

Cycles of change: the latest research



About the author

Mike Ashton is editor of Drug and Alcohol Findings, a free-to-access website featuring the Effectiveness Bank with an extensive range of research resources.

James Prochaska and Carlo DiClemente's ubiquitous 'five stages of change' seems to offer a scientific system to guide clinicians and therapists on how to work with patients – how to recognise when someone is ready to commit to treatment or, if not, to nudge them towards a more receptive stage, and how to avoid wasteful attempts with people not ready to change. Implicitly or explicitly, this system is used to recognise the motivational state of patients and clarify how to promote progression to sustained recovery. Its simplicity is beguiling. But can it really generate change by matching patients to interventions, or does it simply describe one type of change process?

A 'common sense' model of change. The stages of change are the "most eye-catching" aspects of a 'transtheoretical' model of behavioural change, based on a comparison of 'self-changers' versus those in professional smoking-cessation treatment. Testing and applications of the model later extended to other health-related behaviours including substance use.

The stages portray motivational transition as a fixed, segmented sequence leading from 'No acknowledged problem,' through to 'No problem now'. Among its attractions is the feeling that one has gained insight into something important, technical and scientifically valid, yet which accords with common sense: that, for example, it is no use trying to close the deal on a change plan if the client has yet to see the need for change, that what it takes to embed change is not the same as what it takes to generate it, and that overcoming dependent

substance use is no quick fix, but sequentially requires awareness, thought, preparation, implementation and stabilisation, each stage of which must be completed to provide a foundation on which the next stage can build with a chance of success...

The first stage, pre-contemplation, designates people who are not thinking about performing the behaviour in question and are not sufficiently aware of the health implications of their actions.

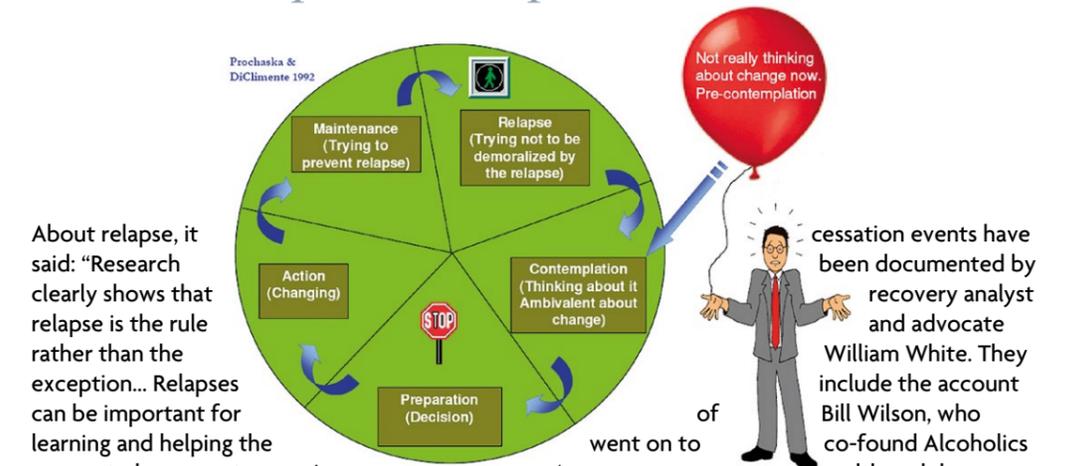
The second stage is contemplation, the stage when people start to think seriously about changing their behaviour, but have not yet acted.

The third stage is preparation, characterised by people preparing themselves and their social world for a change in their behaviour. When individuals successfully and consistently perform the behaviour in question, they are regarded as **being in the action stage.**

Progression from the action stage to the **maintenance stage** occurs when the behaviour in question has been done for six months or more.

Cycle of change. The diagram above right depicts the stages as a cycle of change, showing how the model can accommodate routine lapses and relapses people experience – patients who face set-backs can continue to do (or redo) the work of pre-contemplation, contemplation, preparation, action, and maintenance until they successfully reach their desired point in recovery. Implying that each relapse cycle can take the user closer to lasting remission, the Australian Government Department of Health describe it as an "upward spiral process", involving progress through a series of stages until reaching the "lasting exit" (see page 18).

Mike Ashton of Findings dares to ask if Prochaska and DiClemente's Cycle of Change is a change promoter or benevolent fiction. He rounds up the most pertinent evidence.



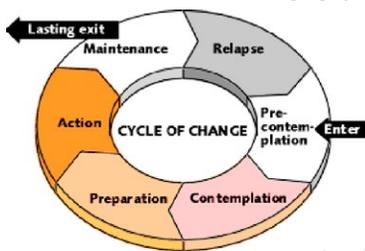
About relapse, it said: "Research clearly shows that relapse is the rule rather than the exception... Relapses can be important for learning and helping the person to become stronger in their resolve to change. Alternatively, relapses can be a trigger for giving up in the quest for change. The key to recovering from a relapse is to review the quit attempt up to that point, identify personal strengths and weaknesses, and develop a plan to resolve those weaknesses to solve similar problems next time they occur." Embedded in this explanation of relapse are the mechanisms that explain how people navigate change. These are known as the 10 processes of change, decisional balance and self-efficacy. Studies have shown that use of the processes of change has helped smokers to quit, employees with low socio-economic status to engage in more physical activity, and members of the public to consume less alcohol.

No planning needed. When behavioural change is intentional, 'cycle of change' and derivative models offer a detailed and possibly valid description. But what if a smoker suddenly becomes disgusted with their smoking, spits out the cigarette half way through, dumps the remnants of the packet in a bin, and never turns back as if something had overtaken them? Intentional change is not the only or it seems the most robust way people initiate change. Unplanned and famously successful drinking-

cessation events have been documented by recovery analyst and advocate William White. They include the account of Bill Wilson, who co-founded Alcoholics Anonymous – although he maintained sobriety with the help of others. That doesn't mean unplanned abandonment of substance use is without causes; at the time, the desperate Wilson was ripe for such an experience. [One UK survey](#) discovered unplanned attempts were commonly triggered by health advice/concerns, expense, and pressure from family/friends, though 1 in 6 respondents could cite no particular reason. In California, a [survey of problem drinkers](#) found that weighing the pros and cons of drinking as a reason for cutting down was much less likely to lead to lasting remission than 'conversion' experiences like hitting rock bottom, traumatic events or a religious or spiritual awakening. And among young people in a trial of a Dutch motivational intervention, spending too long in the contemplative stage might have done more harm than good – in this case, more talking and thinking about cannabis without an accompanying rapid nudge to action and a strategy for dealing with ambivalence, was linked to more rather than less cannabis use.

A 'natural fit' with mutual aid and group therapy? Exemplifying its versatility, the stages of change model has been extrapolated from individual therapy and self-change to non-

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professional mutual aid and group therapy. Describing how they complement each other in practice, one paper [listed engagement with 12-steps \(specifically Alcoholics Anonymous\) alongside each of the five stages](#), arguing that the combination could help treatment providers with client assessment, case formulation, treatment planning, and treatment implementation, and help clients with their progression through treatment.

In 2010, studies were analysed for the [Cochrane collaboration](#), whose verdict was that “Expert systems, tailored self-help materials and individual counselling, appear to be as effective in a stage-based intervention as they are in a non-stage-based form” – in other words, across all relevant studies, it could not be shown that matching to stages led to more non-smokers. More generally, “Direct comparisons between the same intervention in a standard format or modified by stage of change, with each intervention delivered at a similar intensity, demonstrate neither a beneficial nor a detrimental effect of the staged approach.” An earlier assessment for the UK’s National Health Service came to a similar conclusion.

Text in grey:

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Still involved in promoting and developing the application of the transtheoretical model, DiClemente is co-author of a 2nd-edition manual of Group Treatment for Substance Abuse which explains the [10 experiential and behavioural processes](#) or ‘engines of change’, a suite of 17 groups sessions targeted at the early stages of change (precontemplation, contemplation and preparation), and 18 group sessions targeted at people in the later stages (action and maintenance).

Matching interventions to stages of change.

The stages of change model amounts to a broad guide to what (not) to do with patients at different stages of change. But at the crunch point when it actively engages with change through treatment or brief interventions, research support appears to be largely absent. That is true not only of drug and alcohol problems but of therapy for psychological problems in general. In contrast to other factors, the American Psychological Association could only say matching interventions to stage of change was “probably effective” – which [might seem optimistic](#).

The model's strength lies in... portraying intentional change as a process rather than a one-off event... featuring conflict, ambivalence, vacillation and regret. Despite its limitations, there are reasons why the cycle of change model remains valuable, if perhaps not in matching interventions to stage of change. Professor Robin Davidson finds many ways in which [the model might be a positive influence](#) – a kind of benevolent fiction which gives hope to and motivates both worker and client. Likewise Nick Heather and Johannes Hönekopp declared themselves [not yet ready to abandon the cycle of change](#), though argued that it itself needs to change. They saw its strengths as portraying intentional change as a process rather than a one-off event, the insight that the process is essentially motivational, and might progress change through stage-matching. Read more at https://findings.org.uk/PHP/dl.php?file=cycle_change.hot&s=db

