

Redecision Approach to Transformative Change

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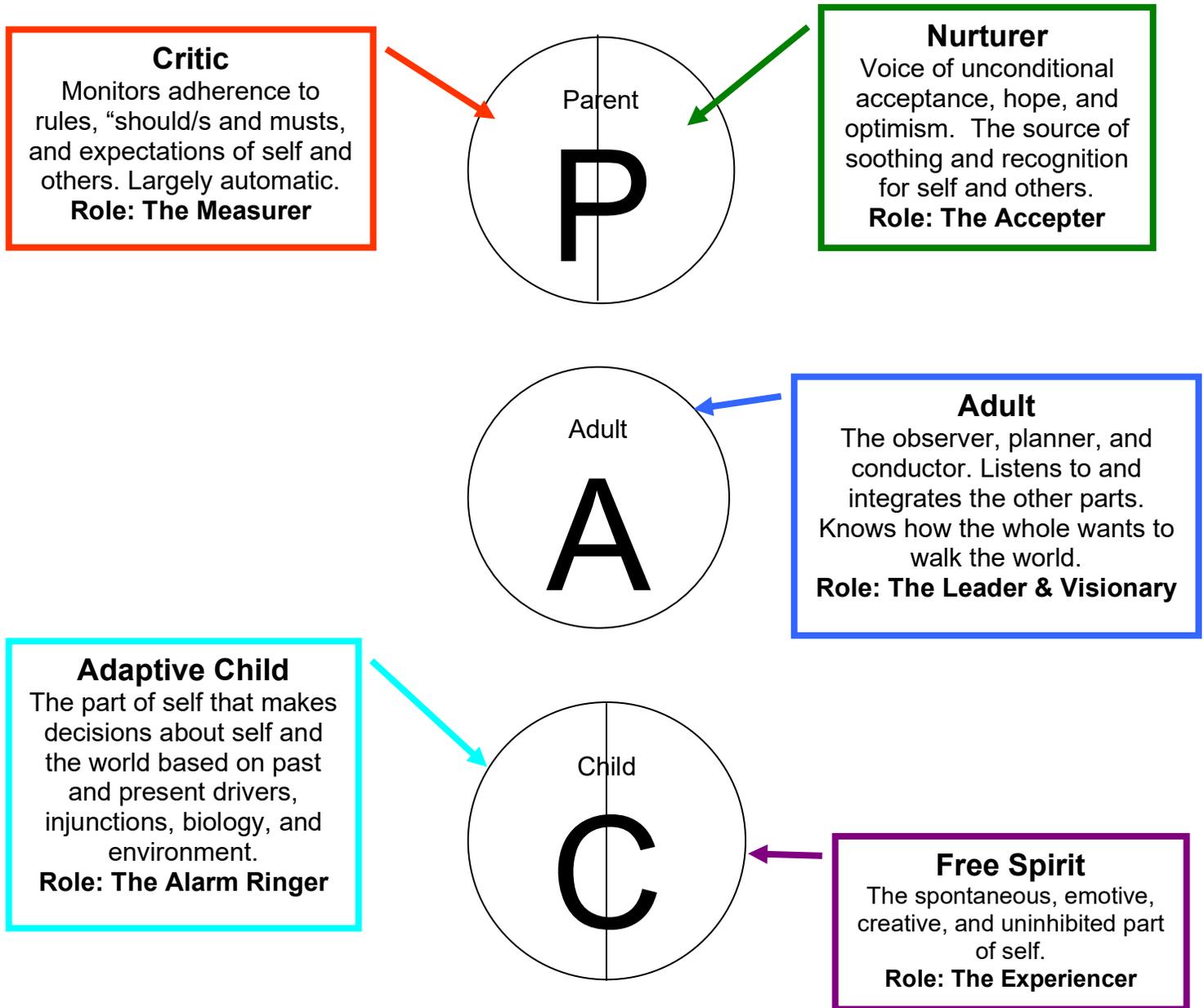
Introduction

My journey to my present theoretical orientation started in 1992 when my boss strongly suggested that I “go get some help” in lieu of firing me. Until then, I considered therapy “touchy-feely trash” and those that sought it as weaklings. After doing some therapy, I decided to do a marathon, eight-day experiential small group therapy program with the thought that it would be a quick way to get this “therapy thing” finished as soon as possible. Very simply, the program changed my entire outlook on and relationship with my life. I have been on a wonderful journey of self-discovery ever since. As important, I became intensely interested in how and why such transformative change was enabled and facilitated. The 8-Day program was based mainly on empirical experience and did not really have a cohesive model to explain why it seemed to be so effective for some people to make very large changes in their lives. My research into facilitating transformative change eventually led me to pursue a doctorate in clinical psychology and to study Redecision Model of Change at the Fielding Graduate University. This approach best met my demand for a cohesive, theoretical model that also translates into practical clinical techniques.

Major Constructs

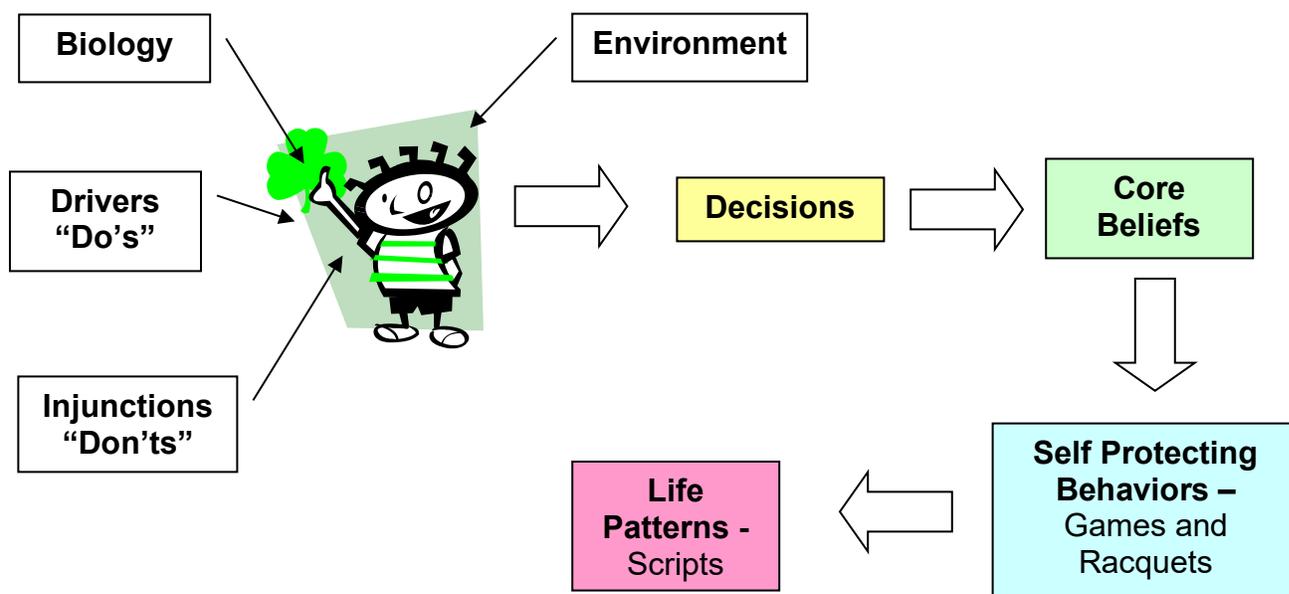
I have found the Redecision Model of Change to be an excellent, well defined model of intra- and interpersonal behavior that is simple for me and my clients to understand. It is an approach that combines behavioral, cognitive, and affective work. It was developed by Bob and Mary Goulding as a result of their work with Fritz Perls and Eric Berne. They combined the clear conceptual framework of Berne’s Transactional Analysis with the powerful experiential tools of Perls’s Gestalt Therapy.

As a theory of personality, transactional analysis provides a picture of how people are structured psychologically using a three part ego-state model. Here is a diagram I created to help explain the model:



The parts are defined, for the most part, by decisions made by the growing child. The decisions are made based on the constant flow of Injunctions ("Don'ts") and Drivers (Do's") as well as environmental and biological factors. As I have conceptualized this process, these decisions create a set of core beliefs about self and the world that drive

thoughts, feelings, and behaviors. Each person adapts in very different and creative ways to these decisions. Here's the way I look at the process:



The ego state model is an effective way of examining how the various voices within each person interact intra-personally as well as well as interpersonally. The concept of life script explains how our present life patterns originated in childhood. The concepts of Rackets and Games provide explanations of how we may continue to replay childhood strategies in grown-up life, even when these produce results that are ultimately self-defeating or painful. While this formulation is similar to the psychodynamic concept of neurosis, Redecision views the causes and present-day usage of such “ineffective coping styles” differently than neurosis. Rather than “unresolved conflict” generating these strategies, Redecision views them as natural adaptive sequela of decisions made in childhood. The usage of these strategies in present day life are not thought to be past emotions overwhelming and interfering with present experience, but rather behaviors, thoughts, and emotions that are still adaptive to one of the “voices” or ego states in the client’s present life.

A very important concept underlying this model is that people are okay - each of us has worth, value and dignity and deserves to be treated accordingly. Further, the model assumes people decide their own destiny in making early decisions and these decisions can be changed. The bottom line of the model: we are always at choice.

Concepts and "Causes" of Dysfunction and Psychopathology

Redecision is a non-pathologizing approach to behavior: whatever ideas, feelings, or behaviors people wish to change were, and possibly still are, adaptive and self protective – they work in some way. Bruce Ecker (1996) calls this concept “symptom coherence.” He suggests that it is important to find the answers to the question: what decisions about self and the world make this symptom more important to have than not to have? As illustrated above, children grow amid positive and negative experiences and receive messages by their caretakers and society. Based on these experiences and messages, they make decisions about themselves and the world that will direct them throughout their lives and influence their behavior. As children, these behaviors were necessary to survive in their families. As adults, however, these behaviors are no longer useful and become hindrances to getting what they want in their lives. As adults, people choose friends and partners who are consistent with and who support the decisions and the subsequent behaviors.

How Changes Come About

Conceptually, lasting change comes about when the Child part “re-decides” a decision made as a child that does not work in their present life. Basic to Redecision is the idea that a self-enhancing rededecision can only be made when a person is experiencing the same intensity of thought, feeling, and behavior that was present when the original decision was made as a child. Gestalt techniques are an extremely effective pathway to re-experience the original pain and have powerful opportunities to rededecide, thereby changing behavior. Psychodynamically inclined people will recognize the role of “insight” in this rededecision process in making conscious these old decisions that were previously out of awareness. Cognitive-Behavioral Therapy (CBT) oriented people might recognize the rededecision process as one of “cognitive restructuring” or “schema change.” Where object-relations oriented people would appreciate that people construct their own representations and experiences of reality (“decisions” in rededecision therapy), the rededecision approach maintains that there is no objective, “correct” version of reality, no “true” interpretation of events toward which a person “should” go. Redecision assumes that there are any number of viable ways a person may “rededecide” that would dispel their presenting problem, and in a spirit of collaboration, the practitioner and the

client consider and try out such possibilities. The Redecision practitioner does not take an objectivist position of being an authority on the “correct” view of reality, but rather helps the client modify their decisions about their own reality to eliminate unwanted consequences or achieve wanted results.

In practice, I collaborate with each client to produce a cycle of change that involves many of the following steps:

1. Negotiating a very clear, behaviorally specific contract concerning the changes the client wants to make. This would be familiar to any practitioner, especially CBT clinicians, practicing “brief therapy.”
2. Finding present examples of the problem the client is experiencing using first person, active, present tense. Again, this would be familiar to most CBT clinicians who examine here and now examples of the presenting issue. The difference would be that a rededecision practitioner will probably have the client “act out” the examples to help activate the feelings and decisions associated with the example.
3. Helping the client describe the problem in terms of the feelings she feels, what she tells herself about herself, and what she is afraid other people say about her.
4. Inviting the client into early scenes congruent with those feelings and the stories she tells herself about herself and others, again using first-person, active, present tense to describe what happened as if it were happening in the here and now.
5. Giving the client the opportunity to rededecide the meaning she made about herself and the world within the scene. I look for evidence of the client’s change in the session by observing her body, emotional states, and energy shifts. The goal is for the client to experience the change in the present moment.
6. Anchoring the change in specific new emotions, different feelings in their body, new perspectives, and new meanings. We will also go over, in detail, how she might implement the new decision outside the session.
7. Possibly “test driving” the new decision in a present-day scene.

The basic assumption is that problem situations in the present represent familiar existential positions resulting from decisions we made regarding ourselves, others, and our destiny in our child past. These decisions represent the very best option we

perceived at the time for taking care of ourselves. The Redecision process allows clients to let go of those past decisions and pursue new options in the present. The primary mechanism of change is not, as psychodynamic approaches might assume, the interpretation and resolution of transference (feelings, thought patterns, and behaviors the client might project onto the practitioner). Rather, the mechanism of change is the new experiences (“rededitions”) resulting from reenactment of an early scene. The scene is guided by the practitioner who serves as a guide at helping the client establish new meanings and new action, based on client-specified goals. It is the experience of the scene and its rededition that leads to change, not explanation and recognition that is the mainstay of other insight-oriented approaches. Most importantly, the client is seen as a capable and powerful agent of change in his or her own life, helped by skillful facilitation, rather than dependent upon an outside expert to interpret, make sense of, or reveal “the truth” (Lennox, 1997).

With regard to transference, its resolution is not a central goal of rededition as it is with psychodynamic approaches. Rededition is designed to discourage and minimize transference (Avery-Dahl, 1997). For example, when a client has feelings of anger or disappointment towards me, I have been trained to put “the therapist” in an “empty chair” and have the client dialogue between themselves and the “therapist.” This technique can diffuse instances of transference and counter transference and I am free to help the client in this dialogue uncover early decisions that caused it. My responsibility, as therapist, is to be very aware of the transference dynamic and be “deliberately in charge of maintaining healthy boundaries” (Avery-Dahl, 1997). The goal is to collaborate with my client with open and upfront exchanges, without becoming a partner in perpetuating the original decision by inviting and participating in covert transactions that lead to mutual dependence.

Strengths and Limitations of the Theory

Strengths: My experience from my clinical work to date has highlighted several strengths of the model:

- Rededition can be a very powerful and effective method for facilitating lasting change very quickly.

- The model is simple and describes parts of self that most clients identify with quite spontaneously.
- The model encourages me to view my clients (and myself!) as powerful agents of change in their own lives. This stance, I have found, is very therapeutic in and of itself.
- The model is extremely flexible in that the meanings, decisions, scenes, and rededitions are all produced by the client. As long as I can stay out of the client's way by not pressing my own agenda, the client is free to identify and use the important familial, cultural, or ethnic nuances that are manifest in his or her decisions. A great example of this flexibility was when an Asian American client did an entire scene in her language of origin – Chinese – playing the roles of her mother, father, and herself. I did not understand a word, but I did understand the emotional energy. When I sensed the energy shift to rededication, I had her speak it in both Chinese and English. The anchoring and test-drive parts of the cycle were also done in English for her present-day relationships¹.

¹ Ethically important in terms of duty to warn and duty to protect in this case was a thorough contextual knowledge of the client, the scene, and her history of non-violence toward others and herself *before the scene was enacted*. Equally important was hearing, in English, the “How I changed” and “What am I going to do now” parts of the cycle to be positive and non-violent. In cases where the client and therapist do not share fluency in a common language, these considerations become problematic, but can be ameliorated with proper informed consent, trained translators, and counselors trained in the use of translators. This procedure has been used to great effectiveness for many years in the multi-cultural environment of Sacramento by WEAVE (Women Escaping A Violent Environment) hotline and crisis counselors.

- The collaborative and spontaneous nature of the model creates sessions that are fun, provocative, and many times, profound – I generally learn plenty and enjoy the sessions immensely.

Limitations: I have also experienced some limitations that may well be a result of my limitations. They are:

- Scene work requires trust of the client in the process and in me as the practitioner. For clients whose major adaptive mechanism is distrust, this can take a while – several sessions – of acknowledging and stroking the adaptive child part of them that made the distrusting decision, and continuously inviting them into different ways that serve their therapeutic goals.
- Clients whose major self limiting decisions are around “doing it right” or “don’t look like a fool,” may have a very hard time allowing themselves into scene work.
- The model assumes that clients are motivated to change and willing, at least on some level, to accept responsibility for their changes. In my private group practice setting, these conditions were usually met. I have read about a local psychologist, Len Campos, who used Redecision very successfully for years in the California Youth Authority – the end of the line for youthful offenders in the state (Campos, 2000).
- It is sometimes hard for me to be patient and “stroke the adaptive child” instead of subtly (or not so subtly) pushing clients into compliance or rebellion when they are not doing what my Critical Parent so clearly sees is their work.
- Great awareness is required of the practitioner to recognize the various “cons” the client might employ. I am susceptible to clients playing the “you’re so wise and I need you to tell me what to do” game. These clients then can maintain the decision that they are dependent upon others for knowledge and action. In other words, clients will always bring into their sessions whatever adaptive mechanisms they have used “out there.”

I notice that most of the limitations I have listed are about me being willing to slow down and be with the parts of my clients’ adaptive mechanisms that will resist the powerful changes that are possible. It is no mistake that I have chosen a therapeutic

model that allows for, and even expects, rapid, deep change – my adaptive mechanisms have been to “get to work,” “get it done,” “be effective,” and “be the best.” Without my awareness and conscious choice to change ego states, it is a good bet that this Critical Parent part of me will stimulate the Adaptive Child part of my client.

Research Support

Redecision falls generally into the theoretical school of Humanistic Psychology. Within this overall theoretical framework, redecision can be considered a specific example of a well-researched therapeutic approach called process-experiential therapy (PET). I review below the outcome research on humanistic, PET, and Redecision as well as some process-outcome research.

Humanistic Psychology Outcome Research

Elliott (2002) performed the largest meta-analysis of humanistic therapy outcome research to date analyzing nearly 100 treatment studies. This analysis reinforces the major conclusion of two previous meta-studies (Elliott, 1995; Greenberg et al., 1994) that humanistic therapies are effective. Elliott (2002) came to several conclusions on the basis of his analysis: 1) Clients who participate in humanistic therapies show, on average, large amounts of change over time; 2) Post-therapy gains in humanistic therapies are stable and maintained over 12 months; 3) Clients who participate in humanistic therapies generally show substantially more change than comparable untreated clients in randomized clinical trials; 4) In randomized clinical trials with comparative treatment controls, clients in humanistic therapies generally show follow-up amounts of change equivalent to clients in non-humanistic therapies, including CBT.

Although the author of this meta-analysis included a wide mix of study types (controlled/uncontrolled, single/group, clinical/natural, randomized/nonrandom), the research is still compelling for several reasons: the large number of studies, the care taken by the author in distinguishing between types of studies, and great convergence of the finding results despite using several different types of meta-analyses, each with its complementary strengths and weaknesses.

Also significant to PET, Elliott (2002) recommended that “Process-directive humanistic therapies (i.e., Process-Experiential Therapy (PET), Gestalt, and focusing-oriented) appear to be particularly promising and should be more widely researched and

used.” This conclusion is consistent with earlier research on the distinction between *process* directiveness (the therapist directs processing work) used in both PET and RT and *content* directiveness (the therapist prescribes client content) prevalent in psychodynamic therapies. Greenberg, et al (1993) found a high degree of process directiveness had a positive correlation with therapy outcomes.

Process-Experiential Outcome Research

Two controlled outcome studies exist, both showing a large advantage for clients in PET versus wait-list control groups. Significantly large effect sizes were found for brief treatment of decisional conflicts (Clarke & Greenberg, 1986), and for a clinically distressed population of adult survivors of childhood sexual abuse (Paivio, 1997).

PET has also been studied in seven comparative outcome studies, five of them in contrast with non-experiential interventions:

- Two studies found that PET was superior to group psycho-educational treatments: Toukmanian and Grech (1991) found more improvement in clients with interpersonal difficulties treated with PET, and Paivio and Greenberg (1995) reported much greater positive change in empty-chair-based PET for clients with unresolved issues with significant others.
- In two studies of very brief treatments, PET was significantly more effective than CBT: Clarke and Greenberg (1986) found that a brief two-chair-based PET was superior to behavioral problem solving for clients with decisional conflicts. Clarke (1993) also reported results from a small-sample study in which PET produced a substantially larger effect size than CBT with meaning-creation tasks.
- Greenberg and Watson (1998) found that clinically depressed clients treated with PET improved somewhat more than clients who received Client Centered Therapy (i.e., without specific treatment tasks).
- Finally, two other PET studies of depression found PET significantly more effective than Client Centered Therapy (Goldman, Greenberg, and Angus, 1999) and generally equivalent results versus CBT (Watson & Stermac, 1999).

In summary, existing research suggests that PET, in general, is superior to wait-list and some common alternative therapeutic approaches such as CBT and CCT.

Specifically, there is strong support for PET as an effective treatment of depression, and some evidence supporting its use for unresolved issues related to abuse.

Redecision Outcome Research

In terms of outcome studies of Redecision specifically, there have been two comparative outcome studies, one using a group format and the other using an individual therapy format.

The first research in support of the Redecision model comes from a large controlled, comparative study of 17 different group processes and leadership styles by Lieberman, Yalom, and Miles (1973). This study was exhaustive in its attempt to examine and compare client outcomes, harm, and leadership styles across different processes and different experts in those processes. Bob Goulding led a Redecision group as part of the study. His group produced the greatest amount of positive changes and the least amount of harm. Additionally, his leadership style contained the elements found to be most effective at facilitating change. This style is identical with the stance and attitude taught by the Gouldings and the Fielding Graduate Institute's own John Gladfelter and Gene Kerfoot: Engaged, positive, alive, caring, dedicated to helping the client find meaning, and providing just enough structure and direction for the client to do his or her work.

This study, while compelling, has limitations on its applicability to individual Redecision. First and most obvious, this was a study of group processes. While group Redecision has been described as "individual therapy in a group" because one person does "work" at a time, it is questionable whether these results can be generalized to individual Redecision. Second, while attempting to control for leader effects by inviting "experts" in each approach, the superior showing of the redecision group could simply be a result of Bob Goulding being a superior group leader and not attributable to the redecision process. Third, all of the participants were drawn from Stanford college students registering for a Race and Prejudice class and therefore its generalizability is limited. Fourth, the groups were "encounter" or personal growth oriented and not specifically designed to examine efficacy with regard to psychological distress or disorder.

The outcome study of Cross and colleagues (Cross, Sheehan, & Khan, 1980, 1982; Sheehan & Cross, 1981) compared individual therapy with psychiatric outpatients using either Redecision or CBT for a 3-month period. Post-therapy results revealed no significant difference between groups in changes in target symptoms, social and personality functions, and psychiatric estimates of change. It is interesting to note that the Redecision, while not particularly symptom oriented, did show slightly stronger symptom reduction at the end of the study and greater improvement based on global estimates of therapists. Follow-up data taken 4 and 12 months after treatment revealed no statistical differences between the two groups (Cross et al., 1982). These results are important in light of the fact that CBT is traditionally regarded as the treatment of choice for strongly disturbed patients.

Process Research

A large amount of research has consistently supported the importance and use of the various processes used in humanistic and PET, and their positive effects on therapeutic outcomes. Examples of these processes include the role of emotions, empathy and other humanistic values, empty-chair work, therapeutic task creation and completion, and client agency. One of the most important process techniques used by PET and Redecision is Gestalt empty-chair dialogue. It is used typically to expose conflict splits between ego states/voices and ultimately to stimulate redécisions. Efficacy of empty-chair dialogue has been well researched by Greenberg and has consistently been found to correlate significantly with positive therapeutic outcomes. In a range of studies, Greenberg and colleagues have compared the empty-chair dialogue method with focusing, empathic mirroring, and cognitive problem solving. I review several of these studies below:

- Comparisons with empathic mirroring have indicated that the empty-chair method leads to greater depth of experiencing, greater change in awareness (L. S. Greenberg, 1975; L. S. Greenberg & Rice, 1981), and improved conflict resolution (L. S. Greenberg & Clarke, 1979; L. S. Greenberg & Dompierre, 1981).
- Comparisons with experiential focusing showed that empty-chair work produced significantly greater depth of experiencing, but that both treatments produced significant shifts in awareness (L. S. Greenberg & Higgins, 1980).

- Comparisons with behavioral problem solving indicated that the empty-chair method was more effective in reducing indecision. Both treatments were superior to a wait-list control for facilitating movement through the stages of decision making (Clarke & Greenberg, 1986).
- Comparisons with Client Centered Therapy showed that PET sessions in which chair dialogues occurred achieved significantly greater depth of experiencing, emotional intensity, and a greater degree of problem resolution versus CCT sessions (Watson & Greenberg, 1996).
- Overall, empty-chair dialogue consistently correlates with positive therapeutic outcomes (Clarke & Greenberg, 1986; C. E. Hill et al., 1988; Meyer, 1981, 1990; Tscheulin, 1983; Buckley et al., 1981; G. E. Jones, Collins, Dabkowski, & Jones, 1988).

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See also "*The Journal of Redecision Therapy*" at www.themetro.com/redecision.