

What's the Definition of Change?! It Depends on Who You Ask . . .

The idea of 'change' and how to 'influence change' is fundamental to human psychology and psychotherapy treatment. However, it is interesting to note that there is **no consensus** within the field regarding the definition of this most central and important topic. From Freud's early development of psychoanalysis until today's current methods of behavioral, cognitive, and psychodynamic approaches, we see that there is **no central model or theory** that provides a common understanding of exactly what 'change' means and entails.

The **confusion and disarray** around what 'change' means has had a disastrous effect on the field of psychology. To this day, it continues to **divide clinicians** in assessing the goals of treatment and what needs to be accomplished. The ongoing uncertainty of this single issue **prevents the field from truly advancing** as a unified profession and science. Unfortunately, this lack of consensus within the field has impacted our standing outside the field as well. Without a systematic definition of 'change', there is the ever present doubt and skepticism by the more 'science based' medical establishment as to the **impact and significance** of psychotherapy treatment.

Although the field of psychology and psychotherapy has never been successful in defining the seemingly **elusive concept** of 'change', it has none-the-less attempted to forge ahead. However, this has been the equivalent to '**placing the cart before the horse**'. As a result the field has developed an array of treatment models which seem to present 'strong face validity', but **only generate inconsistent outcomes**. These models include behavioral, cognitive, and psychodynamic methods. These models are inconsistent in that they seem helpful for the motivated client, but often have little effect on those who would most benefit by changing destructive patterns; - the guarded and treatment resistant client.

Without a clear understanding of 'change', providers often feel perturbed when treatment is not having its desired impact. To relieve this sense of frustration, it is not uncommon for the clinician to **blame the client** when progress does not occur. Clients' are often accused of being: **oppositional, resistant, stubborn, uncooperative, and unmotivated**, to name a few. In fact, the client is not to

blame. From the client's perspective, he is just trying to keep a personal **sense of equilibrium** and maintain his **celebrated sense of self**. Often he does this by maintaining his **status quo identity** with behavior that is comfortable and familiar – even if it appears chaotic and destructive to those on the outside. In reality, it is the clinician's responsibility to move and facilitate the client's progress. However, unless the clinician has a working knowledge of 'change' and the treatment tools needed to capitalize on this knowledge he will continue to feel stymied in his efforts. Without a conceptual understanding of 'change', treatment often becomes a failed attempt at **'trying to fit a square peg in a round hole'**.

False Conventional Wisdoms

To compound the problem, this lack of understanding has resulted in clinical misinformation that over the years has led to many **false 'conventional wisdoms'**. Due to the ongoing repetition of many of these 'conventional wisdoms', many of these assumptions have simply been accepted over the years, to the point where they are now **unquestioned as true**. Many clinicians will be surprised to learn that 'conventional wisdom's' that have become engrained in 'psychology folklore', are often **misleading and off the mark**. These false ideas include: that 'change is a long term process'; the client must willingly cooperate and participate in treatment; the client must want to change in order for progress to occur; along with others. While these 'conventional wisdoms' sound sensible on the surface, they have served to **deprive clinicians of a deeper appreciation and expectation** for what treatment can actually offer.

Separate Definitions

Currently, each of the major orientations (behavioral, cognitive, and psychodynamic) is **divided by separate definitions** of what 'change' means. While each method **promotes the focus of their particular brand**, they do not encompass the actual inclusive context of successful treatment. As a result, these orientations give the impression that they stand alone from each other, although it is **apparent that their intent and goals are the same**.

Regarding the various orientations, some clinicians have argued that the **differing methods 'strengthen treatment'** as it allows for diversity in addressing client issues. They argue that this offers the clinician an opportunity to pool various

resources and **'use what works'**. Unfortunately, while this may sound plausible, this is not what occurs in 'real life' treatment. Particularly for those that are not motivated (resistant) to 'change', the concurrent use of various approaches proves ineffectual as these clients intuitively play off their inconsistent foci, one against the other. As a result, and to the disappointment of the treatment providers, this allows the client to 'slip through the cracks' and **perpetuate his status quo behaviors and attitudes.**

Eclectic, Integrated, and 'Evidence Based' Approaches

To the credit of the field, there has been an ongoing attempt to **reconcile the disparity between methods** and find a way to merge the various orientations. Although attempts to formulate a single definition of 'change' have until now been unsuccessful, most clinicians intuitively recognize that the varying approaches are somehow unified at their core. In the field's search to effectively promote 'change' there has been an attempt to combine **'best practices'**. In recognizing the validity of such an effort, many clinicians have now come to define their approach as **'eclectic' or 'integrated' or 'evidence based'** in the hope that their treatment will provide the 'best of all worlds'.

However, even with the hope of combining 'best practices' the underlying problem in defining 'change' remains unresolved. While well meaning, the attempts to use 'eclectic', 'integrated', or 'evidenced based' approaches do not address the core issue and simply represent another level that **'repackages'** the conventional orientations. As a result, these combined approaches resemble more of a **'tossed salad'** in which the clinician's personal preference and orientation bias will still dictate his treatment emphasis. Therefore, we must recognize that the current focus on 'eclectic', 'integrated', and 'evidence based' approaches **can not and will not** bring the field closer to resolving the central issue of defining 'change'.

Purpose of this Website -

It is hoped that the above comments have indicated to the reader the real and imperative need is to provide a **comprehensive and scientific definition of 'change'**. In addition, it should be understood that such a definition should provide a **'conceptual umbrella'** that is equally relevant and inclusive for behavioral, cognitive, and psychodynamic orientations.

It is therefore the purpose of this website to clearly **define the process and effect of 'change'**. By offering an **in-depth and scientific definition** this work will identify the **'active ingredient'** behind all successful treatment. It is further our goal to educate the clinician as to the underlying mechanism of 'change' and to specifically identify what needs to be accomplished. In so doing, we will address the full spectrum of clients ranging from the 'most motivated' to the 'least motivated'. It is important to recognize that effective treatment is ultimately not about 'convincing', 'behavioral rewards', or 'offering insight', but rather is a matter of influencing the client's ability to make **'free will' choices that will have long term impact in shifting destructive patterns.**

A New Paradigm –

To resolve the stated issue of 'defining change', we offer a **fresh paradigm** that the reader might consider 'outside the box' as compared to theories previously studied.

In explaining the concept of 'change', this paradigm turns to the **core scientific theme** that is central to the **'hard sciences'**. This theme is significant to: astronomy, astrophysics, biology, chemistry, and quantum physics. The theory that dominates each of these sciences, and will now be shown to be relevant to psychology is based on **'orbits-gravity' phenomena.**

If we review this modern age of **exponential scientific growth**, it is clear that the common factor between the 'hard' sciences' is their unified acceptance of 'orbits-gravity' phenomena to support their respective theories. It is through this central theme that these sciences speak a 'common language' in which they can share insights regarding **systems in equilibrium, mass, energy, and energy shifts.**

It is the focus of this work to demonstrate that psychological concepts and treatment goals can be clearly expressed through concepts based on an orbits-gravity model. In so doing we assert that this represents a significant advance for the field of human psychology in that it indicates an overlap with accepted scientific phenomena. In essence it moves the field of psychology from being a **'fringe science'** to one that is central and interconnected to the farthest reaches of scientific understanding.

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