Advances in Behavioral Genetics Require Reconceptualizing Psychotherapy's Major Paradigms

By Stephen Bacon, Ph.D.

Abstract: This article critically examines the current paradigms in psychotherapy in the context of recent advances in behavioral genetics. It argues that the traditional Medical Model, with its focus on diagnosis and application of evidence-based techniques, is increasingly challenged by emerging themes including analyses of the outcome literature, constructionism, and new genetic insights. More specifically, these challenges provide evidence that techniques lack inherent power, that psychotherapy's privileged knowledge is unrelated to outcomes, and that the basic western concept that psychopathology is secondary to dysfunctional history is a construct. This triumvirate of findings argues that psychotherapy primarily occurs in constructed reality as opposed to the current dominant idea that it occurs in fundamental reality. Accepting that it occurs in constructed reality opens the doors to a useful paradigm shift—a shift that gives rise to a variety of factors which should correlate with enhanced outcomes. A number of these new factors are described and explained in order to clarify the nature of the paradigm shift and to point towards new evolutionary directions.

Key Words: Theories of Psychotherapy, Common and Specific Factors, Therapist Training and Experience, Constructionism, Behavioral Genetics, Evolution of Psychotherapy.

The Medical Model dominates the field of psychotherapy. With its commitments to diagnosis, application of evidence-based techniques, and development of psychological systems, the Medical Model characterizes the standard practice of psychotherapy and essentially determines the evolution of the field.

While these statements accurately summarize the current state of psychotherapy, there have been many Medical Model critiques that call into question its accuracy and efficacy. The single biggest theoretical problem arises from the fact that the plethora of psychological systems—with vastly different underlying philosophies and techniques—are all successful and appear to achieve equivalent positive results. Many theorists, recognizing that this level of chaos and inconsistency threatens psychotherapy's scientific identity, are trying to identify the "common factors" shared between systems or attempting to create systemic integration models (Castonguay & Goldfried, 1994).

Constructionism offers a more fundamental critique of the Medical Model by arguing that the concepts that underlie western psychology and psychiatry are culturally derived and context dependent (Burr,

2004). Some constructionists even argue, in line with Foucault, that the Medical Model may implicitly perpetuate power imbalances within western society (Gergen, 2009).

In addition to these more theoretical critiques of the Medical Model, one can also examine it from the perspective of the psychotherapy outcome research. In previous works (Bacon, 2018; 2020) I present a detailed literature review that embodies this approach. To support the primary arguments in this article, I will provide a brief highlight of the basic findings of that review.

The Medical Model is based on the concept that diagnoses describe real, discrete conditions and that they can be remedied by selecting from an armamentarium of evidence-based, effective techniques. The Medical Model accepts that common factors—such as an alliance with a wise and caring psychotherapist—are important but it insists that specific factors—techniques with inherent power—are responsible for a substantial percentage of the effect size. If it can be demonstrated that psychotherapeutic techniques lack inherent power, then the Medical Model will collapse.

Testing the hypothesis that techniques have inherent power is fairly straightforward. If techniques have inherent power, then experienced therapists—who know more techniques and have practiced them more assiduously—should get better outcomes than the inexperienced or less experienced. Similarly, trained therapists—who know psychotherapeutic techniques—should get better outcomes than the less trained or untrained. Moreover, the training and experience effects should be fairly large and easy to detect. Almost all therapists believe that both their training and their experience have substantially improved their therapeutic outcomes.

Following are some highlights from the literature review. 1) Large metanalyses have consistently found a near 0 correlation between experience and outcomes (Christensen and Jacobson, 1994). 2) Paraprofessionals—with much less experience and almost no training—get the same or better results than licensed therapists (Durlak, 1979; Weisz et al, 1995). 3) There is no evidence that training or supervision improve outcomes (Miller, Hubbard, and Chow; 2018; Hill and Knox, 2013; Malouff, 2012). 4) The few studies on untrained therapists versus licensed therapists show that both groups achieve equivalent, positive results (Strupp and Hadley, 1976; Anderson et al, 2016). In sum, there is no evidence for experience or training effects in psychotherapy. Hence, one should accept that techniques lack inherent power.

In addition to the no inherent power finding, the lack of training and experience effects have major implications for the usefulness of psychotherapy's privileged knowledge. Privileged knowledge refers to the idea that each profession is characterized by its unique privileged knowledge—the knowledge that is owned by the profession, the knowledge that must be mastered to succeed at the profession. Privileged knowledge includes psychotherapy techniques but also consists of everything related to mental health—concepts like diagnosis, prognosis, etiology, and client characteristics. Since training consists of the accumulation of privileged knowledge and experience implies that one is practicing/mastering this knowledge, the lack of training and experience effects means privileged knowledge is unrelated to outcomes.

Before concluding that everything that has ever been written or taught about psychotherapy is unrelated to outcomes, it's important to examine exactly what is meant by "privileged knowledge." Take "restful sleep is good for our mental health" as an example. This statement seems valid; it appears to have inherent power; and it is often present in interventions. The problem here is that the "sleep"

statement isn't really part of our privileged knowledge; it's actually "common" knowledge in that everyone, including beginning psychotherapists, already knows it. This common knowledge/privileged knowledge confusion is true of lots of ideas that we use in psychotherapy such as, "socialization is good;" "exercise is helpful for most people;" and "many people feel better if they get a dog or learn to stand up for themselves." In sum, we find ourselves in the awkward position of saying that the useful information in psychotherapy's privileged knowledge is part of common knowledge and our privileged ideas—like what is a schizoaffective disorder—consist of concepts that are unrelated to outcomes. Here's how Miller and Hubble (2011) summarize the disappointing findings about what psychotherapists learn: "The problem isn't that professionals are failing to acquire new knowledge or skills: the problem is that what's learned is unrelated to improved outcomes (p. 30)."

To return to our main theme: the techniques/privileged knowledge results have been presented previously; the purpose of this article is to complement and validate them by presenting some additional findings from the field of Behavioral Genetics. Robert Plomin is one of the senior researchers in this field; he has recently written a book, Blueprint (2018), which contains findings that have enormous implications for the field of psychotherapy. Two of these findings continue the evisceration of the Medical Model in the area of nosology. First, Plomin states that—in place of the hundreds of diagnoses detailed in the DSM V—there are only three diagnoses with underlying genetic differences.

> Hundreds of studies later, the genetic architecture of psychopathology suggests just three broad genetic clusters, in contrast to the dozens of disorders in psychologists' diagnostic manuals. One cluster includes problems like anxiety and depression, which are called internalizing problems because they are directed inward. The second genetic cluster, externalizing problems, includes problems in conduct and aggressiveness in childhood, and, in adulthood, antisocial behaviour, alcohol dependence and other substance abuse. Psychotic experiences such as hallucinations and other extreme thought disorders form the third genetic cluster, which includes schizophrenia, bipolar disorder and major depression. (Plomin, p. 67)

In addition, Plomin offers a second finding about psychiatric diagnoses that is even more provocative. In Blueprint, Plomin introduces the concept of "polygenic scores;" polygenic scores have been developed as a result of the so-called "DNA revolution." Since the decoding of the human genome in 2003, behavioral geneticists have switched their focus from "what is the average genetic contribution to any factor (e.g., to depression)" to "if we examine the individual gnome, can we predict how likely it is that person will develop certain behaviors (e.g., intelligence, schizophrenia, grit, etc.).

The initial, post human-genome-decoding research looked for an interaction between a limited number (e.g., 7 or 13) of genetic factors; unfortunately, testing these factors consistently failed to predict much more that 1% of the effect size. However, the establishment of large genetic databases such as "23 and Me" allowed the geneticists to conduct large scale GWAS (genome-wide association study) analyses. They were surprised at the results. It turns out that most behavioral variables have thousands of interacting genetic factors with no single factor making a large contribution to the outcome. This gave rise to the idea of the individual "polygenic score" which is simply the number of the predictive genetic markers in any particular genome.

Plomin goes on to share his own polygenic scores for various behavioral traits; more importantly, he demonstrates how well these scores predict important outcomes like academic achievement. He acknowledges that this work is in its infancy and predicts that the scores will quickly evolve and improve in their accuracy and usefulness.

Frankly, this is rather remarkable work in itself; however, it has particular implications for psychiatric diagnoses. More specifically, Plomin argues that these polygenic scores suggest that psychology and psychiatry have been confused about the binary--yes or no--nature of diagnoses; he recommends replacing all binary models with the concept of spectrum disorders. A polygenic score for depression or schizophrenia would measure our proclivity to a disorder and range from low to medium to high. Everyone would have a score on every scale. However, manifestation of the symptoms of the disorder would only occur when there is an interaction between current stress levels and our proclivity to that disorder.

> Genetic research shows that the medical model is all wrong when it comes to psychological problems. What we call disorders are merely the extremes of the same genes that work throughout the normal distribution. That is, there are no genes 'for' any psychological disorder. Instead, we all have many of the DNA differences that are related to disorders. The salient question is how many of these we have. The genetic spectrum runs from a few to a lot, and the more we have, the more likely we are to have problems. (Plomin, p. 58)

Just as with the number of diagnoses finding above, this "spectrum versus binary" finding is very challenging for the Medical Model. An oft spoken criticism of the DSM is that the diagnoses are simply descriptive and political and have little grounding in actual science (Bacon, 2018). Plomin validates such criticism and opens the door to a new way to view psychiatric diagnoses.

However, it is Plomin's next big critique of psychiatry that complements the earlier findings about lack of inherent power in techniques and no privileged knowledge effects on outcomes. Plomin's original genetic work tracked the general field; he was interested in demonstrating the strength of genetic factors on behavioral variables. He came to the conclusion that virtually every such variable had genetic influences. He then began to ask, "If on average, 50% of the effects on these variables is genetic, then 50% is environmental. How much of the environmental effects are intentional and sustained (such as schools and families) and how much is random?"

Fortunately for Plomin there is a simple, genetic research paradigm that addresses this question. If you take children adopted at birth, you can easily measure the effect size of intentional nurturance. The correlation with the birth parents measures genetic influence, the correlation with the adoptive parents measures intentional nurturance, and the remaining effect size is due to random environmental effects. Using this paradigm, let's look at weight. Most professionals assume that weight is partly genetic but is also determined by learning in the family context; in other words, some adoptive parents would model and/or impart healthy eating habits and others might be dedicated to junk food. Here's what Plomin discovered.

> The correlation between weight of parents and children is about 0.3 in 'control' families in which parents and their children share both nature and nurture. Is this similarity in weight between parents and their young children a sign of nature or nurture? The CAP

> results provide a clear and consistent answer. The weight of adopted children does not correlate with the weight of their adoptive parents. Their correlation is just about 0. This means that dietary and lifestyle differences of adoptive parents are not at all related to the weight of their adopted children. Similarly, siblings correlate about 0.3 for weight, but when two unrelated children are adopted into the same home their correlation for weight is near 0. Growing up in the same family does not make children similar in weight unless the children share genes." (Plomin, pp. 27-28)

Similarly, if environmental interventions at an early age can influence intelligence and problem solving, then there should be correlations between adoptive parents and adoptive children.

> By sixteen years of age, the correlation for intelligence was the same for adopted children and their biological parents as for children reared by their biological parents. The correlations between these adopted children and their adoptive parents, who share nurture but not nature, hovered near zero. Plomin, (p. 54).

In addition, the probability of divorce should be correlated between adoptive parents and their adoptive children given that these children learn a great deal about intimacy and connection from their home environment; in addition, they would only suffer the trauma of divorce via their adoptive parents.

> "It has long been known that the offspring of divorced parents are more likely to get divorced themselves. Possible environmental explanations leap to mind, for example, living through their parents' divorce causes children to have relationship problems, or because they do not have good models for a stable relationship. However, a recent adoption study in Sweden showed that the link between divorce in parents and divorce in their children is forged genetically, not environmentally. For a sample of 20,000 adopted individuals, the likelihood of divorce was greater if their biological mother, who did not rear the individual, had later in life become divorced than if the adoptive parents who reared them had become divorced." (Plomin, p. 39).

One of the primary assumptions of psychology is that healthy families build good character and dysfunctional families contribute to bad character. Alas, the research fails to support this fundamental concept.

> The absence of evidence for shared environmental influence has been found not only for traditional personality traits like extraversion and neuroticism but also for traits that might seem especially susceptible to parental influence, such as altruism, caring and kindness. These traits are components of a factor that personality researchers call agreeableness. I had always assumed that these traits would show shared environmental influence. …. Unfortunately, subsequent research has not confirmed this finding and I reluctantly admit that even agreeableness shows no influence of shared environment. Grit is another personality trait that has been thought to be due to shared environmental influence, but it also shows the same results as other personality traits: moderate heritability and no shared environmental influence. Nurture does not teach children to be kind or gritty. (Plomin, p. 74).

The genetic research did find some family-related nurture effects in the area of politics and religion but virtually nowhere else. Moreover, Plomin makes an extensive argument that schooling is equally impotent. The conclusion is that good schools and good families provide positive experiences while one is there but there are no lasting effects on character good or bad. After leaving a positive or negative environment we gradually return to our genetic mean.

> Parents obviously matter tremendously in their children's lives. They provide the essential physical and psychological ingredients for children's development. But if genetics provides most of the systematic variance and environmental effects are unsystematic and unstable, this implies that parents don't make much of a difference in their children's outcomes beyond the genes they provide at conception. (Plomin, pp. 82-83).

Plomin's findings are particularly relevant—and potentially upsetting—to our traditional view of the centrality of trauma. Plomin has been looking for evidence of long-term positive effects of intentional environmental interventions with special focus on families and schools; the data reported so far suggests that his failure to find such effects is because they do not exist. Trauma is the flip side of the coin. While no one would argue that trauma has the same level of intentionality that one finds in families and schools, almost all psychotherapists believe that trauma has short-term—*and long-term*—effects. Unfortunately for this belief, Plomin's data about families also applies to the long-term effects of trauma.

For example, the data argues that good families fail to have measurable long-term effects on a variety of psychological variables including altruism, caring, kindness, agreeableness, neuroticism and grit. Any expert on trauma would argue that the existence of trauma would have a long-term negative effect on most if not all of these variables. Low functioning families are defined that way because of the relatively high prevalence of neglect and abuse; in short, they create more trauma. If trauma had a long-term effect, there would necessarily be a correlation with adoptive children and their (dysfunctional) adoptive parents. Since that correlation hovers close to zero, we must conclude that bad families—ones that create and cultivate trauma—fail to have a long-term effect on the adoptive children. In short, there is no support for the concept that trauma has long-term effects on people.

How can this counter-intuitive finding be explained? We know that trauma creates reliable short-term, negative effects on people. If I almost die in a car crash, I'm likely to be scared of driving afterwards. This represents what Plomin describes as the bump-up/bump-down effects seen in good/bad schools and families. Most psychotherapists see this immediate reaction as evolutionarily influenced; it makes sense that I get anxiety when I reexperience something that threatened my life.

While we are certainly evolutionarily selected to avoid life-threatening situations, we are also evolutionarily selected to get over trauma. If my friend is killed by a wild animal when we go to the local watering hole, it's understandable that I'm anxious when I return to that place. However, if it's the main watering hole for my community, I'm going to live a better life—and reproduce more--if I can also recover from my anxiety. In terms of the modern example, it's better for my functioning, and my ability to reproduce, if I can get over my fear of driving.

Naturally the amount of anxiety experienced after trauma, and my ability to recover, have a strong genetic component. And there are at least two other significant determinants on my ability to recover. The first can be called, "structure;" structure defines permanent or semi-permanent environmental

factors that have bearing on recovering from trauma. For example, racism and poverty might be structural factors that impede recovery. The second factor is often called secondary gains; if, for example, I am receiving disability payments for being traumatized, such payments can impede my recovery.

These three factors taken together make it appear that trauma has a long-term effect. Plomin frequently cites examples of psychological variables that appear to be influenced by environment when they are actually the results of genetics. For example, TV watching was long considered to be a pure environmental factor. It seemed obvious that it was the result of parental control, free will, and the behaviors of other family members. However, when Plomin used adoptive study methods, he discovered that there was a significant genetic component to TV watching.

> However, I was stunned when I looked at the correlations for adoptive siblings because they were consistently about half the size of the correlations for non-adoptive siblings. Because adoptive siblings are not related genetically, these results suggest that genetic differences account for about half of the differences between children in how much they watch television. This was mind-boggling because here was an archetypal measure of the environment showing as much genetic influence as we find for psychological traits. (Plomin, p. 41)

Trauma recovery similarly appears to be environmental and is usually seen as proportional to the severity of the event and the level of subsequent psychological support. However, using the same arguments as TV viewing, the apparent long-term trauma victim can be seen as someone with relatively poor "recovery" genetics whose dysphoria is often exacerbated by structural and secondary gains factors.

Finally, individuals with long-term trauma reactions—often diagnosed as PTSD—also have a range of active symptoms such as startle responses, flashbacks, and distrust. Berger and Luckmann, in their classic book, The Social Construction of Reality (1966), explained these symptoms as culturally-constructed. They compared participants in a Voodoo-centered culture with New Yorkers involved in psychoanalysis and concluded that members of differing cultures—even when they experienced a comparable level of suffering—would exhibit symptoms that corresponded to their culture. When I believe I have PTSD in western culture, I will exhibit the symptoms that correspond to that diagnosis.

Plomin's work is central to our understanding of trauma and has significant implications for families and schools but it's most philosophically striking finding concerns the western assumption about the cause of mental health problems. In the west, the most basic assumption about mental health is that our dysfunctionality and dysphoria arise due to past exposure to maladaptive strategies, irrational beliefs, poor modeling, inadequate nurturing, or trauma. Our history explains our psychopathology. Plomin's work argues that this assumption is false.

If Plomin is correct, this argument goes a long way towards explaining the earlier finding: psychotherapy's privileged knowledge is unrelated to outcomes. Since almost all schools of psychotherapy incorporate this assumption about the importance of history, if that assumption is wrong, how can these schools of thought facilitate outcomes?

Obviously, out of our over 300 schools of psychotherapy (Miller, Hubble & Duncan, 2007) a few of them are not built on this assumption; examples of such exceptions include strict behaviorism and Reality Therapy. However, most schools have some psychodynamic element. CBT, for example, implies that one learned bad strategies somewhere and sometime and Bowen' generational contribution to family therapy emphasizes the multi-generational effects of history.

When we take a cross-cultural perspective, one finds that this western idea of the salience of history is the exception rather than the rule when it comes to explaining mental health. Most cultures tend to explain mental illness using concepts like spirit possession, a dysfunctional relationship with the Gods, witchcraft/evil eye, or a lack of a spiritual substance like mana. Historically, in how many cultures does the shaman or healer ask lots of questions about our relationships or mislearnings in childhood?

The concept that history creates psychopathology appears to be scientific because we often develop explanations that are temporal: first this occurred and it caused that. Quantum theory points out that this historical assumption lacks universal validity; chaos theory critiques simple approaches to predictability. Trying to accept that temporal explanations for causality are not always true can create cognitive stress, confusion and dissonance. However, if Plomin is correct, we need to make the adjustment. Besides, this historical finding both confirms and extends the techniques and privileged knowledge discoveries.

Research, Rituals and Constructionism

Now we have three provocative ideas that are directly supported by the research: psychotherapeutic techniques lack inherent power; psychotherapy's privileged knowledge is unrelated to outcomes; and history does not have a long-term, causal relationship with psychopathology. We are also aware that in spite of the way in which these findings negate the Medical Model, psychotherapy has solid outcome research that shows that it works for most people and has an effect size of approximately .8 (Wampold & Imel, 2015). We need an explanation for how so many of our basic assumptions can be incorrect and yet our clients continue to improve.

Fortunately, Jerome Frank (1993) provides a theory that allows us to unite these incongruent elements. He postulates that change in therapy—or even change in shamanic interventions—rests on four principles:

- The legitimacy of the healer is endorsed by the culture and there are some signs (nice office, licensure) of this recognition.
- There is a therapeutic alliance between the healer and the client typically characterized by wisdom and caring.
- The healer offers an explanation for the suffering that is accepted by the client.
- An action or ritual is prescribed with the implicit or explicit understanding that undergoing this ritual will heal the alleged problem defined by the explanation.

The Frank model explains why therapy continues to be effective even though most practitioners endorse incorrect assumptions about how therapy works. Change is activated by beliefs and expectancies; it is not dependent on truths and scientific realities. Even if the exorcists are wrong about the existence of malevolent spirits, their explanation and subsequent healing exorcisms can still lead to improvement. The same is obviously true of western psychotherapy. As long as our clients believe in our explanations and prescriptions, we are still going to get positive outcomes. Anderson, Lunen and Ogles (2010) explain this as follows.

> … (T)herapeutic change occurs because there is a single theory or rationale that is acceptable or believable to both the healer and client. The specifics of the theory and techniques are for all points and purposes irrelevant…… At the same time, it may be said, paraphrasing Winston Churchill, that never has a subject that contributes so little to outcome received so much professional attention and approbation…..
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> As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular treatment approach used is unimportant. In other words, therapeutic techniques are placebo delivery devices. …(Moreover), suffice it to say that techniques work, in large part, if not completely, through the activation and operation of placebo, hope, and expectancy. ….Fortunately, the evidence indicates that therapists need not spend any time searching for the right treatment for a particular disorder. Instead, the "best" methods are those (a) intended or believed to be therapeutic; (b) delivered with a cogent rationale; and, above all, (c) acceptable to the client. (Kindle Locations 3864-3990)

The Frank model also does an excellent job of reconciling the other big problem in psychotherapy: why schools with such different underlying systems and techniques get equivalent results. Once we accept that psychotherapy's main active ingredients are beliefs and expectations seasoned by a good therapeutic relationship, it's clear why they all work. It also explains why beginners equal experts; even beginners can ascertain when the client is engaged in the explanation and can develop a reasonable prescription that fits expectancies.

The lack of learning from experience finding is somewhat harder to explain. Standard psychotherapy theory tells us that the most important factors in client improvement are finding the correct diagnosis and selecting the correct, evidence-based intervention. The research findings argue that those two items are, in fact, the most constructed part of any psychotherapeutic experience; the actual focus should be on the extended common factors described above: therapist charisma, caring, client factors and persuasiveness. How can anyone learn from experience if they are constantly focusing on factors that fail to contribute to outcomes?

Another way to explain these findings is that they occur because psychotherapists believe they are operating in fundamental reality when, in actuality, they are operating in constructed reality. Even using the words "constructionism" or constructed reality requires defining our terms as they are open to wide interpretations. Some constructionists, for example, make the case that whenever we use language, we enter constructed reality (Burr, 2003). For purposes of this discussion, however, we are going to use simpler definitions to discern between the two. Fundamental reality remains the same across cultures

and constructed reality changes across culture. How to build a suspension bridge and the effect of antibiotics would be part of fundamental reality and the definition of femininity or duty would be part of constructed reality.

Held (2007) briefly summarizes some of the therapeutic possibilities that emerge when it is accepted that psychotherapy operates in constructed reality.

> The doors of therapeutic perception and possibility have been opened wide by the recognition that we are actively constructing our mental realities rather than simply uncovering or coping with an objective "truth." (Hoyt, 1996, p.1)
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> …People can (in therapy) be enabled to construct things from different viewpoints, thus liberating them from the oppression of limiting narrative beliefs and relieving the resulting pain. …(They) may come to transcend the restraints imposed by their erstwhile reliance on a determinate set of meanings…For still others a stance toward meaning itself will evolve; one which betokens that tolerance of uncertainty, that freeing of experience which comes from acceptance of unbounded relativity of meaning." (Gergen & Kaye, 1992, p. 183)
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> …In addition to the rejection of totalizing explanations…postmodern thought also rejects strongly deterministic and reductionistic theories…Individuals are free to choose, adopt and change self-images according to shifting life circumstances and needs. A multiplicity of images is increasingly available to everyone. They are democratic in the sense that individual life circumstances (e.g., race, class, age, etc.) provide less constraint on their adoption than in the past. (pp. 33-34)

To make these principles more specific, in constructed reality, if one believes it to be real and true, it is. Of course, these "magical" powers are limited by the beliefs of others. Humans are social animals and as part of that socializing, cultures create views of reality that limit the individual's ability to simply "believe" and have it be so. That said, therapists who recognize that psychotherapy operates in constructed reality have access to far more creativity and fluidity than therapists who believe it operates in fundamental reality.

It is useful to examine how medicine works with these competing realities. While it acknowledges the mind/body connection, the bedside manner, and psychosomatic healing effects, it attempts as much as possible to discover factors that have effects in fundamental reality. For example, double blind studies attempt to subtract the placebo effects that exist in constructed reality from the material effects of the medication in fundamental reality. While there are some medical researchers specializing in aspects of psychosomatic medicine—and all sophisticated medical practitioners acknowledge such effects—the primary effort, as shown by funding, newspaper articles, and prestige, is based on discovering fundamental effects.

Clearly psychotherapy—as medicine's "poor cousin"—has attempted to copy this model and develop interventions that operate in fundamental reality. Beliefs that psychiatric diagnoses are real and cross-cultural and the idea that there are "evidence-based" interventions reflect psychotherapy's commitment to discover interventions that have inherent power—that operate the same cross-

culturally and that have actual effects in fundamental reality. We don't want to simply be "placebologists"—doctors who heal via rituals, expectations and beliefs. We want to argue that psychology is a STEM discipline and that we have all the credibility of medicine, physics and chemistry.

The Frank model is a problem in that it explains the effects of psychotherapy using the same factors that explain the effectiveness of shamanic healing. Put another way, the Frank model explains how psychotherapy works in constructed reality. Conversely, examine a psychiatric explanation that operates in fundamental reality: low thyroid causes depression. It doesn't matter if the client believes in the explanation or not. If they have a thyroid problem, and they are given the appropriate medication, they will improve. Franks' model, on the other hand, requires clients to believe in the explanation and the prescription to achieve improvement. In fundamental reality, belief can be helpful but it's optional; in constructed reality, belief is necessary and required. Psychotherapy mostly operates in constructed reality but its practitioners are taught they are operating in fundamental reality.

Psychotherapists have no problem believing that other culture's mental health interventions operate in constructed reality; they will certainly endorse the idea that shamanic healing is due to placebo factors. Plomin's work, of course, has revealed that the central western belief about mental health, history, is just as constructed as a belief in the evil eye or the centrality of religious rituals. Convincing as Plomin's work, or the lack of power of techniques or privileged knowledge might be, it continues to be challenging for psychotherapy to say to the public, "sorry but we're not about fundamental reality. We proudly operate in the arena of meaning, expectancies and beliefs." Regardless of the discomfort engendered by these findings, however, we need to acknowledge that the presence of this "triumvirate" is a kind of "proof" that psychotherapy operates in constructed reality.

Naturally there are exceptions--low thyroid has already been mentioned and there are many other examples from brain tumors to disease—but these are relatively rare occurrences; the vast majority of psychotherapy takes place primarily or exclusively in constructed reality. That said, the scientific method does continue to have applications in psychotherapy; in fact, the three principles that form the foundation for this paper were all derived "scientifically." However, no one can scientifically explain why the differing schools all work and work equivalently. The scholars attempting to discover the essential factors underlying psychotherapy continue to run into a wall—a wall embodied by the saying, "if the client believes it, it's true and it works." Such a statement makes sense in constructed reality but is an anathema to scientific reasoning. Science operates independent of belief. Philip Dick famously said, "Reality is that which, when you stop believing in it, doesn't go away."

This does not imply that constructionist psychotherapists should reject the mind/body connection. Common knowledge tells us that many factors in fundamental reality affect mental functioning; obvious factors include sleep, exercise, drugs, and nutrition. Hopefully, dedicated researchers will continue to discover mind/body connections that show positive effects in terms of remediating human suffering. While advances in these areas can alleviate some suffering, there will always be a need for constructed reality-based interventions given that the vast majority of human interactions operate in constructed reality.

While the three findings show that psychotherapy operates in constructed reality, for those therapists that believe it operates in material reality—the vast majority of the field—the "triumvirate" makes no sense. They can acknowledge that there are no training and experience effects, and they can understand that this implies that techniques are rituals and privileged knowledge has no connection to

outcomes, but fully integrating these ideas seems counter-intuitive and a violation of common sense. When they hear that no one should claim that their experience makes them more effective with adolescents or eating disorders, they simply reject the statement. When they understand that they can learn a new technique at a workshop but it will only allow them to replicate the level of success they already achieve, it violates their sense of truth. And when they see research showing that a coach whose training consists of one weekend workshop can match the effectiveness of a licensed therapist, there is a gut-level rejection. From a material reality or Medical Model perspective, these statements are invalid. The fact that the research supports them is so difficult to absorb that the prevailing response is to ignore.

Implications for the Evolution of Psychotherapy

Scott Miller (Miller, Hubble & Duncan, 2007) is famous for arguing that psychotherapy as a field has made no significant progress in the past 50 years. This article argues that one of the leading explanations for this lack of progress is the confusion between fundamental reality and constructed reality. Given that psychotherapy actually operates in constructed reality, acknowledging that fact should provide an edge in terms of outcomes. Taking the three findings seriously and literally should help generate enhanced results. At a minimum, simply not focusing on techniques, privileged knowledge or psycho-historical assumptions should free up energy and creativity; in this sense, avoiding going down the same fruitless path over and over in itself has the potential to create improvements.

This paper is too short to explore all of the possible effects of the triumvirate on psychotherapy but some concrete examples of possible improvements can be helpful; these examples can function both to pragmatically illustrate the possibilities inherent in constructionism and to suggest some directions worth further exploration. The following imaginary vignette offers one place to start.

> A therapist is treating a female client for anxiety and shyness. They take a history and discover that she had a critical father. They explain to the client that the experience of being criticized at an early age often manifests later as anxiety and shyness. They are confident that they have hit on the real explanation and the client simply needs to work through her father experiences to become more assertive. Memory consolidation argues that every time we review a memory it changes depending on the context of the review. The work with this therapist results in altering all memories of the father in a critical direction.
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> Unfortunately, that therapist is in an auto accident and the client needs to go to a new therapist. The new therapist listens to the history and says, “I can see why your last therapist focused on the father but I actually think that this is more of an attachment issue in that your mother was on the cold side and failed to nurture you correctly. This new theory seems convincing to the client and, again due to memory consolidation, all of the preexisting mother memories are reconsolidated with a “cold” emphasis.

> This therapist also has an auto accident so the client sees a third therapist who listens to the history and offers a third compelling explanation: "Your peer group and family—in fact the whole culture--had traditional patriarchal values and imbued you with the sense that women should be quiet and subassertive. You need feminist therapy to heal your anxiety and shyness." This last therapist, like the two before, is convinced of the truth of their historical analysis. They succeed at convincing the client about the validity of this latest theory and the memory reconsolidation effects result in feeling that her major relationships were both traditional and patriarchal.

Perhaps the first observation that arises from this vignette concerns the significant differences between the explanations offered by the therapists; it is also striking that the therapists are so confident in the "truth" of their explanations. The observer of the vignette, however, finds this confidence misplaced; how can any of the explanations be true when they differ so significantly? And we need not feel limited to three explanations; if we include all the psychotherapy schools—plus all the shamanic approaches—we might come up with dozens of different explanations for the anxiety! Not surprisingly, the constructionist therapist sees the vignette as confirmation that psychotherapy operates in constructed reality and that this reality is characterized by fluidity, beliefs and expectations.

The confidence of the therapists is supported by their sense that they have "discovered" these truths from the client history; there is little or no awareness that they have been engaged in a creative act. When there is an underlying assumption that one is operating in fundamental reality, discovery is the appropriate metaphor. The independent observer, seeing three significantly different explanations, understands that "creation" is a better and more accurate metaphor than "discovery." This dialectic gives rise to the saying, "in fundamental reality, principles are discovered; in constructed reality, explanations are created."

All three therapists are portrayed as sincere, credible and articulate; moreover, they are sanctioned by the culture as legitimate healers in that each has a license and has been practicing—and achieving therapeutic successes—for many years. It is no wonder that the client finds the varying explanations credible and legitimate. And the coup de grace is delivered by the fact that all of these explanations work in that many of the clients reliably improve. "If it ain't broken, don't fix it;" why draw attention to these incongruencies as long as things are working?

The process of deconstruction can be defined as the ability to discern between what is constructed and what is fundamental. The vignette highlights the necessity of deconstruction; acknowledging the implicit incongruencies in standard psychotherapy and the medical model is the first step towards replacing them with something better. It also serves as a concrete example of a saying, this one derived from Berger and Luckmann: "human suffering is real, the explanations for the suffering are constructed." The explanations masquerade as truths but their incongruity reveals their actual nature: constructions that must be sustained by beliefs.

The second effect of the vignette is to open the door to the concept of fluidity; since psychotherapy is only limited by client beliefs and expectations, therapists are free to work in any direction that effectively and ethically meets client needs. As shown in the vignette, standard therapists quickly align themselves with an explanation, an underlying school of thought, and related techniques. Constructionist therapists are just as dependent on explanations and healing prescriptions; the difference is that their flexibility allows them to prioritize client fit over alignment with expertise.

Constructionists are able to use all their fluidity to ensure that the needs, beliefs, and potentials of the client come first.

The third implication has to do with creating new realities for the client. The client's acceptance of the explanation not only ushers them into a different reality, it also alters their past through the concept of memory reconsolidation. Standard psychotherapy already recognizes that the therapeutic goal is to introduce clients into new realities; however, this generally implies something like giving the client new tools or new life strategies. The vignette reveals that therapists are altering much more than that.

Constructionist therapists, recognizing that explanations are constructions not truths, are required to assume responsibility for their choices. In contrast, when a standard therapist is "discovering" a truth, they might care about how it is conveyed, but there is little responsibility for the actual result; after all, in the end, the client must accept the "truth" about themselves. However, when the constructionist therapist co-creates an explanation, they know that they had many alternatives. They need to listen and understand the client well to know which is the best fit. If the vignette therapists were aware that they are creating a new reality, they might be more careful about what ideas are offered to the client.

A second vignette/example illustrates some additional advantages that arise from a constructionist viewpoint. Imagine a culture where everyone accepts that possession by malevolent spirits creates mental health problems. Standard exorcists believe in malevolent spirits and have developed intricate exorcisms to expel the spirits. As a result of these rituals, many of the clients improve. One exorcist learns that the spirits don't actually exist but are, instead, cultural constructions. They keep this to themself and continue to perform exorcisms. Their secret knowledge, however, gives them an edge over their compatriots and they achieve better outcomes.

This edge manifests in several ways. First, the enlightened exorcist will have less fear than the standard exorcist; malevolent spirits are frightening and it is helpful to realize they are not real. This increase in positivity is not only due to the nonexistence of the spirit; the enlightened exorcist is also in a more dexterous position when it comes to dealing with client symptoms. For example, typical symptoms of exorcism, such as body contortions, strange sounds, and attacks on the exorcist, can be handled more effectively when the exorcist is less frightened and when they know that these symptoms are secondary to cultural expectations—not secondary to an actual malevolent force.

Similarly, there are many psychiatric conditions that have frightening and overwhelming inferences, correlates and prognoses. Borderline Personality Disorder, Bipolar Disorder and many other diagnoses come with alarming implications; in addition, these kinds of diagnoses are sometimes considered uncurable or, at least, highly resistant to healing. Most therapists see substance abuse as a life-long disability requiring accepting the label of alcoholic/addict and significant life restrictions. The "history begats psychopathology" assumption has similar implications; trauma and PTSD involve labels like "survivor" and imply long, painful recovery processes. The "clinically depressed" face recommendations about a life-long medical regimen and the autistic are considered permanently disabled in terms of social functioning. Knowing that all of these explanations are constructed allows the awake therapist to feel some of the same optimism as the enlightened exorcist and have some of the same skill at handling the expected symptoms.

How does this play out pragmatically? The first thing that the enlightened exorcist might do will be to inform the client that the spirit "possessing them" is a relatively benign spirit, one that is rather easy to

expel. Similarly, a constructionist therapist begins by ensuring that the explanation is as modest as possible; not only should it be easy to resolve, but ideally the resolution should be helpful in terms of the client's long-term functioning. A psychiatric example will illustrate these opportunities and limitations.

Every client comes into therapy with an implicit or explicit explanation for their suffering. Standard therapists then add their own explanations for the suffering which vary depending on their alignment with a certain school or psychological system. Constructionists should be aware of both the client's explanation and the standard explanation. If the client's beliefs will allow it, they should co-create a different—and more benign--explanation which is easier to resolve than the client/standard explanations.

This attempt to modify the diagnosis/explanation needs to be done carefully and thoughtfully. For example, if a client came into therapy explaining that they were diagnosed as a borderline by a previous therapist and had researched the condition on the internet and were depressed about what they had read, a constructionist therapist might say, "Yes, I understand why you and your previous therapist hit on the borderline diagnosis. I've listened carefully to your history and am happy to inform you that you have what we might call a "partial borderline condition." In this condition, your borderline functioning is limited to intimate relationships; "partial borderlines" function fine at work and with family and friends. The good news is that this condition is much easier to resolve than the full borderline diagnosis."

Obviously, such a frame can only be advanced if it seems plausible to the client; if the client was having disturbed relationships in every aspect of her life, this dialog wouldn't be useful. However, it is also possible that the statement, "you are high functioning at work and with friends" can actually be helpful in terms of transforming reality. As we discovered with the three therapists helping the anxious woman in the vignette above, credible explanations are capable of altering the client's past as well as their present. If done correctly, and if it fits the client, the suggestion that they are high functioning in certain parts of their life can actually help create that level of functioning. Reality is sufficiently fluid that asserting something sometimes creates it. Finally, what's fundamentally important, however, is that the constructionist therapist is always searching for a more benign, or more useful, or more numinous explanation. When all the explanations are constructed, there's a lot of room for creativity and exploration.

The final area that leaps out of the triumvirate of findings concerns the most famous common factor: a relationship with a wise and caring person. Scott Miller (2004) spent a number of years working on strategies that would directly enhance these factors in therapists and finally concluded that the approach was essentially unworkable.

> Outcomes did not improve. Why? To begin with, we'd forgotten, or at least set aside some troublesome facts. From the outset, we'd been aware of the paradox inherent in any attempt to use the common factors to make specific decision about day-to-day practice. In truth there is and can never be an approach to therapy based on the common factors because the factors are, by definition, common to all approaches.

> Of course, we'd hoped that presenting the factors as principles rather than mandates would circumvent the problem, providing therapist with a flexible framework for tailoring treatment to the needs of the individual client without creating yet another model of treatment….. Indeed, when combined with other studies showing little or no effect for training or experience on treatment outcome, the hope we'd felt at the outset of our work began to feel painfully naïve. (p. 48)

While his warning is worth heeding, there are opportunities available to the constructionist that weren't available to Miller. First, in terms of wisdom: one can argue that there are many forms of wisdom; two of the important ones include a deep knowledge of the characteristics and workings of the culture and a personal knowledge of how to live and persevere in the context of pain and loss. The triumvirate of findings opens the door to another form of wisdom: the understanding that all of our explanations for mental health are constructed and the correlative understanding that our internal mental state is the result of interior constructions. While standard wisdom grasps Shakespeare's famous dictum, "nothing is good or bad but thinking makes it so," it is relatively blind to the constructionist concept that almost all mental health occurs in constructed reality. This deeper understanding of reality and mental health has the capacity to significantly enhance a therapist's wisdom; while clients may not be aware of the details of this enhancement, it is likely that they will feel it.

There is a similar argument to be made in terms of the enhancement of "caring." There is a famous Buddhist saying that is often summarized as, "out of emptiness arises compassion." One of the Buddhist explanations of this saying equates emptiness with a full deconstruction of reality. When the seeker realizes that everything that appears solid is an aspect or a projection of the "non-self," then one arrives at emptiness. The reason that this emptiness leads to compassion is that when the seeker looks on individuals that continue to be beguiled by programming and false self, the feelings of empathy and compassion manifest as one witnesses their suffering. It is true that constructionism is only a beginning step towards the consciousness of emptiness described by the Buddhists, but it is also true that the constructionist has a big edge over the standard therapist in terms of recognizing the ensorcellment of the client.

In addition, the constructionist therapist is necessarily more client-centered than the standard therapist. When psychotherapeutic systems, concepts and explanations are seen as constructed, the therapist is left with one remaining factor: the client themselves and their needs, expectations and beliefs. The constructionist therapist simply devotes more energy and focus on the client than the standard therapist who is distracted by their adherence to psychotherapy's privileged knowledge. This extra focus can be experienced by the client as enhanced "caring."

The final enhancement of the common factors comes in the area of persuasiveness or charisma. In standard psychotherapy, power flows from what one knows; I am effective because I possess special knowledge and because I have learned evidence-based techniques. In constructed reality, given that there is no power available from privileged knowledge, power flows from my relationship with the client and from who I am. Scott Miller captured this concept with his well-known quote, "…far more important than what the therapist is doing is who the therapist is (Duncan, Miller, Wampold, & Hubble, 2010, Kindle Locations 385-386)."

This dynamic implies that the constructionist is similar to the shaman who is not recognized as a healer unless they have experienced some kind of personal transformation. It may be that they have healed themselves of an illness, or perhaps they had a vision, or perhaps they completed an arduous pilgrimage to a sacred space; such experiences are necessary if one is to be seen as a legitimate shaman. This concept that sacred experience enhances one's persuasiveness or charisma is true for both the standard therapist and the constructionist therapist. However, the constructionist has relatively higher motivation given that this is their sole source of power.

This brief exploration of the practical implications of working with the triumvirate of findings has revealed multiple factors that can provide an edge if one is attempting to improve outcomes. First, the constructionist is more positive and expects better outcomes than the standard therapist. They are more flexible and their basic explanation for the client's problem will be less severe, easier to resolve, and have better client fit. They see reality as relatively more fluid than the standard therapist; this gives the constructionist an edge when they are working to co-create new possibilities and realities. They are unencumbered by ineffective expertise—and, because they have nothing else to lean on, they are exclusively client-focused and client-centered. They have a meaningful opportunity to outstrip the standard therapist in terms of the common factors of wisdom, caring, and the cultivation of charisma and persuasiveness.

These are just the beginning of the positive implications of accepting the triumvirate; further examples include the importance of altered states, working with socially constructed reality and the implications of structure, and the need for an existential "place to stand" to balance the relativity problem inherent in constructionism. Those interested in exploring these implications further can review the videos and writings available here (https://www.youtube.com/@constructionistpsychology).

Conclusion

It can be somewhat ironic that an article that purports to deconstruct all techniques and schools of psychotherapy concludes with recommendations about improving therapy outcomes. How can psychotherapy be improved without establishing a new approach that, once again, simply replicates the positive results already achieved by existing schools?

This article has attempted to address this challenge by describing a paradigm shift—a movement away from seeing therapy as operating in fundamental reality to seeing therapy as operating in constructed reality. Constructed reality by its nature is not amenable to techniques, rigid philosophies, and science given that its central tenet is "if you believe it is true, it will be." Most importantly, this paradigm shift is associated with therapeutic implications—implications that have the opportunity to improve psychotherapeutic outcomes.

The first noble truth in Buddhism is the existence of suffering; Berger and Luckmann (1966) also begin with the truth of suffering and then show how and why cultures vary so significantly in their attempts to work with it. It is significant that the second noble truth is the *explanation* for suffering. This article is

all about how to work with explanations; that work begins with the realization that the explanations are essentially constructed. It is this ability to understand the nature of explanations that gives rise to new opportunities in psychotherapy.

Constructionism recognizes that reality is so fluid that the therapist can create new realities with a "wave of the mind;" in this sense, the therapist has a level of existential freedom. However, in a kind of paradox, this freedom is modulated in that constructionism is forced to be more client-centered and client-dependent than standard therapies. All new realities are co-created between client and therapist, although in some situations the client participation is more implicit than explicit.

We are in the change and growth business. In that business, more options are better than fewer options, fluidity is superior to rigidity and client-centered is better than expertise-centered. This article has concentrated on the ways in which the triumvirate of findings and constructionism enhances these factors. These are only the beginning; the potential implications of the paradigm shift have other facets that remain undeveloped.

Finally, some might argue that this paradigm shift from fundamental to constructed reality has already been explored by existing constructionist schools such as Narrative Therapy and Collaborative Therapy. Moreover, humanistic, existential, and transpersonal psychologists frequently eschew diagnoses, see psychotherapeutic interventions as rituals, and attempt to integrate shamanic approaches into psychotherapy. These points are valid and no one would wish to diminish the advances and perspectives that already exist.

However, the triumvirate of findings moves the concept of a paradigm shift further down the road than the previous attempts. First, it is more specific. Previous constructionist therapies do discuss confusion between the medical model, fundamental reality, and constructed reality but they fail to present research demonstrating that techniques lack inherent power, that all privileged knowledge is unrelated to outcomes, and that psycho-history is a western cultural artifact. Taking the triumvirate of findings seriously and literally requires us to deconstruct certain assumptions that are basic to the field.

Second, there are no approaches—constructionists, existential, or whatever—that fully embrace all three findings. It is only when they are taken together that the radical implications of the findings become completely available.

Finally, the triumvirate cannot be easily dismissed with a statement like, "that's just one way of looking at it." The triumvirate is derived from research, not philosophy; unless one can refute the analyses of the outcome literature, and Plomin's genetic analyses, it is inappropriate to dismiss the findings as mere opinion.

In sum, while this is not a new school of therapy; the paradigm shift has the potential to usher in a radical new understanding of how psychotherapy actually works. Although these ideas sometimes appear to be new, one can argue that the dialog between the standard and the constructed, the conscious and the programmed, has been present in some form or another in many cultures. It is often seen as the essence of mysticism, the "secret knowledge" that leads to meaningful spiritual outcomes. Aldous Huxley is famous for calling these ideas, "The Perennial Philosophy." As an example of the way these ideas reoccur across cultures, examine this closing quote by Rumi.

"Out beyond ideas of wrongdoing
and rightdoing there is a field.
I'll meet you there.

When the soul lies down in that grass
the world is too full to talk about."

References

Anderson T, Crowley ME, Himawan L, Holmberg JK, Uhlin BD. (2016). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. *Psychotherapy Research*, 26(5): 511-29. doi: 10.1080/10503307.2015.1049671.

Anderson, T., Lunnen K. M. & Ogles, B. M. (2010). Putting models and techniques in context. In B. L. Duncan, S. D. Miller, B. E. Wampold & M.A Hubble (Eds) *The heart and soul of change* (Kindle Locations 3795-4399). Retrieved from https://www.amazon.com/Heart-Soul-Change-Second-Delivering-ebook/dp/B004T9YTEG

Bacon, Stephen. (2018). *Practicing psychotherapy in constructed reality: Ritual, charisma, and enhancing therapeutic outcomes*. New York: Lexington Books.

Bacon, Stephen. (2020). A Constructionist Extension of the Contextual Model: Ritual, Charisma, and Client Fit. *Journal of Psychotherapy Integration, 30*(4), 506–521. https://doi.org/10.1037/int0000188

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: a treatise in the sociology of knowledge*. New York, NY: Anchor Books.

Burr, V. (2003). *Social constructionism* (2nd edition). New York, NY: Routledge.

Castonguay, L. & Goldfried, M. (1994) Psychotherapy integration: An idea whose time has come. *Applied and Preventive Psychology*, 3 (3), 159-172. https://doi.org/10.1016/S0962-1849(05)80068-X.

Christensen, A., & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*(1), 8–14. https://doi.org/10.1111/j.1467-9280.1994.tb00606.x

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change*: delivering what works in therapy (2nd edition). Retrieved from https://www.amazon.com/Heart-Soul-Change-Second-Delivering-ebook/dp/B004T9YTEG

Durlak, J. A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin, 86*(1), 80–92. https://doi.org/10.1037/0033-2909.86.1.80

Frank, J. & Frank, J. (1993). *Persuasion and healing: A comparative study of psychotherapy (3rd edition)*. Baltimore: Johns Hopkins University Press.

Gergen, K. J. (2009). *An invitation to social construction* (2nd edition). Los Angeles, CA: SAGE Publications Ltd.

Malouff, John. (2012) The need for empirically supported psychology training standards*, Psychotherapy in Austrailia*, 18:3, 28 – 32.

Miller, Scott. (2004) Losing Faith: Arguing for a New Way to Think About Therapy. *Psychotherapy in Australia*, 19:2, 44 – 51.

Miller, S., & Hubble, M. (2011). The road to mastery. *Psychotherapy networker*, 35 (3), 22.

Miller, Scott, Hubble, Mark & Chow, Daryl. (2018). The question of expertise in psychotherapy*. Journal of Expertise,* 1(2), 1-9.

Miller, S., Hubble, M., & Duncan, B. (2007). Supershrinks: what is the secret to their success? *Psychotherapy networker*, 31 (6).

Plomin, R. (2018). Blueprint: how DNA makes us who we are. Cambridge, Massachusetts, The MIT Press.

Strupp, H. H., & Hadley, S. W. (1979). Specific vs nonspecific factors in psychotherapy. A controlled study of outcome. *Archives of General Psychiatry*, 36 (10), 1125–1136. doi:10.1001/archpsyc.1979.01780100095009

Wampold, B. E., & Imel, Z. E. (2015a). *The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd edition).* New York: Routledge.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of Psychotherapy With Children and Adolescents Revisited:: A Meta-Analysis of Treatment Outcome Studies. *Psychological bulletin*, *117*(3), 450-468. https://doi.org/10.1037/0033-2909.117.3.450