Further evidence for dissociation comes from experiments indicating a so-called "hidden observer." For example, the hypnotist instructs a subject that he or she is deaf and then says, "Although you are deaf, perhaps part of you can hear. If so, raise your finger." The finger rises. When asked later, the subject says he heard nothing but suddenly felt his finger rise. The experiment suggests that two distinct systems of consciousness are operating, separated by a partial or total barrier of amnesia.

A different understanding is reflected in the social-cognitive theory of hypnosis, which emphasizes suggestibility rather than dissociation. Social-cognitive theorists interpret the hypnotic trance not as an altered state of consciousness but as one striking effect of the human susceptibility to social influence. Their idea is that the hypnotist and the subject have entered into an implicit agreement that certain things will be allowed to happen and the subject will describe or confirm certain experiences. The subject responds to these "demand characteristics" of the situation, doing and saying what is expected to win the hypnotist's approval. The hypnotic trance is a performance — not mere playacting but the sincere adoption of a role. If this view is correct, hypnotic suggestibility is a result of willingness to comply with suggestions, sensitivity to nuances in personal communication, and a high capacity for sincere make-believe and self-dramatization.

Social-cognitive theorists say that they can increase or decrease a person's apparent hypnotic suggestibility simply by changing the instructions and therefore the subject's expectations. For evidence, they rely heavily on experiments with people who, according to standard tests, are not easily hypnotized. When these simulators pretend to be hypnotized and act accordingly, they are said to respond just like a person in a "genuine" trance. Social-cognitive theorists add that the hidden observer of dissociation theory is not real but a product of suggestion that can also be manipulated by changes in the instructions. Apparent individual differences in hypnotic suggestibility are explained by differences in suggestibility and in the expectations brought to the situation.

In response, advocates of the dissociation theory argue that people who are pretending to be hypnotized respond to suggestions only when they are being observed, unlike people who are truly hypnotized. Also, some people who are told to pretend may actually go into a trance, and susceptibility to social influence may itself sometimes be a hypnotic effect. Some believe the dispute between the theories cannot be resolved, because in the end there is no difference between entering a special state of consciousness and immersed oneself in a performance so deeply that it is no longer experienced as playacting. In either case there are likely to be signs of imaginative absorption, divided attention, and selective recall.

(To be continued …)

Using the Stages of Change

BY JOHN C. NORCROSS, PH.D. AND JAMES O. PROCHASKA, PH.D.

People suffering from mental disorders and behavioral disturbances differ greatly in their readiness to take action to solve their problems. At any given time, about 40% don’t know they have a problem or resist acknowledging the fact. Another 40% are aware of the problem but are not yet ready to act. Only 20% are currently taking action. We have devoted 20 years to investigating the stages of change in people with a variety of mental disorders and behavior problems. We believe that by identifying these stages, mental health professionals can improve their understanding of how therapeutic change comes about, make treatment more effective, and reach millions of people who are not getting the help they need.

The stages

Precontemplation. People at this stage have no serious intention of changing their behavior now or in the foreseeable future. (Some may express a vague wish to change, which is different.) They are generally unaware of their problem or greatly underestimate it. Family members, friends, neighbors, or employers may have a clearer view. When people seek treatment at this stage, it is often under pressure from others.

To decide whether a person is at this stage, we ask whether he or she seriously intends to deal with the problem in the next six months. We also provide a questionnaire asking for agreement or disagreement with such statements as “I guess I have faults, but there’s nothing that I really need to change” and “As far as I’m concerned, I don’t have any problems that need changing.”

Contemplation. At this stage people are aware that a problem exists and have been seriously thinking about overcoming it but have not yet made a commitment to action. They say they are seriously considering change in the next six months. Answering the questionnaire, they agree with such statements as “I have a problem and I really think I should work on it” and “I’ve been thinking that I might want to change something about myself.” Despite good intentions, it is common to languish at this stage for a long time.
Preparation. At this stage, people have already tried to change, so far without success — for example, they have tried to quit smoking or have told someone about symptoms of depression. A person at this stage is still thinking about change and intends to take action in the next month.

Action. This is the stage at which major change occurs, and it requires a considerable commitment of time and energy. People who reach the action stage have successfully changed their behavior or environment for a period lasting from one day to six months. Answering questionnaires, they express agreement with statements like the following: “I am really working hard to change,” and “Anyone can talk about changing; I am actually doing something about it.”

Maintenance. At this stage, the aim is to consolidate gains and avoid relapse. The standard of success is remaining free of the problem behavior, finding some effective substitute for it, or both, for more than six months. Answering our questionnaire, people seeking help at the maintenance stage agree that “I may need a boost right now to help me maintain the change I’ve already made” and “I’m here to prevent myself from having a relapse of my problem.”

Movement along the stages
Most people acting on their own do not successfully negotiate all the stages on their first attempt. Smokers, for example, make an average of three or four attempts before they quit permanently. People often try dozens of times before they succeed in maintaining weight loss. Most patients in treatment have come to the sobering realization that slipping back into depression or anxiety is the rule rather than the exception.

During a relapse, people regress to an earlier stage, and that may make them feel like failures — embarrassed, ashamed, and guilty. They may become demoralized, resist thinking about change, and return to the precontemplation stage. Fortunately, our research indicates that the vast majority — 80% or more — eventually move back to contemplation or preparation. They begin to consider plans for their next action while trying to learn from mistakes and failures. The pattern is a spiral rather than a circle; they do not regress all the way, and as they repeat the stages, they manage the process differently the next time around.

Treatment implications
One lesson is the need to set realistic goals allowing movement to proceed one stage at a time. People who advance one stage during the first month of treatment can double their chance of taking action in the following six months. It is realistic to expect them to progress from precontemplation to contemplation or from contemplation to preparation during that month.

Therapists should also anticipate recycling — the spiral of change. They should let patients understand that some degree of initial failure is nearly universal, help them learn how to avoid relapses, and provide booster sessions to maintain improvement.

Above all, therapists should match the treatment to the stage of change. It is especially important not to treat all patients as though they are in the action stage. The vast majority, when they first see a professional, are not at this stage, and offering only action-oriented programs will serve them poorly. Professionals often provide excellent action-oriented treatments and are disappointed when most clients drop out.

Research has shown which methods are effective at various stages. A recent meta-analysis of 47 studies confirms that experiential and psycho-dynamic methods are most useful at the precontemplation and contemplation stages. The methods associated with cognitive and behavioral therapies are best suited to the stages of action and maintenance. The stage of change also determines the requirements for a therapeutic relationship. Precontemplators, for example, respond best to therapists and family members who gently and persistently provide general support and instruction, like a nurturing parent. At the action stage, people usually respond best to the kind of enthusiastic support and specific advice supplied by a coach.

Therapists should be especially careful to avoid two kinds of mismatch between stages of change and therapeutic methods. Some therapists (and people who undertake change on their own) move into action while relying chiefly on methods more appropriate for the contemplation stage — raising awareness and emotional work. It is a common criticism of classical psychoanalysis — insight alone does not necessarily bring change. Others make the opposite mistake of trying to use behavioral techniques such as skills training and rewards before the contemplation and preparation stages have been traversed. It is a common criticism of purely behavioral treatments — change resulting from action without insight is likely to be temporary.

A person’s stage of change predicts the likelihood that he or she will drop out of treatment. We have found that we can predict dropping out of psychotherapy with 90% accuracy among clients with a variety of mental health problems. Patients who leave soon (after fewer than three sessions) and prematurely (as judged by their therapists) are generally in the precontemplation stage. Patients who terminate therapy early but appropriately (as judged by their therapists) are generally in the contemplation stage. Among those who continue in therapy, the majority are at the contemplation stage.

The stage of change at the beginning of treatment predicts progress in therapy. For example, in an intensive action-oriented smoking cessation program for cardiac patients, 22% of
Many suffer because of the lack of resources for outreach.

In a test of outreach, we offered therapy to a representative sample of 5,000 smokers, letting them know that services would be available for every stage of change. By adapting our appeal to the stage of change, we persuaded 80% of the smokers to participate. Our results were similar in another study involving 4,000 smokers in an HMO and a third study involving 4,000 teenagers with behavior problems and their parents. These successes suggest that it may be possible to produce an enormous impact on mental health by reaching out to people with behavior problems and mental illnesses while keeping in mind the remarkable diversity in their readiness to change.

John C. Norcross, Ph.D., is Professor of Psychology at the University of Scranton and editor of In Session: Journal of Clinical Psychology.

James O. Prochaska, Ph.D., is Professor of Psychology and Director of the Cancer Prevention Center at the University of Rhode Island.

Drs. Prochaska and Norcross are authors of Changing for Good (Avon, 1995) and Systems of Psychotherapy: A Transtheoretical Analysis (Wadsworth, 2002).
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