# *Applying the stages of change*

JAMES O. PROCHASKA, JOHN C. NORCROSS and CARLO C. DICLEMENTE

From a transtheoretical perspective, PROCHASKA, NORCROSS and DICLEMENTE summarise prescriptive and proscriptive guidelines for improving treatments based on five stages of change the client may progress through — precontemplation, contemplation, preparation, action, and maintenance. Change is not viewed as a linear progression through the stages; rather, most clients move through the stages of change in a spiral pattern. While people progress from contemplation to preparation to action to maintenance, most will relapse. Fortunately, most move back to the contemplation stage and into preparation and action. Eleven practice recommendations are advanced against the central need to assess the stage of a client's readiness for change and to tailor interventions accordingly. A small and finite set of change processes or strategies have been identified across hundreds of psychotherapy techniques and across diverse disorders. Eight change process are outlined in detail. In the transtheoretical model, change processes associated with particular therapeutic models are applied optimally at each stage of change accompanied by stage-matched 'relationships of choice'. Guidance is given on how to avoid mismatching stages and processes. Smoking is used as an illustrative problem behaviour.

Over the past thirty years our research has focused on the structure that underlies both self-initiated and treatment-facilitated behaviour change (see DiClemente, 2003; Prochaska & Norcross, 2010; Norcross, Krebs, & Prochaska, 2011). From a transtheoretical perspective, this chapter summarises prescriptive and proscriptive guidelines for improving treatment based on the client's stage of change.

## The stages

### *1. Precontemplation*

In this stage there is no intention to change behaviour in the foreseeable future. Most individuals in this stage are unaware or underaware of their problems. Families, friends, neighbours, or employers, however, are often well aware that the precontemplators have problems. When precontemplators present for psychotherapy, they often do so because of pressure from others. Usually they feel coerced into changing by spouses who threaten to leave, employers who threaten to dismiss them, parents who threaten to disown them, or courts who threaten to punish them.

There are multiple ways to measure the stages of change. In our studies employing the discrete categorisation measurement of stages of change, we ask if the individual is seriously intending to change the problem behaviour in the near future, typically within the next six months. If not, he or she is classified as a precontemplator. Even precontemplators can wish to change, but this is quite different from intending or seriously considering change. Items that are used to identify precontemplation on the continuous stage of change measure include: *"As far as I'm concerned, I don't have any problems that need changing"* and *"I guess I have faults, but there's nothing that I really need to change."* Resistance to recognising or modifying a problem is the hallmark of precontemplation.

### *2. Contemplation*

In this stage people are aware a problem exists and are seriously thinking about overcoming it, but have not yet made a commitment to take action. People can remain stuck in the contemplation stage for long periods. In one study of self-changers we followed a group of 200 smokers in the contemplation stage for two years. The modal response of this group was to remain in the contemplation stage for the entire two years of the project without moving to significant action.

Contemplators struggle with their positive evaluations of their dysfunctional behaviour and the amount of effort, energy, and loss it will cost to overcome it. On discrete measures, individuals who state they are seriously considering changing their behaviour in the next six months

are classified as contemplators. On the continuous measure, these individuals endorse such items as *"I have a problem and I really think I should work on it"* and *"I've been thinking that I might want to change something about myself."* Serious consideration of problem resolution is the central element of contemplation.

### 3. Preparation

This stage combines intention and behavioural criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year. As a group, individuals who are prepared for action report small behavioural changes, such as smoking five fewer cigarettes a day or delaying their first cigarette of the day for 30 minutes longer than precontemplators or contemplators. Although they have reduced their problem behaviours, individuals in the preparation stage have not yet reached a criterion for effective action, such as abstinence from smoking or alcohol abuse. They are intending, however, to take such action in the very near future. On the continuous measure, they score high on both the contemplation and action scales.

### 4. Action

This is the stage in which individuals modify their behaviour, experiences, and/or environment in order to overcome their problems. Action involves the most overt behavioural changes and requires considerable commitment of time and energy. Behavioural changes in the action stage tend to be most visible and externally recognised. Individuals are classified in the action stage if they have successfully altered the dysfunctional behaviour for a period from one day to six months. On the continuous measure, individuals in the action stage endorse statements like *"I am really working hard to change"* and *"Anyone can talk about changing; I am actually doing something about it."* They score high on the action scale and lower on the other scales. Modification of the target behaviour to an acceptable criterion and concerted overt efforts to change are the hallmarks of action.

### 5. Maintenance

In this stage people work to prevent relapse and consolidate the gains attained during action. For addictive behaviours, the maintenance stage extends from six months to an indeterminate period past the initial action. For some behaviours, maintenance can be considered to last a lifetime. Remaining free of the addictive behaviour and engaging in a new incompatible behaviour consistently for more than six months are the criteria for the maintenance stage. On the continuous measure, representative maintenance items are *"I may need a boost right now to help me maintain the changes I've already made"* and *"I'm here to prevent myself from having a relapse of my problem."* Stabilising behaviour change and avoiding relapse are the hallmarks of maintenance.

However, change is not a linear progression through the stages; rather, most clients move through the stages of change in a spiral pattern. People progress from contemplation to preparation to action to maintenance, but most individuals will relapse. During relapse, individuals regress to an earlier stage. Some relapsers feel like they are failures. They are embarrassed, ashamed, and guilty. These individuals become demoralised and resist thinking about behaviour change. As a result, they return to the precontemplation stage and can remain there for various periods of time. Approximately 15% of relapsers in our self-change research regressed to the precontemplation stage. Fortunately, most—85% or so—move back to the contemplation stage and eventually back into preparation and action.

***…change is not a linear progression through the stages; rather, most clients move through the stages of change in a spiral pattern.***

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## Practice Recommendations

### *1. Assess the client's stage of change*

Probably the most obvious and direct implication is the need to assess the stage of a client's readiness for change and to tailor interventions accordingly. Stages of change can be ascertained by multiple means, of which three self-report methods will be described here.

A first and most efficient method is to ask the patient a simple series of questions to identify his or her stage—for example, *"Do you think behaviour X is a problem for you now?"* (if yes, then contemplation, preparation, or action stage; if no, then maintenance or precontemplation stage) and *"When do you intend to change behaviour X?"* (if some day or not soon, then contemplation stage; if in the next month, then preparation; if now, then the action stage). A second method is to assess the stage from a series of mutually exclusive questions, and a third is a continuous measure that yields separate scales for precontemplation, contemplation, action, and maintenance.

### *2. Beware treating all patients as though they are in action*

Professionals frequently design excellent action-oriented treatment and self-help programs, but then are disappointed when only a small percentage of people register or when large numbers drop out of the program after registering. The vast majority of people are not in the action stage. Aggregating across studies and populations, we estimate that 20% are prepared for action, approximately 35% to 40% are in the contemplation stage, and 40% to 45% in the precontemplation stage. Thus, professionals approaching patients and settings only with action-oriented programs are likely to underserve or misserve the majority of their target population.

### *3. Assist clients in moving one stage at a time*

If clients progress from one stage to the next during the first month of treatment, they can double their chances of taking action in the next six months. Among smokers, for example, of the precontemplators who were still in precontemplation at one-month follow-up, only 3% took action by six months. For the precontemplators who progressed to contemplation at one month, 7% took action by six months. Similarly, of the contemplators who remained in contemplation at one month, only 20% took action by six months. At one month, 41% of the contemplators who progressed to the preparation stage attempted to quit by six months. These data indicate that treatments designed to help people progress just one stage in a month may double the chances of participants taking action on their own in the near future.

***If clients progress from one stage to the next during the first month of treatment, they can double their chances of taking action in the next six months.***

**Table 1.** ***Titles, definitions, and representative interventions of eight processes of change***

| Process | Definition: Interventions |
|---|---|
| *1. Consciousness raising* | Increasing information about self and problem: observations; confrontations; interpretations; feedback; bibliotherapy. |
| *2. Self-reevaluation* | Assessing how one feels and thinks about oneself with respect to a problem: value clarification; imagery; corrective emotional experience. |
| *3. Emotional arousal (or dramatic relief)* | Experiencing and expressing feelings about one's problems and solutions: psychodrama; grieving losses; role playing; journaling. |
| *4. Social liberation* | Increasing alternatives for nonproblem behaviors available in society: advocating for rights of repressed; empowering; policy interventions. |
| *5. Self-liberation* | Choosing and committing to act or belief in ability to change: decision-making therapy; New Year's resolutions; logotherapy techniques; commitment-enhancing techniques. |
| *6. Counterconditioning* | Substituting alternatives for anxiety related behaviors: relaxation; desensitisation; assertion; cognitive restructuring. |
| *7. Stimulus control* | Avoiding or countering stimuli that elicit problem behaviors: restructuring one's environment (e.g., removing alcohol or fattening foods); avoiding high-risk cues; fading techniques. |
| *8. Contingency management* | Rewarding oneself or being rewarded by others for making changes: contingency contracts; overt and covert reinforcement; self-reward. |

Source: *Adapted from Prochaska, DiClemente, & Norcross, 1992.*

*4. Recognise that clients in the action stage are far more likely to achieve better and quicker outcomes*

The amount of progress clients make during treatment tends to be a function of their pretreatment stage of change. For example, an intensive action- and maintenance-oriented smoking cessation program for cardiac patients achieved success for 22% of precontemplators, 43% of contemplators, and 76% of those in action or prepared for action at the start of the study were not smoking six months later. This repeated finding has direct implications for selecting and prioritising treatment goals.

*5. Facilitate the insight-action crossover*

Patients in successful treatment evidence steady progression on the stages of change. Patients entering therapy are often in the contemplation or preparation stage. In the midst of treatment, patients typically cross over from contemplation into action. Patients who remain in treatment progress from being prepared for action to taking action over time. That is, they shift from thinking about their problems to doing things to overcome them. Lowered precontemplation scores also indicate that, as engagement in therapy increases, patients reduce their defensiveness and resistance. The progression from contemplation to action is postulated to be essential for beneficial outcome regardless of whether the treatment is action-oriented or insight-oriented.

*6. Anticipate recycling*

Most self-changers and psychotherapy patients will recycle several times through the stages before achieving long-term maintenance. Accordingly, intervention programs and professionals expecting people to progress linearly through the stages are likely to gather disappointing results. Be prepared to include relapse prevention in treatment, anticipate the probability of recycling patients, and minimise therapist guilt and patient shame over recycling.

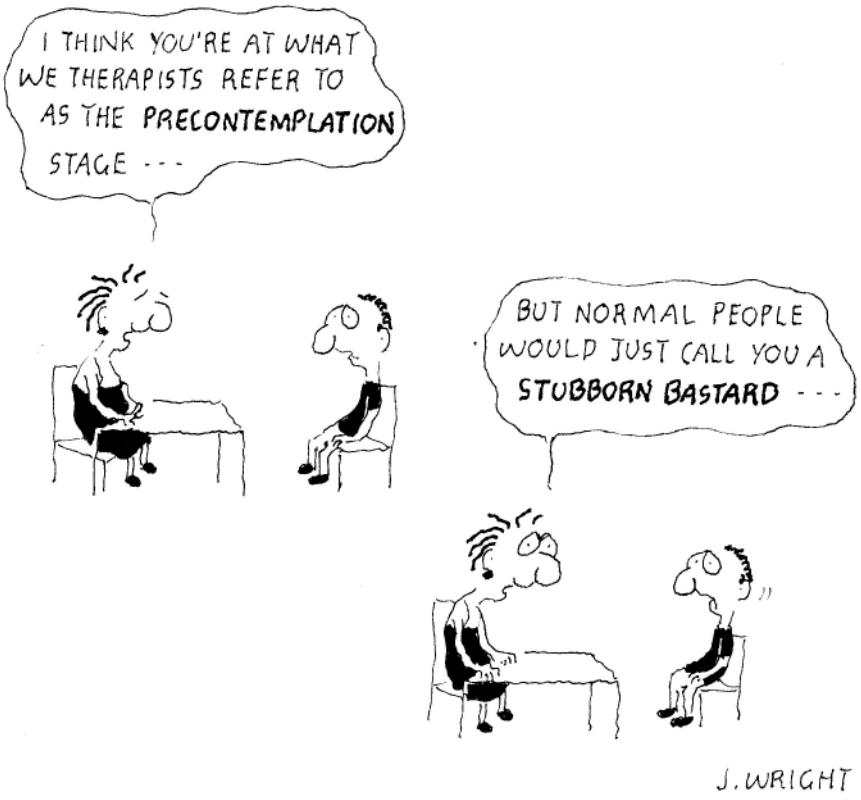
*7. Conceptualise change as processes, not specific techniques*

Literally hundreds of specific psychotherapeutic techniques have been advanced; however, a small and finite set of change processes or strategies underlie these multitudinous techniques.

Change processes are covert and overt activities that individuals engage in when they attempt to modify problem behaviours. Each process is a broad category encompassing multiple techniques, methods, and interventions traditionally associated with disparate theoretical orientations. These change processes can be used within therapy sessions, between therapy sessions, or without therapy sessions.

The processes of change represent an intermediate level of abstraction between meta-theoretical assumptions and specific techniques spawned by those theories. While there are 400-plus ostensibly different psychotherapies, we have been able to identify only twelve different processes of change based on principal components analysis.

Table 1 presents the eight processes receiving the most theoretical and empirical support in our work, along with their definitions and representative examples of specific interventions. A common and finite set of change processes has been identified repeatedly across diverse disorders.




***…professionals approaching patients and settings only with action-oriented programs are likely to underserve or misserve the majority of their target population.***

*8. Do the right things (processes) at the right time (stages)*

Thirty years of research in behavioural medicine, self-change, and psychotherapy converge in showing that different processes of change are differentially effective in certain stages of change; a metaanalysis of 47 studies (Rosen, 2000) found effect sizes of .70 and .80 for the use of different change processes in the stages. In general terms, change processes traditionally associated with the experiential, cognitive, and psychoanalytic

persuasions are most useful during the earlier precontemplation and contemplation stages. Change processes traditionally associated with the existential and behavioural traditions, by contrast, are most useful during action and maintenance.

In the transtheoretical model, particular change processes will be optimally applied at each stage of change. During the precontemplation stage, individuals use the change processes significantly less than people in any of the other stages. Precontemplators process less information about their problems, devote less time and energy to reevaluating themselves, and experience fewer emotional reactions to the negative aspects of their problems. In therapy, these are the most resistant or the least active clients.

Individuals in the contemplation stage are most open to consciousness-raising techniques, such as observations, confrontations, and interpretations, and are much more likely to use bibliotherapy and other educational techniques. Contemplators also profitably employ emotional arousal, which raises emotions and leads to a lowering of negative affect when the person changes. As individuals became more conscious of themselves and the nature of their problems, they are more likely to reevaluate their values, problems, and themselves both affectively and cognitively.

Both movement from precontemplation to contemplation and movement through the contemplation stage entail increased use of cognitive, affective, and evaluative processes of change. Some of these changes continue during the preparation stage. In addition, individuals in preparation begin to take small steps toward action.

During the action stage, people use higher levels of self-liberation or willpower. They believe increasingly that they have the autonomy to change their lives in key ways. Successful action also entails effective use of behavioural processes, such as counterconditioning and stimulus control, in order to modify the conditional stimuli that frequently prompt relapse. Contingency management also comes into frequent use here.

Successful maintenance builds on each of the processes that came before. Specific preparation for maintenance entails an assessment of the conditions under which a person would be likely to relapse and development of alternative responses for coping with such conditions without resorting to self-defeating defenses and pathological responses. Continuing to apply counterconditioning, stimulus control, and contingency management is most effective when based on the conviction that maintaining change supports a sense of self that is highly valued by oneself and significant others.

### *9. Prescribe stage-matched 'relationships of choice' as well as 'treatments of choice'*

Psychotherapists seek to customise or tailor their interpersonal stance to different patients. One way to conceptualise the matter, paralleling the notion of 'treatments of choice' in terms of techniques, is how clinicians determine therapeutic 'relationships of choice' in terms of interpersonal stances (Norcross, 2011).

The research and clinical consensus on the therapist's stance at different stages can be characterised as follows. With precontemplators often the role is like that of a nurturing parent joining with the resistant youngster who is both drawn to and repelled by the prospects of becoming more independent. With contemplators, the therapist role is akin to a Socratic teacher who encourages clients to achieve their own insights and ideas into their condition. With clients who are in the preparation stage, the stance is more like that of an experienced coach who has been through many crucial matches and can provide a fine game plan or can review the person's own action plan. With clients who are progressing into action and maintenance, the psychotherapist becomes more of a consultant who is available to provide expert advice and support when action is not progressing as smoothly as expected.

### *10. Avoid mismatching stages and processes*

A person's stage of change provides proscriptive as well as prescriptive information on treatments of choice. Action-oriented therapies may be quite effective with individuals who are in the preparation or action stages. These same programs may be ineffective or detrimental, however, with individuals in the precontemplation or contemplation stages.

We have observed two frequent mismatches. First, some therapists rely primarily on change processes most indicated for the contemplation stage — consciousness raising, self-reevaluation — while they are moving into the action stage. They try to modify behaviours by becoming more aware, a common criticism of classical psychoanalysis: insight alone does not necessarily bring about behaviour change. Second, other therapists rely primarily on change processes most indicated for the action stage — contingency management, stimulus control, counter-conditioning — without the requisite awareness, decision making, and readiness provided in the contemplation and preparation stages. They try to modify behaviour without awareness, a common criticism of radical behaviourism: overt action without insight is likely to lead to temporary change.

### *11. Think complementarily*

Competing systems of psychotherapy have promulgated purportedly rival processes of change. However, ostensibly contradictory processes become complementary when embedded in the stages of change. Our research has documented consistently that ordinary people in their natural environments and psychotherapists in their consultation rooms can be remarkably effective in synthesising powerful change processes across the stages of change.

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