Arnold Lazarus and Multimodal Therapy

Historical Background and Key Figure

The behavior therapy movement can be divided into several historical periods. The first period marked the shift of focus in psychology from the study of the mind to the study of behavior. Applied behavioral work during this period was infrequent and, when it occurred, was often used more to demonstrate the applicability of behavioral principles than to develop a robust applied technology. The second period was characterized by the application of neo-behavioristic and behavior analytic theory to applied problems. The third period was characterized by the re-emergence of the psychology of mind and the rise of cognitive therapy. The final period is marked by two maturing traditions. On the one hand, the cognitive and neo-behaviorist streams of behavior therapy have combined into an empirical clinical mainstream. On the other, there is a reinvigorated contextualistic behavioral approach to behavior and that form of behaving called ‘mind’ (Gurman & Messer, 1995).

Applied behavioral work defined itself as a distinct sub-disciplinary area. There were two distinguishable traditions within the applied behavioral group. The first began in the United States and was more closely related to operant psychology and the radical behaviorism of B. F. Skinner. The second tradition emerged in Britain and South Africa, and was more closely associated with the neo-behaviorism of stimulus-response-learning theory.

Lazarus, a South African, was one of the first to incorporate cognitive mediational constructs with behavioral theory. He focused on the role of social learning processes in the development of emotional problems and on the use of cognitive restructuring, the
development of social-problem-solving capacities, and the acquisition of behavioral skills in solving them.

Lazarus belongs to a group of pragmatic eclectics, and applies the term ‘technical eclecticism’ to his approach. Technical eclecticism holds that theoretical integration involves fusing theories that are irreconcilable, and that techniques should be combined pragmatically on the basis of observed or presumed clinical efficacy. Lazarus’ multimodal therapy is a good example of this approach. Techniques from Gestalt, cognitive, behavioral, psychodynamic, and family systems therapy all may be applied in one individual’s therapy.

Multimodal therapy centers on the commitment to operate not out of theoretical preference, but out of what seems best for the client. Specifically, it means to use the methods that comparative outcome research has shown to work best with the problems manifested by the clients. This position seems to make sense, especially since no traditional theories of change have succeeded in convincing the professional public of deserving singular precedence; consequently, practitioners and researchers are exploring ways of synthesizing diverse elements into flexible multifaceted orientations.

Lazarus’ therapy is one of the varieties of behavior-shaping approaches. His MMT (Multi Modal Therapy) is a technically eclectic approach. Among other eclectic approaches in recent years, this is a more traditional approach that searches the literature for specific techniques that are most effective for specific types of clients with specific types of problems. The foundation of this approach is actuarial rather than theoretical, applying what the research literature predicts will work best under specific conditions. Technical eclectics use techniques drawn from different sources without necessarily
accepting the theories that generated the procedures even if the assumptions underlying the therapies conflict. Lazarus’ MMT applies the most promising techniques across a range of modalities: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs (captured by the acronym, BASIC I.D.).

The BASIC ID formula provides a systematic and thorough method of assessment and offers an eclectic treatment approach. With such a treatment approach, the client will develop more coping responses and will be less likely to succumb to past behavior patterns.

Multimodal therapy is not so much a ‘school’ of therapy as a way of organizing information obtained from the client and then selecting treatments in terms of the seven interactive modalities of human personality expressed in the acronym BASIC I.D.

Multimodal therapy is a comprehensive treatment approach and may be viewed as an extension of Broad-Spectrum Behavior Therapy. Broad-Spectrum Behavior Therapy is founded on basic learning theory and expands into the area of private events, covert processes, and cognitions. While exposing this theory to further refinement, Lazarus developed an applied conceptualization of this model. Although multimodal therapy uses many techniques from behavior modification, it also incorporates elements of social learning theory, general systems theory, and group communications theory.

Multimodal therapy recognizes the following areas as viable avenues for treatment: a) learning theory operant and classical conditioning; b) modeling and vicarious processes; c) private events-cognitive theory; d) non-conscious processes (not to be confused with the unconscious) that address levels of awareness or conscious comprehension; and e) defensive reactions.
The multimodal approach rests on the assumption that unless the seven discrete but interactive modalities are assessed, treatment is likely to overlook significant concerns. Initial interviews provide an initial overview of a client’s significant Behaviors, Affective responses, Sensory reactions, Images, Cognitions, Interpersonal relationships, and the need for Drugs and other biological interventions. These modalities exist in a state of reciprocal transaction and flux, connected by complex chains of behavior and other psycho-physiological processes.

This framework is used to categorize the client’s problems, plan the therapist’s intervention, and chart the client’s progress. The first six modalities refer to: human behavior; emotional responses; sensory experiences (sight, hearing, smell, touch or taste); conjured up images; thought; interaction with others. The seventh modality refers to the fact that we are biological organisms subject to biochemical influences from food and drugs.

The framework is usually introduced to the client in the first therapy session. It allows the therapist and the client to draw up an organized list of the client’s problems and to plan appropriate treatments for each problem. A framework has the extra benefit of helping the therapist to check that every potential problem area has been covered in assessing the client.

During the treatment, more detailed assessments may be carried out using questionnaires. The client’s strengths in the modalities can be represented as a bar chart, known as the structural profile. The actual profile can be compared with the client’s desired profile - the way he or she would like to be - in order to plan and monitor treatment.
In planning treatment, multimodal therapists draw freely from other schools. They may advise a client to use techniques they themselves do not practice and to do home exercises or reading.

For example, they may use commercially produced relaxation tapes to teach the client to relax. They might even, in consultation with the client, choose treatments from outside what we normally think of as psychotherapy. This might involve diet and exercise when an unhealthy lifestyle might be part of the overall pattern of problems experienced by a client suffering from stress at work.

Multimodal therapists take pains to tailor their approach to each client. They adapt their manner, their dress and even their style of interaction to the needs of the client.

Multimodal therapy is intended to be quick and flexible. Sessions can be as short as 20 minutes or can last several hours, depending on clients’ needs. Progress is reviewed frequently and a typical course of treatment would take six sessions with the gaps between sessions increasing as the client improves.

Lazarus believed that changing one’s behavior could lead to important insights, but he was skeptical that this worked in reverse. As a result, he formulated BASIC I.D., as a tool for therapists to assess clients. The first letter of the acronym “B” represents the behaviors clients want to increase or decrease. “A” stands for affect or emotions, and is used to explore clients’ relationships with anger, joy, and anxiety. “S” refers to sensations; having clients identify physical sensations helps them get a better sense of where in their bodies emotions are physically felt. “I” stands for imagery. This was separated from cognition because people who engage in positive self-talk can still hold
negative mental pictures of themselves that may impede their therapeutic progress. Lazarus believed that helping clients develop positive mental pictures enables them to increase desired behaviors and to have more effective interpersonal interactions. “C” refers to the cognitive functioning of clients and their ability to recognize self-talk, determining the extent to which they participate in irrational self-talk. The second “I” represents interpersonal relations, and its purpose is to identify skill deficiencies or unrealistic expectations from others. Finally, “D” represents drugs and biology. This also is used to indicate how clients view nutrition, exercise, and alcohol or illegal drug use.

Once the interview and questionnaire are completed, the information is evaluated and a treatment plan is designed with special attention paid to the client’s BASIC I.D. ‘firing order’. Lazarus described the firing order as the sequence to which the client responds to certain events. In addition to helping the therapist identify a treatment plan, explaining firing order to clients can prove to be therapeutic by allowing the clients to see the antecedents to their problems.

The therapist, usually in concert with the client, determines which specific problems across the BASIC I.D. are most salient. Whenever possible, the choice of appropriate techniques rests on well-documented research data, but multimodal therapists remain essentially flexible and are willing to improvise when necessary. They are technically eclectic, but remain theoretically consistent, drawing mainly from a broad-based social and cognitive learning theory (because its tenets are open to verification or disproof). Multimodal therapy contends that many problems arise from misinformation and missing information. Therefore, with most outpatients, bibliotherapy, the use of
selected books for home reading, often provides a springboard for enhancing the
treatment process and content (Corsini & Wedding, 2000).

An assiduous attempt is made to tailor the therapy to each client’s unique
requirements. Therefore, in addition to mastering a wide range of effective techniques,
multimodal clinicians address the fact that different relationship styles are also necessary.
Because the therapeutic relationship is the soil that enables the techniques to take root, it
is held that the correct method delivered within and geared to the context of the client’s
interpersonal expectancies, will augment treatment adherence and enhance therapeutic
outcomes. Another issue that requires careful scrutiny is whether individual therapy,
couples therapy, family therapy, or participation in a group (or some combination of the
foregoing) seems advisable. Referrals are effected when necessary and feasible.

Determining the length or amount of data collection depends on both the goals
and the setting of the client. Essentially, data should be collected for long enough to
establish a baseline. The length of the baseline is dependent on the behavior. Reliable
baseline data depends on two factors: a) the counselor’s ability to make accurate
observations of the behaviors, and b) the client’s ability to self-monitor the target
behaviors. The client also must be able to identify the operationally defined behavior, as
well as be motivated to collect the personal data. The counselor must be able to detect
when this is not the case with the client and when the client is providing inaccurate data.
This most often occurs when a client wants to be perceived favorably by the counselor.
Data should always be collected throughout the treatment process and analyzed for
trends. This recommendation enables the counselor to quickly make changes in
treatment and ensures client success in the shortest amount of time.
Evaluation

The efficacy of MMT has been well documented. Lazarus found that using MMT with people who had no success with therapy in the past proved to have significant beneficial results. The efficacy of MMT is clear, and multidimensional rationale has broadened our understanding of holistic helping.

One of the problems with this form of eclecticism is that it often proceeds as if a therapeutic technique is a disembodied procedure that can be readily transported from one context to another, much like a medical technique, without consideration of its new psychotherapeutic context. Therefore a therapeutic procedure such as an interpretation or empathic response does not stand on its own, independent of the framework of meaning created by the entire therapeutic system.

This part-whole interdependence can be illustrated in various ways. For example, a client whose treatment has been primarily cognitive-behavioral may experience a therapist’s shift to empathic/reflective responding as a withholding of needed psychological expertise. Conversely, a client whose treatment has been client-centered or psychoanalytic may experience a shift to cognitive-behavioral interventions as controlling. Although such interventions have the potential to be effective, their meaning and impact should be explored in their new context.

Wachtel and Messer (1998), state that despite Lazarus’ de-emphasis on theory, he acknowledged that every practitioner uses at least some theory to guide the choices. Multimodal therapy, Lazarus asserted, rests primarily on the theoretical foundation of social learning theory, drawing also from general systems theory and communications theory. Indeed, the techniques that Lazarus lists as part of multimodal therapy draw most
heavily from behavioral and cognitive therapies, and minimally, if at all, from psychodynamic and other therapies. This is surprising given Lazarus’ criterion of empirical data for selecting therapies and the accumulating evidence of the effectiveness of such approaches. Lazarus’ eclectic approach appears to fall somewhere between a broadened version of behavior therapy and an eclectic strategy that can choose from among any therapy system if there is empirical data to support that choice.

Technical eclecticism is more actuarial than theoretical, Lazarus claims. That was and is true. A totally atheoretical eclecticism, however, is neither feasible nor desirable. Therapists need to operate from some base of theory in order to guide their practice, and that seems to be the case even for technical eclectics. Lazarus described his technically eclectic Multimodal Therapy as rooted in a social and cognitive learning theory. In fact, because of the presence of such theoretical underpinnings, Stricker in (Wachtel and Messer, 1998) suggests that the approach might be better characterized as assimilative integration. Stricker described truly atheoretical eclecticism as “an undisciplined garb bag of techniques to be used in a near random manner as the mood strikes the therapist” (p.261).
References


