

# health and behavior



By James Prochaska, PhD, Director, Cancer Prevention Research Center, Professor of Psychology, University of Rhode Island

**M**y life's work has been to help people change their behaviors on their own, without psychotherapy. This work began for me after I experienced terrible depression at being unable to help someone overcome the alcoholism that posed a severe threat to his health. Since he refused to seek professional help, it was his loved ones who faced the daunting task of trying to get him to change his behavior. Unfortunately, nothing worked.

That man was my father. He died when I was a junior in college.

After his death, I began to study psychology in an effort to understand what had happened to him and why he so stubbornly refused help, even though he knew the consequences of his refusal. As time went on, I tirelessly sought a method to help people like my father. I learned in my studies that while there were countless ways to treat troubling behavioral issues, no single approach was adequate for them all. Finding a way to integrate different approaches into a new whole would be my first task.

Once out of school and practicing clinical psychology, I sought a way to bring together the profound insights of psychoanalysis, the techniques of behaviorism and the empathetic relationships of humanism. By combining these with the more common components of major therapies, I thought, I might find a way to treat unhealthy behaviors across the board with a new, integrated approach.

In 1978 my colleague and I devised a model for change that we felt addressed all those issues. Our model — the Transtheoretical Model of Behavioral Change — explores the stages leading to positive change that is maintained over time. It provoked a small revolution in the field, because before our initiative, almost all treatment programs were “action-based,” meaning that behavior change was simply a matter of deciding to take action and then moving on that action. For example, someone might say, “I’m going to lose weight.” After a period of time, the individual either succeeds or is unable to sustain his or her good intentions. In my experience, most people fall into the latter category.



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Through our research, we determined that efforts to change lifestyles achieve greater impact if change is understood as an ongoing process with manageable stages. That understanding led us to develop a multi-stage process that has been applied to all major health risk behaviors, including smoking, alcohol and substance abuse, high-risk sexual behavior, unhealthy diets and sedentary lifestyles, and has dealt with teens, adults and noncompliant patients.

The Transtheoretical Model of Behavioral Change is comprised of six stages: pre-contemplation, contemplation, preparation, action, maintenance and termination. The *pre-contemplation* stage is directed at individuals who are not planning to take action for at least the next six months. That doesn't mean they don't want to change, it means that they know it will take a while to make a firm commitment. These people tend to underestimate how their current behavior affects their health negatively and how much change would benefit them.

Once they progress into *contemplation*, the second stage, they have stated their intention to take action within six months. These individuals appreciate the benefits of change, but they understand that there will be some associated negative aspects. For example, if I intend to lose weight in the next six months, I know I've got to give up some of my favorite foods. I'll have to get through times of deprivation and risk failure, but I'm intending to do it anyway.

In the *preparation* stage, the individual intends to take behavior-changing action within the next month, and he or she has a plan. It may be to talk to a physician, to go to a class or clinic, or to send for self-help materials. These individuals have not started to change their behavior, but are working out the details. It is important in this stage to prepare the patient for a difficult road ahead, and to emphasize the dedication required to get through this predictably difficult time.

*Action* is the stage at which people actually decide that the time has come to change their behavior. At this point, all of the preceding work we've done with them, especially in stage three, has conditioned them so they have a better chance of reaching the desired endpoint. After about six months of successfully working on behavioral change, the patient progresses into the *maintenance* stage. In this stage, they don't have to work as hard, but they must continue working to keep from relapsing. At this stage we highlight

and prepare them for the most common causes of relapse — times of stress, depression, anxiety, boredom, loneliness and anger. Since it is imperative to have a plan to cope with such distress, we suggest three coping strategies that can be quite effective: talking with others about the concern, exercising and learning relaxation methods.

*Termination* is what we consider the ideal goal, but evidence indicates that not everybody reaches it. Some people must be prepared for a lifetime of maintenance. Those who do reach the sixth and final stage, despite emotional reversals or any other obstacles, have zero temptation to return to their unhealthy behavior. In this stage they are completely rid of the problem, and it is as if they never had the problem in the first place.

After years of seeing this model used in a wealth of different settings and programs, I soon realized it was gaining momentum in public health practice. Public health professionals can modify our model and other



models of care in any way that works for them. After all, by effecting change early in populations, it is possible to prevent poor health on a much broader scale. For example, our model was used statewide in a California public health campaign that targeted smokers in the pre-contemplation stage. The results of the campaign were excellent, because the public health professionals running the campaign had tailored it for their target population. The plan implementers didn't ask people in the pre-contemplation stage to set a quitting date in the next month. Instead, messages helped them appreciate the benefits of behavioral change, including the benefits to loved ones of not having to breathe second-hand smoke.

We have conducted stage-matching studies of nonsmoking campaigns that have been tried with various populations in primary care settings, MCOs, in high schools and in walk-in clinics. Smoking cessation clinics, where people just walk in off the street, have usually achieved a very low percentage of

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smoker participation, even when the program was offered for free. Our method typically achieves about 80 percent smoker participation.

One of the more rewarding aspects of developing a widely accepted method of practice is finding that your colleagues are teaching it to their students. That, at the very least, assures longevity to your work. Our model is currently being taught in advanced behavioral science and communications courses in schools of public health across the country, where students are using it for intervention research and theory and in fieldwork pertaining to health behavior interventions. A psychologist even uses it in a program aimed at helping doctoral students complete their dissertations.

Despite the sad circumstances that led to my entry into the field of psychology, my career has had a remarkably positive impact on my life. It has had a positive impact on many of my patients, and through others who apply my principles, it has led to a broadening of public health models. To know that an idea you conceived and implemented has affected people's behavior in a way that helps them live healthier and perhaps longer lives is extremely satisfying — and to see your life's work implemented all over world, and with such great success, is truly an honor.

*James O. Prochaska, PhD, is Director of the Cancer Prevention Research Center and Professor of Psychology at the University of Rhode Island. He received his doctorate in Clinical Psychology from Wayne State University. He has served as a consultant to the American Cancer Society, the Centers for Disease Control and Prevention, managed care organizations, the National Health Service of Great Britain, major corporations and numerous universities and research centers. Dr. Prochaska has won many awards, including the Top Five Most Cited Authors in Psychology from the American Psychology Society and an Honorary Chairmanship of Medicine from the University of Birmingham, England.*