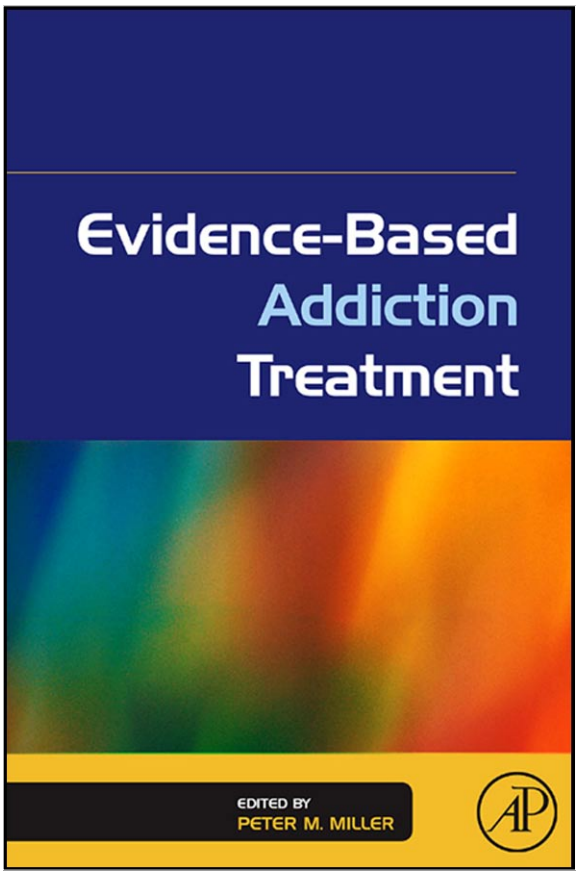

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Chapter | fourteen

How Much Treatment Does a Person Need? Self-Change and the Treatment System

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SUMMARY POINTS

- Treatment programs usually reach only a small fraction of their potential target groups. The assumption that change from addictive behaviors occurs within a wider framework than just professional treatment has received broad support. An analysis of the interface between professional and lay referral systems highlights the need to learn more about the large group of people who refused to accept professional help to solve their addiction problem.
- The traditional concept that resolution of addiction problems can be achieved only by abstinence is no longer tenable given the research findings on self-change and from large longitudinal surveys. The pursuit of low-risk drinking behavior has been shown to be the most frequent self-change strategy.
- The majority of addiction self-change studies indicate a better chance of natural recovery among less severe cases even though survey results show a 25% self-change rate (abstinence or low-risk drinking) also among DSM-IV-dependent cases. Cognitive appraisal and

decisional balancing processes have turned out to be "the motor of self-change" mediated by societal conditions. Maintenance of self-change is much more likely with social support from friends and family combined with a change of lifestyle in which risky behaviors lose their appeal.

- From a sociological point of view, the likelihood of self-change depends, among other factors, on the social stigmatization of addictive behaviors, media portrayals of the nature of addiction, population attitudes about the changeability of misuse and dependency, the availability of drugs, and the makeup of the treatment system.
- Clinicians are still needed and can assist self-change by minimal interventions and/or by facilitating individual appraisal processes. More specifically, therapists may assist self-change by helping set realistic objectives of change. Self-change research also informs treatment providers about the reasons why their programs are not accepted and helps them adopt a more consumer-oriented perspective.
- From a policy point of view, the frequent occurrence of self-change, coupled with the general public's lack of awareness of such recoveries, suggests that disseminating knowledge about the prevalence of self-change could be a type of intervention itself. Individuals who have achieved self-recoveries could make public declarations in order to encourage others to try the self-change process.
- Future research direction perspectives include the use of detailed case analysis to determine if lay strategies may be used in professional settings. This strategy would require an ongoing dialogue between researchers and treatment providers. Prospective longitudinal studies, including control group designs, are needed. Finally, qualitative and quantitative research strategies must be combined in a meaningful way.

PROFESSIONAL HELP AND LAY HELP—TREATMENT SYSTEMS IN CRISIS

In the recent past, addiction treatment systems have come under increasing pressure to legitimize their function and to prove their efficacy and efficiency. Treatment programs usually reach only a small fraction of their potential target groups. The assumption that change from addictive behaviors occurs within a wider framework than just professional treatment has received broad support, most recently from studies based on data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (Cohen, Feinn, Arias, & Kranzler, 2007; Dawson et al., 2005; Dawson, Goldstein, & Grant, 2007; Dawson, Grant, Stinson, & Chou, 2006).

The NESARC sample consisted of 4422 individuals with prior-to-past year onset of DSM-IV alcohol dependence of which only one-quarter reported ever having sought help for alcohol problems. Approximately half of all recoveries were achieved via low-risk drinking rather than abstinence, thus questioning the traditional focus of treatment on chronic, severely dependent cases with abstinence as the only treatment goal. A return to low-risk drinking was far more common among those who recovered without treatment. Finally, in the year of the study, 28% of treated individuals compared to 24% of those who were "never treated" were still dependent (Dawson et al., 2005). However, conclusions based on these findings must be interpreted cautiously, as only prospective studies controlling for background characteristics of the study group would allow definitive conclusions about treatment effectiveness. The NESARC study leads to the notion that various degrees of use, misuse, and addiction must be linked to a treatment continuum ranging from unassisted individual change to residential specialized addiction clinics. At the same time, a range of outcome goals including abstinence as only one among various pathways out of addiction should be taken into consideration. Prominent examples of flexible treatment goals include adoption of the harm reduction approach—initially applied to illicit drug consumption only—in the area of licit drugs (see Klingemann, 2006) and the growing acceptance of controlled drinking programs (see Klingemann & Rosenberg 2009; Koerkel, 2006; Rosenberg & Melville, 2005), as well as moderation management approaches in some countries.

Faced with empirical evidence showing the efficiency of short-term, minimal interventions, inpatient programs in particular have come under increasing pressure. From an international perspective, the expansion of welfare-oriented provision of treatment has come to a halt in the 1980s and has been replaced by an increased emphasis on efficiency, cost control, and evidence-based treatments (Trinder & Reynolds, 2003). This change was accompanied by an increasing acceleration in the treatment system (Klingemann, 2000). However, the attempt to legitimize and promote addiction treatment by emphasizing its scientific basis has not led to a better outreach and acceptance of treatment. The programmatic challenge of evidence-based action has not been adopted in the daily business of addiction treatment. Furthermore, the inherent logic of empirical science implies that more findings often lead to more ambivalence and insecurity. Continuous criticism of available research findings is the driving force of science, although it increases ambivalence in professional practice (Beck, 1999; Cottorell, 1999; Klingemann & Bergmark, 2006).

Currently, treatment systems are challenged by a dwindling trust in expert knowledge, together with an increasing belief in an individual's ability to cope with problems using lay knowledge (Blendon & Benson, 2001; Brooks & Cheng, 2001). The broad acceptance of complementary

and alternative medicine in the health care system illustrates this point (Easthope, Tranter, & Gill, 2000; Eisenberg et al., 1993; Furnam & Lovett, 2001). Back in the 1960s the medical sociologist Freidson (1960, 1961) pointed out that professional problem solutions compete with everyday theories and lay wisdom when people are trying to solve their problems or want to bring about change. Lay theories are often highly complex and not necessarily less useful than knowledge produced by science (see, for example, Ogborne and Smart, 2001, on the perception of moderate drinking or Furnham and Lowick, 1984, on lay theories on "alcoholism").

Keeping these societal changes in mind, the current crisis in addiction treatment systems appears to be caused by an insufficient adaptation of clinical treatment options to potential customers' needs. Expressed differently, treatment programs might not be customized to what the potential patient wants, leading to low levels of acceptance by potential consumers of the services.

An analysis of the interface between professional and lay referral systems highlights the need to learn more about the large group of people who refuse to accept professional help to solve their addiction problem. The focus of treatment research on easy-to-reach clinical populations is one of the reasons that has kept us from progressing in this area, as Orford has argued in his review entitled "Asking the right questions the right way: The need for a shift in research on psychological treatments for addiction." Increased attention to change processes as a dynamic interaction between treatment provider and patient in both clinical and nonclinical populations is at the heart of a reorientation of research in this area (Orford, 2008).

Among the key issues to be addressed are the following.

- What are the barriers keeping individuals from treatment seeking? Are we able to replicate and adopt lay strategies of quitting in professional settings?
- Which strategies of change are chosen when people with addiction problems do not rely on expert help?
- How do substance users incorporate offers of minimal intervention by professionals into their individual change process?
- What can professional treatment providers learn from laypeople changing on their own?

SELF-ORGANIZED QUITTING, SELF-CHANGE FROM ADDICTIVE BEHAVIORS

What is self-change?

The use of the term "self-change" or "spontaneous remission" is by no means restricted to addictions. Clinically, "spontaneous remission" occurs

when an improvement in the state of the patient in the absence of effective treatment can be observed (Roizen, Cahalan, & Shanks, 1978). Working definitions in psychology emphasize cognitive elements of a self-initiated recovery or change in behavior (Biernacki, 1986). The sociological perspective conceptualizes self-change as quitting or interrupting a deviant pattern without formal interventions (Stall, 1983) and/or the mobilization of external resources or social capital ("self-organized quitting"). Working definitions for research typically define self-change by referring to a change in consumption behavior—or not meeting diagnostic criteria for dependence such as DSM-IV any longer—which has been accomplished without professional help or self-help groups within various time frames (e.g., John, 1982). A period of 5 years of remission is considered a relatively stable change (Bischof, Rumpf, Meyer, Hapke, & John, 2007).

Self-change research and the disease concept

The idea that the majority of problem alcohol or drug users give up their problem consumption without massive professional support usually meets with skepticism among both treatment professionals and the general population. This does not mean that professional and self-help treatment options and a differentiated treatment network are no longer needed. However, the self-change approach challenges the concept of addiction as a disease that inevitably progresses in the absence of treatment (Bergmark & Oscarsson, 1987; Burman, 1994). The controversy on abstinence versus the possibility of a return to controlled consumption illustrated the pessimistic view on an individual's chances to change without professional therapy. Commonalities between the change processes involved in individual drug and alcohol careers and "privately organized quitting processes" from nicotine dependency and eating disorders (Biernacki, 1986) usually have been ignored altogether. Therefore, for many years, questions about the possibility and frequency of "natural recoveries" and the change processes underlying them were not raised in mainstream treatment research.

However, research efforts in the area of self-change have gained momentum during the last decades. Peele (1989), a critic of the abstinence dogma and the "the diseasing of America," favors a "strength-based" or empowerment perspective. Furthermore, the increasing acceptance of the harm reduction concept in both the alcohol and drug policy (at least outside the United States) and the recognition of a wide range of outcome parameters, including quality of life and moderation, have contributed to a shift of research perspectives. The improvement of general conditions of life of target groups, for example, work and housing combined with limited

low-threshold interventions, are considered as possible strategies to strengthen the individual's potential to modify addictive behavior.

Self-change studies in practice

RECRUITMENT OF SELF-CHANGERS

Reaching and studying clinical populations are relatively straightforward matters. Studying individuals who have changed on their own and who often do not feel comfortable in sharing this with others (i.e., hidden populations) represents quite a different challenge. Strategies to study natural recovery include cross-sectional or longitudinal population surveys, the analysis of official registers (e.g., police records) over time, snowball sampling techniques, the study of dropouts from waiting lists, and, used most frequently, media recruitment. Survey methods using large population samples are appropriate particularly when the central aim is to obtain rates and outcomes (e.g., abstinence, controlled drinking) of self-change. However, such methods provide little insight into the processes of change. Questions about stages of change, what triggers such processes, and what strategies self-changers use are typically addressed by qualitative studies using media recruitment and snowball sampling. In this regard, however, all methods have drawbacks. Survey methods, especially cross-sectional retrospective designs, require very large samples and lead to a rather superficial analysis of self-change. Snowball sampling mirrors social networks or subcultures and excludes subjects who have weak or no communication ties. This bias is avoided by media recruitment that reaches a wide range of community populations. Then again, media-recruited subjects tend to include more severe cases of individuals who change late in their addiction career and are most likely to choose abstinence as their goal for problem resolution (Rumpf, Bischof, Hapke, Meyer, & John, 2000).

STUDY DESIGN—VALIDITY

Ideal study designs would include the use of control groups, prospective analysis of change processes over long time intervals, and measures to ensure the validity of data. Can we believe retrospective reports of self-changers if they claim a return to controlled drinking? To tackle these issues, some studies have used collateral reports to validate data obtained from study participants and a combination of screening and extensive life history interviews to check the consistency of self-reports. Other studies, using the timeline follow-back method, have demonstrated the validity of self-reports (Sobell & Sobell, 1992; Sobell et al., 2003).

Figure 14.1 shows an example of the typical stages of research fieldwork in finding and selecting self-changers.

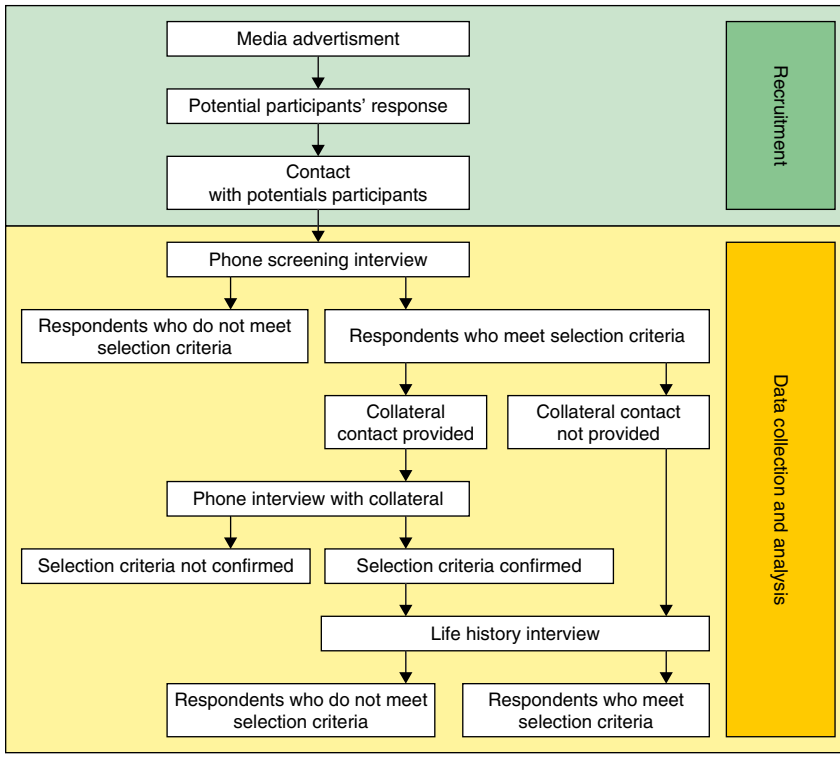

FIGURE 14.1 *Self-change studies: Typical stages of fieldwork and the selection process.*

DEFINITIONAL ISSUES

The meaning of "change in the absence of treatment" requires a working definition of what constitutes treatment (Blomqvist, 1998). In practice, some studies include individuals in the self-change category even when the respondent reports (1) minimal therapeutic intervention at any point in their life, (2) infrequent attendance at self-help groups, or (3) nonspecific interventions (hospital stay without counseling and detox, advice by a general practitioner to quit or cut down). Humphreys, Moos, and Finney (1995) argue that self-help organizations should not be considered as treatment—(1) they can be viewed as a natural community resource and way of life rather than treatment and (2) they do not require public funds or licensure. In addition to the definition of "nontreated," the severity of the addiction prior to self-change must be defined. Researchers in this area have been using various criteria; some studies have focused only on dependence, others also on abuse or harmful use of substances according to ICD-10 or DSM-IV criteria, and some on the perception of severity by study participants. A close look at definitions used is important, as critics of self-change research claim that

self-changers are not dependent (at best, they are at-risk drinkers) and therefore are not comparable to clinical populations.

Research overview and core findings

The state of the art in this area of research has been reviewed by Sobell, Ellingstad, and Sobell (2000), with a special focus on methodological issues. This meta-analysis of 39 studies shows that 79% of alcohol studies and 46% of drug self-change studies report a return to low-risk consumption rather than abstinence in the self-change process (Sobell et al., 2000). A follow-up review by Carballo, Secades-Villa, Fernández-Hermida, García-Rodríguez, Dum, and Sobell (2007) covers 22 studies published between 1999 and 2005 and provides a comparison with Sobell's review. The average duration of the addiction careers of subjects included in self-change studies averaged 12.8 years in Sobell's review and 10.9 years in Carballo's paper. These durations are comparable to clinical populations. The reported average duration of problem resolution through self-change was, on average, 8.0 and 6.3 years, respectively. Approximately half of the studies mentioned health, financial situations, and family situations as the most important triggering factors in self-change, with family support being pivotal for maintenance (Carballo et al., 2007). Klingemann and Sobell (2007) provide the most up-to-date collection of review articles on self-change. This text looks at the field from an international perspective and applies the self-change approach beyond the classic addiction field to nonsubstance-related addictions such as gambling, the desistance from crime, and natural recovery from eating disorders and speech impairments.

Based on these works, the major core findings and research themes include the following.

- The traditional concept that the resolution of addiction problems can be achieved only by abstinence is no longer tenable given the research findings on self-change and recent findings from the NESARC studies mentioned earlier. The pursuit of low-risk drinking behavior has been shown to be the most frequent self-change strategy.
- The majority of addiction self-change studies indicate a better chance of natural recovery among less severe cases (e.g., Cunningham, Blomqvist, Koski-Jännes, & Cordingley, 2005), even though NESARC results show a 25% self-change rate (abstinence or low-risk drinking) among DSM-IV-dependent cases (Dawson et al., 2005).
- Cognitive appraisal and decisional balancing processes, including affective pros and cons for a behavior change, have turned out to be "the motor of self-change" mediated by societal conditions

(e.g., stigma) that facilitate or impede change (Klingemann & Sobell, 2007).

- Maintenance of self-change is much more likely with social support from friends and family (Cloud & Granfield, 2004) combined with a change of lifestyle in which risky behaviors lose their appeal.
- Clinicians are still needed and can assist self-change by minimal interventions and/or by facilitating individual appraisal processes (e.g., Tubman,Wagner, Gil, & Pate, 2002; see overview by Heather and Stockwell, 2004). More specifically, Polivy (2001) notes that therapists may assist self-change by helping set realistic objectives of change, thus avoiding the "false hope syndrome." Self-change research also informs treatment providers about the reasons why their programs are not accepted and helps them adopt a more consumer-oriented perspective.

Figure 14.2 provides an overview of the various parameters guiding self-change processes.

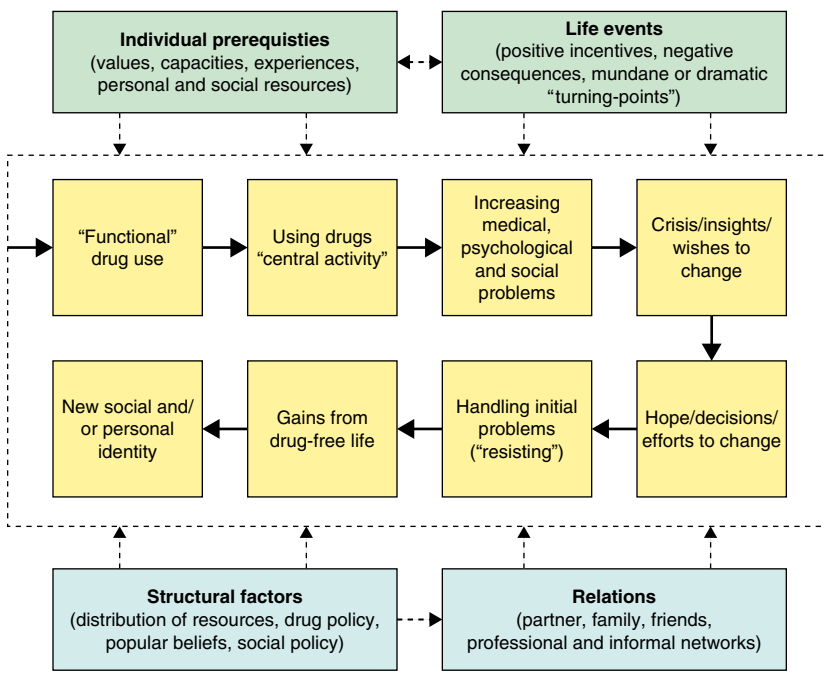

FIGURE 14.2 *Entry into and exit from drug addiction. "Inner logic" and main driving forces (Blomqvist, 2005, p. 159).*

Selected issues

BARRIERS TO TREATMENT

Researchers studying natural recovery have identified various barriers to treatment seeking by addicted individuals. Tucker and Vuchinich (1994) list the following reasons for avoiding treatment even among individuals who are willing to change: potential embarrassment (66%), concerns about stigma or being labeled as an alcoholic (63%), not wanting to share personal problems (58%), negative attitudes toward treatment or hospitals in general (53%), and cost of treatment (13%). Surprisingly, local availability of programs was considered of no importance. Luoma et al. (2007; Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008) found high levels of stigma, both self-imposed and imposed by the treatment system, among patients in 15 U.S. substance abuse treatment centers. Furthermore, the authors note that "experiences with stigma-related rejection continued to be related to number of previous episodes of treatment even after controlling for other explanatory variables" (Luoma et al., 2007). This study among patients in treatment mirrors the negative view of self-changers toward professional treatment. While information about treatment options is easily available and not usually a deterrent to treatment seeking (Copeland, 1997,1998; Klingemann, 1991), questions about the quality of treatment services and the ability of treatment providers to be sensitive to special needs are more prominent barriers to the acceptance of professional help. In a study by Klingemann (1991), respondents typically anticipate moral pressure, inadequate treatment methods, and emotional strain when entering treatment ("therapy robs you of everything…my personality would not have been worth anything anymore"). In addition, subjects mentioned self-change coping strategies (e.g., special diet; spiritual exercises), which are not offered by traditional treatment programs. A study by Copeland (1998) demonstrated gender-specific treatment barriers among addicted women. Women felt that programs with a majority of male clients were not sensitive to their problems, including child care needs, hours of operation, and time requirements for treatment.

When asked about barriers to participation in self-help groups (e.g., Alcoholics Anonymous), self-changers typically mention the strong religious orientation of 12-step groups. In addition, they express a dislike for reliving their alcoholic past instead of focusing on positive, life-changing skills. Respondents also expressed resistance to labeling themselves as "alcoholic" and internalizing the notion of powerlessness and of being a lifelong "recovering alcoholic" (Burman, 1997; Copeland, 1998). From a gender perspective, the dominance of male participants in self-help groups appears to serve as an obstacle to participation by women (Copeland, 1998).

LAY STRATEGIES OF RECOVERY

Self-changers rely on everyday behavioral concepts such as thinking about the negative effects of drugs, developing adequate substitutes for drugs, and distancing oneself physically and cognitively from drugs. More specifically, strategies mentioned in the literature include avoiding drug use environments (change of job or apartment or choosing alternative routes from work to home), eliminating consumption-related stimuli (bottles, ashtrays, syringes), leaving drug subcultures or user networks, and scheduling alternative, pleasurable activities and hobbies. In a qualitative study of self-change strategies in young adults, Finfgeld and Lewis (2002) found that self-changers tried "to seek solid ground" by engaging in school or volunteer activities, child care, writing, painting, and music, as well as abandoning drinking friends. Comparing samples of treated versus natural recovered individuals in Canada, Collins (2006) found low levels of religiousness and spirituality among current alcohol-dependent subjects, as well as among spontaneous remitters. However, a quarter of the natural recovered subjects considered spirituality important for maintenance. Pursuing a spiritual path to problem solving appears to be a more typical characteristic of 12-step programs. Self-changers typically pursue strategies of retreat (self-imposed, physical withdrawal from temptations). Some self-changers use a public pledge and commitment to change as a strategy, whereas others change without such public commitment because of frequent failure in the past and anticipatory regret at having to admit to another failure. Some self-changers report that they keep written diaries during their change, whereas others use images of the negative aspects of their previous addiction experiences.

> "This is where I put my fist through the door when I was drunk…We re-did the entire kitchen, but I left the damaged door as it was." (Burman, 1997)

Finally, "multiple resolutions" are reported by self-changers. Successful techniques of self-change in one problem area (e.g., alcohol) are often applied to other undesirable behaviors (e.g., smoking) (Burman, 1997; Klingemann, 1992; Sobell, Sobell, & Agrawal, 2002).

In summary, qualitative studies on self-change show how impressive and varied the "tool box" of self-changers is.

Trends and recent studies

The self-change concept has been applied to other problem areas, such as gambling (Toneatto et al., 2008), smoking (also cannabis) (Doran, Valenti, Robinson, Britt, & Mattick, 2006; Ellingstad, Sobell, Sobell, Eickleberry, & Golden, 2006), mental illness (Bischof, Rumpf, Meyer, Hapke, & John,

2005b), eating disorders, and criminality (Takala, 2007; overview: Klingemann & Sobell, 2007). In addition, an international perspective in self-change research is gaining ground. Outside of North America, studies have been conducted in Finland (Hänninen & Koski-Jännes, 1999, 2004), Sweden (Blomqvist, 2004), Switzerland (Klingemann, 1991; Klingemann & Aeberhard, 2004), Italy (Scarscelli, 2006), and Spain (Carballo Crespo, Secades Villa, Sobell, Fernández Hermida, & García-Rodríguez, 2004; Carballo et al., 2008).

Because of successful media recruitment strategies that attract more severe cases, self-change studies have begun to focus on addictive problems of long-term duration. Studies have also highlighted self-change processes in early stages of addiction. Vik, Cellucci, and Ivers (2003) reported that 22% of student binge drinkers managed to reduce their alcohol consumption without professional counseling. Misch (2007) suggests that researchers "… observe the natural recovery from excessive alcohol consumption among college students and then identify and extract the active ingredients of that transformation whether they be … processes involving the academic enterprise, the social structure or other variables of college life." From a more general perspective, self-resolution processes in young adulthood can be characterized as a maturing-out process and a transition to independence and adult roles (O'Malley, 2004).

Recent studies have focused increasingly on a better understanding of the process characteristics and course of natural recoveries; more specifically on cultural and group factors and dynamics.

Research on ethnic groups has stressed both commonalities and culture-specific notions related to self-change. A prominent element in the heuristic model of natural recovery among Alaskan natives (the People Awakening study) is a reference to the responsibility to the extended kinship structure (family and community) and disavowal of the notion of alcoholism as an incurable disease (Mohatt et al., 2008).

Bendek, Cory, Spicer, and Team (2004) use anthropological analysis of content to analyze reasons for reducing alcohol consumption among members of American-Indian communities. Results reflect the salient themes in the natural recovery literature, with only partial transformation of self-change processes in the specific cultural context. This study, in addition to Grant's research on "rural women's stories of recovery from addiction," illustrates strategies in the recovery process in areas with little access to treatment. From a methodological point of view, Tucker (2008) comments on the potential merits of such qualitative cultural studies: "By studying natural resolutions, the cultural and other contextual elements that motivate and sustain positive change begin to emerge with clarity not possible in studies of problem drinkers who seek help."

The heterogeneity of nontreated populations has not only been researched from an anthropological perspective in terms of cultural diversity, but also with respect to a number of background variables as predictors of problem resolution. Bischof, Rumpf, Hapke, Meyer, and John (2003) claim "…data suggest strongly that a lack of identifying specific variables of natural recovery in previous research might be due to heterogeneous subgroups of natural remitters…. both resources and stressors play an important role for processes of remission without formal help." In subsequent research they stress the importance of interaction among gender, problem severity, and social capital/social support (Bischof, Rumpf, Meyer, Hapke, & John, 2005a; Bischof et al., 2003, 2007). Cunningham and colleagues (2005) highlight group-specific aspects of the recovery process by analyzing the interaction between addiction severity and reported reasons for recovery. Based on a general population sample, they show that consequence-driven reasons (e.g., particular life events) for recovery compared to drifting-out reasons (e.g., role changes, growing older) occur significantly more frequently among lifetime alcohol-dependent cases than among less severe cases. A third recovery process characterized by "reflective maturational reasons" (e.g., not getting anywhere in life) was not sensitive to problem severity.

Group heterogeneity may also influence the course of change processes over time. Bischof and colleagues (2007) investigated in a 2-year follow-up a self-change population in Germany with an average remission from DSM-IV alcohol dependence at a baseline of 6.7 years. The majority of natural remitters remained in full remission. However, differences were apparent based on subgroups as characterized by different combinations of problems, social support, and addiction severity at baseline. The "low problem–low support" group was the most unstable, with 12.7% utilization of formal help and 6.3% with dependence symptoms compared with the "high problem–medium support" and "low problem–high support" groups, with unstable natural remissions at follow-up of 3 and 4%, respectively (Bischof et al., 2007). The authors comment that "… social support also plays an important role in individuals who remitted from less severe alcohol problems and that these individuals might be in more need to turn to formal help, when critical events take place" (Bischof et al., 2007). The stability of natural recovery from problem alcohol use among natural remitters is also shown by a 4/14-year qualitative follow-up study conducted in Switzerland (Klingemann, 1991, 1992; Klingemann & Aeberhard, 2004). Of 17 alcohol remitters interviewed in 1988, 1992, and 2002, only 4 reported relapse in 1992 but improved their consumption status again by the time of the follow-up interview in 2002 (return to controlled drinking). Of the remaining cases, only 1 respondent received

treatment that was not considered helpful (Klingemann & Aeberhard, 2004). Group heterogeneity is also highlighted in this study by media-recruited subjects who considered themselves as "subjective spontaneous remitters" and who managed their alcohol problems despite the fact that they evaluated treatment exposure negatively. Along the same lines, individuals who engaged in a help-seeking process but did not receive help represent a specific subgroup that cannot be compared with remitters who never sought treatment (e.g., Moos & Moos, 2006). To conclude, the issue of group heterogeneity has methodological implications: Qualitative studies highlight the various meanings that patients attribute to treatment episodes, as well as the interaction between self-management techniques and professional help (see also Orford, 2008). This information is essential in identifying and describing change processes and mechanisms. As DiClemente (2007) states: "Treatment and any type of intervention to modify drinking behaviors enter a flowing stream of process activity and do not encounter a completely stationary object…. It is a collaborative enterprise that when successful interacts with … the change process … than being a mediator or mechanism which completely accounts for a change."

Finally, the field of self-change research has been dominated by an individual, psychological approach. A more recent research trend favors an interdisciplinary approach. The sociological perspective opens a view to societal, structural antecedents of individual self-change processes and asks "what are the characteristics of a self-change-friendly society?"

The likelihood of self-change depends, among other factors, on the social stigmatization of addictive behaviors, media portrayals of the nature of addiction, population attitudes about the changeability of misuse and dependency, the availability of drugs jeopardizing maintenance, and the makeup of the treatment system (consumer versus expert perspective). Recent surveys in various countries show that the disease concept of addiction is still predominant in the general population, which results in skepticism about the chances for untreated recovery or moderation (e.g., Cunningham et al., 2007; Klingemann & Klingemann, 2007).

Future research directions perspectives include the use of detailed case analysis to determine if lay strategies may be used in professional settings. This strategy would require an ongoing dialogue between researchers and treatment providers. Prospective longitudinal studies including control group designs are needed. Finally, qualitative and quantitative research strategies must be combined in a meaningful way. The use of life curve drawings, combined with narrative interviews and computer-assisted content analysis, is an excellent example of this combined approach (see Sobell et al., 2001).

CREATING A SOCIETAL CLIMATE FRIENDLY TO INDIVIDUAL CHANGE: ADVICE FOR POLICY MAKERS

Many individuals with alcohol, drug, tobacco, and gambling problems overcome their addictions without treatment. Unfortunately, awareness of this phenomenon is limited (Cunningham, Sobell, & Sobell, 1998). In this regard, efforts are needed to increase awareness among the general public that many people with addictive behaviors can change on their own. Increased awareness may also encourage friends and relatives to support self-change attempts.

The frequent occurrence of self-change, coupled with the general public's lack of awareness of such recoveries, suggests that disseminating knowledge about the prevalence of self-change could be a type of intervention itself. Individuals who have achieved self-recoveries could make public declarations in order to encourage others to try the self-change process. Efforts could also be made to inform substance abusers about the possibility that others can aid in their recovery by being supportive. Self-help manuals could be widely available and could inform addicted individuals that they may be able to recover without professional treatment. More specifically, natural contact points could be identified for disseminating information on behavior change/health information and "teachable moments" (e.g., medical-visit waiting time, pharmacists as credible reference persons). In addition, Internet health advice and expert systems should be made accessible to large segments of the population. Such policy interventions, in turn, are likely to trigger and facilitate change at the grass roots level (e.g., Mothers against Drunk Driving; Moderation Management, a self-help group for problem drinkers who did not feel comfortable with traditional self-help groups such as Alcoholics Anonymous).

Public health campaigns can be an effective means for raising public awareness. For example, community interventions, rather than targeting individuals for change efforts, could target opinion leaders, medical practitioners, and public health officials. Community-oriented interventions should be developed, including both information campaigns and treatment-umbrella or resource-umbrella organizations that assist individuals in addressing specific problems.

Drug, alcohol, and smoking campaigns are currently conducted to sensitize the public and to influence attitudes and behavior patterns of risk groups. Similar to the question "how does the amount of advertising influence consumption," we may also ask "how is the motivation for and likelihood of self-change affected by national sensitization campaigns?" Unfortunately, the conclusions presented by Wilde (1993)—from a decade ago—demonstrate that mass communication prevention

programs for health are hardly ever evaluated systematically, a criticism that is still valid today.

Attempts to provide information about self-change to policy makers may evoke opposition from a number of fronts. For example, pharmaceutical companies marketing smoking-cessation products, groups seeking more recognition and treatment for recently recognized addictive problems (e.g., gambling), and advocates of traditional substance abuse treatment may be opposed. Strategies will be needed to (a) overcome resistance, (b) build coalitions, and (c) support policies derived from self-change research.

Stereotypes of alcohol (and drug) addiction in the general population can be considered major stumbling blocks to people who try to recover on their own: Stigma will reduce social support. In addition, societal beliefs about the nature and cause of social problems will shape individual and collective responses to individual self-change. How visible are these problems? How confident are we that people may eventually change their eating disorders, heroin or alcohol use, or pathological gambling on their own?

The answers to these questions will depend on the overall attitudes toward the addiction paradigms that prevail in societies. Are addictive behaviors seen as medical problems, social problems, or criminal/moral issues?

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