

What Do Psychotherapy Experts *Actually* Do in Their Sessions? An Analysis of Psychotherapy Integration in Prototypical Demonstrations

Nili Solomonov and Nadia Kuprian
Adelphi University

Sigal Zilcha-Mano
University of Haifa

Bernard S. Gorman and Jacques P. Barber
Adelphi University

In the past few decades there has been an increasing movement toward adopting integrative perspectives. Although the levels of psychotherapy integration shown by therapists in naturalistic and experimental settings have been investigated, not much is known about the levels of integration among psychotherapy experts. The current study examines the levels of psychotherapy integration in psychotherapy sessions of known experts from different orientations, at different time points in history. Ratings of prototypical demonstrations of 9 psychotherapy experts from different therapeutic orientations and from different generations were examined to determine the extent of integration. Psychotherapy integration was observed in all prototypical demonstrations. Experts tended to integrate techniques from other approaches within their own “family”—similarities in the use of techniques were found among experts who identified with an ‘exploratory’ orientation as well as among experts who identified with a ‘directive’ orientation. The current findings show that experts “stay in the family”—they integrate techniques from approaches similar to their own. Furthermore, experts from different generations showed similar levels of psychotherapy integration.

Keywords: process research, prototypical demonstrations, psychotherapy experts, psychotherapy integration, therapeutic techniques

The prevalence of psychotherapy integration has been the focus of a long-lasting debate. The early days of psychotherapy were characterized with intense rivalry and mutual antipathy between proponents of competing theoretical approaches. However, the accumulating evidence on psychotherapy outcome, the fact that different therapies often achieve similar outcome, and the failure of any specific orientation to benefit

all types of clients, have led to an increasing acceptance of psychotherapy integration over the past few decades (see [Castonguay, Reid, Halperin, & Goldfried, 2003](#) and [Norcross, 2005](#) for extensive reviews).

Indeed the number of therapists shifting from specific treatment models to integrative approaches reflects that psychotherapy integration is on the rise ([Ziv-Beiman & Shahar, 2015](#)). Surveys of counselors and psychotherapists have shown that these perspectives are significant sources of influence even among therapists who adhere to a specific treatment model ([McLeod, 2009](#)). [Norcross, Karpiak, and Lister \(2005\)](#) found that 50% of 187 psychologists who reported that they self-identify as eclectic/integrative, adhered to a specific orientation before they became integrative/eclectic.

The interest in psychotherapy integration in the clinical and scientific communities has led to the development of several theoretical ap-

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Nili Solomonov and Nadia Kuprian, The Derner Institute of Advanced Psychological Studies, Adelphi University; Sigal Zilcha-Mano, Department of Psychology, University of Haifa; Bernard S. Gorman and Jacques P. Barber, The Derner Institute of Advanced Psychological Studies, Adelphi University.

Correspondence concerning this article should be addressed to Nili Solomonov, The Derner Institute of Advanced Psychological Studies, Adelphi University, Garden City, NY 11530. E-mail: nilidal@gmail.com

proaches to integration: common factors (Frank & Frank, 1991; Rosenzweig, 1936), technical integration (also known as technical eclecticism; Lazarus, 1967), theoretical integration (Wachtel, 1977), and assimilative integration (Messer, 1992). The assimilative integration approach describes the therapist as working within a specific theoretical and conceptual framework (originally psychodynamic), while employing flexibility and incorporating techniques from other modalities into his work (Messer, 1992). In contrast, the common factors approach emphasizes the importance of the components of therapy shared by all psychotherapies (Frank & Frank, 1991; Lambert & Ogles, 2004; Rosenzweig, 1936), such as building an emotional therapeutic bond, creating a healing setting, providing a culturally sensitive psychological explanation to the client's distress, and employing a set of procedures, which lead to positive and adaptive outcomes (Laska, Gurman, & Wampold, 2014).

With regard to the theoretical integration and technical integration models, theoretical integration places more focus on integrating the theoretical premises and conceptualizations of different approaches while technical integration focuses almost exclusively on the actual techniques being used in therapy without attempting to merge theories (Norcross, 2005). Although each of the four approaches identifies itself as independent, the boundaries are not clear-cut and areas of overlap exist (Stricker, 2010; see Norcross & Goldfried, 2005 for a comprehensive overview).

Because the focus of our study is the use of techniques, rather than theories, we will investigate psychotherapy integration using the working premises of technical integration and common factors approaches. More specifically, we examine the extent to which psychotherapy experts employ technical integration. We chose to look at the work of experts by investigating the therapeutic process in their demonstration tapes since they are often the ones who develop treatment modalities and manuals, and determine the importance of specific techniques over others (i.e., Hill, Thames, & Rardin, 1979; Moreira, & Gonçalves, 2010; Thomas, Hopwood, Woody, Ethier, & Sadler, 2014).

Psychotherapy experts' demonstrations are used extensively by clinical training programs as representative practical illustrations of theo-

retical orientations (Dollarhide, Smith, & Lemberger, 2007; Rønnestad & Skovholt, 2003), and affect the way trainees understand and use these orientations (Rønnestad & Skovholt, 2003; Keats, 2008). Additionally, these demonstrations are often available to the general public and shape clients and professionals' perspectives about treatment approaches (Keats, 2008).

What exactly are senior experts doing in their demonstrations? To what extent is their work actually prototypical or "pure", and to what extent is it integrative? This study attempts to answer these questions by examining experts' use of the following: (a) prescribed techniques—specific to the declared orientation; (b) proscribed techniques—specific to other orientations; (c) common factors—techniques shared by all psychotherapies.

Although not much is known about the use of techniques by experts, experimental and naturalistic studies have shown mixed results. Whereas some determined that experienced therapists use predominantly prescribed techniques (e.g., Barber, Foltz, Crits-Christoph, & Chittams, 2004; Dimidjian et al., 2006; Trijsburg et al., 2002), others have found that therapists often tend to be more integrative than may be expected, even when delivering manualized treatments (e.g., Ablon & Jones, 2002).

The first goal of this study is to examine the degree of purity versus integration in the experts' work by assessing experts' use of techniques. Given that the purpose of demonstrations is to present a treatment model in its "purest" form, we predicted a high use of prescribed techniques and a low use of proscribed techniques with a moderate to high level of common factors techniques. The experts' sessions were expected to demonstrate relatively high levels of "purity" (Luborsky, McLellan, Woody, O'Brien, & Auerbach 1985), meaning low levels of psychotherapy integration. Experts were expected to be consistent in their work, regardless of the client's gender.

The second goal of this study is to examine whether experts' use of integrative techniques changed in the last half century. To address this question, we first employed a synchronic perspective—comparing the use of techniques by experts from the same time period, but from different orientations. We also used a diachronic perspective to compare experts from similar orientations, but from different genera-

tions. It was predicted that similar profiles would be found for experts from different generations who declared similar orientations and that the younger generation would show higher levels of psychotherapy integration.

Method

Materials

Six therapy demonstrations of experts from “old” and “new” generations were used. Selection criteria for demonstration tapes included the following: (a) Therapists were considered to be experts of an identifiable specific therapeutic approach; (b) Therapists were videotaped in a closed room, rather than in front of a live audience; (c) Three therapists from different orientations presented a session with the same client; (d) The clients presented a problem in interpersonal relationships or general distress rather than a specific mental diagnosis; and (e) The client was a real person seeking consultation, rather than an actor.

For the older generation, three demonstrations were taken from the ‘Gloria tapes,’ which were part I of the series, *Three Orientations to Psychotherapy* (Shostrom, 1965). The experts were Carl Rogers for the humanistic or person-centered orientation, Albert Ellis for the Rational Emotive therapy, and Fritz Perls for Process-Experiential Gestalt therapy. Three additional demonstrations were taken from part III of the same series (Shostrom, 1986), where the experts were Aaron Beck for Cognitive Therapy, Donald Meichenbaum for Cognitive Behavior Modification Therapy, and Hans Strup for Psychoanalytic Therapy.

For the ‘new’ generation, three demonstrations were taken from the recently released DVDs, *Three Orientations to Psychotherapy: The Next Generation* (APA, 2013a, 2013b), a project which attempted to present the 21st century version of prototypical demonstrations. The experts who participated were Nancy McWilliams for Psychodynamic Therapy, Judith Beck for Cognitive Therapy, and Leslie Greenberg for Emotion-Focused Therapy. They each taped two sessions with a male and a female client but only one session was presented.

Measure: The MULTI (McCarthy & Barber, 2009)

The MULTI coding system assesses interventions from eight orientations: behavioral, cognitive, dialectical-behavioral, interpersonal, person-centered, psychodynamic, process-experiential, and common factors. The measure consists of 60 items rated on a continuous scale of 1 (*not at all*) to 5 (*very*) according to how typical each intervention was during the session. Subscales were created by averaging items theoretically belonging to each of the eight orientations. The common factor subscale is composed of items representing techniques which are shared by all psychotherapies. Previous studies showed at least moderate ($\alpha < .70$; Shrout, 1995) internal consistency for all subscales and moderate interrater reliability for most subscales (McCarthy & Barber, 2009; McCarthy, Keefe, & Barber, 2014).

The use of prescribed techniques was assessed by examining specific items of the MULTI subscales. For example, in the psychodynamic subscale: “the therapist explored the client’s dreams, wishes, and desires”; in the process-experiential subscale: “the therapist encouraged the client to focus on his/her moment-to-moment experience”; in the interpersonal subscale: “the therapist focused on a specific concern in the client’s relationships”; in the person-centered subscale: “the therapist repeated back to the client (paraphrased) the meaning of what the client was saying”; in the cognitive subscale: “the therapist encouraged the client to look for evidence in support or against his or her beliefs”; in the behavioral subscale: “the therapist encouraged the client to think about, view, or touch things that the client is afraid of”; in the dialectical-behavioral subscale: “the therapist both accepted the client for who he/she is and encouraged him/her to change”; in the common factors subscale – “the therapist worked to give the client hope or encouragement”; “the therapist was warm, sympathetic, and accepting”; the therapist listened carefully to what the client was saying.” The complete measure, including all items, can be found elsewhere (McCarthy & Barber, 2009).

It was determined that a meaningful difference between two experts is a difference of at least 1.5 points in mean rating of a specific item. This cut-off was chosen to differentiate between

low, moderate, and high level use of techniques. A mean rating of ≤ 2 was considered low, 3 was considered moderate, and ≥ 4 was considered high.

After the initial phase of the analysis, given the differences between the experts, we decided to group them into two categories in order to achieve a better understanding of the commonalities among them. One group included experts whose orientation is consistent with an ‘exploratory’ approach (psychodynamic, person-centered and process-experiential) and the other group included experts whose orientation is consistent with a ‘directive’ approach (cognitive, behavioral or dialectical-behavioral). We then calculated the intraclass correlations (ICCs) between the experts of each group to assess the similarities in their profiles (Shrout & Fleiss, 1979). Although we acknowledge that other categories could have been used to group the data (e.g., supportive vs. confrontational interventions), this categorization was chosen as most fitting in face of previous findings supporting such analysis of the MULTI subscales (see McAleavey & Castonguay, 2014 for the aggregation of the MULTI subscales to ‘directive’ and ‘exploratory’ composites).

Judges

Two independent raters rated each of the sessions. The raters were clinical psychology doctoral students with more than 200 hours of training on the MULTI. After observing each session, they rated the sessions without discussing their observations before rating. Ratings for each subscale of the MULTI, for each session, were averaged for further analyses.

Statistical Analyses Overview

To answer our first question and to assess the differences and similarities in the profiles of the experts, we compared their mean ratings for each of the MULTI subscales. The mean of the use of prescribed techniques was measured by calculating the mean of the subscales that were the most closely related to the expert’s declared orientation: the cognitive and the behavioral subscale for Judith Beck, Aaron Beck, Ellis, and Meichenbaum; the psychodynamic subscale for Strupp and McWilliams; the process-experiential and person-centered subscales for Greenberg; the process-experiential subscale for

Perls; and the person-centered subscale for Rogers. Techniques from other subscales for each expert were considered ‘proscribed.’

Then the purity of the experts’ sessions was assessed. First, the experts’ total mean for the use of all subscales of the MULTI as well as their mean for each MULTI subscale were converted to a standardized mean. Purity of treatment was defined by a higher than total average (positive) score for the prescribed subscales, and a lower than total average (negative) score for the other subscales. For example, it would be expected that Greenberg would show positive scores for the process-experiential and person-centered subscales (corresponding with his declared orientation), and a negative standardized mean for the other subscales. The ‘purity’ score was calculated as the standardized mean for the subscales corresponding with the expert’s orientation. A higher purity score indicated a higher use of prescribed techniques by the expert, compared to his overall use of all subscales, while a lower purity score indicated higher levels of psychotherapy integration.

To answer our second question and assess similarities and differences in the profiles of experts within each generation and across generations, we calculated an intraclass correlation for consistency, in a two-way mixed model, for the average rating of both judges (Shrout & Fleiss, 1979). ICCs (ρ_i) were computed between pairs of experts within each generation and between experts from different generations who declared similar orientations. We employed Landis and Koch’s (1977) guidelines: ICC < 0.00 *Poor*; 0.00–0.20 *Slight*; 0.21–0.40 *Fair*; 0.41–0.60 *Moderate*; 0.61–0.80 *Substantial*; 0.81–1.00 *Almost Perfect*.

The second phase was a two-step similarity analysis. First, a ‘Cluster Heatmap’ (Sneath, 1957) was conducted. This is a visualization map of a Complete Linkage Cluster Analysis, which was assessed using the ‘heat map’ function of the statistical software environment R (<http://cran.r-project.org/>). The map displays the subscales of the MULTI (rows) and the experts (columns) in a hierarchal cluster structure. The experts and the subscales are ordered on the margins of the map according to the similarity between them, such that similar subscales and experts who use similar techniques are positioned closer to each other. Furthermore, the cluster heatmap is comprised of a

rectangular tiling such that darker tiles indicate higher levels of use the subscales, and lighter colored tiles indicate lower level of use of the subscales. Additionally, in the horizontal and vertical margins of the tiling, there are hierarchical cluster trees showing hierarchy of similarity and dissimilarity between the subscales and between the experts.

When examining similarity and dissimilarity in a dataset, it is important to make complementary use of both cluster and factor analysis methods. Whereas cluster analysis allows for data to be analyzed as categorical and examines group membership according to clusters, factor analysis enables the use of data as continuous and detects common underlying dimensions by identifying a factor structure (Gorman & Primavera, 1983).

In addition to the cluster analysis, a Principal Component Analysis (PCA; Gabriel, 1971) was conducted, using the biplot function in R (<http://www.r-project.org>) to identify underlying factors, which account for the largest proportion of the variance in the data. A two-dimensional geometric display was created where the spatial position of each of the experts and the subscales in this visual map were determined based on similarity and dissimilarity. For the first component (on the horizontal margin), spatial closeness between subscales indicated similarity. An angle of 180 degrees indicates no similarity and the sharper the angle between two subscales—the more they are similar. Furthermore, experts who were more similar in their use of tech-

niques were positioned closer to each other on the horizontal dimension. The experts were also positioned according to their similarity and dissimilarity on the second component (on the vertical margin) such that if an imaginary line was drawn from each dot representing an expert to each of the subscales, it would indicate that the shorter the line the higher the use of the subscale.

Results

Interrater Reliability (IRR)

Reliability was computed using intraclass correlation (ICC) in a two-way mixed model for consistency (Shrout & Fleiss, 1979). All MULTI subscales showed excellent IRR, $.87 < ICC(2,2) < .96$, and internal consistency ($.87 < \alpha < .96$).

Question 1a: The Experts' Use of Prescribed, Proscribed, and Common Factors Techniques

Experts' mean use of prescribed, proscribed, and common factors techniques are presented in Table 1. As predicted, we found that for all experts, except Meichenbaum and Strupp, the highest means were for the prescribed subscales. Moreover, all the experts, except for Perls, used high levels of common factors techniques. However, whereas we predicted that all experts would use high levels of prescribed

Table 1
Descriptive Statistics for the Experts' Use of Therapeutic Orientations

MULTI subscale	The older generation								
	The new generation			The Gloria films			The Richard films		
	Leslie Greenberg <i>M (SD)</i>	Judith Beck <i>M (SD)</i>	Nancy McWilliams <i>M (SD)</i>	Carl Rogers <i>M</i>	Albert Ellis <i>M</i>	Fritz Perls <i>M</i>	Donald Meichenbaum <i>M</i>	Hans Strupp <i>M</i>	Aaron Beck <i>M</i>
Psychodynamic	3.12 (.17)	2.06 (.20)	3.80 (.29)	2.70	1.50	2.66	2.04	2.08	1.83
Process-experiential	3.94 (.55)	2.50 (.24)	3.22 (.39)	3.22	2.50	3.72	3.16	1.78	2.61
Person-centered	4.03 (.45)	2.75 (.35)	3.89 (.35)	4.00	2.42	3.14	3.29	2.64	2.86
Interpersonal	2.60 (.15)	2.85 (.40)	3.21 (.40)	1.79	2.14	1.50	2.71	2.64	2.07
Cognitive	2.40 (.35)	3.59 (.09)	2.50 (.08)	2.12	3.18	2.62	2.81	1.87	3.50
Behavioral	2.56 (.28)	3.43 (.09)	2.08 (2.07)	1.77	2.93	2.47	2.97	1.67	2.87
Dialectical-behavioral	2.56 (.53)	3.00 (.09)	2.31 (.17)	1.44	2.56	1.67	2.81	1.44	2.41
Common factors	4.43 (.00)	4.43 (.10)	4.60 (2.05)	4.71	4.07	3.29	4.57	4.00	4.71

Note. MULTI = Multitheoretical List of Therapeutic Interventions; SD = standardized deviation.

techniques ($M > 4.00$), only Rogers and Greenberg's prescribed subscales' means fell within that range.

Greenberg, Judith Beck, McWilliams, Rogers, Perls, and Meichenbaum used moderate levels of proscribed techniques—techniques from other orientations. Greenberg used moderate levels of psychodynamic techniques; Judith Beck used moderate levels of DBT techniques; McWilliams used moderate levels of interpersonal, person-centered, and process-experiential techniques; Rogers used moderate levels of process-experiential techniques; Perls used moderate levels of person-centered techniques; and Meichenbaum used moderate levels of process-experiential and person-centered techniques.

Question 1b: The Experts' Use of Psychotherapy Integration—Purity of Treatment Delivered

Experts' standardized means for use of techniques are presented in Table 2. Positive standardized means indicated that the use of a given subscale was higher than the total average use of all subscales, whereas negative means indicated that the use of a given subscale was lower than the total average use of all subscales. High purity could be the result of relatively high use

of prescribed techniques and/or low use of proscribed techniques within an expert's personal profile.

All experts, except Meichenbaum and Strupp, showed positive purity means, indicating that their mean use of prescribed techniques was higher than their mean use of all techniques. Moreover, for all of the experts, except Perls and Strupp, the standardized mean for the common factors subscale was the highest among all of the subscales. Thus, although the use of prescribed techniques varied across the experts, their sessions were characterized by high use of common factors techniques.

All the experts who endorsed an exploratory approach, except for Greenberg, used higher than average levels of techniques from other orientations, indicating use of psychotherapy integration. McWilliams used higher than average person-centered and process-experiential techniques; Rogers used process-experiential techniques; Perls used person-centered and psychodynamic techniques; and Strupp used higher than average person-centered and interpersonal techniques. Among the 'directive' therapists, Meichenbaum was the only expert who used higher than average levels of techniques from other

Table 2
Assessment of Purity: The Experts' Standardized Means for Each Subscale of the MULTI

MULTI subscale	The new generation			The older generation					
	Leslie Greenberg	Judith Beck	Nancy McWilliams	The Gloria films			The Richard films		
				Carl Rogers	Albert Ellis	Fritz Perls	Donald Meichenbaum	Hans Strupp	Aaron Beck
Psychodynamic	-.11	-1.39	.67	-.01	-1.53	.04	-1.39	-.22	-1.13
Process-experiential	.91	-.79	.02	.42	-.21	1.41	.16	-.59	-.27
Person-centered	1.02	-.44	.79	1.09	-.32	.66	.34	.45	.00
Interpersonal	-.77	-.31	.00	-.79	-.69	-1.48	-.46	.45	-.86
Cognitive	-.97	.71	-.80	-.50	.68	.00	-.32	-.48	.70
Behavioral	-.77	.48	-1.28	-.81	.35	-.21	-.10	-.72	.01
Dialectical-behavioral	-.81	-.10	-1.01	-1.09	-.13	-1.86	-.32	-.72	-.49
Common factors	1.52	1.85	1.61	1.69	1.85	.85	2.11	-1.00	2.03
Purity score ^a	.97	.60	.67	1.09	.52	1.41	-.21	-.22	.36

Note. MULTI = Multitheoretical List of Therapeutic Interventions. The table shows standardized means that were calculated by deducting the expert's mean use of a specific subscale from the expert's total mean use of all subscales, and dividing by the total *SD*. For all subscales, higher positive scores are indicative of higher than average use of the subscale; higher negative scores are indicative of lower than average use of the subscale. For each expert, the orientations which are the most similar to his or her declared orientation are in boldface.

^a Purity score is the standardized mean of the subscales that were the most similar to the expert's declared orientation.

approaches (process-experiential and person-centered).

Among all the experts, Perls' purity score was the highest, indicating that he was the least integrative. Only Meichenbaum and Strupp showed negative purity scores, indicating low use of prescribed techniques. Furthermore, Judith and Aaron Beck, Leslie Greenberg, and Albert Ellis's standardized means for all prescribed subscales were negative, indicating relatively high purity.

Question 2: Differences and Similarities in the Experts' Profiles Examined from Synchronic and Diachronic Perspectives

A synchronic perspective: Comparison of experts in each generation.

The "Older Generation": The Gloria Films: Rogers, Ellis, and Perls. A ICC for consistency of .72 was found between Rogers and Perls, indicating *Substantial* similarities in their profiles. However, lower ICCs (in the *Fair* range) were found between Ellis and Rogers ($\rho_i = .36$), as well as between Ellis and Perls ($\rho_i = .30$) indicating less similar profiles. To make better sense of these results we looked at

the experts' mean use of specific techniques (see Table 3). Rogers encouraged Gloria to talk about whatever was on her mind, focused more on the moment-to-moment experience, and used more paraphrasing. In contrast, Perls used more confrontational techniques and focused on identifying defenses and the function of problematic behaviors, as well as role-play and exposure-like interventions. Finally, Ellis took a more directive and practical approach by encouraging Gloria to make changes in her relationships, suggesting practical solutions and teaching her new skills and behaviors.

The "Older Generation": The Richard Films: Hans Strupp, Aaron Beck, and Donald Meichenbaum. An *Almost Perfect* ICC ($\rho_i = .85$) was found between Aaron Beck and Donald Meichenbaum, whereas a lower (but still *Substantial*) ICC ($\rho_i = .60$) was found between Strupp and Aaron Beck. Interestingly, Strupp and Meichenbaum also had *Substantially* similar profiles ($\rho_i = .76$), despite their markedly different approaches.

Notable differences were found in the use of specific techniques (see Table 4). Overall, qualitatively, Strupp made low use of all techniques

Table 3
Use of Specific Therapeutic Techniques by the 'Older Generation'; The Gloria Films: Carl Rogers, Albert Ellis, and Fritz Perls

MULTI item	Carl Rogers	Albert Ellis	Fritz Perls
Process-experiential			
13. Identifying defenses	1.50	1.00	4.00
44. Role play	1.00	1.00	4.00
47. Present focus	5.00	2.25	3.50
Psychodynamic			
14. Free association	4.50	2.00	2.50
20. Symptom function	1.00	1.00	4.00
Cognitive and behavioral			
4. Visualizing events	1.00	1.50	3.50
15. Teaching new skills or behaviors	1.00	3.50	1.00
16. Exposure	1.00	1.00	4.50
17. Assigning homework	1.00	3.50	1.00
29. Providing advice	2.00	4.00	2.00
35. Encouraging change of behavior	1.50	5.00	3.50
48. Consequences of beliefs	2.00	4.50	2.00
Interpersonal			
55. Encouraging change in relationships	1.00	3.00	1.00
Person centered			
10. Paraphrasing	5.00	2.00	2.00

Note. MULTI = Multitheoretical List of Therapeutic Interventions. The experts' mean use of specific techniques are presented. Techniques for which one expert's mean is > 1.5 higher than the other two experts' means are in boldface.

Table 4

Use of Specific Therapeutic Techniques by the Experts of the 'Old Generation': The Richard Films: Hans Strupp, Donald Meichenbaum, and Aaron Beck

MULTI item	Hans Strupp	Donald Meichenbaum	Aaron Beck
Process-experiential			
3. Identifying conflict splits	1.00	3.50	1.50
Cognitive and behavioral			
21. Identifying alternative explanations	2.00	2.00	3.50
37. Evidence search	1.50	1.50	4.00
48. Identifying consequences of beliefs	1.50	2.00	4.50
49. Identifying flaws in reasoning	1.50	2.00	5.00
Dialectical behavioral			
56. Accepting while encouraging change	1.50	4.00	2.00

Note. MULTI = Multitheoretical List of Therapeutic Interventions. The experts' mean use of specific techniques are presented. Techniques for which one expert's mean is > 1.5 higher than the other two experts' means are in boldface.

and was more focused on conducting an assessment of the client's functioning. Meichenbaum also used low levels of prescribed techniques and integrated a process-experiential intervention (identifying conflicted parts of the client's personality) and a DBT intervention (accepting the client's behavior while encouraging him to change). Lastly, Aaron Beck's use of techniques was the most consistent with his declared approach. He identified irrational beliefs and their consequences, and encouraged the client to search for evidence for these beliefs.

The "New Generation": Leslie Greenberg, Nancy McWilliams, and Judith Beck. Experts were consistent in their use of tech-

niques across gender, with an *Almost Perfect* ICC of .82 for Greenberg; .91 for Judith Beck; and .91 for McWilliams. Thus, the means for both clients were averaged for further analysis.

When examining the experts' profiles, an *Almost Perfect* ICC ($\rho_i = .82$) was found between McWilliams and Greenberg, whereas a *Slight* ICC ($\rho_i = .08$) was found between Judith Beck and McWilliams, as well as between Judith Beck and Greenberg ($\rho_i = .15$). In terms of their use of specific techniques (see Table 5), Greenberg mainly focused on the moment-to-moment experience and identifying splits in personality and their consequences. In contrast, Judith Beck used a wide range of cognitive techniques. She

Table 5

Use of Specific Therapeutic Techniques by the Experts of the 'New Generation': Leslie Greenberg, Judith Beck, and Nancy McWilliams

MULTI item	Leslie Greenberg <i>M (SD)</i>	Judith Beck <i>M (SD)</i>	Nancy McWilliams <i>M (SD)</i>
Process-experiential			
3. Identifying conflict splits	4.00 (1.41)	1.25 (.35)	2.50 (.70)
34. Conflict split consequences	3.75 (1.25)	1.25 (.35)	2.25 (.35)
47. Present focus	5.00 (.00)	2.25 (.35)	3.50 (.70)
Cognitive and behavioral			
1. Agenda setting	2.00 (.00)	4.25 (.35)	2.50 (.00)
35. Encouraging change	2.00 (.70)	4.50 (.00)	2.25 (.35)
17. Assigning homework	1.00 (.00)	3.00 (.70)	1.25 (.00)
25. Consequences of new behaviors	1.25 (.35)	4.75 (.35)	1.75 (.35)
37. Evidence search	1.50 (.70)	4.50 (.00)	1.25 (.35)
49. Identifying irrational beliefs	2.00 (.00)	4.25 (.35)	2.50 (.35)
15. Plan to control behaviors	1.50 (.00)	3.25 (.06)	1.00 (.00)
9. Teaching new skills or behaviors	1.75 (.35)	3.50 (.00)	1.00 (.00)

Note. MULTI = Multitheoretical List of Therapeutic Interventions. Techniques for which one expert's mean is > 1.5 points higher than the other two experts' means are in boldface.

set an agenda, identified the irrational beliefs as well as the evidence supporting them, and explored how they relate to symptoms, taught the client skills, encouraged change in behaviors, and even gave homework.

A Diachronic perspective: Comparison of experts from with similar approaches from different generations.

The directive composite. First, an *Almost Perfect* ICC ($\rho_i = .87$) was found between the ‘directive’ experts (Ellis, Judith and Aaron Beck, and Meichenbaum), indicating their highly similar profiles. When examining the use of specific techniques (see Table 6), it was found that they all were high on four specific prescribed techniques: taking a direct stance and focusing on recent experiences, as well as encouraging change and exploring the consequences of change. Although commonality was high, Meichenbaum’s use of other prescribed techniques was lower and he was the only one who integrated an exploratory technique (focusing on splits in personality.)

The exploratory composite. A *Substantial* ICC ($\rho_i = .66$) was found for the ‘exploratory’ experts (McWilliams, Greenberg, Rogers, Perls, and Strupp). When excluding Strupp, who used low levels of all subscales except common factors, the ICC increased ($\rho_i = .77$). When examining specific techniques (see Table 7), all experts, except Strupp, explored feelings and focused on personal meaning of events.

A comprehensive analysis of similarities and differences in the experts’ use of techniques. To further examine the similarities and differences in the experts’ profiles, a

two-step similarity analysis was conducted. A Complete Linkage Cluster Analysis, using a Cluster Heatmap (Figure 1a), revealed two clusters – ‘exploratory’ and ‘directive.’ On the vertical, the ‘exploratory’ subscales (psychodynamic, person-centered, and process-experiential) were spatially positioned closer to each other, indicating their similarity, while the ‘directive’ subscales (cognitive, behavioral, and dialectical—behavioral) were positioned in spatial proximity, indicating similarity among them. The hierarchical trees on the margins of the heatmap produced pairs of similar subscales: cognitive—behavioral; psychodynamic –process-experiential; person-centered—process-experiential; and interpersonal—dialectical-behavioral. When examining the shadings of the tiles, one can identify two clusters of shaded areas: in the upper right corner of the tiling—a cluster for Ellis, Aaron and Judith Beck, and Meichenbaum who all used high levels of ‘directive’ subscales. In the lower left corner there was a second cluster for Greenberg, McWilliams, Rogers, and Perls who all used high levels of ‘exploratory’ subscales.

Second, a Principal Component Analysis was conducted, complimentary to the cluster analysis (see Figure 1b). Two components were identified (comp1, and comp2). Comp1 (on the vertical dimension) indicated that perhaps data was grouped into the two categories used in the study—directive (on the left side of the figure) and exploratory (on the right side). Comp2 may represent the intensity of the use of techniques, such that the closer the expert is to the horizontal margin, the higher the level of use of techniques. Additionally, the figure shows the ex-

Table 6

Use of Specific Therapeutic Techniques by the Experts Who Declared a ‘Directive’ Approach: Aaron Beck, Judith Beck, Donald Meichenbaum, and Albert Ellis

MULTI item	Albert Ellis	Donald Meichenbaum	Aaron Beck	Judith Beck
Process-experiential				
3. Identifying conflict splits	3.50	3.50	1.50	1.25
Cognitive and behavioral				
6. Focus on recent experiences	3.00	4.00	4.00	3.25
25. Exploring consequences of change	4.50	3.00	3.50	4.75
33. Directive stance	4.00	4.00	4.00	4.25
35. Encouraging change	5.00	4.50	4.00	4.50
37. Evidence search	1.50	1.50	4.00	4.50
48. Consequences of beliefs	4.50	2.00	4.50	4.00
49. Identifying flaws in reasoning	4.00	2.00	5.00	4.25

Note. MULTI = Multitheoretical List of Therapeutic Interventions. The experts’ mean use of specific techniques are presented. $M \geq 3$, indicating at least moderate use of a technique, are in boldface.

Table 7

Use of Specific Techniques by 'Exploratory': Leslie Greenberg, Nancy McWilliams, Carl Rogers, Fritz Perls, and Hans Strupp

MULTI item	Leslie Greenberg	Nancy McWilliams	Carl Rogers	Fritz Perls	Hans Strupp
Process-experiential					
3. Identifying conflict splits	4.50	2.50	5.00	4.00	1.00
47. Present focus	5.00	3.50	4.00	5.00	1.50
Psychodynamic					
11. Exploring emotions	5.00	4.50	4.00	3.00	3.50
12. Exploring avoided emotions	4.50	4.50	2.50	3.00	1.50
40. Focus on meaning	4.00	4.25	3.50	3.00	2.00
41. Childhood focus	4.50	4.50	2.50	1.00	3.00

Note. MULTI = Multitheoretical List of Therapeutic Interventions. The experts' mean use of specific techniques are presented. $M \geq 3$, indicating at least moderate use of a technique, are in boldface.

perts' use of subscales such that if an imaginary line is drawn from each expert to each subscale, it seems that directive experts are spatially closer to directive subscales, and the same for the exploratory experts and the corresponding exploratory subscales.

Discussion

This study examined the use of psychotherapy integration by experts of different therapeutic approaches. The first goal was to identify the prescribed, proscribed, and common factors techniques used by experts and to identify their level of purity versus technical integration. Our first hypothesis was partially confirmed. Our results showed that although all the experts, except Perls, showed high levels of use of common factors techniques, they varied in their use of prescribed and proscribed techniques. Interestingly, all the experts integrated low to moderate levels of techniques from other approaches, indicating similarities between prototypical demonstrations conducted by experts from different orientations, suggesting that experts' use higher levels of integration than they may explicitly declare.

When assessing and comparing the experts' levels of psychotherapy integration by examining the purity of their treatment, we found that all the experts, except Strupp and Meichenbaum, used higher than average levels of prescribed techniques. However, it was also found that McWilliams, Rogers, Perls, Meichenbaum, and Strupp used higher than average levels of techniques from other orientations. The fairly extensive use of integration may indicate that it

is actually acceptable and typical for experienced therapists to use techniques from other orientations when they believe it would be beneficial for the specific client (Ablon & Jones, 2002; Ablon, Levy, & Katzenstein, 2006; McCarthy, 2009; McCarthy, Keefe, & Barber, 2016). Moreover, the wide use of proscribed techniques might suggest that psychotherapy integration is even more common among both experts and therapists in naturalistic settings. Perhaps theorists of specific orientations perceive interventions developed by different schools as consistent with their own approach and therefore utilize them.

The high use of common factors techniques by all of the experts, except for Perls, provides support for those arguing that common factors techniques play a central role in different treatments, and that different treatments are not so different from each other (Ablon & Jones, 2002; Ahn & Wampold, 2001; Butler & Strupp, 1986; Wampold, 2001). Furthermore, this finding suggests that it is possible that treatments differ more in theory than in practice (Ablon & Jones, 2002), as theorists emphasize what is different in their approach rather than what they use from prior or different therapeutic systems (Summers & Barber, 2010).

The second goal of the study was to identify similarities and differences between experts from the same generation who declare different orientations, and experts from different time periods who declare similar orientations. We found that within each generation, and across generations, the profiles of experts who declared an 'exploratory' orientation (person-centered, process-experiential, or psychody-

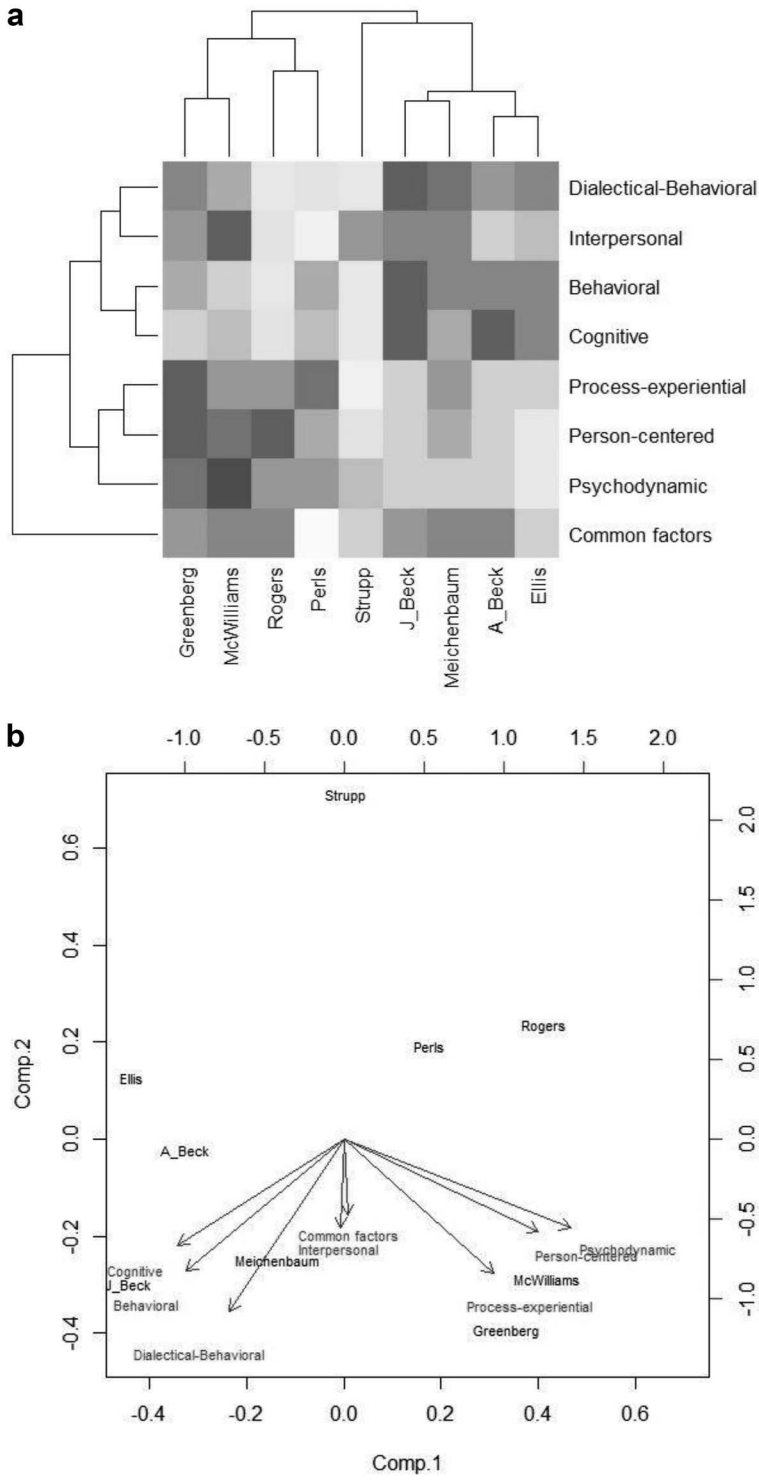


Figure 1 (opposite).

namic) were different than those of the experts who are associated with a 'directive' orientation (cognitive, behavioral, and dialectical-behavioral).

We found that all the experts showed moderate levels of psychotherapy integration. However, they all "stayed in the family" and integrated techniques from their own composite (i.e., directive vs. exploratory). Ellis, Meichenbaum and Judith and Aaron Beck tended to integrate more cognitive, behavioral, and behavioral-dialectical techniques. In contrast, McWilliams, Greenberg, Rogers, and Perls integrated techniques from the psychodynamic, process-experiential, interpersonal, or person-centered orientations. McCarthy, Keefe, and Barber (2016) found a similar pattern among experienced psychodynamic therapists in a RCT (Barber, Barrett, Gallop, Rynn, & Rickels, 2012). Although the therapists in their study, similar to the experts in the current study, were instructed to adhere exclusively to prescribed techniques, they integrated high levels of person-centered techniques (from the exploratory composite). It was also found, similar to our results, that these therapists rarely integrated cognitive and behavioral interventions.

We found marked differences between the 'directive' and 'exploratory' groups. 'Directive' experts focused more on the clients' recent events, encouraged changes in specific behaviors, and explored possible future consequences of such changes. In contrast, 'exploratory' experts focused more on moment-to-moment experiences and clients' emotions, and explored personal meaning. Consistent with these findings, Goldfried, Raue, and Castonguay (1998)

found that experienced psychodynamic-interpersonal therapists in private practices, tended to focus more on the clients' emotions and on general themes in the clients' life, while the cognitive-behavioral experts focused more on encouraging between-session experience, and working in a future time-frame. It is possible that the consistency between the findings of their study and the current study suggests that these specific techniques might be commonly used by experienced practitioners in private practices.

Although many researchers and clinicians believe that there has been a significant increase in levels of integration used by therapists in past decades (Castonguay et al., 2003; Norcross, 2005; Norcross, Karpik, & Lister, 2005; Ziv-Beiman & Shahar, 2015), in this study, experts from different generations showed similar patterns of integration. The experts' use of integration across generations may indicate that although psychotherapy integration only became popular in the past two decades, psychotherapy experts have been employing it in their sessions long before integration became accepted and common. Furthermore, in those tapes, the experts are expected to be consistent with their declared approach and therefore may minimize their use of proscribed techniques, thus leading to an underestimation of the levels of integration in their work.

Finally, this study contributes to the research of psychotherapy integration and has clinical and scientific implications. It presents an innovative way of examining process in videotaped sessions. Through our use of descriptive quantitative analyses, supported by qualitative de-

Figure 1 (opposite). (a) A Cluster heatmap demonstrating similarity and dissimilarity in the experts' use of techniques. Complete Linkage Cluster Analysis of similarity and dissimilarity among the experts. The experts and the MULTI (Multitheoretical List of Interventions) subscales are positioned on the lower horizontal and right vertical margins according to their similarity, such that closeness indicates similarity. On the upper horizontal and left vertical margins are hierarchical trees demonstrating the hierarchy of levels of similarity among the experts and the subscales. The shading of the tiles indicates the levels of use of the therapeutic subscale by the experts, such that darker shading indicates higher use, and light shading indicates lower use of the subscales. (b) Visual mapping of the similarity and dissimilarity in the experts' use of techniques. Principal Component Factor analysis demonstrating similarity and dissimilarity in the experts' use of techniques. On the horizontal dimension (Comp1), the sharper the angle between the MULTI (Multitheoretical List of Interventions) subscales the more similar they are. Furthermore, the closer the spatial position of an expert to a subscale, the higher his or her use of that subscale. On the vertical dimension (Comp2), spatial closeness to the lower vertical margin indicates higher use of techniques.

scriptions, we provided a detailed picture of what experts *actually* do in their sessions, as well as analyzed differences and similarities between them. Future studies can employ these methods on larger samples to compare experienced versus novice therapists, integrative versus nonintegrative therapists, and experts in demonstrations versus in naturalistic settings and/or RCTs. It will also be interesting to assess differences within therapists in their use of integration as they work with different clients with different disorders, and test how fluctuations in levels of purity or use of specific techniques may relate to the client's progress. That being said, it is also important that future studies focus on the process-outcome relationship in the context of use of techniques and integration.

Lastly, our findings have interesting clinical implications. First, the experts' high use of common factors across the board can inform supervisors from all approaches to emphasize the importance of supportive work and focus on a helpful working relationship. Second, as the experts mostly integrated techniques from their own composite, supervisors can be advised to teach trainees how to integrate techniques in the same way. It may sometimes be easier for a beginning clinician to integrate techniques from similar approaches before learning to incorporate techniques from approaches which are markedly different theoretically and technically. Studies such as the current one can assist in such training, as supervisors can use expert demonstrations and their analyses when providing feedback to students and show them teaching examples of use of integration by different treatment models.

Additionally, our findings provide further support the argument that psychotherapy integration exists, to some extent, in all modalities. Thus, psychology departments and training programs should consider providing training and education on integrative models, starting even from the undergraduate level, as it will help students and beginning clinicians to develop a broader and richer understanding of different orientations and a wider set of possible interventions (Ziv-Beiman, 2014).

There are several obvious limitations to our study. First, it is merely descriptive, as we did not address outcome measures, which are not included in prototypical demonstrations. Second, we used only one possible categorization

(‘exploratory’ vs. ‘directive’), and we acknowledge that there are other possible ways to group the experts. Third, there was lack of sufficient statistical power that would allow conducting significance tests. However, it would be extremely difficult to have a large sample of the kinds of experts we rated for this study, and we believe that the quantitative data presented is meaningful and valuable, even in the face of this limitation. Third, our findings regarding comparisons between the experts from different generations should be interpreted with caution, as there are alternative explanations that can account for our results. For example, it is possible that the different time periods, cultural contexts, settings, and clients could have influenced the work of the experts to some extent, thus explaining the differences between them.

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