Stages of Change: Interactions With Treatment Compliance and Involvement

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INTRODUCTION

Some powerful and effective treatment strategies currently are available to assist substance abusers in modifying and stopping their problematic behavior (Anglin and Hser 1992; Carroll and Rounsaville 1990; Miller 1993). As treatment technologies become more sophisticated and effective, the challenge becomes one of exposing clients to and engaging them in their treatments. The problem is illustrated in what can be called the smoking-cessation funnel effect. Often it is easier to get a picture of a total population of individuals who are nicotine dependent than of those who are using illegal drugs. In this illustration of a worksite (figure 1) where 30 percent of the employees are smokers, it quickly becomes apparent that many smokers express some interest in quitting in a general survey. However, when an opportunity for treatment arises, few will volunteer for treatment and sign up. The best estimates with extensive recruiting are that only 4 to 10 percent will sign up, and that only 80 to 90 percent of these show up for treatment (Beiner and Abrams 1991). Attrition, at its very least, would claim another 10 to 20 percent of participating smokers. Finally, once the treatment is completed and subjects are followed up at 6 and 12 months, approximately 60 to 70 percent of the treatment successes will relapse. Even with very liberal and hopeful estimates at each point in the process, the picture of recruitment, retention, participation, and successful change for any one treatment offering will be modest. Noncompliance and lack of long-term success are two of the critical issues in substance abuse treatment that need to be addressed.

A number of strategies have been proposed to increase engagement and participation in treatment, including incentives and rewards, providing information about treatment, easing treatment regimens, enlisting social support of spouses and/or family members, self-selection of treatment goals, court-mandated treatment, offering treatment in such restricted settings as prisons, and treatment matching based on client, intervention,

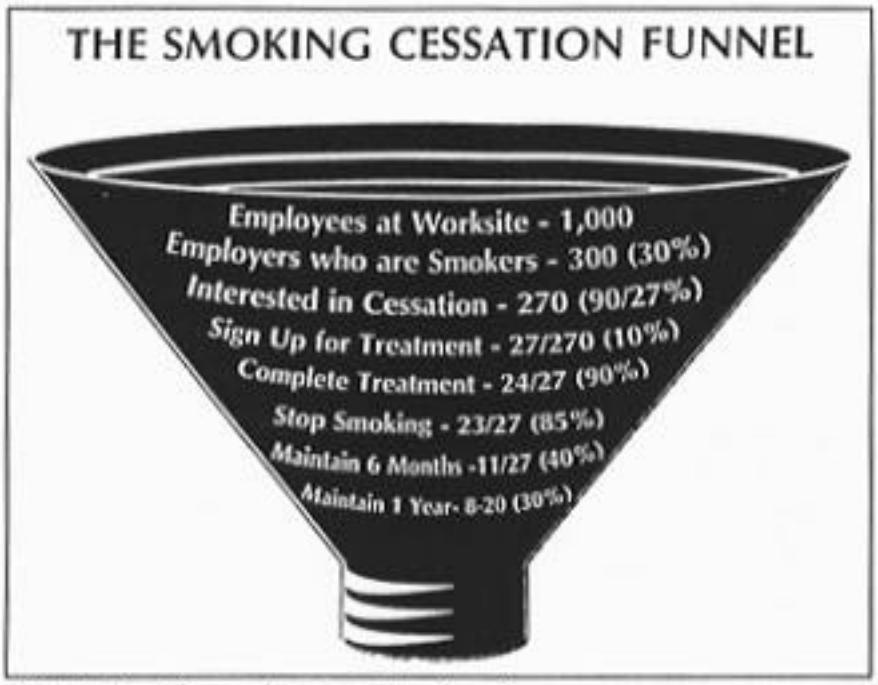

FIGURE 1. *The smoking cessation funnel.*

or therapist characteristics (Becker and Maiman 1980; Beutler 1991; Higgins and Budney 1993; Miller 1993; Project MATCH 1993; Smith and Secrest 1991; Snow 1991; Sobell et al. 1992). It is certainly neces-sary to know whether these strategies work. However, the determination of how well they work is complex and depends on an understanding of how and with whom each strategy might be successful. In this chapter, the authors offer some ideas on the critical dimensions not only for under- standing retention, engagement, and change, but also for evaluating the effectiveness of strategies purporting to modify or improve rates of recruitment, retention, and participation.

Although there has been a great deal of discussion of the critical dimen- sions related to retention and compliance, most of it has focused on variables related to patient characteristics, disease or disorder variables, or treatment or therapeutic relationship variables (Baekeland and Lundwall 1975; Stark 1992). It seems timely to offer some reflections about a dimension that often gets too little attention: the process of behavior change that occurs both within and without treatment. The goal of this chapter is to explain how this process interacts with treatment(s) as well as how it can offer new

insights and a valuable additional perspective to the discussion of retention and participation in treatments. A conceptual perspective will be followed by some research evidence and then by an outline of key implications or recommendations based on this process-of-change perspective.

IMPORTANT DISTINCTIONS FOR UNDERSTANDING COMPLIANCE AND CHANGE

Treatment and the Process of Change

Following a more medical view of substance abuse problems, treatment providers have often assumed that treatment is absolutely necessary for change. It is thought that without treatment, individuals who are depen-dent on alcohol or drugs are condemned to live their lives enslaved by the particular substance of abuse. Change without treatment, in this view, can possibly happen in individuals who abuse substances but not among those who are dependent on a particular substance. In fact, stopping sub-stance use without treatment is most often seen as confirming evidence that the individual was not dependent on a substance. This is a rather circular form of reasoning. The argument is: If a substance abuser can stop using the substance on his or her own, then there must not have been a significant problem because treatment is necessary for successful sobriety or a drug-free existence for dependent substance abusers. This reasoning has become so pervasive that it now permeates the definition of dependence in the "Diagnostic and Statistical Manual of Mental Disorders," 3d ed. revised (DSM-III-R) (American Psychiatric Association (APA) 1987). One criterion for dependence is a "persistent desire or one or more unsuccessful efforts to cut down or control substance use" (APA 1987, p. 168). Problem definition, treatment need, and the process of change have become confused and confounded. This is not to say that treatment is not important for change, but to indicate that treatment and change are not coextensive.

It is important and necessary to disentangle these constructs in order to develop a solid understanding of treatment retention and participation. The following statements represent the proposed theses that are the foundation of this chapter and that can alleviate the confusion.

1. Substance abuse and dependence represent problems that are very difficult to modify. However, there is ample evidence that some individuals can change these behaviors on their own without treatment (DiClemente and Prochaska 1985; Klingemann 1991; Sobell et al. 1993; Tuchfeld 1981). Changes that occur in control groups in clinical trials also support the contention that change occurs with minimal amounts of what are considered the active ingredients of treatment (Lambert et al. 1986).

2. Treatment represents a single and rather specific means of changing substance abuse problems. Most individuals are not successful with a single treatment and often undergo several different—at times, radically different—treatments before they are able to modify their behavior (Brownell et al. 1986; Marlatt and Gordon 1985; Schachter 1982; Skog and Duchert 1993; Wilson 1992). Outcomes from treat-ments are complex and not well represented by a simple success-versus-failure dimension (Marlatt et al. 1988; Mermelstein et al. 1991).

3. Individuals who present for treatment can best be considered self-change failures who differ in their previous change histories and who are at different points in the cycle of change described by DiClemente and Prochaska (1982, 1985; Prochaska and DiClemente 1992) as the stages of change. Current behavior and attitudes toward changing a particular behavior as well as prior attempts to change it that are represented in these stages are critical dimensions for understanding the current status of any substance-abusing client applying for treatment (DiClemente 1993*a,* 1993*b*).

4. The therapist is a broker attempting to bring treatment and client dimensions together in the service of the process of change. The metaphor of a coach or midwife may best characterize the therapist's role in the recruitment, retention, and participation of substance abusers in treatment (DiClemente 1991). Figure 2 illustrates the complex, interactive nature of the relationships among therapist, client, treatment, and change process.

5. Successful long-term change of substance abuse problems represents the ultimate goal of treatment and interventions of all kinds. However, this goal is the culmination of a process that is best understood as a cyclical and spiral movement through the stages of change (Prochaska et al. 1992).

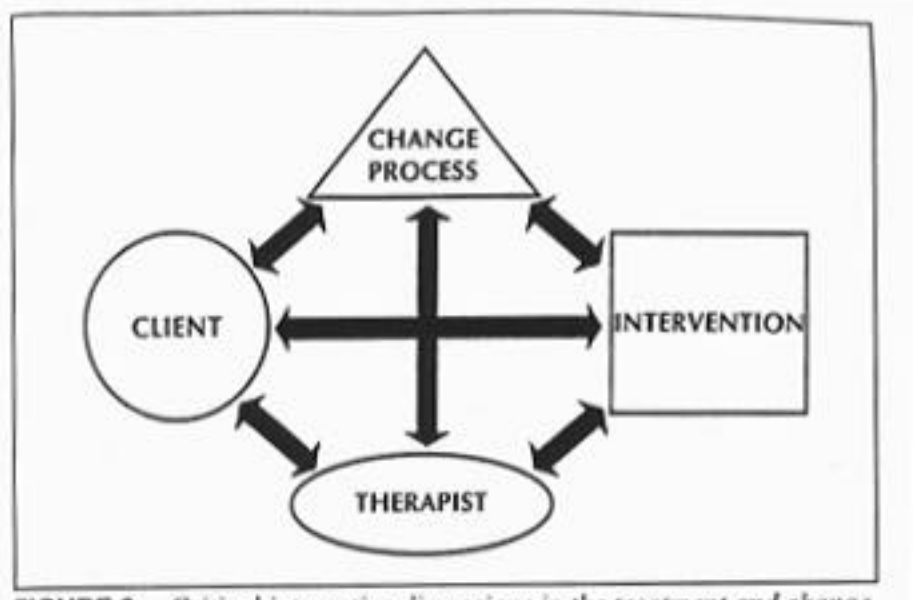

FIGURE 2. *Critical interactive dimensions in the treatment and change process.*

Treatment Compliance or Adherence

Treatment compliance is best defined as the client following the instruc- tions and requirements of the treatment. In this sense it is a rather restricted series of events. The client is asked to attend a certain number of ses-sions, come in regularly to pick up methadone, get regular urine screens, take disulfiram on a regular basis, stop using drugs and/or alcohol, go to 90 Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA) meetings in 90 days, and so forth. All of these are measurable events and observable means of determining whether the client was exposed to a dose of treatment or the active treatment ingredients thought to be responsible for the change.

Dose of treatment is closely associated with compliance. Did the individual take the medication as prescribed, attend the sessions required? There is clear evidence that dose is related to positive outcomes from treatment. Stark (1992) reviewed compliance issues and concluded that treatment completers in alcohol and drug treatment have more positive outcomes and changes than dropouts. Similarly, Anglin and Hser (1992) have shown that increased retention yields better outcomes both in terms of drug use and decreased criminal behavior for different types of treatments.

Simpson (1984) found that length of time in treatment was an important predictor of outcome for the more than 6,000 clients in the Drug Abuse Reporting Program (DARP) followup research. Hubbard and colleagues (1989) found that time in treatment was one of the most important predictors of successful drug abuse treatment in their Treatment Outcome Prospective Study (TOPS) of more than 6,500 clients. Moos and associates (1990) found that amount of treatment predicted outcome for alcoholics. Emrick and fellow researchers (1993) found that frequency of AA attendance and other measures of participation in AA activities were correlated positively with drinking behavior outcomes. Compliance and dose of treatment do seem related to success in modi-fication of substance abuse behaviors. However, relapse rates posttreat-ment for treatment completers are still very high and treatment comple-tion does not ensure success (Brownell et al. 1986; Hubbard et al. 1989; Simpson 1984).

It is easiest to equate compliance with change only when the active ingredients are either pharmacological or biochemical and do not involve intentional behavior change on the part of the client. If a particular medi-cation or drug substitute like methadone is taken as directed, then the desired effects are expected to follow directly and consistently. However, even in these cases, the correlation between the execution of the prescribed behavior and subsequent change is not always large. Individuals who take disulfiram have reported learning to drink over the disulfiram; Moos and colleagues (1990) found that the number of days disulfiram was taken correlated only -0.23 with alcohol consumption and 0.17 with abstinence. Drug abusers who submit to regular drug screens have become very sophisticated in figuring the odds of detection for certain types of consumption. Individuals have gone to hundreds of AA meetings to fulfill court requirements without ever stopping drinking. Emrick and associates (1993), in their synthesis of 13 research studies, found that frequency of AA attendance correlated on average 0.19 with drinking behavior. In fact, a cab driver whom one of the authors met at a conference on AA reported that he had been court ordered to attend AA for 1 year. Not only did he comply with this order, but he attended for another entire year without ever stopping drinking. The bottom line is that compliance is often easy to measure but is not always a marker of behavior change with regard to the target problem behavior.

Treatment Involvement

Treatment involvement is more difficult to assess, but it is often a better prognostic indicator of engagement in the process of change (Orlinsky and Howard 1986). It is axiomatic that individuals who report using treatment strategies, reading treatment materials, doing homework assign-ments, and being active and engaged in group or individual sessions have better treatment outcomes than those who do not (Simpson et al., in press). Treatment involvement is more than treatment compliance. The indi-vidual who is involved is engaged in the treatment process, often has bought into the treatment rationale, and has formulated goals consistent with the treatment philosophy and the therapist's perspective (Sanchez-Craig 1990; Sobell and Sobell 1986-1987). One would expect that indi-viduals who are involved may be developing better working relationships with the therapist (Horvath and Luborsky 1993). Treatment satisfaction has also been related to participation and retention in treatment (DeLeon 1984; Hubbard et al. 1989). Thus involvement is a valuable intermediate measure of treatment outcome because it is associated with a host of positive indicators predictive of treatment success. It is important, how-ever, to understand what links involvement to successful outcome.

Treatment involvement will not be a complete predictor of outcome success unless nonspecific factors of treatment are totally responsible for the outcome of treatment, as has been proposed by several researchers (Frank 1973; Luborsky et al. 1975; Sloane et al. 1975) to explain how different treatments often yield the same or similar outcomes when com-pared in clinical trials. If all that is needed for treatment success is a client engaged and participating in a nonspecific process called therapy, then participation should be highly correlated with success. This is not the case. Even with an intensive examination of the treatment alliance seen as a critical common variable, the relationship between measures of the therapeutic alliance and outcome is in the 0.30 to 0.35 range (Horvath and Luborsky 1993).

There are several complicating factors in linking involvement with success. First, many researchers believe that it is the active ingredients of the treatments, not simply the nonspecific factors, that influence success in treatment. As has been seen in other chapters, most researchers are rather committed to a particular treatment perspective and are not satis-fied with a common factors solution. Evidence also exists that indi-viduals who receive placebo treatments

do not always fare as well as the active treatments (Lambert et al. 1986). Thus, common factors may not be the complete answer to common outcomes. Second, involvement can be a marker of the client's desire to please but not necessarily to change. All therapists have experienced the very compliant client who seems to be doing everything asked except changing the problem behavior.

Finally, involvement in treatment assumes that the suggested critical activities of the treatment are actually the needed ingredients for the client to successfully change or cease the substance-abusing behavior. This is a rather large assumption. The treatment would have to provide most of what is needed by this client at this particular time to make successful change, which would seem to represent and require a rather sophisticated and individualized treatment matching. One must either believe that treatments operate uniformly, a suggestion refuted by Kiesler (1966) and Paul (1967), or there must be a substantial effort at individualizing treat-ment. However, most treatments are not highly individualized and tend to offer the same general program for all who enter that treatment. If there is any sophisticated matching, it tends to be done by the client in choosing or refusing the treatment offered.

THE PROCESS OF CHANGE: STAGES, PROCESSES, AND LEVELS

Over the past 15 years, a group of investigators has been examining the process of change and outlining a transtheoretical model of behavior change particularly as applied to the modification of addictive behaviors. Although the model began as an attempt to provide an integrative, eclectic framework for the excessive proliferation of psychotherapies (Prochaska and DiClemente 1984), the vast majority of the preliminary research using the model focused on tobacco addiction, alcohol depen-dence, and a host of cancer prevention-related behaviors (DiClemente 1993*a*; Prochaska and DiClemente 1992; Prochaska et al. 1992). Only recently has the model been used with illegal drugs of abuse (Abellanas and McLellan 1993; Shaffer 1992; Washton 1989). However, the authors' group of researchers believes that this model contains some critical dimensions of the process of change needed to understand how individuals successfully change various behaviors (Prochaska and DiClemente 1992). This model will be used to describe important aspects of the process of change.

The Stages of Change

The stages of change represent the temporal, motivational, and developmental aspects of the process of change. In terms of recovery from drug or alcohol dependence, the process would begin with the pre-contemplation stage in which individuals are too unwilling, unable, or unknowing to acknowledge drug or alcohol consumption as a problem or to seriously consider changing their behavior. Once individuals begin to consider their addictive behavior to be problematic and to realize that change may be needed, they enter the contemplation stage. Here they consider the pros and cons of the behavior and may decide that there is no problem; that there is a problem but they cannot or will not take action; or that there is a problem and they need to do something.

The decision to take action and a proximal intention to implement that decision moves an individual into the preparation stage. Here the focus is on increasing commitment and making a plan to modify the drug or drinking behavior. Sometimes that plan is made with the realization that cessation or abstinence is the goal. At other times the individual will simply plan to moderate the behavior. In either case, the implementation of the plan initiates the action stage of the process of change.

As everyone who has been involved with addictive behavior treatment knows, entering action does not guarantee long-term success. In fact, the transtheoretical model describes the action stage as continuing for 3 to 6 months. This amount of time is needed to begin to establish either sobriety and abstinence from drugs and alcohol or successfully moderated behavior if the latter is possible. However, real recovery can only be measured by long-term success that lasts for years rather than months and represents the maintenance stage of change.

The path of recovery requires movement from precontemplation through contemplation and preparation in order for an individual to take effective action and arrive at maintained abstinence from alcohol and drugs or maintained nonproblematic drinking. For most individuals the path is not straight and narrow but circular in nature. Relapse and recycling through the stages constitute the rule rather than the exception (Brownell et al. 1986; Prochaska and DiClemente 1992). Relapse experiences contribute information and feedback that can facilitate or hinder subsequent progres-sion through the stages of change. Individuals may learn that certain goals are unrealistic, certain strategies are ineffective, or certain environ-ments are not

conducive to successful change. Most individuals will require several revolutions through the stages of change to achieve successful recovery from any type of addictive behavior.

The stages can be related to the constructs of readiness or resistance to change that are often used in treatment. The concept of denial is ubiqui-tous in the literature. It is often assumed that once alcohol dependence (physiological) is established, denial of the problem and resistance to change are automatic. However, the stages offer a sequential path that begins with the lack of acknowledgment that the behavior is problematic or that change is needed (precontemplation) but moves through several stages before expecting significant action. Denial thus becomes part of the process of change.

The stages of change model also provides a perspective on what has been called spontaneous recovery in the treatment literature (Tuchfeld 1981). The process of recovery is a cyclical one in which individuals often make several attempts on their own to modify or cease their alcohol consump-tion or other problem behavior before requesting any formal treatment. Thus, clients who present for treatment can best be considered self-change failures. If there are failures, it should not be surprising that there are also successes (i.e., individuals who recover from abuse or dependence with minimal or no formal assistance). Therefore, it is important to understand not only the current stage of change for an individual but also to under-stand how often this individual has been through the cycle, either alone or with earlier treatment, to more accurately address his or her needs.

Processes of Change

The importance of the stages of change from a treatment perspective lies in the fact that strategies and activities to promote change differ signifi-cantly across the stages. Individuals in different stages utilize different, specific processes of change (DiClemente et al. 1991; Prochaska and DiClemente 1985), and process activities vary systematically with stage status. Certain types of activities peak in frequency at different points in the cycle of change (Prochaska et al. 1991).

Most theories of therapy or recovery identify one or two critical processes. For example, acknowledging powerlessness, social support, skills development, behavioral self-control, contingency management, and motivational strategies have all been mentioned as the critical components of successful recovery from alcohol

dependence. The transtheoretical model, because of its eclectic perspective, has identified 10 or more specific processes that can be utilized at one or more stages in a change process (see table 1). These processes represent cognitive, affective, behavioral, and environmental activities that appear to account for the principles of change proposed by the major systems of therapy, and that seem to cluster into two larger second-order factors. One repre-sents a cognitive-experiential component and the other a behavioral-environmental component, and the processes have been identified in studies examining smoking cessation, exercise adoption, weight loss, alcohol abstinence, and general psychotherapeutic problems (Prochaska and DiClemente 1992).

The interaction of the stages and processes is one of the most intriguing aspects of the transtheoretical model (DiClemente et al. 1991; Prochaska and DiClemente 1984). Different processes peak in frequency of use at different points in the cycle of change. Cognitive-experiential processes are generally most used in the early stages of contemplation and prepara-tion, while behavioral processes are most employed in the action and maintenance stages (Prochaska et al. 1991). However, the cycle is not as simple as it may sound at first. Higher use of certain processes at some stages actually predicts relapse (DiClemente and Prochaska 1985).

Processes can be used to control or modify smoking behavior rather than to stop smoking behavior (Rossi et al. 1988). One recently completed study demonstrated that shifts in process activity representing use of the right processes at the right time actually predicted smoking abstinence (Perz et al. 1992). Thus, differential process activity needs to be carefully orchestrated across the stages to produce successful and lasting change.

Levels of Change

Whenever one speaks of recovery from alcohol or drug dependence, the focus is on a single target behavior—alcohol or drug consumption. In a laboratory or an ideal world, the best strategy would be to isolate this one problem and focus on getting the individual to utilize the processes necessary to successfully negotiate the stages of change and reach stable maintained change or recovery. In the real world of drinking and drugs it is quite impossible to hold constant all the problems that can cooccur. Because isolation is impossible, it is important to identify problems in various areas of the individual's functioning in order to develop a realistic change or treatment plan (DiClemente and Gordon 1983). In the

TABLE 1. *Processes of change: Definitions and representative interventions identified in the transtheoretical model.*

Process	Definitions	Interventions
Consciousness raising	Increasing information about the problem	Observations, confrontation interpretations, bibliotherapy
Self-reevaluation	Assessing how one feels and thinks about oneself with respect to problem behaviors	Value clarification, imagery, corrective emotional experiences, challenging beliefs and expectations
Self-liberation	Choosing and committing to act or believing in ability to change	Decisionmaking therapy, New Year's resolutions, logotherapy techniques, commitment-enhancing techniques
Counter conditioning	Substituting alternatives for anxiety related to addictive behaviors	Relaxation, desensitization, assertion, positive self-statements
Stimulus control	Avoiding or countering stimuli that elicit problem behaviors	Restructuring one's environment (e.g., removing alcohol or fattening foods), avoiding high-risk cues, fading techniques
Reinforcement management	Rewarding oneself or being rewarded by others for making changes	Contingency contracts, overt and covert reinforcement, self-reward
Helping relationships	Being open and trusting about problems with people who care	Therapeutic alliance, social support, self-help groups
Emotional arousal and dramatic relief	Experiencing and expressing feelings about one's problems and solutions	Psychodrama, grieving losses, role playing
Environmental reevaluation	Assessing how one's problems affect the personal and physical environment	Empathy training, documentaries
Social liberation	Increasing alternatives for nonproblem behaviors available in society	Advocating for rights of the repressed, empowering, policy interventions

transtheoretical framework, this issue is addressed by the identification of five levels of change (Prochaska and DiClemente 1984).

Levels of change represent areas of functioning in which an individual may be experiencing significant problems or conflicts (Prochaska and DiClemente 1984), and the levels help to identify how many and how serious the associated problems are for this individual. The levels and some examples of associated conflicts or problems appear in table 2. The symptomatic/situational level is the most obvious one. Here, alcohol or drug consumption is usually viewed as a behavioral problem as well as a symptom of the alcohol or drug dependence syndrome. But anxiety, depression, psychotic delusions, and delirium tremens are all symptoms that can appear at this level, as can homelessness and other situational problems. There can be multiple problems at each level as well as multiple problems at multiple levels.

TABLE 2. *Levels of change involved in initiation and cessation of addictive behaviors.*

Level of change	Areas of functioning
I. Symptomatic/situational	Substance use pattern
	Micro- and macroenviromnemtal factors
II. Maladaptive	Expectancies
	Beliefs
	Self-evaluation
III. Interpersonal conflicts	Dyadic interaction
	Hostility
	Assertiveness
IV. Family and systems conflicts	Family of orgin
	Legal
	Social network
	Employment
V. Interpe	Self-esteem

rsonal conflicts	
	Self-concept
	Antisocial personality

Maladaptive cognitions represent problems in beliefs or self-statements that may interfere with recovery. Interpersonal conflicts are another level that may or may not be related to the targeted drug or alcohol problem. For many alcohol- or drug-dependent individuals, relationships with spouse or significant other is quite problematic and can contribute to recovery or to continued drinking or drugging.

Families, employment, and social systems are yet other areas in which conflicts can and often do occur. The family and systems level offers a framework for identifying such problems. Finally, the intrapersonal conflicts level offers a view of deep-seated, characterological areas such as narcissism or self-hatred that may be related to recovery.

The levels of change offer a framework for identifying significant problem areas. However, this is not an exercise in discovering pathology or etiology. In terms of the process of change, problems are to be identified that can interfere with an individual's being able to move through the stages of change and achieve the maintenance stage of recovery. Thus, while it may be an interesting exercise to see how many problems can be generated for one individual, the only relevant ones are those that will interfere with change and successful recovery.

IMPORTANT INTERACTIONS BETWEEN THE STAGES OF CHANGE AND THE COMPLIANCE AND INVOLVEMENT OF CLIENTS IN TREATMENT

This section offers several clear implications of viewing the process of change as distinct and interactive with retention, compliance, and participation. Figure 3 illustrates the possible interactions between treatment participation (compliance and involvement) with readiness and movement through the stages of change. Individuals in the far upper right-hand quadrant represent treatment successes. Those in the lower right-hand corner are successful changers who did not participate in or comply with treatment. High compliers with treatment who do not change the problem behavior fit in in the upper left-hand quadrant of the figure. The figure offers a template with which to view these implica-tions. At the end of each implication, strategies to address these concerns in the service of increasing retention, compliance, and participation are described.

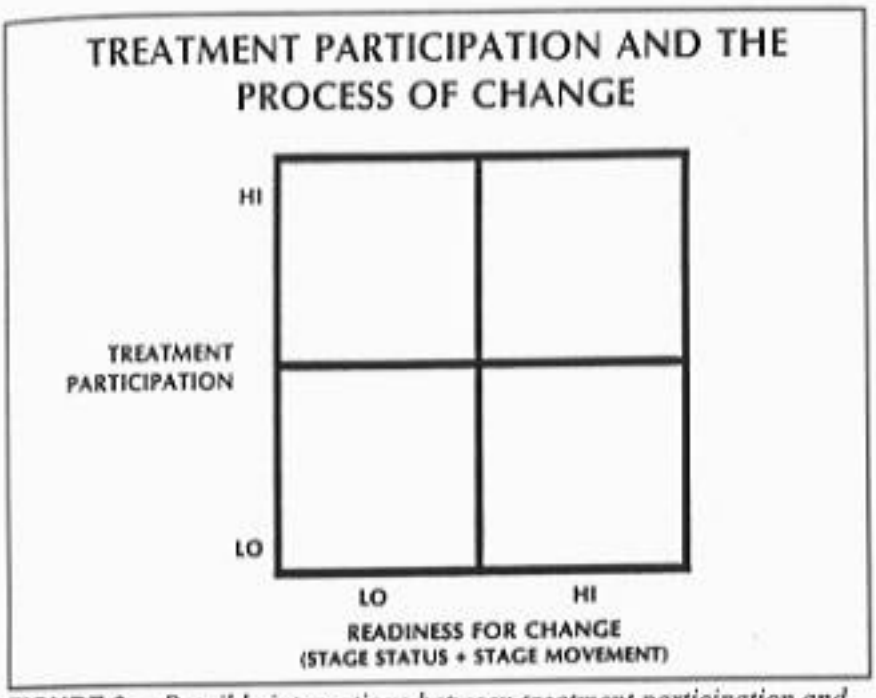

FIGURE 3. *Possible interactions between treatment participation and the process of change.*

Lack of Readiness for Change

Individuals coming to substance abuse treatment are often in early preaction stages of change. Concepts such as denial and hitting bottom, as well as the dramatic dropout rates in most substance abuse treatment programs (particularly outpatient ones) support this contention (Agosti et al. 1991; DeLeon 1984; Emrick et al. 1993; Rees 1985; Simpson and Joe 1993; Wickizer et al. 1994). Lack of engagement and very early dropout from treatment are most probably related to the early-stage status of the clients in the process of change (Miller 1985). As a consequence, strategies and approaches must address the lack of motivation for change, ambivalence about change, lack of a clear problem focus, and the decisionmaking tasks and cognitive experiential processes that characterize the tasks and challenges of these early stages (DiClemente and Prochaska 1985; Miller and Rollnick 1991; Prochaska and DiClemente 1984; Prochaska et al. 1994*a,* 1994*b*).

Suggested Strategies

1. Responding quickly to requests for treatment can maximize whatever motivation is present at the initial request.

2. It is important to focus on client's immediate concerns, not those of the program. Such immediate concerns of the drug-abusing client are the entree to whatever possibilities there are for change.

3. Decisional considerations about the problem and about the prospective change must be assessed. Clients must begin to see change as in their best interest before they can move from early stages toward action.

4. An objective, caring, and respectful approach is essential: Clients can pick up disrespect even if they are intoxicated, and confrontation often results in denial (Miller and Sovereign 1989; Patterson and Forgatch 1985).

5. Objective feedback about the problem and the process of change can help clients, many of whom can become uneasy when the therapist is more invested in their change than they are. Lack of objective and accurate feedback makes the treatment provider unbelievable and not worthy of trust (Miller et al. 1992).

6. Motivational strategies that focus on the individual and his or her immediate environment can be effective (Miller and Rollnick 1991).

Matching Treatment and Stage

Stage-based matching of interventions offers a dynamic, process-oriented approach for developing appropriate treatment expectations and shared mutual goals on the part of therapist and client. Choosing interventions based on stage of change with regard to a specific problem can create a focused working relationship and promote the use of strategies that reflect the client's most immediate tasks in moving toward successful change. Treatment matching that is typically viewed as the connection of stable characteristics of the client with those of the intervention must be replaced with a dynamic matching perspective. Because the client is involved in an ongoing process of change, the intervention should mirror the process.

Suggested Strategies

1. The therapist should identify the stage of change of the client and gather other related information (processes of change, decisional balance, and self-efficacy considerations). Such information can help in developing an indepth understanding of the client that will be helpful in changing the substance-abuse problem or problems.

2. There must be stage-specific feedback systems to guide the client and/or therapist. Feedback systems can simply reflect current level of problems and solutions or provide more intensive normative and ipsative comparisons during the course of treatment (Velicer et al. 1993).

3. The therapist should develop or use approaches and information specific to each stage (DiClemente 1991).

Relapse and Recycling

Individuals move through the stages of change in a cyclical pattern over a long period of time. Relapse and recycling are an integral part of the process of change. Although any single treatment may not create maintained, successful abstinence or modification of the problem, the goal of each treatment should be to promote and accelerate movement through the stages and contribute to the overall process of change in a positive and constructive manner.

Suggested Strategies

1. The client's recent and past course of movement through the stages of change should be evaluated.

2. The therapist should adjust approaches for different earlier patterns of stage movement and change experiences (DiClemente et al. 1992).

3. To the extent possible, treatment should be individualized.

4. Treatment goals should be realistic: A three-session evaluation program for precontemplators may be very realistic; a 3-month program may be more appropriate for someone in preparation or action. The ideal is sequencing and shifting treatment goals as the client progresses through the process of change.

5. The therapist should keep in mind that much of the movement through the stages occurs outside the context of the treatment sessions. Often treatment only provides assistance through certain stages of change.

6. It is important to be aware of stage heterogeneity in the group treatment process. Individuals in different stages can often either facilitate or hinder each others' progress through positive and negative modeling as well as by focusing on appropriate or inappropriate issues (Prochaska et al. 1994*a*).

Different Stages for Diverse Problems

Individuals can be at different stages of change with different substances and problem areas. Programs that assume that the client's motivation parallels the specific stated goals of the treatment program are unrealistic. Different stages of dealing with multiple problems pose a significant and serious obstacle for treatment. Treatment personnel can get stuck arguing about problem areas where the client is less motivated and lose track of the ones where the client is most committed and ready for change (DiClemente et al. 1992).

Suggested Strategies

1. The therapist should be aware of varying levels of motivation in different problem areas.

2. Treatment goals should be chosen carefully and take advantage of current motivations for change and the leverage for achieving it provided by the different problems.

3. For clients with multiple problems, multiple diverse strategies are needed to address varying levels of motivation (Prochaska and DiClemente 1984).

4. The challenge should be to help individuals do the right thing at the right time in dealing with each of the problems or problem areas.

Shifting Strategies for Stage Progression

A good, generic therapy relationship can help or hinder the process of change. The treatment relationship as well as the treatment strategies should shift as clients progress through the stages. A warm, caring, totally accepting relationship can be interpreted by the client as supporting

problematic behavior. A confrontational relationship can create denial and resistance.

Suggested Strategies

1. The focus should be on the client's responsibility for change (Miller et al. 1992).

2. Realistic self-assessment should be supported.

3. Relational strategies can be shifted as clients move through the stages of change (Norcross 1993).

These suggested strategies are simply possible approaches that could improve retention and participation in treatment. Some offer common sense strategies that are intuitively obvious, some are supported by previous research on factors related to attrition and dropout, and others have solid research findings supporting a particular suggestion. All of the suggestions, however, are based on the interaction of the stages of change with the process of engaging and keeping a client in treatment and fostering participation based on the process of change.

SUMMARY AND CONCLUSIONS

Current perspectives on compliance and involvement in treatment often overlook the fact that treatment occurs in the context of a process of change and not vice versa. Each individual moves at a unique pace through a series of stages of change and in a cyclical fashion over a substantial period of time. Treatment personnel and programs should recognize the diversity of stage status in their clients and address each one in a manner compatible with the client’s current stage of change, the tasks needed to move forward in the process of change, and an under-standing of the course of change. Such considerations should assist the therapist in developing strategies to increase the engagement of a wide variety of clients, to improve retention of these clients in a realistic course of treatment, and to foster participation in stage-appropriate tasks that promote successful movement through the stages to sustained, long-term change.

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