Psychotherapy Guidebook

Multimodal Therapy

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e-Book 2015 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

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DEFINITION

Multimodal Therapy is a technically eclectic approach to psychotherapy. While drawing heavily on communications theory, cognitive theory, and social learning theory, multimodal therapists are willing to apply effective methods and techniques from any discipline. In Multimodal Therapy, the most significant process is a careful and systematic inquiry into seven dimensions or modalities of "personality." Every case is thoroughly assessed for problem areas in behavior, affect (moods and emotions), sensation, imagery, cognition, interpersonal relationships, and also in the biochemical/neurophysiological realm. If the medical or physical modality is subsumed under the term "drugs," a very convenient acronym can be constructed. Taking the first letters from behavior, affect, sensation, imagery and cognition, we have BASIC. The interpersonal and drug modalities give us ID. Thus, Multimodal Therapy is the assessment and treatment of the BASIC ID. (It needs to be stressed that the D modality encompasses much more than "drugs" and also includes diet, exercise, nutrition, and many other medical/physical considerations.)

A basic premise is that the seven modalities are interactive (a change in one modality will affect all the others to a greater or lesser extent) and yet each modality is also sufficiently discrete to require specific assessment and therapy. In essence, thorough therapy needs to cover the entire BASIC ID. To ignore, bypass, or overlook one or more of these modalities is to practice incomplete therapy. This leaves patients prone to relapses and/or the development of new problems.

HISTORY

My initial training in psychotherapy was along traditional lines. I was exposed to psychodynamic thinking and most of my clinical supervisors adhered to the principles of Freud, Harry Stack Sullivan, or Carl Rogers. I received some training from Adlerians during my internship and found this orientation, with its emphasis on human dignity and didactic interventions, more appealing and more helpful than the others. But behavior therapy (Wolpe and Lazarus, 1966) offered the widest repertoire of systematic techniques. I found methods like assertiveness training and desensitization far more effective in facilitating observable change than the interpretive methods I was first taught to employ. In retrospect, it is now obvious to me that I made the error of needlessly subscribing to the idea that human neuroses are a result of conditioning, instead of realizing that behavior therapy transcends the constraints of "behaviorism" and is effective for

reasons that animal analogues cannot begin to explain (Lazarus, 1977).

While conducting follow-up studies of clients who had received behavior therapy, I found that about 36 percent had relapsed anywhere from one week to six years after therapy (Lazarus, 1971). Subsequent follow-ups were conducted more thoroughly and revealed an even higher relapse rate, especially in cases who were disturbed and maladjusted rather than merely suffering from minor adjustment problems and situational difficulties.

When looking into the reasons behind the disappointingly high number of relapses, it became evident that people were not falling victim to unconscious forces welling up from unresolved complexes. Most of the people who relapsed had simply not acquired sufficiently effective coping responses to deal with inimical life situations. The usual behavior therapy approach does not deal in sufficient detail with many aspects of affect, sensation, imagery, cognition, and interpersonal factors (Lazarus, 1976). Most practitioners of behavior therapy do not devote sufficient time to "existential problems," or to issues of self-esteem. They gloss over various values, attitudes, beliefs, and neglect several significant nuances of interpersonal functioning. The conventional behavior therapist is also inclined to disregard important areas of defective learning, despite his avowed allegiance to principles of learning. For example, behavioral approaches do not pay attention to the fact that many clients suffer from a lack of information about

their own emotions and motivations. Furthermore, many people are inclined to block thoughts and feelings from their own awareness — another fact that most behavior therapists seem to disavow.

The first series of Multimodal Therapy follow-ups comprised twenty clients after a two-year post-treatment period. Stability and durability of outcomes were clearly established. Only two cases required booster treatments before this period. Their relapses were due to the fact that they had been inadequately prepared to deal with "future shock" (i.e., various inevitable changes in life's circumstances). This problem is probably best handled through imagery (Lazarus, 1978). A second series of follow-ups is presently under way. Initial impressions of the data seem to confirm the fact that Multimodal Therapy produces enduring, positive results.

TECHNIQUE

After establishing rapport, conducting a thorough assessment (which, at the very least, includes a Life-History Questionnaire and a functional analysis of all presenting complaints), and administering any tests deemed necessary, a Modality Profile is constructed. Here is the Modality Profile of a forty-year-old woman whose presenting complaints were: "I drink too much and I worry too much."

MODALITY	PROBLEM	PROPOSED TREATMENT
Behavior	Excessive drinking	Self-monitoring + Aversive imagery
	Carries out various compulsions	Response prevention
Affect	General anxiety	Relaxation training Positive imagery
	Bouts of depression	Positive reinforcement
	Holds back anger	Assertiveness training
Sensation	Tension headaches	Relaxation training
	Low back pain	Orthopedic exercises
Imagery	Scenes involving her mother's criticisms	Role playing + empty chair method
	Nightmares about failure (mostly work related)	Images of mastery
Cognition	Morbid thoughts	Thought stopping
	Categorical imperatives (shoulds, oughts, musts, etc.)	Rational-Emotive Therapy
Interpersonal	Withdraws from many social situations	Social skills training (preferably in group)
	Quarrels with husband	Couples therapy
Drugs	Overweight	Self-monitoring/ self-control
	Possible biological depression	If necessary, have M.D. prescribe antidepressant medication

Comprehensive therapy at the very least calls for the correction of deviant behaviors, unpleasant feelings, negative sensations, intrusive images, irrational beliefs, stressful relationships, and physiological difficulties. Durable results appear to be in direct proportion to the number of specific modalities invoked by any therapeutic system. Lasting change is a function of systematic techniques and specific strategies applied to each modality. Patients are usually troubled by a multitude of specific problems that tend to

require a similar multitude of specific treatments. Multimodal Therapy encompasses:

1) specification of goals and problems,

2) specification of treatment techniques to achieve these goals and remedy these problems, and

3) systematic measurement of the relative success of these techniques.

APPLICATIONS

Multimodal Therapy has been applied to individuals, couples, families, and groups. Target problems include depression, anxiety, psychosomatic difficulties, obesity, sexual inadequacy, and mental retardation (Lazarus, 1976). Other practitioners who use the multimodal approach are encouraged by the results. For instance, I launched a Multimodal Therapy Institute where four of my associates have treated a variety of people with different problems in several settings. Furthermore, in collaboration with Dr. J.J. Shannon of Seton Hall University, a controlled research project is being planned. And finally, Dr. Lillian Brunell has been using Multimodal Therapy on hospitalized patients at Essex County Hospital Center with most promising results.

In essence, Multimodal Therapy provides a useful framework for

detailed assessment, one that is open to validation, and one that permits a problem-centered treatment plan to emerge within the context of patients' needs rather than within the constraints of therapists' theoretical predilections.