UNIT 4 INTEGRATIVE AND MULTIMODAL THERAPIES

Structure

4.0 INTRODUCTION

A major emphasis of this unit is on helping you construct your own integrated approach to psychotherapy. Research has indicated that psychotherapy is moving toward an integrated approach to therapy. Throughout the world, when you ask a psychologist or counsellor what his or her theoretical orientation is, the most frequently given response is integrative or eclectic. It is highly likely that upon graduation, you will integrate one or more of the theories presented in this block. This unit explores in detail the integrative and multimodal approach to therapy. The first part of this unit traces the historical development, variables responsible for, the different models and future of integrative approach. The second half of this unit will explore multimodal therapy. This part will cover the development of theory, basic concepts, explanations for development and maintenance of problems, practice, applications and limitations of multimodal therapy.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the foundational aspects and variables responsible for integration;
- Describe the different paths to integration and future of integrative approach;
- Discuss the concept and development of multimodal therapy; and
- Describe the practice, applications and limitations of multimodal therapy.

4.2 DEFINITION OF INTEGRATIVE PSYCHOTHERAPY

Integrative psychotherapy is an attempt to combine concepts and counselling interventions from more than one theoretical psychotherapy approach. It is not a particular combination of counselling theories, but rather it consists of a framework for developing an integration of theories that you find most appealing and useful for working with clients.

According to Norcross (2005):

Psychotherapy integration is characterised by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy. (pp. 3–4).

4.3 HISTORICAL OVERVIEW OF THE INTEGRATIVE MOVEMENT

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients' problems. From Freud's Wednesday evening meetings

on psychoanalysis, a number of theories were created, including Adler's individual psychology. As each therapist claimed that he had found the one best treatment approach, heated battles arose between various therapy systems. When behaviourism was introduced to the field, clashes took place between psychoanalysts and behaviourists.

During the 1940s, 1950s, and 1960s, therapists tended to operate within primarily one theoretical school. Dollard and Miller's (1950) book, *Personality and Therapy,* was one of the first attempts to combine learning theory with psychoanalysis. In 1977, Paul Wachtel published *Psychoanalysis and Behaviour Therapy: Toward an Integration*. In 1979, James Prochaska offered a transtheoretical approach to psychotherapy, which was the first attempt to create a broad theoretical framework.

In 1979, Marvin Goldfried, Paul Wachtel, and Hans Strupp organised an association, the Society for the Exploration of Psychotherapy Integration (SEPI), for clinicians and academicians interested in integration in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Shortly thereafter in 1982, *The International Journal of Eclectic Psychotherapy* was published, and it later changed its name to the *Journal of Integrative and Eclectic Psychotherapy.* By 1991, it began publishing the *Journal of Psychotherapy Integration*. As the field of psychotherapy has developed over the past several decades, there has been a decline in the ideological cold war among the various schools of psychotherapy (Goldfried, Pachankis, & Bell, 2005).

4.4 VARIABLES RESPOSIBLE FOR GROWTH OF PSYCHOTHERAPY INTEGRATION

Norcross and Newman (1992) have summarised the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

First, they point out that there was simply a proliferation of separate counselling theories and approaches. The integrative psychotherapy movement represented a shift away from what was the prevailing atmosphere of factionalism and competition amongst the psychotherapies and a step toward dialogue and cooperation.

Second, they note that practitioners increasingly recognised the inadequacy of a single theory that is responsive to all clients and their varying problems. No single therapy or group of therapies had demonstrated remarkable superior efficacy in comparison to any other theory.

Third, there was the correlated lack of success of any one theory to explain adequately and predict pathology, personality, or behavioural change.

Fourth, the growth in number and importance of shorter-term, focused psychotherapies was another factor spearheading the integrative psychotherapy movement.

Fifth, both clinicians and academicians began to engage in greater communication with each other that had the net effect of increasing their willingness to conduct collaborative experiments.

Sixth, clinicians had to come to terms with the intrusion into therapy with the realities of limited socioeconomic support by third parties for traditional, long-term psychotherapies. Increasingly, there was a demand for therapist accountability and documentation of the effectiveness of all medical and psychological therapies. Hence, the integration trend in psychotherapy has also been fuelled by external realities, such as insurance reimbursement and the popularity of short-term, prescriptive, and problem-focused therapists.

Seventh, researchers' identification of common factors related to successful therapy outcome influenced clinicians' tendency toward psychotherapy integration. Increasingly, therapists began to recognise there were common factors that cut across the various therapeutic schools.

Eighth, the development of professional organisations such as SEPI, professional network developments, conferences, and journals dedicated to the discussion and study of psychotherapy integration also contributed to the growth of the movement. The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories.

4.5 DIFFERENT WAYS TO PSYCHOTHERAPY INTEGRATION

This section provides an overview of how theorists and practitioners have tried to integrate the various theoretical approaches to therapy. Perhaps in examining how others have integrated their therapy with different concepts and techniques, we might feel more comfortable in thinking about how we might pursue this same avenue. Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

4.5.1 Eclecticism

Eclecticism may be defined as an approach to thought that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena. Eclectics are sometimes criticized for lack of consistency in their thinking. For instance, many psychologists accept some features of behaviourism, yet they do not attempt to use the theory to explain all aspects of client behaviour. Eclecticism in psychology has been caused by the belief that many factors influence human behaviour; therefore, it is important to examine a client from a number of theoretical perspectives.

4.5.2 Differences between Eclecticism and Psychotherapy Integration

Typically, eclectic therapists do not need or have a theoretical basis for either understanding or using a specific technique. They chose a counselling technique because of its efficacy, because it works. For instance, an eclectic therapist might experience a positive change in a client after using a specified counselling technique, yet not investigate any further why the positive change occurred. In

contrast, an integrative therapist would investigate the how and why of client change. Did the client change because she was trying to please the therapist or was she instead becoming more self-directed and empowered?

Integrative and eclectic therapists also differ in the extent to which they adhere to a set of guiding, theoretical principles and view therapy change. Practitioners who call themselves eclectic appear to have little in common, and they do not seem to subscribe to any common set of principles. In contrast, integrationists are concerned not only with what works but why it works. Moreover, clinicians who say they are eclectic tend to be older and more experienced than those who describe themselves as integrationists. This difference is fast disappearing because some graduate schools are beginning to train psychologists to be integrationists.

4.5.3 Theoretical Integration

Theoretical integration is perhaps the most difficult and sophisticated of the three types of psychotherapy integration because it involves bringing together theoretical concepts from disparate theoretical approaches, some of which may present contrasting worldviews. The goal is to integrate not just therapy techniques but also the psychotherapeutic theories involved as Dollard and Miller (1950) did with psychoanalysis and behaviour therapy. Proponents of theoretical integration maintain that it offers new perspectives at the levels of theory and practice because it entails a synthesis of different models of personality functioning, psychopathology, and psychological change.

4.5.4 Assimilative Integration

The assimilative integration approach to psychotherapy involves grounding oneself in one system of psychotherapy but with a view toward selectively incorporating (assimilating) practices and views from other systems. Assimilative integrationists use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems. Practitioners who have labelled themselves as assimilative integrationists are: (1) Gold (1996), who proposed assimilative psychodynamic therapy; (2) Castonguay et al. (2004), who have advocated cognitive-behavioural assimilative therapy; and (3) Safran, who has proposed interpersonal and cognitive assimilative therapy (Safran & Segal, 1990).

Assimilative integrationists believe integration should take place at the practice level rather than at the theory level. Most therapists have been trained in a single theoretical approach, and over time many gradually incorporate techniques and methods of other approaches. Typically, therapists do not totally eliminate the theoretical framework in which they were trained. Instead, they tend to add techniques and different ways of viewing individuals.

4.5.5 The Common Factor Approach

The common factors approach has been influenced by the research and scholarships of such renowned leaders in psychotherapy as Jerome Frank (1973, 1974) and Carl Rogers (1951, 1957). Clearly, Rogers' contributions to common factors research has become so accepted by clinicians throughout the world that his core conditions (or necessary and sufficient conditions to effect change in clients) have become part of the early training of most helping professionals. Researchers and theorists have transformed Rogers' necessary and sufficient

conditions into a broader concept that has become known as "therapeutic alliance" (Hubble, Duncan, & Miller, 1999). The therapeutic alliance is important across the various counselling theory schools; it is the glue that keeps the person coming to therapy week after week. Currently, more than 1,000 studies have been reported on the therapeutic alliance (Hubble, Duncan, & Miller, 1999).

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them.

4.5.6 Multitheoretical Approaches

Recently, therapists have developed multitheoretical approaches to therapy. Multitheoretical frameworks do not attempt to synthesise two or more theories at the theoretical level. Instead, there is an effort to "bring some order to the chaotic diversity in the field of psychotherapy and "preserve the valuable insights of major systems of psychotherapy" (Prochaska & DiClemente, 2005, p. 148). *The goal of multitheoretical approaches is to provide a framework that one can use for using two or more theories.* Two examples of multitheoretical frameworks are (1) the transtheoretical approach by Prochaska and DiClemente, and (2) multitheoretical therapy by Brooks-Harris.

4.5.7 The Transtheoretical Model

The most widely recognised model using a multitheoretical framework has been the transtheoretical model developed by Prochaska and DiClemente (1984, 2005). The transtheoretical model is a model of behavioural change, which has been the basis for developing effective interventions to promote healthy behaviour change. Key constructs are integrated from other counselling theories. The model describes how clients modify problem behaviour or how they develop a positive behaviour. The central organising construct of the model is the stages of change. The theorists maintain that change takes place through five basic stages:

1) precontemplation,
2) contemplation,
3) preparation,
4) action, and
5) maintenance.

In the precontemplation stage, people are not intending to take action in the foreseeable future, usually measured as the next 6 months. During the contemplation stage, people are intending to change within the next 6 months. In the preparation stage, clients are intending to take action in the immediate future, usually measured as the next month. Clients in the action stage have made specific overt modifications in their life styles within the past 6 months. During the maintenance stage, clients work to prevent relapse, a stage which is estimated to last from 6 months to about 5 years. The termination stage of change contains clients who have zero temptation and 100% self-efficacy. They are confident they will not return to their old unhealthy habit as a way of coping.

The transtheoretical model also proposes 10 processes of change, which are the covert and overt activities that people use to progress through the stages. The first 5 processes involve experiential processes of change, while the last 5 are labelled behavioural processes, and these are used primarily for later-stage transitions. For instance, during the experiential processes of change, people experience consciousness rising ("I remember information people gave me about how to stop smoking") and social liberation ("I find society changing in ways that make it easier for me to be a non-smoker"). The 5 behavioural processes of change range from (6) stimulus control to (8) counter-conditioning ("I do other things with my hands to stop smoking") to (10) self-liberation ("I make commitments not to smoke").

The transtheoretical model does not make assumptions about how ready clients are for change in their lives. The model proposes that different individuals will be in different stages and that appropriate interventions must be developed for clients based on their stages of development. The transtheoretical model assumes that the different systems of psychotherapy are complementary and that different theories emphasise different stages and levels of change.

4.5.8 Brooks-Harris' Multitheoretical Model

The most recent multitheoretical model for psychotherapy comes from Brooks-Harris, who provides a framework that describes how different psychotherapy systems come together. Brooks-Harris (2008) begins with the premise that thoughts, actions, and feelings interact with one another and that they are influenced by biological, interpersonal, systemic, and cultural contexts.

Given this overarching premise, he integrates the following theoretical approaches:

1) cognitive,
2) behavioural,
3) experiential,
4) bio psychosocial,
5) psychodynamic,
6) systemic, and
7) multicultural.

A brief explanation of each of these areas is provided below (table 6.5.2). His framework emphasises at what point a therapist might consider using elements of psychodynamic theory or multicultural theory. A major umbrella in multicultural psychotherapy consists of the focal dimensions for therapy and key strategies.

Table: Multi Theoretical Psychotherapy

Cognitive strategies deal with the focal dimension of clients' functional and dysfunctional thoughts.
Behavioural skills–focal dimension of actions encourage effective client actions to deal with challenges.
Experiential interventions result in adaptive feelings.

Bio psychosocial strategies emphasise biology and adaptive health practices.

Psychodynamic-interpersonal skills are used to explore clients' interpersonal patterns and promote undistorted perceptions.

Systemic-constructivist interventions examine the impact of social systems and support adaptive personal narratives.

Multicultural-feminist strategies explore the cultural contexts of clients' issues.

Brooks-Harris presents five principles for psychotherapy integration, which include

1) intentional integration,
2) multidimensional integration,
3) multitheoretical integration,
4) strategy-based integration, and
5) relational integration.

The first principle says that psychotherapy integration should be based on intentional choices. The therapist's intentionality guides his or her focus, conceptualisation, and intervention strategies.

Principle two (multidimensional) proposes that therapists should recognise the rich interaction between multiple dimensions.

The third principle asserts that therapists take into consideration diverse theories to understand their clients and guide their interventions.

The fourth strategy-based principle states that therapists combine specific strategies from different theories. Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled.

The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship.

Brooks-Harris' (2008) model offers a good plan for therapists seeking to implement an integrative multitheoretical approach. He outlines strategies for each of the seven core areas. For instance, cognitive strategies should encourage functional thoughts that are rational and that promote healthy adaptation to the environment. In addition, he enumerates a catalogue of 15 key cognitive strategies, which include identifying thoughts, clarifying the impact of thoughts, challenging irrational thoughts, providing psychoeducation, and supporting bibliotherapy. To integrate behavioural therapy into one's practice, he suggests some of the following catalogue of key strategies: assigning homework, constructing a hierarchy, providing training and rehearsal, determining baselines, and schedules of reinforcement.

4.5.9 Helping Skills Approach to Integration

Clara Hill (2004) has provided a helping skills model to therapy integration. Her model describes three stages of the helping process that are based on different therapy schools. For instance, the first stage of helping is labelled *exploration.*

Using Rogers' client-centered therapy as the therapy school of choice, Hill (2004) emphasises the counselling skills of attending, listening, and reflection of feelings.

The second stage is termed *insight,* and this stage is based on psychoanalytic theory; therefore, such skills as interpreting and dealing with transference are stressed.

The third stage is termed the *action stage,* and this stage is based largely on cognitive-behavioural techniques. Using the helping skills model, training would focus on teaching graduate students techniques associated with each of these three therapeutic schools.

4.6 EVIDENCE-BASED THERAPY AND INTEGRATIVE PRACTICE

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence-based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

The American Psychological Association (2006, p. 273) conceptualises evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." Evidence-based practice emphasises the results of experimental comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both.

The arguments in favour of Evidence based Practice (EBP) are reasonable.

First, clients have a right to treatments that have been proven to be effective.

Second, managed care requires counsellor accountability in choosing a method of treatment.

Increasingly, counsellors may have to consult with research studies to determine which approach is the most efficacious with what mental health disorder.

Helping professionals may be required to answer for using a therapeutic approach with a specific disorder.

4.6.1 Implementation of EBP in Practice

The therapist must gather research that informs him or her about what works in psychotherapy. Such information should be obtained *before treatment is begun.*

There are several major resources for evidence-based practice. For instance, the Cochrane Collaboration sets standards for reviews of medical, health, and mental health treatments and provides "systematic reviews" of related research by disorder.

Cochrane Reviews are designed to help providers, practitioners, and patients make informed decisions about health care and are the most comprehensive, reliable, and relevant source of evidence on which to base these decisions.

Moreover, the United States government also offers treatment guidelines based on EBP principles at the National Guideline Clearinghouse (http://www.guideline.gov/).

This site contains very good information on medication. Other online resources for EBP and treatment guidelines include the American Psychiatric Association (APA), which offers practice guidelines for mental health

http://www.psych.org/psych_pract/treatg/pg.prac_guide.cfm).

Activity

Reflection on Therapist Qualities. The purpose of this exercise is to help you identify and assess your own strengths and weaknesses as future therapists and encourage self-reflection and openness in your group. Identify three things about yourself that you believe will assist you in becoming a good therapist. Record these things in your book.

4.7 FUTURE OF PSYCHOTHERAPY SCHOOLS AND THERAPY INTEGRATION

What does the future look like for psychotherapy schools that have been presented in this book?

Norcross, Hedges, and Prochaska (2002) used a Delphi poll to predict the future of psychotherapy over the next decade. The experts who served as participants in the poll predicted that the following theoretical schools would increase the most: cognitive-behaviour therapy, culture-sensitive multicultural counselling, Beck's cognitive therapy, interpersonal therapy, family systems therapy, behaviour therapy, technical eclecticism, solution-focused therapy, and exposure therapies.

Therapy orientations that were predicted to decrease the most included classical psychoanalysis, implosive therapy, Jungian therapy, transactional analysis, humanistic therapies, and Adlerian therapy.

The poll also showed how psychotherapy is changing. The consensus is that psychotherapy will become more directive, psychoeducational, technological, problem-focused, and briefer in the next decade. Concomitantly, relatively unstructured, historically oriented, and long-term approaches are predicted to decrease i.e. Short term is in, and long term on its way out.

Self Assessment Questions

Fill in the Blanks:

a) ———————————— approach to psychotherapy integration involves having a strong grounding in one system of psychotherapy and a willingness to select practices and views from other systems.

b) ———————————— Psychotherapy maintains that thoughts, actions, and feelings interact with one another and are shaped by biological, interpersonal, systemic, and cultural contexts.

c) ———————————— is a psychotherapy model developed by Prochaska and DiClemente that matches a therapist's approach to a client's readiness to change.

d) ———————————— is an integrative approach that advocates using multiple procedures taken from various therapeutic approaches without specific concern from which theories they come.

e) ———————————— Involves the integration of two or more therapies with an emphasis on integrating the underlying constructs associated with each therapeutic system.

4.8 MULTIMODAL THERAPY

Multimodal counselling and therapy is a technically eclectic and systematic approach. The approach is technically eclectic as it uses techniques taken from many different psychological theories and systems, without necessarily being concerned with the validity of the theoretical principles that underpin the different approaches from which it takes its techniques and methods. The techniques and interventions are applied systematically, based on data from client qualities, the counsellor's clinical skills and specific techniques.

The approach uses a unique assessment procedure which focuses on seven different aspects or dimensions (known as modalities) of human personality. Not only is a serious attempt made to tailor the therapy to each client's unique requirements, but the counsellor also endeavours to match his or her inter-personal style and interaction to the individual needs of each client, thereby maximising the therapeutic outcome.

4.9 DEVELOPMENT OF MULTIMODAL THERAPY

During the 1950s Arnold Lazarus, a psychologist undertook his formal clinical training in South Africa. The main focus of his training was underpinned by psychodynamic and person-centred theory and methods. In addition, he attended seminars provided by Joseph Wolpe, a psychologist, thereby learning about conditioning therapies based on Behaviour Therapy. During 1957 he spent several months as an intern at the Marlborough Day Hospital in London, where the orientation was Adlerian.

He believed that no one system of therapy could provide a complete understanding of either human development or condition. In 1958 he became the first psychologist to use the terms 'behaviour therapist' and 'behaviour therapy' in an academic article.

Lazarus conducted follow up enquiries into clients who had received behaviour therapy and found that many had relapsed. However, when clients had used both behaviour and cognitive techniques, more durable results were obtained. In the early 1970s he started advocating a broad but systematic range of cognitive-behavioural techniques and his follow-up enquiries indicated the importance of breadth if therapeutic gains were to be maintained. This led to the development of Multimodal Therapy which places emphasis on seven discrete but interactive dimensions or modalities which encompass all aspects of human personality.

4.10 BASIC CONCEPTS

4.10.1 Modalities

People are essentially biological organisms (neurophysiological/biochemical entities) who behave (act and react), emote (experience emotional responses), sense (respond to olfactory, tactile, gustatory, visual and auditory stimuli), imagine (conjure up sights, sounds and other events in the mind's eye), think (hold beliefs, opinions, attitudes and values), and interact with one another (tolerate, enjoy or endure various interpersonal relationships). These seven aspects or dimensions of human personality are known as modalities. By referring to these seven modalities as Behaviour, Affect, Sensations, Images, Cognitions, Interpersonal and Drugs/biology, the useful acronym and memory aide BASIC I.D. arises from the first letter of each. ('Affect' is a psychological word for emotion and 'cognitions' represent all thoughts, attitudes and beliefs.)

From the multimodal perspective these seven modalities may interact with each other for example an unpleasant image or daydream and a negative thought may trigger a negative emotion such as anxiety or depression. The multimodal approach rests on the assumption that unless the seven modalities are assessed, counselling is likely to overlook significant concerns. Clients are usually troubled by a multitude of specific problems which should be dealt with by a similar multitude of specific interventions or techniques.

For example, a client may suffer from a simple fear of spiders, anxiety about giving presentations at work, sleep disturbances, a lack of exercise and a poor diet. Each problem will probably need a specific intervention to help the client improve his or her condition.

Multimodal therapists have found that individuals tend to prefer some of the BASIC I.D modalities to others. They are referred to as 'imagery reactors' or 'cognitive reactors' or 'sensory reactors' depending upon which modality they favour.

4.10.2 Principle of Parity

In multimodal therapy the counsellor and client are considered equal in their humanity (the principle of parity). However, the counsellor may be more skilled in certain areas in which the client has particular deficits. Therefore it is not automatically assumed that clients know how to deal with their problems and have the requisite skills. The counsellor may need to model or teach the client various skills and strategies to help overcome his or her problem(s). It should be understood that having superior skills in certain areas does not make counsellors superior human beings!

4.10.3 Thresholds

One key assumption made in multimodal therapy is that people have different thresholds for pain, frustration, stress, external and internal stimuli in the form of sound, light, touch, smell and taste. Psychological interventions can be applied by individuals to help modify these thresholds but often the genetic endowment or predisposition has an overriding influence in the final analysis. For example, a client with a low tolerance to pain may be able to use psychological

distraction techniques such as relaxing imagery, but is still likely to need an anaesthetic when receiving minor fillings at the dentist.

4.11 THE DEVELOPMENT AND MAINTENANCE OF PROBLEMS

Problems develop and are maintained for a variety of reasons. Social learning, systems and communication theories all explain some of the ways problems can arise and how they are maintained. Of course, underlying all problems is the biological and genetic dimension which goes to help make up a human being. We will discuss a few additional key factors.

4.11.1 Misinformation

Over a period of time people may learn incorrect assumptions and beliefs about life. For example, the beliefs 'I must perform well otherwise I'm a failure', or 'I'm worthless if my partner leaves me', or 'Life should be easy', may be learnt or imbibed by listening to significant others such as peers, parents or teachers. These beliefs may lead to considerable stress when external life events conflict with them. Couples may also hold on to unhelpful beliefs or myths such as 'If you feel guilty, confess.'

Due to misinterpreting their doctor's advice many people have misunderstood medical and health-related issues such as treatment of cancer or heart disease. Unless the health professionals correct these errors then patient compliance to medical procedures may be hindered or even non-existent.

4.11.2 Missing Information

Unlike the case with misinformation, with missing information people have not learnt the necessary skills, knowledge or methods to either understand or undertake particular activities or recognise specific problems. For example, people may not have in their repertoire of behaviour job interview skills, friendship skills, communication skills, or assertiveness skills etc. They may not realise that a pain in their left arm could signify heart disease and that it might be strongly advisable to have a medical check-up.

4.11.3 Defensive Reactions

People avoid or defend against discomfort, frustration, pain, or negative emotions such as shame, guilt, depression and anxiety. Although it sounds quite natural to avoid fears or the unbearable pain of loss, people do not learn how to conquer them unless they confront them. For example, if a person has a fear of travelling by airplane he or she could easily avoid this mode of transport. However, there might be certain job expectations that require the person to fly across the Atlantic. If the person wanted to keep the job he or she would need to deal with this problem sooner rather than later. According to learning theory the main method of overcoming flying phobia is to experience exposure to flying. Although this can be partially undertaken using the person's imagination, the most effective technique is to fly on the airplane. Initially this might trigger very high levels of anxiety which only gradually subsides or to which the person habituates after an hour or two of exposure to flying. This is no different from the advice given to horse-riders who fall off their horse: 'Get straight back on the horse immediately.'

4.11.4 Lack of Self Acceptance

People tend to link their behaviour skills deficits directly to their totality as a human being. Depending upon the particular belief the person holds, this tends to lead to anxiety, shame, anger or depression. For example, a person may believe, 'If I fail my exam, I'm a total failure as a human being.' A more realistic and logical way of looking at the situation could be, 'If I fail my exam all it proves is that I've got exam skills deficits. I can still accept myself as a fallible human being.' The unhelpful beliefs may have been imbibed from parents and other significant people in the child's life but they may be reinforced and perpetuated by the person constantly re-indoctrinating him or herself on a regular basis throughout adulthood. In multimodal therapy the content of self- defeating or unrealistic beliefs is examined and is replaced by more self-helping and realistic beliefs.

4.12 PSYCHOLOGICAL HEATH

The key issues discussed above and the path to psychological health can be expressed in the form of the BASIC I.D. modalities below:

Behaviour: ceasing unhelpful behaviours; performing wanted behaviours; stopping unnecessary or irrational avoidances; taking effective behaviours to achieve realistic goals.

Affect: admitting, clarifying and accepting feelings; coping or managing unpleasant feelings and enhancing positive feelings; abreaction (i.e., living and recounting painful experiences and emotions).

Sensation: tension release; sensory pleasuring; awareness of positive and negative sensations; improving threshold tolerance to pain and other stimuli.

Imagery: developing helpful coping images; improving self-image; getting in touch with one's imagination.

Cognition: greater awareness of cognitions; improving problem-solving skills; modifying self-defeating, rigid beliefs; enhancing flexible and realistic thinking; increasing self-acceptance; modifying beliefs that exacerbate low thresholds to frustration or pain (for example, 'I can't stand it' to 'I don't like it but I'm living proof that I can stand it'); correcting misinformation and providing accurate missing information.

Interpersonal: non-judgemental acceptance of others; model useful interpersonal skills; dispersing unhealthy collusions; improve assertiveness, communication, social and friendship skills.

Drugs/biology: better nutrition and exercise; substance abuse cessation; alcohol consumption in moderation; medication when indicated for physical or mental disorders.

4.13 PRACTICE OF MULTIMODAL THERAPY

4.13.1 Goals of Multimodal Therapy

The goals of multimodal therapy are to help clients to have a happier life and achieve their own realistic goals. Therefore the goals are tailored to each client.

A philosophy of long-term hedonism as opposed to short-term hedonism is advocated whereby the client may need to decide how much pleasure they may want in the present compared to the sacrifices they may have to make to attain their desires and wishes. For example, to go to college and obtain a good degree may necessitate working reasonably hard for a period of three years and not attending as many parties as previously.

4.13.2 The Relationship between the Therapist and Client

The relationship is underpinned by core therapeutic conditions suggested by Carl Rogers. These core conditions are empathy, congruence and unconditional positive regard. Although a good therapeutic relationship and adequate rapport are usually necessary, multimodal therapists consider that they are often insufficient for effective therapy. The counsellor-client relationship is considered as the soil that enables the strategies and techniques to take root. The experienced multimodal counsellor hopes to offer a lot more by assessing and treating the client's BASIC I.D., endeavouring to 'leave no stone (or modality) unturned'.

Multimodal counsellors often see themselves in a coach/trainer-trainee or teacher-student relationship as opposed to a doctor-patient relationship, thereby encouraging self-change rather than dependency. Therefore the usual approach taken is active-directive where the counsellor provides information, and suggests possible strategies and interventions to help the client manage or overcome specific problems. However, this would depend upon the issues being discussed and the personality characteristics of the client. Flexible interpersonal styles of the counsellor which match client needs can reduce attrition (i.e. premature termination of therapy) and help the therapeutic relationship and alliance. This approach of the therapist is known in multimodal therapy as being an 'authentic chameleon'.

For example, if a client states that she wants, 'A listening ear to help me get over the loss of my partner' then she may consider an active-directive approach as intrusive and possibly offensive. On the other hand, a client who states, 'I would value your comments and opinions on my problems', may become very irritated by a counsellor who only reflects back the client's sentiments and ideas. Others may want a 'tough, no-nonsense' approach and would find a 'warm, gentle' approach not helpful or conducive to client disclosure.

This flexibility in the counsellor's interpersonal therapeutic style underpins effective multimodal therapy. Counsellors are expected to exhibit different aspects of their own personality to help the therapeutic relationship and clients to reach their goals. The term 'bespoke therapy' has been used to describe the custom-made emphasis of the approach.

Activity

Qualities for Effective Therapists. Create your own list of qualities for the effective therapist. Review that list and discuss them with the people in your small group.

4.13.3 The Process of Change

The process of change may commence even before the first therapy session as clients are usually sent details about the approach with some explanation of the

key techniques such as relaxation or thinking skills. Occasionally, therefore, the client has already started using simple self-help techniques before the therapy formally commences. In Britain, included with the details is a client checklist of issues the client may want to discuss with the counsellor at the first meeting. This checklist encourages the client to ask the counsellor relevant questions about the approach, the counsellor's qualifications and training and contractual issues, thereby giving the client more control of the session and therapy.

During the course of therapy, the client's problems are expressed in terms of the seven BASIC I.D modalities and client change occurs as the major different problems are managed or resolved across the entire BASIC I.D. Initially, sessions are often held weekly. As client gains are made, then the sessions are held with longer intervals in between, such as a fortnight or a month. Termination of counselling usually occurs when clients have dealt with the major problems on their modality profile or feel that they can cope with the remaining problems.

As multimodal therapy is technically eclectic, it will use techniques and interventions from a variety of different therapies. Although these are largely based on behaviour therapy, cognitive therapy and rational emotive behaviour therapy, techniques are also taken from other approaches, such as psychodynamic and Gestalt therapy.

4.14 APPLICATION AND LIMITATIONS

Multimodal therapy has been shown to benefit children, adults and older client groups experiencing a wide range of problems. For example, those suffering from anxiety-related disorders such as agoraphobia, panic attacks, phobias, obsessive- compulsive disorders; depression, post-traumatic stress disorder; sexual problems; anorexia nervosa; obesity; enuresis; substance and alcohol abuse; airsickness; schizophrenia.

As counsellors are expected to adjust their interpersonal style to each client, they may encounter fewer relationship difficulties when compared to other less flexible approaches. This flexible approach should lead to a reduced rate of attrition.

However, as with other therapies, multimodal therapy has its failures. Some clients are not prepared to face their fears, challenge their unhelpful thinking, use coping imagery, practise relaxation techniques, become assertive with significant others, etc. Others may have psychiatric disorders or other difficulties that prevent them from engaging in therapy. Some clients are in the pre-contemplative stage where they have not made up their minds to change and take on the responsibility of counselling. They may need to return to counselling at a later stage in their lives.

Self Assessment Questions

Fill in the Blanks:

a) ————————————- is a comprehensive, systematic, and holistic approach to psychotherapy that seeks to effect durable change in an efficient and humane way.

b) For multimodal therapists, assessment and diagnosis involve a thorough evaluation of the ————.

c) ———————————— category of BASIC I.D includes mental pictures or visualisation.

d) ————————————category of BASIC I.D includes all physical or biological areas, including substance use.

e) In multimodal therapy the major emphasis is on ———————————————.

f) Approach of the therapist in multimodal therapy is known as being an———————————.

4.15 LET US SUM UP

Counselling and psychotherapy are moving toward an integrative approach to psychotherapy. The days of adopting one singular therapy approach and using it for the rest of one's professional development seem to be coming to an end. Psychotherapy integration has become intertwined with the evidence based movement in stressing that various client problems necessitate that the therapist use different solutions. Moreover, increasingly these solutions can be chosen on the basis of empirical outcome research what is known as evidence based studies. One advantage of integrative therapies is that they allow therapists the flexibility to meet the needs of clients who have different presenting issues and who come from a range of cultural contexts.

Psychotherapy integration can take several different paths including assimilative integration, technical eclecticism, common factors integration, and theoretical integration. The movement toward psychotherapy integration encourages therapists to take into consideration the benefits of individual therapeutic approaches. Integrative psychotherapy posits that many treatment methods can be helpful in working with different clients. It is predicted that evidence-based studies will have an important influence on psychotherapy theory integration.

Therapists must understand not only the individual theories so that they can decide for themselves what they feel is appropriate for them, but they also need to establish a multitheoretical or integrative framework from which they can integrate the theories they choose. The framework by Brooks-Harris offers the simplest route to developing your own integrative approach.

Within the next couple of decades, it is predicted that graduate schools will adopt an integrative approach to psychotherapy training because such programs themselves will come under increasing pressure to equip their graduates with therapeutic skills that cross theoretical lines. Ethical guidelines for counsellors and psychologists appear to be headed in the direction of requiring therapists to know evidence-based research (what techniques actually work with what clients with what problems) if they are to exercise an appropriate standard of care for their clients.

Multimodal therapy is a comprehensive, systematic, and holistic approach to psychotherapy that seeks to effect durable change in an efficient and humane way. It is an open system in which the principle of technical eclecticism encourages the constant introduction of new techniques and the refinement or elimination of existing ones, but never in a random or shotgun manner. The major emphasis is

on flexibility. Multimodal therapists subscribe to no dogma other than the principles of theoretical parsimony and therapeutic effectiveness.

Assessments and interventions are structured around seven modalities summarised by the acronym BASIC I.D. (behaviour, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors). This framework allows the therapist to take into account the uniqueness of each individual and to tailor treatment accordingly. The emphasis is constantly on who or what is best for this individual (couple, family, or group). By assessing significant deficits and excesses across the client's BASIC I.D., thorough coverage of diverse interactive problems is facilitated. The therapist's role and the cadence of client-therapist interaction differ from person to person and even from session to session. Some clients respond best to somewhat austere, formal, businesslike transactions; others require gentle, tender, supportive encouragement.

4.16 UNIT END QUESTIONS

1) What key developments stand out in your mind about the integrative movement in psychotherapy?
2) Thoughts about theory integration date back to the 1930s and 1940s. In your opinion, what took so long for the movement to reach its current status?
3) What theories are you considering integrating into your own personal approach to psychotherapy? Explain why.
4) In what ways does multimodal therapy differ from other forms of therapy?
5) Critically discuss the usefulness of the BASIC I.D. assessment procedures.
6) The practice of multimodal therapy places high demands on the therapist. Discuss.
7) Discuss A. Lazarus's view of the authentic chameleon.

4.17 SUGGESTED READINGS

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4.18 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Assimilative integration
2) Multitheoretical Psychotherapy
3) Stages of Change
4) Technical Eclecticism
5) Theoretical Integration.

Self Assessment Questions 2

1) Multimodal therapy
2) BASIC I.D
3) Imagery
4) Drugs and biology
5) Flexibility
6) Authentic chameleon.