Handout 4.1 Stages of Change model

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The Stages of Change model and motivational interviewing

Prochaska and DiClemente proposed readiness for change as a vital mediator of behavioural change. Their trans theoretical model of behaviour change (the ‘Stages of Change’) describes readiness to change as a dynamic process, in which the pros and cons of changing generates ambivalence. Ambivalence is a conflicted state where opposing attitudes or feelings coexist in an individual; they are stuck between simultaneously wanting to change and not wanting to change. Ambivalence is particularly evident in situations where there is conflict between an immediate reward and longer term adverse consequences (eg. substance abuse, weight management). For example, the patient who presents with serious health problems as a result of heavy drinking, who shows genuine concern about the impact of alcohol on his health, and in spite of advice from his practitioner to cut back his drinking, continues to drink at harmful levels, embodies this phenomenon.

The Prochaska and DiClemente Stages of Change model offers a conceptual framework for understanding the incremental processes that people pass through as they change a particular behaviour. This change process is modelled in five parts as a progression from an initial pre-contemplative stage, where the individual is not considering change; to a contemplative stage, where the individual is actively ambivalent about change; to preparation, where the individual begins to plan and commit to change. Successful progression through these stages leads to action, where the necessary steps to achieve change are undertaken. If successful, action leads to the final stage, maintenance, where the person works to maintain and sustain long term change. Relapse is considered an important stage in the change process and is used as an opportunity to learn about sustaining maintenance in the future.

Motivational interviewing (MI) is an effective counselling method that enhances motivation through the resolution of ambivalence. It grew out of the Prochaska and DiClemente model described above and Miller and Rollnick’s work in the field of addiction medicine, which drew on the phrase ‘ready, willing and able’ to outline three critical components of motivation. These were:

- the importance of change for the patient (willingness)
- the confidence to change (ability)
- whether change is an immediate priority (readiness)

Using MI techniques, the practitioner can tailor motivational strategies to the individual’s stage of change according to the Prochaska and DiClemente model (Table 1)
Table 1. Practitioner tasks within the Stages of Change model

<table>
<thead>
<tr>
<th>Patient stage</th>
<th>Practitioner tasks</th>
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<tbody>
<tr>
<td>Precontemplation (Not ready)</td>
<td>Raise doubt and increase the patient's perception of the risks and problems with their current behaviour. Provide harm reduction strategies</td>
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<tr>
<td>Contemplation (Getting ready)</td>
<td>Weigh up the pros and cons of change with the patient and work on helping them tip the balance by: • exploring ambivalence and alternatives • identifying reasons for change/risks of not changing • increasing the patient's confidence in their ability to change</td>
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<tr>
<td>Preparation – action (Ready)</td>
<td>Clear goal setting – help the patient to develop a realistic plan for making a change and to take steps toward change</td>
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<tr>
<td>Maintenance (Sticking to it)</td>
<td>Help the patient to identify and use strategies to prevent relapse</td>
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<tr>
<td>Relapse* (Learning)</td>
<td>Help the patient renew the processes of contemplation and action without becoming stuck or demoralised</td>
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* Relapse is normalised in MI and is used as an opportunity to learn about how to maintain long term behaviour change in the future

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Applications and effectiveness of motivational interviewing

Recent meta-analyses show that MI is equivalent to or better than other treatments such as cognitive behavioural therapy (CBT) or pharmacotherapy, and superior to placebo and non-treatment controls for decreasing alcohol and drug use in adults and adolescents. Motivational interviewing has also been shown to be efficacious in a number of other health conditions, such as smoking cessation, reducing sexual risk behaviours, improving adherence to treatment and medication, as well as diabetes management. In addition, studies support the applicability of MI to HIV
care, such as improving adherence to antiretroviral therapy and the reduction of substance use among HIV positive men and women. As such, MI is an important therapeutic technique that has wide applicability within healthcare settings in motivating people to change. In general practice, possible applications include:

- medication adherence
- management of the SNAP (smoking, nutrition, alcohol and physical activity) risk factors
- engagement in prevention or management programs for diabetes or cardiovascular health
- management of substance abuse problems
- management of problem gambling or sexual risk taking
- pain management
- stress management
- completion of recommended screening or diagnostic tests or specialist/allied health/psychologist referral.