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Article 28

The Revised Stage of Change Model and the Treatment Planning Process

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Understanding counseling begins with a theory to explain the change process. It is treatment planning that provides counselors with the access route to create client change. The treatment planning process has undergone numerous iterations along the way to the form it takes today. Somewhere along the way it stopped being a tool for the counselor and became an icon of managed care gone awry. Counselors must now reclaim treatment planning as the valuable tool that it has been for the profession. By reclaiming treatment planning, we reclaim the change process.

As practitioners, planning for the change process with clients is the single most important skill counselors bring to the therapeutic table. More recently this important process has been reduced to a formula for cure-alls and cookbooks that any technician can administer by following the proper order. That a cookbook recipe to counseling is problematic is well documented by Kendall and Chambless (1998) and Nathan and Gorman (1998).

Why do counselors need to understand change? Understanding the change process elevates counselors from mere technicians to professional practitioners. It also allows counselors to view clients where they are, not where we want them to be, and to see resistance as a part of change processes not an avoidance of change.

However, rarely are there studies in which the internal mechanism creating change can be inferred (Kazdin, 2000). Consequently, the use of theory-dependent models and transtheoretical models, such as the Prochaska and DiClemente (1982) stages of change, can be applied to determine a client's readiness for change. Change is part of a dynamic therapeutic process and, therefore, is open to revisions as clinical experience and research provides more specificity. Freeman and Dolan (2001) have provided such a revision of the Prochaska/DiClemente model. Their revision adds new stages that increase the specificity of change and more appropriately reflect the actual therapeutic process.

The Freeman/Dolan Model

The Freeman/Dolan model takes into account that some people may be unaware of the existence of a problem or the need to change (Noncontemplation). The first two stages demonstrate this understanding. Freeman and Dolan recognized that a counselor can encounter clients who are forced to or required to enter treatment for a number of reasons (i.e., courts). These individuals are placed in a situation where they must decide between therapy and some threat (i.e., jail). At the present time they are not willing to engage in the change process. In some instances they may oppose violently (Anticontemplation) the whole therapeutic process (Dolan, 2004). See Table 1 for a comparison of the Prochaska/DiClemente and Freeman/Dolan Models.

Table 1. Comparison of the Prochaska/DiClemente and Freeman/Dolan Models

Prochaska /DiClemente	Freeman/Dolan
******************	1.Noncontemplation
******************	2. Anticontemplation
1. Precontemplation	3. Precontemplation
2. Contemplation	4. Contemplation
3. Preparation	5. Action Planning
4. Action	6. Action
******************	7. Prelapse
******************	8. Lapse
******************	9. Relapse
5. Maintenance	10. Maintenance

The next two Freeman/Dolan stages (Precontemplation and Contemplation) are not tied to commitment as described in Prochaska/DiClemente (1982). Instead, they are the metacognitive and cognitive functions of the change process. For Freeman/Dolan, the Precontemplation stage occurs when the client begins to consider the consequences, purpose,

and the possibility of change; whereas with the Contemplation stage the client is actively considering and is ready to engage change.

The Preparation stage of Prochaska/DiClemente is timed (within the next month) and requires an unsuccessful attempt at change within the past year. In the Freeman/Dolan model, Action Planning replaces Prochaska/DiClemente's Preparation stage and is designed as an interactive collaborative process between the counselor and the client. The Freeman/Dolan Action stage requires a treatment focus that initiates active treatment planning. The Action stage is the same for both models and is analogous to going from neutral to drive.

The next three stages are completely new and reflect the complex cognitive processes of upsetting the homeostasis of a person through the change process. The first of these stages is Prelapse, in which the client is evaluating whether the change made in the Action stage is beneficial or even needed. This is a cognitive process with no behavioral components. The concept of Prelapse is needed to explain that once changes are made the client initially goes through a rejection process similar to a body going through the rejection of transplanted parts. The Lapse stage is the behavioral manifestation of the unsuccessful resolution of the Prelapse stage. This is usually characterized by a single behavioral event, and if therapeutic redirection occurs (putting the change process back on track), the client returns to the change state. If the resolution of the Prelapse stage is unsuccessful or if redirection is ineffective, then the process will move to Relapse (a return to old behaviors). Relapse includes a reemergence of the behavioral problems, and the cognitive patterns that induce or reinforce the problem behavior.

The lack of these additional stages in the Prochaska/DiClemente model prevents accurate identification and the interventions necessary for the resolution of problems unique to these stages. The Maintenance stage in both models is conceptually similar; however, the focus in Freeman/Dolan is to continually assess and fine tune the changes until they become habitual, and to generalize to other problem areas throughout a person's life. The Freeman/Dolan model, through this expansion, seeks to provide the counselor with a tool that is more efficient and clinically relevant.

The model allows the counselor to more accurately determine where his or her client is on the continuum of change and to factor into the change process any special conditions or circumstances such as cultural differences. The model represents a new way of conceptualizing clients by seeing issues like resistance merely as a part of the change process and not as an obstacle. The model is dynamic and flexible, instead of static or defined by a fixed timeline. As counselors find themselves more accountable to third parties that require justification and empirical support for treatment methods, it is important to explain the actual process that clients experience. The maintenance of change is necessary for this long-term process to occur. For example, identifying for an alcoholic the cognitive distortions (Prelapse) that will lead back to drinking is more effective and humane than waiting for the client to return to drinking (Lapse or Relapse) and then intervene.

In a recent study (Dolan, 2003), the Freeman/Dolan model was found to offer counselors greater ability to accurately identify the stages their clients were in than was true of the Prochaska/DiClemente model. In addition, the participants preferred the Freeman/Dolan model to the original model three to one.

Treatment Planning Basics

Most counselors give lip service to the idea of treatment planning: but why plan? Treatment planning establishes collaboration between counselor and client, acts as a guide for the treatment process, and forces counselor and client to think about outcomes and clarify issues. Also, it can help counselor and client to stay focused on the identified problem, and it helps the counselor to develop interventions best suited to achieve objectives. Further, it provides the counselor with some protection from litigation by demonstrating that the treatment procedures followed are acceptable clinical practices.

Careful treatment planning increases the probability of being successful. However, sometimes treatment approaches do not work, generally for one or more of the following reasons:

- *wrong problem:* focusing on the wrong things to change. *Correction:* Be accurate in terms of problem identification (right problem).
- *wrong time:* misjudging the client's stage or readiness to change. *Correction:* Be appropriate to client's readiness to change (right time).
- *wrong tool:* implementing a less effective strategy for change. *Correction:* Include interventions appropriate to the objectives (right tool).

Change and Treatment Planning

Treatment planning includes three components: (1) Stage or Diagnosis and Assessment; (2) Level or Problem Identification; and (3) Treatment or Strategy Implementation. The SLT model refers to a Stage by Level by Treatment interaction of creating change.

The *Stage* component acknowledges when to change or the current stage of change for the client. Stage is established using questionnaires, and/or formal and informal counselor assessment. Methodology may include assessments such as psychosocial history, mental status, risk assessment, presenting problem, and strengths and weaknesses.

Level of the change process refers to what change is required and is determined through some form of problem list and/or clinical interview. Most theoretical models for conducting counseling contain the "what" of change within the model. Transtheoretical models must offer different methods of viewing the client and what must be changed. Included in the Level of change are (1) cognitive or the mental process of knowing; (2) affective or raw visceral experiences interpreted as emotions and feelings (cognitive labels); (3) behavior or the actions or reactions of persons in response to external or internal; and (4) environment or the context for clients' living.

Treatment refers to how clients change and is composed of the strategies and techniques that are most effective for dealing with specific problems at a certain stage and level of change. As an example, the counselor might use the strategy of refutation for a client's cognitive distortions when the client is in the Contemplation stage and is ready to change.

Seay (1978, 1980) and Seay and Seay (in press) developed a methodology for conceptualizing cases that provides a format for gaining an overall view of the treatment process. Based on presenting problems and thematic dysfunctionalities, the client's problems are presented according to problematic cognition, affect, behavior, and the supporting environment in which they occur. In addition, chosen strategies and techniques that address these problem areas along with achieved outcomes are included. The methodology assumes the following format (See Table 2).

Each problem area is listed under each level (e.g., Environment), including all relevant details. Where possible the counselor should match items across levels (environmental, cognitive, affective, and behavioral). Strategies should be designed such that each is capable of addressing environment, cognition, affect, and behavior or as many levels as possible. Outcomes are included only when actually accomplished.

Table 2. Methodology for Client Case Conceptualization

Name: Date:
Presenting Problem:
Dysfunction Themes:

Environment	Cognition	Affect	Behavior	Strategies	Outcome
E1	C1	A1	B1	S1	O1
E2	C2	A2	B2	S2	O2

Combining the case conceptualization methodology with SLT treatment planning produces a matrix for treatment. Table 3 presents a single problem area for a troubled teen is selected from a more comprehensive case conceptualization treatment plan and presented along with the current and desired stages of change. The presenting problem is that of a teen getting into fights at school. While the overriding picture is of a teen with major problems with home life, his problems are prioritized by immediacy. The school fighting may get him removed so it acquires the status of primary. The strategies of volunteering, cognitive disputation, emotional reeducation, and learning anger takes the teen from the Precontemplation, Anticontemplation, and Noncontemplation stages to an Action stage that directly addresses the problem with potential solutions. Each of the major problem-clusters is treated in a similar manner until sufficient progress is achieved that counseling is no longer warranted.

The Stages of Change model (Freeman & Dolan, 2001) increases the potential for greater success rates of treatment. Determining where the client is in the change process leads to more accurate treatment planning. By combining knowledge of the client's change process (Dolan, 2004) with a comprehensive conceptualization (Seay, 1978) of the client allows for more accurate selection, development, and implementation of treatment strategies.

References

Dolan, M. J. (2004). Stages of Change. In A. Freeman (Ed.), *Encyclopedia of cognitive behavior therapy.* New York: Kluwer Academic/Plenum.

Dolan, M. J. (2003). *Assessment of the revised Stages of Change model.* Unpublished doctoral dissertation, Philadelphia College of Osteopathic Medicine.

Table 3. Treatment Plan and Procedure for Aggressive Teen

Identified Problem Environment	P1: Fights in School Cognition	Affect	Behavior	Change Stage	New Stage
E1: In school with peers multiple incidences a. Volunteer with peers on school activity				Precontemplation	Action/Maintenance
	C1: Belief: Kids and school at fault a. Disputation-Reciprocal causation			Anticontemplative	Contemplative
		A1: Angry over perceived grievances a. Emotional reeducation		Noncontemplative	Action
			B1: Fights kids who get in face a Anger control b. Substitute alternative behaviors	Anticontemplative	Action

Freeman, A., & Dolan, M. (2001). Revisiting Prochaska and DiClemente's Stages of Change theory: An expansion and specification to aid in treatment planning and outcome evaluation. *Cognitive and Behavioral Practice, 8*, 224–234.

Kazdin, A. E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice.* New York: Oxford University Press.

Kendall, P. C., & Chambless, D. L. (Eds.). (1998). Empirically supported psychological therapies [Special section]. *Journal of Counseling and Clinical Psychology, 66,* 3–167

Nathan, P. E., & Gorman, J. M. (Eds.). (1998). *Treatments that work*. New York: Oxford University Press.

Prochaska, J. O., & DeClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice, 20*, 161–173.

Seay, T. A. (1978). *Systematic eclectic therapy*. Jonesboro, TN: Pilgrimage Press.

Seay, T. A. (1980). Toward a single paradigm. *Journal of Counseling and Psychotherapy*, *3*, 47–60.

Seay, T A., & Seay, M. B. (in press). The role of theory in the practice of mental health counseling: History and development. In W. J. Weikel & A. J. Palmo