal. A critical mass of professionals in the field of addiction prevention and treatment have questioned, at one point or another in their career, why treatment programs continue to hold graduation ceremonies for their clients. But because open discussion of the topic can be taboo in treatment settings, for more than a few professionals such questioning only takes place behind closed doors, for fear of being branded “anticlient.”

There are, to be sure, treatment settings that permit intellectual honesty and discourage disingenuous posturing on the subject. At such settings, a reservoir of open conversation on graduation channels into staff and board meetings, but these are likely rare. Given that graduation is a treatment industry norm, it is most probably the case that in far too many treatment settings, discussion remains unheard. Compounding this, there is an unfortunate lack of survey data on client and professional perceptions of graduation ceremonies. But guided by a body of anecdotal evidence, I believe it is imperative to raise provocative and potent questions about treatment systems’ practice and perpetuation of the tradition of graduation ceremonies.

THE PROBLEMATIC SEMANTICS OF GRADUATION

Treatment systems have adapted the lexicon of academia into their everyday operations, occasionally with quite problematic results. The term graduation is one such example. Graduation implies completion, which in turn denotes wholeness or the acquisition of everything needed for a purpose. Similarly, the term commencement (also known as an “exit ritual”) is yet another example in the realm of higher education that denotes “completion” of academic requirements and signals the conclusion of students’ academic careers, and the “special attention paid to honor students symbolizes the institution’s desire to recognize and reward its best and brightest” (Magolda, 2003, p. 787). In effect, the commencement rhetoric would seem to communicate and “prime” certain expectations, norms, images, ideas, and prescriptions—a symbolic message—that may be erroneously transported and applied to the realm of treatment. This is because “the treatment of addictions of high severity, complexity and chronicity [are] patterns that dominate admissions to specialized addiction treatment units” (White, 2014). So unlike a single episode of completing a degree program, the normative pattern of treatment careers of persons in recovery span multiple rounds of program treatment, indicating a “cumulative and facilitative effect” (Hser, Anglin, Grella, Longshore, & Prendergast, 1997, p. 543) on the process of stabilizing
Drug Treatment Graduation Ceremonies

and sustaining long-term recovery initiation and maintenance, respectively (Dennis, Scott, Funk, & Foss, 2005).

In addition, commencement in addiction treatment can be interpreted as completion of treatment requirements. That is, program staff monitor compliance or encourage clients to maintain a compliant-orientated stance in order to graduate or participate in the commencement ceremony. When program staff accord conformity expectations to clients' participation in treatment:

compliance with program goals, rules and norms remains a major focus of treatment. [This] overemphasis on compliance to program rules, norms and assignments overshadows a person-centered, assessment-based, outcomes-driven approach. Lasting change is then compromised. (Mee-Lee, 2013)

Thus when commencement and graduation are used in the context of a client's formal relationship with a treatment setting, wordplay and meaning are critically important barometers of a client's treatment prognosis and to ending his or her treatment term. Treatment staff transmitting the term graduation or commencement essentially declare the client leaves treatment equipped with all the necessary tools and resources to maintain lifelong recovery. It goes without saying, given the complexity of underlying issues that fuel an immensely sophisticated biopsychosocial disorder like addiction, that such an approach, even in implication alone, is highly problematic (Humphreys & McLellan, 2011). Even the term treatment program expresses similar problems:

It is artificial and restrictive, and erroneously implies complete care. It leads to the concept of continuum of care to not exist in treatment [because it permits us not] to think of outpatient as a level of care, [but rather] a definitive treatment that would not be tolerated for other psychiatric or behavioral disorders. (M. Willenbring, personal correspondence, June 17, 2013)

This parlance is one element of a broader philosophical misconception that treatment is the central pathway to recovery and entirely accountable for it. Graduation ceremonies contribute to the impression “that ‘cure’ has occurred: long-term recovery is now self-sustainable without ongoing professional assistance” (White & McLellan, 2008, p. 4). Although it can be a critical element of the recovery process, “treatment interacts with the process of self-change and seems to be a time-limited event in the course of the larger self-change process” (DiClemente, 2006, p. 95). This is because recovery in-and-of-itself is a long-term natural process of self-change in which treatment plays a partial role. “In this perspective, treatment is an adjunct to self-change rather than the other way around” (DiClemente, 2006, p. 91). Thus graduation would imply that treatment is:
the foundation of the recovery process . . . [and belies] . . . the perspective that takes natural change seriously . . . [as it fails to] shift the focus from an overemphasis on interventions and treatments and give[s] increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connections with associated problems, and his or her stage of change. (DiClemente, 2006, p. 95)

GRADUATION’S EFFECT ON RECOVERY, SOBRIETY, ABSTINENCE, AND TREATMENT

Graduation ceremonies can incorrectly redefine clients’ understanding of the nature and dynamics of addiction. The concept of “graduating” treatment can encourage clients to believe that they have graduated from treatment intervention as well as long-term recovery management, which only adds to the confusion around the meanings of recovery, treatment, abstinence, and sobriety. Blurring the distinction between these terms similarly affects the distinction between a client who has worked diligently on building a strong personal recovery program and a client who is willfully disinterested in doing treatment or only going through the motions in cursory fashion.

Graduation ceremonies further obscure the chronic nature of psychiatric disorders. As Mee-Lee (2011) pointedly asked, “How do we teach about the chronic nature of addiction illness when our language contradicts? We never speak of ‘completing’ the schizophrenic or bipolar disorder program; or ‘graduating’ from the diabetes, asthma or hypertension program?” Indeed, one can interpret graduation ceremonies as contradicting the fundamental assumption of the disease model of addiction. The concept of graduation also poses issues for other theories and models of addiction, with the choice model being the notable mainstream exception.

The concept of graduation makes the transition out of treatment appear as the completion of substance use disorder recovery; despite the accepted wisdom that recovery is a lifelong process from which one never truly “graduates” (Laudet, 2007). What happens, then, when a client relapses shortly after graduating? This may be traumatic enough alone, but relapse can be even more demoralizing for clients who lack the necessary replacement skills, rethinking patterns, resources, and recovery behaviors. For other clients, graduation can engender an overblown sense of self-esteem and confidence, which tends to constitute a psychological setup for relapse. As disheartening an experience as it may be, it follows that return to drug use after graduating would likely increase the level and intensity of stigma a client experienced (Luoma et al., 2007).

Still treatment “programs” that “graduate” clients are in essence telling the world that their service delivery is the best match of program character-
istics and tailor-made treatment approaches, principles, and modalities with
the individual, in an all-encompassing fashion that may include pharmacological therapies and medication-assisted treatment to thoroughly address multiple, complex, and interrelated drug use disorder needs and broader, deeply underlying or associative issues accompanying the addiction.

USING GRADUATION TO TREAT DRUG USE AND
FRAME A CLIENT’S LEVEL OF CARE

When treatment staff employ the concept of graduation, they can easily
become misguided in framing and understanding the dimensions of relapse
and dynamics of continued drug use, causing unnecessary problems for
the therapeutic process. For example, this comes across in treatment staff
discussions surrounding a relapse, especially that of a client on the verge
of the graduation spectacle, in the following type of moralizing statements:
We shouldn’t graduate ‘client A’ because he/she relapsed again.” Or “as
the client’s primary counselor, it would be unethical to allow ‘client B’
to graduate.” “If ‘client C’ did graduate it would be a ‘slap in the face’
to graduating clients who have managed to stay clean and sober.” And
“The graduation ceremony will lose its integrity and its reputation in the
community will be damaged if this agency decides to graduate clients who
use drugs just weeks before graduation.”

First, such claims lack clinical reasoning and in emphasis are motivated
more by emotional and political concerns than care for clients. Secondly,
these judgmental phrases suggest that clients can simply exercise willpower
and volitional control over drug use (a derivative of the choice or moral
model of addiction). In terms of language, virtually implying “a connotation
of failure, weakness and shame, of having fallen from a state of grace. Such
overtones are likely to compromise self-regard and add needless affective
meaning to what is a rather common behavioral event” (Miller, 1996, p. S25)

Moreover, graduation demarcates recovery as an all/or nothing pheno-
menon that “equate[s] health with the absence of relapse” (Miller, 1996,
p. S25), which is an aspect of a decades-old cognitive paradigm that has
grown out of sync with the very complex conception of addiction phe-
nomena in the most effective contemporary treatment programs. In effect,
treatment staff:

… blame the patient for relapsing. In addition to that moralistic over-
tone, the very term “relapse” implies that there are only two possible
states: “clean” and “dirty,” “sober” and “relapsed.” Ironically, the very
concept of “relapse” implies the black-and-white thinking that “relapse
prevention” is meant to undo. If you use, you have “relapsed,” are no
longer in recovery and the clock starts over.” (White, 2012)
However, relapse or continued drug use is not a dark abyss, not necessarily disastrous. But the concept of graduation enables a cognitive paradigm that considers drug use worthy of punishment, a signal that the client is inherently unreceptive to treatment and possesses a subpar personal recovery program. Thus a “relapsed” client is found wanting in comparison to the soon-to-be “graduating” client who has not yet relapsed. Hence, “we can’t possibly graduate the relapsed client so soon to graduation” from the “gatekeepers of the realm” of graduation ceremonies. That myopic position does not permit natural consequential responses to drug use like the abstinence violation effect, increase in treatment monitoring, or addressing the flared up symptom(s) of relapse in a therapeutically fashionable way. Instead of addressing relapse through these established formal therapeutic channels including proper assessment and treatment planning (that in part might “aim to improve the quality of the client’s relationships, employment, social support network and leisure time activities,” Miller, 1996, p. S25), the concept of graduation constitutes an addiction paradigm that yokes a client to an arbitrary “treatment” timeline, that is, scheduled graduation. Here the graduation paradigm subordinates psychosocial functioning, actual progress, and behavioral outcomes after the relapse to moving through a program’s levels of care in a timely manner.

Of course, completing a treatment program within a limited time frame is marginally related to the recovery process and has little—if any related—bearing on a client’s actual state of addiction therapy or trajectory of outcome status. Treatment staff who think according to the graduation paradigm will automatically assume that the client’s treatment should default to a higher level of care after relapsing, or even advocate that the client restart a particular level of care. Yet

to simply wash, rinse, and repeat a lapser could possibly be an overuse of resources. If it were any other disease, the treatment would not be to start medication all over again, it would be to address the addiction flare up until symptoms subside to get the healing process back on track. (L. Burgess, personal correspondence, June 13, 2013)

However, the concept of graduation frames the discussion of drug use and how to address it in a manner typically laden with value judgments, coercive control, punitive blame, and false consequences to preserve its supposed integrity.

Portraying the punishment of a relapsed client as therapeutic is a confusion that reasserts the old-fashioned prejudice that “addicts” are more apt to learn the “hard way” through experiencing increased personal hardship and “hitting rock bottom.” From this line of thought it follows then that only a hardline approach to consequences while in treatment, such as the termination of service delivery or prolonging a stay at a particular care level as a form of behavioral control, which easily turns treatment into a form of punishment for drug use, can straighten out the relapsed “addict.”
Mee-Lee (2012) offered astute clinical insight as to why a client who relapsed before graduation should not be penalized in the name of “treatment” by prolonging “completion” of their treatment term:

If the focus is on function, progress and outcomes, our vocabulary shifts to “transferring” or “linking” people to the next level of care rather than “completing” people from a program or level of care. As with any other ongoing, potentially relapsing illness, in addiction we also place clients in whatever level of care matches their severity of illness and level of function. When to transfer? Answer: it depends on their progress and outcome in the level of care to which they were admitted. It is not then a matter of “completing them in the program” at a certain point in their Stages of Change. It involves transferring them to whatever level is the least intensive level, which can safely provide the services they need.

He offers the following example:

A person may have been active in AA, been ready to embrace recovery, but relapsed and needed Level II.1, Intensive Outpatient (IOP) to help get back on track. If she/he is stable and doing well even after a week in II.1, and was ready to get back to their home AA group, that client is ready to be transferred to Level I, Outpatient services. There, they can safely receive more clinical monitoring to supplement their AA attendance. They wouldn’t need to be in IOP for two or three months. (Mee-Lee, 2012)

GRADUATION AS A MEASURE OF PROGRAM SUCCESS AND EFFECTIVENESS

By their very celebratory nature, graduation ceremonies offer treatment systems an often-irresistible opportunity to showcase and promote their services as well as a dedicated time for graduates to “thank us” treatment staff for our hard “conversion” work in clients’ (“transformational”) “change.” Many treatment systems tout their graduation rate as evidence of effective and successful treatment without evidence that increased retention produces better client outcomes (Humphreys, 2013). Funding considerations further compound matters. Funding for, and more generally evaluation of, treatment programs has become heavily weighted toward increasing the number of clients who receive service delivery, with graduation being one of the gold standards of measurement.

Graduation puts far too much emphasis on “making it all the way through” the system, on touting the timing-out of the client as a “success,” as if this was a determining factor and predictor of success in recovery. The unavoidable by-product of this emphasis is the implication that clients who do not make it all the way through to graduation are considered a treatment failure. However, as Mitchell et al. (2011) suggested:
Programs may benefit from redefining their meaning of “retention” so that the goals of patients and care providers can be realigned. When retention is viewed in terms of staying in treatment rather than time spent within a single treatment program, and the outcome of treatment is considered as an accumulation of these treatment experiences, new understandings of treatment progress emerge. (p. 106)

Moreover, to measure treatment success by the yardstick of relapse is highly problematic, because relapse reflects the habitual and biochemical nature of substance use addiction. In addition, relapse can produce therapeutic benefits such as a residual opportunity to critique a client’s addiction and aspects of their recovery, repair complacency in treatment, foster awareness of the relapse cycle, and a client’s personal dynamics of addiction, cultivate continued emotional growth, develop maturity in the application of recovery tools, learn lessons that would prevent future relapse. Thus, the more important issue is the long-term direction of the client after drug use, which is not inevitably down the path of progressive deterioration.

A recovery management perspective characterizes relapse as one developmental task in a recovery characterized in terms of the general stages of a time-dependent process. Using such models diminishes the risk of future lifetime relapse to below 15% after 4 to 5 years (White & Kelly, 2011b). Graduation ceremonies, in contrast, can produce a misconstrued perception about the very nature of addiction, one that may even threaten to eclipse a client’s success story. Measuring treatment success based on graduation rate is misguided because many clients return to treatment in a longer narrative of ultimate recovery. Along the way, they make gains, earn insights, and implement changes, all of which accumulate and rollover into subsequent treatment episodes as part of a long-term recovery process (McLellan, Lewis, O’Brien, & Kleber, 2000). Yet treatment centers have been known to stake a wholesale claim on clients’ transformations as if due to a distinct treatment experience, and even to take credit for why clients are “doing well” in their treatment program.

Take, for example, a female client discharged from a treatment center for displaying aggressive behavior attributed to an “anger problem.” The client then enrolls in a different treatment center, where she comes to view her earlier discharge as a turning point in her recovery. The discharge is the trigger that “made something click” and leads her to work diligently on her anger problem and to internalize anger control strategies for the first time. Toward the end of her treatment term, she attributes her success in managing her anger to the discharge she received from her previous treatment episode.

Clients who “volunteer” themselves for public-sector substance use disorder treatment offer another example. Clients do not necessarily stick around for the treatment center itself but rather to gain favor with individuals in their life who have demanded or incentivized their “graduation” from treatment.
Clients in public treatment often enter through the funnel of the judicial system (Substance Abuse and Mental Health Services Administration, 2014), either as a bargain to avoid jail time, or under coercion from a court or probation officer. Clients are emotionally manipulated by fear of punishment and prolonged loss of freedom. Fear of returning to jail for violating the terms of probation is often a determining factor in motivating clients away from dropping out of treatment and toward full “completion” of a program (Perron & Bright, 2008).

Moreover, some treatment systems exaggerate and misrepresent the potency of their own program’s effects that actually came from other factors than treatment, per se. Such treatment systems subsume all positive client outcomes under the umbrella of their programs, as if the treatment system has devised a rigorous methodology for distinguishing the particular impact of clinical interventions and procedures from any other factor. The grounds of such illegitimate credit include (1) overlooking client response bias in self-reports that artificially amplify the overall impact of treatment; (2) overestimating or over-reporting symptomatology resulting in exaggerated clinical severity and the superficial appearance of greater change once follow-up assessments produce a more accurate self-report; (3) negating natural regression to the mean improvement or remission of symptomatology simply from passage of time; (4) obscuring the impact of support services clients seek outside of treatment such as case management, therapy, couples counseling, pharmacotherapy etc.; (5) omitting therapeutic affect of client–peer group interactions, social networks, and social affiliations outside of treatment; (6) neglecting the placebo effect in the counselor-client relationship vis-à-vis the benefit of merely receiving attention and misattributing therapeutic gains to treatment interventions; and (7) ignoring the process of organic trial-and-error learning independent of treatment that naturally leads to improvement and change unfolding over time (Bootzin & Caspi, 2002; Davis, 2002; Novella, 2010; Siegel, 2002). Nonetheless, treatment systems more often than not take full credit for clients’ timing out of their programs and hail their clients’ graduation as evidence of successful treatment.

INSURANCE PROVIDERS’ IMPACT ON GRADUATION

The modern treatment structure with its graduation ceremonies is in many ways guided by insurance providers. The insurance-friendly treatment process usually starts with a client receiving a particular level of care and then being offered a lower intensity of care that is more structurally lax, lower in treatment dosage, and far shorter than required, imposing critical restrictions on longitudinal case care monitoring and limiting care delivery (McLellan et al., 2000). The amount of time a client spends at a particular level of care is arbitrarily dictated by the severely limited amount of time for
which insurance companies make funding available. “An acute-care model of intervention characterized by a single episode of self-contained and unlinked intervention focused on symptom reduction and delivered within a short timeframe” (White & Kelly, 2011a, p. 1).

In such a system, treatment providers risk economic loss when professionals take liberties in moving their clients between levels of care, whether for reasons of progress or their completion of treatment plan goals. The economic priorities of insurance companies incentivize developing a treatment process like an assembly line in which counselors are heavily weighted with burdensome caseloads that degrade the overall treatment quality. Bluntly, client-driven treatment can be bad for business. The system’s framework penalizes treatment providers for accurately placing, moving, and withholding changes in a patient’s level of care that run counter to guidelines of insurance providers. Here, again, Mee-Lee’s (2011) observation is instructive:

For some clients, the unintended negative consequence is that they focus on “doing their time” in the program rather than “doing treatment.” We want their energy to be on taking responsibility to track their improvement in function, not their compliance with a predetermined length of stay.

**DISCUSSION**

I do not wish to discount, discredit, or otherwise diminish in any way the subjective feelings of clients responding to their circumstances and honestly working to meet the expectations of the public spectacle that is their graduation ceremony. Nonetheless, I argue that a graduation certificate has no value other than as verification of being exposed to treatment. A graduation ceremony is a celebration that generates plenty of feel-good emotions, among clients and among attending family members and treatment staff. But its impact beyond graduation is debatable. Treatment completion ceremonies are supposed to strengthen a client’s commitment to personal recovery, even if only momentarily, but there is scant data on long-term posttreatment quality-of-life indicators to back up the claim that “graduates” have better long-term outcomes than nongraduate treatment “completers.”

The data on posttreatment return episodes hang ominously over graduation ceremonies, and the facts do not speak well for this model. “The majority (64%) of persons entering addiction treatment in the USA already have one or more prior treatment episodes, including 22% with three or four prior admissions and 19% with five or more prior admissions” (White & Kelly, 2011a, p. 68). The number of clients who return to treatment after “completing” or “graduating” tells a somber story about addiction treatment that graduation ceremonies fail to capture. In tone and spirit, the therapeutic
legitimacy of graduation ceremonies is, at a minimum, highly questionable and seems to be anything but auspicious (Humphreys & McLellan, 2011). The necessity of any type of large ceremony is hardly a given.

Any kind of pageantry, particularly for meth addicts, may in fact feed into a predilection for bravado, ultimately reinforcing primal and midbrain functioning that heightens the risk of relapse, both on the day of graduation and in subsequent weeks. (A. Nunnari, personal correspondence, June 4, 2013)

And though great significance has traditionally been placed on termination during therapy, such an emphasis has been driven by clients’ wishes. As has been widely observed, clients’ graduation speeches often gloss over the things they intend to work on in their ongoing recovery. Such speeches show a lack of reflection and forward planning in recovery, a byproduct of the fact that graduations “tend to signal an ending rather than a beginning [with focus] on one’s past life in addiction or what one experienced in treatment” (W. White, personal correspondence, June 10, 2013).

Additionally, the amount of time, energy and effort that clients and staff channel into preparing and executing graduation ceremonies assigns them excess meaning and value, which runs the risk of overshadowing a message and expectation regarding a solidly constructed Continuing Care (CC) transition plan for recovery maintenance after treatment. In the weeks leading up to graduation ceremonies, clients are often observed being so worried, stressed, and excited about “graduating” from treatment as to overshadow its more important aspects. Substance use disorder treatment graduations are, by definition, part of treatment and so should have a clear and intentional therapeutic value. As White suggested, “The creation of a recovery plan directed to the future, [including] what is required and what it means to achieve long-term recovery, signals the beginning of a life in recovery within the community” (W. White, personal correspondence, June 10, 2013).

Why not, then, rebrand, reformat, and convert graduation ceremonies as a “life in recovery transition day” centered on the sharing of a solid, longitudinal, community-based Continuing Care Recovery Plan (CCRP) in supporting the later stages of recovery? Why not symbolically enlarge a CCRP for a client’s intimate support system—a network of family, friends, and sponsor, all in attendance to share, build, and cement the bonds to transition? Why not build a CCRP that guides a client toward fully understanding his or her progress, present recovery issues, and “posttreatment” recovery efforts?

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