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Clinical Applications of the Transtheoretical Model of Readiness for Change

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"It is in changing that things find repose."(Heraclitus, circa 480 BC)

How may we best describe the phenomenon of change in human behaviour? What do we look for to distinguish between change that is in a nascent state versus mature change, or change that is close to a new repose or resolution? What kind of observations do we make to facilitate therapeutic change? What criteria do we rely on to evaluate the efficacy of our effort to build, strengthen, and reinforce change processes? The first systematic response to some of these questions may be found in the fragments of the writings of Heraclitus, whose work signalled a paradigm shift in the Pre-Socratic science of his day. More recently, and within the context of clinical health psychology, Prochaska and colleagues have formulated a systematic response to these questions with the transtheoretical model of readiness for change (TTM). This model developed from their early examination of converging themes in the practice of psychotherapy. It reflects a paradigm committed to identifying and assimilating transtheoretical insights and methods for facilitating change in psychotherapy. Many health promotion experts in clinical health psychology are currently weighing the merits of the TTM. The following article offers a brief, uncritical summary of the principal areas of clinical practice where clinicians might undertake their own review of this model.

As a diagnostic guide, the TTM has provided evidence-based guidelines that highlight consistencies in change across a diverse range of presenting problems. These include smoking, exercise habits, dietary behaviour, safe sex practices, condom use, alcohol use, cocaine use, mammography screening, delinquent behaviour among adolescents, sun screen use, physician behaviour in doing preventive clinical practices, and readiness to begin psychotherapy. More recent applications of the TTM encompass readiness to respond to medical emergencies with CPR and readiness to self-manage chronic pain. In each of these areas, and in studies where subjective reports described self-initiated change as well as therapy-induced change, a stage-based model emerged as the best way of representing the phenomenon of readiness for change. TTM stages include Precontemplation (not entertaining thoughts of change), Contemplation (readiness to change within a six-month period), Preparation for Action (readiness to change within 30 days and concurrent experimentation with change), Action (change initiated within six months), and Maintenance (change sustained for six months or longer). Relapse, or the return to a previous maladaptive way of managing a problem, is viewed as the normative outcome in our initial change attempts. The model is therefore a dynamic one, where

each new cycle through the stages offers novel learning experiences about how impediments may finally be overcome.

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TTM interventions have been developed using empirical guidelines from the above observations. This therapy is distinct since it matches therapeutic goals to the client's presenting stage of change. The rationale behind this procedure is that the stage of change reflects systematic relationships among three factors that have significantly accounted for client progress in considering, planning, initiating, and sustaining change. The client's attitudinal disposition to change is an important predictor of change through the early stages of readiness. It is operationally defined in terms of a decisional balance, where the client juxtaposes personally salient pros with salient cons for initiating change. Processes of change that are highlighted and monitored in the pre-action stages are cognitive-affective in nature. They reflect the client's exploration and reevaluation of personal priorities and values. In effect, precontemplative and contemplative clients are encouraged to develop a narrative summary of their presenting problem so that relevant schemata can become more explicit. Behavioural processes are highlighted in the later stages of change to ensure that clients have appropriate skills to sustain therapeutic gains as they encounter events that might trigger a return to their previous difficulty. Self-efficacy typically rises monotonically across stages. It is initially supported through pre-action stages by the therapist's reinforcing perceived choice and commitment to change. Following the client's entry into action, efficacy is developed through performance-based feedback.

The TTM has provided clinicians with a method and heuristic guide for evaluating treatment efficacy by assessing therapeutic shifts in decisional balance, change processes, and perceived efficacy. This information is often used as a source of motivational and efficacy-building feedback for both the client and clinician. It has proven quite valuable in therapy since it reflects treatment gains prior to any evidence of obvious behavioural improvements.

Thomas Kuhn has suggested that discoveries in science follow a common course. An anomaly is observed. Efforts follow to make the anomaly predictable. Eventually, there emerges a new way of understanding or working with a previously familiar phenomenon. The jury is still out on whether the TTM will be accepted as a new paradigm of the relationship between expressed desire to change, overt evidence of change, and relapse back to problem behaviours. On that note, Heraclitus is known for another relevant comment: "Although it is better to hide our ignorance, this is hard to do when we relax over wine." There is always the risk of reviewing the TTM with an unimaginative sobriety, or of using it with an overindulgent enthusiasm. To date, it is reasonable to consider the TTM a good empirically-driven model. But the ultimate judgement about its contribution will arguably stand on the informal experiments that occur in our clinical practices, and the degree to which we feel that the good enhances our confidence in finding the better in the art and science of clinical health psychology.