2005

Bridging professional- and mutual-help through a unifying theory of change

Brad Olson, National Louis University
Leonard Jason, DePaul University

Available at: https://works.bepress.com/brad_olson/6/
Bridging professional and mutual-help: An application of the transtheoretical model to the mutual-help organization

Bradley D. Olson ∗, Leonard A. Jason, Joseph R. Ferrari, Tresza D. Hutcheson

Center for Community Research, DePaul University, 990 W. Fullerton, Chicago, IL 60614, USA

Abstract

The authors suggest that the mental health system of the nation could benefit by more fully embracing the idea of mutual-help (i.e., self-help), and this collaboration could be facilitated by the utilization of a well-established clinical theory to elucidate the psychological processes at work within mutual-help organizations. The processes of change of the transtheoretical model is offered as one potential framework. This well-established model has been used to help psychologists better understand clinical and professional phenomena, but, to date, has been used less frequently with non-professional interventions. This article applies the ten processes of change of the transtheoretical model to mutual-help organizations, focusing on four groups, including Alcoholics Anonymous (AA), Oxford House, GROW, and Schizophrenics Anonymous. The advantages of the transtheoretical model and its potential ability to act as a common language across clinical professionals and mutual-help organizations are discussed. In addition, advantages of bolstering the present mental health system using combinations of both forms of care along the recovery continuum are described.

© 2005 Elsevier Ltd. All rights reserved.

Keywords: Self-help; Mutual-help; Alcoholics Anonymous; Transtheoretical model; Treatment; Alcohol and drug; GROW; Schizophrenics Anonymous; Oxford House

Nearly three decades ago, George Albee (1968) voiced a concern that professional psychologists would be unable to meet the mental health needs of the nation, a prediction based largely on his expectation that there would be an insufficient number of professionals to meet the demand for such services. Many of Albee’s statements predated the fragility of the present behavioral health system and the difficulties faced trying to provide help to everyone in need of services. In the present health system, the number of disorders covered by insurance agencies has dropped, the number of therapy sessions has been severely capped, and general access to professional therapy has been reduced such that many individuals must pay for services immediately or forego treatment altogether (Simmons, 2001).

A complementary form of care that could supplement professional help, provide aftercare once professional treatment has ended, and avoid the largely “profit-motivated orientation” of present-day delivery systems is needed (Simmons, 2001). The mutual-help organization, also known as the self-help group, is an option for care that meets these criteria. Mutual-help has growth throughout the last century and reached a height in the 1970s when a large contingent of consumers became dissatisfied with professional services and directed their attention toward the grassroots mutual-help group to compensate for the lack of help perceived to be coming from the professional health system. Mutual-help was further legitimized by the federal government and Surgeon General who saw in these groups an additional form of support for a wide range of medical, mental health, and other social problems (Borkman, 1990; Humphreys & Rappaport, 1994; Tracey & Toro, 1989). Unfortunately, these efforts have been guided by little psychological theory (Humphreys, Finney, & Moos, 1994; Humphreys & Rapport, 1994); and this is precisely what Albee (1968) believed psychologists should be doing—creating and utilizing better theories, while those without higher degrees played a more significant role in the delivery of mental health services.

It is a significant challenge for any single theory to organize the processes at work in mutual-help and to capture the complexity and diversity of such groups, particularly since mutual-help is not simply a clinical intervention. One guide
to mutual-help organizations, moreover, lists groups for over 500 specific problems from addictions to posttraumatic stress disorder to HIV/AIDS (Isenberg, 1999). Although many differences exist in the ways these varied groups approach recovery, conceptual similarities are also present, and guiding theory can help researchers and practitioners derive commonalities across these diverse groups into a single, general model of mutual help (Humphreys & Rappaport, 1994; Humphreys et al., 1994).

There are further advantages to utilizing a well-established clinical framework to understand mutual-help. First, if applicable, such a model could produce greater confidence in mutual help by highlighting its strengths within a clinical model. Second, if professionals and mutual-help organizations acquire a common language, more productive dialogue is likely to follow and perhaps the subsequent creation of more effective combinations of professional and mutual help.

One common characteristic across the wide variety of mutual-help groups is that all members are trying to recover from one problem or another. Recovery constitutes movement toward a resolution of those problems or its symptoms. From the perspective of the stages of change component of the transtheoretical model, recovery involves an oftentimes non-linear progression through the stages of change. An extensive discussion of the stages of change, unfortunately, is beyond the scope of this paper. Instead, the present manuscript focuses on the ways each process of change most effectively reduces symptoms and associated problems through behavioral and cognitive methods.

The processes of change, one of the three components of the transtheoretical model (see Table 1 for definitions). The processes of change framework found within the transtheoretical model is one of the most well-established theories of change (Prochaska, DiClemente, & Norcross, 1992). The theory draws from a wide variety of psychological schools of thought, and has been empirically supported through an array of research findings in such areas such as smoking cessation, eating disorders, and substance abuse (see Prochaska, Johnson, & Lee, 1998 for a review).

The processes of change framework found within the transtheoretical model is one of the most well-established theories of change (Prochaska, DiClemente, & Norcross, 1992). The theory draws from a wide variety of psychological schools of thought, and has been empirically supported through an array of research findings in such areas such as smoking cessation, eating disorders, and substance abuse (see Prochaska, Johnson, & Lee, 1998 for a review).

Table 1
Definitions of processes of change

<table>
<thead>
<tr>
<th>Process of change</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consciousness raising</td>
<td>Cognitively acknowledging that the problem is a problem and that one possesses the problem</td>
</tr>
<tr>
<td>2. Self-reevaluation</td>
<td>Assessing identity and emotions and determining how perceptions of identity can hamper recovery</td>
</tr>
<tr>
<td>3. Helping relationships</td>
<td>Accepting help and receiving social support from caring others</td>
</tr>
<tr>
<td>4. Self-liberation</td>
<td>Acquiring ability to make decisions, committing to decisions, often leading to action on those decisions</td>
</tr>
<tr>
<td>5. Environmental reevaluation</td>
<td>Assessing how problems impact the personal and physical environment</td>
</tr>
<tr>
<td>6. Dramatic relief/emotional arousal</td>
<td>Experiencing and expressing feelings about the problem</td>
</tr>
<tr>
<td>7. Stimulus control</td>
<td>Avoiding or learning to counteract stimuli and high-risk cues likely to trigger problematic behaviors</td>
</tr>
<tr>
<td>8. Reinforcement management</td>
<td>Rewarding self or others for positive change</td>
</tr>
<tr>
<td>9. Counterconditioning</td>
<td>Finding events that counteract the anxiety that often accompanies various disorders</td>
</tr>
<tr>
<td>10. Social liberation</td>
<td>Realizing the existence of the problem in society, and trying to help and work against the social ills</td>
</tr>
</tbody>
</table>

The theory has a great applicability to a variety of problems and disorders. The transtheoretical model has been applied beyond individual to organizational frameworks (Velasquez, Maurer, Crouch, & DiClemente, 2001) and theoretically applied to Alcoholics Anonymous (DiClemente, 1993). The present manuscript differs from this earlier work by applying the processes of change to the existing empirical literature on mutual-help across a variety of clinical domains (e.g., schizophrenia as well as substance abuse addiction).

Despite the large number of mutual-help organizations and the substantial literature on mutual help, the present paper focuses on four specific groups, including Alcoholics Anonymous, Oxford House (a mutual-help residence for individuals recovering from substance abuse problems), GROW (for various mental disorders) (Rappaport et al., 1985; Toro et al., 1988), and Schizophrenics Anonymous (Salern, Reischl, Gallacher, & Randall, 2000). Each group was chosen due to its substantial empirical literature. The groups further represent both substance abuse and other mental health disorders, making it possible to evaluate whether the processes of change apply to a range of mental health problems and their corresponding approaches to recovery. While not every mutual-help organization reviewed has research on it related to each of the processes of change, the primary emphasis of the manuscript is to demonstrate, through the transtheoretical model, the potential for the mutual-help organization to...
produce a general form of psychological change across mental health conditions. In this article, we will first summarize the primary goals of these four groups and then review the empirical literature on these organizations within the structure of the ten transtheoretical processes.

1. Mutual-help organizations

1.1. Alcoholic Anonymous

The prototype of the mutual-help approach is the 12-step program, with Alcoholic Anonymous (AA) being the primary exemplar (McCurdy & Miller, 1993). AA is centered around group meetings and 12-step work where members share their experiences with others, acknowledge their powerlessness over addiction, take personal inventory, recognize past harms caused to others, and take numerous other approaches to recovery (Enrick, Tongan, Montgomery, & Little, 1993). Twelve-step members also obtain guidance from sponsors, individuals more advanced in their recovery who guide and support newer members through the recovery process.

1.2. Oxford House

The mutual-help residence Oxford House can be described as a 24-hour twelve-step program. It is a democratic, community-based approach that involves no professional staff (Jason, 1997; Jason et al., 1994). Internationally, over 1000 houses exist, all of them rented, single-sex homes, located in middle-class neighborhoods (Jason et al., 1997). Most decisions that affect a house, including the choice of new residents and who becomes a house officer (e.g., president, treasurer), are all democratically determined. House members are required to avoid alcohol and drugs, maintain their portion of the house rent, and refrain from disruptive or isolationist behavior. Beyond these fundamental guidelines, houses are set up to foster self-determination. Members are not required to follow specific courses of recovery and, unlike virtually every other form of residential care, no maximum-stay rule exists, allowing residents as much time as needed to further the recovery process (Oxford House Manual, 2001; Read, 1995).

1.3. GROW

One mutual-help organization also developing from twelve-step principles is GROW, a program that works on general mental health problems, including depression, anxiety, phobias, and posttraumatic stress disorder, while also helping individuals overcome bereavement, divorce, and general loneliness. GROW originated when a handful of formerly hospitalized psychiatric clients attending AA meetings realized the benefits of mutual help, but felt a strong need for a more exclusive focus on psychiatric disorders (Zimmerman et al., 1991). The GROW organization has since developed into over 700 programs (Rappaport et al., 1985; Toro et al., 1988). In addition to weekly meetings, GROW provides members with social activities, an extensive consumer-authored literature, and various roles and responsibilities central to the workings of the organization.

1.4. Schizophrenics Anonymous

Schizophrenics Anonymous is a national group providing fellow members with social support, companionship, current information on schizophrenia and coping mechanisms believed to facilitate recovery (Salem et al., 2000). The program is intended to help members resolve past troubled relationships, engage more effectively in current social interactions, achieve personal growth through responsibility taking, and to work more effectively against the stereotypes and stigmas associated with the illness.

In order to understand the potential of the mutual-help organization to facilitate recovery through the processes of change and to determine the likelihood of such groups to supplement, and even enhance, professional treatment, we next examine the literature on these four mutual-help organizations within the processes of change framework of the transtheoretical model.

2. Processes of change and mutual help

2.1. Consciousness raising

The consciousness raising process within the transtheoretical model requires an awareness and acknowledgement that the problem or disorder is a significant influence in one’s life. The process becomes more developed as the person is further educated in the causes, consequences, and treatments of problematic behaviors (Prochaska et al., 1998). Professional mental health facilities can develop the consciousness raising process in clients, but not necessarily more effectively than AA, Oxford House, Schizophrenics Anonymous, or GROW groups. For instance, Snow, Prochaska, and Rossi (1994) found associations between AA affiliation and reports of consciousness raising, likely due to the strong emphasis on group members acknowledging the existence of their problems during group meetings, such as introducing oneself as an “alcoholic.” The public disclosure and the internal belief change likely to follow such admissions can make speakers more self-identified with and cognizant of the difficulties caused by addiction (Prochaska et al., 1998).

The process of consciousness raising can also develop through the acquisition of new information. It was found that information-giving occurred more when GROW meetings were run by indigenous leaders than when run by professional leaders (Toro et al., 1988). New information at meetings is often based on recent professional research, but experiential knowledge, knowledge gained from real-world experience, is
the most commonly presented type of information, and even more common than statements of emotional support (Salem, Bogat, & Reid, 1997).

Regardless of the specific mutual-help group, the information presented in a typical meeting may range from suggestions on coping with depression to methods of refusing heroin when risky stimuli are encountered. In Schizophrenics Anonymous, information is provided on managing symptoms, coping with interpersonal difficulties, recognizing the need to seek help from others, avoiding social isolation, and realizing that the disorder is caused by chemical imbalances in the brain and that, therefore, hallucinations and delusions should not be taken literally (Randall, Salem, & Reischl, 2001). Many discussions in Schizophrenics Anonymous meetings are additionally about the importance of receiving conventional care and seeking out sound professional help (Walsh, 1994).

2.2. Self-reevaluation

The self-reevaluation process of the transtheoretical model requires that people acknowledge the incompatibility of their present identity with recovery, and that progress requires substantial changes in the self, one’s values, and one’s maladaptive cognitions, all requiring internalized attitude change. This form of change can occur in mutual-help groups through the ability of members to positively influence each other through clinical and social psychological means, including the formation of group norms, the strengthening of group cohesion, and the existence of effective leadership.

Based on French and Raven’s (1959) theory of power, Salem et al. (2000) describe two forms of influence commonly exerted in mutual-help groups that contribute to fundamental changes within a person’s belief-system. One type of influence is expert power, having its source in perceptions that the influencing agent has specialized knowledge about a particular topic. Expert influence is often attributed solely to professional therapists. However, in a study on Schizophrenics Anonymous, Salem et al. (2000) found that members perceive indigenous leaders to have as much expert power as professional therapists (with both indigenous leaders and professional therapists perceived as having more expert power than other mutual-help members). The expert power attributed to indigenous leaders is at least partly derived from real-life experiences with the problem, a form of knowledge called experiential expertise, often perceived by mutual-help members to be at least as valid as academically-derived knowledge (Borkman, 1990; Salem et al., 2000).

Another source of attitude change is referent power, a form of influence derived from shared ingroup membership. Referent power is likely to be the most prevalent source of attitude change in mutual-help groups (Powell, 1987). Salem et al. (2000) found that Schizophrenics Anonymous members perceive that indigenous leaders and regular members have more referent power than professionals. Referent power in mutual-help members is derived from the role mutual-help communities have as reference groups who, through the sharing of stories and experiences, form norms, providing a basis for comparative self-evaluation, subsequently leading to changes in self-identity (Kloos, 2001; Powell, 1987; Randall et al., 2001). Kloos argues that one of the primary methods by which GROW members recover is through the internalization of community norms, helping them redefine themselves in relation to their mental illness, a process believed to occur in the form of storytelling. Randall et al. (2001) also argue that personal identity in Schizophrenics Anonymous evolves through the internalization of community narratives, which, again, are reflected in the individuals’ personal stories (see also Mankowski & Rappaport, 1995, for a discussion of personal and community narratives and the reconceptualization of cognitive scripts in mutual help).

Adherence to group norms and the internalization of community narratives is likely to be strong in mutual-help groups because many factors in these settings have been known to increase the effectiveness of social influence, such as group engagement and strong leadership (Maton & Salem, 1995; Medvène, 1992; Turner, 1991; Walsh, 1994). In GROW, for instance, mutual-help groups run by indigenous leaders are perceived by members as having greater group cohesion than professionally-run groups (Revenson & Cassel, 1991; Toro et al., 1988). Toro, Rappaport, and Seidman (1987) also found that mutual-help groups with indigenous leaders were more active and engaged than professional leaders. Indigenous leaders, despite the personal issues they may be working on in their lives, are known to be inspired, talented, and committed to their settings (Maton & Salem, 1995; Walsh, 1994).

Referent power is also likely to increase through the sharing of ingroup values, common past experiences, and other related characteristics at the core of the group’s functioning (Festinger, 1954; Turner, 1991). Shared characteristics can involve the common goal of overcoming substance abuse, depression, or schizophrenia, bringing the group together for the sole purpose of recovering from a single problem. Several studies have shown that successful group initiation is increased when mutual-help members perceive themselves as having similar attributes as group leaders (Salem, Gant, & Campbell, 1998; Salem et al., 2000). Mutual-help members are additionally more likely to turn toward the assistance of others who share similar past experiences (Schubert & Borkman, 1994). These factors, whether classified as referent or expert power, can contribute significantly to the development of self-reevaluation, and are likely to exist, at the very least, to an equal degree within professional- and mutual-help.

2.3. Helping relationships

One of the single factors that may best differentiate professional and mutual help within the transtheoretical model is the helping relationships process, defined by an individual’s ability to receive social support from others (Prochaska et al., 1998). Fellowship, support, and companionship are beneficial to recovery from a wide range of psychological
disorders and problems. For alcohol dependent individuals, confictual and unsupportive post-treatment friendship networks have perpetuated continued alcohol problems (Humphreys, Moos, & Finney, 1996). Social support for substance use abstinence has additionally been found to effectively counter the pressure of substance-use-support networks (Longabaugh, Wirtz, Beattie, Noel, & Stout, 1995). Longitudinal studies have also shown that the absence of social support is a causal factor in depression and that its presence can have a buffering effect against stressful events (Paykel & Cooper, 1992). The evidence on depression suggests the disorder is 13 times more likely in those who are socially isolated (Beach, Arias, & O'Leary, 1986).

It is often difficult for professionals to provide adequate social support during and after treatment. During treatment, large caseloads and other organizational factors within such facilities often prevent practitioners from reducing the hierarchical structure that exists between counselor and client. Following treatment, it is not within the professional's roles to provide the clients with non-using social support networks to maintain treatment gains. The mutual-help group is able to make up for this inability by providing an "encompassing peer-based support system" (Maton & Salem, 1995) that continually works to replace factors in the post-treatment environment that originally contributed to the problem.

In the area of substance abuse, Snow et al. (1994) found that higher AA affiliation scores (as assessed by the processes of change questionnaire) were associated with higher helping relationship scores, and that the correlations between these two dimensions were the strongest of all processes examined. Several other studies have shown that participation in AA improves relationship quality and increases the number of abstinent individuals in members' social networks (Humphreys & Noke, 1997; Kus, 1991). Other studies have shown that, particularly for individuals who have heavier drinking networks prior to the study, AA meetings can lead to long-term improvements in abstinent social support networks (Zywiak, Longabaugh, & Wirtz, 2002). Similarly, Jason et al. (1997) found that "fellowship with similar peers" was the highest rated of all experiences among Oxford House residents and rated significantly higher, after a six-month follow-up, than expectations before entering the house.

The helping relationships process in GROW is reflected in the fact that 88% of members state that there is someone in their lives with whom they can share anything, and of this 88 and 58% named another GROW member as this person (Roberts et al., 1991). This support from other members can take the form of affirmative emotional support, problem-solving techniques, or even tangible help with daily tasks (Rappaport, Reschil, & Zimmerman, 1992). While tolerance for disagreement is acceptable in GROW (Kloos, 2001), positive comments are seven times more frequent than negative ones (Roberts et al.), suggesting some balance between healthy discussion about issues and affirmative responses to members' attempts to recover.

Helping relationships in Schizophrenics Anonymous similarly play an even more central role than problem-solving (Walsh, 1994). Social support is particularly necessary for many people with schizophrenia because individuals with this disorder often have smaller support networks and report less satisfaction with those networks than individuals without schizophrenia or even those with affective disorders (Furukawa, Harai, Hirai, Kitamura, & Takahashi, 1999). Outside of Schizophrenics Anonymous meetings, members have few outlets to share their experiences of hallucinations, delusions, and hospitalizations (Randall, Salem, & Reischl, 2001), explaining why helping relationship-like discussions are among the most common activities in meetings. Based on a content analysis of members' interactions over a three-month period, the most common activities reported were "updating the group on their daily attempts to maintain their mental health" and "general sharing of the prior week's activities" (Walsh, 1994). Meeting discussions also reveal a frequent need to obtain help coping with depression—a common need even when symptoms of schizophrenia are in remission. Help is also provided to contend with medication side effects, reduce temptations to quit medications, and to more effectively obtain advice from professionals (Walsh, 1994).

2.4. Self-liberation

The process of self-liberation within the transtheoretical model is defined as the likelihood of a person changing behaviors, having the commitment and recommitment to act on his or her beliefs, and is often accompanied by the tendency to follow through with actions that can lead to recovery (Prochaska et al., 1992, 1998). Self-liberation is based on the notion that self-governance and greater responsibility can lead to action through increases in self-efficacy, the belief that one's efforts will succeed and promote recovery (Prochaska, 1995). There is evidence for the benefits of a more natural healing process that occurs through the learning of independent coping skills (Chazan, Levi, & Tal, 1989; Kooyman, 1993; Valliant, 1995). Findings also suggest that a sense of attachment, loyalty, or feelings of oneness with a treatment program can more successfully facilitate recovery (Beattie, Longabaugh, & Fava, 1992; Beattie et al., 1993; Longabaugh, Beattie, Noel, Stout, & Malloy, 1993; Moos, 1994).

Many inpatient treatment programs and mental health facilities offer clients little control over the direction of treatment plans and provide few other sources of self-governance (Jason, Olson, Ferrari, & Davis, 2004). Furthermore, clients often receive too little individualized care, are given a date by which they must leave to make room for future residents, and must occasionally contend with the detrimental effects of counselor burnout, a problem that may occur more in professional settings than in mutual-help groups (see for instance Revenson & Cassel, 1991).

In line with self-liberation, one of the central organizing features of GROW is having a “belief system that inspires
growth, is strengths-based, and is focused beyond the self” (Maton & Salem, 1995). Toro et al. (1987) also found that GROW fostered independence in its members. In coding and analyzing members’ discussions of their recovery, it was found that, compared to residents in a hospital-based system, members in a residential GROW setting focused on communal rather than individualistic issues, showing their concern for the whole organization, and reflecting a greater degree of self-liberation within the mutual-help setting (Kloos, 2001). GROW members were also found to have higher self-expressiveness and self-discovery when they were run by indigenous rather than professional leaders (Toro et al., 1988).

Oxford House is characterized by a similar emphasis on self-liberation, suggested in Jason et al.’s (1997) findings that residents report experiencing more self-autonomy and spiritual growth than expected before residing in the setting, and that residents describe their communities as “structured but not overly structured” and “well-governed but not overly authoritative.” The emphasis on self-liberation is evident in the Oxford House philosophy that, “The fewer the rules, the more likely it will be that a house will be successful” (Oxford House Manual, 2001). Many of the rules that do exist tend to be instituted and implemented by house members. Self-liberation is also facilitated in these settings because members are less likely to feel resentment toward authority figures within a democratic system. Due to the absence of a maximum length-of-stay policy, members also have the necessary time to establish habits and internalize attitudes conducive to recovery.

Self-liberation is also developed in mutual-help groups through new roles and responsibilities that are likely to increase self-efficacy. GROW places a particularly high value in group members’ abilities to solve their own problems and acquire real-world knowledge to better cope with everyday stressors (Kloos, 2001; Maton & Salem, 1995). One of the most well-known characteristics of GROW is its intentionally understaffed setting that provides easily obtainable leadership roles (Barker, 1960; Maton & Salem; Rapaport et al., 1992). Forty-three percent of GROW members take on formal leadership responsibilities (Heil, 1989; as cited in Maton & Salem), and qualitative analyses of recovery descriptions suggest these roles are instrumental in building an identity consistent with recovery (Kloos, 2001).

Oxford House has an equally accessible role structure, with responsibilities fundamental to the success of each house. One elected role is house treasurer, a position that may be filled by a member with no previous experience filling out a checkbook, leading that person to learn quickly the balancing of financial records. Examples such as these reflect the finding that the acquisition of “personal responsibility” is reported as significantly greater after six months of living in a house (Jason et al., 1997). Self-liberation through greater responsibility can also occur through employment. Each Oxford House is dependent on members working to pay rent.

The structure and foundation of the Oxford House model is built to foster self-liberation. When discussing the underlying principles of forming the first house, Paul Molloy, a co-founder, states that the strict supervision in institutional facilities is justified only to the extent that recovering individuals are “physically and mentally exhausted,” and, as recovery progresses, individuals become increasingly dissatisfied with the authority inherent in these programs. It is inevitable, he continues, that extended stays in formal treatment programs will only lead recovering individuals to abandon their sense of personal responsibility (Oxford House Manual, 2001). A similar longing for a more liberating form of recovery can be found in the histories of all groups reviewed in this article.

2.5. Environmental reevaluation

The environmental reevaluation process of the transtheoretical model involves the recognition that one’s problems have impacted other components of past and present environments, including acquaintances. The interpersonal impact of one’s actions on others and ecological issues are central concerns within these recovery communities. Twelve-step programs like AA are sharply focused on psychologically resolving past, destructive social interactions and improving current social interactions. In fact, few of the 12-steps address abstinence from alcohol and drugs, focusing instead largely on interpersonal relationships (DiClemente, 1993). Environmental reevaluation is directly addressed in Steps 8 and 9, which state that the recovering person should make a list of all person harmed and make amends wherever possible except when doing so would injure the person harmed or others. Environmental reevaluation is further represented in Step 10, stating that a person should continue to take personal inventory and admit when wrong, making cognitively salient the need to resolve past and current problematic interpersonal events.

A study of GROW found the majority of participants reporting the group benefited them most because it “helped them see others’ points of view” (Young & Williams, 1987). Schizophrenics Anonymous includes a step that emphasizes reconciliation with others, stating that the recovering person should forgive and release anyone who has injured or harmed them in any way (Randall et al., 2001). With more and more time spent attending Schizophrenics Anonymous meetings, members describe their social networks expanding outside of meetings, which could, at one point, only occur with great anxiety. Members begin to have more and more of these interactions with family members and professionals who at one point had been perceived to have dauntingly powerful positions (Walsh, 1994). The meetings help members negotiate these relationships, discuss ways to interact more effectively with others, and to help overcome the stigma often associated with the disorder (Walsh, 1994).

The facilitation of environmental reevaluation may be particularly effective in communal-based residences like Oxford House. In Oxford House, residents learn to interact more
often replaces members’ biological families (Olson et al., 2002). The daily events allow members to practice negotiation skills to better reduce conflict and understand how their actions impact others. Members also improve their social interactions by observing more established members modeling effective social skills and coping strategies that are less refined in newer members (Oxford House Manual, 2001).

2.6. Emotional arousal/dramatic relief

The emotional arousal/dramatic relief process, here referred to as emotional arousal, involves the therapeutic outpouring of emotion or catharsis (Prochaska et al., 1998). The therapeutic benefit of emotional experiences has long been thought to be central to the recovery process. Professional forms of therapy and mutual-help meetings can both produce strong emotions. In one study on GROW, however, indigenous mutual-help leaders were found to focus more on emotional support than professional leaders (Tracey & Toro, 1989). The importance of emotional support is demonstrated by further findings in the study suggesting that more successful outcomes occurred when group leaders responded more to members’ descriptions of emotional experiences, regardless of leader type.

The therapeutic benefits of emotional experiences and cognitive information are closely intertwined, particularly in mutual-help groups. Some researchers assert that catharsis in mutual-help settings is most beneficial when accompanied by cognitive learning—for instance, when an emotional experience contributes to a person’s ability to resolve a problem (Kurtz, 1997). Within the transtheoretical model, cognitive processes of change such as self-reevaluation and environmental reevaluation are likely integral to the emotional arousal process. When mutual-help members publicly present their personal narratives at meetings, they are likely not only to acquire the positive cognitive benefits, but emotional benefits as well. In another example, similar referent group others in GROW have been found to produce more positive emotions than non-reference group others (Roberts et al., 1991), perhaps because referent group others, who have lived through the experience, are perceived to have a more genuine empathy than those who have never experienced the problem. Emotional arousal may also interact with environmental reevaluation, illustrated by a woman in Schizophrenics Anonymous who explained that it was only when she was able to release herself from feelings of shame and failure that she was able to overcome her resentment toward others who had harmed her (Randall et al., 2001).

The intersection of interpersonal relationships and emotional bonds also plays out fully in Oxford House where members live together as a non-traditional yet surrogate family that often replaces members’ biological families (Olson et al., 2002).

2.7. Stimulus control

Research on substance abuse suggests that stimuli present within drug-using contexts can have a substantial impact on relapse due to the reinforcing nature of addictive substances and the context-dependent conditioning in the physical and social features of the environment where drugs are taken (Carlson, 1999). For this reason, recovery from addiction often requires individuals to remove themselves as completely as possible from high-risk environments. The stimulus control process within the transtheoretical model involves the learning of methods to avoid or counteract high-risk environmental cues likely to trigger problematic behaviors (Prochaska et al., 1992). While residential treatment programs offer a temporary form of stimulus control, clients are often discharged from these facilities before they have acquired the essential cognitive and emotional skills necessary to sustain recovery in the presence of non-abstinent family and friends or other stimuli (e.g., neighborhood settings) (Prochaska et al., 1992).

Mutual-help groups like AA and Oxford House create stimulus control partly through the development of attachments to non-using others, and thereby removing their common everyday activities from more dangerous contexts and attachments to non-abstinent others (see Kus, 1991; Humphreys & Nock, 1997; Humphreys et al., 1996). The finding that higher levels of AA Affiliation are associated with higher levels of stimulus control supports the hypothesis that groups reduce the probability of exposure to threatening stimuli (Snow et al., 1994). Substance abstinent networks offer many forms of support but perhaps none stronger than those that counter illicit substance use by providing use-avoidant settings and activities, factors that strongly bolster stimulus control.

Corroborating evidence is found in Oxford House, where participants, after having lived in a house for six months, more strongly characterized the homes as safe living settings, largely because they provided physical and psychological security from drug-using contexts (Jason et al., 1997). Oxford Houses likely provide an even greater form of stimulus control than AA meetings since it is provided within a 24-h, residential context. As the Oxford House manual (2001) states.

Alcoholics Anonymous provides a framework to change physically, mentally, and spiritually. The degree to which we were able to successfully change our lives had a direct relationship to Alcoholics Anonymous and Narcotics Anonymous. Many of us soon learned, however, that living along or living among our old drinking companions made it more difficult to practice the principles necessary for continued sobriety.

Oxford Houses possess the advantages of increasing attendance to AA and NA meetings, yet has many advantages for individuals in early stages of recovery because they can return to a safe environment once a meeting ends.
2.8. Reinforcement management

Reinforcement management is a behavioral process of the transtheoretical model that involves the availability of rewards for engaging in behaviors likely to facilitate recovery (Prochaska et al., 1998). A large component of drug addiction is due to conditioning processes whereby individuals receive immediate reinforcement for taking drugs thereby increasing the probability the behaviors will recur (Carlson, 1999). Conditioning processes play an equally important role in recovery. With other mental health disorders (e.g., schizophrenia), behavioral processes are also central to recovery, regardless of the etiological role these processes play in the development of the disorder.

While mental health practitioners can in no way be expected to use behavioral management techniques with a client on a daily basis, particularly when a client leaves treatment, mutual-help members consistently provide daily rewards. Oxford House residents, for instance, reinforce each other throughout the day, and members, leaders, and sponsors of all mutual-help organizations provide frequent environmental contingencies by praising completed “step work,” and reminding each other frequently, verbally and behaviorally, about the advantages to greater competence and better decision-making. There is a close association between reinforcement management and the actions of close peers, supported by a significant positive association between AA affiliation and a measure combining reinforcement management with counterconditioning, the next process to be discussed (Snow et al., 1994).

Life in Oxford House can also provide more behavioral processes through a “tough love” atmosphere where other members provide punitive contingencies in the forms of contracts and fines for actions that negatively impact other house members. Many of the contingencies in mutual-help are also found beyond the intentional reinforcement or punishment provided directly by other members, arising as dramatically in the natural contingencies provided by the organizational structure of the setting, its rules, policies, and traditions. The consistent social and environmental contingencies associated with these meetings and other daily interactions are among the most underlying and least understood mechanisms of mutual help.

2.9. Counterconditioning

The counterconditioning process within the transtheoretical model involves a person’s ability to find healthy resources (e.g., activities or cognitions) and distractions that counter negative emotions such as sadness, nervousness, or loneliness, all of which can substantially interfere with recovery (Oxford House Manual, 2001; Salem, Seidman, & Rappaport, 1988). GROW members report that primary benefits of the group have been reductions in anxiety and loneliness, benefits derived from counterconditioning processes that occur both within and outside of meetings (Young & Williams, 1987). Members spend significant time with other group members, engaging in small talk, and receiving substantial emotional support (Roberts et al., 1999; Toro et al., 1988). Counterconditioning can occur through various pleasurable, stress-reducing activities such as bowling, shopping, and picnics, all healthy substitutes for spending time alone and ruminating on problems. Other members are frequently available for late night discussions when anxiety and life pressures are likely to have detrimental effects and healthy forms of distraction are needed most (Oxford House Manual, 2001; Salem et al., Maton & Salem, 1995; Walsh, 1994).

2.10. Social liberation

The final process, social liberation, involves the person in recovery focusing attention away from oneself and developing a broader recognition of social issues that contributed to the targeted problem. Through the development of greater social consciousness, the social liberation process encourages recovering individuals to take more helping-related attitudes toward others who face similar problems; problems socially liberated people have worked hard to overcome.

Mutual-help members may implicitly or explicitly gain objective therapeutic benefits from this helping behavior, representing a well-known phenomenon called the helper-therapy principle (Biessman, 1963) and a related concept called bidirectional support where well-being is increased when individuals help others while simultaneously being helped by others (Maton, 1988).

Members of GROW are expected to act as both helper and receiver of help (Salem et al., 1988), and this notion is reflected in the frequently recited GROW phrase, “If you need help, help others” (Maton & Salem, 1995). In support of the helper-therapy principle, one study found that mutual-help participants who offered assistance to others tended to have better psychosocial adjustment over time (Roberts et al., 1999). The experiences of both giving and receiving help are positively associated with individual well-being and a more positive appraisal of the group by members (Maton, 1988).

One possible explanation of the helper-therapy principle is that when people provide informational guidance to others, their own social functioning improves, either because providing guidance facilitates the working through of one’s own difficulties (Silverman, 1976) or because guidance reinforces
the helper’s own personal learning (Roberts et al., 1991). Other explanations of social liberation suggest that helping others increases one’s feeling of competence and social usefulness, allowing one to take on strength-based roles that have not been fully exercised in other areas of life (Gartner & Riessman, 1997; Roberts et al.).

Social liberation is reflected in the 12th step of AA, which addresses the necessity of members carrying on the AA message to others in recovery and practicing AA principles in all their affairs. AA sponsors, more than anyone else, best represent people who have transformed a philosophy of self-concern into a desire to help others. This 12th step attitude is prevalent in Oxford House alumni who have worked through recovery long enough to have developed broader concerns for others, leading them, for instance, to become more involved in social and municipal affairs, and even advocacy.

A further reflection of social liberation and the helper-therapy principle is that, when asked how they most benefited from the organization, 67% of GROW members reported that the group “Taught [them they] could help others,” the highest percentage of all listed categories (Young & Williams, 1987). Kloos (2003) additionally found that the stories of GROW residents included more socially-valued roles than those of hospital-based residents. Whereas traditionally-based hospital residents focused primarily on what needed to be done for their own rehabilitation, GROW participants were more interested in finding ways to give back to others. Of those who had returned after leaving the program, the more traditionally-based hospital residents returned to visit staff, while former GROW residents returned to, again, give back to current residents.

3. Conclusion

Researchers have proposed different sets of change processes with which to better explain mutual help (see for instance Morgenstern & McCrady, 1993), although it is evident from this review that the transtheoretical model provides an almost ideal framework. The common language it affords has the potential to build dialogue among researchers, clinicians, and consumers, promising to bring about greater understanding of the role mutual-help plays in clinical treatment plans and thereby furthering the reach of professional care. Future challenges for the transtheoretical model lie in its ability to guide clinical decisions regarding the sequences and combinations of mutual and professional help, produce the most lasting forms of recovery across the continuum of care, help clinicians set better recovery goals, and foster the most appropriate processes of change according to each person’s needs and his or her stage of recovery (see Carbonari & DiClemente, 2000).

While it is important to recognize that mutual-help groups should not simply be reduced to another form of clinical intervention, there are a number of ways to improve the collaboration between professionals and mutual-help organizations. One potential form of integration is to use mutual-help in conjunction with therapy, providing a form of low-cost, supplementary support. This combination might particularly benefit clients with comorbid problems such as the common co-occurrence of schizophrenia and substance use (see Bellack & DiClemente, 1999). Such a person could simultaneously receive treatment from a practitioner while living in Oxford House and attending Schizophrenics Anonymous meetings. These combinations could work to free therapist resources by providing appropriate forms of helping relationships and influencing other processes of change outside of therapy, thus allowing the therapist to target other processes of change.

Professional- and mutual-help can also be addressed within a client’s treatment plan by utilizing mutual-help as a form of aftercare. Certain mental conditions require a lifetime of care, and yet the average length of services has continually been reduced due to national health care costs. Few models can provide the ongoing yet low-cost support provided by mutual-help.

Perhaps the single most important way the transtheoretical model can aid clinicians is by providing a mechanism through which more efficient and collaborative treatment decisions can be made by matching clients to the most appropriate forms of care based on the client’s progression within the stages of change. The vast literature on the transtheoretical model suggests that clients benefit most when treatment influences the particular processes of change associated with the person’s location within the stages of change. An individual attempting to overcome a substance abuse addiction and initially working on the process of consciousness raising, a process associated with earlier stages of change, might receive the best initial care in an inpatient treatment center or therapeutic community, while a person working on self-reevaluation, a process further along, might benefit more by living in an Oxford House-like mutual-help residence.

It was not within the scope of this review to address how the processes facilitated in mutual help interact with the stages of change. While the 12 steps might be considered to be built on a stage model, there has been no published attempt to map these steps onto the transtheoretical stages. Due to the absence of this or any other stage research in the mutual-help literature, it was not possible to include such an integration in the present review. This suggests that mutual-help researchers should investigate how interactions within mutual-help groups differ for members within different stages of recovery, and whether the processes developed occur within the stages described by the transtheoretical model.

One last point is that, despite the present emphasis on commonalities across mutual-help settings, researchers may also find it useful to investigate differences in the various forms of mutual-help groups. Because Oxford House is a more time intensive setting than a typical meeting, for example, the residences could have a different impact on the processes and stages of change compared to other mutual-help groups. While these differences may eventually be fruitful to
examine, it is perhaps most important to first recognize the similarities across these forms of care. When Albee (1968) expressed his concern regarding the future state of professional help and suggested that psychologists spend more time working on theory and letting individuals with higher degrees provide much of the needed mental health services, he did not, of course, intend to exclude professionals altogether from the mental health delivery system. Both forms of care can positively influence the ten processes of change and any strict theoretical divisions between professional help and self-help are likely to be detrimental to both mental health providers and consumers. The future research likely to contribute most to creating comprehensive change will work at the interface of both modes of care. A logical next step for this research is to engage in construct validation (Cronbach & Meehl, 1955), prospectively examining the ways in which the processes of change and stages of change interact within the net of professional and mutual help. Based on the theory’s fit with the existing mutual-help literature, the transtheoretical model has a propitious start.

Acknowledgements

The authors appreciate the financial support provided by NIAAA grant AA12218-02. The authors also thank Lucia D’Arlach, Margaret I. Davis, Kathy Erickson, and Bertel Williams for helpful input on earlier drafts.

References


