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Self-Change from Alcohol and Drug Abuse: Often-Cited Classics

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The Setting

As maintained by Toulmin (1961), a certain event or condition can appear as a phenomenon—something that is problematic and needs explaining—only against the background of some inferred “state of natural order.” This proposition is worth bearing in mind when revisiting and trying to summarize the key findings and major implications of some of the studies that have historically been most often cited in the debate over the existence, incidence, and character of self-change in addictive behaviors. Admittedly, the selection of studies for the following brief review has been, by necessity, somewhat arbitrary. Nonetheless, it is evident that the vast majority of what may be termed the “classics” in this field originated in the United States in the 1960s and 1970s. To some extent, this may be explained by the dominance, in a global perspective, of U.S. alcohol and drug research at the time. However, the attention paid to these studies and the controversy raised by the issue of self-change may also be reflective of a cultural setting particularly conducive for making this topic stand out. Through the influence of the alcohol movement, the popular “disease model” of drinking problems had, by the early 1960s, become an almost uncontested foundation in alcohol research as well as policy in the United States (Mulford, 1984). According to this model, alcoholism is an irreversible and inexorably progressive process due to some inborn characteristics in certain people. Similarly, but for different reasons, narcotic drugs (i.e., at the time opium and its derivatives) were assumed to have chemical properties that made them capable of enslaving users, more or less instantly and for life. Consequently, increasing resources were spent on the creation of treatment facilities for people with drinking problems and in preventing any use of narcotic drugs.

While terms like *natural recovery* or *spontaneous remission* may initially seem compatible with a medical or biochemical notion of addiction, the suggestion that problem drinking or heroin use might be transient conditions struck at the heart of widespread and firmly rooted beliefs, and challenged strong vested interests in the prevention and treatment fields. Had social-psychological or “natural processes” models been generally accepted to account for addictive

problems, the idea that many people may grow out of their problematic drinking or drug use with time would, in all probability, simply have stood out as “the natural thing” (Mulford, 1984; Peele, 1985).

Before proceeding to a review of the “classics,” it should be pointed out that many of the studies that, at the time, were most frequently quoted as evidence for the existence of self-change were designed to address other research questions. Therefore, potential failures in providing a conclusive basis for judgment on this specific issue should not necessarily be attributed to flaws and weaknesses in the methodology of these studies. In effect, to the extent that self-change or some semantic equivalent was used in these studies, the term was typically adopted as a provisional metaphor for putative and still little understood psychological and/or social processes.

The “Pioneering Studies”

Charles Winick (1962), often referred to as the researcher who first drew attention to the phenomenon of self-change, conjectured that a “maturing out” process might be partly responsible for the fact that approximately two-thirds of the 16,725 addicts (defined as regular users of opiates) originally reported to the Federal Bureau of Narcotics between 1953 and 1954 were not reported again at the end of 1959. Based on the experience that only a slight minority of regular narcotic users could avoid coming to the attention of the authorities during a 2-year period, he argued that inactive status, with consideration for an uncertain number who had died, indicated the cessation of drug use. Winick also found that almost three-quarters of the 7,234 addicts who had become inactive during the period 1955–1960 had ceased their drug use before the age of 38. In addition, a comparison of the age distribution of the inactive sample with that of the total population of registered addicts up to 1955 showed that persons between 30 and 40 years old were clearly over-represented in the former group. Finally, the mean length of the addiction period among the inactive cases was found to have been 8.6 years and more than 80% were reported to have stopped their use before the tenth year of their addiction.

These findings led Winick to speculate about a natural “life cycle” of heroin addiction. Essentially, the hypothesis was that opiate addicts begin their habit as a way of coping with the emotional challenges and strains of early adulthood and cease with their habit when they belatedly, as the result of some homeostatic process, were able to confront and cope with adult responsibilities without using drugs. As a designation of this putative process, he chose the street term *maturing out*. In a later analysis, Winick (1964) plotted the length of the addiction in inactive cases against age at onset. This analysis corroborated that the vast majority of the inactive cases had started their use in their late teens or early 20s and had stopped using in their late 20s or 30s. However, a small subgroup of persons with a very early onset proved

to have been addicted for a considerably longer time than the average of the group, meaning that there was an inverse correlation between age of onset and length of addiction. Winick's conclusion was that these data essentially supported his "maturing out" notion regarding the majority of "intermediate users," but that long-term addicts as well as a small group of short-term users may require other designations. In retrospect, the major merit of Winick's study is that it drew attention to the fact, unrecognized or even denied at the time, that a substantial number of addicted heroin users achieve enduring abstinence with time. At the same time, his calculations contain a good deal of uncertainty, lacking data for certain critical variables (e.g., mortality rates, potential treatment effects, exact dates of cessation of drug use). Moreover, the proposed explanation did not rely on empirical data for the emotional experiences of the respondents.

A few years later, the Australian psychiatrist Les Drew (1968) called attention to the fact that a large number of clinical studies unanimously showed that the quotient of identified alcoholics, in relation to the population in a specific age-group, tended to peak prior to the age of 50 years and then decrease substantially. Drawing on the results of other studies, Drew acknowledged that one reason for the reduction of alcohol problems in older age groups might be related to increased mortality among alcohol abusers and, to a lesser degree, the beneficial effects of treatment. However, viewing these explanations as insufficient, he also found reason to conclude that a process of self-change probably accounts for a significant proportion of alcohol abusers who cease to appear in alcohol statistics as their age increases. As potential forces involved in such a process, Drew suggested a number of factors accompanying aging (e.g., increasing maturity and responsibility, decreasing drive, increasing social withdrawal, changing social pressures, declining financial resources). Among factors that may hamper self-change processes included social isolation and the early onset of severe complications of alcohol abuse. As in Winick's case, what makes Drew's paper somewhat of a milestone is not its empirical data, which were less than perfect, but rather it presented a strong and not easily ignored case against the notion of alcohol abuse as an inexorably progressive and irreversible condition, widely accepted at the time, although it largely lacked an empirical basis (Pattison, Sobell, & Sobell, 1977).

Subsequent Research on Self-Change

The literature pertaining to self-change published in the decades following the "pioneering studies" presents a rather disparate mix of treatment and population studies, cross-sectional and longitudinal studies, and other addiction studies. This chapter will present a selection of such studies that were published before what may be called the "second wave" of self-change research commenced in the early 1990s. Although varying with regard to

sample size, type, overall research questions, and methods, the studies to be discussed were selected because they were seminal reports that produced new insights and/or raised controversy and public debate at the time of publication. As will soon be obvious, the studies selected all address either drug or alcohol problems. Research concerning self-change for gambling, smoking, and a number of other problems is discussed in later chapters in this volume. It should be pointed out, however, that there were some early forerunners of today's research on self-change from other addictions as well. Schachter (1982), in a seminal article, presented data on the self-cure of smoking and obesity in two different nontherapeutic populations. In short, this study showed that about two thirds of those who had, in a lifetime perspective, tried to stop smoking or reduce their weight, had in fact succeeded. The success rates of self-change in the Schachter study were higher than those usually reported for people who were treated for smoking or obesity. Schachter argues that this discrepancy may partly be due to self-selection into treatment of the severest cases, but that the main explanation is likely to be the fact that treatment studies typically report the outcome of a single attempt to quit smoking or to lose weight, whereas self-change studies reflect the cumulative effects of multiple efforts. Emphasizing that treatment studies may give rise to flawed conclusions about the intractability of addiction problems, the author implicitly points to the need for longitudinal research on self-change as well as on the role of treatment in life-change (Blomqvist, 1996).

The following pages will first examine a limited number of studies in the drug research field that can be deemed "classic" works pertaining to the issue of self-change. This will be followed by a somewhat larger number of similar studies in the alcohol research field. To enhance comprehension, each section contains a summary table of the aims, results, and main implications of the reviewed studies.

Studies of Drug Use and Drug Addiction

Table 2.1 shows a variety of information from four classic self-change drug studies that are discussed below.

Treatment Studies

Winick's study, based on official records of known drug users, may be seen as prototypical of many of the early self-change studies in the drug field. Unfortunately, studies of drug use and drug addiction in the general population are still rare (Sobell, Ellingstad, & Sobell, 2000). As for treatment research in the drug field, a limited number of studies during the 1960s and 1970s indicated that only a rather small percentage, seldom more than 1 in 10, remained continuously abstinent for 5–10 years after hospital treatment (Maddux & Desmond, 1980). However, with one exception, these studies did not include a control group that would have allowed for analyses exploring rates of and

TABLE 2.1. Characteristics of classic studies on self-change in drug use.

Author (year)	Winick (1962, 1964)	Snow (1973)	Burt Associates (1977)	Robins (1974a,b, 1993); Robins, Davis, & Goodwin(1974); Robins, Davis, & Nurco (1974); Robins, Helzer, & Davis (1975); Robins, Helzer, Hesselbrock, & Wish (1980)
Data sources; respondents	Official records of regular opiate users (Federal Bureau of Narcotics)	Records of drug addicts in New York (New York City Narcotics Register)	360 heroin addicts followed up 1–3 years after treatment	Enlisted men, returning from Vietnam in September 1971
Principal aims	To assess the long-term outcome of registered drug users	To replicate Winick's studies, taking into account factors such as mortality and institutionalization	To evaluate the National Treatment Association's Program by comparing treated and minimally treated subjects	To estimate drug use and problems among servicemen in Vietnam and the need for drug addiction treatment after returning home
Main results	About 2/3 became inactive in a 5-year period. The majority stopped after < 10 years use, in their late 20s or 30s	About 1/4 stopped using in a 4-year period	Almost 1/3 had recovered (no use and social stability during 2 months before interview) and 1/3 had improved. Subjects who stayed ≤ 5 days did not differ from those who stayed longer	Almost 1/2 of all men had used opiates in Vietnam, and 20% had been addicted. The great majority did not resume use on return. Of those who did, less than 10% got readdicted, mostly for only a brief period. Less than 20% of those who were addicted in Vietnam had shown any signs of readdiction 3 years after return

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TABLE 2.1. Characteristics of classic studies on self-change in drug use—Cont'd.

Conclusions bearing on self-change	There may be a natural life cycle of drug addiction, and most addicts seem to “mature out” of their addiction	“Maturing out” may be less common than suggested in Winick’s studies	Many heroin addicts positively change in a relatively short time frame. Treatment does not seem to add to the recovery rate	Drug addiction is not a unitary and intractable disorder, but a complex and often transitory phenomenon. Transitions between use, addiction, and recovery are probably driven by different sets of factors
Comments	The number who actually stopped may have been exaggerated. The putative “maturing out” process was not supported by empirical data	The lower rate of recoveries may partly be explained by the unique situation in New York and/or by changes in the drug scene since Winick’s studies	The study and control groups may not have been fully comparable. The “recovery” criterion may have captured temporary changes	The “Vietnam experience” may have been a facsimile of drug use and addiction in the population, demonstrating much more flux and “natural recovery” than in treatment-seeking groups

forces behind untreated recovery (Sobell, Sobell, Toneatto, & Leo, 1993). The one exception was Burt Associates's (1977) evaluation of the National Treatment Association programs, based on interviews 1 to 3 years later with 81% of the 360 initially treated heroin addicts. Here, one-third of these individuals had stayed in treatment 5 days or less and were used as a comparison group. Almost one third (29%) were found to be "fully recovered" (i.e., no use of illicit drugs and no arrests plus social stability during the 2 months prior to the interview) and an additional 37% were judged as "partly recovered." The crucial findings pertaining to self-change were that there were no significant differences between the treated and control groups and time in treatment was not associated with outcome. However, the study does not give evidence that the treatment and control groups were comparable in relevant aspects. Moreover, the 2-month criterion for assessing recovery may be cited as evidence for confounding a temporary hiatus in one's drug use with stable recovery.

The Vietnam Experience

The most frequently cited and hotly debated self-change study in the drug field is Lee Robins's follow-up of returning Vietnam veterans, published in a series of reports and articles during the period 1973–1980. This study was originally set up by the Nixon administration through the Special Action Office on Drug Abuse Prevention to estimate the size of the drug use problem among servicemen in Vietnam and after their return, and to provide a basis for planning proper treatment facilities. The study employed two samples of all enlisted men who left Vietnam to return home in September 1971. The first was a simple random sample of all eligible respondents. The other was a random sample of all men who had screened "drug positive" by urine tests before departure. Since all men were warned they would be screened, not having managed to stop using before leaving was seen as a sign of stronger addiction. After correcting for a small overlap between the samples and deducting a minority who could not be reached for an interview, the two samples were comprised of 451 and 469 men, respectively. The first reported analyses concerned respondents' drug use in Vietnam and during the first 8–12 months after their return to the United States (Robins, 1974a,b; Robins, Davis, & Goodwin, 1974; Robins, Davis, & Nurco, 1974). A later analysis was based on data from a 3-year follow-up of the same samples (Robins, Helzer, Hesselbrock, & Wish, 1980). As for drug use in Vietnam, the study found that almost half of Army enlisted men had used narcotics; 34% had tried heroin and 38% had tried opium. Further, approximately 80% had used marijuana (not classified as a narcotic in this study). Almost half of those who had used narcotics had done so more than weekly for greater than 6 months. Overall, one out of five (20%) of all returning men admitted to having been "addicted" to narcotics while in Vietnam (i.e., had felt "strung out" and experienced repeated and prolonged withdrawal symptoms). The predominant route of administration was smoking and less than 10% had ever injected. Compared with soldiers

who used no drugs or only marijuana, drug users tended to be younger, more often single, less well-educated, reared in broken homes, and from larger cities. However, most of the men who used narcotic drugs in Vietnam had not used before service and showed no signs of pre-Vietnam social deviance.

Regarding drug use during the first year after return, only about 10% of the general sample and one third of those who had tested "drug positive" at departure proved to have used any narcotics. More interestingly, less than one in ten of all men who had used since returning had experienced any signs of addiction. In the drug positive sample the corresponding proportion was one in five. That is, only 7% in the drug positive sample and 12% of all men who had been addicted in Vietnam were found to still have been addicted after returning stateside (Robins, Davis, & Goodwin, 1974; Robins, Davis, & Nurco, 1974). When the veterans were followed for an additional 2-year period, these figures rose somewhat. Nonetheless, fewer than 20% of those who were addicted in Vietnam and had resumed narcotic use in the United States were found to have been addicted at any time, and mostly for only a brief period in the 3 years since returning. Collectively, these results were clearly at odds with conventional beliefs at the time. They were counter to reported outcomes of treated cases that generally had shown high rates of readdiction after as short a time period as 6 months. Analyses of the addicted veterans' reception toward treatment further showed that the intervention was at best responsible for only a tiny fraction of the remarkable recovery rates. In effect, less than 2% of those who had used narcotics in Vietnam and only 6% in the "drug-positive" sample went to drug abuse treatment after returning to the United States (Robins, Helzer, & Davis, 1975). Moreover, those who sought treatment showed the same readdiction rates as clients in other treatment outcome studies. Lastly, the results indicated that recovery from drug addiction did not require abstinence. In effect, even among those who were addicted in Vietnam and had used heroin regularly after return, half of the cases were not re-addicted.

The results presented by Robins and her colleagues were met with considerable skepticism by the press as well as large parts of the research community (Robins, 1993). In fact, attempts to dispute or explain away their findings still continue, even in the scientific literature. Apart from raising suspicions that the results were tailored to satisfy military authorities' interests in demonstrating that soldiers serving in Vietnam had not been consigned to a life-enduring dependence on drugs, critics have concentrated on attempts to show that the results lack generalizability. One line of reasoning has been that the Vietnam veterans never were "real addicts." The argument put forth is that the strains and misery of war made addiction a "normal reaction" and that the relatively benign outcome after return was thus irrelevant to addiction in the United States. Another line of thinking states that the veterans' circumstances after return made them different from addicts who started their heroin use in the United States (i.e., returning meant living in a new setting where one would not know where to access heroin and where factors that could serve as stimuli to relapse were essentially absent). In her "look back" article two decades after the initial study, Robins (1993) finds reasons to repudiate these objections

and defends most of the original conclusions. Concerning the explanation of addiction in Vietnam, she highlights that addiction had generally begun before the soldiers were exposed to combat and that the dose–response curve, strongly indicative of a causal link, did not apply to the relation between combat exposure and addiction. Moreover, the respondents themselves did not explain their heroin use as a reaction to fear or stress, but rather as a way of making the boring life in the Army more endurable and enjoyable, factors that may explain casual use in the United States as well. Since, like under “normal” conditions, earlier antisocial behavior was indeed an important predictor for drug addiction in Vietnam, the author is inclined to see high availability and lack of alternative recreational activities as the main explanations for the remarkable rate of use; this was also seen among young men without earlier signs of personal or social problems. The argument that the impressive recovery rates after return could be explained by very limited availability and lack of stimuli to use in the new environment, is clearly contradicted by the fact that only a small fraction of those who continued using in the United States actually became readdicted.

According to Robins herself (1993), looking back over the past two decades the most important implications of the study, although still not entirely incorporated in public and scientific views of heroin use, are as follows: (a) “Few of the Vietnam addicts would have become addicted if they had remained in the US. However, their history of brief addiction followed by spontaneous recovery, both in Vietnam and afterwards, was not out of line with the American experience; only with American beliefs” (p. 1051), (b) addiction looks very different if one studies it in a general population rather than in treated cases, and (c) addiction is a complex and multifaceted phenomenon and further understanding would be facilitated if the focus was shifted from attempts to grasp the entity of addiction to the transitions between use, addiction, and recovery; the latter are probably driven by different sets of interacting forces.

What Did the “Classics” Teach Us about Drug Addiction?

At the surface, the studies just reviewed seem to indicate that recovery rates are very high among “situational” heroin addicts, such as most of Robins’s enlisted men, moderately high to high among narcotic addicts in official registers, and remarkably low among treatment-seeking addicts. Certainly, all of the studies may have claimed to have contributed knowledge in demonstrating that the prevailing notion of heroin as an instantly and interminably addictive drug was a myth, related to its legal status and official rhetoric rather than to empirical facts. The most probable explanation of these widely varying estimates of self-change is—besides methodological divergences—that these different types of studies covered rather different points on the heroin use and abuse continuum. Without reliable data allowing for a comparison between studies of different drug problem severity, it may be conjectured that heroin use and addiction among enlisted men in Vietnam may, except for the high overall prevalence, have been a fairly good facsimile of heroin use and addiction in the general

population. Although a small proportion became readicted after returning, for most of these users addiction turned out to be a transient condition, strongly influenced by environmental and developmental factors. The veterans who did become readicted may be more representative of a much smaller group whose problematic heroin use is intertwined with a number of other social and psychological problems, and who eventually seek treatment. In this group, possibly with an earlier onset of heroin use than the average user and often with a relatively long history of problematic use before the first admission, addiction often seems to have developed into a truly self-defeating process that may be difficult to break with or without professional help. Indeed, prevailing notions of heroin addiction as a generally progressive and irreversible condition may even function as a self-fulfilling prophecy in accelerating such a process.

As for studies of “heroin addicts” in official registers, these may have covered a continuum ranging from users registered only for minor drug offenses to severely addicted and recurrently treated persons, which would explain the middle-range rates of self-change found in these studies. However, due to methodological flaws in Winick’s nonetheless pioneering study, the author’s conclusion that about two thirds of all registered addicts eventually “mature out” of their addiction may have been somewhat exaggerated. Snow (1973), in a replication based on data in the New York City Narcotics Register, tried to account for respondents who had died, been admitted to treatment, or were institutionalized and found that about one-fourth of the registered addicts had “matured out” of their addiction over a 4-year period. On the other hand, the lower rate found by Snow may also, at least partly, be explained by the unique situation in New York City and/or overall changes in the drug scene between the 1950s and the 1960s.

In their review of the incidence literature on self-change from heroin addiction, Waldorf and Biernacki (1979) concluded that studies over the past two decades had amply demonstrated that a significant number of heroin addicts naturally recover from their addiction without treatment intervention. At the same time they deplored the virtual absence of studies providing information concerning the psychological, social, and environmental mechanisms and processes that may be used to bring about such changes. In addition, they pointed to the need to explore the characteristics and resources of people who recover naturally and to compare these with their treated counterparts and with the larger population. With this review, and the same authors’ subsequent attempt to put their proposed research program into practice (1981; Biernacki, 1986; Waldorf, 1983), the “second wave” of research on self-change, which provides the main focus for this book, may be said to have commenced, at least regarding the area of drugs.

Studies of Alcoholism, Drinking Patterns, and Drinking Problems

Table 2.2 shows a variety of information from nine classic self-change alcohol studies that are discussed below.

TABLE 2.2. Characteristics of classic studies on self-change in alcohol use.

Author (year)	Drew (1968)	Kendell & Staton (1966)	Kissin, Rosenblatt, & Machover (1968)
Data sources; respondents	Literature review of studies reporting prevalence rates for alcoholism by age groups	Subjects who declined or were refused treatment for their alcoholism at the Maudsley Hospital (London) and a comparison group of clients who were treated at the same clinic	Clients treated in three different programs and an untreated wait-list control group
Principal aims	To assess changes in alcoholism rates over the life span	To assess treatment effects and "spontaneous recovery" in alcoholics	To compare the outcome of different treatments and of an untreated control group
Main results	Studies from different countries display a common pattern in that the quotient of alcoholics in relation to the population in a specific age group peaks before the age of 50 and decreases substantially thereafter	Half of the untreated subjects had recovered (no serious disruption due to drinking) at the follow-up, 2–13 years after initial assessment. The improvement rate in treated subjects was similar, except for more abstinent cases	Improvement (largely abstinent and socially/vocationally stable for 6+ months at a 1-year follow-up) ranged between 17% and 20% in the treated groups, but was only 4% in the untreated group
Conclusions bearing on self-change	The decrease of alcoholism in older age groups is not sufficiently explained by increased morality and potential treatment effects. There may be a process of "spontaneous recovery" driven by factors normally accompanying aging	"Spontaneous recovery" seems to be relatively common. Treatment promotes abstinence, but does not seem to add to overall improvement	"Spontaneous recovery" in alcoholism is relatively rare and treated clients fare much better
Comments	The data used did not allow for an exact estimation of the impact of factors such as increased mortality or potential treatment effects. The study presented a strong case against the notion of alcoholism as an inexorably progressive and irreversible "disease"	Previous treatment experiences in the study groups were not reported. Treated and untreated samples may not have been comparable in all significant aspects	Using a wait-list group as control may have biased results. Study attrition was almost 50% and may have seriously jeopardized valid conclusions

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TABLE 2.2. Characteristics of classic studies on self-change in alcohol use—Cont'd.

Author (year)	Cahalan (1970); Cahalan, Cisin, & Crossley (1969); Knupfer (1972)	Cahalan & Room (1974)	Clark (1976); Clark & Cahalan (1976)
Data sources; respondents	National and regional probability samples of adult U.S. citizens	National ($n = 1561$) and regional ($n = 780$) probability samples of adult American men	Cahalan's and Room's regional (San Francisco) sample followed up 4 years after the initial interview
Principal aims	To give a detailed and representative account of American drinking practices and drinking problems	To analyze drinking problems, their inter-correlations, and their associations with drinking and with demographic and contextual factors	To assess the development over time of problem drinking and drinking problems
Main results	Drinking patterns and various drinking problems were found to be strongly associated with such factors as ethnicity, social class, sex, and age. Heavy drinking and drinking problems were found to be much less prevalent in women and in the older age group. More than 3/4 of all recoveries from problematic drinking occurred without treatment (Knupfer, 1972)	Strong ethnic and socioeconomic determinants were found for both drinking and problem drinking. Specific drinking problems were found to be only modestly intercorrelated and to vary with contextual and ecological factors. Heavy drinking and drinking problems were found to be more prevalent among men than women, and much more prevalent in younger than in older age groups	"Loss of control" as a problem-drinking symptom was found to come and go over rather brief periods (Clark, 1976). Specific symptoms showed low persistence over time, even if continued involvement with some problems was relatively common. A great proportion of all respondents with some drinking problems at Time 1 reported a complete absence of problems at Time 2
Conclusions bearing on self-change	The traditional alcoholism notion is ill fitted to capture the general population's drinking experiences. Drinking problems tend to be transitory, generally passing with age without treatment	Problem drinking is a heterogeneous condition and problem drinkers constitute a heterogeneous group. People may shift in and out of problem categories, depending on age and changing contextual factors	There is a great deal of flux in problem drinking. The "key symptoms" of the alcoholism paradigm are not a one-way gate to worse problems
Comments	The studies relied on cross-sectional data and did not directly address change over time. "Problem drinking" was predominantly assessed by a simple summary score	Analyses were mainly based on cross-sectional data, and did not directly address change over time	The follow-up period may be claimed to have been too brief to capture the prolonged course of problem drinking

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TABLE 2.2. Characteristics of classic studies on self-change in alcohol use—Cont'd.

Author (year)	Roizen, Cahalan, & Shanks (1978)	Fillmore (1975, 1987a,b); Fillmore & Midanik (1984); Temple & Fillmore (1985)	Valliant (1983, 1995)
Data sources; respondents	A subsample of 521 men in the San Francisco sample with some drinking problem at Time 1 and no treatment experience at Time 2	Probability samples followed up over extended periods, sometimes (Fillmore, 1987b) complemented by cross-sectional analyses of various birth cohorts	Men in a community ("Core City") sample, followed from adolescence until their old age. Additional data from a college sample and a follow-up of a clinical sample
Principal aims	To explore variations in the rate of "spontaneous remission" related to initial problem severity and different outcome standards	To explore variations in drinking and drinking problems over the life span among men and women	To explore the long-term course of alcoholism and alcohol abuse
Main results	Improvement rates varied between 11% and 71%, depending on criteria used for defining problem drinking at Time 1 and improvement at Time 2. The proportion with no problems at all at Time 2 varied between 12% (Ss scoring the highest at Time 1) and 30% (Ss scoring the lowest at Time 1)	Among men, the incidence of heavy drinking and drinking problems was found to be highest in early adulthood, decreasing with age; the chronicity of problem drinking was found to be highest in middle age. In women, heavy drinking and drinking problems were much less common in younger years, increasing slightly in the middle years, and decreasing thereafter. Chances of remission were found to vary greatly with sex and age with the lowest rates in middle-aged women	At the age of 47, more than 1/2 of all men ever classified as alcohol abusers but never subjected to formal treatment were abstinent or drinking without symptoms. Among abusers who did receive treatment, almost 1/2 were symptom-free, of whom the majority were abstinent. Of all previous abusers drinking without symptoms at the age of 47, 1/3 later relapsed into alcohol abuse as compared with < 1/5 of those who were abstinent. Of all dependent subjects later to have achieved abstinence for 2+ years, 4/10 later relapsed, sometimes after as long as 10 years
Conclusions bearing on self-change	Since there is no natural boundary between alcoholics and nonalcoholics in the population, "natural recovery" can be equated with a number of arbitrary standards. Dealing with remission as a prognostic and diagnostic issue requires different research designs and will yield different results	Drinking patterns and drinking problems vary with sex and age, are susceptible to cultural norms, and are often transitory. Only certain combinations of early problem drinking signs seem to predict chronicity of problems	Alcoholism has its own dynamics and is best envisaged as a disease, in the same vein as hypertension or coronary disorders. Abstinence is the only viable alternative to addictive drinking and principles of AA may be said to comprise the fundamental elements of effective remedy
Comments	The study may be claimed to have had crucial implications for further research on "natural recovery"	Controlling for potential bias due to specific historical conditions or unique aspects of particular birth cohorts did not alter overall conclusions	An alternative interpretation of the data is that up to 1/2 of all alcohol abusers, depending on the definition used, recover naturally and that the "natural course" of alcohol problems is better captured by a "natural process" than by a disease model

Studies of Identified Alcohol Abusers

Drew's (1968) seminal article, building on secondary cross-sectional data, included no attempts at estimating the incidence of self-change among individuals with alcohol problems. However, Smart (1975), in the first extensive literature review in this area, reports a number of studies that followed untreated identified alcohol abusers or problem drinkers at two time points. Except for a few early investigations of mostly anecdotal interest, the studies conducted between 1965 and 1975 yielded overall recovery rates varying between 4% and 40% and annual recovery rates between 1% and 33%. A closer examination reveals that these varying results are most likely due to differences regarding study groups (e.g., registered abusers, self-identified alcohol abusers in health surveys, convicted felons identified as alcohol abusers, etc.), recovery criteria (e.g., not found in treatment records, abstinent, drinking without problems, etc.), and follow-up periods (ranging from 6 months to 13 years).

As maintained by Smart, another problem with many of these studies is that untreated alcohol abusers may differ from those who seek and receive treatment in important respects influencing prognosis. Thus, studies of self-change should do as treatment studies and use control groups. However, the only two studies of self-change among treatment-seeking alcohol abusers that had been reported at that time also showed clearly different results. Kendell and Staton (1966) found that one-half of a group of diagnosed alcohol abusers, who were either refused or declined treatment (at Maudsley Hospital in London) and who received no treatment during the follow-up period, had improved at the follow-up 2 to 13 years later; that is, they had not experienced serious disruption due to drinking. In contrast, Kissin, Rosenblatt, and Machover (1968), in a comparative study of three different treatments, found that no more than 4% of an untreated control group had improved in a 1-year period after the assessment. Improvement, in this case, was defined as total abstinence or near-total abstinence and social and vocational stability during the previous 6 months. Further, Kendell and Staton found that the improvement rates in their untreated sample differed little from those in a treated sample from the same hospital (except for a higher proportion of abstinent cases in the latter group), while Kissin and colleagues found the treated respondents to have fared much better (recovery rates ranging between about 17% and 20%) than their untreated counterparts. However, it should be noted that the total attrition in the latter study was almost 50%, although the rates within different samples were not reported; in addition, all dropouts were classified as not improved. Thus, the reported data may well have underrated remission in the total sample and overrated the difference between treated and untreated samples. Moreover, it is unclear whether the treated and untreated groups in any of the studies were really comparable. That is, Kendell and Staton actually borrowed their treated comparison group from another study. Kissin and colleagues, for their part, tried to assign clients randomly to a wait-list, but had to drop from their control group respondents whose request for treatment

persisted beyond the 6 months they had been advised to wait, and who then had to be assigned to a treatment group.

In summary, as pointed out by Blomqvist (1996), making inferences about self-change from control or wait-list groups in treatment studies may, in fact, be a rather unreliable endeavor. On the one hand, because treatment effects may be cumulative, such groups should ideally include only previously untreated respondents. On the other hand, this may make them truly incomparable to treatment groups in which readmitted clients, probably representing the severest cases, are likely to be clearly overrepresented. Further, this type of study design presupposes clients voluntarily seeking treatment. However, reluctance to enter treatment may be a typical characteristic of “self-change” and even part of the motivation to change (Blomqvist, 1996).

The “Problem Drinking” Paradigm

Whereas studies of treatment-seeking respondents, identified as alcohol abusers, may give a rather circumscribed picture of self-change, a quite different type of evidence, at least indirectly bearing on the same issue, comes from emerging survey research on drinking and drinking problems in the general population, mainly by Don Cahalan and his colleagues in the Social Research Group (later called the Alcohol Research Group) at Berkeley. In a forerunner to the Berkeley group’s publications, Cahalan, Cisin, and Crossley (1969) described the detailed drinking patterns of adult Americans, based on personal interviews with 2,756 persons, representative of the total population and conducted in late 1964 and early 1965. In summary, this study showed that drinking patterns, as well as a variety of “drinking problems” with different prevalence rates, were strongly associated with factors such as ethnic origin, social class, sex, and age. The finding most relevant to the discussion of self-change was that both drinking and “heavy drinking” were much less common among both men and women aged 50 and older than in younger age groups. Following up a subsample of the same respondents approximately 3 to 4 years later, Cahalan (1970) more directly addressed the issue of problem drinking. Based on the heterogeneity and variability of drinking-related problems (even over rather short periods of time) found in the study, Cahalan argued that “problem drinking,” at least as a provisional concept, might better capture the realities of the general population’s troubles with alcohol than the traditional alcoholism notion. Concerning self-change, this study showed that problem drinking (defined as 7 or greater on an 11-item problem scale) was much more common in the younger than the older age groups. Whereas one-quarter of all men aged 21–29 scored as problem drinkers, this was true for only 13% of the men aged 51–60 and only 1% of those over 70 years old. The prevalence of problem drinking increased with lower socioeconomic status, and women showed a much lower prevalence than did men. Nonetheless, the decline of problems with age was observable in all groups. Using a similar additive problem-drinking score, Knupfer (1972) examined drinking problems

in two adult San Francisco probability samples (one male, and one of both sexes). Among her findings, about one-third of those who ever scored “high” on the drinking score were stably recovered, and less than one-quarter of all recoveries had included any kind of treatment.

While these early surveys, favoring summary problems scores as the dependent variable in their analyses, came close to substituting “drinking problems” for “alcoholism” as a new unitary concept (Room, 1983), Cahalan and Room’s (1974) “Problem Drinking Among American Men” adopted a disaggregated approach, a concept entirely different from the old alcoholism paradigm. This study utilized data from the samples previously investigated by Cahalan and colleagues, supplemented by an additional, national probability sample of adult men interviewed in 1969. The pooled data from the first two surveys yielded a total of 1,561 men aged 21 to 59, and the supplementary sample included 978 men in the same age range. In addition, the book presented some initial analyses of a probability sample of 786 San Francisco men interviewed in late 1967 and early 1968. The core finding of this study was that problem designations seem to be arbitrary and transitory, and that people moved readily into and out of problem categories. Regarding prevalence of problems, the study showed that between 6% and 24% of all men exhibited at least some signs of 1 of 13 types of actual or potential drinking problems during the last 3 years. The prevalence rates of problems of “high severity” of each type were considerably lower (often only one-half of that of “minimal severity” of the same problem). Although about three-quarters of those with one problem of high severity also had at least one other problem, the overall picture was that of a very heterogeneous collection of drinking problems and people with drinking problems. Thus, even if pairwise comparisons of the problem measures showed moderately high intercorrelations, these were predominantly attributable to the large proportion of men with no problems at all. One interesting finding, for example, was that symptomatic drinking (signs of physical dependence) was more strongly associated with psychological dependence than with heavy intake. The study also confirmed earlier findings, indicating strong ethnic and socioeconomic determinants of drinking and drinking problems. For instance, problem drinking patterns and tangible consequences of drinking were both associated with a disadvantaged status with regard to socioeconomy, ethnicity, family history, and work history. Further, this study showed the great influence of contextual or ecological factors on drinking patterns and drinking problems. For example, whereas living in an abstaining neighborhood was negatively correlated with both drinking and heavy drinking, those who did drink in this environment were more likely than others to be very heavy drinkers. At the same time, while heavy drinkers in dry neighborhoods did not appear to be more personally maladjusted than other heavy drinkers, the proportion experiencing tangible consequences was markedly higher. Finally, the researchers once again found heavy intake as well as problem drinking patterns to be most common in the younger age groups, declining with age.

Studies Directly Addressing Change over Time

In summary, the results of the referenced studies indicated that there may be a great deal of flux in problem drinking, and that the pattern of progressive worsening of problems, suggested by the “alcoholism” paradigm, was in many respects ill fitted to account for problem drinking in the general population. However, the analyses were mainly based on cross-sectional data and did not provide direct evidence about change over time in drinking patterns and problems. Thus, for example, they may have left room for other explanations regarding the decline in drinking problems with age other than simply self-change (e.g., generational differences in drinking habits, increased mortality among problem drinkers, potential treatment effects). It is true that Cahalan provided some longitudinal analyses in his 1970 book; that is, using a summary index of problem drinking (based on psychological dependence and frequent intoxication), he showed that 22% of the men and 9% of the women had changed their problem drinking status materially, in either direction, since the original interview 3–4 years earlier. In addition, both this study and the subsequent study by Cahalan and Room included some retrospective data, indicating a substantial “maturing out” of potentially severe drinking problems.

However, it was not until Clark’s (1976) and Clark and Cahalan’s (1976) reporting of data obtained by a second wave of interviews, from the San Francisco sample about 4 years later, that the Berkeley group more directly addressed the issue of change, based on repeated observations of the same respondents. In the first of these articles, Clark related “loss of control,” the core concept of the alcoholism paradigm, to other measures of heavy drinking and drinking problems. To summarize his findings, this variable was only one among many in predicting drinking problems, and loss of control over drinking, instead of being a one-way gate to worse problems, appeared to come and go over even as brief a period as 4 years. Clark and Cahalan presented further data challenging the alleged progressiveness of alcoholism by failing to demonstrate either the persistence of “early symptoms” of alcoholism over longer periods or the accumulation of further drinking problems over time among respondents with such symptoms. Rather, these analyses showed that even if continued involvement in *some* alcohol problems was common, continuity of any *particular* problem over time was low. Moreover, one quarter to one-half (depending on the particular problem) of all respondents with drinking problems at the time of the first interview reported a complete absence of problems 4 years later.

Finally, in a seminal study based on a subsample of the same panel, Roizen, Cahalan, and Shanks (1978) directly addressed the question of self-change among untreated problem drinkers. The sample consisted of the 521 men who reported some drinking problems at the time of the first interview, who never had any contact with a treatment agency or group, and who could be reached at the follow-up, about 4 years after the first interview. By using a variety of criteria for problem drinking at Time 1 as well as for improvement at Time 2,

Roizen and colleagues found improvement rates varying from 11% to 71%. The highest rate was obtained when problem drinking was defined as 11 points on an 11-item overall problem scale, and improvement was measured as a drop of 1 or more points at Time 2. When the criterion was shifted to “no problems at all” at Time 2 (virtually no one was totally abstinent), the recovery rate dropped to 12% in the group with the highest problem score at Time 1 and to 30% among those with the lowest score at Time 1. In a subsample of 57 men defined to match a clinical population in problem severity, the improvement rates, depending on criteria, ranged from 14% to 59%. These findings, showing that remission can be equated with a variety of more or less arbitrary standards, falling between abstinence and any improvement, were described by the authors as a corollary of the fact that there is no natural boundary between alcohol abusers and non-alcohol abusers in the general population. In addition, they highlighted that the question of remission from alcohol problems does not constitute a single research problem, but rather a number of problems requiring different approaches. For example, they pointed out that dealing with remission as a “prognostic” problem (i.e., following diagnosed or “known” cases to explore factors associated with improvement and persistence) presumes the validity of the diagnostic measures that placed the respondents in the problem category in the first place. However, longitudinal studies of individuals’ drinking problems can also be viewed as a way of testing various diagnostic categories; at least, in essence, they are assumed to capture a lifelong condition. Indeed, the tautological claim that self-change simply represents a diagnostic failure in the first place can still be heard. By a number of analyses, the authors demonstrated that designing one’s study to address, for example, prognostic versus diagnostic research questions may yield different results, even when the same data are utilized.

Longitudinal Research

Although the Berkeley group’s panel studies demonstrated great variability in drinking and drinking problems over time, the study periods were relatively short, not allowing for definite conclusions about the long-term course of problem drinking. This limitation was partly overcome by a series of studies by Kaye Fillmore who adopted a much longer time frame. In the first study in this series, Fillmore (1975) followed 206 respondents from a large study of drinking patterns and problems among 17,000 U.S. college students, initially interviewed 20 years earlier. Even if the sample size was small—the study was designed to explore the feasibility of a larger study which was subsequently not funded—the results replicated the findings of earlier cross-sectional studies by showing a substantial decrease in most types of drinking problems from early adulthood to middle age. For example, according to a summary score, 42% of the men were “problem drinkers” during their college years, but only 17% in middle age.

However, the type of problem characteristic of early problem drinking did not prove to be a particularly good predictor of later problems. Rather, as the author concluded, unique combinations of early problems tended to predict unique combinations of later problems. For example, among men, early drinking-related problems such as accidents, arrests, belligerence, or interference with schoolwork did not predict later problems unless associated with recurrent intoxication and symptomatic drinking. Further, binge drinking tended to precede other early problems and to predict later problems only if associated with symptomatic drinking. A noteworthy finding was that “psychological dependence” was the measure yielding the highest prevalence rates at both time points, but had a relatively low overlap with other measures and was a poor predictor of future problem drinking. The author concludes that psychological dependence might, to a certain degree, be an American drinking norm rather than a symptom of problem drinking. Another important finding, emphasized by Fillmore, was the tangible difference between men and women with regard to the prevalence of problem drinking as well as specific drinking problems and changes over time. For example, the decline in problem drinking with age was characteristic of men only. Actually, women, with a much lower prevalence of any drinking problems during their college years, had slightly more problems in their middle age. Based on a closer analysis of these divergences, the author found them to indicate the influence of norms and social expectations in men’s and women’s drinking.

During the following years, Fillmore provided further evidence of the variability over time of drinking patterns and problems in both men (Fillmore & Midanik, 1984; Temple & Fillmore, 1985) and women (Fillmore, 1987a). In a methodologically important article (Fillmore, 1987b), she supplemented longitudinal data with cross-sectional analyses of different birth cohorts. In this way the study was able to control for potential bias in the longitudinal analyses, due to specific historical conditions (e.g., prohibition or wartime) and other unique aspects of specific birth cohorts. Even with these controls, the study reiterated the findings that the incidence of heavy drinking, among men, was relatively high in early adulthood, decreasing with age, and that chronicity of alcohol problems (persistence over the study periods, 5–7 years) was highest in the middle years, decreasing thereafter. Reviewing evidence of self-change from alcohol problems for a committee of the Institute of Medicine, Fillmore, Hartka, Johnstone, Spiegelman, and Temple (1988) made the following summary statement:

[There is] a higher prevalence of problems in youth, but erratic and non-chronic with a 50–60 percent chance of remission both in the long and short term among men and more than 70 percent chance of remission among women; in middle age, a much lower prevalence, but chronic with a 30–40 percent chance of remission among men and about a 30 percent chance among women; in older age, a great deal lower prevalence of problems, which were more likely chronic, with a 60–80 percent chance of remission among men and a 50–60 percent chance of remission among women. (p. 29)

Is Self-Change Part of the “Natural History” of Alcoholism?

Notwithstanding that remission levels were shown to be highly responsive to measurement criteria, the Berkeley group's population studies demonstrated a substantial amount of self-change in drinking problems, even among people with high problem drinking scores. However, even if these studies may be claimed to have disproved the conventional picture of such problems as long-lasting, inexorably worsening with time, and even interminable, most of them obtained their data at only two time points, often with a relatively short time period elapsing between them. Thus, they may still be criticized for not being able to fully refute the possibility that alcohol abusers or severe problem drinkers are strongly susceptible to relapse even after a rather long period of abstinence or problem-free drinking. This question is one of the main themes in George Vaillant's (1983, 1995) now 50-year-long study of the long-term course of alcohol problems. Although in many respects it is the most impressive research endeavor to date in this field, it has yielded the most varying interpretations and has caused the most heated debates. Vaillant's study is based on data from Harvard Medical School's Study of Adult Development, following a community sample of 660 men from adolescence into late middle life and further into old age. The respondents fell into the following two groups: an upper-middle-class College sample of 204 persons and a less privileged Core City sample of 456 persons. In his major report from 1983, Vaillant follows the 110 surviving persons in the Core City sample ever classified as alcohol abusers (defined as greater than 4 points on the Problem Drinking Scale for at least 1 year) until the age of 47. In addition, he occasionally reports on the outcome of the 26 abusers in the College sample, and some data from an 8-year follow-up of 106 persons in a clinical sample, treated in a program combining individual counseling, psychoeducation, and regular Alcohol Anonymous (AA) meetings.

Regarding the origin and nature of addiction to alcohol, Vaillant (1983), not totally unlike the referenced population studies, finds developing alcohol abuse to be associated with ethnic background, early social problems, and parents' alcohol problems, but not with, for example, childhood emotional problems or environmental weaknesses. Nonetheless, based on the alleged persistence of addictive drinking and the high intercorrelations between a number of measures of alcohol abuse and dependence, he maintains that alcoholism is a unitary phenomenon and is best envisaged as a disease, in the same vein as it makes sense to regard hypertension or coronary arterial disorders as diseases. In both versions of his book, Vaillant further asserts that total abstinence is the only viable alternative to addictive drinking and that the principles of AA can be said to comprise all that is necessary to achieve such a solution. However, as pointed out by Peele (1983), these conclusions are not unambiguously supported by the empirical findings of Vaillant's own study. For example, more than one-quarter of the untreated alcohol abusers in the Core City sample were stably abstinent at the

age of 47, and almost as many were drinking without symptoms (Vaillant, 1983). Among abusers in the same sample who had hospital or clinic visits during the follow-up period (and whose alcohol abuse was often more clearly “progressive”), slightly less than one-half had ceased with their abuse, predominantly by becoming abstinent. In contrast, less than one-third of the clinical sample (who had been referred to AA as part of their treatment) were judged to be in stable remission at the 8-year follow-up, and only 5% had not relapsed at any time during the follow-up period (Vaillant, 1983).

To support his conclusions in the face of the above-cited findings, Vaillant, in the original edition of his book, takes the view that a return to social drinking, which was a common outcome among the untreated abusers in the Core City sample, should not, by necessity, be equated with stable recovery. Rather, he maintains, giving a number of case histories as examples, that a return to “a symptomatic drinking” pattern constitutes a rather ambiguous outcome, often representing borderline cases between moderate drinking and alcohol abuse. In the updated version, based on an additional 12-year follow-up (Vaillant, 1995), he presents evidence claimed to demonstrate that ex-abusers may drink for extended periods without symptoms and still relapse, and that the period of continuous abstinence required to be able to predict stable remission may in fact be much longer than the 6-month criterion adopted in many treatment studies. The empirical findings cited to support these claims are, for instance, that almost one-third of the Core City abusers, judged to be drinking socially at the age of 47, later relapsed into alcohol abuse as compared with less than one-fifth of the abstainers. Further, following up all 56 men in the combined Core City and College samples who were ever judged to have been dependent on alcohol (DSM-III; APA, 1980) and later to have achieved abstinence for greater than 2 years, Vaillant finds that 4 out of 10 relapsed at some later time point, in some cases after as long as 10 years or more. In regards to predictors of stable abstinence, he finds that neither childhood antecedents, risk factors for alcohol abuse, nor most indicators of problem severity can single out future abstainers from future chronic cases. However, becoming abstinent was moderately associated with being of Irish (as opposed to French-Mediterranean) ancestry, having ever been a binge drinker, and being extensively involved in AA.

In summary, and largely in accordance with other studies, Vaillant’s longitudinal endeavor may be said to have shown that many alcohol abusers—perhaps as many as one-half, depending on how broadly “abuse” is defined—eventually do recover naturally, at least sometimes, without quitting their drinking altogether. At the same time, his data indicate that for a smaller group the problem may develop into a more or less “chronic” stage, from which sustained abstinence indeed seems to be the safest route. Although admitting that alcoholism can be defined by a sociological model just as well as by a medical model (Vaillant, 1983), the author insists that its course in these latter cases seems to be driven by its own dynamic, legitimizing the use of the disease notion.

The “Classics” in the Alcohol Field: A Summary Appraisal

Perhaps the best way of resolving the apparent contradictions in some of Vaillant’s conclusions, and of reconciling the seemingly diverging images of self-change given by studies of identified alcohol abusers and epidemiological research, is to paraphrase Room (1977), who talks about “the two worlds of alcohol problems.” Thus, from the clinical perspective, addiction to alcohol may well be viewed as an inexorably progressive “disease,” manifested by increasing and increasingly stereotypic drinking, accompanied by a continuous alienation from conventional life and normal social networks, and with relatively few examples of stable remission, either “spontaneously” or with the help of treatment. In population probability samples, on the other hand, alcohol problems will typically stand out as relatively common, heterogeneous and poorly intercorrelated, and largely transient, with self-change as the typical outcome. However, this does not necessarily mean that these two types of studies deal with groups of people who are initially and vitally different. Rather, they may be seen as focusing on different parts of a continuum, the field of vision in clinical studies typically restricted to the one end, or even as using different paradigms and language to account for representations of basically the same phenomena. In fact, the seemingly progressive and predictable course of alcoholism, as it appears in clinical studies, is likely to be a “retrospective illusion,” created by a number of overlapping factors (e.g., that it is indeed the severest cases that tend to turn up in treatment and often do so repeatedly, that they generally come to treatment when they are at the bottom of a cycle, and/or that people may adapt the stories they tell clinicians to what they believe to be viable in this context; Peele, 1999). As amply illustrated by examples from Mulford (1984), the empirical facts that some individuals’ drinking tends to evolve into a vicious circle, and that the option of stable remission decreases—and is likely to require more strain—the deeper into this circle a person has come, do not prove that there are vital inborn differences between future alcohol abusers and future non-alcohol abusers.

As evidenced by this review, research and debate on self-change in the addiction field, possibly due to the perceived controversial nature of the topic, has long focused on incidence and prevalence rates. Only a few of the early studies (e.g., Ludwig, 1985; Saunders & Kershaw, 1979; Tuchfeld, 1981) addressed reasons for quitting or cutting down drinking among untreated respondents. However, due to differences in scope and methods and levels of analysis, the findings of these studies are difficult to compare and can scarcely claim to have given a consistent picture of the forces behind self-change. What has contributed to later theorizing in the field, however, is Tuchfeld’s (1981) suggestion that treated and untreated recoveries may be similar in form but different in content, and Vaillant’s (1983) attempt to discern the common “healing forces” behind enduring solutions. At the methodological level, the study first reported by Sobell, Sobell, and Toneatto in 1992 introduced several important improvements (e.g., a thorough assessment of respondents’ drinking histories to ensure that there were recoveries from severe alcohol problems, structured

inventories to record environmental changes, comparisons with a nonrecovered control group to avoid attributing recovery to events and experiences common to all problem drinkers). Thus, setting a standard for investigations to come, this study can be seen as the first in the “second wave” of self-change research in the alcohol field.

Summing Up: Conclusions and Implications

What can safely be deduced about self-change from these “early classics”? In order to give a valid answer to this question, it might be helpful to return to the opening remarks of this chapter. The notion of self-change first attracted attention and became the subject of dispute and controversy at a time and place where the intended phenomenon was perceived as a challenge and threat to widely cherished notions of drug and alcohol problems and to strongly vested interests in the expanding prevention and treatment fields. During the same period, much of the empirical data that furnished the, at times, heated debate emerged as the side products of research essentially focusing on other issues. Consequently, the “classics” cannot be claimed to have given conclusive answers to simplistic questions such as “How common is self-change?” or “Who is the typical self-changer?”. Rather, and perhaps more importantly, they may be claimed to have settled a number of widespread, but poorly substantiated, beliefs about drug and alcohol use related problems which, at the time, permeated both the popular mind and society’s ways of trying to deal with these issues. In summary, they showed such problems to be multifaceted and heterogeneous, and more strongly associated with ethnic, sociocultural, and contextual factors than with, for example, heredity or childhood experiences. Contrary to what had been commonly believed regarding the long-term course of drug use or problem drinking, the research demonstrated a great deal of variability and flux over often rather short periods and a general decline of most types of problems with age. It needs to be emphasized, however, that this general picture does not refute the existence of a continuum of individual “problem careers,” ranging from temporary and relatively mild to long-lasting and increasingly severe problems, showing great resistance to any change effort, with or without treatment.

Overall, these findings fit rather poorly with traditional disease or dependence paradigms and demonstrate the need for more complex explanatory models, taking into account psychological and sociodemographic factors as well as culturally and subculturally induced values, options, and alternatives (Blomqvist, 1998; Mulford, 1984; Peele, 1985). Concerning the incidence of self-change, the early studies have amply demonstrated that people rather often change drug use and drinking habits, perceived by themselves or others to be a problem, for the better. At the same time, they have clearly indicated that recovery rates are highly sensitive to measurement (i.e., criteria used to define “addiction” and “improvement,” length of study periods). Certainly, the incidence rates may also depend on how the boundary between

treatment interventions and naturally occurring events and processes is drawn (Blomqvist, 1996; Moos, 1994).

By demonstrating that “‘spontaneous recovery’ is no more a unitary phenomenon than is addiction itself” (Blomqvist, 1996, p. 1819), the studies discussed in this chapter may be viewed as helpful in pointing toward future research in this area regarding more complex and possibly more fruitful questions than incidence rates or allegedly stable predictors of self-change. At least indirectly, they revealed that there may not be a single route out of one uniform condition defined as addiction, but rather multiple paths out of a wide range of more or less severe substance use-related predicaments. Moreover, the options for stable recovery as well as the specific course of the change process may vary with problem severity in addition to personal and sociocultural circumstances. This, of course, does not make continued research any less urgent, but rather calls for more sophisticated attempts to uncover the complex web of interacting biological, psychological, social, and cultural forces that may assist people in overcoming self-defeating engagements in drug or alcohol use, irrespective of whether this process partly occurs within the context of formal treatment (Blomqvist & Cameron, 2002). Viewed in this light, the vast implications of the studies reviewed in this chapter may be claimed to be far from having been fully acknowledged by all, either in the general public or in the research and treatment fields. Indeed, as will become evident from other chapters in this book, many of the issues raised by these early publications are still strikingly topical.

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