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Hostile and Favorable Societal Climates for Self-Change: Some Lessons for Policymakers

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Introduction

When individuals vote, decide on what to wear or what to eat, they do not do so in a societal vacuum; rather, their actions are influenced and affected by society's values, trends, commercials, and campaigns. From our daily experience, it seems plausible that social and cognitive processes are intertwined. However, in the area of natural recovery research, decisional processes of self-change are often viewed as occurring mainly within the individual or from interactions between individuals. This is not surprising given the importance of clinical psychology and psychiatry in this area as well as the methodological difficulties in measuring society's impact on individual behavior.

From a sociological point of view, the role of primary and secondary groups, organizational settings, societal belief systems, and opportunity structures—all of which may promote or impede self-change—has largely been neglected. Exceptions are the concept of social capital including multilevel resources for change (Granfield & Cloud, 1999) and attempts to apply staging models to understanding health behavior and lifestyle changes within an organizational and environmental framework (Oldenburg, Glanz, & French, 1999). As a result of this restricted point of view, our understanding of the spontaneous recovery process suffers from an individualistic (as compared with a societal) bias. To address such a gap, this chapter intends to highlight links between individual clinical views and social factors such as public images of addiction, treatment systems, the role of the media, and policy measures. These macro-societal aspects are of interest to policymakers.

> "Could be about attitudes in the society. Against those who have problems. Even if it is classified as a disease, I don't think that is how it is seen by most people. They rather think it is your own fault, at least kind of. … So, some better understanding in society for those kind of people who have problems. That would make it easier for them I think. One maybe would dare to make a first step." (shop owner, SINR interview, Stockholm)

Images of Alcohol and Drug Addiction in the General Population: Stigma, Social Support, and Change Optimism

Societal beliefs about social problems and their nature shape individual and collective responses to individual self-change. How visible are these problems? How confident are researchers 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 concept of addiction or the paradigms that prevail in societies. Are addictive behaviors seen as medical problems, social problems, or as criminal or immoral in nature? 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 on the images they see in the general population and more precisely in their reference groups.

A Canadian survey (Cunningham, Sobell, & Sobell, 1998) showed that for potential self-changers who are in the precontemplation phase or weighing strategies for implementing change, the images of the nature of addiction and the public visibility of successful natural recovery were very important. 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. It seems plausible to assume that societal stigma kept people from telling others about their self-change process; that is, only 5% of self-changers said they did not tell others they had stopped smoking, whereas almost five times more (24%) did not tell others they had stopped drinking. Even though self-changers had a success story to tell, they probably anticipated a negative or ambivalent societal response of varying strength according to the type of addiction.

Although there is a vast literature on the nature of stereotypes and attitudes toward addiction, the perception of self-change processes in the public is clearly underresearched. Only recently have efforts been made to explore attitudinal dimensions of the perception of self-change in the general population. The study on "Societal Images of Natural Recovery from Addictions" (SINR) is an international multicity study conducted thus far in Bern and Fribourg (Switzerland), Frankfurt (Germany), Santa Marta and Bogota (Colombia), Warsaw (Poland), Stockholm (Sweden), Helsinki (Finland), and Toronto (Canada). This collaborative project explored, from a sociological perspective, the social conditions influencing personal change (Zulewska-Sak & Dabrowska, 2004). The aim of the study was to identify dimensions of public attitudes toward self-change using "purposive sampling" in communal settings. In each of the cities, 15 key informants from different social and professional backgrounds (e.g., journalists, law enforcement representatives, health care and mental health treatment professionals, so-called everyday therapists such as barkeepers and taxi drivers) were interviewed regarding

the following: (a) their beliefs in chances for self-change, (b) barriers to self-change (Zulewska-Sak, 2004, 2005; Zulewska-Sak & Dabrowska, 2005), and (c) how to promote self-change. Results demonstrate the sophistication of everyday perceptions concerning drug problems. "Without using technical or scientific terms, most respondents appear to be competent barefoot drug policy makers" (Klingemann, 2003, p. 14).

The study results were used as a starting point for the first representative survey study conducted in Switzerland in 2004 which directly measured relevant self-change factors such as "self-change optimism," "social distance," and "self-reported helping behavior." Quotes from the qualitative material from the SINR study mentioned above are used throughout this chapter to illustrate societal conditions pertinent to self-change. It is assumed that disbelief in the possibility of change will discourage potential self-changers. Furthermore, this pessimism will undermine social support by collaterals, which does not seem worth the effort. These assumptions still need to be investigated empirically. Do people believe that addicts can quit on their own? Asked about addiction *in general*, respondents see, on average, a 24% chance for change without professional help which points to a widely held disbelief in natural recovery (see Figure 9.1). More specifically, 26% of the respondents believe there is no chance at all to change.

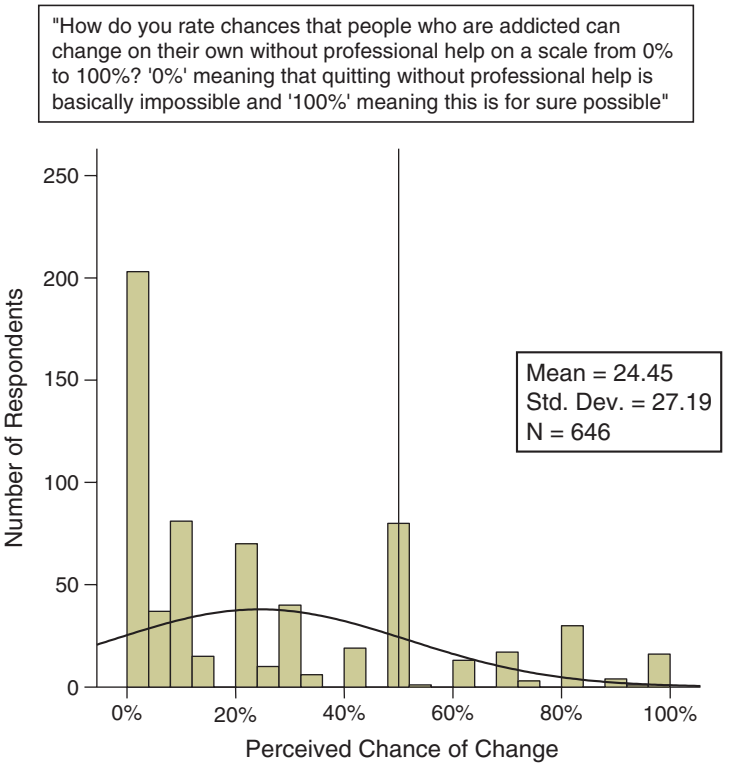

FIGURE 9.1. General optimism for self-change from addictive behaviors.

> "Very difficult. I have met a few people, also friends, who swore they would make it and blah-blah, but it was just talk. It's very difficult, once you fall into it, to get out of that circle. It's totally difficult, from what I've seen. And with therapy, they have really made it, a few of them, and a few are dead, those who haven't done it. There are totally extreme differences." (hairdresser, SINR interview, Frankfurt)

Of the total respondents, 12% believe there is an equal chance to change with or without professional help.

> "Cause I think this is some kind of a lottery. Fifty-fifty, this way or that way." (taxi driver, SINR interview, Warsaw)

A minority (3%; a subgroup which merits a more in-depth analysis) is completely *sure* that addicts can change their lives without paid professionals.

> "In my opinion it's the most important, dominant factor that an addicted person should come to such an inner decision, that he wants to recover from addiction. … There are addictions easier to recover from… but there are also such addictions where recovery is a long-term process… which doesn't necessarily have to be a success. But I think there are more factors that are easy to deal with than such ones where the help of specialists is required." (lawyer, SINR interview, Warsaw)

As the preceding quotes from the SINR study illustrate nicely, lay theories on addiction are by no means simplistic. The representative survey confirms this by revealing that two-thirds of the population think the chances for self-change depend on the substance to which the person is addicted. This should not come as a surprise if one thinks about the diverging images of licit and illicit drugs in the public arena transmitted by the media. That is, when presented with a list of various addictive behaviors and asked to rate the chances of natural recovery, respondents are more optimistic about self-change from smoking tobacco and cannabis (attributing about a fifty-fifty chance) than about spontaneous remission from hard drugs such as heroin and cocaine (only in approximately 13% of the cases do they see this as a possibility). Men tend to be more optimistic than women, except for the consensus on hard drugs and prescription drugs, in which no significant differences were detected.

Gambling, alcohol, and prescription drugs range in the middle with about a one third perceived chance for natural recovery. This rank order may reflect to some extent the availability of professional treatment (basically none for smoking and cannabis abuse) and may correlate with perceived dangerousness of the substance.

Tobacco and cannabis addiction are set apart from other substances in the public mind, which has implications for policy. That is, with about 70% nonsmokers in the population and increasing pressure from policymakers

to pass smoking bans, "change optimism" seems to be most relevant and could possibly be included in campaign concepts. Major conclusions from this study, which still need to be validated through future research in other countries, include the following:

- "Change optimism" proves to be strongly culture-bound and across all types of addictive behaviors is significantly higher in the Francophone minority part of the country, which implements harsher drug policies than in the German-speaking region, which has a higher acceptance of harm reduction policies. In both cases, a gap between the public trust in the ability to make informed choices and the official policymakers discourse can be noted.
- Political views have most impact on the self-change climate when they relate to current debates and high levels of sensitization; a right-wing orientation favors optimism to change from pathological gambling (ongoing debate about casinos and lottery legislation) and proponents of cannabis legalization (a core issue of the debate on the new narcotics law) are significantly optimistic about self-change possibilities from cannabis misuse.
- Personal experience with addiction problems facilitates specific self-change optimism. It significantly increases with self-reported consumption of alcohol and cannabis, respectively. A result which can be interpreted from the general finding is that involuntarily taken risks tend to be underestimated.

Treatment Systems and the Acceptance of Treatment

Self-change or natural recovery is defined as the successful resolution of a behavior perceived as problematic, a process which is primarily driven by the motivation and power of the individual and social forces without relying on treatment or expert help or intervention. The changes that an individual makes through self-change rather than treatment depend to some extent on the availability of treatment resources (Kavanagh, Sitharthan, Spilsbury, & Vignaedra, 1999). This accessibility will vary greatly according to the type of problem at a given time.

> "There is very little treatment for compulsive shopping and gambling. Yes, you can put it that way, that the less help there is out there, the more people have to rely on themselves to heal." (psychologist, SINR interview, Bern)

The treatment of nicotine dependence illustrates this point nicely. Hughes (1999) claims that the statement that 90–95% of smokers who quit do so on their own without treatment is no longer correct. He argues that given the increasing sale of over-the-counter and nonprescription medications as well as bupropion (Wellbutrin) in the United States, 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 and the

response to some psychiatric disorders. At the turn of the last century, few clinicians thought of depression as a disorder; instead, most believed it could be cured by simple motivation and, thus, few treatment resources were made available. Currently, almost all clinicians agree that clinical depression needs treatment. Perhaps the understanding of nicotine by administrators, clinicians, and the public in the 1990s is where the knowledge of depression was in the early 1900s.

However, the availability of treatment does not only depend on the prevailing concept of a disease or addiction, but also on political parameters. In the last two decades, while expansive growth could be seen in drug treatment systems in most countries, it was at the expense of treatment resources available for alcohol abusers. Taking Switzerland for example, the treatment network for approximately 30,000 drug abusers, compared with the counseling and care services available to more than eight times that number of alcohol abusers, is disproportionately well developed and differentiated (Klingemann, 1998).

The images of addiction and prevailing drug, alcohol, or tobacco policies 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 many countries. Their diffusion and adoption depends on a number of endogenous and exogenous influences such as the moral judgment in the population and the adherence to international drug control (Klingemann & Hunt, 1998; Klingemann & Klingemann, 1999).

> "I do suppose that low-threshold initiatives in the area of drugs, for example when heroin is given for free, or other such programs, they have a certain positive effect on the probability of entering a self-healing process, because people are somehow accepted there." (psychologist, SINR interview, Bern)

Even if equity is assumed in availability of professional help at a given time in a given country, individuals' perception of the accessibility of treatment may still vary and therefore affect the probability that they will look for their own solution and not seek professional assistance.

> "When I have a problem, I don't confide in strangers, rather contact close friends." (hairdresser, SINR interview, Warsaw)

In part, a barrier to treatment is the ability of providers to tailor their services to the needs of potential clients. This is mirrored by statements of the SINR respondents who emphasize that treatment has to be individualized; that is, what works for one person does not necessarily work for another person.

"Important to find treatment which is suited for the specific person. … You see that people are different and need different kinds of treatment suited for their needs." (journalist, SINR interview, Stockholm)

"So for me that [self-help groups] would be an appropriate possibility, if you are afraid to have your life analyzed with strangers. This is a big fear, even if we think we have quite an easy threshold, but in principle it is very, very high." (head of an outpatient facility for alcohol addicts, SINR interview, Frankfurt)

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 is culturally supported beliefs. For example, Western values strengthen the idea that individuals have to ideally overcome problems without affecting others (i.e., individual will power and strength) and by downplaying the influence of other circumstances (see Barker and Hunt's chapter in this volume). From a systems perspective, the inability of treatment providers to reach the majority of their target groups points to the increasing importance of lay help, informal referral systems, and therefore also self-change processes. In modern societies, the authority of experts and societal elites, such as scientists and politicians, has been fading in general. The emerging distance between the lay populace and professional treatment also shows the limits of medication and expert help in addiction intervention. This opens an analytical viewpoint that has yet to be discussed—the perspective of the consumer. On both the individual and systems levels, the consumer of treatment services is viewed, according to the sick role definition by Parsons (1951), as a passive, compliant recipient of beneficial treatment by a specialist authority. This is further illustrated by the top-down planning of treatment programs based on scientific paradigms about the nature of addiction, expert knowledge and professional socialization, and the severity of addiction problems.

Yet, addiction treatment is an interaction between the provider and the consumer. Experts are also influenced by their lay counterparts and need their consent to operate and succeed. A better understanding for the dynamics and future changes of treatment systems and the role of natural recovery or assisted self-change will be facilitated by researching the interface between professional and lay cultures and referral systems (Freidson, 1960; Klingemann & Bergmark, 2006). This includes, among others, the following topics:

- The comparison of experts' and lay persons' ideas and concepts of addiction, consequences of addictive behaviors, risk assessment, and the perceived efficiency of formal and informal support
- Individual and organizational strategies to adapt to clients' needs
- Lay strategies to control and check professionals' behavior (e.g., via Internet, second opinion)
- Understanding consumer treatment choices and decisions not to seek professional help

In spite of these underresearched topics, there is at least some evidence that treatment systems have converged in particular areas closer to the target groups they intend to reach. Some indicators for such a development are the following:

- The partial adoption of the *stepped-care* model and brief interventions which acknowledges the everyday life context of clients while using beneficial evidence-based practices
- The long-term trend toward outpatient treatment which brings interventions *closer to the community* and avoids removing clients from daily context, as opposed to inpatient programs
- The inclusion of *affective, spiritual alternative elements* into treatment programs going beyond the "specific symptoms, evidence only" philosophy

To conclude, the current shortcomings in addiction treatment can be viewed from the perspective of self-change research as a lack of trust and confidence. Helping people to change can only be achieved in a self-change friendly society with treatment professionals who are equally legitimized by their professional community and their customers whose needs they are expected to match.

Self-Change in the Global Village: Media Images and Health Information Management as Social Capital

The Portrayal of Alcohol and Drug Users in the Media

The way in which social problems are presented in print, electronic media, and other public arenas can exert considerable influence on stereotypes or the willingness to provide informal support and help.

> "Well, one of the possibilities [to make self-change easier] is certainly information, that you … I don't know exactly … show some ways, in newspapers, in books, on the radio, and in TV programs, how people could also quit on their own. Or maybe even in schools, explaining that to people." (journalist, SINR interview, Bern)

Advertising for smoking and alcohol is subject to various restrictions in some countries and it is generally claimed that only brand-specific market shares are at stake (Godfrey, 1995). Although there are no studies showing how advertisement exposure affects recovery, one can speculate that self-change from nicotine and alcohol problems might be more easily accomplished where cues for use are less frequent. The images of smoking, alcohol use, and illicit drug use presented on television, radio, and in print can be understood both as a reflection of and major influence on public opinion about substance use.

Lemmens, Vaeth, and Greenfield (1999) have presented a content analysis of the portrayal of alcohol-related issues in five national newspapers in

the United States from 1985 to 1991. Most articles reported alcohol issues neutrally or negatively. Furthermore, a general shift since the 1960s was noted, characterized by emphasizing public health issues, deemphasizing clinical aspects, and stressing external environmental factors more than the biopsychological definition of alcohol-related behavior.

Such changes in media messages may be more conducive to natural recoveries by not glorifying drinking and by stressing the role of environmental factors rather than intrapsychic factors. However, more recent media studies reveal a more differentiated picture by type of drugs. For example, the comprehensive literature review in "Here's Looking at You, Kid': Alcohol, Drugs, and Tobacco in Entertainment Media," prepared for The National Center on Addiction and Substance Abuse at Columbia University by Roberts and Christenson (2000), examined research on the frequency and nature of media portrayals of the use of alcohol, tobacco, and illicit drugs. Results show that for television alcohol remains the substance most likely to be portrayed, with no large past or current changes in frequency; the most recent data indicate that three out of every four episodes of the most popular shows depict alcohol use (Roberts & Christenson, 2000). Drinking has generally been presented as a routine, problem-free activity. If anything, the overall message is largely positive, in that those who drink on television are more likely to be central characters, more attractive, and of higher status then those who do not drink (Mathios, Avery, Bisogni, & Shanahan, 1998). Older studies, such as the analysis of 48 German and American soap operas and crime series shown on German television, also highlight the reinforcement of positive, beverage-specific social stereotypes such as the association between beer and friendship (Weiderer, 1997).

Portrayal of tobacco use decreased markedly on TV from the 1950s through the 1980s, but rose during the 1990s, with the most recent data indicating that 22% of episodes of the most popular shows depict tobacco use (Roberts & Christenson, 2000). Christenson, Henriksen, and Roberts (2000) found that negative statements were made about smoking in 23% of the shows in which smoking occurred, yet explicit refusals occurred in none of 31 episodes that showed tobacco use.

According to Roberts and Christenson (2000), illicit drug use portrayals appear to be more frequent now than in the 1970s; currently about one in five episodes of top television shows portray illicit drug use. In their own study, Christenson et al. (2000) found that when drug use appears on television it is often portrayed negatively; that is, 67% of episodes that portrayed illicit drug use also depicted negative consequences, while only 3% contained statements that could be interpreted as pro-use.

Although the impact of television on viewers and potential risk groups is difficult to assess, one can assume that modeling influences people, especially in later stages of change (Rogers, Vaughan, & Shefner-Rogers, 1995; Slater, 1997). Such modeling approaches, based on social learning theory, proved to be quite efficient by using, for instance, melodrama. The more positive portrayal of alcohol and tobacco use in the media, compared with illicit

drugs, is consistent with the attitudes in the population about the possibility of self-change from various types of addiction reviewed earlier.

Active Information Retrieval and Media Use as a Tool for Self-Change

Individuals involved in self-change and their collaterals are not only passively exposed to addiction-related messages in the media, but once they have reached the contemplation/action stage of change they may also extend their human capital by actively seeking information useful to gain control of their habit. The concept of human capital, as a part of the social capital for successful self-change, refers to knowledge, understanding, skills, and other personal attributes that can be used to achieve one's desired goals and successfully negotiate personal difficulties (Granfield & Cloud, 1999).

Using "How to…" Books

Written material can assist people in the recovery process. Most bookstores have a "Self-help" section. People trying to gather information about what they can do concerning their eating, sex, drinking, or work stress problems can turn to some type of bibliotherapy. Self-help material may (a) be based explicitly on the principles of self-change and stages of change theory, (b) help to monitor and structure personal observations (e.g., drinking occasions and quantities consumed), and (c) provide general information with no stepwise or didactic program. Self-help manuals are available for both problem drinkers and their partners (Barber & Gilbertson, 1998). The appeal of the "how to improve your life" literature on the book market is probably due to the choice it leaves readers, its time flexibility, and its confidentiality (e.g., Carlson's 1998 book on simple ways to minimize job stress was a national bestseller in the United States). Self-help material has a middle position between manuals requiring minimal contact with a therapist (Heather, 2001) and personal diaries that help monitor personal changes including addiction problems.

> "Thursday 3 August: 8 st. 11, thigh circumstance 18 inches (honestly what is the bloody point), alcohol units 0, cigarettes 25 (excellent considering), negative thoughts: approx. 445 per hour, positive thoughts 0." ("Bridget Jones's Diary," by Helen Fielding, 1999, p. 184)

Using the Internet, Cyber Hugs, and Telephone Helplines

Health information and related discussions lists, chat rooms, and cyber self-help groups on the Internet are becoming increasingly popular and are a standard item for many providers (Maxwell, 1998). Examples include McCartney's (1999) resources on perinatal nursing and Moran's (1999) information on geriatric rehabilitation.

These sources can also be tapped by individuals trying to come to terms with their addiction problem on their own. Major advantages for many self-quitters are anonymity and the opportunity to compare advice. Young people and individuals living in remote areas are probably most inclined to use the Internet to improve their health status and possibly to handle problems with addictive behaviors. There are numerous websites for addiction information and counseling such as Smart Recovery, Web of Addiction, Moderation Management, and NHS Direct Online ("Advice On-line," 2000). Behavioral self-control training has also been made available via the computer and could produce substantial reductions in the consumption of heavy drinkers. The Drinker's Check-Up is a brief motivational intervention designed to assist clients achieving moderation or abstinence (Saladin & Santa Ana, 2004).

Lastly, the use of popular self-help books is most likely skewed by social strata. This is probably even more the case with Internet usage because it varies with age, income, gender, and educational level (Korgaonkar & Wolin, 1999). The possibility to easily retrieve health-related information from the Internet is by no means equally distributed among societal groups or countries. In North America, which represents only 5.1% of the world population, the Internet penetration rate amounts to 69.1% compared with Europe with a rate of 31.2% (12.4% of the world population), Asia with a rate of 10.8% (56.4% of the world population), and Africa with a rate of 3.6% (14.1% of the world population; "Internet World Stats," 2006). This distribution of access to self-change-related information on the Internet appears to be in reverse proportion to the needs and development of treatment systems in these regions.

Compared with Internet use, many more people have access to telephone helplines. A rationale for helplines is that, given the stigma of addiction, receiving initial help from an anonymous therapist might be more acceptable than face-to-face contact. Helplines can provide immediate motivational material, brief counseling, and information on what kind of treatment is available and how to seek it. Lichtenstein, Glasgow, Lando, Ossip-Klein, and Boles (1996) conducted a meta-analysis of 13 studies of helplines for smoking cessation. Such helplines appear to be efficient and useful as a public intervention for large populations. Meta-analysis confirmed a significant increase in long-term abstinence rates.

An American study (Hughes, Riggs, & Carpenter, 2001) of a convenience sample of 30 helplines for alcohol- cocaine- heroin- marijuana- or tobacco-dependent individuals seeking treatment analyzed the quality of the service by making "undercover" client calls. Responses were categorized as helpful (sending useful mailings, referrals to self-help programs or a drug dependence treatment center), neutral (referrals to another national helpline), or unhelpful (incorrect information such as "nicotine is not really addicting," or inadequate responses, for instance, unfulfilled promises to return a call or declining competence with respect to the caller's problem). Almost none of the U.S. helplines attempted to give concrete therapeutic advice over the phone (which seems to be the case in Europe); instead they served almost exclusively as

referral agencies or mailed written information. The percentage of helplines for illicit drugs described by the evaluators as helpful was relatively low (25% for marijuana) in comparison with alcohol telephone counseling, which was coded as 41% helpful.

To conclude, specific features of the various forms of low-threshold help possibly influence their usefulness for various subgroups of potential self-changers. That is, easy access and personal voice contact by telephone may be attractive for some groups, whereas more neutral contact with Internet websites may be more valuable for others. The former allows for a more passive and guided approach, while the latter provides a more active role, critically comparing information on the web. The use of various types of media may depend not only on group characteristics, but also on the individual's specific stage of change.

Media Campaigns Setting the Stage for Change?

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 of "How does the amount of advertising influence consumption?", one may also ask, "How are the motivation for and chances of self-change affected by national sensitization campaigns?" Wilde's (1991) conclusion from a decade ago asserted that mass communication prevention programs for health were hardly ever evaluated systematically, a criticism that is still valid today.

Conceptual shortcomings and a lack of theoretical underpinnings are seldom identified as reasons for failure. Slater (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 precontemplation to contemplation are agenda setting, situational theory, and multistep flow which lead to interpersonal discussion of the problem behavior. 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 (i.e., social learning theory). Finally, the iterative process from preparation to action may require continued messages which help maintain the motivation and keep the behavior change goal salient. Providing more persuasive evidence and using more directive messages have been useful for probing behavior change. At the same time, this may cause reactance among potential self-changers (Slater, 1999). The stage specific definition of campaign objectives 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 behaviors has rarely been done in the addiction field.

The following three Swiss campaigns, where ideas and findings from natural recovery research have been used as conceptual foundations, will be briefly described: (a) the 1997 drug campaign "A Sober Look at Drugs" concentrated on self-efficacy, (b) the 1999 alcohol campaign "Handle With Care" used a stages of change approach, and (c) the 1999/2000 tobacco campaign "Milestone" focused on significant life events as agents of self-change. As part of an experimental approach to drug policies (Klingemann & Hunt, 1998), the prevention debate in Switzerland has moved from a traditional, substance-specific informational approach toward an orientation concerning health promotion and empowerment of the individual to successfully cope with life's challenges. The focus has shifted to protective factors (e.g., individuals' beliefs in having control over their life, having confidence in other people, trusting in one's ability to overcome setbacks, seeing difficulties as a positive challenge, finding meaningful objectives in life). From this approach, prevention is viewed as a concern of society as a whole. Key elements and ideas from natural recovery research can be used for campaigns based on this mode of thinking.

"A Sober Look at Drugs"

The Federal Drug Sensitizing Campaigns, which started in 1991, set out to promote a better understanding of drug issues among the public at large and included, among others, the following studies: (a) a 7-year follow-up of heroin users conducted by the Zurich Institute for Addiction Research (Dobler-Mikola, Zimmer-Höfler, Uchtenhagen, & Korbel , 1991), (b) natural recovery studies on alcohol and heroin remitters by the Swiss Institute for the Prevention of Alcohol and Drug Problems (Klingemann, 1992), and (c) an epidemiological survey among heroin and cocaine users done by the University of Bern (Estermann, Herrmann, Hügi, & Nydegger, 1996). These three studies provided empirical data which were used by the campaign organizers to illustrate their point. The national poster campaign, launched in 1997 under the theme of "A Sober Look at Drugs," tried to change the attitude "once an addict always an addict," by giving information about the chances of stopping drug use and trying to strengthen hope and optimism with the slogan "Getting into drugs does not mean to stay with them—Most drug users succeed in quitting their habit" (see Figure 9.2).

Even though annual campaign budgets for these studies (about $2 million U.S.) were low compared with commercial advertising, the objectives were reached. A representative survey conducted in 1997 showed a positive reaction and a good recall rate of 31% for that year's campaign. The (stigma relevant) perceived rate of drug users quitting rose from 18% in 1996 to 29% in 1997 (Moeri, 1997). Those directly concerned with the problem preferred the more direct and specific message, "Coercion is no help most of the time but with our support most drug users will manage to quit." This is consistent with Slater's (1999) stage-specific recommendations for media

FIGURE 9.2. Poster campaign for "A Sober Look at Drugs."

campaigns mentioned earlier. Taken together, self-efficacy and mobilizing social support for self-change was at the center of this campaign.

"Handle With Care"

The campaign "Handle With Care" was the first-ever, large-scale alcohol prevention program in Switzerland. It was sponsored by the Swiss Alcohol Board and launched by the Swiss Office for Public Health and the Swiss Institute for the Prevention of Alcohol and Other Drug Problems as part of the National Alcohol Program 1998–2002. The "Handle With Care" logo was

a bottle opener which was repeated in all messages and incorporated in billboard poster campaigns that started in July 1999 with ads in the print media published simultaneously. This campaign went a step further than "A Sober Look at Drugs" by adopting the theoretical underpinnings of a simple stages of change model. The objectives of this campaign were to gently push at-risk consumers who were in the precontemplation stage forward to the contemplation stage and to influence motivated at-risk consumers to move toward the action phase. The campaign was based on the results of a representative survey conducted in November 1998. The distribution across consumption patterns and stages showed that 84% of all respondents were in the precontemplation stage, 6.5% were in the contemplation stage, and a remarkable 9.5% were in the action stage. Males thought about their drinking more than women while age and linguistic region were not related to stage progression.

Five 18-second TV spots labeled "minor mishaps" were shown on all Swiss TV channels and non-Swiss channels with Swiss advertising slots starting in March 1999. These spots featured everyday scenarios showing self-confident individuals consuming alcohol and ending up with minor mishaps such as the following:

A man starting to pour a glass of wine but misses the glass (wet socks clip), a woman burping at a ladies tea party (burp clip), a man dropping ashes from a cigar into the glass of another guest (ashes clip), a man falling off his chair (falling clip), and a woman almost going to the men's restroom (wrong door clip). All situations are in leisure-time settings and meant to be nondramatic. The spots end with the on-screen question "Everything under control?," prompting viewers to evaluate if their alcohol consumption is maybe a bit problematic and should be given more thought ("Spectra," 1999a,b).

"Handle With Care" was targeted at the population segment progressing to the action stage and promoted self-monitoring material consistent with the principles of assisted self-change and minimal intervention. To monitor one's own alcohol consumption, a handy alcohol slide ruler was distributed in physicians' waiting rooms and at counseling agencies (see Figure 9.3).

The program was still operating in 2006, although with a lower budget, combined with a community prevention program and new elements such as an information table in credit card form to monitor one's Blood Alcohol Concentration level and an Internet game ("Space Bar," 2006). The current content of messages has shifted to a more traditional emphasis on alcohol-related negative consequences. It remains to be seen to what extent the new Swiss National Alcohol Program 2007–2011, which is still being planned, will draw on the ideas and results of self-change research.

"Milestone"

"A lifestyle is born. Milestone—the most pleasurable non-smoking campaign since we know cigarettes!" This was the opening slogan when the campaign was launched in October 1999 by the Swiss Cancer League and

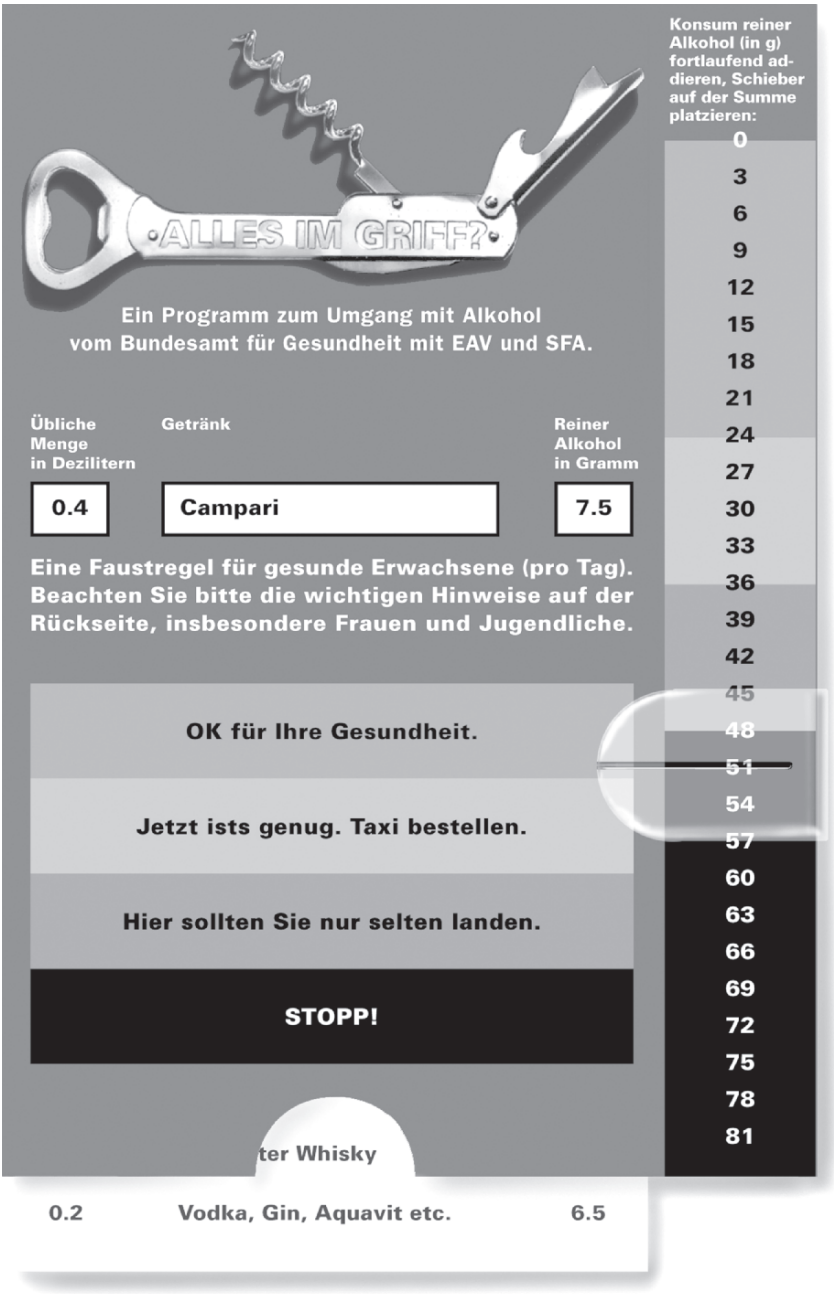

FIGURE 9.3. Tools to assist self-change: Alcohol slide ruler distributed during the "Handle With Care" campaign.

the Swiss Office of Public Health. The concept of "Milestone" is explicitly based on significant life events that trigger spontaneous remission, a classic theme of natural recovery. Key elements are the special moments which make life worthwhile and break through the daily routine such as "the first child, the sumptuous wedding, the new sports car, the trip around the world, the dream job, the successful exam, the important birthday, the new apartment with a view on the lake. … 'Milestone' symbolizes the end of a phase in your life and a new beginning" (see Figure 9.4; "Swiss Cancer League," 1999).

The campaign was aiming specifically at dissonant smokers in the contemplation phase and wanted to provide chronic smokers with the motivation necessary to quit. It was the first largely Internet-based campaign in Switzerland, although it also used a telephone helpline and printed informational material. First, smokers signed up on the website and defined their personal milestone—a date and event marking the start of their attempt to quit smoking. This was part of a public data base including portraits of all the participants. Second, they received an e-mail on their quit date reminding them of their intention. After 3 months participants

FIGURE 9.4. Life events as personal milestones for change when quitting smoking.

received another e-mail asking them to report their success or failure. Finally, reported successes were filed under the category "congratulations" and the participants received a gift. Those reporting failures were encouraged to resubscribe by choosing another milestone (i.e., another quit date). During the phase of remission, the website offered tools for assisted self-change such as information on nicotine replacement, self-help groups, and self-monitoring devices. After 100 days of the campaign, about 300 people had signed up and indicated a personal milestone. During the first 3 months the website had 25,000 visitors and 18,000 of them downloaded the nonsmoking questionnaire ("Swiss Cancer League," 2000; see also Siegenthaler, 2000). More recent campaigns have not used the idea of individual turning points. For example, the poster used as part of the Swiss National Program on Tobacco Prevention (2001–2005) emphasized negative consequences of tobacco, with a focus on passive smoking (www.rauchenschadet.ch). Which approach will influence dissonant smokers more and facilitate self-change remains to be seen.

Structural Prevention and Chances of Change: How Far Is It to the Next Pub and Where Am I Still Allowed to Smoke?

Availability of alcohol and drugs is subject to change and varies greatly between societies, groups, and regions. Taxation policies and various degrees of competition on drug markets will influence prices and consumption patterns (e.g., Klingemann, 1994; Öesterberg, 1992). Most of the discussion in the natural recovery field has focused on general consumption levels and has not been concerned with addiction and effects on individual behavior. How sensitive are drug consumers in various stages of change to price changes? Are substitution processes (i.e., one drug for another) affected by differential prices, health policies, or income fluctuations? In this context Godfrey (1995) highlights interesting implications of Becker and Murphy's (1988) economic model of rational addiction for self-change processes by stating the following:

> 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 behavior patterns such as "binges," abrupt discontinuity of consumption, and repeated quitting behavior are also consistent with this model of "rational behavior." (p. 180)

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

> "This is difficult, we have to change the structure of society and that is not made just like that. I think it's really difficult." (hairdresser, SINR interview, Stockholm)

The definition of alcohol-related social harm and ideas regarding what should be done about it vary across time and within the same country, as demonstrated by trend studies in the Netherlands. For example, Bongers, Goor, and Garretsen (1998) define the social climate on alcohol as the blend of different views on drinking, conceptions of alcohol-related problems, and appropriate measures for dealing with them. The study dealt with, among other things, tolerance toward 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.

Taking an example from Switzerland, the liberalization of the markets has allowed for longer hours of operation, the abolishment of the so-called need clause (limiting the number of outlets as a function of the population), and the introduction of unified tax rates for distilled spirits after a ruling of the World Trade Organization in July 1999. The British government has also reformed the licensing laws and changed opening hours since 2000, even though national opinion polls do not necessarily show public support for such a policy ("Alcohol Policy," 2000; "Minister Lays Down the Law," 2000; "White Paper," 2000).

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

Comparing the United States and Canada in 1989/1990, Giesbrecht and Greenfield (1999) 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 services to drunken customers or providing information on treatment.

In a recent study, Giesbrecht, Anglin, and Ialomiteanu (2005) presented survey respondents with a list of evidence-rated policy measures according to a World Health Organization-sponsored project. The respondents consisted of Ontarians drawn from cross-sectional surveys conducted with representative samples of adults between 1993 and 2003. Results showed that lay people indicated support for a wide range of policies, including both evidence-based measures (e.g., introducing a monopoly retailing system, raising the minimum legal drinking age) and less effective strategies (e.g., banning alcohol- and smoking-related advertisements on shows popular with young viewers, using warning labels). In some cases, support for effective policies (e.g., raising taxes

on alcohol, restricting outlet density) was modest. This shows that the attitudes toward policy measures which would improve structural conditions for self-change are not necessarily viewed by the public as negative and should be taken into account. Not only in treatment, but also in policy, acceptance of citizens and consumers is pivotal for the implementation of change.

Finally, the most recent and impressive example of environmental changes potentially relevant to self-change is the partial or complete ban on smoking, not only in the United States (Clean Indoor Air Act, 2003) and Ireland (Public Health Tobacco Act, 2003), but also in Italy (2005), Norway (1996), Spain (2006), Scotland (2006), New Zealand, Australia, South Africa, Tanzania, Canada, and Bhutan. In Switzerland, preliminary steps have been taken to curb tobacco consumption, such as the smoking ban on public transportation in December 2005 and discussions of smoking restrictions in restaurants and bars in various cantons (see Figure 9.5).

Research on the impact of smoking bans on smoking behavior and self-change processes is scarce so far. Indirect measures include reductions in cigarette sales, the air quality in public indoor places, and smoking-related health problems (e.g., respiratory problems; see Allwright et al., 2005). Direct measures focus on the effects of reduced access to smoking at the workplace on smokers as well as nonsmoking employees and finally on customers and smokers in general. It remains to be seen if reported declines in cigarette sales, for instance an 11.3% reduction in Ireland by the market leader Gallaher (www.rauchenschadet.ch), will continue into the future. As to the effect of workplace smoking bans, older studies demonstrated that heavier smokers benefit most and that "the imposition of environmental restrictions may make long-term controlled smoking more viable in itself, and a useful way station for those who would eventually like to stop smoking completely" (Borland, Chapman, Owen, & Hill, 1990, p. 180). The comprehensive systematic review of 26 studies on the effect of smoke-free workplaces on smoking behavior by Fichtenberg and Glantz (2002) comes to the conclusion that "while producing benefits for non-smokers … smoke-free work places make it easier for smokers to reduce or stop smoking" (p. 190). More specifically, a consumption reduction of 29% can be assumed. Also, smoking bans seem to have some effects on smoking cessation in general, at least in the short term. The Tobacco Control study has shown that the smoking ban in Ireland helped people quit smoking and 83% of Irish smokers responded positively to the ban (Eaton, 2005). Italy's smoking ban in public places has led to an 8% drop in cigarette consumption (23% among 15- to 24-year-olds; Dobson, 2005) and the study by Fichtenberg and Glantz (2002) mentioned above shows that a smoking ban at all workplaces would lead to a 4.5% drop in per capita consumption in the United States.

Although the causality is unclear, one can assume that these restrictions will support self-change processes. The Australian study by Trotter, Wakefield, and Borland (2002) on the perceived effects of smoking bans in bars, nightclubs, and gaming venues on smoking behavior focused on socially cued smoking

FIGURE 9.5. Poster campaign for the introduction of a smoking ban on public transportation in Switzerland.

and readiness to quit. Of the smokers frequently going to those places, 70% reported smoking more in these settings and 25% said they would be more likely to quit if bans were imposed. From a self-change perspective an interesting finding is that, compared with smokers not likely to quit after a ban, smokers who reported they would quit tended to be younger and indicated socially

cued consumption. They were also in favor of bans and 2.22 times more likely to be in the contemplation or preparation stages of change. So far there are no studies which directly address the effect of smoking bans on self-change from smoking (and possibly gambling and problem alcohol use), but it could be speculated that at least dissonant smokers who are already contemplating changing might benefit considerably from these environmental changes.

Motivation of Change and References to Society and Politics of Self-Change

Most likely, individuals interviewed about why they recovered will not make reference to society, outlet density, or similar macro-concepts. Most of the contextual references (i.e., environmental features) discussed in this chapter are not often revealed in narrative accounts presented in natural recovery research. This could be an artifact and consequence of the individualistic bias described in the introduction. However, this does not mean that the macro-societal factors outlined in this chapter do not have an effect on the change process at the individual level. Identity transformation processes do become visible when people talk about religious and spiritual experiences as the causes of their remission and when they assume professional roles as helpers to foster their change and make productive use of their past deviant experiences for current respectable roles (Klingemann, 1999).

The promotion of a "self-change friendly society" might include efforts to influence social interactions between addicts and the general population, which may reduce social distance and encourage social support. Such a policy would also take into consideration societal images of various addictions and present counterarguments to addiction-related attributions of dangerousness and blame.

> "Addiction [should] be more accepted in this society here, [should be] talked about more openly, so that addicts don't necessarily feel rejection from public life…. Prejudices are so big, that people who are addicted can't work, they are not in a position to be independent." (social worker, SINR interview, Frankfurt)

Interactions between the various self-change context parameters and the empirical study of the link between context and individual change could be studied best in limited communal settings similar to community prevention programs under the following slogan: "Creating our self-change friendly town—steps to a communal self-change laboratory."

> "It could be that the environment should pay more attention to it and be more supportive … but it depends on what stage you are in and if you listen to others. You cannot clear the country from drugs or alcohol. It seems unrealistic that all the narcotics would disappear." (social worker, SINR interview, Stockholm)

Future research is also needed to expand the range of indicators for self-change friendly societies. These concepts need to be empirically validated and tested on a cross-national level. Their relevance for the prevalence of self-change rates and the evolution of self-change processes over time should be subject to closer investigation. Aggregate data analysis and connecting context variables with individual behavior, such as the stages of change approach, will be methodological challenges for self-change research to come closer to answering the old question "why do (or don't) people change?"

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