

NRCFCPP Concurrent Permanency Planning Curriculum

Module 3: *Stages of Change*



Notes

Understanding the Change Process/Cycle of Change

(Adapted from materials developed by Laura Williams, NRCFCPP Consultant)

Session Outline

Review/Preview

Stages of change Lecture *30 minutes*

Recognizing stages *15 minutes*

Objectives

This module will teach participants:

- The characteristics of each stage of change in the Prochaska/DiClemente model of Trans-Theoretical Change;
- The major techniques or strategies to help clients move to the next phase or stage in the process of change.
- The importance of full disclosure about what needs to happen for parents to reunify with their children.

Time *75 minutes*

Session Material, Handouts and overheads

Materials:

Overhead Projector/Screen

Wall Posters of the Stages of Change *(optional)*

Handouts

3.1 Cycle of Change

3.2 Stage of Change – Description

3.3 What Helps People Change

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Notes

Overheads

The Change Cycle
Stages of Change
What Helps People Change
“What’s My Stage” Pages

Session Framework

Introduce this section by making the following points about the Cycle of Change.

Change wheel

In 1982 **James Prochaska and Carlo DiClemente** developed a useful model describing how people change. The model was based on self-help change, but research has shown it to underpin all types of change related to behaviors such as addictions to smoking, eating, using drugs. It’s not been found to be applicable to sexual abuse situations.

This is a unifying theory of change – called the Trans-Theoretical Theory of Change – which takes into consideration the range of theories about how people change (Freud, Jung, Rogers, etc). It assists us in understanding where our clients may be in the cycle of change and how to engage and work with them depending on the stage they are in. Knowing this helps us to help our clients want to change.

Circle of Change Overhead

Note that it’s a circle:

- There are entry and exit points; change takes many tries.
- It’s normal for people to travel around before reaching a stable change. Smokers went between approximately 3 and 7 times, with an average of 4, before finally quitting for good.
(Ask if anyone has had an experience quitting smoking and if there is anyone who would want to share. Trainers share experiences as appropriate.)
- Each relapse brings you one step closer to recovery. Not to encourage relapse, but to prevent demoralization.
- There are different stages: trainer names them for the group. People can go through the stages rapidly – physicians have been known to take people through these quickly.

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- Relapse is a ‘slip’ not a fall “off the wagon.” Relapse can be an opportunity for change and growth bringing one closer to recovery, not further away.

Stages

Also note that people present differently at each stage. This will mean that caseworkers will need to use different techniques or strategies at each stage to engage the family member in making changes in the behaviors that have resulted in the involvement of child welfare services.

If you meet “resistance” you may need to change strategies for communication and engagement. Resistance often results from the wrong interventions at the wrong time.

Let’s explore this concept of “resistance”:

- Most people who are faced with change are not ready to take action (80%).
- Several stages must be passed through BEFORE action occurs.
- Object is to move people from one stage to the next, NOT directly to action or maintenance. Stage-specific communication skills and strategies are required.” As an example put the following on a flip chart and discuss: When people who quit smoking entered a study at different stages the results were different.

In a study of how smokers change over time, we learn that the stage clients are in when they engage in change impacts how they move into action and maintenance of change.

- Of those who entered in the Pre-contemplation phase and moved on to the action phase, only 6% were abstinent after 18 months
- 15% of those who entered in the Contemplation phase moved on to action and were abstinent after 18 months
- 24%¹ of those who entered in the Determination phase moved on to action and were abstinent after 18 months

¹ *Changing for Good*, James O. Prochaska, John C. Norcross, Carlo C. Diclemente (Avon: New York), 1994

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Notes

Stages of Change

Using overheads/handouts describing each change stage. Comment that these stages are in the Change Module of the handout packet. Review each stage and refer to the types of behaviors associated with each stage and the strategies that work to engage clients, not trigger ‘resistance.’

When we push or use an inappropriate strategy, we may contribute to the person’s inability to make change. Include reference to common defense mechanisms (usually seen in Pre-Contemplation that keep people from changing).

Discussion

Pre-contemplation

Description:

- Who Me?
- Someone else, other than the person, knows about the problem, e.g. person who reported abuse.
- Often person **surprised** when subject is brought up
- Seldom present for treatment unless **coerced** when they become defensive contemplators

Comment that in the Pre-Contemplation Stage in particular, we may see a range of defense mechanisms that prevent people from hearing/understanding the need for change. Pre-contemplation is characterized by four varieties of the basic defense mechanisms:

- Making the least of it: **denial and minimization**. Denial filters out information. (I don’t have a problem.) Minimization makes light of it. (I hardly hit him at all). Another way clients will let us know they are in Pre-Contemplation is through...
- Good excuses: **rationalization** = plausible explanations for behavior that others can easily see are full of holes (I need drugs to relax.) **Intellectualization** uses abstract analysis to rob events of personal significance (My uncle drank a pint of whiskey a day and lived to be 90).
- Turning outward: **Projection** and **displacement**. Displacement (scape-goating) putting feelings elsewhere (the problem is you took my kid; constant criticizing of wife to avoid hearing her criticism). **Projection** is diagnosing in another the problems you have.
- Turning inward: **internalization**. Swallowing feelings, leading to self-blame, low self-esteem, depression. (I can’t do it; I just can’t do it; I shouldn’t have tried.)

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So what do we do?

Strategy

- Provide **information and feedback** to raise problem awareness and possibility of change – shows them where they are in relation to others
- Raise doubt to increase the client's perception of risks and problems with current behavior.
- Help them do a self-assessment.
- **Identify relationships** that help rather than enable
- Create **awareness of defenses** especially in a therapeutic situation.
- Prescriptive **advice** can be counterproductive – can only create resistance to change.

Contemplation

Description

- Ambivalence: Seesaw of considering and rejecting change
- Reasons for concern and justifications for lack of concern.
- Give an example of a client at this stage [I don't really think I have a drug problem. I may do more drugs than are healthy, but I don't use more than my friends. Sometimes I feel desperate for a fix, but I'm not an addict. I could quit if I wanted to.]

Strategy

- Elicit reasons on both sides and tip the balance in favor of change.
- Strengthen self-efficacy for change.
- Double reflections help to clarify the see saw or ambivalent feelings.
- Use clients' language and goals.

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Determination

Description

- Motivated to make a change.
- I've got to do something about this problem.
- This is serious! Something has to change.
- What can I do? How can I change?
- Window of opportunity – open for a short time – either advance to slip back

Strategy:

- Articulate the choices in client's words.
- Suggest choices.
- Probe client's thinking about options.

Action

Description:

- Often thought of as therapeutic process
- **Doing** things to make a change

Strategy

- Cheering on
- Supporting client in taking steps toward change
- Reflecting back goals, providing real support

Maintenance

Description

- Sustain change
- Prevent relapse
- Learn different skills that needed to change

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Strategy:

- Help the client to identify and use strategies to prevent relapse

Relapse

Description

- Oops
- Step backward
- Relapse that is a “slip” is minor
- Relapse that leads to falling off the wagon is major
- Challenge is to start again and not get demoralized
- Use relapse as opportunity to grow

Strategy

- Help prepare for and expect relapse
- Avoid demoralization
- Urge them to continue on wheel of change
- Don't give up
- Clarify consequences
-

Likened this change process to the stages of reactions people go through when they experience loss/separation:

- Shock
- Denial
- Anger
- Bargaining
- Acceptance
- Moving on

Summary

Review the **Handout 3.2: What Helps People to Change?** Connect these to the kind of things people said they wanted to know and how they wanted to be treated during the morning exercise.

Advice - share

Barriers – remove

Choices – provide

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- D**esirability – decrease
- E**mpathy - show
- F**eedback - provide
- G**oals - develop
- H**elping - actively

Comment that these strategies help people want to change and feel ready to move to the next level – with the right education and support!

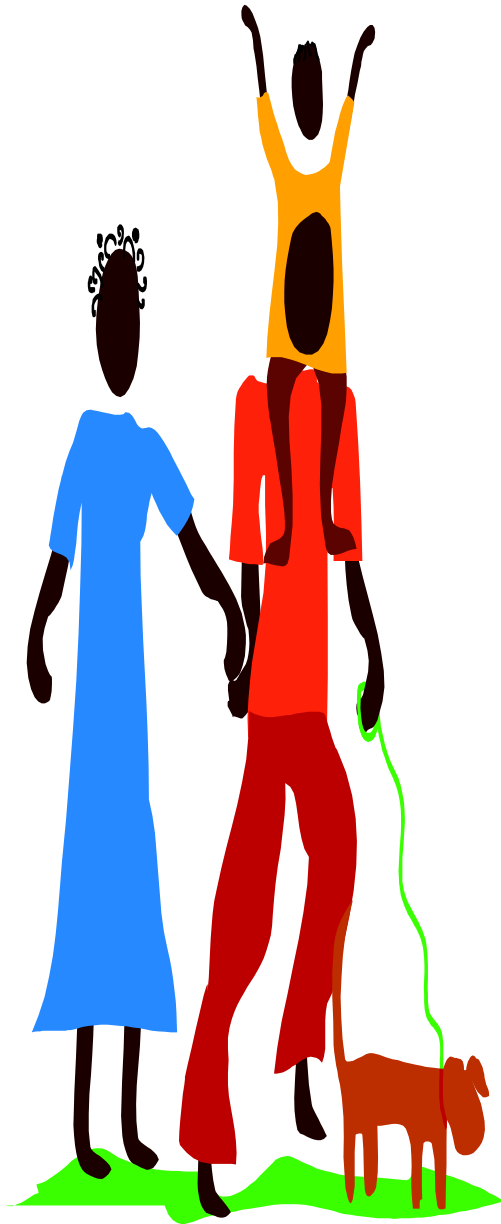
Notes

In Pre-contemplation,
the person is unaware,
unwilling, or too discouraged
to change within the
next six months.





In *contemplation*,
the person is
thinking about
changing a
behavior within
next six months.



In *maintenance*
the Person
continues to
maintain
behavioral
change
*[for at least six
months]*
until it becomes
permanent.



In *action*
the person is
actively doing
things to
change or
modify
behavior.



In *relapse*
he person returns
to pattern of
behavior that s/he
has begun to
change and thus
returns to one of
the first three
stages.



In *determination* (*preparation*) the person is seriously considering and planning to change a behavior within 30 days and has taken steps toward change.

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Closing Exercise:

What's My Stage

The purpose of the "What's My Stage" exercise is to:

- Give participants practice in recognizing the stages
- Use active learning to increase retention

Directions

To run the activity:

- Say: "Let's try to apply these stages to things you may hear child welfare clients say."
- Say: "I will show an overhead of a statement. You tell me the stage you think the client is in. I'll count your responses and mark them on the overhead."
- Discuss the results and correct if necessary.
- Repeat until 8-10 statements have been read and discussed.
- Make the exercise fast and fun.

Notes

What's My Stage

“I feed her fine. She
just doesn't eat.”

She's a small baby”

What's My Stage?

“I didn't call the clinic because I lost the phone number you gave me.”

What's My Stage?

“I've been clean. I've
just had a hard time
getting to the clinic

What's My Stage?



“Yeah, that drug program is really helping me not to use

**What’s My
Stage?**



“My drug tests show I’ve been clean for 6 months!”

What's My Stage?

“Those drugs the police found are my boyfriend's. I don't do drugs.”

What's My Stage?

I don't think I really have a problem with drugs. Probably I do too much for my own health, but I don't use any more than my friends do. Sometimes I feel pretty bad in the morning, and it worried me that the kids had to fend for themselves. But I'm not addicted. I can quit whenever I want to and not miss it."

What's My Stage?

“I can't stay clean as long as my boyfriend is around. I've got to do something about him.”

What's My Stage?

“I’ve tried so many times. I do O.K. for a while but it’s too late for me.”



What's My Stage?

“All you do is nag me
about taking drugs.
Just leave me alone.”

What's My Stage?

“I called that program you recommended.”

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What Motivates People to Take Action to Change?

(Developed by Laura Williams, California Department of Social Services, Adoption Initiative. August 2000. Based on *Motivational Interviewing* by William Miller and Stephen Rollnick)

Strategies and Research Findings

Giving Advice

- Advise and assessment
- Single counseling session at hospital ER for alcohol related illnesses/injuries increased return for treatment from 5% to 65%² and from 6% to 78%³
- Physician advice to stop smoking increased non-smoking from .3% to 3.3%⁴
- 3-hour assessment and 1 hour advice session as effective as full treatment (AA, medication, outpatient counseling, and inpatient care as needed) at both 12 and 24 month follow-up⁵
- 3-hour assessment and 1-hour advise session as effective as therapist-directed treatment⁶

Removing Barriers

- Attendance at aftercare meetings could be predicted from the distance a person had to travel in order to attend⁷
- 100% of clients who had barriers removed [therapist call AA member, while client in office; client talked to AA member who offered transportation and to accompany to AA meeting; AA member gave reminder call] attended AA meeting while 0% who only received encouragement attended.⁸

Notes

² Chafetz 1961; Chafetz et. al 1962 as quoted in *Motivational Interviewing* by William R. Miller and Stephen Rollnick, 1991

³ Chafetz 1968; Chafetz et al 1964 1962 as quoted in *Motivational Interviewing*

⁴ Russell, Wilson, Taylor, and Baker (1979) as quoted by William R. Miller in *Psychological Bulletin*, 1985, Vol. 98, No 1. "Motivation for Treatment: A Review With Special Emphasis on Alcoholism"

⁵ Edwards et al, 1977 as quoted in "Motivation for Treatment: A Review With Special Emphasis on Alcoholism"

⁶ Miller, Gribskov, and Martell, 1981; Miller and Taylor, 1980; Miller, Taylor, and West, 1980 as quoted in "Motivation for Treatment: A Review With Special Emphasis on Alcoholism"

⁷ Prue, Keame, Cornell and Foy, 1979 as quoted in *Motivational Interviewing*

⁸ Sission and Mallams (1981) as quoted in *Motivational Interviewing*

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Providing **Choices**

- Number of treatment alternatives increased treatment acceptance and overall success rate⁹
- Client selection of abstinence versus moderation as a goal increased patient compliance. 68% of those choosing abstinence didn't drink compared to 37% of those who were told that abstinence was the goal.¹⁰

Decreasing **Desirability**

- Aversive counter conditioning is effective in treating alcohol abuse¹¹

Practicing **Empathy**

- An empathic therapeutic style is associated with greater long-term behavior changes¹²

Providing **Feedback**

- Self-dissatisfaction is predictive of effort expended to reduce the discrepancy between the present and desired state, but only in the presence of feedback.¹³
- Change in verbal behavior resulting from observation occurred only in the presence of feedback.¹⁴
- **But**, negative feedback such as showing a client a videotape of himself while intoxicated, or distressed couples before marital therapy is ineffective.¹⁵

Clarifying **Goals**

- Feedback in the absence of a provided goal was ineffective in increasing exercise while a goal plus feedback resulted in marked behavior change.¹⁶

⁹ Kissin, Platz, and Su (1971) as quoted in *Motivational Interviewing*

¹⁰ Thorton, Gottheil, Gellens, and Alterman (1977) as quoted in *Motivational Interviewing*

¹¹ Kanfer, 1980 as quoted in "Motivation for Treatment"

¹² Miller and Soveerign, 1989; Miller, Taylor, and West, 1980; Patterson and Forgatch, 1985; Valle, 1981 as quoted in *Motivational Interviewing*

¹³ Bandura and Cervone (1983) as quoted in *Motivational Interviewing*

¹⁴ Richards, Anderson, and Baker (1978) as quoted in *Motivational Interviewing*

¹⁵ Bailey and Sowder, 1970; Baker, Udin, and Volgler, 1975; Faia and Shean, 1976;

Feinstein and Tamerin, 1972; Paredes et al., 1969, 1971; Weiss and Summers (1983) as quoted in "Motivation for Treatment"

¹⁶ Bandura and Cervone (1983) as quoted in "Motivation for Treatment"

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- The addition of a goal to feedback resulted in significant weight loss when feedback alone resulted in a slight weight gain¹⁷

Active **Helping**

- Receipt of a hand-written personal letter of concern following alcohol screening reduced self-referral from 31% to 50% with those getting the letter coming in sooner and more sober.¹⁸
- When a primary care worker sent a hand written follow-up note when an appointment was missed, the treatment drop out rate decreased from 51% to 28%.¹⁹
- 44% of those who received a follow-up telephone call returned for treatment within one week while only 8% of the uncalled group returned.²⁰
- 82% of referrals are completed when the counselor placed the call, versus 35% when the responsibility was left to the client.²¹

What Doesn't Motivate Clients to Take Action?

External **Pressure**

- The mere external initiation of treatment is not associated with favorable compliance. Those seeking help are more likely to enter and comply with treatment than are those brought or referred by others.²²
- Coerced versus voluntary clients show approximately equal rates of successful outcome within the same program.²³

Client **Distress**

- Client distress is a two-edged sword. Although it may inspire the search for a change strategy, the strategy chosen may be one of fear reduction [minimizing risk, underestimating treatment benefit] rather than adaptive behavior change.²⁴

Low **Self-Esteem**

¹⁷ Bandura and Simon (1977) as quoted in "Motivation for Treatment"

¹⁸ Koumans and Muller (1965) as quoted in "Motivation for Treatment"

¹⁹ Panepinto and Higgins (1969) as quoted in "Motivation for Treatment"

²⁰ Nierenbery, Sobell, and Sobell (1980) as quoted in "Motivation for Treatment"

²¹ Kogan (1957) as quoted in "Motivation for Treatment"

²² Chafetz, Blane, and Hill, 1970; Corrigan, 1974; Kogan, 1957 as quoted in "Motivation for Treatment"

²³ Freedberg and Johnston, 1978, 1980; Gallant et al., 1973; Miller, 1978; Sedmark and

Dordevic-Bankovic, 1978; Smart, 1974) as quoted in "Motivation for Treatment"

²⁴ Miller "Motivation for Treatment," page 95.

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Notes

- Low self-esteem can undermine action by a desire to avoid failure or disappointment.²⁵

Breaking Denial

- The character defense mechanism of denial has been found to be no more frequent among alcoholics than among non-alcoholics²⁶
Denial has shown no consistent relation to outcome.²⁷

Label Acceptance

- Self-labeling²⁸ as “alcoholic” is unrelated to problem recognition.

Problem Recognition

- Problem recognition is not sufficient for recovery²⁹
- Alcoholics with a poor outcome showed a high level of problem recognition.³⁰

²⁵ Mozdierz and Semyck, 1980; Rothbaum et al., 1982 as quoted in “Motivation for Treatment.”

²⁶ Chess, Neuringer, and Goldstein, 1971; Donovan, Rohsenaw, Schau, and O’Leary, 1977; Skinner and Allen, 1983 as quoted in “Motivation for Treatment.”

²⁷ Moore and Murphy, 1961; O’Leary, Rohsenow, Schau, and Donovan, 1977; Lemere, O’Hollaren and Maxwell, 1958; Trice, 1957; Orford, 1973 as quoted in “Motivation for Treatment.”

²⁸ Shaw, Cartwright, Spratley, and Harwin, 1978 as quoted in “Motivation for Treatment.”

²⁹ Blane, 1968; Moore and Murphy, 1961 as quoted in “Motivation for Treatment.”

³⁰ Porlick, Armor, and Braiker, 1981 as quoted in “Motivation for Treatment.”