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MULTIMODAL BEHAVIOR THERAPY: TREATING THE "BASIC ID"

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This paper examines the necessary and sufficient conditions for achieving long-lasting therapeutic change. The rationale for recommending direct intervention across seven distinct but inter-related modalities is outlined in some detail. Other systems of psychotherapy are briefly compared to the multimodal behavior therapy procedures advocated herein. A case presentation is provided in order to lend substance to the general notion that durable clinical results are in direct proportion to the number of specific modalities deliberately invoked by any therapeutic system.

Progress in the field of psychotherapy is hindered by a factor that is endemic in our society: an item is considered newsworthy, and accolades are accorded when claims run counter to the dictates of common sense. Thus everything from megavitamins to anal lavages and primal screams gains staunch adherents who, in their frenetic search for a panacea, often breed confusion worse confounded. The present paper emphasizes that patients are usually troubled by a multitude of *specific* problems which should be dealt with by a similar multitude of *specific* treatments. The approach advocated herein is very different from those systems which cluster presenting problems into ill-defined constructs and then direct one or two treatment procedures at these constructs. The basic assumption is that durable (long-lasting) therapeutic results depend upon the amount of effort expended by patient and therapist across at least six or seven parameters.

Research into the interaction between technique and relationship variables in therapy has shown that an effective therapist "must be more than a 'nice guy' who can exude prescribed interpersonal conditions—he must have an armamentarium of scientifically derived skills and techniques to supplement his effective interpersonal relations" (19, p. 8). Deliberately excluded from the present formulation is the empathic, nonjudgmental warmth, wit and wisdom which characterize those therapists who help rather than harm their clients (2). If this were an article on surgical techniques and procedures, we would presuppose that individuals who apply the prescribed methods are free from pronounced tremors and possess more than a modicum of manual dexterity. Thus, it is hoped that multimodal behavioral procedures will attract nonmechanistic therapists who are flexible, empathic and genuinely concerned about the welfare of their clients.

The main impetus for all forms of treatment probably stems from the general urgency of human problems and the need for practical assistance. This has lent acceptance to technically faulty work that would not pass muster in other fields, and every informed practitioner is all too well aware of the fragmentary and contradictory theories that hold sway in the absence of experimental evidence. Apart from the plethora of different techniques, systems and theories, we have conflicting models and paradigm clashes as exemplified by the differences be-

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tween radical behaviorists and devout phenomenologists. Attempts to blend divergent models into integrative or eclectic harmony may often result in no more than syncretistic muddles (17, 19). And yet without general guiding principles that cut across all systems of therapy, we are left with cabalistic vignettes in place of experimental data or even clinical evidence. Multimodal behavior 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.

Since all patients are influenced by processes that lie beyond the therapist's control and comprehension, the field of psychological treatment and intervention is likely to foster superstitious fallacies as readily as well established facts. The tendency to ascribe causative properties to the *last* event in any sequence is all too well known (*e.g.*, her stomach pains must be due to the sausage she just ate for lunch). Thus a patient, after grappling with a problem for years, starts massaging his left kneecap while plucking his right ear lobe and experiences immediate and lasting relief from tenacious symptoms. If a therapist happens to be close at hand, a new technique is likely to be born and placed alongside the parade of other "breakthroughs" with the screamers, confronters, disclosers, relaxers, dreamers, and desensitizers. And if the therapist happens to be sufficiently naïve, enthusiastic and charismatic, we will probably never convince him, his students, or his successful patients that the knee-and-ear technique per se is not the significant agent of change. To guard against this penchant, we must insist upon the precise specification of the operations by which systematic assessment of the efficacy of a treatment for a specific problem is made on a regular basis.

The foregoing variables plus the power struggle between psychiatrists and psychologists and the various schools therein tend to hamper progress. The field, over the span of the past 8 years, is described by two leading research clinicians as "chaotic" (4, 5). Part of the confusion may also be ascribed to the fact that there is a human (but unscientific) penchant to search for unitary treatments and cures. How nice if insight alone or a soul-searing scream could pave the way to mental health. How simple and convenient for countless addicts if aversion therapy afforded long-lasting results. And what a boon to phobic sufferers if their morbid fears were enduringly assuaged by systematic desensitization and assertive training methods. But while short-lived relief is available to most, we must concur with Lesse that for most syndromes "there is very little proof at this time that any one given technique is superior to another in the long-range therapy of a particular type of psychogenic problem" (13, p. 330).

Notwithstanding the biases that lead to theoretical befuddlement, most clinicians would probably agree with the pragmatic assumption that the more a patient learns in therapy, the less likely he is to relapse afterwards. Thus, an alcoholic treated only by aversion therapy would be more likely to relapse than his counterpart who had also received relaxation therapy (3). The benefits that accrue from aversion therapy plus relaxation training would be further potentiated by the addition of assertive training, family therapy, and vocational guidance (12). This general statement implies that *lasting change* is at the very least a function of combined *techniques, strategies,* and *modalities.* This vitiates the search for a panacea, or a single therapeutic modality. But a point of diminishing returns obviously exists. If two aspirins are good for you, 10 are not 5 times better. When and why should we stop pushing everything from transcendental meditation to hot and cold sitz baths at our clients? Conversely, how, when, where, and why do we infer that in a given instance, meditation

plus sensitivity training is preferable to psychodrama and contingency contracting? Above all, how can we wield Occam's razor to dissect the chaos of these diverse psychotherapeutic enterprises into meaningful and congruent components?

SEVEN MODALITIES

An arbitrary division created *sui generis* would simply turn back the clock on the composite theories and facts that psychologists have amassed to date. It is no accident that ever since the publication of Brentano's *Psychologie vom empirischen Standpunkte* in 1874, acts like ideation, together with feeling states and sensory judgments, have comprised the main subject matter of general psychology. In other words, psychology as the scientific study of behavior has long been concerned with sensation, imagery, cognition, emotion, and interpersonal relationships. If we examine psychotherapeutic processes in the light of each of these basic modalities, seemingly disparate systems are brought into clearer focus, and the necessary and sufficient conditions for long-lasting therapeutic change might readily be discerned.

Every patient-therapist interaction involves *behavior* (be it lying down on a couch and free associating, or actively role playing a significant encounter), *affect* (be it the silent joy of nonjudgmental acceptance, or the sobbing release of pent-up anger), *sensation* (which covers a wide range of sensory stimuli from the spontaneous awareness of bodily discomfort to the deliberate cultivation of specific sensual delights), *imagery* (be it the fleeting glimpse of a childhood memory, or the contrived perception of a calm-producing scene), and *cognition* (the insights, philosophies, ideas, and judgments that constitute our fundamental values, attitudes and beliefs). All of these take place within the context of an *interpersonal* relationship, or various interpersonal relationships. An added dimension with many patients is their need for medication or *drugs* (*e.g.*, phenothiazine derivatives and various antidepressants and mood regulators). Taking the first letter of each of the foregoing italicized words, we have the acronym BASIC ID. *Obviously, the proposed seven modalities are interdependent and interactive.*

If we approach a patient *de novo* and inquire in detail about his salient behaviors, affective responses, sensations, images, cognitions, interpersonal relationships, and his need for drugs or medication, we will probably know more about him than we can hope to obtain from routine history taking and psychological tests. Whether or not these general guidelines can provide all that we need to know in order to be of therapeutic service is an empirical question.[2]

OTHER SYSTEMS

While it is important to determine whether the BASIC ID and the various combinations thereof are sufficiently exhaustive to encompass most vagaries of human conduct, it is perhaps more compelling first to view, very briefly, a few existing systems of therapy in the light of these modalities. Most systems deal with the majority of modalities *en passant;* very few pay specific and direct attention to each particular zone. Psychoanalysis deals almost exclusively with cognitive-affective interchanges. The neo-Reichian school of bioenergetics (14) focuses upon behavior (in the form of "body language"), and the sensory-affective dimension. Encounter groups and Gestalt therapy display a similar suspicion of the "head" and are inclined to neglect cognitive material for the sake of "gut reactions" or affective and sensory responses. Gestalt therapists also employ role playing and imagery techniques. The Masters and Johnson (15) sex-training regimen deals explicitly with sexual behavior, affective processes, the "sensate focus," various re-educative features and the correction of

[2] Some may argue that the absence of a "spiritual" dimension is an obvious hiatus, although in the interests of parsimony, it can be shown that cognitive-affective interchanges readily provide the necessary vinculum.

misconceptions, all within a dyadic context, preceded by routine medical and laboratory examinations. They do not avail themselves of imagery techniques (*e.g.*, desensitization, self-hypnosis, or fantasy projection), a fact which may limit their overall success rate.

Perhaps it is worth stressing at this point that the major hypothesis, backed by the writer's clinical data (8, 11), is that *durable results are in direct proportion to the number of specific modalities deliberately invoked by any therapeutic system.* Psychoanalysis, for instance, is grossly limited because penetrating insights can hardly be expected to restore effective functioning in people with deficient response repertoires—they need explicit training, modeling, and shaping for the acquisition of adaptive social patterns. Conversely, nothing short of coercive manipulation is likely to develop new response patterns that are at variance with people's fundamental belief systems. Indeed, insight, self-understanding, and the correction of irrational beliefs must usually precede behavior change whenever faulty assumptions govern the channels of manifest behavior. In other instances, behavior change must occur before "insight" can develop (8). Thus, cognitive restructuring and overt behavior training are often reciprocal. This should not be misconstrued as implying that a judicious blend of psychoanalysis and behavior therapy is being advocated. Psychoanalytic theory is unscientific and needlessly complex; behavioristic theory is often mechanistic and needlessly simplistic. The points being emphasized transcend any given system or school of therapy. However, adherence to social learning theory (1) as the most elegant theoretical system to explain our therapeutic sorties places the writer's identification within the province of behavior therapy—hence "multimodal behavior therapy." Perhaps the plainest way of expressing our major thesis is to stress that comprehensive treatment at the very least calls for the correction of irrational beliefs, deviant behaviors, unpleasant feelings, intrusive images, stressful relationships, negative sensations, and possible biochemical imbalance. To the extent that problem identification (diagnosis) systematically explores each of these modalities, whereupon therapeutic intervention remedies whatever deficits and maladaptive patterns emerge, treatment outcomes will be positive and long-lasting. To ignore any of these modalities is to practice a brand of therapy that is incomplete. Of course, not every case requires attention to each modality, but this conclusion can only be reached after each area has been carefully investigated during problem identification (*i.e.*, diagnosis). A similar position stressing comprehensive assessment and therapy has been advocated by Kanfer and Saslow (7).

PROBLEM IDENTIFICATION

Faulty problem identification (inadequate assessment) is probably the greatest impediment to successful therapy. The major advantage of a multimodal orientation is that it provides a systematic framework for conceptualizing presenting complaints within a meaningful context. A young man with the seemingly monosymptomatic complaint of "claustrophobia" was seen to be troubled by much more than "confined or crowded spaces" as soon as the basic modalities had been scanned. The main impact upon his *behavior* was his inability to attend social gatherings, plus the inconvenience of avoiding elevators, public transportation, and locked doors. The *affective* concomitants of his avoidance behavior were high levels of general anxiety and frequent panic attacks (*e.g.*, when a barber shop became crowded, and at the check-out counter of a supermarket). The *sensory* modality revealed the fact that he was constantly tense and suffered from muscle spasms. His *imagery* seemed to focus on death, burials, and other morbid themes. The *cognitive* area revealed a tendency to catastrophize and to demean himself. At the *interpersonal* level, his wife was inclined to mother him and to reinforce his avoidance behavior. This information, *obtained after*

a cursory 10- to 15-minute inquiry, immediately underscored crucial antecedent and maintaining factors that warranted more detailed exploration as a prelude to meaningful therapeutic intervention.

In contrast with the foregoing case, little more than *sensory unawareness* in a 22-year-old woman seemed to be the basis for complaints of pervasive anxiety, existential panic and generalized depression. She was so preoccupied with lofty thoughts and abstract ideation that she remained impervious to most visual, auditory, tactile and other sensory stimuli. Treatment was simply a matter of instructing her to attend to a wide range of specific sensations. "I want you to relax in a bath of warm water and to examine exact temperature contrasts in various parts of your body and study all the accompanying sensations." "When you walk into a room I want you to pay special attention to every object, and afterwards, write down a description from memory." "Spend the next 10 minutes listening to all the sounds that you can hear and observe their effects upon you." "Pick up that orange. Look at it. Feel its weight, its texture, its temperature. Now start peeling it with that knife. Stop peeling and smell the orange. Run your tongue over the outside of the peel. Now feel the difference between the outside and the inside of the peel. . . ." These simple exercises in sensory awareness were extraordinarily effective in bringing her in touch with her environment and in diminishing her panic, anxiety and depression. She was then amenable to more basic therapy beyond her presenting complaints.

The multimodal approach to therapy is similar to what is called "the problem-oriented record approach." This emphasis upon problem specification is just coming into its own in psychiatry as evidenced in a recent article by Hayes-Roth, Longabaugh, and Ryback (6). In medicine this approach to record keeping and treatment is slightly older, being best illustrated by Weed's work (18). Multimodal behavior therapy not only underscores the value of this new approach, but also provides a conceptual framework for its psychiatric implementation. Let us now turn to a case illustration of its use.

CASE ILLUSTRATION

A case presentation should lend substance to the string of assertions outlined on the foregoing pages.

Mary Ann aged 24 was diagnosed as a chronic undifferentiated schizophrenic. Shortly after her third admission to a mental hospital, her parents referred her to the writer for treatment. According to the hospital reports, her prognosis was poor. She was overweight, apathetic and withdrawn, but against a background of lethargic indifference, one would detect an ephemeral smile, a sparkle of humor, a sudden glow of warmth, a witty remark, an apposite comment, a poignant revelation. She was heavily medicated (Trilafon 8 mg. t.i.d., Vivactil 10 mg. t.i.d., Cogentin 2 mg. b.d.), and throughout the course of therapy she continued seeing a psychiatrist once a month who adjusted her intake of drugs.

A life history questionnaire, followed by an initial interview, revealed that well intentioned but misguided parents had created a breeding ground for guilty attitudes, especially in matters pertaining to sex. Moreover, an older sister, 5 years her senior, had aggravated the situation "by tormenting me from the day I was born." Her vulnerability to peer pressure during puberty had rendered her prone to "everything but heroin." Nevertheless, she had excelled at school, and her first noticeable breakdown occurred at age 18, shortly after graduating from high school. "I was on a religious kick and kept hearing voices." Her second hospital admission followed a suicidal gesture at age 21, and her third admission was heralded by her sister's sudden demise soon after the patient turned 24.

Since she was a mine of sexual misinformation, her uncertainties and conflicts with regard to sex became an obvious area for therapeutic intervention. The book *Sex*

Without Guilt by Albert Ellis (1965 Grove Press edition) served as a useful springboard toward the correction of more basic areas of sexual uncertainty and anxiety. Meanwhile, careful questioning revealed the following Modality Profile:

Modality	Problem	Proposed Treatment
Behavior	Inappropriate withdrawal responses	Assertive training
	Frequent crying	Nonreinforcement
	Unkempt appearance	Grooming instructions
	Excessive eating	Low calorie regimen
	Negative self-statements	Positive self-talk assignments
	Poor eye contact	Rehearsal techniques
	Mumbling of words with poor voice projection	Verbal projection exercises
	Avoidance of heterosexual situations	Re-education and desensitization
Affect	Unable to express overt anger	Role playing
	Frequent anxiety	Relaxation training and reassurance
	Absence of enthusiasm and spontaneous joy	Positive imagery procedures
	Panic attacks (usually precipitated by criticism from authority figures)	Desensitization and assertive training
	Suicidal feelings	Time projection techniques
	Emptiness and aloneness	General relationship building
Sensation	Stomach spasms	Abdominal breathing and relaxing
	Out of touch with most sensual pleasures	Sensate focus method
	Tension in jaw and neck	Differential relaxation
	Frequent lower back pains	Orthopedic exercises
	Inner tremors	Gendlin's focusing methods (8, p. 232)
Imagery	Distressing scenes of sister's funeral	Desensitization
	Mother's angry face shouting "You fool!"	Empty chair technique
	Performing fellatio on God	Blow up technique (implosion)
	Recurring dreams about airplane bombings	Eidetic imagery invoking feelings of being safe
Cognition	Irrational self-talk: "I am evil." "I must suffer." "Sex is dirty." "I am inferior."	Deliberate rational disputation and corrective self-talk
	Syllogistic reasoning, overgeneralization	Parsing of irrational sentences
	Sexual misinformation	Sexual education
Interpersonal relationships	Characterized by childlike dependence	Specific self-sufficiency assignments
	Easily exploited/submissive	Assertive training
	Overly suspicious	Exaggerated role taking
	Secondary gains from parental concern	Explain reinforcement principles to parents and try to enlist their help
	Manipulative tendencies	Training in direct and confrontative behaviors

The Modality Profile may strike the reader as a fragmented, or mechanistic barrage of techniques that would call for a disjointed array of therapeutic maneuvers. In actual practice, the procedures follow logically and blend smoothly into meaningful interventions.

During the course of therapy as more data emerged and as a clearer picture of the patient became apparent, the Modality Profile was constantly revised. Therapy was mainly a process of devising ways and means to remedy Mary Ann's shortcomings and problem areas throughout the basic modalities. The concept of "technical eclecticism" came into its own (10). In other words, a wide array of therapeutic methods drawn from numerous disciplines was applied, but to remain theoretically consistent, the active ingredients of every technique were sought within the province of social learning theory.

In Mary Ann's case, the array of therapeutic methods selected to restructure her life included familiar behavior therapy techniques such as desensitization, assertive training, role playing, and modeling, but many additional procedures were employed such as time projection, cognitive restructuring, eidetic imagery, and exaggerated role taking as described in some of the writer's recent publications (8, 9). The empty chair technique (16) and other methods borrowed from Gestalt therapy and encounter group procedures were added to the treatment regimen. Mary Ann was also seen with her parents for eight sessions, and was in a group for 30 weeks.

During the course of therapy she became engaged and was seen with her fiancé for premarital counseling for several sessions.

The treatment period covered the span of 13 months at the end of which time she was coping admirably without medication and has continued to do so now for more than a year. This case was chosen for illustrative purposes because so often, people diagnosed as "psychotic" receive little more than chemotherapy and emotional support. Yet, in the writer's experience, once the florid symptoms are controlled by medication, many people are amenable to multimodal behavior therapy. It is tragic that large numbers of people who can be reached and helped by multimodal behavior therapy are often left to vegetate.

CONCLUSIONS

Those who favor working with one or two specific modalities may inquire what evidence there is to support the contention that *multimodal* treatment is necessary. At present, the writer's follow-up studies (*e.g.*, 8, 11) have shown that relapse all too commonly ensues after the usual behavior therapy programs, despite the fact that behavioral treatments usually cover more modalities than most other forms of therapy. Of course, the run of the mill behavior therapist does not devote as much attention to imagery techniques as we are advocating (even when using covert reinforcement procedures and imaginal desensitization), nor does he delve meticulously enough into cognitive material, being especially neglectful of various philosophical values and their bearing on self-worth.

Another fact worth emphasizing is that in order to offset "future shock" multimodal therapy attempts to anticipate areas of stress that the client is likely to experience in time to come. Thus, one may use imaginal rehearsal to prepare people to cope with the marriage of a child, a possible change in occupation, the purchase of a new home, the process of aging, and so forth. In my experience, these psychological "fire drills" can serve an important preventive function.

As one investigates each modality, a clear understanding of the individual and his interpersonal context emerges. Even with a "simple phobia," new light is shed, and unexpected information is often gleaned when examining the behavioral, affective, sensory, imaginal, cognitive and interpersonal consequences of the avoidance responses.

Whenever a plateau is reached in therapy and progress falters, the writer has found it enormously productive to examine each modality in turn in order to determine a possibly neglected area of concern. More often than not, new material emerges and therapy proceeds apace.

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