

What Does It Mean to Have A Meaning Problem? Meaning, Skill, and the Mechanisms of Change in Psychotherapy

(Forthcoming in *Philosophy, Psychiatry, & Psychology*)

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Abstract:

Psychotherapy is effective. Since the 1970's, meta-analyses, and meta-analyses of meta-analyses, have consistently shown a significant effect size for psychotherapeutic interventions when compared to no treatment or placebo treatments. This effectiveness is normally taken as a sign of the scientific legitimization of clinical psychotherapy. A significant problem, however, is that most psychotherapies appear to be equally effective. This poses a problem for specific psychotherapies: they may work, but likely not for the reasons that ground their theoretical explanations for their effectiveness. A prominent explanation for the findings of common efficacy in psychotherapy is to postulate that all successful therapies work by altering maladaptive meanings and providing patients with new, more adaptive meanings. This paper argues that the 'meaning view' of psychological change is likely mistaken; psychological problems are not normally problems of meaning nor are they directly ameliorated by changes in meaning. This paper then outlines a skill-based explanation for the findings of the common efficacy of psychotherapy.

1. Introduction

Psychotherapy is effective. Since the 1970's meta-analyses, and meta-analyses of meta-analyses, have consistently shown a significant effect size for psychotherapeutic interventions when compared to no treatment or placebo treatments (e.g. Smith & Glass, 1977; Luborsky et al., 2002; Wampold et al., 1997). This effectiveness is normally taken as a sign of the scientific legitimization of clinical psychotherapy. A significant problem, however, is that psychotherapies with distinct, and often incommensurate, theoretical foundations appear to be equally effective. While individual studies directly comparing therapies, or comparing therapies to placebos, often show the superiority (if often only minor) of one particular therapy over another, meta-analyses of clinical studies consistently show a general lack of statistically significant differences between the outcomes of most forms of standardized psychological interventions (e.g., Bergin & Garfield, 1994; Hubble, Duncan, & Miller, 1999; Lambert, 2013;

Wampold & Imel, 2015). This poses a problem for specific psychotherapies: they may work, but likely not for the reasons that ground their theoretical explanations for their effectiveness.

The two prominent types of explanation for the finding of common therapeutic efficacy have been to either (1) challenge the accuracy and/or methodology of meta-analyses that purport to show an equivalence of effectiveness across different therapies (e.g., Crits-Christoph, 1997; Butler et al., 2006; Marcus et al., 2014), or (2) to attempt to identify underlying common factors that would explain the common efficacy of seemingly disparate therapeutic techniques and theories (e.g., Rosenzweig, 1936; Frank & Frank, 1991; Wampold & Imel, 2015). The type (1) explanations normally accept that different therapies may tend to work equally well for mild psychological impairments, but argue that more severe or chronic impairments (such as personality disorders, eating disorders, or obsessive-compulsive disorders) are best treated by specific therapeutic techniques. However, this response, predictably, can be, and is, made by advocates of theoretically incommensurate therapies and is in conflict with the large number of studies showing general efficacy of multiple forms of therapy for both mild and severe forms of psychopathology (Wampold & Imel, 2015).¹ This dispute shows no sign of a resolution, but even if it is the case that some therapies are found to be more successful in treating some psychological maladies, it still must be explained why most forms of psychological disturbances respond equally as well to different, and often theoretically incompatible psychotherapies.

The most common type (2) explanation has been to postulate that non-specific (to any given theory) common factors (such as an emotionally charged confiding relationship, a healing setting, and a coherent theory/rationale) explain psychological change (as opposed to the specific factors postulated by distinct theories) (e.g., Frank & Frank, 1991; Messer & Wampold, 2002; Miller et al., 2005). According to this view, theoretically and functionally distinct therapies such as cognitive behavioral therapy (CBT) and psychodynamic therapies are supposed to be efficacious only because they share particular therapeutic ingredients common to all efficacious therapies. The empirical or theoretical ‘truth’ of the particular delivery method is taken to be irrelevant; all that matters is that the therapy succeeds in delivering the common factors that lead to psychological healing (e.g., Frank, 1995; Wampold, 2001).

The so-called ‘common factors’ theories, while plausible, are also in need of a model of the relation between the common factors and therapeutic change; they need to explain why the

¹ While most meta-analyses support the Dodo bird findings, not all published meta-analyses support the claim of general therapeutic efficacy. For example, Cuijpers et al., (2008) found a slight superiority in efficacy for interpersonal therapy for depression (though this difference did not last over time). Similarly, a recent meta-analysis by Marcus et al., (2014) found CBT to be ‘slightly more effective’ (p. 519) than other therapies in treating primary symptoms, though they found that ‘treatment differences...usually dissipate at follow up [of around 6 months]’ (p. 529). Though, see Wampold et al., (2017) for a criticism of these findings.

common factors are supposed to enable psychological healing. According to influential common factors models proposed by psychologists Jerome Frank (Frank, 1961; Frank & Frank, 1991), Bruce Wampold (Wampold, 2001; Wampold & Imel, 2015), and Aaron Beck (Beck, 1987, 1991, 2004; Alford & Beck, 1998), psychotherapies are supposed to work by altering maladaptive meanings and providing patients with new, salubrious, and more adaptive meanings.² These models share the assumptions that the alteration of meanings is the primary mechanism of change in psychotherapy and that the problem being addressed in psychological interventions is primarily a problem of maladaptive meanings.

This essay will address three interrelated philosophical and theoretical questions concerning the ‘meaning theory’ of psychological change. First, what does meaning have to do with psychopathology? Is psychopathology a problem of meaning, or is it merely ameliorated in part by a meaning-based solution? And finally, what is supposed to be maladaptive about the meanings being altered in psychotherapy (and what is adaptive about the meanings that replace them)? This essay argues that the meaning theory of psychological change is likely mistaken; psychological disorders are not normally problems of meaning nor are they directly ameliorated by changes in meaning. Rather, psychotherapeutic change is best explained by the development of the patient’s self-regulatory skills. According to the skill view outlined here, the therapeutic common factors are effective only insofar as they help enable skilled action.

2. The Common Factors Theories

The findings of common psychotherapeutic efficacy has been christened the ‘Dodo bird’ effect, after the psychiatrist Saul Rosenzweig’s (1936) reference to the Dodo’s pronouncement in *Alice in Wonderland* that: “Everybody has won and all must have prizes”. Rosenzweig’s Dodo bird claim was directed toward the apparent lack of differences in outcomes of rival therapies despite the proliferation of theories and inter/intra-theoretical disputes. Rosenzweig also offered the first attempt at an explanation for the Dodo bird findings: effective therapies are likely effective because “there are inevitably certain *unrecognized* factors in any therapeutic situation— factors that may be even more important than those being purposefully employed” (1936, p. 412). In the recent psychological literature, there have been three significant attempts to identify these ‘unrecognized factors’ and explain the common efficacy of psychotherapies: Frank’s persuasion theory, Wampold’s contextualist model, and Beck’s integrative cognitive theory.

² For similar common factor views, see: Miller, Duncan, & Hubble (2005); Lambert (1992); Orlinsky & Howard (1986); Goldfried (1980); Anderson, Lunnen, & Ogles (2010).

The most influential starting point for explaining the Dodo bird effect is Jerome Frank's claim that therapy is best understood as a form of rhetoric (Frank, 1961; Frank & Frank, 1991). According to Frank, all successful psychological healing systems share four non-specific (to any given theory) common factors: an emotionally charged confiding relationship, a healing setting, a healing ritual, and a coherent theory/rationale. Psychological healing is conceived of as a matter of persuasion with the common factors being necessary enabling components. According to Frank (1991):

the aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meanings of experience to more favorable ones (p. 30).

Frank's 'assumptive worlds' are supposed to be meaning-making interpretations of all external and internal stimuli based on "assumptions about what is dangerous, safe, important, unimportant, good, bad, and so on" (1991, p. 24). These assumptions (both conscious and unconscious) form highly structured attitudes, beliefs, and behavioral dispositions. Frank claims that individuals seek psychological help in order to combat 'demoralization', which results from unhealthy, unfavorable, or somehow maladaptive assumptive worlds. To be demoralized, in this context, is "to deprive a person of spirit, courage, to dishearten, bewilder, to throw a person into disorder or confusion" (1991, p. 35). The four hypothesized common factors are supposed to promote healing by restructuring the patient's 'assumptive world' to a more favorable and remoralized state.

Frank's persuasion theory is clear about the source of psychological problems: psychopathology is primarily caused by maladaptive meanings (or demoralized assumptive worlds), and psychotherapy, when effective, is effective because it remoralizes patients by challenging their maladaptive meanings and replacing them with more adaptive ones. According to Frank (1991):

effective psychotherapies combat demoralization by persuading patients to transform these pathogenic meanings to ones that rekindle hope, enhance mastery, heighten self-esteem, and reintegrate patients with their groups (p. 52).

Wampold's contextual model is derived from, and meant to be largely consistent with, Frank's common factor theory.³ The "basic premise" of Wampold's model is that "the benefits of

³ The difference between Frank's and Wampold's theories is minimal. The primary differences between the theories are the number of common factors (i.e., Frank's four compared to Wampold's three), and Wampold's greater emphasis on the holistic nature of the common factors. of the therapeutic 'real relationship'. According to Wampold, Frank's common factors model '[contains] a set of common factors, each of which makes an independent contribution to outcome...in a contextual conceptualization of common factors, specific therapeutic actions...cannot be isolated and studied independently' (2001, p. 26).

psychotherapy accrue through social processes and that the [clinician/patient] relationship, broadly defined, is the bedrock of psychotherapy effectiveness” (2015, p. 50). The idea here is that psychological healing is an inherently interpersonal process, with the common factors playing a necessary enabling role in establishing and maintaining the patient/clinician relationship. The effectiveness of psychotherapy is supposed to be explained by three necessary common factors that influence the healing relationship: the ‘real relationship’, client expectations, and specific ingredients (i.e., specific psychotherapies). The real relationship is defined as an intimate personal relationship between the therapist and the patient, marked by empathy and caring on behalf of the healer and trust and emotional openness by the patient. The alteration of the patient’s expectations is considered necessary for psychological change insofar as it instills hopefulness (or remoralization) and, most importantly, because it challenges the patient’s folk-explanation for her psychological distress. According to this model, successful psychotherapy “provides an explanation for the client’s difficulties that is adaptive in the sense that it provides a means to overcome or cope with the difficulties” (2015, p. 58). The specific ingredient (i.e., the particular therapy) is claimed to be a necessary ingredient in successful therapy because it provides the patient with a coherent explanation for her problem and a cogent rationale for the expected healing process. As with Frank’s common factors theory, Wampold’s contextualist model posits that the truth or empirical status of the particular therapeutic ingredient is irrelevant to the healing; all that is necessary for psychological healing is that the patient accept the theoretical rationale, emotionally connect with the therapist, and adopt a more salubrious explanation for her psychological problem.

Wampold’s contextual model, like Frank’s persuasion theory, conceives of psychotherapy as a process of challenging and modifying patient-meanings. The ameliorative effects of psychotherapy are supposed to be explained by modifications of the meaning of patients’ folk-psychological beliefs about their psychological functioning. The therapeutic ‘real’ relationship, patient expectations, and a novel theoretical rationale are claimed to be essential aspects of psychotherapy because they enable the patient to construct or adopt new, more adaptive explanations of the meaning of his or her psychological problem. According to Wampold:

The essential aspect of psychotherapy is that a new, more adaptive explanation is acquired by the patient...what is critical to psychotherapy is understanding the patient’s explanation (i.e., the patient’s folk psychology) and modifying it to be more adaptive (2007, p. 862-3).

This new, ‘adaptive’ explanation is supposed to be salubrious because:

the contextual model states that the treatment procedures used are beneficial to the client because of the meaning attributed to those procedures rather than because of their specific effects. (2001, p. 27)

Wampold's contextualist model is less explicit than Frank's about identifying the primary causes of psychological maladies (as opposed to the causes of psychological healing), but is similarly based on the assumption that the psychological problems being addressed by therapy are problems of meaning. The contextual model frames psychological healing as process of altering patients' 'explanations' of their mental functioning from the (somehow) maladaptive to the adaptive. According to Wampold:

it is my contention that the patient's idiosyncratic explanations of mental functions are deeply involved in creating the patient's problems, that psychotherapy is intimately involved in altering these explanations (2007, p. 862)

Similarly, in reference to the 'real relationship', Wampold claims that:

a critical component of how [a good patient/therapist relationship] leads to change is involved in replacing a maladaptive explanation with an adaptive one. The maladaptive explanation is discouraging because the client cannot see how any action will lead to progress: Put simply, they are stuck (2010, p. 70).

The contextualist model, like the persuasion model from which it was built, assumes that the alteration of maladaptive meanings are the primary mechanism of change in psychopathology. Therapy is supposed to help patients become 'unstuck' by challenging and replacing their maladaptive meanings and explanations with more salubrious interpretations.

The third major common factors theory is derived from Beck's cognitive-behavioral therapy (CBT), the dominant form of psychotherapy in North America. According to this view, if other forms of therapy are effective, it is only because they are (either implicitly or explicitly) doing cognitive therapy (Beck, 1987; Alford & Beck, 1998; Beck, 2004). Note that the conditional in the last statement should be taken as truly conditional; Beck and colleagues routinely publish studies that purport to show the clinical and theoretical superiority of CBT over other forms of psychotherapy (e.g., Beck & Dozois, 2011; Butler et al., 2006; Beck, 2005). At its most basic, the cognitive model of psychotherapy posits that cognitions (i.e., thoughts, beliefs, and assumptions) play the primary role in the development and treatment of dysfunctional psychological states (Beck, 1967, 1979; Clark & Beck, 1999; J. Beck, 2011). Cognitive therapy aims at identifying and challenging maladaptive thoughts and beliefs (either directly through

introspection and talk therapy or indirectly through behavioral change) and replacing them with more adaptive interpretations.

The alteration of patient-meanings plays a central role in Beck's cognitive theory of psychopathology and psychological change. According to the cognitive model:

Psychopathology results from maladaptive meanings constructed regarding the self, the environmental context (experience), and the future (goals), which together are termed the *cognitive triad*. Each clinical syndrome has characteristic maladaptive meanings associated with the components of the cognitive triad (Alford & Beck, 1998, p. 17).

Cognitive theory is grounded on the assumption that 'information processing', or the transformation of endogenous and exogenous stimuli into meaningful representations, is the primary function of the human mind (Clark & Beck, 1999). Clark & Beck (1999) state that, "the central tenet of the cognitive model is that human information processing or meaning construction influences all emotional and behavioral experiences" (p. 55) and that the "modification of meaning-assignment structures is central to the human change process" (p. 70). According to the cognitive model, psychological disorders are the result of maladaptive schemas (i.e., the "basic structures that integrate and attach meaning to events") and modes (i.e., interconnected clusters of schemas) (Alford & Beck, 1998, p. 36).⁴

The cognitive model posits that how an individual's 'core schemas' (used interchangeably with 'core beliefs') organize and process incoming stimuli determines how that individual organizes and conceptualizes his or her "personal construction of reality" (Clark & Beck, 1999, p. 60). Therapy is supposed to be successful because it challenges the patient's specific maladaptive core beliefs (e.g., "I am unlovable" or "the world is unsafe"), either directly (as in CBT interventions) or indirectly (as in other non-cognitive, but efficacious, treatments), and provides patients with more adaptive and salubrious interpretations of the world

According to Beck's integrative cognitive theory, the modification of maladaptive schemas is supposed to be *the* common factor found in effective psychological treatments. Alford and Beck (1998) state that:

⁴ Beck's use of the term "schema" is often ambiguous. Beck normally uses the terms "schema" and "core belief" interchangeably. See: Beck et al., 1979, p. 4; Beck, 1991, p. 195; Beck, 1997, p. 58; Clark & Beck, 1999, pp. 82-83; Wenzel, Chapman, Newman, Beck, & Brown, 2006, pp. 504-505; DeRubeis, Webb, Tang, & Beck, 2010, pp. 280-281; Clark & Beck, 2010, p.36). Beck also sometimes uses the term belief to mean the content of schema (e.g., Beck, Davis, & Freeman, 2015, pp. 30-33).

“the analysis of the therapeutic components and procedure of psychoanalysis, behavior therapy, and other systems of psychotherapy suggests one common factor— the modification of core beliefs or schemas’ (p. 99).

Of course, most theories accept that at some level therapy changes the way we think; cognitive theory is making the much more substantive claim that groupings of specific, consciously accessible maladaptive beliefs, thoughts, and assumptions (e.g., ‘If I’m not a success, I’m a failure’) are the primary mechanisms of both psychological dysfunction and change (Beck, 1991; Alford & Beck, 1998). Cognitive theory posits that “individuals can become aware of the content and processes of their thinking”, and that psychotherapy is effective when it enables patients to identify and challenge their maladaptive cognitive content and processes and “shift their cognitive appraisals from one’s that are unhealthy and maladaptive to ones that are evidence-based and adaptive” (Beck & Dozois, 2011, p. 400).

Despite Beck’s claim that cognitive modification is the sole common factor, there is significant overlap with both Frank and Wampold’s theories. Beck’s integrative cognitive theory acknowledges that remoralization (or in Beck’s terms, “expectations for improvement”) is typically an important constituent of effective therapy (Alford & Beck, 1998, p. 45), and it also accepts that the therapeutic relationship is a “major vehicle for improvement” (Alford & Beck, 1998, p. 48). It differs from the other two theories, however, in claiming “cognitive primacy”. According to Beck’s cognitive theory, “all other psychological processes are explained by means of cognitive concepts...cognition alone provides meaning (or coherence) to the various other basic psychological processes” (Alford & Beck, 1998, p. 45). The other putative common factors, then, may *influence* healing, but they are supposed to be salubrious only insofar as they help enable the alteration of patients’ maladaptive core beliefs or schemas.

2.1 Meanings in Psychotherapy

What the three common factors theories have in common is a shared assumption that the alteration of patient-meanings is the primary mechanism of change in psychotherapy. The common factors (whatever they may be) are supposed to be necessary constituents of successful psychotherapy only insofar as they enable patients to alter their maladaptive thoughts, beliefs, or attitudes. The theories differ (if only slightly) in identifying the specific common factors that are supposed to enable this change in meaning.

The three models also share a belief-based conception of ‘meaning’; they all assume that the meanings being altered in therapy are, or are determined by, doxastic attitudes. According to Frank, “meanings are determined by an organized set of assumptions, attitudes, or beliefs...that

we have termed the assumptive world” (1991, p. 50). According to Wampold, patients’ meaning-making explanations for their psychological problems are either adaptive or maladaptive mental states “formed from their own psychological beliefs” (Wampold & Imel, 2015, p. 58). And, according to Beck, meaning-making schemas are “attitudes, beliefs, and assumptions which influence the way an individual orients himself to a situation, recognizes and labels the salient features, and conceptualizes the experience” (1964, p. 561). Successful therapy, then, is just supposed to be a matter of convincing the patient to accept more adaptive doxastic states.

So, according to the three common factors theories, the alteration of maladaptive patient-meanings is supposed to explain why the common factors lead to salubrious psychological change, and, thus explain the cause of the Dodo bird findings of the general efficacy of psychotherapy. The second half of this paper argues that this view is likely mistaken, and outlines a skill-based alternative to the meaning-based explanation of psychological change.

3. The Problems with Meaning

The main common factors theories assume that meanings are the primary mechanisms of change in psychotherapy. What is left unclear from this explanation is why certain meanings or explanations are harmful or maladaptive. What exactly is maladaptive or harmful about the meanings being challenged and replaced? And what is it about ‘adaptive’ meanings that is supposed to be ameliorative? The four most plausible explanations given by the common factors theories are that the content, valence, hopefulness, and dominance of the meanings explains whether they are adaptive or maladaptive, and thus why therapy is effective. This section considers, and rejects, all four answers. Alterations in patient-meanings clearly play *a* role in explaining psychological healing, but a further variable is needed to explain why changes in meaning (be they changes in content, valence, hopefulness, or dominance) may be salubrious.

3.1 The Meaning Content Hypothesis

The common factors theories all focus to some extent on the *content* of patient-meanings as a target of psychotherapeutic interventions. Beck’s CBT aims to accurately identify, then challenge, specific maladaptive core beliefs (e.g., ‘my value as a person depends on what others think of me’ or ‘I should always be at peak efficiency’) (Beck, 1979), while both Frank’s and Wampold’s models claim that successful therapy replaces patients’ maladaptive ‘idiosyncratic explanations’ or ‘assumptive worlds’. Call this the ‘Meaning Content Hypothesis’:

Meaning Content Hypothesis: specific meaning-content is maladaptive. Effective psychotherapies challenge and alter the maladaptive content of patients' meaning attributions.

This does not work. The common factors theories cannot consistently claim that it is the particular content of the meanings that is maladaptive, while also maintaining that the specific content of the therapy is irrelevant to its success. Different therapies target different meanings. Consider the plurality of meaning contents that different psychotherapies attribute to pathological anxiety. The content being addressed in Freudian treatments range from the patients' perceived loss of some object to subconscious castration anxiety (Freud, 1936). Modern psychodynamic psychotherapy targets patients' unacknowledged rage and subconscious fantasies (Busch et al., 1999). Radical acceptance therapy targets patients' self-judgments and unworthiness-centered belief content (Brach, 2003). While cognitive therapy for anxiety focuses on directly challenging threat-based content (Clark & Beck, 2011). According to the Dodo bird findings, these therapies are all supposed to be effective in treating anxiety; everyone wins and all get prizes. And according to the common factors theories, this common efficacy is explained by a change in meaning. But if specific meaning-contents are the variables of control in psychotherapy, and different therapies target different meanings, then everyone should not be winning.

The common factors theories are explicit in stating that the content of a specific therapy is supposed to be irrelevant to its success. For example:

The criterion of the 'truth' a psychotherapeutic interpretation, as of a religious text, is its plausibility. The 'truest' interpretation would be one that is most satisfying or that makes the most sense to the particular person or interpretative community (Frank, & Frank, 1991, p. 73).

The truth of the explanation is unimportant to the outcome of psychotherapy. The power of the treatment rests on the patient accepting the explanation rather than whether the explanation is 'scientifically' correct (Wampold, 2007, p. 863).

Techniques from diverse systems of psychotherapy (cognitive, behavioral, psychodynamic, humanistic, and experiential) enable patients to disconfirm the basic dysfunctional beliefs embodied in the dysfunctional schemas...Regardless of the approach to cognitive modification (direct or indirect), the dysfunctional beliefs that are activated during acute episodes of a disorder are no longer found when the episode is over (Alford & Beck, 1998, p. 99).

So, according to the common factor theories, both the Freudian focus on sexuality and subconscious wishes and the CBT-based focus on consciously accessible thoughts and beliefs are supposed to be effective because, *despite their differences in content*, they are hypothesized to share some underlying common factor(s). Similarly, the specific content of the maladaptive patient-meanings being treated in any particular therapy, as well as the content of the successful patient's new, and more adaptive meanings, should be irrelevant to explaining the ameliorating powers of the common factors (and successful therapies in general). The common factors theories are committed to the claim that it is immaterial to the success of therapy, and thus to patients' mental health, whether patients' specific meaning attributions are focused on existential terror, perceived loss, thoughts of unworthiness, learned behavioral rules, spiritual closeness to a creator, or whatever. Whether one views the world through a Freudian inspired worldview (i.e., one constituted in part by subconscious, non-cognitive drives and desires) or a CBT inspired folk-psychological theory of mind (i.e., one that assumes a theory of cognitive functioning that includes consciously accessible, hierarchically structured, and logically connected thoughts and beliefs) is supposed to have no direct influence on one's psychological health. Similarly, whether a patient attributes her psychological distress to repressed subconscious memories of childhood trauma or to consciously accessible maladaptive core beliefs is, according to the common factors models, irrelevant to the patient's mental health. The common factors theories are committed to the claim that particular theories of psychological functioning are only relevant to psychological health insofar as they offer the patient *a* coherent explanation for her problem; the truth of the explanation, and its particular content, is supposed to have no necessary relation to mental health.

One option available to an advocate of the content hypothesis is to claim that while different therapies may target different thoughts, beliefs, and assumptions, they are only effective because they are either directly or indirectly altering specific patient-meanings. Beck's integrative cognitive theory takes this view. So, for example, while a psychodynamic treatment of panic disorder may focus on uncovering patients' unconscious "compromise between angry feelings and fantasies and fears of abandonment" (Busch et al., 1999, p. 235), and CBT for panic disorder may focus on uncovering and challenging patients' "catastrophic misinterpretation of bodily sensations" (Clark & Beck, 2010, p. 292), both forms of psychotherapy are supposed to be effective because both are challenging specific maladaptive core beliefs such as "heart palpitations are dangerous" and "I could suffocate to death". CBT is supposed to do this directly, while psychodynamic (and all other efficacious) therapies challenge these specific beliefs indirectly. However, this approach doesn't work either. First, this option is available to all theories of psychotherapy; *any* theory can claim that all other efficacious therapies are effective only because the content of these therapies is translatable (however tortuously) to

the content of the therapy in question. Second, and most seriously, the translation claim doesn't explain why the direct or indirect alteration of specific patient-meanings appears to make no statistically significant difference to the success of therapy. If the alteration of specific patient-meanings is the mechanism of change in psychotherapy, then it is mystery why the success of psychotherapy should have no necessary relation to the actual thoughts, beliefs, and assumptions being explicitly altered in therapy.

3.2 The Meaning Valence Hypothesis

The common factors theories, then, also need an explanation for why the disparate meanings being changed in therapy are health-promoting. One option is to claim that the *valence* of a patient's meanings is the locus of both treatment and development in psychopathology. Call this the 'Meaning Valence Hypothesis':

Meaning Valence Hypothesis: the alteration of the valence of patient-meanings (e.g., from negative to positive) explains therapy's common efficacy.

This, on the surface, may seem plausible and seems to be assumed by all three theories. Both Frank (1991) and Wampold (2007) claim that patients come to therapy because they are demoralized, while Beck states that mental disorders are marked by positively or negatively polarized core beliefs (Clark & Beck, 1999). Indeed, it is well established that positively or negatively valenced thoughts are associated with emotions valenced in corresponding directions. Negative thoughts are correlated with negative feelings and low mood while positive thinking is correlated with an increase in positive mood and the experience of well-being (Clark & Beck, 1999; Fredrickson et al., 2008). It may be thought, then, that valence of one's meanings (whatever their specific content) is the primary cause of psychopathology and the primary control variable in psychological healing. Negatively valenced meanings (e.g., 'I am unlovable') may be the primary cause of maladaptive psychological states such as depression, while positively (or neutrally) valenced meanings may be the primary cause of adaptive (or at least non-maladaptive) psychological states. According to this view, then, the alteration of the valence of patient-meanings (e.g., from negative to positive) explains therapy's common efficacy. However, while plausible, this is likely not the case; the valence of meanings may affect mood, but it does not explain why low or high mood becomes pathological.

The problem here is that the valence of a person's meanings does not explain why some meanings are supposed to be pathological and others healthy. Negative or pessimistically valenced meanings do not necessarily lead to depression, despair, or demoralization, and positively valenced meanings are not necessarily salubrious. For example, a number of studies

show Asian-Americans to be significantly more pessimistic (though not less optimistic) than European-Americans (e.g., Chang, 1996, 2002; Hardin & Leong, 2005). However, this significant difference in experienced pessimistic meaning-attributions does not correlate with an increase in maladaptive psychological states (such as depression or anxiety); Asian-Americans are just as mentally healthy (or ill) as the national average (e.g., Chang, 2002). Similarly, nihilistic philosophers (or any adherent to world views that deny the existence of inherent meaning in life) and futurists who forecast coming centuries to be constituted by an inevitable human destruction of the planet, are, as far as anyone can tell, not necessarily mentally ill despite spending much of their mental lives thinking about, and endorsing, negatively valenced ideas. Pessimism and negatively valenced thoughts may be correlated with pathological low mood, but the valence itself does not explain the pathology. Negatively valenced meaning-attributions about the world, self, or future may affect one's happiness or mood, but they needn't have any effect on one's mental health.

The converse is also true: positive meaning-attributions needn't lead to adaptive psychological states. Manic episodes are diagnosed in the DSM-5 in part by the symptoms of persistent elevated mood, elevated self-esteem, and extreme goal-directed behavior (APA, 2013). Individuals experiencing manic states often describe them as exhilarating, hopeful periods of optimism and high self-regard, and these symptoms can range from weeks to months in duration. However, a person experiencing a manic episode is not normally considered psychologically well-functioning just because she is experiencing positively valenced thoughts about herself, her world, and her future. On the contrary, in many cases (such as in the case of bipolar disorders) positive-valenced meaning content is not salubrious, and is in fact maladaptive.

It is certainly true that the valence of a person's meanings is often strongly correlated with the adaptiveness of her or his psychological state. It would be surprising if a person diagnosed with major depression had frequent positively valenced thoughts about herself and her world. But it is a mistake to conflate the valence of a person's meanings with the primary cause for her dysfunction or to consider it the primary variable of control in therapy. Believing that the future is doomed does not make you pathologically depressed, just as believing that you are wonderful and the future is full of opportunity (as one might think while in a manic state) does not make you non-pathological. The valence of an individual's meanings may lead to mood changes, but not, by itself, to pathological mood or psychological health. Something besides the valence or the content of meaning attributions is needed to explain the Dodo bird effect.

3.3 The Hope Hypothesis

One possible explanation, similar to the valence hypothesis, is to claim that meaning change is salubrious, at least in part, because it raises patients' expectations and instills hopefulness. Call this the 'Hope Hypothesis':

The Hope Hypothesis: meaning change is salubrious, at least in part, because it raises patients' expectations and hopefulness.

Frank's and Wampold's common factors theories both adopt this view.⁵ According to Frank, this new hope helps to remoralize the patient, while Wampold claims that raised expectations influence patients to accept new, more adaptive explanations for their psychological problems. Both Wampold and Frank are likely correct in arguing that hope and expectations of improvement are important parts of successful therapies. An important aspect of any therapy is motivating the patient to participate, and hope often is a powerful motivating force. But there is a significant disanalogy between hopefulness and mental health: expecting, hoping, or believing that one is psychologically healthy does not make one healthy. Individuals dealing with common maladaptive psychological issues such as mania or narcissistic personality disorder often think they are fine, or even great, and often have very high expectations about their future. Mania, as noted above, is marked by what we can call *super*-moralization (as opposed to demoralization), while pathological narcissism is marked by grandiose views of one's self, future, and place in the world (APA, 2013). Hopeful and super-moralized cognitions are often part of the problem being treated in psychotherapy (Gruber et al., 2011; Gruber, 2011; Greenhouse et al., 2000). A significant difficulty in treating these psychological problems is convincing the patients that they have a problem that needs treating in the first place. If positive and hopeful expectations is the explanation for improved mental health, then we should expect hopeful individuals to be psychologically well functioning; but this is often not the case. Successful psychological interventions may, and likely very often do, raise the expectations of patients and heighten their perceived sense of self-efficacy, but this change in expectations cannot be the primary control variable in psychological healing given that that hopefulness and positively valenced expectations are not always a good thing for mental health.

⁵ Beck's cognitive theory acknowledges that increased expectations play a significant role in successful therapy, but claims that these expectations are salubrious only insofar as they help engender changes in core schemas (e.g., Beck et al., 1979; Alford & Beck, 1998).

3.4 The Meaning Dominance Hypothesis

A final meaning-based explanation for the efficacy of the common factors, found to varying degrees in all three theories, is that maladaptive meanings (somehow) exclude other, more adaptive, meanings and come to *dominate* the mental life of individuals experiencing mental disorders. The idea, here, is that successful therapy enables a more balanced mental life. Call this the 'Meaning Dominance Hypothesis':

The Meaning Dominance Hypothesis: Maladaptive patient-meanings (somehow) dominate an individual's mental life during instances of mental disorder. Meaning change is salubrious, at least in part, because it enables the inclusion of other, more adaptive, patient-meanings.

Frank clearly endorses this view. He claims that maladaptive assumptive worlds are 'resistant to change' and biased towards 'confirmatory experiences', and argues that successful therapy helps patients modify these meaning-attributions to be more harmonious and adaptable to changes in circumstance (1991, p. 32, pp. 50-51). Wampold's contextualist theory is consistent with the dominance hypothesis, but does not explicitly endorse this claim. As noted, the contextualist theory argues that individuals seeking therapy have idiosyncratic folk-explanations for their distress that leave them 'stuck' (Wampold, 2010, p. 70). It is consistent with this view to hold that these maladaptive explanations are intransigent because they dominate or exclude other, more adaptive, explanations. Beck explicitly endorses the dominance hypothesis. According to the Beckian cognitive theory, mental disorders are marked 'hyperactive idiosyncratic schemas' that '[because] of their greater strength...displace...more appropriate schemas' (Beck, 1967, p. 286). In the case of depression, 'specific idiosyncratic schemas assume a dominant role in directing the thought processes' (Beck, 1964, p. 564), and these 'depressive schema [are] so potent that the patients are unable to energize other schemas sufficiently to offset its dominance' (Beck, 1967, p. 286). Successful therapy is supposed to identify, then challenge these dominant maladaptive schemas, thus weakening the strength of maladaptive modes of thinking and allowing for more 'appropriate' core beliefs to structure one's interpretations of incoming stimuli.

There is some initial plausibility to this hypothesis. Indeed, an intuitive way of describing mental disorders such as depression, anxiety, or obsessive disorders is as mental states that are (somehow) dominated by specific doxastic states (e.g., depressive beliefs, anxious or worried thoughts, or obsessions). Successful therapy, then, would just be a process of weakening the strength of certain patient-meanings to enable more adaptive meanings to structure how individuals interpret the world. The problem, however, is that, if tenable, the dominance

hypothesis cannot be a claim about dominant *meanings*. If this hypothesis is supposed to be an explanation for why the doxastic states being altered in psychotherapy are maladaptive, and why the new doxastic states arrived at through therapy are salubrious, then the dominance hypothesis runs into the same problems as the content, valence, and hope hypotheses. Namely, there is nothing necessarily maladaptive about the ‘dominant’ beliefs, assumptions, or thoughts being altered in therapy, and nothing necessarily salubrious about the new meanings arrived at through therapy.

The same meanings may be present and dominant in both disordered and non-disordered states. For example, Beck hypothesizes that the minds of depressed individuals are often dominated by purportedly maladaptive beliefs such as ‘If I’m not on top, I’m a flop’, ‘In order to be happy, I have to be successful in whatever I undertake’, and ‘It’s wonderful to be popular, famous, wealthy; it’s terrible to be unpopular, mediocre’ (Beck, 1976, p. 255). However, the minds of non-pathological optimists and extremely goal-directed individuals may be described as being dominated by these exact same beliefs. Similarly, both depressive and philosophically nihilistic world views may be dominated by the same ‘maladaptive’ core beliefs such as ‘the future is pointless’ or ‘I don’t see any point to living’ (Beck, 1967, p. 12, p. 84). The thoughts of both achievement-oriented optimists and philosophical nihilists can be driven by rigid, change-resistant beliefs that dominate their work and personal lives, yet rather than being pathologized, these mindsets are (at least sometimes) lauded for their single-mindedness and stubbornly-held doxastic states. The problem for the meaning-based dominance hypothesis is that while the predominance of certain beliefs may be associated with specific disorders (e.g., the predominance of negatively valenced beliefs may be associated with depression), the predominance or absence of specific patient-meanings has no necessary relationship with mental health. The dominance of any doxastic state (or states), then, does not explain why some belief states are adaptive, while others are maladaptive.

The common factors theories, then, are missing a tenable explanation as to why the presence of the common factors in psychological treatments is salubrious. Beck, Frank, and Wampold’s theories assume that the success of the therapeutic common factors is explained by the alteration of patient-meanings. This section has argued that this view is likely mistaken. While therapy may often succeed by changing how patients attribute meaning to, and conceive of, the world, it still needs to be explained why providing patients with new meanings can be health-promoting.⁶ The meaning dominance hypothesis, however, does point us in the

⁶ Note that this paper is not making the (fallacious) argument from (1) ‘some people meeting conditions C are not ill’, to (2) ‘interventions on conditions C cannot, per se, be therapeutic. Rather, the argument here moves from (1) some people meeting conditions C are not ill, to (2) explanations for the efficacy of therapy can’t appeal to ameliorating C as the full story as to why folks heal (given that C, by itself, is not a problem). So, interventions on C can be therapeutic, but the explanation for why they

direction of a more plausible explanation for the common efficacy of psychotherapy. The final section of this paper argues that dominance hypothesis is right in claiming that mental illness is marked by a 'dominated' mind, the mistake is in positing that this dominance is explained by the strength of particular doxastic states. The dominance hypothesis should not be a claim about meaning, but rather should be a claim about what individuals are *able* to do with these meanings (and mental phenomena, more generally). A more plausible dominance hypothesis will be a claim about skilled action, not meaning. According to this alternative view, the efficacy the common factors, and thus psychotherapy, is best explained not by the alteration of meanings, but by the enabling and development of the patients' skill of regulating how they respond to these meanings.

4. Alternative Hypothesis: Skill and Psychological Healing

The last section of this paper outlines the beginning of a skill-based explanation for the success of the therapeutic common factors that is compatible with versions of the three major common factors theories. The 'skill hypothesis' argues that the primary mechanism of change in psychotherapy is the patient's skill of self-regulation. According to this view, psychotherapy is best understood as *themed* skill training. What the common therapeutic factors have in common is that they provide patients with the skill to regulate their responses to their thoughts, emotions, and behavior. The explanatory focus here is on the modification of skilled action (such as the alteration of how responds to one's doxastic states), rather than the alteration of the content, valence, hopefulness, or dominance of patient-meanings. If changes in patient-meanings are salubrious it is only because the alteration of meaning allows patients to construct a coherent conceptual framework from which to develop regulatory skill. Psychological healing, according to this view, is skilled action that psychotherapy helps cultivate.

This paper adopts theory-neutral conceptions of skill and self-regulation. Self-regulation is defined here as the process of altering or controlling how one responds to stimuli.⁷ This includes stimuli that is created both exogenously (e.g., the words and actions of others) and endogenously (e.g., one's own thoughts, feelings, beliefs, and inclinations). Note that the focus here is on how one *responds* to mental content, not on the nature of the content itself. Self-regulation does not require the (likely impossible) ability to completely control the generation of all of one's thoughts, emotions, and behaviors, nor does it require that one only feel or think

are therapeutic (e.g., that they are altering maladaptive meanings), needs an explanation that does not just appeal to the badness of C.

⁷ Psychological theories of self-regulation normally focus on the ability of individuals to regulate their behavior to some 'ultimate' distal goal or to their conception of an 'idealized self' (e.g., Carver & Sheier, 1981; Baumeister et al., 1994; Fujita, 2011). This paper is adopting a much narrower conception of self-regulation. The focus here is on whether folks are able to alter, modify, or control their responses to their mental phenomena *regardless* of the standard that they are attempting to regulate to.

what one wishes. Rather, the focus of self-regulation is on one's ability to alter, override, or control how one responds to one's mental content, rather than on the specific content, valence, or hopefulness of one's doxastic states. Skill, here, is defined as the ability to act intelligently.⁸ The 'intelligence' constraint is meant to distinguish skill from merely reflexive, lucky, or successful action. Theories of skill differ over how to specify intelligence, but, minimally, intelligent action requires the ability to adapt, learn, and intentionally modify one's behavior in response to new information. Unskilled behavior, in contrast, is marked by an inability to control or intelligently modify how one performs some act. *Skilled* self-regulation, then, is the exercise of the ability to intelligently alter or control how one responds to one's thoughts, emotions, and environment.

The focus on the improvement of patients' skill of self-regulation, rather than the alteration of patients' meanings, explains why the psychotherapeutic common factors are salubrious. Successful psychotherapy necessarily provides patients with the skill to alter or control how they respond to their mental phenomena. Consider, for example, the DSM-5's list of the symptoms of common disorders: generalized anxiety disorder is marked by excessive anxiety and worried thought, and problems controlling these thoughts; major depression is marked by persistent sadness or lack of pleasure and negatively valenced moods; bipolar disorders are often marked by the periods of both extreme and unregulated negative and positively valenced emotions and cognitions; while schizophrenia is marked by a combination of delusions, hallucinations, disorganized speech, and diminished emotion or motivation (APA, 2013).⁹ Different theories of psychological healing offer differing, and often disparate, explanations for the causes and best treatment of these symptoms, but, if successful, no therapy leaves individuals *unable* to regulate how they respond to these symptoms.¹⁰ For example, regardless of the theoretical rationale, no successful therapy for depression will leave patients unable to alter or control how they respond to their negatively valenced thoughts or dysphoric mood, while no successful therapy for anxiety will leave individuals unable to regulate how they respond to their worry and anxious feelings. Regardless of whether a psychotherapy focuses on challenging maladaptive core beliefs or on providing insight to unconscious conflicts, all successful therapies will provide patients with the tools to alter or control how they respond to the symptoms of their disorder.

⁸ This paper is not committed to the metaphysical claim that skill just *is* ability.

⁹ These are not exhaustive definitions.

¹⁰ 'Success' here is judged either by symptom reduction or by a patient no longer fitting a standardized diagnostic criterion. Of course, not all therapies consider symptom reduction the ultimate end-goal of therapeutic interventions. But, if the efficacy of therapies is to be plausibly statistically compared, the comparison needs to be based on controlled studies using similar diagnostic criteria.

Psychotherapy need not, and often does not, completely excise these symptoms from patients' mental lives. The successful treatment of anxiety and depression, for example, does not require that individuals no longer feel anxious or dysphoric, nor does it require that they no longer experience intense worry or negative thoughts (APA, 2013). Similarly, obsessive thoughts, compulsions, hallucinations, and extremely elevated mood can all be present without an individual fitting the diagnostic criteria of any mental disorder (APA, 2013). The skill hypothesis' focus on skilled action, rather than meaning, explains why these same doxastic attitudes can be present, and even dominant, in both healthy and disordered mental states. The difference, for example, between a philosopher whose mental life is dominated by thoughts about the meaninglessness of human existence, and an individual experiencing major depression is that the philosopher, presumably, is able to regulate how she responds to the negative content, valence, and hopelessness of her thoughts, assumptions, and beliefs, while the individual experiencing a depressive state cannot. The nihilist philosopher may even feel intense sadness and angst due to the content and valence of her doxastic attitudes, but unlike the individual experiencing a mental disorder, the nihilist is able to override, alter, or otherwise modify her negatively valenced thoughts, beliefs, and assumptions (even if she chooses not to). Similarly, while the same doxastic attitudes can be predominant in both extreme optimism and mania (e.g., inflated self-esteem, high-risk behavior, intense goal-directed behavior), extreme optimists are able to regulate their responses these 'symptoms', while individuals experiencing manic episodes cannot. Achievement-focused optimists may orient much of their mental and emotional lives towards the achievement of some (possibly unrealistic) goal, and this goal-dominated mindset may be harmful, but it is not necessarily disordered (and, at least in the case of business and the arts, it is sometimes admired). The problem being ameliorated in psychotherapy is not the presence, valence, or strength of any particular doxastic attitude, but is rather a problem of individuals' skill in regulating these mental states.

The skill hypothesis explains what is right about the meaning dominance view. Mental disorders are marked by dominated minds, but this dominance is best understood as the inability to skillfully self-regulate. Consider, for example, Beck's (1967) description of a mind dominated by depression:

The vulnerability of the depression-prone person is attributable to the constellation of enduring negative attitudes about self, world, and future. Even though these attitudes (or concepts) may not be prominent or even discernible at a given time, they persist in a latent state like an explosive charge ready to be detonated by an appropriate set of conditions. Once activated, these concepts dominate the person's thinking and lead to the typical depressive symptomology (p. 277)

Beck is likely correct in claiming that depression is marked by a dominated mind, but as we've seen, there is nothing necessarily maladaptive about the content, valence, or hopefulness of the attitudes or concepts that are predominant in depression. Rather, in the case of depression (and mental disorder full stop), individuals are no longer able to intelligently alter or control how they respond to these predominant attitudes or concepts. The minds of individuals seeking psychotherapy may be 'stuck' or 'dominated', but they are only dominated insofar as individuals are unable to flexibly regulate how they respond to their mental content. Psychotherapy, if successful, enables patients to engage in skilled action to offset this dominance.

4.1 The Skill Hypothesis and the Common Factors

The skill hypothesis, like the meaning view, is meant to be a general claim explaining the efficacy of the therapeutic common factors and is compatible with versions of all three common factors theories. The theories of Frank, Wampold, and Beck attempt to answer two questions: (1) *what* are the common therapeutic techniques or processes that underlie all effective psychotherapies, and (2) *why* do these techniques or processes engender psychological healing. In response to the 'what' question, Frank postulated four common factors (a healing relationship, a healing setting, a healing ritual, and a coherent rationale), Wampold three (the real relationship, the client's expectations, and a coherent rationale), and Beck one (the modification of core beliefs). In response to the 'why' question, all three theories postulate that changes in patient-meanings are the primary mechanism of change in psychotherapy, and thus explain why the presence of the common-factors are salubrious. This paper challenges only the later claim.

The skill hypothesis is not committed to the truth of any particular answer to the 'what' question. It is possible, for example, that one of Frank, Wampold, or Beck is right about which common factors are required for successful therapy. This is still an open question. This paper only disputes their explanations for *why* these common factors are salubrious (whatever they end up being). Beck, then, may be correct in claiming that *the* common factor in effective psychotherapy is the modification of core beliefs or schemas. His mistake, however, is in arguing that the modification of patient-meanings explains *why* the presence of this common factor leads to psychological healing. The claim, here, is that the success of therapeutic interventions (regardless of the specific common factors) is best explained by the improvement of individuals' regulatory skill, not their personal meanings. The alteration of the content, valence, hopefulness, or dominance of patient meanings, along with other factors, may play a role in psychological healing, but the primary control variable is the patient's skill. The problem

being ameliorated in psychotherapy is not necessarily *what* patients thinks, believes, or feels, but rather *how*.

5. Conclusion

The Dodo bird findings create a problem for psychotherapeutic theories of psychological change. If all therapies are winning and getting prizes, regardless of theoretical and practical orientations, what explains the shared efficacy? Common factors theories maintain that the efficacy of psychotherapy is explained by shared mechanisms of change that enable adaptive alterations of the patient's maladaptive meanings. This paper has argued that the meaning view cannot fully explain the efficacy of therapy and is itself in need of a theoretical explanation. The skill view is meant to provide the beginning of such an explanation.

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