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Blueprint to build strong foundations for change

PROFESSOR CARLO DICLEMENTE'S STAGES OF CHANGE MODEL IS FETED WORLDWIDE FOR ENHANCING THE UNDERSTANDING AND SKILLS WHICH MAKE A SUBSTANCE-ABUSE TREATMENT PROVIDER EFFECTIVE. IT HELPS CLINICIANS DEVELOP THOUGHTFUL, INDIVIDUALLY TAILORED, SCIENTIFICALLY GROUNDED TREATMENT PLANS – NOW HE EXTENDS IT TO POLICY AND PROGRAMMES

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PhD is internationally recognised as co-creator, with Dr James Prochaska, of the Transtheoretical Model of Change, which identifies stages of change and other factors that predict treatment outcomes and allows many more people to enter treatment programmes at earlier stages of readiness.

He is the author of many scientific articles, and co-author of *Changing for Good*, *The Transtheoretical Model*, *Substance Abuse Treatment and the Stages of Change*, *Group Treatment for Substance Abuse: A Stages of Change Therapy Manual* and *Addiction and Change: How Addictions Develop and Addicted People Recover*.

For 20 years, he has led research in health and addictive behaviours including Project Match, the world's most exhaustive research into the impact of alcohol treatment.

Current research interests include smoking, substance abuse treatment, dual diagnosis, early intervention with problem drinkers, pregnancy smoking cessation, and initiation of health-protection/health-threatening behaviours.

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Research tells us that central qualities of the effective clinician are empathy, warmth and positive regard. It also tells us that developing and implementing a clearly articulated treatment plan and providing treatment for the problems a client presents are effective skills. But putting these qualities and skills into action is a challenge.

How does an individual clinician learn to express these central human qualities of caring and compassion with clients who are often difficult and unhappy about being in treatment, and whose central disorder is often characterised by behaviours which do not easily elicit empathy? And given the incredible heterogeneity among substance-use clients, how can a clinician develop a personalised treatment plan grounded in science?

Further, how can we apply those same principles to other workers in the field of substance-use treatment, including members of drug/alcohol action teams? Is there a common framework? Can the process of change be applied at a systemic level as well as at an individual level?

We will seek to answer these questions in more depth at the UK/European Symposium in London on 19-21 May. But let's open up the issue... Deepening our understanding of addiction can also deepen our understanding of the implications for policy and programmes. It can let us see that we need a common framework – such as *Models of Care* – and a common assessment tool, which has eluded drug/alcohol action teams, to their increasingly vocal frustration. Deep understanding of what our clients are all about, and the meaning of what we are doing, can lead us to a conceptualisation of the entire process of change and the entire continuum of care.

WHAT IS THE STAGES OF CHANGE MODEL? Developing genuine understanding of – even empathy for – a client requires professionals to look beyond that client's behaviour when using alcohol or drugs, and to understand the nature of substance-use disorders and difficulties inherent in changing long-standing, pervasive patterns of thought and behaviour. They are helped in this by the 'stages of change' model, combined with a good treatment plan.

The current model posits five stages of change: precontemplation, contemplation, preparation, action and maintenance. People in the first stage show no sign of intent to change a problem behaviour, be it because of a lack

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of awareness, unwillingness or a lack of hope because previous attempts failed. Contemplators are more visibly distressed about their problem behaviours than precontemplators and have begun to weigh the positives and negatives of change.

The preparation stage covers people who are ready to change both attitude and behaviour, and to change soon. When people are in the action stage, behaviour change has clearly begun. So they need skills to implement specific change methods. They also need to be aware of the psychological – cognitive, behavioural and emotional – events which can work against their best efforts. And they need to learn how to prevent major reversals, such as having a relapse and returning to pre-change patterns. The action stage lasts an average of about six months.

The last major stage of change is maintenance, where people sustain and strengthen improvements they have made. They can take a few years to feel “secure”.

All of this is voluntary rather than coerced change. Indeed, the stages of change are a model of “how to think” rather than “how to do”. They describe attitudes, intentions and behaviours related to the tasks of change, which the UKESAD presentations hope to reinforce. Note that the “change” sought is specific: commitment to change one behaviour might say nothing about commitment to change a related behaviour. And each stage refers to a time period and to tasks which a person or organisation must complete before moving to the next stage.

COMMON CHARACTERISTICS. Let’s look at the commonalities of clients in the five stages of change – then readers can draw their own conclusions as to the similarities at a systemic level for change in our field.

The common characteristics of people in the precontemplative stage are: defensive, resistant to suggestion of problems associated with their use/behaviour, uncommitted or passive in treatment/work, consciously or unconsciously avoiding steps to change their behaviour, lacking awareness of a problem, often pressured by others to change, feeling coerced and ‘put upon’ by significant others.

The characteristics of contemplators of change are: seeking to evaluate and understand their actions, distressed, desirous of exerting control or mastery, thinking about making change, have not begun taking action and are not yet prepared to do so, many previous attempts to change, evaluating pros and cons of their behaviour and of changing it.

Now we come to the preparation stage, where people: intend to change their behaviour, are ready to change attitude and behaviour, are on the verge of

taking action, are engaged in the change process, are prepared to make firm commitments to follow through on the action option they choose, and are making or have made the decision to change.

Common characteristics of people in the action stage are that they have: decided to change, verbalised or otherwise shown a firm commitment to change, tried to modify behaviour and/or environment, demonstrated motivation, and are willing to follow suggested strategies and activities for change.

And what do we share at the maintenance stage? Characteristics are: working to sustain changes achieved to date, focusing considerable attention on avoiding slips or relapses, feeling fear or anxiety about relapse and facing high-risk situations, and less frequent but often intense temptations to return to old habits.

MOTIVATIONAL STRATEGIES to promote change include giving advice, practising empathy, removing barriers, providing feedback, providing choice, clarifying goals, decreasing desirability of unhealthy habits, and active helping.

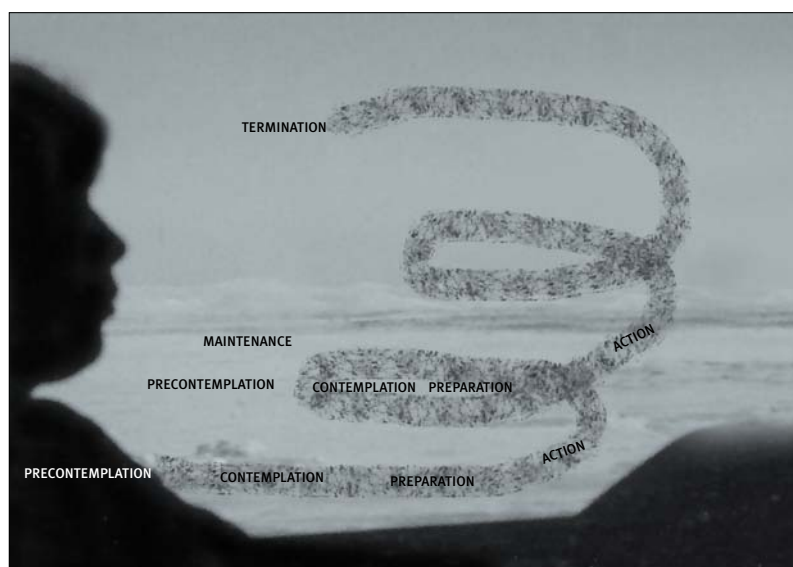
CLINICAL STRATEGIES for people in the action stage include maintaining engagement in the change process/treatment, supporting a realistic view of change through small successive steps, acknowledging the difficulties, helping people to identify high-risk situations through a functional analysis and developing coping strategies to overcome these, helping people to find new reinforcers of positive change, and helping people to assess if they have strong support networks.

Clinical strategies for people in the maintenance stage include helping them to identify and sample drug-free sources of satisfaction, supporting lifestyle changes, affirming people’s resolve and self-efficacy, helping them to practise and apply new coping strategies to avoid a return to unhealthy habits, and maintaining supportive contact.

TREATMENT/ACTION PLANNING. Based on information gathered during assessment, this is created in collaboration with each person wishing to change and addresses mutually agreed goals. It serves a variety of purposes, including prioritising short- and long-term goals, choosing the optimal interventions for specific goals, identifying barriers to the achievement of goals, and monitoring progress towards goals over time.

For our new purposes, goals can be as much on a national or local level as they can be on a personal level. They can include decrease in or cessation of substance use, which can impact on other goals such as improving family and employment situations, extending social support networks, and returning to school or college. One obvious benefit of prioritising goals is that attention is focused on the most pressing problems.

“THERE IS A GROWING BODY OF LITERATURE WHICH APPEARS TO SUPPORT THE RELATIONSHIP OF STAGES OF CHANGE TO IMPORTANT OUTCOMES... IN MANY BEHAVIOURS”



Another is that successes in these main areas often place people in a better position to address secondary goals.

It is important to recognise the treatment/action plan as flexible and changeable. Unexpected needs or problems can arise. Some goals might depend on others. Some might take longer than anticipated.

COMMON FEATURES OF TREATMENT PLANS INCLUDE:

- developed as a result of a comprehensive assessment and modified over time as warranted
- reflects participation from appropriate disciplines – medicine, psychiatry, psychology, social work or vocational rehabilitation – as warranted
- reflects the person’s presenting needs and specifies their strengths and limitations
- consists of specific goals which pertain to the attainment, maintenance and/or re-establishment of physical and emotional health
- identifies specific objectives which relate directly to the treatment/change goals
- specifies the frequency of treatment/change contacts
- includes provisions for periodic re-evaluations and revisions, as needed, of the plan, and
- identifies criteria for determining if goals have been achieved, as well as for terminating change.

Some qualities of well-formed treatment/change goals are that they are: salient and meaningful to the person or organisation wishing change, incremental and so more manageable, concrete, specific and behaviour focused, able to increase desired behaviours, realistic and achievable, seen as requiring work and effort, and are appropriate for the projected change period.

FUTURE DIRECTIONS. In addition to its popularity with many addiction counsellors and researchers, the

stages of change model should prove useful in tracking and predicting change. Most people have followed problematic paths over many years and made multiple attempts to change before being successful. They get stuck at certain points in the process of change and invest more time and energy in *not* changing than in activities to promote change. There is an ebb and flow, and important, distinct tasks which mark the process.

People can move forward and backward through the stages, and they can do so quickly. Their tasks involve a number of dimensions – motivation, decision making, efficacy, coping activities – which have an ongoing influence on the change process, can be accomplished quickly or slowly, and can be done more or less completely. These stages of change seem to resemble the stage dimensions of personality development proposed by Erickson in 1963.

Moving through change does not appear to be a case of doing more of the same thing, but instead doing the right thing at the right time. There is also a growing body of literature which appears to support the relationship of stages to important outcomes.

One advantage of the model is that the process of change is assumed to be the same for substance-abuse problems as well as other life problems. It has been applied to changes related to many behaviours, including anxiety, medication compliance and health protection. The stages cover considerable ground, since the process of intentional behaviour change is central in the life of an individual, with major implications for growth and development. There are few models which can be applied to such a variety of behaviours with such consistent results... Let’s change together.