many forms, is considered the treatment of choice (Barlow & Beck, 1984; Barlow & Wolfe, 1981). Freud readily understood the process of reducing phobic behavior, but he decided that the desirable content of psychoanalysis—the therapeutic goal—was to make the unconscious conscious (Norcross, 1991).

Table 16.1 also reveals that psychotherapy systems have largely ignored the impact of common or nonspecific factors in producing change. Anywhere from 10% to 35% of change can be attributed to expectation or placebo (see Chapter 1 and Lambert, 2004). Our assumption is that the critical process of change in placebo groups is that clients have chosen to change. They have made a commitment to change, as affirmed by their continuing attendance at placebo sessions. The placebo sessions provide a public forum for them to make their commitment known, and it is generally believed that a public commitment is more likely to be lived up to than is a private decision.

From this point of view the critical question becomes: Just which change processes do people use to solve their own problems? Psychotherapists should not be so arrogant as to believe that people do not solve psychological problems without professional assistance. One strategy of our research program is to study people who successfully change their behaviors on their own. We will soon see how research on self-changers and therapy changers has enhanced the transtheoretical model.

In fact, our studies indicate that people in the natural environment use many different processes of change to overcome problems (Prochaska et al., 1995). Most psychotherapy systems, however, emphasize only two or three processes. One of the positions of the transtheoretical model is that therapists should be at least as cognitively complex as their clients. They should think in terms of a more comprehensive set of processes and apply techniques to engage each process when indicated.

## STAGES OF CHANGE

The optimal use of change processes involves understanding the stages of change through which people progress. The stages are the second dimension of change that we discovered empirically.

When we tried to assess how frequently people applied the change processes in self-change and psychotherapy, they kept saying that it depended on what point in the course of change we were talking about. At different points they used different processes. In their own words, our psychotherapy patients and self-change volunteers were describing the phenomena we now call **stages of change.** Stages of change had not been identified in any of the major systems of psychotherapy. These stages are a relatively unique contribution from the integrative tradition.

The stages represent specific constellations of attitudes, intentions, and behaviors related to an individual's readiness in the cycle of change. They provide a temporal dimension, in that change is a phenomenon that unfolds over time. Each stage reflects not only a period of time but also a set of tasks required for movement to the next stage. Although the time an individual spends in each stage varies, the tasks to be accomplished are assumed to be invariant.

Change unfolds over a series of five stages: **precontemplation, contemplation, preparation, action,** and **maintenance.** If change is initially unsuccessful, then people will recycle back into earlier stages. When change is complete and stable, then

termination is reached. What follows is a description of each stage and the tasks to be accomplished to progress to the next stage.

## Precontemplation

In this stage, there is no intention to change behavior in the foreseeable future. Many individuals in the precontemplation stage are unaware or underaware of their problems. As G. K. Chesterton once said, "It isn't that they can't see the solution. It is that they can't see the problem." Families, friends, neighbors, or employees, however, are often well aware that the precontemplator has problems. When precontemplators present for psychotherapy, they often do so because of pressure from others. Usually they feel coerced into changing by a spouse who threatens to leave, an employer who threatens to dismiss them, parents who threaten to disown them, or judges who threaten to punish them. They may even demonstrate change as long as the pressure is on. Once the pressure is off, however, they often quickly return to their old ways.

Even precontemplators can wish to change, but this is quite different from intending or seriously considering change in the foreseeable future. Items that are used to identify precontemplation on a 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" (McConnaughy et al., 1983). Resistance to recognizing a problem is the hallmark of precontemplation.

Precontemplators are not considering altering their behavior in the foreseeable future and, as a consequence, engage in little change-process activity. In order to move ahead, they need to acknowledge or "own" the problem, increase awareness of the negative aspects of the problem, and accurately evaluate self-regulation capacities.

## 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. On the continuous measure these individuals endorse items such 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.

The essence of the contemplation stage is beautifully communicated in an incident related by Benjamin (1987). He was walking home one evening when a stranger approached him and inquired about the location of a certain street. Benjamin pointed it out to the stranger and provided specific instructions. After readily understanding and accepting the instructions, the stranger began to walk in the opposite direction. Benjamin said, "You are headed in the wrong direction." The stranger replied, "Yes, I know. I am not quite ready yet." This is contemplation: knowing where you want to go, but not being quite ready yet to go there.

People can remain stuck in the contemplation stage for long periods. In one of our self-change studies, we followed a group of 200 contemplators for 2 years. The modal response of this group was to remain in the contemplation stage for the entire 2 years without ever moving to significant action.

Contemplators, then, are evaluating options. To move forward in the cycle of change, they must avoid the trap of obsessive rumination for years—what we call chronic contemplation—and make a firm decision to begin to take action. These small steps of preliminary action, these "baby steps" lead them into the next stage.

## Preparation

The preparation stage combines intention and behavioral criteria. Individuals in this stage are intending to take action immediately and report some small behavioral changes, such as smoking five fewer cigarettes or delaying their first cigarette of the day for 30 minutes longer than precontemplators or contemplators (DiClemente et al., 1991). Although they have made some reductions in their problem behaviors, individuals in the preparation stage have not yet reached a criterion for effective action, such as abstinence from smoking, alcohol, or heroin. They are intending, however, to take such action in the very near future. On a continuous measure, they score high on both the contemplation and action scales.

Like anyone on the verge of momentous actions, individuals in the preparation stage need to set goals and priorities. In addition, they need to dedicate themselves to an action plan they choose. Often they are already engaged in change processes that would increase self-regulation and initiate behavior change.

## Action

In this stage, individuals modify their behavior, experiences, and/or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires a considerable commitment of time and energy. Modifications of a problem made in the action stage tend to be most visible and receive the greatest external recognition. People, including professionals, often erroneously equate action with change. As a consequence, they overlook the requisite work that prepares changers for action and the huge efforts necessary to maintain the changes following action.

Individuals are classified as being in the action stage if they have successfully altered a problem behavior for a period of 1 day to 6 months. Successfully altering a problem behavior means reaching a specific criterion, such as abstinence. With smoking, for example, cutting down by 50% or changing to lower tar and nicotine cigarettes are changes that can help prepare people for action, but they do not satisfy the criterion for successful action. On a continuous measure, individuals in the action stage endorse statements such as "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 scales assessing the other stages of change. Modification of the target behavior to an acceptable criterion and significant overt efforts to change are the hallmarks of action.

People in the action stage require the skills to use the key action-oriented change processes, such as counterconditioning, stimulus control, and contingency management, to interrupt habitual patterns of behavior and adopt more productive patterns. They become aware of the pitfalls that might undermine continued action, whether these are cognitive (abstinence violation expectations), behavioral (apparently

irrelevant decisions), emotional (exacerbation of stress or depression), or environmental (lack of reinforcement or spousal support) in nature. In this way, they will acquire effective strategies to prevent lapses or slips from becoming complete relapses.

## Maintenance

In this stage, people work to prevent relapse and consolidate the gains attained during action. Traditionally, maintenance has been viewed as a static stage. However, maintenance is a continuation, not an absence, of change. For chronic problems, this stage extends from 6 months to an indeterminate period past the initial action. For some problems, maintenance can be considered to last a lifetime.

Remaining free of the chronic problem and/or consistently engaging in a new incompatible behavior for more than 6 months is the criterion 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." Stabilizing behavior change and avoiding relapse are the hallmarks of maintenance.

## Recycling

As is now well known, most people taking action to change behavior do not successfully maintain their gains on their first attempt. Many New Year's resolvers, for example, report 5 or more years of consecutive pledges before maintaining the behavioral goal for at least 6 months (Norcross & Vangarelli, 1989). **Relapse and recycling** through the stages occur quite frequently as individuals attempt to modify behavior.

Although psychotherapy is typically effective in the short run, relapse is the most common, long-term outcome in the treatment of addictions and serious mental disorders. In a classic review of outcome literature on alcoholics, heroin addicts, and habitual smokers, relapse curves across these different substances showed a strikingly similar pattern. Within 3 months of treatment completion, nearly two thirds of all patients had relapsed, with a majority of these relapses occurring within the first month following treatment termination (Hunt, Barnett, & Branch, 1971). Early treatment approaches focused on changing behavior but not necessarily on maintaining those changes over time. This resulted in a "revolving door" or recycling in which treatment completers returned to treatment following each relapse (Roberts & Marlatt, 1998).

**Relapse prevention** (RP) is self-management training designed to avoid recycling and to enhance the maintenance stage (Marlatt & Gordon, 1985). With skills training as the cornerstone, RP teaches clients how to:

- Understand relapse as a process
- Identify high-risk situations
- Learn how to cope with cravings and urges to engage in the addictive behavior
- Reduce the harm of relapse by minimizing the negative consequences and learning from the experience
- Achieve a balanced lifestyle, centered on the fulcrum of moderation (Roberts & Marlatt, 1998)

We should note in passing that the accumulating research on RP yields positive findings. A meta-analysis was performed to evaluate the effectiveness of RP in 26 studies representing a sample of 9,504 patients (Irvin et al., 1999). Results indicated that RP was generally effective, certainly more so than no-treatment controls, and particularly effective for alcohol and polysubstance use disorders.

Because relapse or recycling is the rule rather than the exception in behavior change, we found that we needed to modify our original stage model. Initially we conceptualized change as a linear progression through the stages; people were supposed to progress simply and discretely through each step. Linear progression is a possible but relatively rare phenomenon with chronic disorders, such as the addictions and mental disorders.

Figure 16.1 presents a spiral pattern of how many people actually move through the stages of change. In this spiral pattern, people can progress from contemplation to preparation to action to maintenance, but many individuals will relapse. During relapse, individuals regress to an earlier stage. Some relapsers feel like failures—embarrassed, ashamed, and guilty. These individuals become demoralized and resist thinking about behavior change. As a result, they return to the precontemplation stage and can remain there for various periods of time. Approximately 15% of relapsers regress back to the precontemplation stage (Prochaska & DiClemente, 1984).

Fortunately, this research indicates that the vast majority of relapsers—85% of self-changers, for example—recycle back to the contemplation or preparation stage. They begin to consider plans for their next action attempt, while trying to learn from their recent efforts. The spiral pattern suggests that most relapsers do not revolve endlessly in circles and that they do not regress all the way back to where they began. Instead, each time relapsers recycle through the stages, they potentially learn from their mistakes and can try something different the next time around.

## Termination

Termination of a problem occurs when a person no longer experiences any temptation to return to troubled behaviors and no longer has to make any efforts to keep from relapsing. Obviously, termination of treatment and termination of a problem

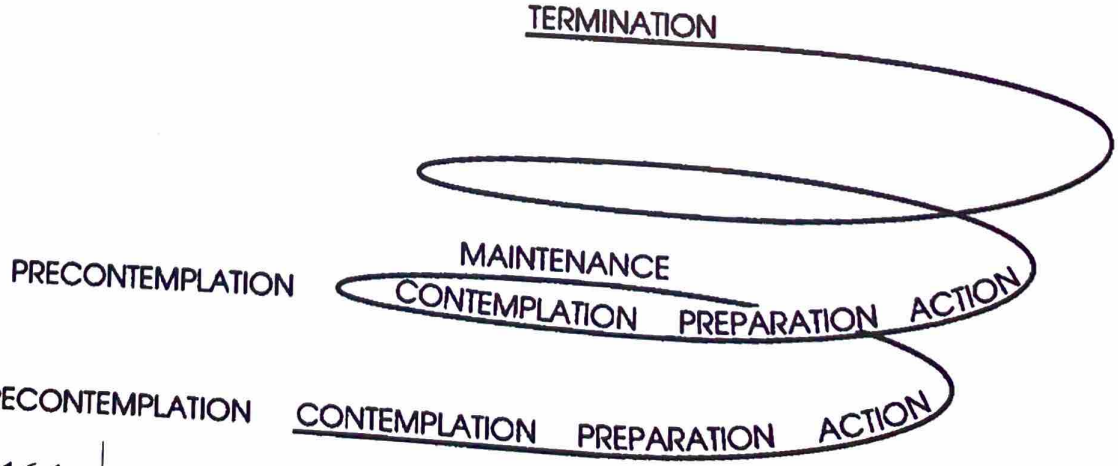


Figure 16.1

are not coincidental. Psychotherapy frequently ends before serious problems terminate entirely. Consequently, it is expected that, for many clinical disorders, patients will return for booster sessions, most often when they feel they may be slipping back from previous gains. Also, because treatment terminates before most problems have reached their termination, clients tend to experience anxiety and distress over the termination of therapy.

## Clients in Different Stages

Individuals who seek our professional assistance do not arrive at our doorstep in the identical stage of change. Patients entering treatment programs at two different outpatient clinics and at a large alcoholism treatment center demonstrated a variety of profiles on the stages-of-change scale (DiClemente & Hughes, 1990; McConnaughy et al., 1989). The type of screening and the particular demands made by the treatment program can influence the numbers of people in different stages who present for help, but it is unlikely that any program would recruit clients only from one stage unless it preassessed stage of change as a selection criterion. For most practitioners and programs, patients represent a heterogeneous group in terms of readiness to change.

A patient's pretreatment stage of change is an important determinant of prognosis. The further along clients are in the stages of change at the beginning of therapy, the more quickly they can be predicted to progress. When therapy involves two or more clients working together, as in couples treatment, then therapy can be expected to progress most smoothly when each of the clients is at the same stage of change. If one partner is ready for action while the other has not contemplated what change will mean, then treatment will be difficult at best. The therapist is then in the difficult position of being damned by one spouse for moving too slowly or resisted by the other for moving too quickly.

With family therapy, it is almost axiomatic that some of the family members will occupy different stages. Perhaps this is one reason homeostasis as a source of resistance has been such a key concept in systemic perspectives. Getting all family members to the same stage of change at about the same time is no small challenge.

## Representative Studies on the Stages

Literally hundreds of published studies have used the stages-of-change measures. We will review here the results of a handful of representative studies on the clinical utility and predictive validity of the stages of change.

The amount of progress clients make following intervention tends to be a function of their pretreatment stage of change (e.g., Prochaska & DiClemente, 1992a; Prochaska et al., 1992). This has been found to be true for brain-impaired patients in rehabilitation programs (Lam et al., 1988), panic-disordered patients receiving antianxiety medication (Beitman et al., 1994), cardiac patients undergoing counseling (Ockene et al., 1992), and Mexican Americans enrolled in community programs for smoking cessation (Gottlieb et al., 1990). This strong stage effect applies immediately following intervention, as well as 12 and 18 months afterward (Prochaska et al., 1993).

In one study, we examined the percentage of 570 smokers who were not smoking over an 18-month period as a function of the stage of change before random assignment to four treatments. The amount of success was directly related to the stage they were in before treatment (Prochaska & DiClemente, 1992a). To treat all of these smokers as if they were the same would be naïve; yet that is what we have traditionally done in many treatment programs.

If clients progress from one stage to the next during the first month of treatment, they can double their chances of taking action during the initial 6 months of the treatment. Of the precontemplators who were still in precontemplation at 1-month follow-up, only 3% took action by 6 months; of the precontemplators who had progressed to contemplation at 1 month, 7% took action by 6 months. Similarly, of the contemplators who remained in contemplation at 1 month, only 20% took action by 6 months; of the contemplators who had progressed to the preparation stage at 1 month, 41% attempted to quit by 6 months. These data demonstrate that treatments that help people progress just one stage in a month can double the chances of participants' taking action on their own in the near future (Prochaska & DiClemente, 1992a).

Another study (Brogan et al., 1999) demonstrated that the stages of change can predict who remains in psychotherapy. For some time clinicians have known that approximately 40% of patients terminate psychotherapy prematurely; however, the characteristics of these dropouts have not been reliably known. Premature termination from psychotherapy was predicted using variables traditionally among the best predictors of therapy outcome—client characteristics, such as demographics, and problem characteristics, such as duration and intensity—but these variables had zero ability to predict therapy dropouts. When the stages and processes of change were used, 93% of the premature terminators—as opposed to therapy continuers and early but appropriate terminators—were correctly identified. The stage profile of the 40% who dropped out of therapy was that of precontemplators. The stage profile of the 20% who terminated quickly but appropriately was that of people in the action stage. The stage profile of the therapy continuers was similar to that of contemplators.

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

An intensive action- and maintenance-oriented smoking cessation program for cardiac patients was highly successful for those patients in the preparation and action stages. This same program failed, however, with smokers in the precontemplation and contemplation stages (Ockene et al., 1988). Patients in this special-care program received personal counseling in the hospital and monthly telephone counseling calls for 6 months following hospitalization. Of the patients who began the program in the action or preparation stage, an impressive 94% were not smoking at 6-month follow-up. This percentage is significantly higher than the 66% nonsmoking rate of patients in similar stages who received regular care for their smoking problem. The special-care program had no significant effects, however,

with patients in the precontemplation and contemplation stages. For patients in these stages, regular care did as well or better.

Independent of the treatment received, there was a clear relationship between pretreatment stage and outcome. Patients who were not smoking at 12 months included 22% of all precontemplators, 43% of the contemplators, and 76% of those in action or prepared for action at the start of the study.

## INTEGRATION OF STAGES AND PROCESSES

One of the most powerful findings to emerge from our research is that particular processes of change are more effective during particular stages of change. Twenty-five years of research in behavioral medicine and psychotherapy converge in showing that different processes of change are differentially effective in certain stages of change. A meta-analysis (Rosen, 2000) of 47 cross-sectional studies examining the relationship of the stages and the processes of change showed large effect sizes (.70 and .80).

The integration of stages and processes of change can serve as an important guide for psychotherapists. Once a patient's stage of change is evident, the therapist would know which processes to apply in order to help that patient progress to the next stage of change. Rather than apply the change processes in a haphazard or trial-and-error manner, therapists can use them in a much more systematic and efficient style.

Table 16.2 diagrams the integration between the stages and processes of change (Prochaska, Norcross, & DiClemente, 1995). Specifically, the table shows the change processes used most often during the five stages of change. Let us now review how this integration can systematically direct psychotherapy.

During precontemplation, individuals use change processes significantly less than people in any other stage. We found that precontemplators process less information about their problems; spend less time and energy reevaluating themselves; experience fewer emotional reactions to the negative aspects of their problems; are

TABLE 16.2 | STAGES OF CHANGE IN WHICH CHANGE PROCESSES ARE MOST EMPHASIZED

| Stages of Change | | | | |
|---|---|---|---|---|
| Precontemplation | Contemplation | Preparation | Action | Maintenance |
| Consciousness raising | | | | |
| Dramatic relief | | | | |
| | Environmental reevaluation | | | |
| | Self-reevaluation | | | |
| | | Self-liberation | | |
| | | | Contingency management | |
| | | | Counterconditioning | |
| | | | Stimulus control | |

less open with significant others about their problems; and do little to shift their attention or their environment in the direction of overcoming their problems. In treatment, these patients have been historically labeled resistant or defensive.

What can help people move from precontemplation to contemplation? Table 16.2 suggests that several change processes are most effective. First, **consciousness raising** methods—such as observations, education, and interpretations—can help clients become more aware of the causes, consequences, and cures of their problems. To move to the contemplation stage, clients will become more aware of the negative consequences of their behavior. Often we have to first help clients become more aware of their defenses before they can become more conscious of what they are defending against. Second, the process of **dramatic relief** (or catharsis) provides clients with motivating emotional experiences, such as those used in Gestalt methods like the empty chair. These experiences can release emotions related to problem behaviors. Life events can also move precontemplators emotionally, such as the disease or death of a friend or lover, especially if such events are problem related.

Clients in the contemplation stage are most open to consciousness raising methods, such as feedback, observations, bibliotherapy, and other educational interventions. As clients become increasingly more aware of themselves and the nature of their problems, they are freer to reevaluate themselves both affectively and cognitively. The **self-reevaluation** process includes an assessment of which values clients will try to actualize, act on, and make real, and which they will let die. The more central problems are to clients' core values, the more their reevaluation will involve changes in their sense of self. Contemplators also use **environmental reevaluation**, that is, they deeply consider the effects their behaviors exert on their environment, especially the people they care about most.

Movement from precontemplation to contemplation, and movement through the contemplation stage, involves increased use of cognitive, affective, and evaluative processes of change. To better prepare individuals for action, changes are required in how they think and feel about their problems and how they value their destructive lifestyles.

Preparation indicates a readiness to change in the near future and incorporation of valuable lessons from past change attempts. Preparers are on the verge of taking action and need to set goals and priorities accordingly. They often develop an action plan for how they are going to proceed. In addition, they will make firm commitments to follow through on the action option they choose. In fact, they are often already engaged in processes that would increase self-regulation and initiate behavior change (DiClemente et al., 1991).

Individuals typically begin by taking some small steps toward action. They may use counterconditioning and stimulus control to begin reducing their problem behaviors. Counterconditioning involves substituting healthier alternatives in conditions that normally elicit problems, such as relaxation instead of anxiety. Stimulus control involves managing the presence or absence of situations or cues that elicit problems, such as not stopping at a bar after work. Addicted individuals may delay their use of substances each day or may control the number of situations in which they rely on the addictive substances.

As they prepare for the action stage, it is important that clients act from a sense of **self-liberation**. They need to believe that they possess the autonomy to

change their lives in key ways. Yet they also need to accept that coercive forces are as much a part of life as is autonomy. Self-liberation is based in part on a sense of **self-efficacy** (Bandura, 1977, 1982)—the belief that one's own efforts play a critical role in succeeding in the face of difficult situations.

The action stage, however, requires more than merely an affective and cognitive foundation. Clients must also be effective with behavioral processes—such as **counterconditioning, contingency management,** and **stimulus control**—to cope with those conditions that can coerce them into relapsing. Therapists can provide skills training, if necessary, in behavioral processes to increase the probability that clients will be successful when they do take action.

Successful maintenance builds on each process that has come before, and also involves a candid assessment of the conditions under which a person is likely to relapse. Clients assess their alternatives for coping with such coercive conditions without resorting to self-defeating defenses and pathological responses. Perhaps most crucial is the sense that one is becoming more of the kind of person one wants to be. Continuing to use counterconditioning, contingency management, and stimulus control is most effective when it is based on the conviction that maintaining change maintains a sense of self that is highly valued by oneself and at least one significant other.

To sum up: We have determined that effective behavior change depends on doing the right things (processes) at the right time (stages). We have observed two frequent mismatches in this respect. First, some clients (and clinicians) rely primarily on change processes most indicated for the contemplation stage—consciousness raising, self-reevaluation—while they are moving to the action stage. They try to modify behaviors by becoming more aware, a common criticism of classical psychoanalysis: insight alone does not necessarily bring about behavior change. Second, other clients (and clinicians) rely primarily on change processes most indicated for the action stage—contingency management, stimulus control, counterconditioning—without the requisite awareness, decision making, and readiness provided in the contemplation and preparation stages. They try to modify behavior without awareness, a common criticism of radical behaviorism: overt action without insight is likely to lead to temporary change (Prochaska et al., 1992).

Competing systems of psychotherapy have promulgated apparently rival processes of change. However, ostensibly contradictory processes become complementary when embedded in the stages of change. Specifically, change processes traditionally associated with the experiential, cognitive, and psychoanalytic persuasions are most useful during the precontemplation and contemplation stages. Change processes traditionally associated with the existential and behavioral traditions, by contrast, are most useful during the action and maintenance stages.

Research has been highly supportive of the core constructs of the transtheoretical approach and the integration of the stages and processes of change. Longitudinal studies affirm the relevance of these constructs for predicting premature termination and treatment outcome. Comparative outcome studies attest to the value of stage-matched interventions. Population-based studies support the importance of developing interventions that match the needs of individuals at all stages of change (see Prochaska & Norcross, 2002, and Prochaska et al., 1995, for reviews).

## LEVELS OF CHANGE

At this point in our analysis, it may appear that we are restricting our discussion to a single, well-defined problem. However, as we all realize, reality is not so accommodating, and human behavior is not so simple. Although we can isolate certain disorders, these occur in the context of complex, interrelated levels of human functioning. The third core dimension of the transtheoretical approach addresses this issue.

The **levels of change** represent a hierarchical organization of five distinct but interrelated levels of psychological problems that can be addressed in psychotherapy. These levels are:

1. Symptom/situational problems
2. Maladaptive cognitions
3. Current interpersonal conflicts
4. Family/systems conflicts
5. Intrapersonal conflicts

Psychotherapy systems have attributed psychological problems primarily to one or two levels of change and have targeted their methods to these levels. Behavior therapists have focused on the symptom and situational determinants, cognitive therapists on maladaptive cognitions, family therapists on the family/systems level, and psychoanalytic therapists on intrapersonal conflicts. A critical point in treatment occurs when psychotherapists and patients agree on the level to which they attribute the problem and on the level (or levels) they will mutually target to modify the disorder.

What is the key level of content for psychotherapy? The answer depends on the therapist's preferred theory of personality and psychopathology and/or the client's preferred theory of problems. As an integrative model, transtheoretical therapy appreciates the validity of each level. How critical each level is can vary for different clients even when they are presenting with the same disorder.

Consider, for example, three cases of vaginismus, a sexual disorder characterized by the involuntary contraction of the muscles surrounding the vagina when penetration is attempted. Case A recovered by focusing solely on the symptom/situational level and changing the situations under which the couple had sexual encounters. Case B, a difficult success, clearly had current interpersonal problems of communication and control that contributed to the maintenance of vaginismus. Case C, a failure, appeared to have critical involvement of family/systems conflicts, with the young woman experiencing her sexuality as still under the control of her mother's rules.

Given five different levels of change, how can psychotherapists proceed systematically across them? In the transtheoretical model, we prefer to intervene initially at the symptom/situational level because change tends to occur more quickly at this more conscious and contemporary level of problems. The further down the hierarchy we proceed, the further removed from awareness and the present the determinants of the problem are likely to be. That is, "deeper" levels involve more unconscious and historical conflicts contributing to the disorder. Thus, we predict that the deeper the level that needs to be changed, the longer and more complex psychotherapy is likely to be.

What's more, the further removed in history are the determinants of the problem, the greater the resistance to trying to change those determinants. One of the reasons for increased resistance is that deeper attributions tend to be more threatening to self-esteem than are more surface attributions. It is more threatening, for example, to believe that vaginismus is due to hostility toward a father figure than to believe that the anticipation of painful intercourse elicits fear and involuntary circumvaginal muscle contractions. A transtheoretical guideline is to use the least threatening attributions that can be therapeutically justified, because our clinical formulations have the potential for producing damage in their own right.

The levels of change, it should be emphasized, are not independent or isolated; on the contrary, change at any one level is likely to produce change at other levels. Symptoms often involve intrapersonal conflicts; maladaptive cognitions often reflect family/system beliefs or rules. In the transtheoretical approach, therapists are prepared to intervene at any of the levels of change, though the preference is to begin at the highest and most contemporary level that clinical assessment and disciplined judgment can justify.

## PUTTING IT ALL TOGETHER

In summary, the transtheoretical model sees therapeutic integration as the differential application of the processes of change at specific stages of change according to the identified problem level. In colloquial terms, we have identified the basics of *how* (processes), *when* (stages), and *what* (levels) to change.

Integrating the levels with the stages and processes of change provides a model for intervening hierarchically and effectively across a broad range of therapeutic content. Table 16.3 illustrates the integration of levels, stages, and processes of change.

**TABLE 16.3** | INTEGRATION OF PSYCHOTHERAPY SYSTEMS WITHIN THE TRANSTHEORETICAL MODEL

| | Stages of Change | | | | |
|---|---|---|---|---|---|
| **Levels** | **Precontemplation** | **Contemplation** | **Preparation** | **Action** | **Maintenance** |
| Symptom/situational | Motivational interviewing | | | | Behavior therapy<br>EMDR and exposure |
| Maladaptive cognitions | | Adlerian therapy | Rational-emotive behavior therapy<br>Cognitive therapy | | |
| Interpersonal conflicts | Sullivanian therapy | Transactional analysis | Interpersonal therapy (IPT) | | |
| Family systems/conflicts | Strategic therapy | Bowenian therapy | | | Structural therapy |
| Intrapersonal conflicts | Psychoanalytic therapy | Existential therapy | Gestalt therapy | | |

Three strategies can be employed for intervening across multiple levels of change. The first is that of **shifting levels**. Psychotherapy would typically focus initially on the client's symptoms and the situations supporting the symptoms. If the change processes could be applied effectively at the first level and the patient could progress through each stage of change, psychotherapy could be completed without shifting to a deeper level of analysis. If treating only the symptoms was not effective enough, then therapy would shift to a focus on maladaptive cognitions that are supporting the symptoms. The processes of change would be applied to cognitive content with the goal of progressing through each stage of change. If progress was not sufficient at the cognitive level, then therapy would shift to current interpersonal conflicts. The processes would now be applied at an interpersonal level, with the goal of progressing through each stage of change. The same pattern of successfully progressing through the stages or shifting levels would be followed until the client had sufficiently improved or until the deepest, least conscious, and most resistant intrapersonal conflicts had been analyzed.

The second strategy is to focus on **key levels**. There are certain clear-cut cases in which a high degree of consensual validation would emerge among clinicians regarding the causes of a client's problems. If the available evidence is unambiguous and points to one key level of causality, then the psychotherapist would work first and foremost at this key level of intervention. These cases are relatively easy to formulate once the clinical data are in, though that does not mean that they are necessarily easy to treat.

The third alternative is the **maximum impact strategy**. With complex cases, it is sometimes clear that variables at every level are involved as a cause, an effect, or a maintainer of the client's problems. For maximum impact, interventions can be created that engage the patient at each and every level of change. This creates a synergy of change interventions. The maximum impact strategy will be illustrated in the transtheoretical analysis of Mrs. C.

As should now be evident, the length of psychotherapy varies according to both the stage and the level of change, as well as how hard and how well clients work between sessions. Clients who enter treatment prepared to take action can have brief but successful therapies, typically in 6 to 12 sessions. The more defenses patients have to work through and the less successful work they have been able to do before entering treatment, the longer the course of psychotherapy is likely to be, typically ranging from 6 to 24 months.

It follows, then, that clients with problems at the situational and cognitive levels can typically expect comparatively brief treatment. For patients saddled with disorders more deeply embedded in the context of a dysfunctional family of origin or a pathogenic intrapersonal history, psychotherapy will typically take longer. Problems that develop in a current interpersonal relationship are usually of more moderate duration, averaging about 12 months. Problems that are multilevel in origin usually necessitate longer treatment.

We hope that psychotherapy research will progress to the point where we will know that a specific level of intervention is most effective with particular types of patients afflicted with particular disorders. Research already suggests that about half of the patients with focal phobias can be effectively helped by modifying the situational determinants of their phobias. Research does not suggest, however,

what to do with the 50% of phobic patients who drop out or fail to progress at the situational level (Barlow & Wolfe, 1981). Until clear-cut research is available for guiding therapeutic interventions with specific disorders, the transtheoretical model provides an efficient and effective guide for various client presentations.

**Theoretical complementarity** is the key to integrating the major systems of psychotherapy. Table 16.3 illustrates where leading systems of therapy fit best within the integrative framework of the transtheoretical model. In general terms, the psychoanalytic and experiential psychotherapies are most useful during the earlier precontemplation and contemplation stages. Existential, cognitive, and interpersonal therapies are particularly well suited to the preparation and action stages. The behavior and exposure therapies, by contrast, are most useful during action and maintenance. Each theoretical persuasion has a place, a differential place, in the "big picture" of behavior change.

Depending on the level and stage we are targeting, different therapy systems will play a more or less prominent role. Behavior therapy and exposure therapy, for example, have developed specific methods at the symptom/situational level for clients who are ready for action. At the maladaptive cognition level, Ellis's rational-emotive behavior therapy and Beck's cognitive therapy are most indicated for clients in the preparation and action stages.

Two prominent psychotherapies missing from Table 16.3 are Rogers's person-centered therapy and multicultural therapy. His system has been most eloquent in articulating and demonstrating the therapeutic relationship as a critical process of change. Rogers's influence on the transtheoretical approach cuts across the stages and levels of change. Multicultural therapy primarily concerns what content should be addressed in psychotherapy, not how behavior change occurs. Thus, multicultural content also cuts across all stages and levels of change.

Much of psychotherapy research has traditionally been dedicated to determining whether one type of therapy is more effective than an alternative therapy for a specific disorder. Such horse-race contests have resulted in a disappointing abundance of ties (Smith, Glass, & Miller, 1980; Stiles et al., 1986; Wampold, 2001). After nearly 50 years of research, we can only partially specify which treatment is best for which type of client with which type of problem.

The transtheoretical model offers a unique means of treatment matching: match to the client's stage and level of change. Because troubled people vary in their readiness to take action on their disorders, then treatments should vary in terms of how much action they demand of clients. Behavior modifiers have been ingenious in their ability to develop action-oriented methods, but these action-oriented methods may be appropriate only for the small percentage of people who are prepared for action at any given time.

A patient and therapist each working at different stages is a recipe for resistance. If the therapist is action-oriented and the client is a precontemplator, then the client will experience the therapist as insensitive and coercive, like a parent pressuring for change when the client isn't convinced that change is needed. Conversely, if the patient is prepared to take action and the therapist relies almost exclusively on consciousness raising and self-reevaluation processes, the client will experience treatment as moving much too slowly, whereas the therapist may perceive the client as acting out.

Similarly, clients who believe that immediate situational changes will improve their symptoms are likely to be resistant to spending much time becoming more conscious of their childhood. Clinicians who depend heavily on situationally focused techniques, such as desensitization, may experience resistance from patients who are convinced that their phobias are rooted in much deeper levels. A client being treated with systematic desensitization for a social phobia by one of our graduate students complained, "It seems to me that the therapy you are using is like treating a cancer with aspirin."

If therapists can only work effectively at one level of change, then they had better have the luxury of selecting patients who match that level. In choosing a psychotherapist, clients are often implicitly seeking someone who works at a level that they believe is most relevant to their problems. This is a leading reason why some clients prefer behavior therapists, whereas others seek psychoanalytic therapists, and still others seek interpersonal or family therapists. A transtheoretical therapist can be trained to match the needs of a much broader range of clients. Such therapists would require adequate training in the theories and techniques appropriate to each level of change. What we don't know with certainty at this point is what constitutes adequate training to facilitate behavior change at each level.

Psychotherapists who are well matched to a client's stage and level of change are likely to experience the therapeutic process as progressing reasonably smoothly. Of course, patients can become stuck in a stage, but at least the psychotherapist is aware of not contributing to the stagnation.

A case in point: Many patients stuck in the contemplation stage tend to substitute thinking and reflecting for acting. They become very comfortable with clinicians who prefer contemplation-oriented processes such as consciousness raising and self-reevaluation. But encouraging such clients to go deeper and deeper into more levels of their problems can be **iatrogenic**; that is, the treatment itself can produce negative outcomes, such as feeding into their problems of being "chronic contemplators." At some point, action must be taken. But a therapist who has not been trained to effectively use action-oriented processes might prefer to avoid action in the same way that chronic contemplators avoid action. After years and years of archaeological expeditions into the deepest levels of personality, such patients may yell out like the character on the cover of *The New Yorker* magazine: "Help, I'm being held captive in psychotherapy!"

## THE TRANSTHEORETICAL RELATIONSHIP

In general, the transtheoretical psychotherapist is seen as an expert on change—not having all the answers, but being aware of the critical dimensions of change and offering some assistance in this regard. Clients' enormous self-change potential will be tapped in order to effect behavior change. In fact, clients need to shoulder much of the burden of change and look to the therapist for guidance on how to conceptualize the problem and ways to free themselves to move from one stage to the next.

As with any interactive endeavor, rapport must be built in order to accomplish the work. The transtheoretical therapist will be empathic, supportive, and responsive. However, the nature of support and the therapy relationship will be tailored to the patients' stage of change.