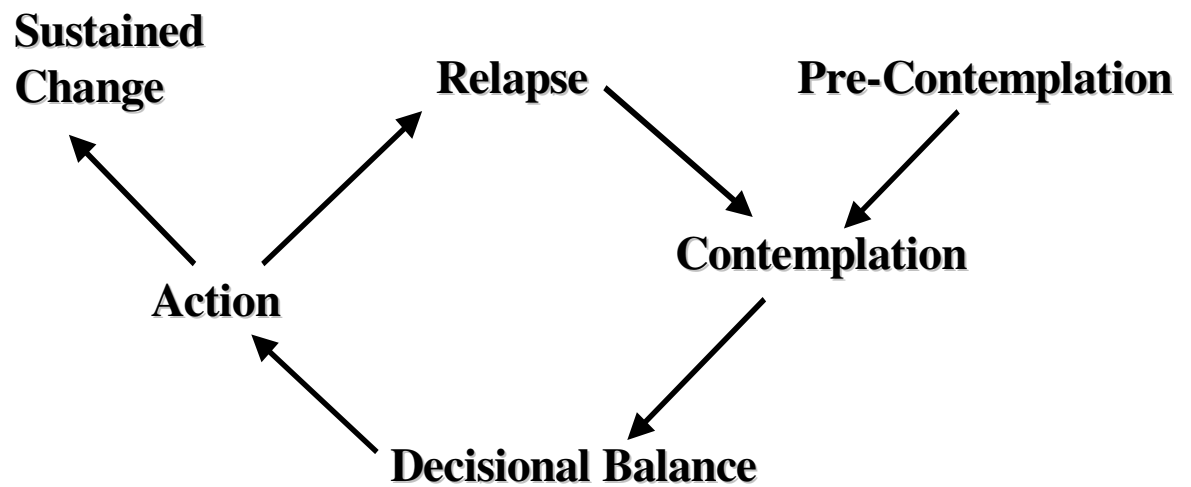


THE CYCLE OF CHANGE



Adapted from: Prochaska, J.O., and DiClemente, C.C. (1984). *The transtheoretical approach: crossing the traditional boundaries of therapy*. Homewood, IL. Dow-Jones/Irwin.

The Cycle of Change

What motivates clients to change? According to Prochaska and DiClemente's (1984) *transtheoretical model* of behavior change, clients move through a series

of stages from not thinking about change (*pre-contemplation*), to being unsure about it (*contemplation*), ready for change (*determination*), engaged in change (*action*), and keeping going (*maintenance*). However, *relapse* is often the rule rather than the exception, during which individuals regress to an earlier stage. Most successful changers are likely to have cycled through all or some of these stages several times before entering maintenance or achieving permanent change (Prochaska, DiClemente, & Norcross, 1992).

The main implication of the model is that clients at different stages are likely to benefit from different interventions. Prochaska and colleagues (1994) have demonstrated that these processes of change are distinct and measurable, and that efficient self-change depends on doing the right things (processes) at the right time (stages).

Miller & Rollnick (1991) outlined a range of *motivational interviewing* techniques to specifically enhance the client's motivation to change depending on where they are in Prochaska & DiClemente's stages of change:

- Pre-contemplation: Raise doubt – increase the client's perception of problems with "the way things are now".
- Contemplation: Tip the balance – evoke reasons to change, risks of not changing, and strengthen the client's self-belief.
- Determination: Help the client to determine the best course of action to take in seeking change.
- Action: Help the client to take steps towards change.
- Maintenance: Help the client to identify and use strategies to prevent relapse.
- Relapse: Help the client to renew the process of contemplation, determination, and action, without becoming stuck or demoralized.

This approach is guided by 5 general principles (Rollnick & Miller, 1995), which have particular resonance for coaching:

1. Express empathy, through the use of reflective listening.
2. Develop discrepancy between the clients' goals and present behaviour
3. Avoid argument; by assuming the client is responsible for the decision to change.
4. Roll with resistance, rather than confront it.
5. Support and encourage self-belief and optimism for change

The emphasis on *ambivalence*, where the client simultaneously wants to change and still maintain their current behaviours, implies a state of psychological discontent. This is the point of resistance when the client faces a conflict between what they *said* they were going to do and what they *believe* about

themselves or the situation. In social psychology this is called 'cognitive dissonance' (Elliott & Devine, 1994; Harmon-Jones 2000).

For example, the client might feel *dissonance* due to inconsistency between an achievement-oriented self-concept and feeling "exposed" in the coaching session when they seem unable to demonstrate a particular skill important to them (such as talking more effectively to the MD). The existence of dissonance is considered to be psychologically uncomfortable and the client is motivated to try to reduce the dissonance through a number of strategies (Harmon-Jones & Mills, 1999). In other words, clients will alter the way they think in the face of situations that could create cognitive conflicts.

Motivational interviewing seeks to arouse this, and then focus the behaviours arising from it so that they help to move the client in the direction of change (Emmons & Rollnick, 2001).

References

- Elliot, A., & Devine, P.G. (1994). On the motivational nature of cognitive dissonance: dissonance as psychological discomfort. *Journal of Personality and Social Psychology*, 67(3), 382-394.
- Emmons, K.M., & Rollnick, S. (2001). Motivational interviewing in health care settings: opportunities and limitations. *American Journal of Preventive Medicine*, 20(1), 68-74.
- Harmon-Jones, E. (2000). Cognitive dissonance and experienced negative affect: evidence that dissonance increases experienced negative affect even in the absence of aversive consequences. *Personality and Social Psychology Bulletin*, 26(12), 1490-1501.
- Harmon-Jones, E. & Mills, J. (1999). An introduction to cognitive dissonance theory and an overview of current perspectives on the theory. In E. Harmon-Jones & J. Mills (Eds). *Cognitive dissonance: progress on a pivotal theory in social psychology* (pp. 3-21), Washington DC: American Psychological Society.
- Miller, W.R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York, NY: Guilford Press.
- Prochaska, J.O., DiClemente, C.C. (1984). *The transtheoretical approach: Crossing the boundaries of therapy*. Homewood, IL: Dow-Jones/Irwin.
- Prochaska, J.O., DiClemente, C.C., Norcross, J.C. (1992). In search of how people change. *American Psychologist*, 47(9), 1102-1114.
- Prochaska, J.O., Velicer, W.F., Rossi, J.S., Goldstein, M.G., et al. (1994). Stages of change and decisional balance for 12 problem behaviours. *Health Psychology*, 13(1), 39-46.
- Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, 325-334.
- Rollnick, S, Butler, C.C., Stott, N. (1997). Helping smokers make decisions: the enhancement of brief intervention for general medical practice. *Patient Education and Counseling*, 31, 191-203.