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Promoting "natural recovery" from addiction and social support: Towards a self-change friendly society

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Natural Recovery Research 'Maturing Out'

The literature shows the broad range and impressive development of natural research into the self-change process over the past decade. In particular, general population studies have shown that self-change is a major pathway to recovery (Klingemann 2001) (Sobell, Sobell et al. 1992; Sobell, Cunningham et al. 1996; Sobell, Sobell et al. 2002).

Creating a Societal Climate Friendly to Individual Change: Advice for Policy-Makers

Many individuals who have had problems alcohol, drugs, tobacco, and gambling solve their problems without treatment. Unfortunately, most people are not aware that such recoveries occur (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 make it easier for friends and relatives to encourage substance abusers to stop or reduce their use.

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 would be a type of intervention itself. Individuals who have

achieved such recoveries could make public declarations in order to help others consider engaging in the self-change process. Some effort should also be made to inform substance abusers about the possibility that others can aid their recovery by being supportive. Self-help manuals should be widely available and should inform individuals with addictive behaviors that they can recover without professional treatment. More specifically, natural contact points need to 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 like Alcoholics Anonymous).

Public health and education campaigns can be an effective means for raising public awareness. An example is community interventions in which, rather than targeting individuals for change efforts, the targets are opinion leaders, medical practitioners, or public health officials. Community-oriented interventions should be developed, including both information campaigns and treatment-umbrella or resource-umbrella organizations that assist individuals to function and to address specific problems.

Drug, alcohol and smoking campaigns are launched 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 ask How are the motivation for and chances of self-change affected by national sensitization campaigns? Unfortunately Wildes conclusion- from a decade ago- asserts that mass communication prevention programs for health are hardly ever systematically evaluated, a criticism that is still valid today (Wilde 1991).

Conceptual shortcomings and a lack of theoretical underpinning are seldomly identified as reasons for failure. Slate (1999) has suggested that the stages-of-change model could in fact provide a framework for integrating theories of media effects on self and others and prove to be useful for the planning of communication campaigns to change health behaviors.

More specifically, relevant theories for the transition from pre-contemplation to contemplation are agenda setting, situational theory, and multi-step flow which lead to interpersonal discussion of the problem behaviour. Initial awareness can be built by using simple sources and dramatic messages. Moving from contemplation to preparation assumes the acceptance of the campaign messages and the perception of models and skills illustrated in engaging narrative or entertainment programming (social learning theory). Finally, the iterative process from preparation to action requires continued messages which help maintain the motivation and keep the behavior salient. Providing harder evidence, increasing language intensity, and using more directive messages has been useful for probing behaviour change. At the same time this might cause resistance with self-changers who are not ready to change (see Slater 1999: 344-347). The stage specific definition of campaign objectives tailoring message content accordingly and using stages of change as the primary basis of audience segmentation seems to be a promising avenue to promote natural recovery.
However, using the stages-of-change model to integrate theories that address health communication campaigns in general and facilitate self-change of problem behaviour has rarely been done in the addiction field.

Barriers to Putting Policy Advice into Practice

Attempts to implement advice for policy makers may evoke opposition. For example, those that might be opposed to such advice are 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. 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 for people who try to recover on their own: Stigma will reduce social support. Societal beliefs about social problems and their nature 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? How much time should we reasonably give them?

The answers to these questions will depend on the overall concept of addiction or the paradigms that prevail in societies. Are addictive behaviors seen as a medical problems, social problems or as criminal or immoral in nature? The disease concept once an addict always an addict is at the heart of natural recovery research. Of interest in this context is the informal social response to natural recovery! It can be assumed that the social support or tolerance potential quitters experience in their attempt at self-change will be contingent upon the images in the general population and more precisely in the quitters reference groups.

The preceding point can be illustrated using one example from Switzerland .Consecutive surveys on the image of the alcoholic in the mirror of the public opinion, conducted in 1975, 1984 and 1992 demonstrated highly visible alcohol problems and a high sensitized population. For example, 28% of the respondents in 1975 knew of a case of alcoholism; in 1984 the figure was 40% (Miller and Weiss 1984: 28), and remained at a relatively high level in 1992. During the same the period (1975 to 1992) known cases, especially at workplace rose from 6% to 15% (Fahrenkrug 1992: 594, 595). Interestingly, the characteristics that society attributes to alcoholics have remained relatively unchanged and, in fact, are consistent with the traditional disease concept and moral connotations of addiction. More specifically, as compared to the earlier studies, the 1992 survey showed that respondents were less inclined to attribute the characteristics lazy, stubborn, and egoistic when confronted with a semantic profile of the typical alcoholic. While a more medical view could be hailed as reduced stigma, there can be a downside to de-stigmatization. For example, although an individual is seen as suffering from a disorder rather than misbehaving the perception of severely dependents alcohol abusers as chronically diseased and plagued with loss of control may reduce access to occupations which may require a great degree of control over machinery and may discourage social support for such careers among substance abusers. Klingemann's study on alcohol and heroin remitters has shown how much these images are still at work, even when the subjects have accomplished change: Successful heroin spontaneous remitters who reported themselves as self-changers experienced negative reactions to the report by others far more frequently than alcohol spontaneous remitters, which again points to differences in stigmatization as a function of societal images (Klingemann, 1992: 1376 - 1378).

For potential self-changers who are in the pre-contemplation phase or weighing strategies for implementing change, the images of the nature of addiction and the public visibility of successful natural recovery are very important as reflections on a Canadian survey illustrate. Whereas 53% of the respondents, who had overcome their dependence without treatment knew of similar cases, only 14% in a general population group were aware of self-change cases. The other study groups (significant others of self-changers, unsuccessful self-changers and treatment cases) fell within these two

extremes. Societal stigma kept people from telling others about their successful self-change process: only 5% of self-changers said they did not tell others that they had stopped smoking, whereas five times more (24%) did not tell others they had stopped drinking (Cunningham et al., 1998: 401).

Self-Change and Treatment: Striking the Right Balance

The treatment industry will not necessarily oppose the idea of self-change because prompting substance abusers to attempt self-change can also lead to involving them more in treatment. This would be consistent with current trends in the treatment system. In fact, Peele (1988) has argued that we are in the midst of a tremendous "treatment splurge." When treatment of substance abuse expands, the natural direction for this expansion is to less severely dependent individuals, because such individuals are more amenable to change, more appealing to deal with, and better able to pay for treatment than those who are more severely dependent. Sobell and Sobell (1993) have described intermediate forms of treatment such as "Guided Self-Change" for this population. However, unless the treatment system in the U.S. is radically remodeled (for example, it is almost completely abstinence-oriented), recruiting less severely impaired users into treatment will continue to be a problem. In traditional programs such users are typically required to acknowledge they are substance abusers, and that they are addicted. Those who refuse to label themselves are accused of being in "denial."

When we consider research on gamblers who change on their own but do not see themselves as having had a problem, we may detect a paradoxical effect from so-called denial. That is, for a sizable proportion of natural recoveries, the process of change takes into account, and may even be based on the refusal to label oneself as having a severe addiction.

It should be kept in mind when advocating self-change that we must not discourage people from seeking treatment when they need it. Some substance abusers may not be able to recover without treatment and we do not want to reduce the likelihood that they will be able to receive treatment. In addition, learning about barriers to treatment and making specific types of treatment more accessible and acceptable for under-served populations (e .g., HIV + substance abuser; women) should not lead to an

artificial expansion of the treatment industry. Any efforts to change beliefs about the extent of self-directed recovery versus professional treatment should be introduced prudently and monitored to be sure the efforts are not discouraging people from entering treatment or self-help groups.

Advice for Treatment Providers

The evidence resulting from self-change research endorses the concept of *stepped care.* It is based on a view of recoveries that considers routes of change ranging from self-change to assisted self-change to guided self-change (e.g., brief interventions, discussions with physicians) to more intensive outpatient and inpatient treatments. Bibliotherapy is a good example for assisted self-change:

Written material can assist people in the recovery process. In most book stores there is a Self Help section. People trying to figure out what they can do about their eating, sex, drinking or work stress problems can turn to some type of bibliotherapy. Self-help material may (1) be based explicitly on the principles of self-change and stages of change theory, (2) help to monitor and structure personal observations (e.g. drinking occasions and quantities consumed), and (3) the written material can simply be of a general informative nature with no stepwise or didactic program. Self-help manuals are available both for the problem drinker and their partners (Barber and Gilbertson 1998). The appeal of the how to improve your life type of literature on the book market (e.g. Carlson (1998) on simple ways to minimize job stress and improve conflict management as a national bestseller in the United States) is probably also due to the choice it leaves readers, its time flexibility and confidentiality it provides. Self-help material has a middle position between manuals requiring minimal contact with a therapist (see Heather 1986, Noschis 1988) to personal diaries that help to monitor personal changes including addiction problems:

“Thursday 3 August: 8st 11, thigh circumstance 18 inches (honestly what is bloody point), alcohol units 0, cigarettes 25 (excellent considering), negative thoughts: approx. 445 per hour, positive thoughts 0. Bridget Jones’s diary p. 184, by Helen Fielding). “

For self-change or assisted self-change we need to provide choice and diversity, including harm reduction approaches. These efforts are likely to encounter resistance from those who hold traditional views because outcomes in which addicts do not cease drug use will not be viewed as acceptable. Harm reduction programs (e.g., server training for bar keepers, special design of beer glasses and drinking guidelines) are intended to minimize health problems, without necessarily resolving the addiction (DesJarlais, 1995). Nonetheless, harm reduction programs improve people's lives

(Dimeff and Marlatt 1998). Harm reduction should be considered improvement, and such a transition may be a precursor, over the long run to a more fully remitted state.

More important than increased levels of treatment is the shift in intervention modalities and structure suggested by natural recovery data. Among the changes in treatment that follow from the recognition of the frequent occurrence of natural recoveries are the following:

- Language used by health care practitioners with their clients needs to change. Terms such as “addict” and “alcoholic” carry stigma. Not only is there no clinical advantage to labelling, it lead to reluctance to seek or enter treatment. Motivational interviewing teaches us how to approach clients to increase their readiness to change or to strengthen their commitment to change (Substance Abuse and Mental Health Administration, 1999). Along these same lines, interventions should be designed to have consumer appeal (Abel and Kruger 1998).
- Interventions need to be flexible so they can focus on improved functioning as well as cessation of substance use.
- Gradual improvements in a person’s addictive career, and particularly non-abstinence outcomes, should be important, acceptable, and documented aspects of treatment.
- Self-change outcomes and methods should be well publicized.

The chances that an individual changes through self-change rather than treatment will depend to some extent on the availability of treatment resources (Kavanagh et al. 1999). This availability will vary greatly according to the type of problem at a given time. The treatment of smoking illustrates this point nicely. Hughes claims that the statement 90-95% of smokers who quit, quit on their own without treatment is no longer correct given the increasing sale of medications such as OTC, NR and bupropion in the United States; therefore 37% of all quits in 1998 could be attributed to medication use. He draws an interesting parallel between the growth of this branch of the treatment industry with the response to some psychiatric disorders: Few clinicians thought of depression as a disorder at the time. Most believed it could be cured by simple motivation and, thus, few treatment resources were made available. Nowadays almost all clinicians agree that clinical depression needs treatment Perhaps administrators, clinicians and the public understanding of nicotine in the 1990s is where the understanding of depression was in the early 1900s. (Hughes 1999: 324, emphasis by the author).

Fast growth can also be seen in the drug treatment systems in most countries at the expense of treatment resources available for alcohol abusers. Taking Switzerland for example, the treatment network for approximately 30000 drug abusers, compared with the counselling and care services available to more than eight times that number of alcohol abusers, is disproportionately well developed and differentiated (Klingemann 1998:100).

The images of addiction and prevailing drug, alcohol, or tobacco policies will also largely determine the type of treatment methods and models. Most prominently, harm reduction measures, heroin prescription, and large scale substitution or replacement therapies are available in all countries. Their diffusion and adoption will depend on a number of endogenous and exogenous influences such as the moral judgement in the population and the adherence to international drug control (see Klingemann and Klingemann 1999: 115, Klingemann and Hunt 1998).

But even if we assume equity in the availability of professional help at a given time in a given country, peoples perception of the availability of treatment still may vary and therefore affect the probability that they may look for their own solution and not seek professional assistance. In part, a barriers to treatment will depend on the ability of treatment providers to tailor the services they offer to the needs of potential clients. Natural recovery research provides valuable information on the question of why people do not seek treatment. Lack of information, stigma, and the belief that treatment does not offer what is needed are some of the main reasons (Klingemann 1991, 1992). Another important reason are culturally supported beliefs. For example, Western ethics and cultural values strengthen the idea that everybody has to overcome a problem ideally without affecting others, (i.e. individual willpower and strength), downplaying the influence of environmental factors.

Structural prevention and chances of change

Availability of alcohol and drugs is subject to change and may vary greatly between societies, groups, and regions. Taxation policies and various degrees of competition on drug markets will influence prices and consumption patterns, (e.g. Sterberg 1992; Klingemann 1994:152). Most of the discussion in this natural recovery field has focused on general consumption levels and has not been concerned with addiction and effects

on individual behaviour. How sensitive are alcohol addicts in various stages of change to price change? Are substitution processes (i.e., one drug for another) affected by differential prices, health policies, or income fluctuations? In this context Godfrey points out interesting implications of Becker and Murphy's economic model of rational addiction (1988) for self-change processes:

> ...permanent changes in prices may have small short-run effects, but the long run demand for addictive goods is predicted to be more elastic than the demand for non-addictive goods. Some addictive behaviour patterns such as binges, abrupt discontinuity of consumption, and repeated quitting behaviour (emphasis by the author) are also consistent with this model of rational behaviour (Godfrey 1994: 180).

Self-reward schemes of quitters (spending the money I saved for something else I like) and the pressure to quit because of the increasing financial burden to keep up the habit up could serve as examples of how these environmental conditions can affect individual behavior.

Contextual conditions for change are by no means stable over time and across countries. For example, conditions for self-change have been altered in the Nordic countries with the erosion of the Nordic alcohol monopolies after they joined the European Union (Holder et al. 1998). In 2000 the European Commission refused to extend exemption clauses for Sweden which limited alcohol imports.

Comparing the USA and Canada in 1989/1990, Giesbrecht and Greenfield found a greater polarization of opinion within both countries for policy items relating to promotion of alcohol or control of physical, demographic or economic access, and virtually no polarization with regard to curtailing service to drunken customers or providing information on treatment (Giesbrecht and Greenfield 1999; emphasis by the authors).

Within the same country, the definition of alcohol-related social harm and ideas regarding what should be done about it also can vary over time, such as show trend studies in the Netherlands. For example, Bongers, Goor & Garretsen (1998) define social climate on alcohol as the blend of different views on drinking, conceptions of alcohol-related problems, and the defining of appropriate measures for dealing with them (Bongers, 1998: 141).The study dealt with, among other things, tolerance towards drinking behavior of close relatives and drinking behavior at a party, and found that tolerance increased between 1958 and 1994. Furthermore, it was found that support for

advertisement restrictions and higher prices for alcoholic beverages in the Dutch population is fading (Bongers, 1998: 144).

Taking another example from Switzerland, a recent liberalization of the markets has opened the way for longer opening hours, abolished the so-called need-clause (limiting the number of outlets as a function of the population) and led to the introduction of unified tax rates for distilled spirits after a ruling of the World Trade Organization in July, 1999. The British Government also plans to reform the licensing regulations even though national opinion polls do not necessarily show public support for such a policy (Alcohol Alert 2000: 2-4, 6,7). Ironically, recent American studies have highlighted the potential merits of structural alcohol prevention and restrictions in the community. Scribners study in 24 urban residential tracts in New Orleans investigated the effect the number of retail alcohol outlets (liquor, grocery and convenience stores) had on individual attitudes towards drinking and alcohol consumption. They found that certain neighborhoods had an over concentration of alcohol outlets (i.e., 5 per 3,000 people). Not surprisingly, alcohol consumption in these areas was 11% higher. Although it is impossible to know if the number of outlets increased regional consumption, or if they were in response to preexisting regional demands, especially interesting with respect to self-change is the correlation of these environmental conditions with collaterals attitudes. Views toward drinking were 15% to 16% more favorable than in residential tracts with lower outlet density (Scribner et al 2000 February issue of Alcoholism: Clinical and Experimental Research 2000, 24)

"This result is very different from what we had believed, that everyone's individual behavior was controlled by just their individual characteristics. But now we see that the neighborhood that people live in counts for a significant portion of their individual behavior. That's huge. In the last four or five years, people in community organizations in cities such as Los Angeles, Washington, New Orleans, Oakland and Chicago have become aware of a link between higher densities of alcohol outlets and higher incidences of alcohol-related outcomes" (Dr. Richard Scribner, Professor of Preventative Medicine, Louisiana State University -Health Services Center; interview with Medical Tribune 15 February 2000).

Improving the Basis for Evidence-Based Policies: Advice for the Research Community

Methodological groundwork for research into the process of self-change needs to be improved in the following ways:

- There is a need for prospective studies that help answer questions of causal relationships, and for a better integration of qualitative and quantitative approaches.
- Improvements in methodological design are needed, such as the use of control groups, validity tests using interviews with collaterals, and the development of standardized instruments to measure self-change over time (Abbott, Quinn et al. 1995).
- Studies of addictive behavior change need to link verbal reports to observational data. We need to keep in mind that the illusion of control favors attributions to temporally contiguous "causes" - the phenomenon of "telling more than we can know."

We need to focus future applied research on the following substantive topics:

- Comparative studies that include in a single research design various problem areas – particularly licit and illicit drugs as well as eating disorders, medication misuse, and addictions unrelated to substance use.
- Increased attention to the social contextual factors, "social capital," and social response to natural recoveries that ultimately affect the chances for sustained self-change.
- The investigation of change processes into different cultural contexts.
- A better understanding of the phenomenon of drifting out of problems "without any reasons."
- Research that combines cross-sectional research designs with in-depth qualitative methods has great potential for advancing knowledge about self-change.
- Studies on the process of change in addictive behavior among persons with different help–seeking experiences would be helpful because it may be possible to relate etiological processes to routes of change and care seeking.
- Studies on the role of spiritual factors in natural recovery studies such as "legal highs" (e. g., sensation seeking, religious experiences).

- Natural experiments of social contextual capitalizing upon natural recoveries events such as local disasters as well as legal changes like modifications of gambling regulations and smoking restrictions in public places.

Conclusions

Scientists have to remove their research hats occasionally and take an active part in shaping policy on addictive behaviors. Although changing public images of addictions can be an objective for scientists, they must be knowledgeable and skillful in their interactions with the media. Visible research networks can be used to bring science to the public. The examples of media campaigns based on empirical findings from the self-change literature indicate that science can influence policy. For example, social scientists working together with policy makers within the framework of the Swiss National Alcohol Action Plan (which in turn was based on an WHO initiative) have successfully “marketed” their ideas.

In addition, it is critical that scientists and health care providers learn to interact with and learn from each other (Sobell, 1996). Implementing brief interventions in practice and studying the solutions and coping strategies that successful self-changers use is essential. In terms of knowledge management, self-change research needs to be connected with treatment and political systems. To this time, advice presented has been segmented for policy, treatment, and science. These areas need to be networked with actions based on the concerns of multiple stakeholders.

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