CHAPTER 24

TOWARD A GENERAL MODEL OF PERSONAL CHANGE

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Although we might agree that change is a condition of existence, we nevertheless appear to take for granted constancy and stability in our own nature. It is as if we recognize that the world changes around us, yet we cling to a view of ourselves as relatively unchanging. People generally hold low expectations for personal change in themselves and others and regard such change as difficult to achieve (Silver, 1989). Nevertheless, there are times in some people's lives when they confront dramatic personal change, whether imposed or freely sought. How do people change? What psychological processes underlie personal change? What, if any, are the common elements of deep-seated personal changes that may follow events as disparate as victimization and psychotherapy?

In this chapter we will attempt to address these questions, with the intent of developing a general understanding of personal change. First, we will discuss several parameters that are important for defining and limiting the phenomenon we refer to as personal change. We will then propose a heuristic model of the common process underlying personal change. We believe that common processes are likely to underlie personal change, whether it results from psychotherapy, consciousness-raising, victimization, brainwashing, or seemingly spontaneous religious conversion; the proposed model represents an attempt to delineate the common elements of diverse change phenomena. Finally, this model will be applied specifically to two domains that are often associated with personal change: the aftermath of extreme negative events and psychotherapy.

PARAMETERS OF PERSONAL CHANGE

People can and do change in many ways. We move from infancy to adolescence and adulthood. Along the way we presumably learn about ourselves and our world. A person may go from playing no instrument to becoming a violin virtuoso. An individual may become a great soccer player or mathematician, or may learn to be a wonderful teacher; these clearly involve personal changes. When people say that someone has changed, they
are essentially claiming that the person is different from the way he or she was (Silka, 1989). These examples illustrate instances involving perceptions of difference, yet they do not seem to capture the type of personal change we have chosen to address in this chapter.

We are committed to an understanding of personal change in terms of the basic assumptions people hold about themselves and their world; that is, people have changed to the extent that changes occur at the level of people's conceptual systems. All of us hold basic assumptions that enable us to make sense of our world and serve as guides for our behavior. Parkes (1971, 1975) is referring to this set of basic assumptions when he discusses his concept of "assumptive world." Epstein's (1973, 1979, 1980) "theory of reality," Bowlby's (1969) "world models," and Marris' (1975) "structures of meaning" all describe a basic conceptual system, developed over time, that provide us with expectations about ourselves and the world. Similarly, Snyder (1989; Snyder & Higgins, 1988) has developed the construct of a personal theory of self and discusses the process of "reality negotiation," which involves incorporating new information into one's self-theory. These assumptions—about the world and ourselves—provide us with a sense of order and predictability, and generally are unquestioned and unchallenged. Our fundamental assumptions generally serve us well, and we therefore take them for granted. Yet, it is change in our assumptive worlds that constitutes "real" personal change.

Certainly, change occurs in people's behaviors; individuals may alter their behaviors because of situational demands or volitional decision. We would argue, however, that personal change has occurred to the extent that this behavior change is represented in one's conceptual system. Changes in behavior may reflect changes in one's assumptions, and one would expect behavioral changes to follow changes in people's assumptive worlds. However, behavioral changes also may precede changes in people's conceptual systems, a phenomenon often reported by social psychologists (consider, for example, the large literature on cognitive dissonance; e.g., Festinger, 1957; Brehm & Cohen, 1962; Wicklund & Brehm, 1976). In such cases, one's behaviors are used as data to be conceptually understood and incorporated at the level of one's assumptions. It is change in the conceptual system, whether derived from perceptions of one's own behavior, one's experiences, or other incoming information, that best defines personal change.

This assumptive world perspective is a broad explanatory framework that can be used to understand both major and minor instances of change. Thus, changes such as learning a new instrument or becoming an expert at some sport are no doubt represented at the level of one's conceptual system, as are instances of deep-seated personal change. To arrive at a better understanding of the latter, of what might be referred to as personality change, one needs to consider the parameters for defining such change. What are the important dimensions for understanding different types of personal change? Two dimensions seem particularly worth considering. The first involves the depth and breadth of the change in question; the second involves the extent to which a change is gradual and incremental versus more "catastrophic." Differences among types of personal change can largely be understood in terms of placement along these dimensions. The type of change addressed in this chapter falls toward the extreme end of the two continua: change that is deep and broad, as well as accelerated and dramatic.

The depth and breadth of personal change can be understood in terms of where change occurs in one's assumptive world. As Epstein (1980) has argued, our conceptual systems are hierarchically organized, with higher and lower order postulates. The basic assumptions considered above represent our highest order postulates. They are the most abstract, global, generalized assumptions that we hold and are at the foundation of the system. Lower order postulates are narrow, more specific generalizations; "I am a good piano player" or "I am a good basketball player" represent lower order postulates, whereas "I am a good person" represents a higher order postulate. Lower level postulates, or assumptions, are more directly reflections of our experience, involving specific abilities or interactions with the world. They are subject to the "direct test of experience" (Epstein, 1980).

As one moves up the hierarchy of postulates, change becomes more difficult. Thus, with broader assumptions, such as those reflecting beliefs about interactions of groups of people, political beliefs, or strongly held cultural notions (e.g., the appropriate roles of men and women), change will be far more difficult to effect than at the lower level of postulates. The highest order postulates, our most general beliefs about the world
and ourselves, are still more difficult to alter. Change at this level represents the most deep-seated personal change, for the assumptions here are not only our deepest, but our broadest. Change here, at the foundation of the conceptual system, is most apt to affect assumptions at all of the other levels.

Change can occur at any level of our assumptive world. The more global and generalized the belief, the greater the personal change. Although most recent work on schemas has stressed the extent to which people's schemas do not change (for a review, see Fiske & Taylor, 1984), change is no doubt far more common than attested to in this literature. Every time we learn something new, some schema is changing. The acquisition of skills and knowledge is no doubt represented by changes in our conceptual system, although these changes typically occur among our lower order postulates, reflecting beliefs about particular stimuli and evaluations of specific abilities. Further, these changes generally involve adding to prior assumptions rather than invalidating and changing them; in this sense there is no clash with the old, but rather a process of building on the old. This additive process is typical of gradual change, an endpoint of the second dimension that may define personal change.

Just as change at the level of our lower order postulates is quite common and gradual, it typically occurs incrementally. Such changes are rarely noticed as they occur, just as the gradual changes in a child's physical growth are not noticed on a day-to-day basis, but rather must be compared with some relatively distant past marker to be recognized as substantial. Small, gradual changes in our more narrow generalizations are common; they represent ordinary learning and daily interactions. We generally think of learning as "adding to" our knowledge base. These are the types of changes that Kuhn (1962) refers to when he discusses the "additive adjustment of theory." These do not create a condition of crisis or scientific revolution, but rather involve cumulative, incremental changes to the theory. Watzlawick and his colleagues (Watzlawick, Weakland, & Fish, 1974) are referring to this type of change when they write of "first-order change," which involves change in a system without any fundamental changes occurring in the system. This type of change also is described by Rothbart (1981) in his discussion of the "bookkeeping model" of changing stereotypes. In this case, schemas change slowly, bit by bit, in the face of incongruent information; the change involves minor adjustments, made over time.

Compare this with a second model of change—the conversion model—also proposed by Rothbart (1981). This type of change involves a few extremely critical instances that are very salient; the information provided is highly incongruent, and the change is more or less "catastrophic." These instances involve a type of "gestalt switch" and characterize a more dramatic personal change. Watzlawick (Watzlawick et al., 1974) writes of "second-order change" as a change "whose occurrence changes the system itself" (p. 10). Kuhn's conception of change in the aftermath of scientific revolutions also reflects this more catastrophic change. The scientific theory has been stretched too far; it cannot account for the anomalies that confront the theory, and the theory must therefore be altered, not gradually or in a minor way. Rather, a new theory is required, one that can account for both the old and new data. Similarly, dramatic personal change is neither additive nor gradual, but involves noncumulative changes in people's fundamental assumptions about the world.

Personal change may occur as a consequence of many distinct life experiences, including victimization, psychotherapy, groups devoted to support or consciousness-raising, or even particularly persuasive written material. In most cases, this type of dramatic personal change occurs as a result of nonnormative events that are pursued by or imposed on an individual. More normative life events, such as normative role changes, can at times trigger deep-seated, dramatic changes, although we would argue that for most people these changes are gradual and, more important, additive; they are added to one's preexisting views of oneself and do not challenge these views. Thus, the woman in our society who has been raised to view herself as a caregiver and nurturer is not apt to make fundamental changes in the way she sees herself when she becomes a mother for the first time. The "data" she incorporates will be added to her assumptions about herself.

Those people whose beliefs are fundamentally changed rather than added to as a result of new roles are those whose personal changes are more deep-seated and dramatic. Thus, for some, becoming a parent for the first time may fundamentally change views of oneself; what one learns generalizes to fundamental beliefs about oneself that challenge preexisting beliefs. In these instances, basic assumptions are altered; the process does
not involve small, incremental additions to one's prior assumptions, but more dramatic changes in one's assumptions.

Again, personal change is far more common than we generally realize. Most changes, however, are of the sort represented by knowledge learning and physical growth—gradual and incremental. These are certainly instances of change; the person changes as a result. In these instances, however, assumptions are not challenged or threatened; the change is additive, the new beliefs essentially fit. The more dramatic instances of personal change addressed in this chapter are reflections of challenge, threat, and change at the level of one's basic assumptions. There is a qualitative shift at this level of belief, not simply a quantitative one. Just as new scientific theories arise out of crisis, when prior theories are stretched too far, we believe dramatic personal change, at the level of our higher order postulates, involves crisis and confrontation.

**A HEURISTIC MODEL OF PERSONAL CHANGE**

Using the framework of assumptive worlds, we propose that there are four central elements involved in the process of dramatic personal change: confrontation, resistance, validation, and integration. This process involves recognizing anomalous "data" (confrontation), opposing any change implied by the new information, typically through ignoring or reinterpreting the new data (resistance), realizing the validity and "truth value" of the new information (validation), and finally, integrating the new data and one's prior assumptions (integration). Although we regard these as core ingredients of the process, we do not claim that this list is exhaustive. Rather, these elements are intended as the rudiments of a heuristic model of change, which is presented in Figure 24.1.

The four elements are essentially microprocesses, and they are temporarily ordered such that confrontation represents the first stage of the overall process and integration the last. The arrows between resistance and validation indicate that these interim processes often alternate in occurrence; that is, resistance is apt to appear soon after confrontation, to be followed by the process of validation, which in turn often results in some new resistance, which may again be followed by validation. When the process of validation is complete, the person moves on to the stage of integration. The process of personal change may be closed at any point along this continuum; the greater the movement to the right, however, the greater the likelihood of change. This movement, from confrontation through resistance and validation to integration, constitutes a general model of change that we believe can be used to describe the process of personal change, regardless of triggering event. An understanding of the four components of the model, described in general as follows, will be enriched in the last sections of the chapter, in which the model is applied to instances of personal change following victimization and psychotherapy.

**Confrontation**

Confrontation entails the recognition of anomalous data. In other words, an individual comes face to face with information that simply does not fit preexisting assumptions. This information can be presented in the form of powerful personal experiences, such as serious illness or loss, or through the intervention of others, such as parents, teachers, and therapists. In either case, the viability of our fundamental assumptions is threatened; there is a discrepancy between one's beliefs and the new data.

Generally, our fundamental assumptions are outside of our awareness; we take them for granted and function on the basis of these basic postulates, but they are ordinarily likely to be preconscious (Epstein, 1984) rather than in our day-to-day awareness. Confrontations with anomalies generally force us to objectify and examine these assumptions. The preexisting beliefs, which had never been questioned or challenged, are suddenly brought into awareness to be evaluated, worked on, and worked over.

It is probably the case that the psychological confrontation between old and new beliefs can take place outside of conscious awareness; the emotional concomitants of this confrontation—characterized primarily by anxiety, which signals cognitive disintegration (Averill, 1976)—would still be evident. Nevertheless, it is probably more often the case that the anomalous information "brings to consciousness" the preexisting assumptions. It is interesting to note that consciousness-raising, which aims at altering fairly high order postulates in one's assumptive world, has a label that is descriptive of this process. Such groups involve bringing to consciousness those very basic
assumptions that are assumed to reflect one's own oppression (e.g., Nassi & Abramowitz, 1981). The early stages of consciousness-raising involve the revelation and sharing of personal experiences, the communal creation of data that are used, in the end, to transform the members' basic assumptions.

Confrontation with anomalous data essentially calls forth and challenges our basic assumptions. It is the initial impetus for change. Such anomalous data are essential for the process of change. Generally, new information is not threatening and does not lead to major changes in our assumptive worlds. Rather, it leads to relatively small changes in our narrow generalizations, or lower order postulates, that respond to daily interactions and direct feedback; or, at the level of more fundamental assumptions, it is assimilated through incremental, additive changes rather than qualitative shifts in these high order postulates. With minimal massage or reinterpretation, even discrepant or anomalous new information can be altered to fit our preexisting assumptions. Occasionally, however, we are confronted by new information that is clearly anomalous; it cannot be readily assimilated nor easily altered to fit. In such cases there is a confrontation between the new data and the old assumptions. The latter are challenged, yet do not bend gracefully. Rather, we respond to this "threat" with resistance.

Resistance

The process of personal change is rarely a smooth one. People have a need for stability and coherence in their conceptual systems (Epstein, 1980, 1984; Nisbett & Ross, 1980). This stability provides us with a sense of psychological equilibrium. We eschew changes in our assumptive worlds, and we are particularly threatened by challenges posed to our most basic assumptions about the world and ourselves.

Psychological research on schemas, our stored knowledge about particular stimuli, has demonstrated that cognitively we are very conservative; we reinterpret and misremember data to fit our preexisting schemas (for a review see Fiske & Taylor, 1984). Our basic assumptions about the world are essentially our most abstract, generalized cognitive-emotional schemas, and we strive to incorporate new information within the framework of our basic assumptions rather than alter our assumptions. When the viability of such assumptions is called into question by anomalous information, we resist the changes implied by these anomalies. We may ignore or deny the new data, or continue to work at reinterpreting the new information so that it no longer poses a great threat.

Once confronted with anomalous data, the process of change remains a difficult one, for it is extremely unsettling to give up prior views of oneself and the world. These are the basic assumptions that have been developed over years of experience and have provided the person with a sense of coherence and comfort. In a sense, then, this resistance to change is a positive component of the change process, for it suggests that the required change in assumptions is likely to be an important, fundamental one. The absence of resistance raises the question of the depth or significance of the personal change to be effected.

In understanding resistance, it is not the valence of the basic assumptions that is important, but rather the stability and coherence they have afforded the individual in the past. Thus, data that threatens deeply held positive or negative views of oneself are apt to be forcefully resisted, for it is the stability of the system rather than its valence.
that is crucial to an understanding of this process. Change is never easy, for it involves a cognitive crisis. A person is confronted with new, anomalous data; an assumptive world must be established that can account for this new information. Resistance to such change is to be expected if the assumptions that are affected are fundamental to the person's conceptual system.

Validation

Challenges to one's assumptive world will be resisted, sometimes so successfully that the process of change is foreclosed. Sometimes, however, the anomalous data simply do not go away. The new data are too real, too compelling to leave alone, and must be accounted for by the individual. The process of validation is central to an understanding of change, for it is only in the face of "real" or "valid" anomalies that the process of change continues to unfold, such that personal change may be effected.

Given our need for stability and our general resistance to change, it is in many ways remarkable that people ever experience major personal changes. Our cognitive conservatism generally serves us well, and one can argue, very rationally, that we should not change old theories unless there is a very good reason for doing so; in fact, philosophers of science have made precisely this argument (e.g., Popper, 1963). We should not readily give up theories, but should give them more than a fair chance to survive. Yet, humans have the ability to learn, and this learning is generally in the service of developing theories that are useful maps of ourselves and our world, theories that are accurate enough to serve as viable guides to everyday living. Just as scientists test the validity of data, so too do individuals in their daily lives; the process of validation is no doubt more informal, yet nevertheless important, because valid information is not readily ignored. Anomalous data are only problematic when regarded as valid and well grounded; in other words, people must try to account for the anomalous when it is too real and too compelling to ignore, deny or discount. How, then, do we establish that something is worthy of belief?

The basis for establishing "truth value" is related to our ways of knowing. Traditionally, a primary distinction in sources of knowledge has been made between perception and apperception. Perception involves our knowledge of the external world, which is gained through our senses (e.g., hearing, seeing), and apperception involves our knowledge of our internal world, which is gained through an awareness of ourselves, particularly our emotions. Brickman's (1978) proposal of two types of validity roughly parallels this distinction. He has argued that there are really two types of validity, inferential and phenomenological validity. The former corresponds to ways of knowing used in science; evidence is provided by calculation, typified by experiments, and unambiguous outcomes are sought. In the case of phenomenological validity, evidence is provided by involvement and is typified by personal experience. Further, meaningful rather than unambiguous outcomes are sought. Brickman (1978) asserted that the question of calculation versus involvement as a way of knowing is an old one. He wrote

It is captured in the contrast between the pull of a case study and the power of a statistical sample. . . . We are surprised, and sometimes despairing, at the extent to which people allow a single case or several dramatic cases to override the evidence of a statistical sample. . . . Yet, the present analysis suggests that it may not always be wrong to do so. Phenomenological validity can only be found in direct experience or in its next best form, vicarious experience gained through the vivid portrayal of someone else's direct experience. (Brickman, 1978, p. 24)

These two types of validity correspond to Epstein's (1980, 1985) cognitive-experiential self-theory of personality. Epstein argued that we have two minds, a rational mind and an "experiential" mind. The former is logical and analytic and expresses itself in words and numbers. The experiential mind is intimately connected with emotions; it is more directly tied to experience and represents reality primarily through images. The experiential mind operates automatically, providing us with an automatic way of responding to the world. These minds can be integrated, but also at times may be a source of conflict. Thus, Epstein (1985) wrote of the person whorationally decides to become a physician because of the high pay, high status, and high respect given to this profession; further, the person's parents have always wanted him or her to be a doctor, so the decision would please them. On the other hand, the individual's experiential conceptual system, which is influenced by emotions derived from past experiences, views becoming a physician as extremely unappealing. Both
sources of information provide valid information. Epstein (1985) argued that although most people tend to consciously identify themselves with their rational conceptual system, in fact their behaviors are often far more determined by their experiential systems, by what "feels" good and bad. It is also possible that people differ in the extent to which they rely on different types of knowing and validity in establishing the truth value of data and experiences.

Considering the perspective of Brickman (1978) and Epstein (1985), there are two different ways of knowing; one is a logical-rational means, represented by inferential validity and established by our intellect. The other is represented by phenomenological validity and is established by our emotions. Interestingly, recent work on the two sides of the brain presents an anatomical analog to these two ways of knowing. The left side of the brain is associated with reason and intellectual knowledge, thereby paralleling the rational mind, whereas the right side of the brain is associated with feelings and emotions, thereby paralleling the experiential mind. Whether the two types of knowing are actually processed in distinctly different parts of the brain and in different ways remains an open question. Nevertheless, the two sides of the brain present an intriguing metaphor for thinking about our two ways of knowing.

There are no doubt particular rules of evidence that are used to calculate validity by the rational mind (i.e., inferential validity). We would argue that a primary rule is that of consensus (see Brickman, 1978); that is, a very significant piece of evidence used by the rational mind in calculating validity is the belief of others. In the case of an experiment, qualified scientists agree on the criteria for inferential validity. The rational mind engages in a logical analysis of data, and a primary component of this analysis involves attention to the beliefs of qualified or important others. Do well-respected authorities in the field, or those qualified to make a judgment, believe this? Do other people important to me believe this? Consciousness-raising groups and support groups make good use of this consensual criteria of validity. Propositions appear more valid and convincing when attested to by important others. As we will argue below, the impact of therapy may in part be attributable to the power of the therapist to convince the client of the validity of the anomalous data (see Frank, 1961). The validity of information provided by clinicians, then, is no doubt derived in part from their roles as qualified observers of human behavior.

We believe, however, that these analyses of change are incomplete; rather, personal change that involves shifts in people's fundamental assumptions requires experiential, or phenomenological, validity as well. In other words, deep-seated change requires emotional "knowledge" of the new information's truth value, knowledge that is generally attained through direct personal experience rather than through the persuasive efforts of others or any rational calculation of what is worthy of belief.

The special significance or emotional experience in changing people's assumptions can be illustrated in the domain of people's stereotypes of minority groups. There is considerable literature that attests to the great difficulties involved in changing people's stereotypes of other groups (see, e.g., Hamilton, 1981; Rothbart & Oliver, 1985). Simply providing people with incongruous information about outgroups (i.e., information that does not fit their stereotypes) is not effective in changing people's attitudes toward specific outgroups. Yet, in an intriguing classroom demonstration aimed at teaching students about prejudice and discrimination, a teacher in a small town gave children the experience of being members of ingroups and outgroups. As described in a television documentary in the 1980s, the teacher divided her class on the basis of eye color and arbitrarily gave one group greater privileges than another; the privileged eye color was changed the second day of the demonstration so that all children had a chance to be a member of the favored group and the discriminated group. Even 10 to 15 years after the demonstration, the now-grown children testified to the powerful impact of this demonstration, claiming that it had a profound impact on their understanding of others and their treatment of outgroup members. Evidently, the understanding achieved by these children resulted because they experienced rejection themselves.

Anomalous data, when regarded as valid, are not ignored, but set the wheels of personal change in motion. In the process of accepting the validity of new information, resistance is likely to alternate with validation, as the threat to the old assumptions is increasingly apparent. Validation can come in the form of rational evidence, largely involving consensual validation by others. It also can come in the language of emotions. In the case of dramatic personal change, rational calculation
is not apt to be sufficient. The validity derived from direct experience involves emotional knowing, and it is this that is most likely to lead to an acceptance of anomalies and the ultimate integration of new data and old assumptions.

**Integration**

In the end, a person rebuilds or establishes a new, viable set of basic assumptions. The new, anomalous data are regarded as valid, not simply to be denied, discounted, or ignored. In most instances, the individual will not simply discard pre-existing views, but, rather, will integrate the old and new. Old assumptions will not remain intact, assimilating the new beliefs or existing, in whole, beside new assumptions. Rather, these assumptions will be altered. The process is largely dialectical, resulting in a synthesis of the old and new assumptions. For most people this does not represent a complete break with old ways of seeing oneself and the world; even when there is dramatic personal change and people see themselves very differently, a sense of continuity of self is largely maintained. Not simply the new, but the old must make sense.

For some individuals, the new assumptive world is, on balance, primarily a reflection of the new, powerful data. For others, it is largely representative of prior postulates. Here, the valence of the beliefs may play an important role, in contrast to the irrelevance of valence for the process of resistance. To the extent that the prior beliefs were more positive, an individual may be more motivated to retain them in the new assumptive world; to the extent that the new views are more positive, the motivation may be to minimize the prior assumptions. In either case, the process of resolving the cognitive crisis is an arduous one, involving powerful emotions and creative coping strategies. The rebuilt assumptive world is qualitatively different from what existed before, and the person feels like a changed individual. The difficult task of presenting oneself to others—for feedback and support—now begins.

**PERSONAL CHANGE FOLLOWING TRAUMATIC NEGATIVE EVENTS**

To a considerable extent, our interest in personal change originally stemmed from our interest in the psychological aftermath of victimization. Victims of crime, disease, early loss of a loved one, and natural disasters often report having changed considerably as a result of their misfortune (e.g., Janoff-Bulman, 1979; Taylor, 1983; Veronen & Kilpatrick, 1983). In the words of one rape victim we interviewed, “It’s like I’ve walked through a door.” Things are not the same on the other side. Interestingly, despite people’s generally low expectations of change in individuals, we have very clear expectations of change for people who have been victimized through such events as sexual assault or life-threatening illness (Silka, 1989).

As a result of her work with a variety of victimized populations, including victims of rape, serious accidents, divorce, and early loss of a loved one, Janoff-Bulman (1985; 1989; Janoff-Bulman & Frieze, 1983; Janoff-Bulman & Timko, 1987) has argued that a common psychological process underlies the reactions of victims, regardless of their victimization. The trauma of victimization, she claims, is best understood in terms of the intense challenge posed to victims’ basic assumptions about themselves and their world.

Among the most fundamental assumptions we hold are beliefs about our self-worth and about the meaningfulness and benevolence of the world (Janoff-Bulman, 1985, 1989). People’s assumptions in our culture tend to be positively biased. Such biased assumptions begin during an early period of responsive caregiving, at which time the child begins to develop preverbal conceptions of a good, predictable world in which one is worthy of care (Janoff-Bulman, in press); they also are supported by (and are reflections of) a society that views optimism and happiness as the norm for the condition of humankind. In general, people believe in a world that is benevolent and meaningful, and they believe in their own self-worth. In other words, we believe that we are good, decent people, that the world and other people are good, and that events in our world “make sense” and do not happen randomly; that is, we believe things happen to people because they deserve it (i.e., we invoke principles of justice; Lerner, 1980) because they have acted so as to bring about the outcome (i.e., we invoke principles of control; Seligman, 1975). Together, these beliefs about benevolence, meaningfulness, and self-worth provide us with a sense of safety and security. We maintain an “illusion of invulnerability” or “unrealistic optimism” (Janoff-Bulman & Lang-Gunn, 1989; Perloff, 1983; Weinstein, 1980; Weinstein & Lachendorf, 1982). We overestimate the likelihood of positive events happening to us and underesti-
mate the likelihood of negative events. Assumptions about the benevolence and meaningfulness of the world and the worthiness of the self are among the highest order postulates in our conceptual systems. These fundamental assumptions provide us with a sense of relative invulnerability. And it is these very basic assumptions that are changed by the experience of victimization which, we maintain, can be understood in terms of the processes of confrontation, resistance, validation, and integration.

Confrontation in Victimization-Induced Change

There are events in people's lives that simply cannot be accounted for by our basic assumptions, the assumptions we have developed and maintained over years of experience. Victimization—crimes, life-threatening illnesses, serious accidents, natural disasters—force people to question their most fundamental assumptions about themselves and the world (Janoff-Bulman, 1985, 1989; Janoff-Bulman & Frieze, 1983). The data from their negative experience do not fit; the data cannot be readily integrated. Suddenly the victim is confronted with the possibility of a conceptual system that does not work—a system that cannot account for what has happened. The individual who has maintained a belief in his or her own relative invulnerability, by believing in the benevolence and meaningfulness of the world and his or her own self-worth, has been victimized and can no longer believe, "It can't happen to me."

Extreme negative events pose a dramatic assault on the victim's basic assumptions (Janoff-Bulman, 1985, 1989; Janoff-Bulman & Frieze, 1983). The powerful feelings of anxiety, confusion, and depression that are frequently experienced in the immediate aftermath of victimization reflect the victim's cognitive-emotional crisis, the potential threat of complete disintegration of the victim's assumptive world. The data of this experience—that the world is not benevolent or meaningful, or that the victim is not worthy—does not fit with preexisting assumptions. The crisis is profound, because it is the fundamental assumptions that are attacked. We have a need for stability and coherence in our conceptual systems, and yet the experience of victimization leads people to question the very assumptions that had afforded them such stability and coherence. It is not surprising, then, that resistance to change, primarily in the form of denial, is extremely common following victimization.

Resistance in Victimization-Induced Change

Denial is an extremely common response to victimization. It usually involves disbelief that some traumatic event has occurred, or more commonly, a lack of recognition of the seriousness of the negative event. In a review of studies reporting victims' reactions, Janoff-Bulman and Timko (1987) concluded, "From an examination of the literature, it becomes very apparent that researchers investigating reactions to negative life events frequently find a great deal of denial, and the denial is generally regarded as a normal part of the coping process" (p. 148). Extensive denial has been reported as an early response by burn and polio victims (Hamburg & Adams, 1967), terminally ill patients (Hackett & Weisman, 1969; Weisman, 1972; Weisman & Hackett, 1967), patients with chronic lung failure (Dudley, Verney, Masuda, Martin, & Holmes, 1969), cardiac patients (Cassem & Hackett, 1971; Druss & Kornfeld, 1967), crime victims (Bard & Sangrey, 1979), and concentration camp victims (Eitinger, 1982). The reality of their victimization is too threatening to confront immediately and all at once. The data do not fit, and they are confronted with the possibility of a complete breakdown of their conceptual systems.

Through the early use of denial, victims resist the onslaught of threatening information. Although it has often been regarded as maladaptive in the psychiatric literature, denial may in fact play a very adaptive role in the early stages of the victim's coping process (Janoff-Bulman & Timko, 1987; Epstein, 1967, 1983; Horowitz, 1980, 1982, 1983; Lazarus, 1983). Denial precludes total psychological breakdown by enabling victims to pace their recovery following trauma; excessive amounts of anxiety and confusion are reduced. "A dramatic, unmodulated attack on the primary postulates of one's assumptive world is controlled by the process of denial, which allows the individual to face slowly and gradually the realities of the external world and incorporate them into his or her internal world" (Janoff-Bulman & Timko, 1987, p. 147).

In the case of victimization, personal change is
not freely sought, but rather imposed. An extreme, negative event occurs and the data from the experience powerfully challenges old assumptions. Change in these basic assumptions is resisted, not because the new assumptions would be more negative, but rather because the stability of the old system, which had been developed and solidified over many years, is now seriously threatened.

The common process of denial following victimization reflects the depth of the assumptions that are challenged by victimization. Yet, denial also serves the adaptive function of pacing information, so that victims are not overwhelmed by the assault on their assumptions. Typically, denial decreases over time, and victims recognize the "truth value" of their experience and work to integrate the new data.

**Validation in Victimization-Induced Change**

Victimization provides the victim with anomalous new data, data that may include such "facts" as the world is not always good, there are events that don't make sense, good people cannot always avoid misfortune. In the case of extreme negative events, the validity of this new data is rarely questioned. Phenomenological validity is extremely high. The victim's experience is too vivid and emotionally compelling to be ignored or dismissed. The traumatic event has not been read about in a book or newspaper, or related by another person; it has been powerfully, directly experienced by the victim.

Rationally, we know that negative events such as crime and serious disease happen, but emotionally, at some gut level, we do not believe such events will happen to us. Reading about these events (i.e., being provided with facts about real cases of victimization) has little effect on people and their basic assumptions about the world. We change our basic assumptions by directly experiencing such events, or, in some cases, by indirectly experiencing them through other people very close to us who have been victimized. In these cases, empathic responses also make the event very emotionally real and personal change may be forthcoming. Validity is not a problematic process in the case of victimization; victims know—emotionally and experientially—the "truth value" of the data derived from their experience.

**Integration in Victimization-Induced Change**

The legacy of victimization is often a change in people's assumptive worlds.Victims' basic assumptions are challenged by anomalous data. Resistance in the form of denial is commonly used and, with time, dissipates. The data are too valid to be denied over the long run. They must be dealt with, worked on, and integrated at the level of the victim's assumptive world. Coping with victimization involves rebuilding a viable set of basic assumptions of the world and oneself, a set of assumptions that can account for the data of the victimizing experience. This is not an easy task; the assumptions in question are the fundamental ones, the assumptions that form the foundation of the victim's assumptive world. Further, in arriving at a viable set of assumptions, the victim is motivated not only by the need to account for the new negative experience, but also by the need to account for his or her past experiences, which had been well served by the victim's prior assumptions. People resist change in their conceptual systems, and yet victims cannot ignore their seemingly anomalous, powerful negative experience.

How do victims integrate their experience? This difficult process is facilitated by a number of coping strategies. These strategies minimize the challenge posed to the victim's assumptive world by minimizing the negative implications of the victimization. Thus, several strategies enable victims to bolster positive assumptions of self-worth and the benevolence of the world. Thus, victims try to compare themselves with others worse off than themselves and invent hypothetical others for this social comparison if real others do not seem to exist (Taylor, Wood, & Lichtman, 1983; Wills, 1981). Victims often reinterpret their experience, at least partially, in a positive light; they look for benefits to be derived from their experience (Bulman & Wortman, 1977; Silver & Wortman, 1980; Taylor, 1983; Taylor, Wood, & Lichtman, 1983). Victims often report a newfound appreciation of life and a recognition of what is really important, as well as a newfound sense of their own strengths and possibilities.

Another coping strategy that is far more adaptive than meets the eye is self-blame, which is extremely common following victimization (for a review, see Janoff-Bulman & Lang-Gunn, 1989). Given its association with depression (e.g., Beck,
1967), self-blame is generally regarded as a maladaptive strategy for victims. Nevertheless, it appears that self-blame is not a monolithic concept, but refers to at least two distinct self-attributitional phenomena: behavioral and characterological self-blame (Janoff-Bulman, 1979). Although the latter, which involves blaming the kind of person you are (i.e., one's character or stable traits) is maladaptive, there is considerable empirical evidence indicating that behavioral self-blame—blaming some action you engaged in or failed to engage in—is adaptive (e.g., Affleck, Allen, Tennen, McGrade, & Ratzan, 1985; Baum, Fleming, & Singer, 1983; Janoff-Bulman, 1979; Peterson, Schwartz, & Seligman, 1981; Tennen, Affleck, & Gerschman, 1986; Timko & Janoff-Bulman, 1985). Behavioral self-blame enables victims to minimize the need for change in their assumptive world. Victims who blame their behaviors are largely able to maintain their preexisting assumptions, particularly regarding the meaningfulness of the world and their own self-worth. If the victimization can be understood in terms of their own behaviors, then the world remains meaningful (i.e., people control outcomes); further, victims can believe that they did a foolish thing without generalizing this to a belief that they are foolish people. Positive self-worth is thereby minimally affected.

Victims use a number of cognitive strategies to help them resolve their cognitive-emotional crisis. These strategies, involving particular interpretations of their victimization, minimize the need for conceptual change by bolstering some prior assumptions. A complete overthrow of the old system is thereby generally avoided. In the end, victims integrate the old assumptions and new data, such that old and new experiences can be accounted for by their assumptive world.

Victims do change. Their basic assumptions generally do not look the same following their experience. Some victims, such as those exhibiting posttraumatic stress disorder, seem unable to rebuild a viable conceptual system; their lives are pervaded by anxiety and a state of cognitive disintegration. Others rebuild a system based almost entirely on the negative implications of their victimization. These victims have often experienced an event that is particularly difficult to assimilate; and these events are often those that seem to preclude the use of some common strategies (e.g., deriving benefit, behaviorally self-blaming). There is evidence, for example, that rape victims who were raped in seemingly safe situations, such as when they were sleeping in their beds in a locked home, have the most difficult time years after the event (Schepple & Bart, 1983). Recent research on the long-term negative effects of the unexpected loss of a child or spouse in auto accidents suggests the difficulty of assimilating these types of extreme events.

Most victims, however, rebuild a set of assumptions that reflects their experience yet provides some continuity with past assumptions (Janoff-Bulman, 1989). The world does not look the same, but it is not entirely negative. They recognize the limitations of our existence; people cannot control everything; bad things do happen, all events do not make sense. As one rape victim told us:

An event like rape separates you from the mainstream. It forces you to develop a personal philosophy; you have to do thinking and searching. The world is more dangerous to me now. I know there is evil, that really anything could happen. I could die tomorrow.

And these are the words of a cancer patient we interviewed:

The world isn't what it was to me. I don't see things the same way. I know about chance now, that bad things happen when you don't expect them.

People's expectations about the impact of traumatic life events seem well-founded (Silka, 1989). Victims do experience personal change following their negative experience, and this change takes place at the level of their basic assumptions about the world. Generally, there is a qualitative change in their basic assumptions that reflects some new combination of their traumatic experience and their preexisting assumptions.

**APPLICATIONS TO PSYCHOTHERAPY**

Personal change is generally regarded as one of the primary goals, if not the preeminent goal, of people who seek psychotherapy. Given the tremendous diversity of theories and styles that inform psychotherapy, it is not surprising that clinicians' beliefs differ widely regarding how this change should be effected. Fundamental theoretical differences about the role of insight, the necessity of addressing specific symptoms, the nature and importance of the therapeutic relationship,
and the relative benefit of behavioral change versus increased self-knowledge all lead to widely divergent approaches to therapeutic change.

The disarmingly basic question, "How does therapy work?" has yet to be answered satisfactorily. The literature on psychotherapy process and outcome is enormous, complex, and daunting in its scope (see Garfield & Bergin, 1986, for a comprehensive review). A vast number of factors have been implicated in therapeutic change. Orlinsky and Howard (1986) list 34 variables relevant to therapeutic outcome, categorizing them in terms of provision and implementation of a therapeutic contract, interventions made by the therapist, patient participation, and dimensions of the therapeutic bond. In a review chapter of psychotherapy effectiveness, Lambert, Shapiro, and Bergin (1986) suggest that "a major factor in maintaining treatment gains seems to be the degree to which patients . . . recognize that changes are partially the result of effective patient effort" (p. 165). Factors as diverse as the amount of patient speech during therapy sessions (e.g., McDaniel, Stiles, & McGaughey, 1981; Staples & Sloane, 1976) and the timeliness with which therapy is begun after a patient makes initial contact (e.g., Roth, Rhudick, Shaskan, Slobin, Wilkinson, & Young, 1964; Uhlenhuth & Duncan, 1968; Zeiss, Lewinsohn, & Munoz, 1979) have been implicated in the process of therapeutic change.

Given the amalgam of treatment approaches and change-related variables that represent the current state of the art, is it possible to discuss a metaprocess for understanding therapeutic change? We would like to posit that the heuristic model of personal change presented above, involving the processes of confrontation, resistance, validation, and integration, provides a suitable template across modalities. Although different types of therapy will use different clinical strategies, we believe that they can all be described within the explanatory framework provided by the proposed model. Thus, for example, confrontation or validation may appear distinctly different across therapist orientations, yet they nevertheless will be reflected in the therapeutic process. Further, the present model may provide one means of organizing, and thereby better understanding, the complex literature on psychotherapy outcome. Specific change-related variables (e.g., client motivation, client-therapist relationship) may be associated with distinct components of the proposed model.

In applying this model, we are first committing ourselves to an understanding of therapeutic change in terms of people's basic assumptions. The goal of therapy is to alter people's basic assumptions about themselves and/or their world so that they may feel good and function better. Frank (1961) similarly argued for understanding the aim of psychotherapy in terms of changes in people's assumptive worlds. He, too, recognized the significance of people's fundamental assumptions—those that are our most abstract, highest order postulates—for understanding people's views of themselves and interactions in the world. However, he then equated these assumptions with attitudes, and maintained that therapy could best be understood as an influence process. According to Frank (1961), the therapist's sources of influence—power and similarity—provide the primary basis for understanding successful psychotherapeutic change. As will be discussed below, we believe that the therapist-as-persuader plays a role, though not the primary role, in understanding personal change through therapy.

Given the tremendous diversity of psychotherapy modalities, any attempt to apply the proposed model of personal change in a comprehensive way would be a task of immense scope. Our aim is more modest. Rather than fully describe all or most psychotherapy orientations from the perspective of the model, we instead hope to illustrate its applicability by presenting specific examples of strategies and processes drawn from a number of different therapy modes, including behavioral, cognitive, psychoanalytic, paradoxical, and gestalt treatments. The complexity and richness of specific theories are afforded less priority than is optimal. Rather, our interest is in examining what we regard as broad therapy-related phenomena, the underlying or metaprocess of personal change. Certainly, therapy does not always result in deep personal change. People may experience very little change, or change some specific behavior and some concomitant narrow generalization about themselves or their world. Sometimes, however, people experience deep-seated change, change in basic assumptions about themselves and their world. We believe that when this happens, it is because the process of psychotherapy proceeds along a course delineated by our heuristic model of personal change. How then, can psychotherapeutic change be understood in terms of confrontation, resistance, validation, and integration?
Confrontation in Psychotherapy-Induced Change

Confrontation entails the recognition of new data, or information, that do not fit; these anomalous data lead to the questioning of basic assumptions. The early stages of therapy involve clarifying the discrepancy between new information or experiences and prior assumptions. Often this discrepancy is explicit to clients prior to their first therapy session; it is what got them to therapy in the first place. Sometimes anomalous data have been presented in the form of particular life events (e.g., divorce or some relationship termination, being fired from a job, a specific illness, failing in school) that cannot be assimilated. Sometimes it involves bumping into one’s limits, not achieving what one set out to do. In these instances, the confrontation between old assumptions and anomalous information is largely prepackaged for the therapist and is “delivered” to the therapist for help in effecting change.

For others entering psychotherapy, the nature of personal distress is not well articulated or understood. These clients may be experiencing a great deal of anxiety or may report being stuck or demoralized. Something is not working. With these individuals, the therapist attempts to find, objectify, and label the difficulty; the therapist leads the client to question old assumptions by presenting new “data” in the course of therapy. Whether made explicit first by the client or the therapist, the endpoint of this first process involves challenging old assumptions. Just as victimization leads individuals to objectify and come face to face with old assumptions, similarly psychotherapy leads clients to objectify and question old assumptions. The therapist may do this through verbal discourse or direct behavioral intervention; in either case, a threat to the client’s conceptual system is established through the confrontation of new, anomalous data.

It should be noted that “confrontation” is meant here to specify a challenge within, or to, the assumptive belief system of an individual. We do not mean to imply that a confrontational or oppositional interpersonal stance is a prerequisite, or even a preferred method, of achieving this confrontation. Rather, we are asserting that confronting an individual’s maladaptive assumptions can be seen as an integral and fundamental aspect of psychotherapy across a range of modalities.

Confrontation counteracts complacency and sets the stage for change. In some therapies, direct challenge of old assumptions is an explicit, obvious aspect of treatment. For example, cognitive therapists elicit and test “automatic thoughts,” which are those “thoughts that intervene between outside events and the individual’s emotional reactions to them. They often go unnoticed because they are part of a repetitive pattern of thinking . . . ” (Beck & Young, 1985, p. 215). The automatic, unquestioned nature of these thoughts suggests the conceptual link between these cognitions and people’s basic assumptions, although the latter can best be understood as our deepest cognitive-emotional schemas, and not solely cognitions that may exist at any level of the conceptual system. In cognitive therapy, therapists explicitly identify and challenge people’s automatic thoughts and attempt to provide other more adaptive cognitions to take their place.

The psychoanalytic process of interpretation also can be regarded as representing confrontation. According to Malan (1979), interpretation partly involves presenting to a patient a succinct and relevant statement of how his or her current actions or emotions are influenced by past events. By relating the present to the past, new experiences are used to uncover old, unquestioned assumptions. Translated into the language of the current model, the act of psychoanalytic interpretation involves uncovering and objectifying some of the fundamental assumptions by which clients make sense of themselves and the world, and discerning where those assumptions are maladaptive, outdated, or discrepant with new experience.

While the process of confrontation exists across modalities, the mechanics vary greatly, as does the theoretical framework for understanding pathology and conceptualizing the appropriate path for change. Thus, in psychoanalytic therapies, challenging old assumptions often occurs through an exchange that emphasizes the continued effects of early infancy and childhood. Behavior therapists emphasize the actual behaviors in which a person is engaged, and how these might be self-defeating or inappropriate; client attention to and practice of new behaviors are the routes to questioning old assumptions. Cognitive therapists emphasize and challenge the adaptiveness of specific cognitions. Therapists practiced in paradoxical interventions may not verbalize a confrontation, but instead set a task for the client that exemplifies it.

These differences in theory and technique yield significantly different means of clinical assess-
ment, formulation, and intervention. Yet while the guidelines by which a clinical problem is formulated differ from theory to theory, the need to formulate the problem remains constant. Regardless of orientation, this formulation can be conceptualized in terms of assumptive worlds. For the individual in psychotherapy, the first element of change involves questioning basic assumptions. Anomalous data, provided by significant events prior to therapy or by the therapist during treatment (through, for example, testing, interpretation, behavioral exercises, or paradoxical treatments), serve to identify and challenge fundamental aspects of the client’s assumptive world.

Resistance in Therapy-Induced Change

Resistance reflects the difficulty of relinquishing the fundamental rules by which an individual has come to make sense of him or herself and the world. Because of its strong connection with certain schools of thought, the concept of resistance has been disclaimed by other schools. As used here, resistance is regarded as the deep hesitancy to abandon or alter old assumptions. As such, it can be used as a transtheoretical construct, bridging concepts as divergent as psychoanalytic defense mechanisms and failure to complete cognitive-behavioral homework assignments.

Changing old assumptions, even if maladaptive, threatens the person’s sense of stability and coherence. The resistance to change no doubt also reflects the fear of an unknown, new conceptual system; there may be a fear of losing the old and having nothing, no new framework of understanding, to replace it. The old system, even if dysfunctional, is familiar and comfortable; a dysfunctional set of assumptions may be preferable to none at all. Behavior therapists argue that it is not enough to eradicate maladaptive behaviors; equal emphasis must be placed on creating and positively reinforcing new behaviors. In object relations theory, Fairbairn (1952) theorized that having a bad internal object relation was better than having no object at all. According to Ogden (1983), all external and internal object ties are being severed. Therefore, he clings desperately to any object tie (external or internal), even ones that are experienced as bad, when that is all that is available. (p. 236)

Given that a “dysfunctional reality” is better than no reality at all, resistance in psychotherapy can be seen as the inability, or fear, to accept the demands of a new reality and set of assumptions. These demands will be variously defined, according to the dictates of the theory and the prescribed nature of the interventions. Thus, while object relations theory may emphasize the difficulty of abandoning an internal object, behavior therapies may focus on the difficulty of breaking entrenched patterns of interaction, and family systems theories will highlight the interpersonal pressure to maintain old ways of being.

Regardless of the type of therapy, however, resistance by clients is an all-too-familiar phenomenon. Clients commonly reject either the provider of care (i.e., the therapist) or the advice given by the provider (Pomerleau & Rodin, 1986). In rejecting the provider, clients may devalue the therapist, arguing, for example, that he or she is too inexperienced with specific problems, not smart enough, only interested in money, too distant, too uncaring, or not a good match; the role of the therapist in the client’s life may be minimized, thereby lessening the therapist’s presumed influence, and, in turn, the client’s impetus to change.

Clients’ resistance can take varied behavioral forms as well. A client may stop coming to treatment after an initial session or two, or in midcourse. In behavioral or cognitive therapies, clients may not do their homework assignments; they may not engage in new behaviors or practice self-efficacy statements, for example. Clients may come late to therapy sessions. They may identify their problem, but then fill the therapy session with boring, superficial information, to save only the last minute or two for a discussion of anxiety-laden material. Patients also may engage in denial, rationalization, and intellectualization (the classic psychoanalytic defense mechanisms), and may externalize blame onto others, thereby attempting to minimize the need for personal change.

Although it creates problems in therapy, resistance can be understood as an indication that basic assumptions have been challenged and questioned. People defend against threats, and clients that make some progress in therapy will naturally experience a threat to their conceptual system. Re-
sistance should be expected if the viability of fundamental assumptions are at stake. For personal change to occur, however, resistance must be overcome. This involves realizing and accepting the “truth value” of new data and changed assumptions. Individuals must feel confident that their acceptance will not entail the need to abandon prior assumptions, with nothing to replace them. Overcoming or working through resistance goes hand in hand with the process of validation, and the two may in fact be defined in terms of one another: resistance is the inability to accept the validity of the new beliefs, and validation is the process by which resistance can be overcome. These two processes often alternate over the course of therapy; as new data and assumptions are increasingly validated, the conceptual system is threatened and resistance emerges as a protective response. Over time, resistance subsides, as the process of validation gains momentum. The cycle of resistance-validation-resistance will continue until the process of validation is completed. What does this process entail in psychotherapy?

**Validation in Therapy-Induced Change**

Validation in psychotherapy is the process by which clients are able to accept the discrepant data, overcome resistance to change, and begin to incorporate new beliefs about themselves and the world into their fundamental assumptive framework. In some therapies, the necessity for validation is made quite explicit and becomes a focal point of intervention. It may take the form of active permission to change granted by the therapist, or the encouraged repetition of self-efficacy statements (e.g., Bandura, 1977, 1978). It may involve strategies to enlist social support or change the client’s patterns of interpersonal activity, or to provide the opportunity for clients to practice new roles or behaviors, such as in role-playing or psychodrama.

These strategies attempt to address the patient’s need for validation, but provide an incomplete picture of the processes involved. We believe validation in therapy is a two-stage process. The first stage is a “readiness” to accept new truth value; the client must be willing to listen and be open to the new data and assumptions implicit or explicit in the therapeutic exchange. The second stage entails making the leap and actually accepting this new therapy-induced perspective. The two types of validity discussed above—inferential and phenomenological (Brickman, 1978)—are related to these two stages. We believe that inferential validity and rational, logical analysis play the primary role in the first stage of validation; in contrast, phenomenological validity and emotional experience (Epstein, 1985) play the crucial role in the second part of this process.

In the first stage, clients must convince themselves that the challenge posed to their assumptive world is worthy of attention. Why not continue to resist the threat? The answer for the client rests with the social influence features of the therapy. At this stage, the client’s rational analysis suggests that there are two reasons to listen to the therapist. To the extent that the therapist is regarded as qualified—as an “expert” of sorts on human behavior—and, in addition, appears to truly want to help the client, the client should, over time, move through this first phase of validation. These social influence aspects of psychotherapy are those discussed by Frank (1961). He wrote, “The success of all methods and schools of psychotherapy depends in the first instance on the patient’s conviction that the therapist cares about him and is competent to help him” (Frank, 1961, p. 165). The therapist functions, at first, as a person who persuades, by virtue of his or her personal strengths (e.g., self-confidence, expertise, apparent concern for others) and the status accorded psychotherapies as helping agents in our society.

This part of the validation process is by far the easier of the two to complete. The second phase involves more than a willingness to listen, for it entails acceptance, and with acceptance, change in fundamental assumptions. It may be that much of therapeutic activity can be seen as satisfying the first phase of the validation process, that of creating an environment in which change is given ample opportunity to occur. By laying the groundwork for the validation of new beliefs, many of the details of therapeutic business can facilitate change—but will not be sufficient in and of themselves to produce change. A warm, supportive “holding” environment, for example, may allow an individual to listen to possibilities for change, to test hypotheses, and to voice fears and anxieties, but it will not bring on the change. Or, the frequent repetition of an idea or interpretation may gradually make it more accessible and tenable, but is alone unlikely to lead to personal change.

The tenacity of individuals’ inability to change
is one of the central, most vexing problems of psychotherapy. Clients can arrive at dazzling insights regarding their difficulties. They can earnestly apply themselves to the most detailed behavioral regimens, or dedicate themselves to attempting new roles in their lives. Yet still, amid real desire and heartfelt cries of “Why can’t I change?” the struggle to alter old dysfunctional patterns or reach new levels of functioning remains enormously difficult. Clients in psychotherapy may rationally believe the “data” that are exchanged in therapy; the new assumptions may seem valid and therefore acceptable from a reasoned, intelligent analysis. Yet, we believe, this is not sufficient for completion of the validation process. Such rational belief is not sufficient for change.

Reflecting a somewhat similar perspective, Hollon and Beck (1986) wrote, “There is not, as yet, compelling evidence that cognitive therapy works, when it works, by virtue of changing beliefs and/or information processing [italics added], although that remains a very viable possibility” (p. 451). By implication, addressing cognitions alone may be insufficient to create the necessary “truth value” for new fundamental assumptions. In the psychoanalytic literature, the concept of “abreaction” (Freud & Breuer, 1924) conveys an analogous message. Abreaction, the process by which verbally reliving previous events can have a therapeutic or cathartic benefit, necessarily involves an emotional investment in the disclosure for change to occur (see La Planche & Pontalis, 1973, for a fuller definition). For true belief and acceptance to transpire, and change to occur, the client must validate the new data and assumptions through the language of experience and emotions (Epstein, 1985). Phenomenological validity (Brickman, 1978), and not inferential validity, provides the crucial test. Somehow the client must come to “feel” that the new assumptions are valid. Emotions must be powerfully involved. Through actual emotional experience we must come to understand the maladaptive nature of our prior assumptions and the validity of the perspectives provided in therapy.

The therapeutic relationship itself may facilitate this emotional, experiential component of the validation process. The client-therapist relationship consistently emerges as a crucial variable in successful psychotherapy (Garfield & Bergin, 1986). A warm, supportive therapeutic environment may facilitate important emotional experiences, for a person may feel free to experiment with new roles, with new ways of interacting. A client may feel safe enough to deeply, emotionally experience or reexperience powerful events and interactions. Consistent with this perspective is the orientation of client-centered therapists, who assert that a therapist’s unconditional positive regard is an extremely important component in effecting therapeutic change (Rogers, 1961). In psychoanalysis, therapeutic treatment includes analysis of the transference. In this case, the “here and now” interpersonal interactions between client and therapist are used to highlight the client’s unconscious assumptions. The interpersonal interactions of client and therapist may provide an important experiential, emotional component for validation. Also from a psychoanalytic perspective, Kohut (1971) wrote of mirroring, which involves providing a reflective emotional experience for clients, thereby allowing and tacitly encouraging them to voice the emotions that may have been unacceptable in the person’s early history.

A concept that appears to be reemerging in current discussions of therapeutic change is that of the “corrective emotional experience.” It is likely that modern usage of the term differs from that originally intended by Alexander and French (1946). In its original usage, the authors were proposing a specific model of brief psychoanalytic therapy that involved a very active role for the therapist. They argued that the therapist needs to provide, for the purposes of counterbalance, the emotions that were presumed to be lacking from caregivers in the patient’s early development. In modern usage, the term is theoretically broader, and also implies a consistently empathic and warm stance on the part of the therapist. The assumption is that in therapy the client is able to relive certain emotional experiences to correct for past errors. In this manner, clients may experience and thereby validate, phenomenologically, new ways of seeing themselves and their world.

Behavioral techniques that provide experiences with personal mastery, role-playing, and “cognitive rehearsal,” in which a client imagines, step by step, successfully performing new activities, may also provide validating experiences, particularly to the extent that these new behaviors involve strong emotions. Therapies that focus on paradoxical interventions may also facilitate the process of phenomenological validity. As discussed above, the presentation of a paradox can represent a confrontation to the assumptive system. The valida-
tion comes with the experiential understanding of a different way of functioning, which is achieved perhaps by rejecting the paradox, perhaps by embracing it. This new understanding need not rely on insight, nor on dictated cognitive changes, but the result is the same: a change in an individual’s beliefs about him or herself.

Integration in Therapy-Induced Change

The process of change eventually involves integrating one’s new experiences and assumptions into a new, synthesized conceptual system. There is an integration of new and old assumptions, and an assumptive world that is different from both emerges. This new set of assumptions provides the individual with a more adaptive way of functioning in the world, while simultaneously providing the individual with a sense of continuity with the past.

Often a person becomes completely immersed in new views of the self or world validated by the therapeutic experience. Over time, however, these new views become somewhat tempered and integrated with older, preexisting beliefs. This process of integration has been exemplified in models that address identity formation within minority cultures. For example, Hall, Cross, and Freedle’s (1972) model of black identity formation, or Cass’ (1979) model of gay/lesbian identity formation both postulate that once an individual has successfully passed through the struggle of self-acceptance (i.e., after the new assumptions have been validated), he or she then becomes immersed in the minority subculture. Old beliefs and assumptions are rejected and only new ones are considered viable. This period of immersion in the new yields, however, to a process of synthesis, in which old and new beliefs are incorporated into a new assumptive world.

Similarly, in those cases where therapy has served as catalyst for dramatic growth and change, it is likely that the changes will be tempered in time, as an altered, synthesized assumptive framework emerges. This often involves, in part, a reconceptualization of one’s past. The process of discovering new meaning for old events or feelings is an example of how the assumptive framework can be modified and reinvested with a bias toward new, more positive basic assumptions. Frankl (1973) discussed how the significance of a specific moment or a specific realization can reactively reshape the meaning of one’s entire life. The work of therapy and its aftermath need not involve only introducing new assumptions, but also redefining the old ones, so that they may continue to reflect the data of a person’s changing life.

SUMMARY AND CONCLUSIONS

The model we have proposed is an attempt to delineate processes that we believe are common to the experience of personal change, regardless of the catalyst for change. Confrontation, resistance, validation, and integration are themselves complex processes that we believe describe the course of personal change. Although a person’s experience of these four model components may differ dramatically across types of change (e.g., victimization-induced vs. psychotherapy-induced), we maintain that the metalevel descriptions of these four components, which include functional analyses of the four processes, are actually quite similar. Confrontation involves recognizing the anomalous and the challenge posed to one’s old assumptions. Resistance entails attempts to ward off change through cognitive (e.g., denial, denigration of a therapist) or behavioral (e.g., missing therapy sessions) means. Validation involves establishing the “truth value” of new data and new assumptions. It is probably the crux of change, particularly psychotherapeutic change, but should be understood as one component of the entire model. Finally, integration is the synthesis of old and new assumptions, so that personal change is recognized and yet continuity with the past is preserved.

This chapter no doubt raises many questions, perhaps many more than it answers. The applications of the model to victimization and therapy are intended to promote interest rather than make converts. To date, personal change is a poorly understood, little-studied, yet extremely compelling psychological phenomenon. We hope that the proposed model can serve as a heuristic for exploring and understanding the fundamental elements of this extraordinary human process.

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