3.1 Overview to Theories of Change and Well-Being

The ultimate goal of integrated behavioral health practice is to help people achieve a state of well-being. Well-being is dynamic and multidimensional. It involves individual behavior change, a sense of personal self-efficacy and empowerment, positive interpersonal relationships and support, access to basic resources and treatment, and opportunities for meaningful engagement in the community. All of these factors interact and reinforce each other to lead to whole health. Providers of behavioral health services play varying roles in promoting each of these areas in the way they engage with clients, how they assess their needs, and how they plan and treat identified areas of intervention. This chapter will help providers understand how people change and what psychosocial factors promote and hinder their recovery and well-being. It will outline the practices that lead to recovery and wellness as well as the practices that can get in the way of progress.

In the first part of this chapter, I review a set of theories focused on recovery and well-being. The first theory in this set, the mental health recovery model (Slade 2009; Leamy et al. 2011; Mancini 2006; Mancini et al. 2005), proposes that recovery from behavioral health disorders is a multidimensional process that involves developing insight, a positive sense of self, social support, wellness skills, and developing a sense of meaning and purpose in one’s life (Leamy et al. 2011; Mancini 2003, 2006; Mancini et al. 2005, 2008). The second theory in this set is the theory of subjective well-being. Subjective well-being (Diener 1984) is a theory that posits that well-being is comprised of three concepts: (1) high life satisfaction; (2) high positive affect (feeling good); and (3) limited or low negative affect (feeling bad). The third theory is the theory of psychological well-being (Ryff 2014). This theory views well-being as the achievement of a life of meaning and personal growth. I discuss how these theories can orient providers toward practices that enhance recovery and well-being, and to avoid practices that can interfere with their clients’ pursuit of health.
In the second part of this chapter, I review three theories that help us understand the process of how people change health-related behaviors. The first theory is the transtheoretical model of change (Prochaska et al. 1992), which posits that people go through a series of stages as they consider change and that interventions should be tailored to match a person’s particular stage of change. The second is the theory of reasoned action (Ajzen and Fishbein 1980), which posits that behavior is the result of intention, attitudes, and norms regarding a particular target behavior. The third theory of change that I review is the health belief model (Janz and Becker 1984), which posits that people change their behaviors to the degree they understand the amount of risk they are exposed to, and how much control they have to reduce their risk exposure. At the end of each section, I identify common practices and interventions that are relevant to each set of theories. For instance, I provide an overview of practices and interventions that are recovery-oriented and focus on helping people achieve a state of well-being beyond symptom remission. I also provide an overview of interventions that are stage-based, that is, interventions that are responsive to, and aligned with, a person’s particular stage of change and that are most likely to be effective in helping people take up the behaviors that promote health and leave unhealthy behaviors behind.

### 3.2 Theories of Recovery and Well-Being

Well-being has been the focus of research and inquiry for much of recorded history. The Buddha described well-being as a state of joy and emptiness embodied as freedom from suffering rooted in craving and desire. The Buddha believed that we all have the power to achieve joy and well-being in the here and now. All we have to do is change how we think. Or perhaps more precisely, stop thinking so much about the past and the future and just focus on the present moment—letting go of desire and grasping to achieve a state of loving kindness toward oneself and all beings. This concept is the root of positive psychology and cognitive behavioral therapy—two theoretical approaches to practice that are central to this text.

More recently, Aristotle explored two types of well-being: hedonic and eudemonic. He characterized *hedonic* well-being as simply the experience of pleasure and the absence of pain. This is most closely aligned with the psychological concept of *subjective well-being* (Diener 1984). Aristotle characterized *eudemonic* well-being as a type of happiness rooted in an authentic, functional life characterized as possessing a deep sense of meaning, purpose, competence, and quality relationships. This is most closely aligned with the concept of *psychological well-being* and the *mental health recovery model* (Ryff 2014; Slade 2009). In this section, I review each of these models in order to demystify well-being, identify the contexts that contribute to establishing well-being, and to frame our practice moving forward in this text.
3.2.1 The Recovery Model

3.2.1.1 Recovery Overview

The emergence of the recovery model approximately three decades ago dispelled long held myths about the chronicity of serious behavioral health disorders. Since that time, the mental health recovery model has been a vision guiding behavioral health service development for persons with serious psychiatric disabilities, such as major depression, anxiety, schizophrenia spectrum disorders, and bipolar spectrum disorders. The recovery model is comprised of at least three strands of scholarship. One area of scholarship emerged from the convergence of results of several longitudinal studies that discovered that recovery from severe forms of psychiatric distress was common and expected (Harding et al. 1987). The second area of scholarship was on the emergence of evidence-based, recovery-oriented practices within the field of psychiatric rehabilitation that were found to lead to positive outcomes for persons with serious mental illness. These psychiatric rehabilitation treatments were found to help improve outcomes in the areas of employment, independent living, co-occurring substance use disorders, social skills, family relationships, and wellness skills (Anthony 1993; Drake et al. 2005). The third area of influence was the rise of the consumer, survivor, ex-patient (CSX) movement. This is a diverse, multifaceted social justice movement comprised of former and current recipients of mental health services and their allies. Engaged scholarship and activism from this movement led to the widespread recognition of the stigma, oppression, and human rights abuses endured by persons with psychiatric disabilities. The CSX movement continues to fight for mental health policies and service systems based on human rights, self-determination, and choice among a wide range of professional and non-professional treatment alternatives (Chamberlin 1988; Deegan 1997).

The concept of mental health recovery consists of complex and overlapping perspectives and orientations (Davidson et al. 2009; Slade 2009). Two domains of recovery have emerged. The first domain is clinical recovery. Clinical recovery is rooted in the medical model of illness. This form of recovery is defined as the achievement of a set of objective, measurable clinical outcomes, such as stabilization or remission of psychiatric symptoms or reduced psychiatric hospitalizations (Davidson et al. 2009; Slade 2009). A second domain of recovery and the focus of this section has been labeled social or personal recovery (Slade 2009). This model of mental health recovery is rooted in personal accounts from persons with lived experience of psychiatric disability and recovery and position recovery as a complex, multidimensional, and subjective journey of growth, healing, and transformation (Leamy et al. 2011; Mancini et al. 2005). This process involves overcoming the social and functional impacts of mental illness to achieve a positive sense of self and a life of purpose, hope, empowerment, meaningful relationships, authenticity, self-determination, and holistic well-being (Anthony 1993; Leamy et al. 2011; Mancini et al. 2005; Mancini 2006; Slade 2009). One of the most widely cited definitions of recovery is one offered by Anthony (1993). He describes recovery as:
“…a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” (pg. 17)

In this perspective, recovery is more than an outcome that results from the application of specific interventions or practices. It is a process of (re)establishing one’s life and place in the world. Recovery involves more than symptom management. It is the development of pursuits, interests, and relationships and the sense of mastery and self-efficacy that follows. It is living life on one’s own terms and embracing the personal responsibility that comes with that level of autonomy and self-determination (Mancini 2007).

3.2.1.2 Factors That Facilitate and Hinder Recovery

Several elements comprise the recovery process. Figure 3.1 displays the main processes that comprise recovery that will be discussed below. The first element is that recovery is a process of moving from a psychological place of exclusion, internalized stigma and despair to a place of inclusion, hopefulness, and well-being (Dell et al. In Press; Mancini et al. 2005; Mancini 2006). Systematic reviews have identified several components of the recovery process. Ellison et al. (2018) synthesized systematic and other literature reviews and found that recovery was conceptualized as emerging from empowerment, person-centered practice, meaning and purpose, and hope for the future. Likewise, other reviews on recovery have found broad

Fig. 3.1 Domains of recovery (Based on Dell et al. In Press)
support for the CHIME framework of recovery (Dell et al. Under Review; van Weeghel et al. 2019). The CHIME framework (Leamy et al. 2011) identifies five components of recovery: (1) Connectedness with others through meaningful relationships; (2) hope for the future; (3) development of a positive identity; (4) a sense of meaning and purpose; and (5) empowerment (Leamy et al. 2011).

Recovery is largely a process of positive identity development or movement from a negative identity marked by internalized stigma, helplessness, and despair to an identity marked by self-efficacy, insight into one’s illness and wellness, and acceptance of one’s self. Persons diagnosed with behavioral health disorders often develop an internalized sense of stigma where they view themselves through the stigmatized lens of society (De Ruysscher et al. 2017; Leamy et al. 2011; McKenzie-Smith 2019; McCarthy-Jones et al. 2013). What leads to this negative sense of self is the experience of stigma from others, troubling symptoms, and lack of resources. For instance, a person with a behavioral health disorder struggles with confusing, scary, and debilitating symptoms. At the same time, they experience people withdrawing from them or communicating to them directly or indirectly that they are broken, deviant, incapable, and sick. Stigma for persons with behavioral health disorders is severe. This is even more true for Black, Indigenous, and People of Color (BIPOC); Transgender and Gender Nonconforming (TGNC) persons; and Lesbian, Gay, and Bisexual (LGB) persons with psychiatric disabilities. Stigma is not an abstract concept. A person with psychiatric disabilities can lose their autonomy over their affairs, be physically restrained and assaulted, have their children taken away, experience abandonment by their family, and experience harsh, disabling, or ineffective treatment from oppressive healthcare providers and systems. Persons with psychiatric disabilities can internalize stigma and oppression and become lost to themselves. How, then, does one (re)develop a sense of confidence, self-efficacy, and self-worth? How does one develop a sense of hope for the future? How does one believe in themselves again (or for the first time)? In other words, how does one enter into recovery? Several factors contributing to recovery have been identified.

**Social Support** Social isolation is the single most impactful risk factor preventing recovery in persons with behavioral health disorders. Positive relationships with family, friends, intimate partners, and peer and non-peer professionals have consistently been found to be a determining factor in recovery because they help people feel connected to the world and give people a sense of belonging. Positive relationships communicate to the person that they are valued and important. Relationships are also sources of practical support that include money, transportation, food, shelter, and connections to employment. Most importantly, relationships contribute to an internal sense of connection, which is a vital ingredient for recovery (De Ruysscher et al. 2017; Leamy et al. 2011; Lovell 2019; McCarthy-Jones et al. 2013; Temesgen et al. 2019).

**Meaning and Purpose** The development of meaning and purpose through relationships, activities, and the pursuit of positive social roles has also been identified as an important component of recovery (Clarke et al. 2016; De Ruysscher et al.
The experience of mental illness can result in a life that is isolated and devoid of meaningful goals, functional roles, and pursuits. Recovery involves becoming a part of something bigger than one’s self through developing pursuits through hobbies, professional development, employment, education, activism, volunteering, and participating in other enriching activities and groups (Mancini et al. 2005; Mancini 2006).

**Autonomy and Control** Autonomy, control, and personal responsibility are core elements of mental health recovery model (Clarke et al. 2016; De Ruysscher et al. 2017; Leamy et al. 2011; McCarthy-Jones et al. 2013). Autonomy and control mean having the freedom to make informed treatment decisions and life choices. Recovery cannot occur in environments where a person is helpless, powerless, coerced, paternalized, abused, or denied the liberty to make decisions about their life (Dell et al. In Press; Leamy et al. 2011; Lovell 2019; McKenzie-Smith 2019; McCarthy-Jones et al. 2013; Temesgen et al. 2019; Wood and Alsawy 2018). Recovery involves a life in which a person exercises personal responsibility and self-determination in their personal choices, pursuits, behaviors, and decisions. To have autonomy is to have power, to have control over one’s fate and to be able to make decisions about one’s life and treatment. Personal responsibility is about being accountable for the decisions one makes. It is about taking the necessary steps that either lead to recovery, or taking responsibility for the consequences of individual choices. This means that people can choose among a variety of treatment alternatives, are free to pursue their dreams and aspirations, and have control over the decisions of their lives in terms of where, with whom, and how to live.

Being a part of the mental health treatment system sometimes involves a loss of independence, being coerced into treatments and living arrangements, and enduring paternalism and false choices among a range of bad options. Treatment professionals sometimes encourage consumers to “play it safe” and avoid the stresses of work, independent living, and social networks and instead live less fulfilling lives in order to avoid relapses in symptoms. Advocates counter that recovery must be built around the pursuit of goals, taking personal responsibility for their actions and “getting a life” and all of which that entails. Recovery involves taking risks, reflection, and learning from successes and failures. Autonomy and control can be enhanced in treatment relationships with providers marked by collaboration, shared decision-making, and choice (Mancini et al. 2005).

**Acceptance and Insight** Becoming aware and enlightened about one’s illness is one of the most important factors that lead to and maintain recovery. This enlightenment involves the development of insight into one’s illness and acceptance of the illness as part of one’s life that requires management and actions that promote and maintain wellness. Insight and acceptance are often initiated through access to person-centered and recovery-oriented services, settings, and providers. Recovery-oriented services are designed to serve a variety of bio-psycho-social domains of living, such as physical health, socialization, vocational pursuits, independent living, and psychiatric symptoms (De Ruysscher et al. 2017; Hine et al. 2018; Lovell
Professionals that are recovery-oriented practice from a perspective of respect, collaboration, warmth, honesty, and are non-judgmental and supportive (Clarke et al. 2016; De Ruysscher et al. 2017; Lovell 2019; McCarthy-Jones et al. 2013; Slade et al. 2012; Woodgate et al. 2017). Peer providers represent important professionals in the development of acceptance and insight. Peer providers are persons who have a lived experience of mental illness and recovery and use that experience to help others with psychiatric disabilities. They can coach people on how to live with and manage the effects of the illness and are key sources of hope and insight (De Ruysscher et al. 2017; Mancini 2018; McKenzie-Smith 2019; McCarthy-Jones et al. 2013; Temesgen et al. 2019).

Developing insight and awareness is also dependent on having access to treatments and wellness strategies designed to manage symptoms and improve the person’s ability to achieve and maintain holistic health (Dell et al. In Press; De Ruysscher et al. 2017; Kaite et al. 2015; Lovell 2019). While medications can be important strategies for wellness, it is important that clients have a relationship with professionals committed to shared decision-making and managing adverse effects from medication. Learning wellness skills and strategies from peer providers, supportive professionals, and through trial and error can lead to the development of an arsenal of effective strategies to maintain recovery.

Social Determinants of Health  Recovery is not solely an internal process, but also requires access to resources, power, and safe environments. It is a process contingent on the dynamic interaction between the individual and their social and environmental contexts (Dell et al. In Press; Hine et al. 2018; Stuart et al. 2017; Wood and Alsawy 2018). It can only happen in an environment that is free from coercion, violence, and trauma and that include access to basic resources, services, opportunities, and connection (Clarke et al. 2016; Hine et al. 2018; Kaite et al. 2015; Lovell 2019; McCarthy-Jones et al. 2013; McKenzie-Smith 2019; Shepherd et al. 2016; Stuart et al. 2017). Inpatient and outpatient service settings and providers must operate from a trauma-informed lens and ensure clients feel secure and safe. Access to adequate income, affordable health care, transportation, adequate and stable housing, and basic resources such as clothing, food, and utilities provide the foundation to health and are essential to recovery.

3.2.1.3 Recovery-Oriented Practices That Promote Wellness

Recovery-oriented practice is characterized as being strength-based, person-centered, trauma-informed, and collaborative. Recovery-oriented practice and approaches are designed to engage clients and help them develop the skills, perspectives, and capacities needed to participate fully in the communities in which they
choose to live. Recovery models focus on utilizing person-centered care dedicated to shared decision-making and engaging clients in treatments designed to help them achieve whole health (Adams and Grieder 2014; Berwick 2009; Stanhope and Ashenberg-Straussner 2018; Tondora et al. 2014). Several of these practices address social determinants of health such as housing stability, employment, safety, and access to basic resources as well as assist clients in developing the skills needed to live meaningfully in the community. Practices that address social determinants of health can improve health, increase care quality, and enhance client satisfaction while lowering healthcare costs (Andermann 2018; Kerman and Kidd 2020).

Recovery-oriented approaches that meet these aims include supported employment (Kinoshita et al. 2013) and housing-first programs (Tsemberis et al. 2004) that can facilitate access to basic resources and lead to the development of meaning, purpose, and autonomy through employment, independent living, and recreational and volunteer pursuits.

Another recovery-oriented approach mentioned earlier includes services provided by peer professionals who have a lived experience of mental illness and recovery and use their personal stories and perspectives to help others in their recovery journeys (Mancini 2018, 2019). Peers build authentic and supportive relationships with clients and use their shared experiences to create a sense of hope and empowerment by providing a counter-narrative to the stigmatized stories people have developed about themselves. These counter-narratives help to dismantle the effects of internalized oppression often experienced by persons with behavioral health disorders (Mancini 2019; Mancini 2018). The utilization of peer-provided services may also promote better treatment engagement, social connections, and insight by helping people learn how to accept and manage their illness through the development of skills designed to promote well-being (Cook et al. 2013).

Families also play a vital role in the recovery process for persons with psychiatric disabilities. Family psychoeducation programs help families of persons with psychiatric disabilities develop a better understanding of behavioral health disorders and how these conditions impact the family and their loved ones. Family psychoeducation programs support families by: (1) increasing their knowledge about mental illness; (2) building their confidence, reducing their sense of isolation, and relieving stress; (3) providing them with the tools to understand what their loved one is going through and how to be better advocates and allies. These programs can improve family relationships, which can then lead to improved practical and emotional support for persons with behavioral health conditions (McFarlane 2016).

Recovery-oriented practices seek to help people with psychiatric disabilities achieve a holistic sense of well-being. As we will see, recovery-oriented approaches share several commonalities with theories of well-being that exist in the field of psychology. We turn to two of these theories, psychological and subjective well-being, next.
### 3.2.2 Theories of Well-Being

#### 3.2.2.1 Well-Being Overview

Well-being has been a concept that has been studied in psychology for decades. The concept of well-being dates back to the third century when Aristotle conceptualized eudemonic and hedonic well-being. Hedonic well-being, or “feeling good,” is the experience of positive emotion or pleasure and the avoidance of pain or negative emotion (Ryan and Deci 2001), while eudemonic well-being is the experience of a life rooted in meaning, achievement, and purpose. Psychological research has debated these to two forms of well-being for a long time. Hedonic well-being has been re-conceptualized as subjective well-being, while psychological well-being is a construct most aligned with eudemonic well-being. The field of positive psychology has been one forum where these debates have played out. We will not re-enact those debates here. Instead, we will consider the implications of subjective and psychological well-being for our practice and how they can help us assist the people we work with in their recoveries. It is important to understand the contextual factors that contribute to well-being so that providers can seek to educate their clients on how they can bring well-being about, and to know the social and environmental resources and contexts necessary to establish and maintain well-being.

#### 3.2.2.2 Psychological Well-Being

As mentioned, the eudemonic view of well-being is living a life of meaning, purpose, and achievement (e.g., authenticity, truth, virtue, harmony, contemplation, personal development) (Ryan and Deci 2001). Psychological well-being (PWB) (Ryff 1989, 2014) is the view of well-being most closely associated with the eudemonic view of well-being. PWB is defined as living a functional life dedicated to meaning and personal growth (Ryff 1989). It is predicated on more than “feeling good,” and involves six components including: (1) having a sense of purpose in life; (2) living life authentically and true to oneself (autonomy); (3) personal growth or living a life that maximizes one’s talents; (4) environmental mastery or managing one’s affairs with competence; (5) supportive, positive personal relationships; and (6) and self-acceptance or an accurate evaluation and acceptance of one’s talents and shortcomings (Ryff 2014).

A person high in psychological well-being is autonomous; independent; unconcerned about how others see them; has a high level of self-efficacy in a multitude of domains; views themselves as continually developing; has a number of warm, trusting relationships with adults; has a sense of purpose in life; and has a positive view of themselves (e.g., self-esteem). In short, the person who experiences a high amount of psychological well-being is a person who is secure, independent, competent, engaged, purposeful, confident, and feels a sense of belonging as part of a community. A person low on psychological well-being is over-reliant on the
judgment and evaluations of others, cannot manage their lives or take care of themselves, feels stuck, has few confidantes or trustworthy people in their lives, lack a sense of meaning or purpose in their lives, and lacks a general positive view of the self (Ryff 2014).

Research has also linked personality traits to psychological well-being. For instance, openness to experience was associated with personal growth, and agreeableness was associated with positive relationships with others. Extraversion was associated with mastery of the environment and conscientiousness was associated with purpose in life (Schmutte and Ryff 1997). Other variables are also associated with psychological well-being including optimism (Ferguson and Goodwin 2010), self-esteem (Paradise and Kernis 2002), and emotional regulation strategies (Gross and John 2003). Healthy behaviors such as proper exercise, good sleep, having a faith life, and having good friendships have been associated with increased psychological well-being and mental health more generally (Grzywacz and Keyes 2004). Further, those with high levels of psychological well-being have shown decreases in stress and inflammation via biological markers, such as cortisol and cytokine levels as well as better sleep and lower risk for cardiovascular disease (Ryff et al. 2004; Ryff 2014). Psychological (and subjective) well-being have both been shown to be associated with reduced risk for metabolic syndrome (Morozink-Boylan and Ryff 2015) and improved cardiovascular health (Boehm and K zbansky 2012). Purpose in life has also been associated with reduced heart disease (Kim et al. 2012) and cerebrovascular disease (Kim et al. 2013). Major depression has been linked to low PWB (Keyes 2002).

3.2.2.3 Subjective Well-Being

The hedonic view of well-being is associated with the psychological concept of subjective well-being (SWB). Subjective well-being (Diener 1984) is associated with three concepts: (1) life satisfaction or how a person assesses their life as a whole and how satisfied they are with it; (2) positive affect or “feeling good”; and (3) the absence of negative affect or “feeling bad” (Metler and Busseri 2017). People who view their overall life as satisfactory and have a fair amount of positive affect and limited amounts of negative affect generally score highly on tests of subjective well-being. Personality traits positively associated with SWB include extroversion and agreeableness, while neuroticism was negatively correlated with SWB (DeNeve and Cooper 1998).

Research suggests that SWB and PWB are not dichotomous, but rather are components to a broader concept of well-being that also includes grit, hope, and a meaning orientation to happiness (Disabato et al. 2016). Research has found that hedonic and eudemonic well-being are largely correlated and are part of a broader concept of well-being that includes both experiencing pleasure and striving toward personal growth (Vittersø and Søholt 2011). In other words, subjective well-being (Diener 1984) and psychological well-being (Ryff 1989) may be parts of one overarching model of well-being. It appears that in regard to well-being, it is
important have both a sense of satisfaction with life and a sense of meaning and purpose (2016).

Psychological and subjective well-being have parallels with the personal and clinical models of recovery discussed above. Subjective well-being may be more closely associated with clinical recovery due to its focus on reduction of negative symptoms and the improvement of positive affect. Psychological well-being, with its focus on meaning, relationships, and purpose, may be more aligned with the personal recovery model, suggesting that both may be necessary. Studies of depressed and anxious patients in symptom remission still showed low levels of PWB. This indicates that while reducing symptoms is important, it is not enough as a measure of recovery or well-being (Rafanelli et al. 2000; Fava et al. 2001; Ryff 2014). Well-being therapy in conjunction with cognitive behavioral therapy (CBT) provided sequentially after CBT has shown increases in PWB. Well-being therapy strategies have clients engage in tasks that help them focus on positive experiences and assist them in engaging in positive relationships and activities to encourage the elements of PWB (Fava 1999; Fava et al. 1998).

3.2.2.4 PERMA and Flourishing

Martin Seligman, a pioneer in the area of positive psychology, has proposed that human flourishing may be a combination of psychological and subjective well-being (2011). His model of well-being is comprised of five interrelated components using the acronym PERMA: (1) Positive emotions (feeling good); (2) Engagement or flow in activities; (3) positive, high-quality Relationships; (4) Meaning or a sense of being a part of something bigger than oneself; and (5) Achievement or grit in the face of frustrations (Seligman 2011). PERMA and SWB have been found to be highly correlated, suggesting that SWB may be an accurate way to measure well-being (or at least good enough) (Goodman et al. 2018). However, as Seligman has argued, measuring well-being is not the same as building well-being. He suggests that PERMA contains the elements that build well-being and are thus important concepts to consider when working with actual clients in practice (Seligman 2018). In this way, PERMA can be viewed as having clinical relevance in that the five elements are the building blocks of well-being rather than as a discreet form of well-being (Seligman 2018). Figure 3.2 outlines the main elements that comprise well-being from this perspective.

Several positive psychology interventions designed to enhance PWB, SWB, and reduce depression have been found to have positive and sustainable effects (Bolier et al. 2013). They suggest the importance of combining positive psychology interventions (PPI) with other problem-oriented interventions such as cognitive behavioral therapy, problem-solving therapy, and interpersonal therapy. These interventions include optimism and gratitude exercises (Boehm et al. 2011), practicing gratitude and counting blessings (Emmons and McCullough 2003), individual positive psychotherapy (Seligman et al. 2006), and other interventions such as active constructive responding, gratitude visits, life summary, and three good things exercises (Schueller and Parks 2012).
Achieving recovery and well-being often involves making changes in behavior away from unhealthy behaviors and habits toward healthier behaviors. This is often in areas where behavioral health providers can assist clients the most in their recovery journeys. Change involves several components including motivation, information, and support. In this section, I review three theories of health behavior change. The first theory is the transtheoretical model of change (Prochaska et al. 1992). This theory posits that people go through a series of stages in their motivation and intention to change. The second is the theory of reasoned action (Ajzen and Fishbein 1980), which posits that behavior is the result of a combination of intention, attitudes, and norms. The third theory of change is the health belief model (Janz and Becker 1984), which posits that people change their behaviors to the degree they are informed about their risk and susceptibility to a condition and how much confidence they have that they can change. In the sections that follow I will discuss the components of each theory and provide information about assessment and treatment practices relevant for each theory.
3.3.1 Transtheoretical Model of Change

The transtheoretical model of change (TTM) (Prochaska et al. 1992) has been one of the most utilized models of change in social work, medicine, public health, psychology, and addiction treatment. The central tenet of this model is that behavior change is dependent on people’s readiness to change their behavior. The model has been used to understand and assess behavior change in relation to smoking, drinking, and drug use; adherence to medication; weight management; and diet adherence. The central concept of the model rests on the assumption that readiness to change progresses through a series of stages that include: precontemplation, contemplation, preparation, action, and maintenance. Providers can use these stages to inform treatment decisions and align selected interventions with a client’s readiness to change resulting in a more effective approach to treatment (Prochaska et al. 1992). Table 3.1 outlines the stages of change and identifies stage-based practices that align with each stage.

A person in the precontemplation stage of change has no intention of changing their behaviors in the near future. People in precontemplation are often unaware that their behavior has health consequences, or are indifferent or unconcerned about the consequences of their behavior. A person in precontemplation is committed to the behavior and will actively resist efforts to change their mind or behavior. There is no ambivalence in their belief about continuing the behavior. If you asked a person about their intention to change a particular behavior their answer would be “No” or “I don’t have a problem.” There is little to no “change talk” and they have no intention to change (Prochaska et al. 1992). For instance, a client who is in precontemplation about their smoking may say when asked about their behavior, “I don’t need to quit. I feel fine and my father smoked until he was in his 80s. I’m only 35 so I’m not worried about it.” A person in precontemplation about their harmful drinking habits may state, “I work hard and I deserve to have a little fun once in a while. People need to just relax. I can handle my drinking. They have the problem, not me.” People in precontemplation will often get defensive and resist suggestions to change behavior. People in precontemplation are indifferent or resistant to change.

Contemplation is a stage in which a person is seriously considering change in the next 6 months, but continues to weigh the benefits and risks of making a change in behavior. A person in contemplation demonstrates a degree of ambivalence toward change (e.g., not sure if they want to change or not) and acknowledges that they and/or their loved ones may experience negative consequences of a particular behavior. They may voice a desire to change, but admit that they don’t know how to change or are unsure if they want to change. People in contemplation lack commitment and action around change (Prochaska et al. 1992). This stage is defined by ambivalence. A person may spend a long time in contemplation. In this stage a person may admit that they know they “should” (i.e., lose weight, exercise, eat healthier, stop smoking, reduce drinking, stop using drugs) and may intend to change in the future, but they have not made a plan, nor have they engaged in or committed any actions toward change. For instance, a person who screens positive for problem drinking
Table 3.1  Stages of change and stage-based interventions (Based on Prochaska et al. 1992)

| Stage of change | Definition | Example | Stage-based interventions |
|-----------------|------------|---------|--------------------------|
| Precontemplation | No intention to change behavior Commitment to behavior is high Ambivalence is low Little talk of change | Person says: I don’t have a problem. They have the problem. | Outreach and engagement Empathic listening Build relationship Harm reduction Addressing practical needs Crisis interventions Continued assessment |
| Contemplation    | Person has begun to consider change in the near future Ambivalence toward change is high in regard to confidence and/or importance No commitment to take action | Person says: I know I should probably stop (smoking, drinking, getting high, eating sweets), but I (like it, don’t want to lose my friends, deserve to have a little fun…). | Motivational interviewing Brief motivational interventions Psychoeducation Build awareness of problem Decisional balance exercise Offer a menu of treatment options |
| Preparation      | Person intends to take action soon and/or has taken initial steps toward action Seeking information May have set a date Intention is high | Person says: I need to do this. I’m tired and I need to make a change. I can’t keep going on like this. | Motivational interventions Goal-setting/clarification Support client Consider and resolve potential barriers to success Provide access to treatment resources Problem-solving skill development Peer support/self-help Family support |
| Action           | Committed to change Successful in modifying behavior for about 6 months. Person has achieved initial goals and/or clinical benchmarks Potential for relapse is high | Person may have quit smoking; lost weight; reduced or eliminated drinking, drug use, or other risk behaviors; and/or completed a treatment program. | Cognitive-behavioral treatments Skill development Substance abuse counseling Medication-assisted treatments Relapse prevention Self-help/12-step programs Family support |

(continued)
may acknowledge a need to cut down on their drinking for health or marital reasons, but may be concerned that they will lose friends or experience concern about giving up a favored activity despite its negative consequences. People in contemplation may be concerned about the amount of time, cost, effort, and negative consequences associated with engaging in an action or stopping an addictive behavior. As a result, they spend a lot of time considering the pros and cons of a particular action. In the example used above, a person in contemplation for their problem drinking may voice their ambivalence by saying things like: (1) “I know I should probably cut down, but I work hard and I think I deserve to blow off some steam once in a while”; or (2) “I would like to cut down, but I’m afraid I may lose my friends if I do.” People in contemplation are thinking about change.

In the preparation stage, a person intends to take action soon (e.g., within the next month or two). It is a combination of the intention to take action and action itself in the form of small, incremental steps (Prochaska et al. 1992). Examples of small steps toward change can include cutting down on drinking or smoking, switching to a less harmful substance, eating healthier, exercising occasionally, researching or purchasing a gym membership, setting a date to change a behavior, setting up an appointment for treatment or a treatment consultation, or agreeing to go to therapy. This stage may also include people who have taken steps to change in the past year, but have been unsuccessful in their attempts. In this stage, people are in a mixture of contemplation and action. They are getting ready for change and making small strides.

People in the action stage have successfully modified their behavior. Being in the action stage requires the achievement of certain criteria for a period of time that is less than 6 months. The action stage is defined by the achievement of advanced criteria through explicit change behaviors or efforts (Prochaska et al. 1992). They have entered and completed addiction or psychological treatment. They may have quit smoking, drinking, or drugs and have not used for several months. They may have successfully integrated a diet or treatment regimen into their routine. Or they have lost weight or achieved a particular clinical benchmark (e.g., cholesterol, glucose, T-cell, or blood pressure level). They are committed to change, have engaged in significant change efforts, and have achieved results. They are doing it.

| Stage of change | Definition                                                                 | Example                                                                 | Stage-based interventions |
|-----------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------|
| Maintenance     | Person has sustained change for more than 6 months  
Continues make strides and consolidate successes  
Has accomplished goals for more than 6 months | Person has developed strong skills and a determined commitment to be well. | Continue relapse prevention. Continue self-help. Integration of healthy lifestyle behaviors into other areas of life |
In maintenance a person continues their change efforts and makes strides to consolidate and sustain gains (Prochaska et al. 1992). A person in the maintenance stage has achieved their criteria for at least six or more months and is now working on learning and executing relapse prevention efforts in order to maintain their gains. They have done it and are trying to sustain and extend their gains.

Three things are important to recognize in relation to the stages of change. First, a person may move backwards and forwards through the various stages of change. Successful attempts to change behavior typically involve relapse and repeated attempts to change. This is a normal part of the process and should not be considered as a failure, but as a learning opportunity. Relapse is an expectation and an opportunity to learn new strategies to gain future success. Second, each stage of change has a particular set of intervention strategies that are most effective. For instance, harm reduction, motivational and education strategies are most appropriate for persons in precontemplation (Mancini et al. 2008). In this stage, building awareness of the problem and ways to solve it, while also providing safer or less harmful alternatives to the behavior are important (e.g., needle exchange programs, carrying and knowing how to use Narcan, condom use). In contemplation, relevant approaches include brief interventions and motivational interviewing approaches that help people understand their ambivalence toward change and evaluate the pros and cons of continuing or changing the status quo. Helping motivate people toward making a decision about change would be the most effective approach in this stage. In preparation and action stages, a provider would use a combination of motivational interviewing strategies to continue to support change, and cognitive behavioral and other active treatment approaches to build skills and capacities to assist the person in their change efforts. Inpatient or outpatient treatment programs, self-help groups, cognitive behavioral approaches to therapy, nutritional support, and medication regimens are most effective in these stages. In maintenance, it is most important to give people the skills and tools to avoid relapse and maintain gains. This may also involve helping people change their lifestyles and environments, such as finding new social networks, moving locations, changing jobs, and establishing new routines to maintain health and prevent relapse. It may also involve learning new skills to manage cravings and avoid risky situations, learn assertiveness and problem solving skills in order to manage situations that can jeopardize their recovery, or learn new skills around employment, eating, sleeping, daily living, and relationships. It is important for behavior health agencies to integrate billing, records, assessment and treatment practices, and professional development activities that promote the routine and effective use of stage-based interventions when helping clients with behavioral health issues into their policies and procedures (Mancini and Linhorst 2010; Mancini and Miner 2013; Mancini and Wyrick-Waugh 2013).

Third, a person may simultaneously be in different stages of change for different behaviors. For instance, a person may be in preparation stage for their diabetes management plan, maintenance for past problem drinking behavior, and precontemplation for smoking marijuana. It is important to accurately assess a person’s stage of change for each target behavior and adjust the approach for each target. A provider will have to blend approaches identified above to effectively address each
target area. Also, if the engagement in one preferred behavior gets in the way of change efforts for other target behaviors, this will have to be made apparent to the client. For example, a person who actively wants to eliminate cocaine use and is in the action stage, but who also is in contemplation about their marijuana usage, may find that using marijuana triggers the craving associated with cocaine use. In this scenario it may not be possible for the person to successfully abstain from cocaine, while also using marijuana. This will need to be brought to light to the client and a plan of action developed.

### 3.3.2 Health Belief Model of Change

The origins of the Health Belief Model of Change (HBM) dates back to the 1950s, and was developed by social psychologists in the US Public Health Service as a means to develop a conceptual understanding of how a person chooses to engage in behaviors that promote health or help avoid disease (e.g., screening, immunizations, preventative medicine) (Rosenstock 1974). The health belief model has been widely studied and has a high degree of empirical support (Carpenter 2010). A person’s beliefs regarding a particular target health behavior are influenced by several constructs. The first construct is the person’s level of perceived susceptibility to the risk of developing a disease (Janz and Becker 1984). Perceived susceptibility to a disease can range from no susceptibility to high susceptibility. If a person believes that they are highly susceptible or at a high risk of developing a disease or condition, then they are more likely to take action to avoid that disease state. Alternatively, if a person believes that they are not likely to be susceptible to a disease (e.g., low risk), then they may not feel compelled to make healthy choices or follow advice related to healthy behavior. For example, a smoker may believe that they are not susceptible to lung disease if, for instance, a close relative was a heavy smoker and lived a long time without contracting lung disease.

The second construct that is important is the perceived seriousness or threat of the disease condition and the severity of the consequences of the disease (Janz and Becker 1984). If the person believes that developing a particular condition is a serious threat to one’s health, then they will be more likely to engage in behaviors that help them avoid that particular disease state. If a person does not believe that a particular disease state is serious, then they will be less likely to engage in behaviors that are designed to avoid the disease state. For example, if a person does not believe that the flu is particularly worrisome, they will be less likely to get a flu shot. A person’s perceived threat is the combination of their level of perceived susceptibility and perceived seriousness of the disease. The higher the perceived threat, the more likely a person is to engage in behaviors that lead to enhanced health and well-being. The lower the perceived threat, the less likely a person is to engage in behaviors that promote health or avoid disease. Perceptions of a person’s susceptibility, seriousness, and threat toward a disease are contingent on education and awareness.
of the disease or condition (Janz and Becker 1984). Figure 3.3 outlines the main components of the health belief model.

Whether a person engages in healthy behaviors or in behaviors that reduce the risk to a particular condition also depends on the perceived benefits and barriers to taking action. If a person perceives that the benefits of taking a particular action are high and that the likelihood of taking that action will reduce the risk to a particular disease condition, then the person is more likely to take action. Likewise, if a person perceives significant barriers to engaging in a particular action, then they are less likely to take action. Barriers can include financial cost, access to resources, perceived side effects or risk of a particular behavior, inconvenience, lack of time, physical or emotional pain or loss, and loss of social and other benefits due to the behavior. Several modifying variables also influence whether a person will engage in a behavior. These can include demographic variables such as age, gender, race, and ethnicity as well as other social variables that include peer group influences, social class, education, and access to information and other healthcare resources.

In the HBM, cues or triggers to action are often required to prompt a behavior that promotes health. These cues can be internal or physical (e.g., pain, anxiety), external (e.g., media advertisement, news event, or health promotion education campaigns or communications), or interpersonal (e.g., messages or signals from loved ones, loved one experiencing a positive or negative health-related consequence of a target behavior). For instance, recent new stories discussing an outbreak of lung disease and death linked to vaping might cue a person to consider stopping the behavior. Another example might be if a person sees a news story close to home that involves an outbreak of COVID-19, they may be more likely to avoid crowds, wear a mask, or cancel travel plans. A person who sees a loved one or friends wearing a mask in public may be more likely to wear a mask themselves. A suspicious

![Fig. 3.3 Health belief model](image-url)
mole might prompt a person to get a body scan and use more sunscreen regularly, especially if a loved one has developed skin cancer. A comment by their doctor that they may be drinking too much may initiate a person to reduce their drinking.

A final concept relevant to the HBM is the concept of self-efficacy. Self-efficacy refers to the perceived ability or competence of a person to engage in a particular health-related behavior successfully (Janz and Becker 1984). How well a person believes they possess the capability of engaging in healthy behaviors will influence whether they take action. In summary, according to the HBM, the decision to take action regarding one’s health can include reducing or quitting substances, eating healthier, screening for health problems, wearing a mask, getting immunizations, engaging in safer sex practices, using seat belts and helmets, taking medication, engaging in exercise and stress reduction activities, or leaving an abusive relationship. Engaging in these actions rests on a dynamic interaction of several factors: (1) the presence of a cue or trigger to take action; (2) the perceived risk and seriousness of negative health consequences and susceptibility to disease; (3) the benefits and risks of taking action; and (4) the self-efficacy one possesses in their ability to successfully engage in taking action (Janz and Becker 1984). Modifying variables include age, sex, gender, and race/ethnicity as well as social factors such as peers/family, social class, education, and access to information and awareness. Practices that are important to helping people change behaviors or take action in the face of a negative health consequence include: (1) providing education about the susceptibility and risks associated with a disease; (2) informing, motivating, and coaching people about behaviors that they can do that are effective in reducing harm; (3) providing skills and resources designed to increase competence and self-efficacy around change behaviors; and (4) providing people with resources that can enable them to make changes such as assistance with income, transportation, insurance, and access to treatment, medication, or equipment (e.g., masks, helmets, nicotine replacement therapy, clean needles). Integrated care is one important area that can help people take action. Integrated care provides convenient access to education and awareness (information), tools, motivation, and assistance in taking action in one convenient setting.

3.3.3 Theory of Reasoned Action

The theory of reasoned action (TRA) is another social psychological theory of human behavior change (Ajzen and Albarracin 2007; Ajzen and Fishbein 1980; Fishbein 2008; Fishbein and Ajzen 2010). The central tenet of the TRA is that intention is the driving force of determining whether people will change their behaviors. Intention to perform a target behavior is also impacted by three components: Attitudes, normative pressure, and perceived control. Figure 3.4 outlines the main components of TRA.

Attitudes toward a particular behavior are determined by the beliefs that people hold about the behavior and its consequences—they can be instrumental (i.e., What
are the costs vs. benefits?) or experiential (i.e., What have I experienced in the past?) (McEachan et al. 2016). This may be influenced by past attempts to engage in the behavior (outcomes) or learned beliefs about the positive or negative consequences of performing the behavior. For instance, how important are the perceived benefits of the behavior (health, happiness, social harmony, economic) compared to the perceived costs of performing the behavior (loss of pleasure, financial costs, social costs).

**Normative pressure** refers to what a person believes others think about the target behavior (Manning 2009). These pressures can be from one’s peer group or a reference group. People can be influenced by what peers think about a behavior and whether they are performing the target behavior themselves. In order words, “What do others think about this behavior?” “What do they think I should do?” and “What are people close to me doing?”

And lastly, **perceived control** has to do with whether or not a person believes they have the autonomy, skills, and resources to perform the target behavior effectively (Yzer 2012). In other words, “Can I do it?” These three components lead to the intention to perform an act or target behavior. They are, in turn, influenced by a variety of variables, such as past experiences, demographics, personality, temperament, affectivity (e.g., risk aversion, conscientiousness, openness, surgency, negative/positive affectivity), attitudes toward risk and change, and exposure to media and other messaging.

The theory of reasoned action helps us to identify how to help people make a decision about a particular target behavior by helping us understand what is getting in their way. For instance, if a person does not have an intention to perform a

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**Fig. 3.4** Theory of reasoned action
behavior that is deemed healthy, or change a behavior that is unhealthy, what is the reason behind the lack of intention? Motivational interviewing approaches that help people explore the pros and cons of a particular behavior change may help people consider change. However, if a person has the intention to change, but lacks the skills and capacities to change, then skill development may be the better intervention. If perceived lack of self-efficacy is the problem, then a combination of information, skill development, rehearsal, and support may be in order. The deployment of peer providers can be useful in this situation because they act as role models that both inspire people and provide important practice advice and information. If a person lacks the resources to change a behavior, then interventions that provide more practical support such as income enhancement, recreational activities, medication, transportation, housing, or food access may be more appropriate. For instance, if a person has an intention to stop opioid use, but lacks the ability to cope with cravings and is surrounded by other users, then a combination of medications to control cravings; helping the person identify alternative activities during the day such as employment, treatment groups, or recreational activities; and helping the person change social circles may be the best approach to treatment. TRA, like other change theories, helps providers assess the factors influencing a client’s intention and motivation to change and can, therefore, assist clients and providers in selecting appropriate, person-centered interventions.

3.4 Summary and Conclusion

Recovery and well-being are a dynamic process of whole health facilitated by positive relationships, access to basic resources, and treatment provided via warm, supportive relationships. Integrated behavioral health practice and person-centered care are wholly compatible with recovery-oriented practices and approaches that facilitate well-being. These approaches, when combined with an understanding of change theories, can help providers engage in assessment and intervention practices that match a client’s particular intention to change. Unfortunately, many of our clients engage in behaviors that negatively impact their health and interfere with their ability to move toward well-being. This can be frustrating as a provider, but it is not always the case that a person doesn’t want to change. They might lack the resources and capacity to change. Intention can be influenced by multiple factors. Clients may not believe change is worth it and would instead benefit from safer ways to continue their behaviors. They may lack the skills, resources, social support, and peer structures to encourage change, or they may need a change in scenery or access to other information from trusted sources such as peer providers. The above theories help providers in understanding the underlying factors influencing client behavior so that they can design interventions that help people make choices that lead to recovery, whole health, and well-being.
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