

## BRIEF REPORT

### RINGING IN THE NEW YEAR: THE CHANGE PROCESSES AND REPORTED OUTCOMES OF RESOLUTIONS

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**Abstract** — This study tracked the coping processes and self-reported outcomes of 213 adults making New Year's resolutions in order to identify prospective variables which predict successful self-change and to examine the relative effectiveness of various coping strategies. Prior to January 1st, participants provided information on their resolutions, demographic characteristics, and five variables previously associated with positive outcome. Subsequent telephone interviews ascertained short-term retrospective accounts of the utilization of 14 coping strategies and self-reported outcomes over six months. Readiness to change and self-efficacy, but not social support or behavioral skills, prospectively predicted successful outcome at both one week and one month. Successful resolvers were also found to report employing significantly more behavioral strategies and less self-blame and wishful thinking than unsuccessful resolvers. These findings are discussed within the context of previous research on self-initiated change, and several implications for clinical practice are offered.

It is now widely recognized that many people can modify their addictive and consumptive behaviors on their own without formal treatment. Successful smoking cessation and weight loss among nontherapeutic populations are relatively common events (Perri & Richards, 1977; Schacter, 1982; Shiffman & Wells, 1985). Between 75% and 95% of exsmokers in our country have quit without a formal cessation program (Adult Use of Tobacco, 1976; Lichtenstein, 1982), and estimates of the proportion of individuals in control groups who recover from alcohol abuse range from 32% to 53% (Armor, Polich, & Stambul, 1978; Moos & Finney, 1983; Polich, Armor, & Braiker, 1981).

Until quite recently, there has been little research conducted on natural, self-initiated attempts to modify addictive behaviors (Cowen, 1982; Prochaska & DiClemente, 1983; Schacter, 1982; Shiffman, 1984). Pioneering work in self-change has, unfortunately, been characterized by methodological inadequacies, such as relying primarily on retrospective analyses and using small, possibly unrepresentative, samples (Glasgow, Klesges, Mizes, & Pechacek, 1985).

The annual tradition of making New Year's resolutions presents a prime opportunity to investigate the genesis and maintenance of naturally-occurring attempts to change addictive behaviors. Such resolutions offer the advantages of involving self-initiated plans (as opposed to those of a professional change agent) and beginning at a standard, mutually accepted date — the first day of the New Year (Marlatt & Kaplan, 1972). Furthermore, over one-half of adults routinely make New Year's resolutions (Epcot Poll, 1985), the majority of which pertain to health behaviors, notably

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smoking cessation, weight loss, and alcohol reduction (Curry & Marlatt, 1985; Marlatt & Kaplan, 1972).

The present study was designed to track, longitudinally, the coping processes and self-reported outcomes of New Year's resolutions for two primary purposes: (1) to identify prospective variables which predict successful self-change, and (2) to examine the relative effectiveness of various coping strategies.

#### METHOD

##### *Participants*

The New Year's Resolution Project staff received more than 300 telephone calls during a two evening period (December 30 and 31, 1985) as part of a local television news broadcast. Viewers were invited to participate in the study by calling a local telephone exchange, and the number was periodically flashed across the bottom of the television screen throughout the two evenings.

The two principal criteria for study eligibility were being at least 16 years old and having an operational definition of a resolution. Over 50 telephone calls were placed by children (under age 16) who pledged to alter their own behavior in the forthcoming year (see Zelig, 1964). Twenty-two additional calls were placed by adults who, despite efforts of the interviewer, were unable or unwilling to specify measurable behaviors associated with the resolutions. Examples in this category were efforts to "straighten my life out" and "getting some happiness."

The initial sample thus consisted of 213 adults — 131 women and 82 men — with at least one operational resolution. They ranged in age from 16 to 75 years ( $M = 39.8$ ,  $SD = 14.0$ ) and resided entirely in northeastern Pennsylvania. For those with a primary resolution of smoking cessation ( $n = 63$ ), the average number of daily cigarettes smoked in December was 29.2 (median = 20.0). Smoking history varied between 1 and 55 years ( $M = 20.1$ ,  $SD = 12.7$ ), indicative of a chronic smoker sample comparable to those found in formal treatment programs. For those with a primary resolution of weight loss ( $n = 81$ ), the average number of previous attempts to lose weight was 9.9 (median = 4.0). These subjects estimated that they were an average of 37 pounds overweight ( $SD = 24.9$ ) for an average of 6.9 years ( $SD = 8.7$ ).

##### *Procedures and instruments*

The initial telephone contact was a brief structured interview conducted by undergraduate and graduate psychology students. Callers were asked to nominate their "most important or number one resolution for 1986" and, as needed, were prompted for an operational definition of the resolution. Participants were then asked one question apiece about five variables in regard to their primary resolution. These variables were readiness to change, desire to change, confidence to change (self-efficacy), skills to change, and support for change (social support), each measured on a five-point, Likert-type scale with higher numerical values indicating greater endorsement. Information was also collected on demographic characteristics, additional resolutions, and willingness to be contacted for follow-up interviews. Two hundred (94%) of the initial 213 so consented.

These 200 participants were subsequently telephoned for structured interviews at six intervals (1 week, 2 weeks, 3 weeks, 1 month, 3 months, 6 months). The first follow-up interview at one week assessed participants' utilization of 14 coping processes (see Table 3) during the past week. Ten of these processes were adapted from the *Processes of Change Scale* (Norcross & Prochaska, 1986; Norcross, Prochaska,

Table 1. Rates of telephone contact and self-reported success at six intervals

Interval	% Eligible Contacted	% Reported Success
1 Week	86%	77%
2 Weeks	96%	66%
3 Weeks	95%	60%
1 Month	98%	55%
3 Months	86%	43%
6 Months	71%	40%

& DiClemente, 1986; Prochaska & DiClemente, 1983, 1985; Prochaska, DiClemente, Velicer, Gimpil, & Norcross, 1985) and the remaining four from the *Ways of Coping Checklist* (Aldwin, Folkman, Schafer, Coyne, & Lazarus, 1980; Folkman & Lazarus, 1980). In each case, participants rated how frequently they had employed the method in the past week (since January 1) in order to maintain their resolution on a five-point scale (1 = never, 2 = seldom, 3 = occasionally, 4 = often, 5 = repeatedly).

Each interview ascertained the resolver's perception of the outcome on a four-point scale, equally divided between failure (totally failed, mostly failed) and success (mostly succeeded, totally succeeded). Finally, at the 1st week and the 6th month follow-up contacts, participants were asked what effect their success (or failure) with the resolution had on their self-esteem and future self-change plans.

#### RESULTS

The 213 participants made an average of 1.8 New Year's resolutions. Smoking cessation (30%) and weight loss (38%) together accounted for two-thirds of the resolutions. Relationship improvement (5%), reduction in alcohol consumption (2%), and an increase in monetary savings (2%) were also popular resolutions. The "other" category, representing 23% of the primary pledges, contained a multivarious range of idiosyncratic responses. Representative examples include temper control, setting aside time for self, making decisions myself, and learning to say no.

Preliminary analyses indicated that the types of primary resolutions did not differ from the types of secondary resolutions, and all subsequent information was collected with regard to the participant's primary resolution. Initial analyses also revealed, contrary to our expectations, that the specific resolution was *not* related to self-reported outcome at any of the six follow-up intervals and only minimally to specific coping processes. Consequently, the analyses were conducted on the pooled resolutions of the entire sample rather than on the separate resolutions of smaller subsamples.

Between 71% and 98% of the eligible participants were contacted at each time interval and, as expected, the proportion of self-reported success decreased over time. As shown in Table 1, there did not appear to be a systematic relationship between the percentage of those contacted and the reported success rate. Over three quarters of the sample maintained their pledges for the first week; four in ten stated that they kept their resolutions for a full six months.

The participants' rating on five prospective variables — readiness to change, desire to change, confidence to change, skills to change, and support for change — were ascertained during the first telephone interview before January 1. These vari-

Table 2. ANOVA results on prospective variables between successful and unsuccessful resolvers at one week and one month

Variable	1 Week					1 Month				
	Success ( <i>n</i> = 132)		Nonsuccess ( <i>n</i> = 38)		<i>F</i> (1, 169)	Success ( <i>n</i> = 87)		Nonsuccess ( <i>n</i> = 71)		<i>F</i> (1, 157)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Readiness to change	3.5	1.3	3.1	1.3	3.4*	3.7	1.2	3.0	1.4	11.9**
Desire to change	4.6	.8	4.8	.6	1.8	4.7	.6	4.6	.9	.6
Confidence to change	3.9	1.0	3.2	1.4	12.5**	3.9	1.1	3.4	1.3	5.1*
Skills to change	3.1	1.3	3.0	1.6	.2	3.1	1.3	3.1	1.5	.1
Support for change	4.3	1.2	4.6	1.0	1.7	4.3	1.2	4.4	1.1	.2

Note. Each item used a 5-point, Likert-type format with higher numerical values indicating greater endorsement.

\* $p < .05$ . \*\* $p < .01$ .

ables were not significantly related to participant gender, age, or primary resolution. Univariate analyses of variance (ANOVAs) for continuous measures were performed on the five prospective variables between the successful ( $n = 132$ ) and unsuccessful ( $n = 38$ ) resolvers at the first week and again at the first month. Although self-reported outcome data were collected over six months, the one week and one month intervals were selected a priori for statistical analyses based on sample size and clinical utility considerations. These results are displayed in Table 2.

Two prospective variables significantly discriminated between the unsuccessful and successful resolvers at both one week and one month. First, prior to changing, successful resolvers rated themselves as more prepared to change. Second, successful resolvers expressed higher levels of confidence to change (self-efficacy) than their unsuccessful counterparts.

Interestingly, support for change (social support) and skills to change (behavioral skills) failed to distinguish the two groups at either interval. Desire to change, in similar fashion, also did not discriminate. In fact, the unsuccessful resolvers at week 1 tended to report a greater desire to change than the successful resolvers.

Once into January, participants reported their use of 14 coping strategies at that time and during the past week. Four coping strategies differentiated successful and unsuccessful resolvers at both one week and one month. As can be seen in Table 3, the use of self liberation (e.g., willpower) and stimulus control (e.g., kept things around to remind you not to give in to the problem) strategies was related to positive outcome. Conversely, self-blame (e.g., criticize, lecture, or blame myself) and wishful thinking (e.g., wish the problem would go away) were inversely related to outcome; unsuccessful resolvers reported employing significantly more of these processes. In addition, at week 1 but not at month 1, reinforcement management (e.g., rewarded myself for changing) strategies discriminated between successful and unsuccessful resolvers, with the former reporting significantly more utilization.

Finally, participants were asked two questions during the one week and six month follow-up interviews: "What effect has this experience with your resolution had on your self-esteem/self-confidence?" and "What effect has this experience with your resolution had on your chances of trying to change this behavior again in the future?" On both occasions, an unsuccessful experience had a significantly ( $p < .001$ ) negative impact on self-esteem. The mean rating at week 1 for unsuccessful re-

Table 3. ANOVA results on change processes between successful and unsuccessful resolvers at one week and one month intervals

Variable	1 Week					1 Month				
	Success ( <i>n</i> = 132)		Nonsuccess ( <i>n</i> = 38)		<i>F</i> (1, 169)	Success ( <i>n</i> = 87)		Nonsuccess ( <i>n</i> = 71)		<i>F</i> (1, 157)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Counter-conditioning	2.7	1.4	2.7	1.4	.02	2.7	1.4	2.8	1.4	.2
Self liberation	4.0	1.0	3.0	1.4	21.1**	4.0	1.1	3.5	1.3	6.3**
Catharsis	3.5	1.3	3.3	1.3	.9	3.5	1.2	3.3	1.3	1.0
Environmental reevaluation	2.2	1.4	2.5	1.5	1.2	2.1	1.4	2.5	1.5	1.9
Helping relationship	3.5	1.4	3.3	1.3	.6	3.5	1.3	3.5	1.3	.1
Interpersonal systems control	2.1	1.3	1.8	1.0	1.7	2.2	1.3	2.0	1.2	.9
Reinforcement management	2.0	1.3	1.6	1.0	2.7*	2.0	1.3	1.7	1.2	1.4
Self reevaluation	3.5	1.5	3.8	1.1	1.4	3.4	1.4	3.7	1.3	2.3
Stimulus control	2.6	1.6	2.1	1.4	3.5*	2.8	1.6	2.3	1.5	3.8*
Substance use	1.2	.7	1.2	.6	.1	1.2	.7	1.2	.6	.2
Blame self	2.9	1.5	3.6	1.2	6.5**	2.8	1.5	3.3	1.4	4.5*
Avoidance	2.6	1.3	2.2	1.2	2.5	2.7	1.4	2.4	1.2	2.0
Wishful thinking	3.5	1.6	4.2	1.0	6.2**	3.3	1.6	4.0	1.2	10.0**
Minimize threat	2.2	1.3	2.4	1.4	.4	2.3	1.4	2.4	1.4	.4

Note. Each item used a 5-point, Likert-type format with higher numerical values indicating greater endorsement.  
\**p* < .05. \*\**p* < .01.

solvers, for example, was 2.6, between "negative effect" and "no effect." The average rating for successful resolvers at the same time was 4.2, between "positive effect" and "very positive effect." However, on neither follow-up, did the success (or failure) of the resolution have any effect on future self-change plans.

#### DISCUSSION

The present study adds to the growing number of investigations to prospectively evaluate variables predictive of successful self-change in the natural environment. While encompassing a wide range of behaviors, New Year's resolutions predominantly address addictive behaviors — notably smoking cessation and weight loss. The prominence of these behaviors among annual resolutions speaks to their prevalence and attendant risks in therapeutic as well as nontherapeutic populations.

Seventy-seven percent of the participants kept their primary resolution for one week, 55% for one month, and 40% for six months. These success rates were probably elevated due to the volunteer composition of the sample, the self-report outcome criterion, and the demand characteristics of the study. Nonetheless, these figures are concordant with those of Marlatt and Kaplan (1972), whose 15 week success rates for multiple resolutions were 50% and 38% for men and women, respectively. The success and durability of New Year's resolutions — like self-change behaviors in general — have been routinely underestimated by professionals and laypersons alike.

Nonetheless, New Year's resolutions should not be entered into lightly or thoughtlessly. Common sense, clinical experience, and these findings point to the

deleterious impact of failure experiences on self-esteem. Even flippant resolutions spontaneously offered as New Year's eve diversions may have negative effects on the person's confidence. Somewhat more comforting is the knowledge that a failure experience did *not* significantly reduce the odds of engaging in subsequent self-change behaviors.

Readiness to change (Prochaska & DiClemente, 1983; McConaughy, Prochaska, & Velicer, 1983) and self-efficacy (Bandura, 1979, 1982) prospectively predicted successful outcome at both one week and one month follow-up. This pattern confirms the practice of preparing oneself for action and inducing realistic confidence for behavioral change. Self-rated desire to change was not related to eventual outcome nor, surprisingly, was social support. Of course, the reduced variation in a single item may have proved insensitive to true differences in these complex variables. Still, several studies employing measures with sufficient range have not found social support to be predictive of self-change outcome (see Cohen et al., 1987; Glasgow et al., 1985).

Strikingly similar results to the present findings were obtained by Glasgow et al. (1985) in their investigation of 134 stop-smoking contestants. Successful abstainers used self-reward strategies and positive self-statements/reminders more often than did less successful subjects; in our study, these processes were labeled reinforcement management and stimulus control, respectively. Glasgow and associates, in addition, determined that unsuccessful participants, more than successful contestants, tended to use negative self-statements/reminders, for example, "how weak I'll be if I smoke." The corresponding term in the present investigation is self-blame, also found to be inversely associated with success in this study.

The accumulating evidence permits us to offer several recommendations for behavior change in both treatment programs and natural environments. The positive effects of reinforcement management and stimulus control as well as the negative effects of self-blame on self-initiated change have now been replicated across investigators and problem behaviors, including smoking (e.g., Curry & Marlatt, 1985; Glasgow et al., 1985; Perri, Richards, & Schultheis, 1977; Prochaska & DiClemente, 1983; Shiffman, 1984), obesity (e.g., Bellack, Glanz, & Simon, 1976; Norcross et al., 1986; Perri & Richards, 1977), and depression (e.g., Doerfler & Richards, 1981; Norcross & Prochaska, 1986; Rippere, 1979). Ironically, the research evidence points to what is *not* helpful at least as much as to what *is* helpful. Helpful are a realistic readiness to change, positive expectancies for change, contingency management, and stimulus control strategies. Unhelpful are contemplation in place of action, punitive self-statements, and reliance on fantasy.

In closing, we are led to reflect on the collective inability of the self-change/coping literature to contribute to our broader understanding and treatment of addictive behaviors. The meager cross-fertilization can certainly be attributed to the paucity of research on coping with addictions and inadequate methodology (Shiffman & Wills, 1985). More important, perhaps, is the penchant for viewing behavior change as problem-invariant and technique-oriented. This condition can be remedied and research utilization enhanced by directing our attention to the underlying *processes* (or principles) of change which transcend technique and disorder. The delineation of the active processes of change will facilitate the overdue integration of treatment research and coping research as well as professionals specializing in disparate problem behaviors.

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