One of the greatest challenges in medicine is motivating the reluctant patient. Most patients with substance-use problems cannot, or will not, acknowledge the adverse role tobacco, alcohol and other drugs play in their lives. The 20th Report of the US Surgeon General, “Nicotine Addiction,” concludes that “nicotine and therefore tobacco products are addictive.” The report further concludes that the processes that determine tobacco addiction are similar to those that determine addiction to other drugs such as heroin and cocaine.

Through such understanding, osteopathic physicians may be better able to assist tobacco users in quitting. As a consequence, practitioners of addiction medicine recognize the three fundamental R’s: Recognition, retention and recurrence to treat chemical dependencies.

The first R involves efforts to motivate patients to recognize the potentially damaging effects of substance use.

The second R aims to retain patients in treatment, while the third R involves activities designed to prevent a recurrence or relapse. The three R’s collectively form a theoretical framework for what is more formally known as the five stages of change.

The five stages of change (see Figure 1) are a guide physicians can use to identify the level patients are at and motivate them as effectively as possible. The Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment outline the five stages of change in detail through a Treatment Improvement Protocol, “Enhancing Motivation for Change in Substance Abuse Treatment.”

The five stages of change are a framework physicians can use to help better manage a patient’s behavioral environment. Specific strategies aligned with each of the five stages help clinicians motivate and prepare patients for change. The five stages of change represent a cycle. Within this cycle, patients can progress or regress. The strategies for each stage build on the three Rs of recognition, retention and recurrence with the last stage of change representing the optimum goal. Change begins with “precontemplation,” progresses to “contemplation,” then to “preparation,” followed by “action” and culminating in the “maintenance” of healthy behavior.

Precontemplation stage
Static behavior can often be found at the precontemplation stage. At this stage, patients do not see or express any interest in the need for change. Many individuals with substance-use problems, including tobacco use, are firmly entrenched in this stage.

Contemplation stage
The first evidence of dynamic behavior is often first seen during the contem-
plation stage. At this stage, individuals express a tentative belief in the possibility that the substances they use might be harmful.

The hallmark of this stage is ambivalence and skepticism. Skepticism is not the same as denial but instead allows some degree of personal reflection. Patients will be receptive to new information or they are likely to be reassured that current behavior is acceptable in the absence of information.

Physicians have a crucial role to play by influencing the “see-sawing” ambivalence characteristic of contemplation in a direction favoring change.

**Preparation stage**

When physicians tip the balance in favor of patients acknowledging a healthy choice, the patients enter the preparation stage. Preparation is a thoughtful stage of reflection focused on making plans. It may also entail some token efforts to curb substance use.

**Action stage**

In the action stage, patients fully recognize a problem, and they take observable steps to reduce substance use. Once again, physicians have an important part to play. Patients are quite receptive to change at this point and would readily accept specific guidance.

**Maintenance stage**

Maintenance is the final and most mature stage of change. During the maintenance stage, physicians’ motivational efforts are directed toward promoting hard-won gains and preventing recurrence. For relapse-prevention efforts to be sustained, patients must understand which environmental and biobehavioral triggers contribute to recurrence.

The stages of change are a cycle in which both forward and backward movement can occur. For example, if patients encounter a particularly persuasive environmental or biobehavioral stimulus, they may resume substance use. Instead of considering this “falling off the wagon” a failure, the philosophy inherent in this stage of change helps explain the behavior as a movement backward. The same strategies previously effective in promoting forward movement will probably prove useful again.

**Motivating patients**

The physician’s ultimate goal in healthcare is either preventive or restorative in nature. Motivation is the key element that can make or break a patient’s success. Physician suggestions for each stage of change, beginning with general strategies and then moving to a specific example involving tobacco, will help heighten the physician’s role in the process.

When it comes to accepting any change, most individuals comfortably remain in the precontemplation stage. With this in mind, first efforts by physicians must naturally center on building a good relationship with patients. Trust rarely motivates people.

Once physicians have assessed the presence of a basic rapport, the foundation is laid to gently question patients’ harmful behaviors. This can take the form of a matter-of-fact disclosure of risks associated with the behavior, the use of self-assessment surveys, and statistics or epidemiology related to the behavior. Physicians can also periodically readdress the issue in subsequent visits.

Although patients do not necessarily proceed in a linear, step-by-step way through the stages of change, for the sake of this discussion we will be presenting it that way. With that in mind, should physicians successfully coax patients through the stages of change, the next phase would be contemplation.

As a result of the strategies physicians implemented in the precontemplation stage, patients now doubt their target behavior. The physician’s strategy now is directed toward tipping ambivalence toward a healthy choice. One way to facilitate the process is to join with the patients in evaluating the pros and cons their behaviors. Throughout this process, physicians should emphasize the patient’s primary role in making the decision.

Once again, physicians’ efforts are successful in motivating the patient.
The patient is now committed to change but uncertain of the best steps. At this juncture, physicians can excel as educators. They can provide the meat and potatoes in discussing the menu of treatment choices. This can be an opportune moment to suggest a behavioral contract specifying treatment elements such as the start date.

Support and encouragement

The physician is pleased that a previously reluctant patient is now actively engaged in treatment. During the action phase, the physician provides vital support and encouragement. For example, the patient needs to understand that long-held target behaviors do not remit instantly but gradually with persistent treatment.

The action phase is also the time to begin identifying environmental and biobehavioral triggers that complicate abstinence. Because the target behavior, which probably occupied a central point in patients’ lives, is now diminishing, physicians should explore healthy replacement behaviors.

When patients successfully complete a course of treatment and begin maintaining healthy lifestyle changes, physicians can encourage their lifestyle change through supportive comments. They can also work with patients to reduce relapse triggers and have coping strategies in place should the patients suffer a recurrence.

Relapses should be viewed as an opportunity for patients to understand triggers to smoke and potentially reassert control. Physicians can help the process through a nonjudgmental discussion exploring factors contributing to the recurrence and how to cope more successfully with urges to smoke.

Patient profile

Motivational strategies can be used to help tobacco-dependent patients support other behavioral changes like weight loss, diabetes control and exercise.

For example, a patient with a several-year history of “spit,” or smokeless tobacco use walks into your office. The first encounter with this patient is punctuated by his repeated spitting into a brown stained bottle. Your first impulse may be to demand that the patient cease and desist but you decide otherwise because that action might destroy any hope of establishing goodwill. As the physical examination progresses, you gently raise doubts about conducting a thorough evaluation in light of the persistent spitting. No more is said of the matter.

You present the patient with the preliminary results of the diagnostic assessment at the next visit. The patient expresses concerns about some of the tests and wonders if his tobacco use might have influenced the results. The physician takes this as an opportunity to discuss the pros and cons of smokeless tobacco.

About a week later, you receive a phone call from the patient. He conveys his wife’s concerns about his tobacco use. During the phone call, the physician again weighs the advantages and disadvantages of tobacco and encourages the patient to learn more by consulting a Web site.

Three months later, the patient returns for another appointment and expresses what appears to be a genuine commitment to stopping tobacco. During the appointment he notes that his wife is avoiding physical contact with him; damage to a sofa when his handy bottle spilled, and their’s interest in rid-
ding himself of a “nasty habit.” You applaud his motivation to change, suggest several behavioral programs that help tobacco users quit, and mention medications that might be helpful. In addition, you negotiate with the patient a quit date two weeks in the future.

The patient enters the action phase two weeks later. He attends a five-day behavioral program supplemented with an online support program. And he agrees to a nicotine-replacement medication. To encouraging his efforts, you remind the patient to take “little steps” and expect steady but slow progress. You also spend some time briefly explaining relapse triggers.

After successfully completing the active treatment, the patient enters the maintenance phase. Your efforts must be directed toward maintaining the gains. This can be accomplished by positive comments supporting the lifestyle change. The patient recognizes that he is less of a “social pariah,” has more money, sleeps better and cleans his furniture less often.

As this scenario demonstrates, physicians have an important role in managing motivation. Physicians must understand where patients reside in the five stages of change. Once patients are assessed, strategies to motivate them must be tailored in such a way to advance the patients toward healthy choices.

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