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Bridging Technical Eclecticism and Theoretical Integration: Assimilative Integration

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Assimilative integration is a new type of psychotherapy integration introduced by Messer in 1992. This paper explains the "where, what, when, and how" of this integrative route, outlines its advantages and weaknesses, and discusses areas for potential assimilative practice in various models of therapy. Following a brief review of the current status of psychotherapy integration and its practices, assimilative integration is conceptualized as a "mini theoretical integration" and as "theoretical eclecticism"; it is offered as a bridge between theoretical integration and technical eclecticism. Assimilative integration is proposed as the best theoretically and empirically based integrative approach available at this time, particularly for therapists who have been trained in a single mode of therapy before they became integrationists.

KEY WORDS: assimilative integration; psychotherapy theory; psychotherapy integration.

Although it has been almost 65 years since the first integrative ideas entered the field of psychotherapy in a dramatic way (French, 1933), the formal psychotherapy integration movement has a history of only 15 years. The Society for The Exploration of Psychotherapy Integration presently numbers several hundred members in 28 countries worldwide (SEPI, 1998), and many other therapists are positively inclined toward SEPIs outlook and goals. By 1995, more than 150 training programs, courses, and workshops in psychotherapy integration were being offered worldwide, many of them in doctoral level graduate programs in clinical, counseling or school psychology, or in psychiatry residencies (Norcross & Kaplan, 1995).

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Although there is a general satisfaction among SEPI members with the movement (Figured & Norcross, 1996), some have felt that it has reached a plateau (e.g., Greenberg in Greenberg & Brownell, 1997) and have called for more research (Figured & Norcross, 1996; Greenberg & Brownell, 1997; Norcross, 1997). They say that the period of initial exploration and rapprochement in the field should wane, and a stage of evaluation, redefinition, and empirical research in the application of integrative therapies and ideas should emerge (see also Beitman, 1994; Norcross, 1997). It has been 12 years since an NIMH conference on integration issued research recommendations for the field (Wolfe & Goldfried, 1988). Perhaps another high-level conference is now necessary to evaluate and redirect the movement.

Meanwhile, several efforts have been devoted to the review of major areas of integrative interest, such as common factors (Norcross, 1993, 1995; Weinberger, 1995, followed by nine commentaries), technical eclecticism (Norcross, 1993, 1995), and empirically supported treatments (ESTs; Glass & Arnkoff, 1996). With this special issue on assimilative integration, attention seems to be broadening to a theoretical and also pragmatic approach to integration. What follows is a very brief review of the three major types of integration (i.e., theoretical integration, technical eclecticism, and common factors; see also Gold, 1996; Hawkins & Nestoros, 1997; Norcross & Goldfried, 1992) and an exploration of the value of assimilative integration.

THEORETICAL INTEGRATION—THE IDEAL, OPTIMISTIC, BUT UTOPIAN VIEW

Theoretical integration attempts a conceptual synthesis of different psychotherapies in the search for a new, superordinate theoretical framework that can meaningfully guide research and practice (Norcross & Newman, 1992). The first and perhaps best example of this kind of integration is Wachtel's *Cyclical Psychodynamics* (Gold & Wachtel, 1993; Wachtel, 1977, 1987, 1997). Other examples include the *Unified Psychotherapy* of Allen (1993), the *Active Self Model* of Andrews (1993), and the *Cognitive Analytic Therapy* of Ryle (1990).

Although the final and ideal aim of theoretical integration is to integrate as many theories as possible, if not all of them, the existing models succeed in integrating two or three theories at most. A second limitation is that they may focus only on specific psychological disorders and are not appropriately developed for use with all diagnostic categories. A third and major weakness of the existing theoretical integrative models is the eclectic integration of only those aspects of the pure theories that are compatible with each other. Due to the existing differences between schools of therapy and their

inherent contrasting worldviews (see Andrews, 1989; Goldfried & Newman, 1992; Messer, 1992; Messer & Winokur, 1980, 1984; Norcross & Thomas, 1988), theoretical integration seems to be the most difficult route for psychotherapy integration. This is especially apparent if the goal is to achieve theoretical integration at all related levels, such as theories of personality and psychopathology, worldviews, and metatheoretical and epistemological assumptions (see also Safran & Messer, 1997). A fourth and equally important limitation of theoretical integration is that it lacks systematic empirical validation at this point.

Although many consider theoretical integration either impossible or premature, others remain optimistic about this prospect. For example, Gaston (1995) suggests the development of an integrative theory of personality as a feasible first step for an integrative theory of psychotherapy. Further, the existing models of theoretical integration have provided promising examples of integrating theories in ways that would have been considered impossible a few years ago and have inspired theoretical integrationists to further pursue this type of integration. Although theoretical integration is progressing slowly, it is not yet fully actualized. The difficulty of attaining theoretical integration has shifted many therapists' attention to technical eclecticism and common factors.

TECHNICAL ECLECTICISM—THE PRAGMATIC AND ADAPTIVE BUT INCOMPLETE VIEW

Technical eclecticism is an empirically based approach, which advocates selectively combining the best techniques, regardless of their theoretical origin, and applies them in such a way as to maximize the therapeutic results for a specific client in as short a time as possible. Eclecticism varies from haphazard, arbitrary, and idiosyncratic eclecticism (syncretism), to systematic, empirically validated models of treatment selection (Lazarus, Beutler, & Norcross, 1992; Norcross & Newman, 1992). However, even the most scientific and sophisticated eclectic models (e.g., Beutler's model: Beutler & Clarkin, 1990) are not related to any theory of personality and psychopathology that could also provide a comprehensive theoretical framework, which can explain, predict, and guide human behavior and change. Eclecticism and prescriptive matching, based on the research recommendation of Paul (1967) "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" are usually explored through the use of aptitude by treatment interaction (ATI) designs. Even if we reduce the 1.5 million possible interactions to under one thousand to prioritize matching research (as suggested by Beutler, 1991), we still have

a lot of work to do to reach this goal. Although in the right direction, this painful task will probably remain incomplete for a long time, at least until we find a meaningful theory to organize, explain, and guide prescriptive matching research adequately. Anderson (1998) recently proposed the five-factor model of personality as a theoretical umbrella to organize the findings and guide personality-related aptitude by treatment interaction research.

Unfortunately, the continuous change of clients' diagnoses and other variables during the therapy prevents a clear demonstration of aptitude by treatment interactions (Beutler, 1991; Safran, Greenberg, & Rice, 1988; Safran & Messer, 1997). This calls for context-sensitive, phase-specific aptitude by treatment interaction research and practice in psychotherapy, instead of applying a single therapy to a static diagnosis. Moreover, both personality-matched eclecticism (e.g., Beutler & Clarkin, 1990) and phases of change-matched eclecticism (e.g., Stiles *et al.*, 1990) alone have experienced difficulties demonstrating consistent ATI findings and providing a complete approach to treatment selection and eclectic practice (see Beutler, Goodrich, Fisher, & Williams, 1998; Project MATCH Research Group, 1997; Stiles, Shankland, Wright, & Field, 1997). Theory-driven, personality-prescriptive matching in specific stages of therapy and change might be a step further in resolving these difficulties (i.e., by integrating personality-matched and stages of change-matched eclectic research; Lampropoulos & Spengler, 1999).

COMMON FACTORS—A LOGICAL COMPROMISE BUT RESTRICTED VIEW

The common factors approach is the search for common elements in all effective therapies regardless of the varying terminology. This approach has yielded several lists of proposed common factors (see Grencavage & Norcross, 1990), and has facilitated a rapprochement between different therapies, and considerable research (Hubble, Duncan, & Miller, 1999; Wiser, Goldfried, Raue, & Vakoch, 1996). Nevertheless, there are many serious methodological issues in common factors research and practice that obscure its further development. One of these weaknesses is that what appears to be commonalities on the surface may represent important differences upon a closer look (Messer & Winokur, 1980; Safran & Messer, 1997). Safran and Messer (1997) have further argued against a "procrustean" rationale in search for commonalities that will ignore important and meaningful differences between therapeutic orientations. In a similar critique, the common factors approach is limited in that it represents a consensus in an abstract level, and provides only a general framework for psychotherapy integration that cannot adequately guide integrative practice and research (Lampropoulos, 2000). Definitional issues and recommendations

for research in common factors are available in the roundtables edited by Norcross (1993, 1995), a major paper by Weinberger (1995), followed by nine reactions, and an edited book by Hubble *et al.* (1999).

ASSIMILATIVE INTEGRATION AS A BRIDGE BETWEEN THEORETICAL INTEGRATION AND TECHNICAL ECLECTICISM

Assimilative integration has been suggested by Messer (Lazarus & Messer, 1991; Messer, 1992) as an alternative to technical eclecticism. It proposes that when techniques from different theoretical approaches are incorporated into one's main theoretical orientation, their meaning interacts with the meaning of the "host" theory, and both the imported technique and the pre-existing theory are mutually transformed and shaped into the final product, namely the new assimilative integrative model.

To set the context for proposing and explaining the role of assimilative integration, the logic underlying it and therapists' motivation for using it will be described. The rationale in the mind of the therapist may go something like this: "I have been trained and practiced in a specific theoretical approach that I like and believe in, which is relatively efficient with most clients and most problems. Moreover, it is rather difficult, if not impossible, to integrate all aspects of my theory to all aspects of one or more other theories (i.e., achieve theoretical integration) or treat scientifically and harmoniously all clients/problems in all situations with the best empirically validated intervention (i.e., achieve science-based eclecticism). Therefore, I will retain my original theory while also incorporating those empirically supported interventions that will remediate my therapy's weaknesses and those theoretical aspects that are compatible with but are missing from my theory, trying to keep the result theoretically coherent and clinically meaningful." In this sense, assimilative integration may be offered as the reconciliation of the two major but contrasting views of psychotherapy integration: theoretical integration and eclecticism. Assimilative integration may be the best way to integrate theory and empirical findings, and achieve maximum flexibility and effectiveness under a guiding theoretical framework. However, to successfully assimilate techniques derived from other theories into one's favored theory and mode of therapy, certain prescribed conditions should exist.

1. *The "where" of assimilation*: One's *theory* of therapy should have at least some empirically validated or informed components, before trying to assimilate other techniques into it. We assume that most therapists have been trained and practice treatments that have been shown to be effective in treating at least some types of problems and

individuals, as well as offering some convincing theoretical explanations for them. There is no reason to assimilate a technique into an empirically invalid framework.

2. *The "what" of assimilation*: The *techniques* to be assimilated into one's theory must be empirically supported or at least empirically informed, optimally meeting the criteria and guidelines proposed by APAs Divisions of Clinical and Counseling Psychology, respectively (guidelines but not criteria have been officially accepted by Division of Counseling Psychology, to be used by individual researchers in ESTs reviews; B. E. Wampold, personal communication, November 16, 1998). Empirically supported brief interventions, either drawn from larger manualized intervention packages (i.e., techniques used in manualized ESTs) or validated independently, may be particularly useful for assimilation purposes, because they are usually short-term, problem-focused, and contain sound components. Such examples include the two-chair dialogue for conflict resolution (Clarke & Greenberg, 1986), specific exposure techniques for specific anxiety disorders (for a review see Emmelkamp, 1994), the empty-chair technique for unfinished business (Paivio & Greenberg, 1995), the behavioral activation (BA) component of cognitive therapy for depression (Jacobson *et al.*, 1996), and the coping skills (CS) component of stress inoculation (West, Horan, & Games, 1984). The last two examples also highlight the usefulness of empirical findings from dismantling research strategies for assimilation purposes (i.e., component analysis; research that compares interventions with some of their components to identify the active ingredients and discard the useless ones). The same is true for aptitude by treatment interaction research (particularly those that focus on single techniques or "little treatments" instead of whole treatment packages; Shoham & Rohrbaugh, 1995) that can continuously provide empirically supported techniques to be assimilated, where appropriate. Of course, the reason for assimilating these techniques or interventions into one's theory should be to address specific problems for which these interventions have been validated, and for which one's theory has no interventions available to deal with them. For example, psychodynamic/humanistic therapists may find it useful to assimilate an action-oriented technique such as the testing of a desired behavior in vivo to evaluate the effectiveness of new behaviors for clients.
3. *The "when" of assimilation*: The *circumstances and the rationale* for selecting the appropriate techniques to be assimilated and used each time must also be empirically guided. Research findings from the field of technical eclecticism that are in fact general frameworks for

intervention selections are already available (e.g., Beutler & Clarkin, 1990; Beutler & Williams, in press) and can serve these goals. For example, the use of paradoxical interventions for resistant clients has been justified by research (Shoham-Salomon, Avner, & Neeman, 1989), and can be assimilated into a humanistic approach to engage these "difficult" clients.

4. *The "how" of assimilation*: The *way* in which assimilation is carried out requires careful thought by adherents of every theory. Not all techniques can be easily assimilated into one's theory without contradicting or even opposing its central meaning and world view (Messer, 1989). Although difficult to achieve, there may be ways to do so. For example, one can assimilate "open paradox" (Hill, 1992) into humanistic therapies without violating the meaning and nature of humanistic tradition. The therapist informs clients about the rationale and purpose of the paradox while collaborating with them in designing and executing the intervention. As documented by the relevant research literature and Hill's personal experience, this does not limit the effectiveness of the paradox. In contrast, the traditional use of paradox (that has been characterized as manipulative and deceitful) will seriously and directly contradict the philosophy of the humanistic therapy because it disregards *clients' right and ability* to know, agree, and participate in their own change by actualizing their free will and potential. Further, a client being treated in a humanistic framework may perceive any traditional paradoxical interventions as a "betrayal" of the relationship, as disrespectful, and as indicating the therapist's distrust of the client's internal ability to change. This may further cause ruptures in the working alliance and damage both internal attributions of change and clients' future self-efficacy to maintain change, as well as distort and confuse the therapist's provision of a coherent rationale for change. This is a good example of how an intervention assimilated poorly can damage several therapeutic factors. It is obvious that the manner of the assimilative process itself is a major challenge for assimilative integrationists.
5. *The coherence of assimilation*: Assimilative integrative therapies need to be *theoretically reevaluated*. This means that the final product of assimilative integration must be theoretically compatible with the main propositions and principles of the main guiding theory, without seriously altering it (see the relevance of contextualism in Safran and Messer, 1997). Otherwise, the result will be either (a) a new theoretically integrative therapy, or (b) a technical eclecticism similar to multimodal therapy (where techniques are incorporated without consideration of their theoretical origin and the new

psychotherapeutic context; Lazarus, 1992, 1995), or (c) a meaningless, contradictory hodgepodge that will be useless or even harmful in practice.

6. *The effectiveness of assimilation*: Assimilative integrative therapies need to be *empirically evaluated and (re)validated*. The new product of assimilation must be tested in qualitative or quantitative case studies. The decontextualization of effective interventions and their use in another mode of therapy does not mean that they will be as effective or harmonious in their new framework (see also Shoham & Rohrbaugh, 1996). Testing will be difficult if many interventions have been assimilated into one's therapy, but it is necessary to avoid creating and practicing an ineffective, idiosyncratic assimilative integration (a common and probably contiguous disease of assimilative integration's cousin, eclecticism).

Some Advantages and Disadvantages of Assimilative Integration

The main advantage of assimilative integration is that it allows therapists to continue practicing in the framework of their preferred theoretical orientation without losing the benefits of effective techniques generated in other systems. Therapists do not have to abandon the theoretical framework in which they were trained and have practiced for years, and in which they have invested considerable time, effort, and resources. Nor do they have to change the beliefs around which they built their professional and even personal identity, self-esteem, and professional credibility (Lazarus, 1990; Norcross & Thomas, 1988; Safran, 1998). For example, the "open paradox" respects therapists' humanistic beliefs, while at the same time addresses issues of resistant and "difficult" clients. Thus, at the same time, by choosing the route of assimilative integration, therapists can transcend limitations of their original theory, using some highly effective, but previously "forbidden" techniques. In that way they break free from the frustration caused by the use of ineffective techniques, which may be the only ones that are available and sanctioned in their theoretical domain. By practicing assimilative integration, the cognitive dissonance between faith in one's orientation and its effectiveness is reduced: adherents of different theoretical orientations no longer have to either disregard the empirical findings or change their theory to reduce the dissonance, as might have happened in the past.

Although in assimilative practice one's core theoretical beliefs may not be challenged, one has to change peripheral ideas and accommodate new ones into one's schemas about therapy. Nevertheless, this part of assimilation is not expected to be difficult for assimilative integrationists; it would be

rather welcome and a relief because it would allow them to correct and complement the weaknesses of their models, both in theory and practice. Furthermore, clients will often assist therapists in their assimilative/accommodative role/function, by acting "integratively" and guiding them according to their own "integrative" needs (Gold, 1994, 1996, 1999), and personal theories of change (Duncan, 1999).

Another advantage of assimilative integration is that it offers a much needed theoretical framework that can guide practice. In that sense it is more desirable than eclecticism insofar as it already comes with a more or less comprehensive and complete theory of personality, psychopathology, and change. Many scientists and practitioners in the field of psychotherapy (e.g., Henry, 1996) have stated the need to keep practice and research tied to theory.

The main disadvantage of the assimilative approach to integration is that it entails the danger of yet further increases in the number of psychotherapies. The 400 different therapies reported by Karasu (1986) are ever increasing, with the addition of several integrative approaches. Some integrationists have already pointed out the dangers of the proliferation of integrative psychotherapies (e.g., Lazarus, in Lazarus & Messer, 1991). If we count the possible combinations of assimilative integration as separate models, the numbers will be rather staggering. Nevertheless, the paradox of increasing the number of therapies by integrating them is resolved if we consider each assimilative integrative practice as an integrative variation of a single therapeutic model applied by an informed integrative therapist rather than a new therapy.

Potential Areas for Assimilative Practice

Each major therapeutic model must attend to its weaknesses, and assimilate both in theory and practice those processes that seem necessary for psychotherapeutic change. According to Weinberger (1995) and Glass and Arnkoff (1993), not all therapies fully and equally utilize the so-called common factors that are associated with therapeutic change (which are not so common as we believe; see Messer and Winokur, 1981). Thus, operating from an assimilative integration perspective, each theory could concentrate on assimilating processes/interventions that may be neglected in its theory or practice, such as the therapeutic relationship in cognitive–behavioral therapies, the exposure/confrontation of the problem in humanistic therapies, and the acquisition of mastery over the problem outside the consulting room in psychodynamic–experiential–humanistic therapies.

The refinements of cognitive therapy (Safran, 1998; Safran & Segal, 1990) are a good example of such assimilative practices in which the

limitations of cognitive therapy are addressed by focusing on processes such as the development of the therapeutic relationship and the role of emotion in change. The enhancement of neglected but necessary change processes, such as a focus on the relationships, will probably result in increased effectiveness of cognitive and behavioral therapies. Indeed, findings of the Stony Brook research program in psychotherapy demonstrate how the quality of therapeutic alliance and high levels of clients' emotional experience in cognitive therapy are positively associated with change (Wiser *et al.*, 1996). Similarly, the focus of cognitive–behavioral therapies on addressing areas that have been traditionally emphasized by psychodynamic/humanistic therapies, such as the relationship, might account for the equivalent outcomes that the former show with the latter at the earlier stages of change according to the Second Sheffield Psychotherapy Project (Stiles *et al.*, 1997). This was contrary to two stage models' (i.e., Prochaska and DiClemente's Transtheoretical model and Stiles' Assimilation model) prediction of better performance of insight-oriented, psychodynamic/interpersonal therapies at the early levels of change, due to their focus on the formation of the relationship/alliance, clients' exploratory behavior, and their awareness and insight. Again, findings of the Stony Brook program confirm an equal focus of cognitive–behavioral and psychodynamic–interpersonal therapies on increasing clients' awareness of both interpersonal and intrapersonal issues (Wiser *et al.*, 1996).

On the other hand, psychodynamic/experiential therapies need to focus on the processes of change that follow the acquisition of insight because the lack of action-oriented processes seem to diminish their overall effectiveness. For example, in a recent analysis of the Second Sheffield Psychotherapy Project, CBT outperformed psychodynamic–interpersonal therapy at the later, action-oriented stages of change (Stiles *et al.*, 1997). As another example, in a qualitative comparison of a successful versus an unsuccessful case treated for depression with process–experiential therapy, Honos-Webb, Stiles, Greenberg, and Goldman (1998) reported that according to the seven levels of assimilation of problematic experience proposed by the Assimilation model of Stiles *et al.* (1990), the successful case reached only the beginning of *working through a problem* (level 5). These findings raise questions about psychodynamic/humanistic therapies' ability to transcend the stage of insight and proceed with problem solution, as well as the learning, testing, and mastery of new behaviors, steps necessary to a more complete change. A good effort in this direction is the Assimilative Psychodynamic approach proposed by Stricker and Gold (1996; Gold & Stricker, 1993). This approach operates mainly within a psychodynamic framework but incorporates cognitive, behavioral, systemic, and experiential interventions. It also actively targets overt behavior, conscious cognition and affect, and interpersonal relationships, when appropriate.

INTEGRATIVE CONCLUSIONS

This paper has proposed assimilative integration as a bridge between technical eclecticism and theoretical integration. In integrating interventions, assimilative integration seriously considers theory, but the integration is done to a more modest extent. In that sense, assimilative integration is a *"mini" theoretical integration* that differs both quantitatively and qualitatively from a grand theoretical integration. In addition, assimilative integration seriously considers empirical findings and shares the selectivity, adaptability, and clinical utility of technical eclecticism. When it is done in a context-sensitive, theory-compatible, and coherent way (as opposed to technical eclecticism), it justifies the description of assimilative integration as a form of "*theoretical eclecticism*."

I have also proposed that assimilative integration "integrates" theoretical integration and technical eclecticism in such a way that may reconcile some of the movement's conflicts. Particularly regarding clinical practice, it is probably the best theoretical and empirical solution that the integration movement has to offer today, combining empirical validity and systematic guidance from a theoretically coherent framework. Nevertheless, this does not mean that common factors and eclectic research and practice have nothing to offer. Eclectic and differential effectiveness research and research on common factors, operationalized through ATI, dismantling, parametric, and additive designs and qualitative research, can greatly enhance our knowledge of psychotherapy and change, and provide us with findings to be "assimilated" in clinical practice. In addition, training in the identification and practice of common and specific factors is also valuable for the education of novice therapists (Lampropoulos, 2000; Lampropoulos, Moahi-Gulubane, & Dixon, 1999) to ensure an empirically supported practice as well as a good understanding of how therapy works.

It is difficult to predict if the integration of the future will come from the empirical validation of theoretical integration models or the organization of eclectic findings into theories. It may be a combination of both because theories can be tested and validated or falsified (Popper, 1965), and empirical data can generate theories. Both theory-driven (top–down) and data-based (bottom–up) investigations and formulations (Goldfried, Castonguay, & Safran, 1992) can contribute to our knowledge and promote psychotherapy integration. Until a final integration is achieved, if ever it can or will be (see the views on pluralism by Safran & Messer, 1997), and in the absence of a superordinate and empirically validated grand theoretical integration, or a theoretically coherent and adequate technical eclecticism, assimilative integration appears to be the route of choice and a suitable integrative vehicle to carry out clinical practice.

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