Chapter 33

Natural Recovery from Alcohol Problems

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Synopsis

Disputes regarding the dogma of abstinence or the claim that it is possible to revert to controlled drinking illustrate a deep-seated lack of belief in the individual's chances of changing without treatment. However, when people do change from substance misuse, most of them change on their own. Features common to the successful quitting of alcohol, gambling, overeating and drug taking are mostly ignored. In general, the hypothesis of "spontaneous recovery" challenges the concept of addiction as a disease that is in principle irreversible and progressive. At the same time, the spectrum of definitions of the different terms describing this phenomenon is varied. In clinical usage, "spontaneous remission" simply means "an improvement in the patient's condition without effective treatment"; psychological working definitions emphasize the individual's own cognitive achievement; from a sociological viewpoint, the primary consideration is the exit from a deviant career without formal intervention. Theoretically, the increasing adoption in the clinical domain of Prochaska & DiClemente's (1983) stages of change model has been described as an important paradigm shift.

The variety of theoretical aspects of self-change is also associated with numerous practical problems of research methodology, which are outlined in this chapter after a discussion of definitional issues. Studies in this area have been mostly conducted either from a survey/cohort perspective or from a qualitative in-depth approach attempting to "zoom in" on the change process. Canadian population surveys have suggested that about 78% of interviewees with alcohol problems had overcome them without professional treatment. A considerable proportion had reverted to moderate, controlled consumption. Intensive case studies in smaller samples highlight, among other things, the role of social support and control and the influence of life events or stress factors in the motivation to overcome problem use, and point to an impressively creative potential of individual coping strategies.

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This chapter not only provides a review of self-change research but also outlines treatment and policy implications. Policy planners in the addiction field find themselves faced with growing criticism of the increasing and costly impact of professional therapy and the abstinence dogma in various spheres of life. Under-utilization of the resources of numerous treatment services also raises questions about the reasons for "treatment rejection" and supports the view that, from the study of clinical populations only it is not possible to understand the needs of the much more important hidden population of problem drinkers. In this context, the concept of "assisted natural remission" is introduced and illustrated by various forms of bibliotherapy. Finally, psychological models and perspectives on change need to be complemented by a sociological approach. This views the societal climate of opinion (discrimination, judgements of different types of deviance in the general population and in the media) and objective features of the treatment system (barriers to treatment and perceptions of available programs) as key parameters which can promote or impede individual chances for change.

"SELF-HEALING": TABOO IN RESEARCH AND THERAPY?

> Michael Caine, his days of philandering and heavy drinking well and truly behind him, says that he is too old to mess around with women. The 65 year-old actor's film career has taken on a new life with his portrayal of a sleazy impresario in *Little Voice*, winning a Golden Globe award and sparking speculation that an Oscar might be next. "I used to do a bottle of vodka a day in the 1960s—no problem. You are just topping yourself up", Caine told *The Times* of London in an interview. Meeting the model Shakira Baksh changed all that. "I stopped when I met my wife", he said. "Romance took over and, of course, women do not like drunks" (*International Herald Tribune*, p. 20; "People", February 2, 1999).

The idea that alcoholics can overcome their dependence without extensive professional help has been, and to some extent still is, met with disbelief among many professionals in the treatment and social care field, as well as among the general public. The tenet, "once an alcoholic, always an alcoholic" is shared not just by adherents of Alcoholics Anonymous, and disputes regarding the dogma of abstinence or the claim that it is possible to revert to controlled drinking or drug-taking illustrate the deep-seated lack of belief in the individual's chances of change without treatment. As a rule, features common to the progression of individual drug and alcohol careers, on the one hand, and to "privately organized remission processes" in people with eating disorders and smokers, on the other (Tinker & Tucker, 1997), are mostly ignored. Although this *Handbook* is about alcohol problems, we will also address other problem areas, because there are many informative studies of natural remission covering a range of substances, and results point to similarities between various types of recovery, consequently supporting an underlying concept of addiction.

In general, the notion of "spontaneous recovery" contradicts the concept of addiction as a disease that is, in principle, irreversible and progressive. Similar attitudes are found in the sociological labelling approach, which for a long time focused one-sidedly on the progressive consolidation of deviant careers and viewed the individual as a victim of stigmatization by the agencies of social control (Sack, 1978).

DEFINITIONS

Concepts such as "spontaneous remission" and "natural recovery" are not in any way new, neither are they confined to specific types of addiction, such as alcoholism or drug consumption. The relative significance of attempts at self-change, as compared with success

rates in treatment in the clinical domain, was the subject of early studies of the neuroses (Eysenck & Rachman, 1973). Coping strategies, creative avoidance and self-protection mechanisms in schizophrenics have also been treated in various ways in psychiatric research and related very broadly to psychological and behavioural approaches to coping behaviour (Böker et al., 1984). In addition to cognitive models of personality (see Miller, 1981), the sociology of life histories (Kohli, 1978), the principles of humanistic psychology (Hay, 1984) and psychoanalytical interpretations of self-destructive behaviour (Battegay, 1988) have been offered as primary theoretical concepts, irrespective of the specific problem area concerned.

The spectrum of definitions of the different terms related to the phenomenon is therefore equally varied. In clinical usage, "spontaneous remission" means simply "an improvement in the patient's condition without effective treatment" (Roizen, Cahalan & Shanks, 1978). Psychological working definitions emphasize the individual's own cognitive achievement ("self-initiated recovery or change in behaviour"; Marlatt & Gordon, 1985). From a sociological viewpoint, the primary consideration is the exit from a deviant career without formal intervention (Stall, 1983). "Natural" and "spontaneous" are increasingly being replaced as keywords by neutral terms, such as "untreated recovery". Nevertheless, common to all these conceptualizations is the assumption that an *unwanted* condition is overcome without professional help.

These approaches can be seen in perspective if self-destructive behaviour is viewed in functional terms as an, albeit unsuccessful, attempt at self-change. Thus, Lange (1981) concludes, again from observations of schizophrenics, that the development of a psychosis in many patients might be interpreted in wholly positive terms as a defensive reaction against a society which suppresses self-realization and thus is viewed as an attempt at self-change.

A variety of theoretical aspects are also associated with numerous practical problems of research methodology. Hidden or unregistered study populations cannot be recruited by means of conventional sampling techniques, while alternative "active case finding" strategies have also their limitations. Snowball procedures reflect local communication networks, while recruitment through the media generates other selective effects—responding to a media call is already a sign of a basic willingness to change and of a more severe problem at hand. Along these lines, a systematic comparison of media recruitment and survey sampling among natural remitters from problem alcohol use from a large-scale German study showed that media recruitment leads to biased samples, with more severely dependent subjects and fewer controlled drinking remitters; media-recruited individuals also believed more strongly than general population survey subjects that treatment would take too much time and effort (Rumpf et al., 2000). Both active case-finding and media calls only reach people who are or were *aware* of their addiction.

An ethical problem in this research area is the risk that successful "spontaneous remitters" will once again be destabilized or discriminated against *through the research contacts*. Finally, the recording and measurement of the processes of change in life histories or variations in addictive behaviour place heavy demands on study instruments or analytical methods, with little opportunity for using standardized procedures.

THE STATE OF RESEARCH

Major starting points for the discussion of self-change phenomena in addiction research are the literature reviews by Smart (1975) in the field of alcoholism, by Waldorf & Biernacki (1979) on overcoming heroin addiction, and the attempt at a comparative review of self-change in eating disorders, nicotine, alcohol and heroin addiction by Stall & Biernacki

(1986). Overall, it can be seen that self-change is not a rare phenomenon and that success rates approximate to those of professional treatment (cf. Blomqvist, 1996). Figures for specific self-change rates naturally vary with the definitional criteria used. We end up with very different remission rates if we choose, for instance, life-long abstinence or return to moderate drinking as reference points, and if we compare subjects with a long drinking history with mildly dependent cases. Taking into account the fact that treatment provision reaches only a minority of those with problems, and bearing in mind the considerable variation in addictive behaviour according to numerous longitudinal studies (Fillmore et al., 1988), this finding is hardly surprising. Canadian population surveys have suggested that about 78% of interviewees with alcohol problems had overcome them without professional treatment. A considerable proportion (38–63%, depending on the survey) had reverted to moderately controlled consumption (Sobell, Cunningham & Sobell, 1996a). Even when eating disorders, medication misuse and gambling addiction were included, only 12% of those interviewed in a population sample by McCartney (1996) had resorted to professional treatment (mainly general practitioners and self-help groups).

Intensive case studies in smaller samples highlight, among other things, the role of social support and control and the influence of life events or stress factors on the motivation to overcome problem use, and point to the creative potential of individual control strategies (Blackwell, 1983). The analytical phase model of self-change, proposed by Stall & Biernacki (1986), has proved to be a useful framework for integrating numerous individual events. In this model, the first phase of remission involves the emergence of a motivation for change; the second phase, the public negotiation of a new, non-stigmatized identity; and the third phase, the stabilization of what has been achieved. According to Stall & Biernacki, in the decision phase, persistent financial and health problems may be considered a specific trigger for the motivation for change, but so can the stress from social sanctions. In the second phase, when sometimes far-reaching changes in lifestyle are instigated but are complicated by withdrawal reactions, the mobilization of social resources is important. In this context, Granfield & Cloud (in press) have introduced the concept of "recovery capital", which is used to refer to the total sum of one's resources (social, physical and human) that can be brought to bear in an effort to overcome alcohol and drug dependency—maintaining bridges with non-using family members and friends, relying on a supportive "safety net" and the commitments of other people, and relying on legal rights with respect to labour market employment, to mention just a few elements. This recovery capital tends to be distributed unevenly between social classes, an aspect that has been little studied (Granfield & Cloud, in press). These more sociologically-orientated approaches to individual life-history change processes correspond to the six-stage model of Prochaska & DiClemente in the clinical domain (see Prochaska, Norcross & DiClemente, 1994), which has to some extent been described as a paradigm shift (Burman, 1997) and has gained broad acceptance in research. It involves a more detailed analytical distinction between "precontemplation" (no change is considered), "contemplation" (medium-term intention to change), "preparation" (immediate intention to change and initial preparatory action), "action" (attempts at changing behaviour) and "maintenance" (continued efforts to change behaviour and continuous support of the new behaviour).

After a lengthy period of neglect of the whole area of spontaneous recovery, a change began during the 1990s which, once again, made discussion of the importance of self-change respectable. Policy planners in the addiction field found themselves faced with growing criticism of the increasing (and also costly) impact of professional therapy, and of the abstinence dogma, in various spheres of life (Peele, 1989). Economic considerations in the financing of treatment sparked interest in so-called minimal intervention, such as long-term, low-intensity case monitoring (Stout et al., 1999) and "assisted spontaneous remissions". The low acceptance or under-utilization of the resources of numerous treatment services

also raised questions about the reasons for treatment rejection and supported the view that it was not possible to understand, from the study of clinical populations only, the needs and possibilities for change among the much more important "hidden problem group". A successful outreach for this group implied, also, the increasingly pragmatic recognition of the concept of harm reduction or low-threshold intervention which, on its part, was also based on a more realistic assessment of the possibilities and acceptance of professional forms of therapy. The idea of harm minimization is not in any way new in the alcohol area, but has gained increasing significance, particularly in view of interesting parallels with other drugs (Plant, Single & Stockwell, 1997).

These general developments have also stimulated research efforts, offered a wider framework for understanding addiction-related change processes or divorced them from a fixation on therapy (Miller, 1998), and encouraged discussion and re-assessment of research available so far. An example from the most recent past is the re-assessment of Vaillant's (1983, 1995) unique long-term study on the natural history of alcoholism.

Taken as a whole, these more recent studies largely confirm the stage model mentioned earlier, which stresses cognitive cost–benefit processes (Prochaska & DiClemente, 1983). This finding also appears to apply in cross-addiction and cross-cultural comparisons. Tinker & Tucker (1997), in their study of overcoming problems of obesity with and without treatment support, observed a combination of short- and long-term, predominantly negative, influences on motivation similar to self-remission processes from studies of addiction problems. In an interview study in Sweden, similar behaviour-orientated control strategies were found in alcohol, tobacco and drug spontaneous remitters (e.g. altered life conception, change in social contacts) (Mariezcurrena, 1996). In an English study which, for the first time, compared smoking, eating disorders, alcoholism and gambling addiction, the overriding importance of subjective will-power and motivation for change (awareness of reasons for change, particularly social pressure and change in life circumstances, such as new job, etc.) was apparent (McCartney, 1996). Social-class-specific opportunities and forms of treatment-free remission were found in a small mixed sample of drug and alcohol addicts (Granfield & Cloud, 1996) and also in a large-scale analysis of problem drinkers (Humphreys, Moos & Finney, 1995). According to this, middle-class addicts with good social networks and, in particular, an intact feeling of self-worth developed into moderate/controlled alcohol consumers, whereas members of the lower social class, subscribing to a "hitting bottom" syndrome, became abstinent significantly more often (Humphreys et al., 1995). With regard to the "abstinence strategy" and "controlled drinking" types of self-change, interesting distinctions can be drawn in life-event profiles. According to King & Tucker (1998), a 4 year group comparison showed that abstaining spontaneous remitters exhibited a steady decrease in the number of reported negative life events, whereas controlled drinking spontaneous remitters (but also stabilized for many years) reported an increase in the fourth year. The authors postulate that:

> . . . as their drinking remained normalized and less central as a life problem, the moderation drinkers were increasingly able to tolerate some instability and change without resuming problem drinking . . . by comparison, the environments of abstainers were increasingly uneventful . . . (p. 541).

According to the only Swiss study available, it was possible to identify motivation, implementation and stabilization phases from an in-depth analysis of the life histories of heroin and alcohol spontaneous remitters, as well as the significance of cognitive decision and learning processes. As this is one of the few comparative prospective studies, main results from the first (1989) and second (1992/1993 and 1996) phases of the research will be highlighted in somewhat greater detail. The 30 heroin and 30 alcohol spontaneous remitters

generally went through a conscious phase of preliminary deliberation, with an objectively high "loss stress" (i.e. the number of negatively experienced life events during the year preceding spontaneous recovery), which progressed to a serious motivation for change through additional, in most cases positive and social, triggers. Contrary to previous findings, support played *no* role in the decision implementation (although it probably did in medium-term stabilization). The spontaneous remitters tend to withdraw in this vulnerable phase and are unaware of informal and professional help provision or reject it as inappropriate. They apply an impressive repertoire of implementation techniques and everyday methods. Specifically, spontaneous remitters resort to distancing techniques (e.g. throwing away the contents of the bar; changing the journey home to avoid passing the pub, etc.), drug-related substitution ideas (e.g. instead of alcohol, new cosmo-organic nutrition, coffee consumption, etc.), the imagination of effects (e.g. anticipated effects of further consumption; a belief that one is specifically vulnerable to alcohol), and individual behaviour management (e.g. hobbies, reading) (Klingemann, 1992).

These concrete resources used in implementing change have generally received little attention in research; one exception is the extensive narrative material in the study by Burman (1997) of 38 male and female alcoholic spontaneous remitters. Burman's typology of self-change strategies, similar in many respects to the Swiss study, included: "bargaining with time—a trial commitment", "programmed self-talks and public announcements", "preserving painful memories" and "journalling".

Overall, the self-remission process in alcohol and heroin spontaneous remitters appeared to follow a *similar* basic pattern. However, differences were apparent which pointed to a more difficult course of self-remission, but also a more stable natural recovery, in heroin spontaneous remitters. According to the findings from the first study, heroin spontaneous remitters had a harder task in the first place to achieve control because, for example, of initial stress levels and persistent craving problems. However, the prognosis for this group was more favourable in terms of medium-term stabilization than that for alcohol spontaneous remitters; the self-assessment of their future progress, as well as that of others, was more positive than in the alcohol reference group. This was all the more surprising because the stress situation of heroin spontaneous remitters at the time of the interview always appeared relatively more precarious than in the reference group. This could be tentatively explained by the relatively more pronounced cognitive support and social orientation of the self-remission decision in the preliminary phase, as well as the establishment of primarily *non*-substance drug substitutes (e.g. religion, relationships) in the stabilization phase among heroin remitters. It is precisely the combination of the pressure from continuing public stigmatization, on the one hand, and perceived primary group support, on the other, which might be interpreted as an ideal basis for challenging the inner-directed remitter to pursue new goals in life.

A comparison of alcohol and heroin cases ($n = 30$ in each group, 100% retrieval) in a follow-up study 4 years later confirmed the tendency for a more positive outcome for self-change in the latter group. Only three out of 30 non-treated heroin remitters reported a fully-blown relapse (with an additional three cases indicating a lapse) compared to nine out of 30 non-treated alcohol remitters (with two additional lapses). Natural recovery from alcohol problems seems to be much more difficult than quitting illicit drug use. Alcohol remitters continue to be confronted with risk situations and easy availability, whereas the drug world is far less culturally integrated.

Future Research Priorities

Having outlined some of the more important research findings in this area of work, we will now indicate where we think future research is especially needed.

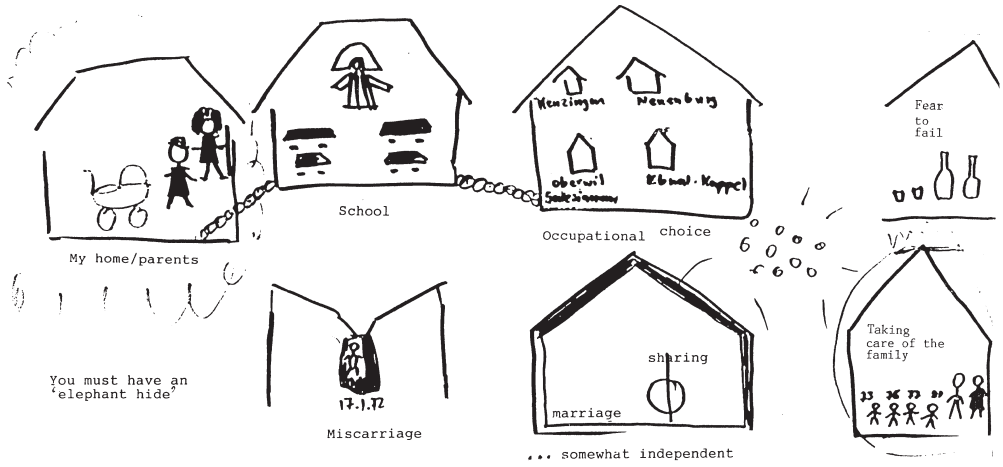

Figure 33.1 'Biographical drawing' of a spontaneous remitter from problem alcohol use (female 35 years old, works in a kindergarten). From Klingemann (1990), with permission

1. *Prospective longitudinal studies*, which help answer questions of causal relationship, and a better integration of qualitative and quantitative approaches. A clear-cut survey approach falls short of the very complicated life histories of spontaneous remitters. The combined use of open-ended questions, narrative approaches, projective methods and standardized questionnaires seems to be promising. If one looks at the complicated ups and downs of the life-charts of spontaneous remitters, one realizes that one can never hope to capture these transitions, passages and career shifts with a series of simple questionnaire items. Figure 33.1, taken from the Swiss study mentioned above, illustrates this very clearly (see also the first use of this method by Alasuuntari, 1986, with a sample of blue-collar alcoholics in Finland).
2. *Improvements in methodological design*, such as the incorporation of control groups and validity tests by interviews with collaterals. Comparing different "true" stories of recovery helps to get a better understanding of how individuals managed to quit. Collaterals tend to be more distanced; quitters may exaggerate their problems of the past to see themselves as "heroes".
3. *Comparative studies*, which include various problem areas—particularly licit and illicit drugs, but also eating disorders, medication misuse and substance-unrelated addictions (e.g. gambling addiction)—in an integrated research design. Above all, increased attention should be paid to the question of multiple problem solutions. Is it easier for people who quit drinking also to stop smoking? Does one success experience carry over to other types of addiction and encourage people to work on other problems as well?
4. *Increased attention to societal conditions*, which might promote or impede individual change. By way of example, mention may be made of the varying degrees of stigmatization of addiction and other social problems by the public and the different ways the media portray alcoholics, drug addicts and gamblers, which in turn will influence perceived chances of change and willingness to help such people.
5. *Investigation of change processes in different cultural contexts*. The few findings available so far do not point to distinct cultural differences but, on the contrary, underline the overriding dominant role of cognitive appraisal processes in very different

countries such as the USA, Switzerland, Canada (Sobell et al., 1999) and Australia (Brady, 1995). It seems that health problems, life objectives, support and pressure from collaterals are *leitmotivs*, which show up almost universally. However, the different focus and development of alcohol (Klingemann, Takala & Hunt, 1992) and drug (Klingemann & Hunt, 1998) treatment systems already indicate significant influences on remission rates and individual control strategies. If little alcohol treatment is available in a specific country and access is difficult in terms of cost and admission criteria, natural recovery rates may be higher than in countries with elaborate treatment systems and guaranteed individual rights to proper treatment. Natural recovery from smoking is the rule, with no specific treatment offered in most cases (Steward, 1999).

CONCLUSIONS FOR TREATMENT AND FOR ALCOHOL POLICY

The provisional demonstration of effective self-change processes does not in any way make professional intervention superfluous. What is required, however, is harmonization of various treatment programmes and specific interventions tailored to the needs of groups targeted for spontaneous remissions at critical points. Finfgeld (1998) discusses how health care providers might promote the process of change and help people to "reinvest in themselves" by, for instance, teaching life management skills and providing accurate problem information.

Bibliotherapy can be regarded as the most prominent case of "assisted spontaneous remission". The basic idea is that written material can assist the individual in the recovery process. This material can be categorized according to the way it is administered, the underlying didactic impetus/content, the target group it is intended should use the manual, and the producer/source. More precisely, we can distinguish between self-help manuals, which are entirely self-administered, those that require minimal contact with a therapist, and manuals used in the context of regular therapeutic meetings. As to the last-named, drinking diaries have been developed to provide doctors with an interactive and cost-effective method of responding to low-dependence problem drinkers they encounter in their practice. In Scotland, the DRAMS scheme (Drinking Responsibly and Moderately with Self-Control) was tested (Heather, 1986) and subsequently adopted also in different cultural contexts (e.g. in Switzerland; Noschis, 1988).

Furthermore, self-help material may be based explicitly on the principles of self-management and stages of change theory to facilitate the transition to the action and maintenance stages. The material may simply help to monitor and structure personal observations of drinking occasions and quantities consumed, or the written material can be simply of a general informative nature, with no stepwise or didactic programme whatever. Self-help manuals are available for both problem drinkers and their partners (Barber & Gilbertson, 1998). While all this material is produced by professionals for people ready to change, there are also cases of "natural bibliotherapy", when spontaneous remitters keep a diary themselves or use related books or materials not produced by professionals as a self-help manual in the strict sense.

> At the time we always drank a lot at Christmas, heavily, and so it wasn't that nice for the kids. I was always in a bad mood and it seemed that the whole world was against me—and then it struck me—I thought, "Now I've really got to do something about this". Anyway, on the 24th we were in a library with our daughter to take a book back—I still don't know exactly how it happened—there was this shelf—I still had a headache from the night before and I was a little

> unsteady on my feet but something drew—no idea how it happened—either way, something drew me to this shelf and at head height there were various books: "ways away from alcohol"—this book, that book, lots of books on drugs and such like—and then I simply picked up two books, took them home and started reading on Saturday night right through into Sunday—I was reading and crying and from then on I knew, as I had already known, "You've got to do something". And the book—incredibly well-written because—well there it was at the beginning—you should only read it when you haven't touched a drop. And so I waited another day (laughs) to get everything out of my system, and then I began to read. And there were so many things in the book that you know full well yourself—but that it takes the book to show you—that's how it is. And then you do the test and insert the points and at the end you add them up and see how many you have. And then you are shocked—5 points is critical and I had 22—it gave me courage (laughs) and then you want to flick back through the pages but when you read further—the very next paragraph—it says stop, don't do it: "why are you flicking back through the pages?". And you laugh because the book caught you out, and then you get to thinking, "How would it be if I stopped drinking altogether?" (Case No. 112, Klingemann, 1992).

Studies by Heather (1986), Heather, Kissoon-Singh and Fenton (1990) and others (e.g. Miller & Taylor 1980) clearly demonstrate the benefits of self-help manuals compared with other forms of brief low-threshold interventions, such as the use of telephone help-lines. However, as the short case description above illustrates, "it is necessary to establish whether it is the self-management ingredients of a self-help manual that make for effective bibliotherapy or the act of reading any reasonably relevant and well-intentioned material" (Heather, 1986, p. 338). Finally, cognitive impairment by alcohol diminishes the capability for self-regulation and monitoring of one's own behaviour and limits the use of these manuals mainly to low-dependence cases.

In this context, addicts' perceptions of treatment programmes are highly instructive and highlight corrections that are necessary to available help. Happel, Fischer & Wittfeld (1993) observed that self-activated forms of strategy and control to achieve remission frequently contradict concepts shared by official drug professionals. Thus, for example, a positive view of the period of addiction in one's own life history is instead depicted as "persistent thinking about addiction", and everyday methods of coping with the problem are often not recognized or picked up by the professional treatment provider. As a result, demands for unconventional support of the individual's own efforts and greater utilization of the skills of those affected can be made. More recent research also points to the fact that cognitive appraisal processes may generally be considered as a basis of motivation for change, irrespective of the specific remission strategy later chosen involving treatment or self-change. Often astonishing similarities between the everyday methods of spontaneous remitters and the methods of paid therapists (Tinker & Tucker, 1997) can be noted.

What can therapists learn from spontaneous remitters? Is it possible to replicate or integrate powerful motivators and facilitators of change in real life in treatment activities? Blomqvist (1996) shows the practical and political limits of such a transfer in practice by pointing out that: ". . . many such activities are most likely to lose their authenticity when explicitly used for therapeutic purposes, thereby creating a 'problem of imitation' ", and warns, ". . . the same idea may be taken as an argument for restricting treatment offers to the most destitute cases, whose prospect of encountering in their 'natural environment' experiences that may promote change are extremely poor" (p. 1830).

Case material from a Swiss study illustrates this point nicely. Could Yvonne's bottle trick be used by others or copied by therapists?

> "OK", I said, about 3 or 4 years ago, "I can't go on like this". I made up my mind I wanted to be a writer, a journalist, and you just can't do that on alcohol, I couldn't write like that. And then I got out a bottle of whisky and I said to myself, "There must be a way", and I looked at

> the bottle for a long time and I got the idea that you could dilute it. And then I started, on the first day I had a little drink, a small glass, just like I always had these little drinks, I poured it from the full bottle and then water, I poured a little glass of water in. And so on, every day I had a glass, two, three glasses till nothing was left in the bottle except water, but the taste of whisky, that was still in the bottle and every day I poured myself a drink or two, until there was only water left . . . I drank that, thinking that it was "whisky"—and so it was for me . . . And then I started drinking coffee—by the litre! (laughs) (subject aged 54, cutter, excerpts from the tape-recorded summary of the auto-remission; Klingemann, 1992).

People's perceptions of available treatment programmes and their own everyday methods are not the only factors that determine whether self-change or expert advice is sought. We also need to consider the physical and geographical problems of access, stigmatization/reputation of treatment, and costs and time demands for a potential patient. Copeland (1997) describes the gender-specific aspects of these limitations. The increasing acceptance of concepts such as "harm reduction" and "low-threshold intervention" is a reflection of the effort to improve general accessibility to treatment and overcome specific barriers, such as time schedules, costs, the possibility of bringing children along, and rigid admission criteria. Happel et al. (1993) urge greater individualization in the treatment system, and complaints about poor gender-specific provision are consistent with the conclusions from an analysis of remission processes (Lind-Krämer & Timper-Nittel, 1991).

Reflecting definitions of spontaneous remission discussed at the outset, basic questions are raised as to what should be considered to be "treatment" and what community reactions to alcohol and drug problems are legitimate and effective. Do material support and aids to survival or the use of complete treatment programmes smooth the path to successful self-change in the medium term, or do they undermine the potential for self-help and self-change (Blomqvist, 1996)? The provision of minimal intervention in conjunction with proactive alcohol prevention in the community context is a highly promising avenue (Sobell et al., 1996b). However, the decisive factor is the acceptance by populations that already have an initial impetus for change (spontaneous remitters in the contemplation/appraisal phase), and that would not benefit from costly outpatient or inpatient care to begin with.

In addition to these therapeutic perspectives, we need to consider the important role of the conditions for a *self-change-friendly societal climate* in the broader sense. More specifically, the perception of possibilities for change by the addict as well as by others and willingness to talk about it interact closely with images of addictive behaviour held by the general public. The major discrepancy between the objective prevalence of self-change processes and their public visibility and evaluation is illustrated by a comparison between groups with different experiences of treatment and consumption behaviour in a Canadian study. Whereas 53% of interviewees who had overcome their dependence without treatment knew of similar cases, only 14% in one (admittedly non-representative) population group were aware of self-change cases. The other study groups (third parties in respect of spontaneous remitters, unsuccessful spontaneous remitters and treatment cases) fell between these two extremes (Cunningham, Sobell & Sobell, 1998).

What is the reason for a distortion of awareness to such an extent that even people whose sensitivity to self-change processes is heightened by their own experience still underestimate the phenomenon? An important factor is the problem-specific stigma. While only 5% of spontaneous remitters in the Canadian study had inhibitions about telling others they had stopped smoking, 24% of interviewees considered it inadvisable to declare publicly that they had abandoned an alcohol career (Cunningham et al., 1998). In his study, Klingemann (1992) showed how people react when they learn that someone has overcome a problem with alcohol or heroin. First, among both heroin and alcohol spontaneous remitters, it was primarily employers and colleagues, as well as neighbours—in other words, groups which can hand out "rewards" or "punishments" to the individual—who were not

informed about the self-change. Second, successful heroin spontaneous remitters who "confessed" to self-change reported negative reactions far more frequently than alcohol spontaneous remitters, which again points to differing degrees of stigmatization.

A reduced potential for stigmatization and increased social support, together with an increased belief in self-efficacy on an individual level, can improve the chances of remission for addicts. They, too, are consumers of mass media messages (Elwood & Ataabadi, 1997), a circumstance which is used in research as a recruitment strategy, but which in public work and prevention is given too little consideration. Last, if these findings are seen at a macrosocial level, then undoubtedly the way in which social problems are presented in the public (media) arena (Widmer, Boller & Coray, 1997) can exert a considerable influence on collective stereotypes and the willingness to provide informal support and help.

National alcohol policy and prevention campaigns can have a definite effect at this level and promote a favourable climate for self-change. An interesting example is the prevention campaign "Handle with Care" run in 1999. This publicity campaign by the Swiss Federal Office of Public Health used slogans and TV advertisements focusing on binge drinking situations (bowling evening, birthday party, disco, etc.). An attempt was made here to induce a transition from the precontemplation to the contemplation phase. In addition, the situational reference does not require continuous monitoring of one's behaviour but it increases the individual awareness of the problem and reinforces relevant avoidance and control strategies. Close attention should, however, be paid to ensuring that the threshold of inhibition for seeking treatment in more serious cases is not *raised* as a result of the propagation of self-help potential among the public (Cunningham et al., 1998).

Finally, from a macrosocietal perspective, one might also assume that more general cultural values and societal belief systems will influence chances for self-change. One might plausibly assume that individually-centred, achievement-orientated Western societies in particular offer good preconditions for self-change philosophies, with active individuals believing in their abilities to resolve the problem situated at the centre. In contrast to this, the disease concept tends as a rule to imply a more passive patient role and expensive expert involvement or, as in the case of the AA movement, even demands an acknowledgement of powerlessness over alcohol and a life-long, ongoing recovery process. Welfare agencies, collective approaches, the belief in state intervention and expert knowledge place far less emphasis on the individual potential for remission and would probably tend more to impede self-change processes. Burman (1997) illustrates this point in her qualitative study in respect of the assessment of self-help groups by spontaneous remitters:

> Many respondents resisted the mandatory labelling, as well as the philosophy of powerlessness over alcohol and recovering as an endless process. As one man stated: "I can't keep seeing myself as an alcoholic if I'm ever going to close that door, *take control* and move on with my life" (p. 47, emphasis added).

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KEY WORKS AND SUGGESTION FOR FURTHER READING

Blomqvist, J. (1996). Paths to recovery from substance misuse: change of lifestyle and the role of treatment. *Substance Use and Misuse*, **31**, 1807–1852.

This review article provides an excellent overview of natural recovery research. Blomqvist argues for the integration of outcome research and research on spontaneous recovery and raises the issue of the definition of "treatment".

Moos, R.H. (1994). Treated or untreated, an addiction is not an island unto itself. *Addiction*, **89**, 507–509.

The title says it all. Best to be read after a comprehensive review article.

Vaillant, G.E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry*, **53**, 243–249.

For those who do not have time to read Vaillant's (1995) book, this article presents the complex study in a nutshell and raises core questions about the natural history of alcoholism from a clinical perspective.

Brady, M. (1995). *Giving Away the Grog. Aboriginal Accounts of Drinking and Not Drinking*. Canberra: Commonwealth Department of Human Services and Health.

This is a fine collection of narratives of Australian aborigines, which illustrates change processes in an unfamiliar cultural context.

Peele, S. (1989). *Diseasing of America—Addiction Treatment Out of Control*. Lexington, MA: Lexington Books).

A provocative book, especially for a North American readership used to the 12-step philosophy and the "war on drugs" rhetoric. More a policy book than a scientific reader, the book suggests why natural recovery research has sparked so much controversy.

Miller, W.R. (1998). Why do people change addictive behavior? The 1996 H. David Archibald Lecture. *Addiction*, **93**, 163–172.

This article puts the influential transtheoretical model of change by Prochaska and his colleagues into perspective and focuses on the concept of "assisted natural recovery", touching upon principles of motivational interviewing, self-efficacy and brief intervention.

Klingemann, H., Sobell, L., Barker, J. et al. (2001). *Promoting Self-change from Problem Substance Use: Practical Implications for Policy, Prevention and Treatment*. Dordrecht: Kluwer Academic.

This book offers an up-to-date review of self-change from problem use of licit and illicit drugs, and from gambling, and provides a "tool-box" for the practice-oriented reader.

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