Journal of Psychotherapy Integration., 11, 105-116.

Assimilative and Accommodative Integration: the Basic Dialectics

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Two basic styles in psychotherapy integration can be described, in which respectively the assimilative or the accommodative mode of proceeding preponderate. The first is chosen by those who wish to keep a firm grounding in any one theoretical system, into which they incorporate perspectives or practices from other schools, reinterpreted and reformulated in their own terms. The second is favored by those who prefer to practice eclectically, without worrying too much about the contradictions and incompatibilities among the different approaches. The latter therapists can remain at this purely eclectic level, or move on towards a proper integration. In this case the integration does not usually happen on the base of a preferred system, as in theoretical integration, but rather follows the line of the common factors approach. This integration mode has a prevalent accommodative character. It points to a basic structure that is common to the different methods, and becomes clearer the more the relation is freed of the constriction of theoretical models. An attempt is made to show the substantial complementarity and the dialectical relation that links the two fundamental modes of psychotherapy integration.

Key words: psychotherapy integration; accommodation; assimilation; common factors; dialectics.

The psychotherapy integration field is characterized by two main thrusts. The first promotes pluralism, the second, unity. In the former, everyone feels free to explore the field in his or her own way, while in the latter, everyone feels that he or she is part of a community. If pluralism prevailed, the field of psychotherapy integration, which already is not much integrated in itself, would probably undergo a further disintegration. If unity prevailed, the dominating position of a unitary view could inhibit the main strength of the field, that is, the living side by side of many perspectives.

I will try to show that the pluralistic thrust is represented by assimilative theoretical integration, while the thrust towards unity is represented by the common factors approach. Both approaches are necessary, but neither of them is sufficient. This thesis must, first of all, confront the common opinion that there are "three generally accepted ways in which the methods and concepts of two or more schools of psychotherapy may be combined or synthesized" (Stricker and Gold, 1996). These three are the common factors approach, theoretical integration, and technical eclecticism.

To begin with, the three can be boiled down to two if we consider that only the first and the second are sufficiently defined, while the third describes integrative modes that are better comprehended in the first two. Alberti (1997) observed, in fact, that "technical eclecticism is not a pure combination of heterogeneous techniques, but always

a way of treating in which a particular view of pathogenesis and therapy incorporates techniques of different provenance, reinterpreting them on its own terms and making them consistent with its own aim". From this standpoint there seems to be no substantial difference between technical eclecticism and theoretical integration, as in both one starts with an idiosyncratic view and proceeds in an assimilative way. Not all cases of eclecticism, however, are reducible to this model. There is also a type of relatively "pure" eclecticism, in which the assimilative trend, even if present, is not the dominant mode. These "pure eclectics" can remain such, or move on towards a proper integration. In this case the integration does not happen on the base of a preferred system, as in theoretical integration. Instead, it follows the line of the common factors approach and, therefore, has a prevalent accommodative character as will be discussed below.

Secondly, the expressions "theoretical integration" and "assimilative integration" can be considered interchangeable. On the one hand it is inevitable for theoretical integration to proceed in an assimilative way, and, on the other hand it is equally necessary for the assimilative process to produce some accommodation in the theory of departure, in order to incorporate the new elements. As Piaget (1967) pointed out, "every assimilation is accompanied by an accommodation". Assimilative integration is not coincident with the "ideal" theoretical integration, because by definition the emphasis is on assimilation and not on a balance between assimilation and integration. As the thrust to assimilation is as a rule stronger than that to accommodation, one can state that assimilative integration is the way theoretical integration proceeds in practice.

I will try to show the substantial complementarity of the two fundamental psychotherapy integration modes: the common factors approach and theoretical integration, and the dialectical relation that binds them together.

Assimilative integration

Assimilative integration has been defined as "a mode of integration (which) favors a firm grounding in any one system of psychotherapy, but with a willingness to incorporate or assimilate, in a considered fashion, perspectives or practices from other schools" (Messer, 1992). The emphasis, in this definition, is on "firm grounding" in any one theoretical system. This should not be seen in general as a primarily defensive maneuver, or a wish to impose one's ideas on others. There is little doubt that the allegiance to any one theory, provided it is sufficiently consistent and rigorous (as are all major psychotherapy methods), is preferable to ad-lib eclecticism, a sort of lack of method, in which one jumps from one perspective to the other without caring for compatibilities and connections. The greater emphasis on assimilation versus accommodation, though understandable and justifiable, brings however some consequences with it that should be carefully evaluated.

In 1989 members of the International Psychoanalytic Association met in Rome in search of "Common Ground". They did not find it. As Roy Schafer (1990) pointed out, all psychoanalysts use the same key words, but in quite different meanings and frames. It is by now clear that there no longer exists one psychoanalysis, but many (Wallerstein, 1990). Therefore, there exists no single “psychodynamic” approach; there exist many -- different and incompatible. The same is true for cognitive therapy, gestalt, or whatever: such is the dis-integrated reality of our field.

Let us say, we have 20 different psychodynamic approaches. What happens when we introduce the principle of assimilation into this reality? Let us assume that one of these 20 approaches is homogeneous, that all its adherents apply it in exactly the same way. When they come to assimilate, each one does so according to his or her tastes and idiosyncrasies. What do we get as a result? Given enough time, each will develop his or her own personal approach. Among these new approaches, new incompatibilities will unavoidably arise. In the end, our field will be more disintegrated than before. Maybe all therapists will say that they have assimilated cognitive-behavioral and gestalt principles and techniques onto a psychodynamic base. However, this will still not prevent their approaches from being substantially different and incompatible.

The joint effect of multiplication of paradigms, and assimilation that further multiplies them, is that we have almost as many psychotherapies as psychotherapists. The dis-integration of the field could not be greater. On the other hand, it is right to say that assimilation is a pro-integrative process, because every therapist integrates modes that originate in other approaches into his or her approach. But he or she does so in an individual, idiosyncratic way, one that fits his or her particular gifts, capacities and needs. We have therefore a double movement: the individual psychotherapist becomes more and more integrated, while at the same time the psychotherapy field becomes more and more dis-integrated. The main advantage of the process of assimilative integration is, therefore, the professional and cultural growth of the therapist, whose scope widens and whose theoretical-technical instruments become more sophisticated. The other side of this gain, however, is the sweeping and uncontrollable proliferation of perspectives with the confusion of tongues and incommunicability.

In an attempt to come to terms with this paradox, we can compare the therapist's position vis-à-vis different theories with the position she has vis-a-vis her patient. The comparison is legitimate because in both cases the therapist is faced with positions different from hers, with which she must somehow reckon. The relation to the patient can be equally understoodthrough the Piagetian perspective of assimilation and accommodation. This was Wachtel's (1981) understanding when he proposed to substitute the Piagetian schema for the Freudian distinction between "accurate" and "distorted" perceptions, on which respectively "real relationships" and "transference relations" would rest. Wachtel suggests that that part of the relationship experience in which assimilation is strongly predominant should still be referred to as transference -- which is never totally arbitrary since assimilation can never be pure and total (Gill,1984). In other words, it would make sense to continue to call transference the relational experience in which a person holds firmly to his schemata and does not know how to, or does not want to, suspend them in order to open up to the experience of whatever contradicts them. It goes without saying that the therapist who sticks to her own theories or beliefs and does not know how to, or does not want to leave that ground to listen to whatever contradicts them is engaging in transference or countertransference.

For a therapy to proceed, it is necessary for at least one of the two partners to be willing to question his or her transference or countertransference, therefore softening his or her assimilative position to take on a more accommodative attitude. This does not mean, however, that assimilation is equivalent to a pathologically defensive attitude, nor accommodation to mental opening and dialogue. Assimilation becomes pathological only when it is strongly predominant, while the same can be said of accommodation. "Ideally,

one might expect to see a fairly even balance between assimilation and accommodation, with neither predominating to any great extent" (Wachtel, 1981). A fairly even balance is desirable. Too much assimilation prevents dialogue and learning, inasmuch as one cannot really listen to anything that is not foreseen by one's schemata, while too much accommodation favors incoherence, fragmentation, or confusing eclecticism. In both cases a disintegrative effect is produced.

In the dialectics between asserting oneself and sharing a relationship, assimilation represents the movement towards *emancipation-differentiation*, while accommodation represents the movement towards *reintegration* into a wider unity. The process gets stuck or fragmented, when one of the two movements prevails to the point of suppressing the other. As for psychotherapy integration, the assimilative movement leads to freedom and pluralism, with a trend towards anarchy -- hundreds of schools, thousands of subgroups, each with its jargon and rituals. In other words, assimilative integration leads to enrichment of the field and to pluralism but, at the same time, feeds a dis-integrative drift. To avoid this, it has to be balanced by its opposite, whose main characteristics will be described below.

Accommodative integration

To begin with, genuine accommodation should be clearly distinguished from pseudo-accommodation. Let us consider, for instance, the case of two spouses who, over several decades, adapt more and more to each other, modifying themselves according to what each one expects from the other. Such adaptation can be maturational or evolutionary. Yet this adaptation may end in nothing but a false self *à deux*. The same could be said of the process of reciprocal adaptation between a charismatic leader and a crowd, or between analyst and analysand after years of analysis. In all of these cases each one adapts to the conscious or unconscious "knowing" of the other (theories, models, schemata, fantasies). How can we tell this pseudo-adaptation – in fact a reciprocal collusive manipulation – from a true adaptation to reality? True accommodation, unlike pseudo-accommodation, is *not a negotiation between knowings*. It is the emergence of new knowledge that results from a questioning of any schema or theory.

This brings us to the definition of the *psychotherapy field* that I have discussed elsewhere (Carere-Comes, 1999): the *relational space generated by the inner logic of the therapeutic process, not by the therapist's or the patient's personal and ideological preferences*. This definition implies that a therapeutic field will not be generated as long as patients or therapists succeed in imposing their personal or ideological preferences upon the process. For instance, at the beginning of the treatment both patients and therapists may be persuaded that they know what is to be done. Patients may want to be freed of their symptoms without any significant change in their lifestyle. Therapists may want patients to explore and work through their Oedipus complex as a prerequisite for any lasting change. But if the symptom happens to be the by-product of a wrong attitude or belief unconnected to the Oedipus complex, both patient and therapist will have to change their minds for any useful work to be done.

The prerequisite for a truly therapeutic process to develop is the capacity to *neutralize* both the therapist's theory, and the patient's expectation, in order to explore

the nature of the presented problem and its possible solutions. Of course, important changes can also be achieved if this condition is absent, for instance by a therapist who applies a manualized model. In such a case, however, we must assume that, after a preliminary assessment, the patient has been assigned to this kind of treatment. In other words the hypothesis is that this patient needs just this sort of treatment, and the validity of this hypothesis will only be verified at the end of the prescribed treatment. Only the need or set of needs that match the model are considered, while all of the patient's other needs will be glossed over. Such an operation is justified and required by research, whose aim is to establish the efficacy of a given approach for a given disorder. Yet, it is disrespectful and manipulative if displaced into genuine therapy, where the isolation of one need in a process in which needs are multiple and variable, even within the same session, is arbitrary.

The most common definition of psychotherapy ("every method of treating psychological or somatic disorders that employs psychological means and, more precisely, the relation between patient and therapist;" Laplanche & Pontalis, 1967) does not make a clear distinction between psychotherapy proper and manipulative practices of all sorts. This distinction, which is crucial, shifts the attention from change *per se* to the way change is achieved. In the case of what I consider real therapy, change is achieved as a result of a process in which nothing is taken for granted, and the meaning of all conscious and unconscious demands of the patient is analyzed or monitored. In the other case, change is the result of a stereotyped approach in which both the needs of patients and the ways to meet them are foreseen in advance by a theory or a manual.

What is decisive is the relation of the therapist to the theory, which is either of *identification* as in stereotyped treatments, or of *use*, as in real therapy. Identification happens when the therapist has no other ground on which to stand other than his or her own theory. Rather than identify with the theory, the therapist of genuine therapy uses it when it is useful and sets it aside when it is not. It is obvious that freedom from theories must be grounded in the ability to stand in an atheoretical space—the capacity to entrust oneself to the unknowable origin of all knowledge (Bion, 1970).

The difference, then, between the true therapist and the soul manipulator disguised as a scientist or a priest, is the *ongoing neutralization of every expectation, theory, or ideology, for a listening that is as much as possible unconditional, and a responding that is as much as possible adequate to the needs at hand*. ("As much as possible" means that a pure neutrality or objectivity is impossible). Genuine therapy does not depend on the theory of the therapist but, on the contrary, on his or her freedom from any theory -- that is, the freedom to use or not to use any theory. Only on the basis of such freedom does it become possible to study the "metatheoretical" characteristics of therapy -- i.e., the factors that are common to any approach.

Every form of psychotherapy is based upon the development and refinement of therapeutic factors that are potentially present in every relationship between human beings. The therapeutic dialogue is nothing but the professional form of the dialogue that takes place everywhere between two persons moved by the will to uncover some truth through the honest exposition and comparison of their respective positions. Just as there can be no true dialogue if the will is lacking to put all implied assumptions at stake, there can be no true therapeutic dialogue if the ability to doubt the validity of any basic therapeutic assumption is lacking. Without this will, one cannot speak of dialogue, but

only of persuasion, and indoctrination.

However, we cannot expect every therapist to have developed full mastery and competence in all therapeutic factors that are potentially in play in an interpersonal relationship. On the contrary, it is inevitable for a therapist to become more familiar with a particular sector of the therapeutic field, due to his or her preferences and interests, above and beyond his or her formal training. Moreover, in many or most cases one starts with a certain approach, and goes on assimilating other approaches for his or her whole professional life. If an assimilative path is chosen by so many therapists, how can this fact be reconciled with the requirement of taking nothing for granted in order to form an authentically therapeutic relation? In other words, how is it possible to take an assimilative path, and still do genuine therapy?

An assimilative position, which by definition "favors a firm grounding in any one system of psychotherapy", does not necessarily exclude any or all accommodative modification. On the contrary, "the process of accommodation is the inevitable partner of assimilation" (Stricker and Gold, 1996). It is true that if a process is defined as assimilative, it is because assimilation prevails over accommodation; but prevalence does not mean exclusion of the necessary counterpart. An assimilative style can be compared to a conservative position, but the difference between an enlightened conservative position and an obtuse one is decisive, as is the difference between a prudent liberal position and a reckless one. As was seen above, excesses in both directions, assimilative or accommodative, are harmful to the process. One's individual temperament determines whether one belongs to the conservative or liberal wing, but a balance is reached in both cases if a sufficient connection is maintained with the opposite pole.

The temperamentally eclectic therapist, ready to widen his or her scope to include different views and techniques, should learn from the well grounded therapist the prudence and patience that are necessary to avoid arbitrary rapprochements and unmanageable blends. The assimilative therapist, on the other hand, should try to illuminate his or her conservativeness with ideas from the accommodative side. Let us see, then, what seems to be clear enough on this side.

The common factors

In the search for *basic psychotherapy factors* one should first of all demarcate psychotherapy proper from all stereotyped treatments, which are justified only when applied on selected patients, for short times, and for the aims of research. Psychotherapy is basically an *ethical* operation in which the question that must be asked constantly is what is good for a particular person at any one moment and in any one context. In genuine therapy the pretence to answer that question from scratch should be set aside, as the power to decide what is important should not be delegated to any one theory. Therefore, any stereotyped treatment, unless it is intended solely as research, is substantially unethical -- that is, abusive and manipulative. Basic psychotherapy factors will not be drawn from a survey of abusive treatments. Instead it will develop only from the study of genuine therapy, which adapts flexibly moment by moment to the needs of the patient, as they bubble up and are perceived by both members of the therapeutic

couple. On the other hand, it is obviously justifiable to isolate one or another of these factors to study them analytically through randomized clinical trials.

If it is clear that two kinds of research exist – one in the field (real therapy), the other in the laboratory (manualized treatments) – it should also be clear that the former must precede the latter, and not the contrary. If we keep in mind in particular that the search for "common factors" concerns those factors that are common to real therapies, and not to manualized treatments, the therapeutic factor par excellence is the *ongoing and systematic neutralization of every personal, theoretical and ideological presupposition*. Without this, the therapy itself fails. As convictions and presuppositions can be found at both conscious and unconscious levels, and permeate and infiltrate every aspect of the relationship, the meanings that both members of the therapeutic couple give to whatever happens in the relation must be analyzed or monitored constantly. And because the analysis of the experience of the relationship, broadly defined as transference and countertransference analysis (Gill, 1984), is the distinctive trait of psychoanalytic treatments, one can state, as Migone (1995) did, that psychotherapy (real psychotherapy) *cannot but be psychoanalytic*. If instead of using the phrase "interpreting the transference", we prefer to say "monitoring the experience of the relationship", we only change the label, not the operation.

This notion, however, should be put side by side with this one: *psychotherapy cannot be just psychoanalytic*. There are two reasons: a "purely" psychoanalytic psychotherapy does not exist in real practice (Wallerstein, 1986). Secondly, if it ever existed, it would be nothing but theoretical abuse consisting of committing a person for a long time period, to a proceeding whose presuppositions and rules are rigidly set in advance, without any possibility of modifying them to meet the needs that come forth in the course of the process.

These two principles can be synthesized as follows: the ongoing and systematic analysis of the experience of the relation is the home base of the therapist--that vertex of the therapy field where the therapist should always return to examine the meaning to him or her and to the patient of whatever happens in the whole relational field. Once the first vertex has been defined, one can proceed to identify other vertices of the field, or the fundamental modes or factors of real psychotherapy. I have described these other modes or factors elsewhere (Carere-Comes, 1999). I have tried to show that a limited number of basic operative modes exist and can be described in any real therapy (yet not in any stereotyped treatment) -- *general strategies or basic rules of a generative grammar of every real psychotherapy*. This set of basic rules constitues the *general theory of the field* to which the common factors approach to integration is naturally oriented, while the assimilative integrationist seems to do very well without it. My thesis is that these two general approaches of assimilative integration and common factors need each other and are, therefore, dialectically connected. Although a therapist can feel more at ease on one or the other side of this polarity, disconnection from the other pole can have undesirable consequences.

A general theory of the field could help assimilative therapists avoid *too* firm a footing in their base theory which could lead them to lose sight of their patients' needs. Such a general theory could assist them to effect those small accommodations in their basic style that would be sufficient to manage the case; or to recognize that such major accommodations are needed as to necessitate referral of the patient to another therapist.

But a therapist, such as myself, who calls himself "integrative", with no modifying adjectives or allegiances of any sort, , must acknowledge his connection to the assimilative side. In fact, even if he can take distance from all known theories, and try to study the properties of the field without any particular bias, his vision will still be that of a human therapist, not of God's eye -- inevitably conditioned, as such, by all sorts of personal and cultural factors. Because of these factors, his theory, though presented as general, will in fact describe only that part of the field that he will be able to illuminate. In other words, for all a therapist does to produce a "metatheory", this will, in the end, be just a theory like any other. In this perspective, any "general" theory will be seen as just one more theory, to which he tries to assimilate all other theories.

We have therefore two exigencies, whose complementarity should be clearly noted. On the one hand, we need a map of the basic responses to the cardinal psychological and existential needs of the human being. On the other hand, all therapists should be free to develop the individual approach that they feel to be most consonant with their preferences and abilities.. If the former requirement prevailed, and the reference to a general system, however defined, became mandatory, there would be the risk of a transformation of such system into a totalizing ideology. If, instead, the latter prevailed, pluralism would be the result--as happens in our postmodern epoch. In this instance, the anchorage to a shared set of values would be lost, with the resulting state of fragmentation and incommunicability which presently characterizes our discipline.

If neither of the two exigencies prevailed, but a positive dialectical tension between them were established, the integrationist movement could acquire the more definite identity that it does not yet possess. Currently the integrationist movement is nothing but an "area of interest" in which disparate and loosely connected ideas exist side by side. A general theory of the field would serve as a reference for the many assimilative integrations, and, reciprocally, these would provide materials and stimuli for the ongoing correction and enrichment of the general (common factors) theory. For this optimal balance between the two poles of integration to come about, it is necessary that neither of them prevail. Every general theory, theory of the unified field, or common factors theory, should be restrained from hegemony by the critique coming from the assimilative/pluralistic side, that brings it back to the state of being a psychotherapy theory like any other. Similarly every assimilative approach should be responsive to the call from the opposite pole and be prepared to accommodate to the general, common factors theory.

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