Hypnosis within the Practice of Multimodal Therapy

Gary B. Kelley, Ph.D., ABMP, FICPPM
ASCH Approved Consultant
ASCH Annual Scientific Meeting & Workshops
St. Louis, Missouri
March 11-15, 2016

Dr. Gary B. Kelley, Ph.D. has no financial interests to disclose

Learning Objectives

• This presentation will focus on:
  • an overview of multimodal therapy
  • the history of the multimodal approach
  • applications of multimodal therapy
  • treatment techniques used in multimodal therapy
  • The use of hypnosis in psychotherapy and multimodal therapy in particular
History of Multimodal Therapy

• In 1958 Lazarus introduced the terms behavior therapy and behavior therapist
• In 1965 Lazarus wrote a paper on a multimodal approach to alcoholism
• Over time Lazarus becomes a stronger proponent of a broad based approach and advocated against “narrow-band behavior therapy”

Progression

• From Adlerian
• To Behaviorist
• To Multimodal Therapist

“To legitimize behavioral intervention as an essential part of effective clinical practice, I introduced the terms ‘behavior therapy’ and ‘behavior therapist’ into the scientific and professional literature. I was never a radical behaviorist” (Lazarus, 1958)
While behavior therapy often enabled some seriously disturbed individuals to make impressive headway, these gains were usually not maintained, (N=19, of whom 13 had relapsed within three years.)

The entire range of addictions fared poorly after a three-year follow-up (i.e., addiction to drugs, alcohol, or food).

Follow-ups revealed that behavior therapy was significantly less effective with cases involving:

- Extended interpersonal (systems) problems
- When cognitive restructuring called for more than the correction of misconceptions or the straightforward alteration of negative self-talk
- When intrusive images conjured up a gloomy and troubled future
- When affective reactions were characterized by extremes (e.g., pervasive anxiety with intermittent panic attacks, or chronic anaesthesia or deadness of feeling)

Goals of Multimodal Therapy

- The goal of Multimodal Therapy is to create customized treatment for each patient depending on their psychological or behavioral problems.
The Multimodal Position

“The aim of MMT is to come up with the best methods for each client rather than force all clients to fit the same therapy...Three depressed clients might be given very different treatments...The only goal is helping clients make desired changes as rapidly as possible”

Zilbergeld

Emotions or affective responses are triggered by some stimulus that is evaluated cognitively by the individual. From a multimodal perspective, the sequence of events that results in emotional disturbance may proceed as follows:

(Plutchik, 1980)

First, through one or more of the senses, a person hears something, sees, smells, or tastes something that is cognitively appraised (i.e., perceived as a danger or loss), closely followed by images (a succession of fleeting yet vivid pictures of gloom and doom) that result in overt behavior (e.g., flight or fight) and that usually have other interpersonal repercussions (e.g., avoidance or control).
## Multimodal Therapy

- Focuses on seven discrete but interactive modalities
- Views all modalities as crucial and existing in a state of reciprocal transaction and flux
- Successful treatment occurs when all modalities are addressed
- Multimodal Life History Inventory (Lazarus & Lazarus, 1991) administered to assess client in each modality

## Distinctive Features of Multimodal Therapy

- Specific and comprehensive attention given to the entire BASIC I.D.
- Use of second-order BASIC I.D. assessments
- Use of modality profiles
- Use of structural profiles
- Deliberate bridging procedures
- Tracking the modality firing order

## Multimodal Life History Inventory

- Developed (Lazarus & Lazarus) in 1991
- 15 page inventory administered to assess clients in each modality
- Questionnaire assesses antecedents, current problems and maintaining factors
The biological modality influences each link in the chain by introducing various chemicals into the system (e.g., adrenaline).

There is close-knit interaction among the various modalities; hence, the arrows go in both directions.
The affective chain does not invariably follow a Sensory-Cognitive-Imagery-Behavioral-Interpersonal sequence. The “firing order” may commence with any modality.

Multimodal Therapy Compared to Other Approaches

The Multimodal Therapist is not concerned with theoretical orientation, but rather

What works, for whom, and under what particular circumstances?

Theoretical Underpinnings of MMT
Theoretical Background

• Classical conditioning
• Operant conditioning
• Social learning theory
• Cognitive theory

➢ Rest on a broad-based social and cognitive learning theory, while also drawing on effective techniques from many additional disciplines—without necessarily subscribing to their particular theories (i.e., it espouses technical eclecticism).

Social learning theory also recognizes that association plays a key role in all learning processes. An association may be said to exist when responses evoked by one set of stimuli are similar to those elicited by other stimuli.
The basic social learning triad is made up of classical (respondent) conditioning, operant (instrumental conditioning), and modeling and other vicarious processes.

Also added to the foregoing is the idiosyncratic use of language, expectancies, selective attention, goals and performance standards, as well as the impact of the individual’s numerous values, attitudes, and beliefs.

MMT’s Assumption About People

- People:
  - Move
  - Feel
  - Sense
  - Imagine
  - Think
  - Relate interpersonally
- MMT is based on the assumption that most psychological problems are multifaceted, multidetermined, and multilayered, and that comprehensive therapy calls for a careful assessment of seven dimensions or “modalities” in which individuals operate—Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships and Biological processes.

- Social learning theory states that all behaviors (normal and abnormal) are created, maintained, and modified through environmental events.

- Cognitive theory is based on the finding that cognitive processes determine the influence of external events, and can in turn be affected by the social and environmental consequences of behavior. As such, the main focus is on the constant reciprocity between personal actions and environmental consequences.
Personality and MMT
BASIC I.D.

- Behaviors
- Affective responses
- Sensory reactions
- Images
- Cognitions
- Interpersonal relationships
- Drugs and other biological interventions

Using BASIC ID

- Identify issues across BASIC ID
- Note the primary modality
- Build from the primary modality
- Note the modality firing order
- Use techniques appropriate to each modality

The elements of a rapid yet thorough assessment involve the following range of questions:
### B: Behavior.

- What is this individual doing that is getting in the way of his or her happiness or personal fulfillment (self-defeating actions, maladaptive behaviors)? What does the client need to increase and decrease? What should he or she stop doing and start doing?

### A: Affect.

- What emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, or combinations thereof, and to what extent (e.g., irritation vs. rage; sadness vs. profound melancholy)? What appears to generate these negative affects—certain cognitions, images, interpersonal conflicts? And how does the person respond (behave) when feeling a certain way? It is important to look for interactive processes—what impact do various behaviors have on the person’s affect and vice versa? How does this influence each of the other modalities?

### S: Sensation.

- Are there specific sensory complaints (e.g., tension, chronic pain, tremors)? What feelings, thoughts, and behaviors are connected to these negative sensations? What positive sensations (e.g., visual, auditory, tactile, olfactory, and gustatory delights) does the person report? This includes the individual as a sensual and sexual being. When called for, the enhancement or cultivation of erotic pleasure is a viable therapeutic goal (Rosen & Leiblum, 1995).
I: Imagery.

• What fantasies and images are predominant? What is the person’s “self-image”? Are there specific images of success or failure? Are there negative or intrusive images (e.g., flashbacks to unhappy or traumatic experiences)? And how are these images connected to ongoing cognitions, behaviors, affective reactions, etc.?

C: Cognition.

• Can we determine the individual’s main attitudes, values, beliefs, and opinions? What are this person’s predominant shoulds, oughts, and musts? Are there any definite dysfunctional beliefs or irrational ideas? Can we detect any untoward automatic thoughts that undermine his or her functioning?

I: Interpersonal.

• Interpersonally, who are the significant others in this individual’s life? What does he or she want, desire, expect, and receive from them; and what does he or she, in turn, give to them and do for them? What relationships give him or her particular pleasure and pain?
D: Drugs/Biology.

- Is this person biologically healthy and health-conscious? Does he or she have any medical complaints or concerns? What relevant details pertain to diet, weight, sleep, exercise, and use of alcohol and drugs?

The multimodal hierarchy

The Formula

➢ Formula for brief but comprehensive psychotherapy:
First: Determine whether there are significant problems in each of the following modalities:

1) Behavior
2) Affect
3) Sensation
4) Imagery
5) Cognition
6) Interpersonal relationships
7) Drugs-Biology

Second:

➢ In concert with the client, select three or four pivotal problems that require specific attention.

Third:

➢ If so indicated, make sure the patient undergoes a physical examination and, if necessary, receives medication or psychotropic drugs.
Fourth:

➢ Whenever possible, apply empirically validated methods of treatment to specific problems.

Multimodal position embodies the following four principles:

1. Human beings act and interact across the seven modalities of the BASIC I.D.
2. These modalities are connected by complex chains of behavior and other psychophysiological events, and they exist in a state of reciprocal transaction.

3. Accurate evaluation (diagnosis) is served by the systematic assessment of each modality and its interaction with every other.

4. Comprehensive therapy calls for specific correction of significant problems across the BASIC I.D.
Eight Issues

• For a therapist to be effective, retain a constructive focus, arrive at creative solutions, and be both short-term and comprehensive, the following eight issues must be ruled out or adequately dealt with, if necessary:

1. Conflicting or ambivalent feelings or reactions
2. Maladaptive behaviors
3. Misinformation (especially dysfunctional beliefs)
4. Missing information (e.g., skill deficits, ignorance, or naivete)
5. Interpersonal pressures and demands
6. Biological dysfunctions
7. External stressors outside the immediate interpersonal network (e.g., poor living conditions, unsafe environment)
8. Traumatic experiences (e.g., sexual abuse or gross neglect in childhood)

Examples of Treatment Techniques across BASIC I.D.

• Behaviors
  - Extinction
  - Counterconditioning
  - Positive reinforcement
  - Negative Reinforcement
  - Punishment
• Affective responses
  - Abreaction
  - Owning and accepting feelings
• Sensory reactions
  - Tension release
  - Sensory pleasuring
Examples of Treatment Techniques across BASIC I.D.

- Images
  - Creating coping images
- Cognitions
  - Cognitive restructuring
  - Awareness
- Interpersonal relationships
  - Modeling
  - Dispersing unhealthy conclusions
  - Paradoxical maneuvers
  - Nonjudgmental acceptance
- Drugs and other biological interventions

Technical Eclecticism vs. Theoretical Integration

Technical Eclecticism

It cannot be overstated that the effectiveness of specific techniques may have absolutely no connection to the theories that spawned them. Techniques, may, in fact, prove effective for reasons that do not remotely relate to the theoretical ideas that gave birth to them.
Multimodal Therapy

- **Tracking** refers to a careful examination of the firing order of the different modalities

Tracking

- Tracking is a strategy that may be employed when clients are puzzled by affective reactions. The first step in tracking involves asking the client to recount the unpleasant event or incident. The client is then asked to consider what behaviors, affective responses, images, sensations, and cognitions come to mind.

Bridging

- Bridging is a strategy that is probably employed by most effective therapists. First, the therapist would deliberately attune the client’s preferred modality. The therapist would begin the bridging technique by exploring the client’s presented modality.
- After a five to ten minute discourse, the therapist would then endeavor to branch off into other directions that seem more productive. This sudden switch may then begin to elicit more pertinent information.
- Thus, starting where the client is and then bridging into a different modality, most clients then seem to be willing to traverse the more emotionally charged areas they may have originally been avoiding.
Structural Profile Inventory

- The Structural Profile Inventory is a 35-item Inventory. The SPI yields a quantitative BASIC I.D. graph that depicts a person’s degree of activity, emotionality, sensory awareness, imagery potential, cognitive propensities, interpersonal leanings, and biological considerations (Lazarus, 1997).

---

Structural Profile

Here are seven rating scales pertaining to various tendencies that people have. Using a scale of 0 to 6 (6 is high—it characterizes you, or you rely on it greatly; 0 means that it does not describe you, or you rarely rely on it), please rate yourself in each of the seven areas.

---

Behavior: How active are you? How much of a doer are you? Do you like to keep busy?
Rating: 6 5 4 3 2 1 0

Affect: How emotional are you? How deeply do you feel things? Are you inclined to impassioned or soul-stirring inner reactions?
Rating: 6 5 4 3 2 1 0

Sensation: How much do you focus on the pleasures and pains derived from your senses? How tuned in are you to your bodily sensations—food, sex, music, art?
Rating: 6 5 4 3 2 1 0

Imagery: Do you have a vivid imagination? Do you engage in fantasy and daydreaming? Do you think in pictures?
Rating: 6 5 4 3 2 1 0
**Cognition:** How much of a thinker are you? Do you like to analyze things, make plans, reason things through?  
Rating: 6 5 4 3 2 1 0

**Interpersonal:** How much of a social being are you? How important are other people to you? Do you gravitate to people? Do you desire intimacy with others?  
Rating: 6 5 4 3 2 1 0

**Drugs/Biology:** Are you healthy and health-conscious? Do you take good care of your body and physical health? Do you avoid overeating, ingestion of unnecessary drugs, excessive amounts of alcohol, and exposure to other substances that may be harmful?  
Rating: 6 5 4 3 2 1 0

Scores on a Structural Profile also tend to provide clues for technique selection— for example, clients with high ratings in “Imagery” but low scores in “Cognition” are likely to respond better to visualization methods than to the usual methods of cognitive restructuring.

In couples therapy, it can prove illuminating for partners to compare their respective ratings and also to anticipate what scores their spouses would attribute to them. Thus, we have yet another rapid method of gaining understanding and facilitating therapeutic progress.
Second-order BASIC IDs

» The BASIC ID analysis can be applied to any problem identified on the first BASIC ID analysis.

“Hypnosis” as a Facilitator in Behavior Therapy

Arnold A. Lazarus

University College, Rutgers University

Clients who requested hypnosis and received a standard relaxation sequence that substituted the word “hypnosis” for “relaxation” wherever possible, showed more subjective and objective improvements than those who received ordinary relaxation therapy.
The differences in outcome are attributed to "expectancy fulfillment".

In evaluating the effectiveness of hypnotic intervention, perhaps the most useless question to ask would be “Is hypnosis effective?” Effective for whom, for what, and under which particular conditions, would be an obvious retort.

The question of whether or not behavior therapy techniques are enhanced by the addition of hypnotic suggestions in clients who request to be hypnotized.


Hypnotically Augmented Psychotherapy: The Unique Contributions of the Hypnotically Trained Clinician

Michael Jay Diamond

Los Angeles, California

Psychotherapists trained in clinical hypnosis have made a number of unique contributions to the psychotherapeutic endeavor particularly in the areas of psychotherapeutic theory, technique, and practice.
Nine factors indexing the contribution of hypnotherapists:

1) Communication focus
2) Maximizing expectation and belief
3) Mind-body emphasis
4) Handling of resistance
5) Employing trance phenomena
6) Using archaic levels of relationship
7) Stressing healthy, adaptive ego functions
8) Using therapist trance
9) Permitting responsible creativity

How Hypnosis May Potentiate Psychotherapy

Jean Holroyd
University of California, Los Angeles

Hypnotherapy is defined as doing psychotherapy in the hypnotic state. Nine characteristics of trance probably potentiate psychotherapy:

- Changes in attention and awareness
- Imagery enhancement
- Increase in dissociation
- Decrease of reality orientation
- Increase in suggestibility
- Increased accessibility of mind-body interactions
- Diminution of initiative resulting in a sense of non-voluntariness
- Increased availability or manipulability of affect
- Development of a fusional relationship (rapport)
The Role of Hypnosis in Psychotherapy

Thurman Mott, Jr., M.D.
University of Maryland School of Medicine
Room 260 Howard Hall
685 West Baltimore Street, Baltimore, Md. 21201

Some factors of importance in the use of hypnosis include the hypnotic state, the hypnotic context, and hypnotic suggestion.

Treatment Theories & Multimodal Structural Profile Inventory

• Herman MC, (1993) found responses on 140 returned questionnaires indicated that a psychotherapist’s theoretical orientation is consistent with his/her dominant modalities of functioning. This would suggest that many therapists may tend to apply therapeutic techniques based on their own functioning, rather than on the needs of their clients.
Multimodal Induction
Hypnotic inductions often focus on and access multiple modalities

Multimodal Self Help & Treatment Plan

Multimodal Self Help & Treatment Plan

Multimodal Self Help & Treatment Plan
Multimodal suggestion uses suggested changes in Belief systems, Expectations, Sensations, and perceptions, Thoughts and images, Motives, and Emotions, and therefore may be referred to by the acronym, BEST ME (Gibbons, 1999, 2001). BEST ME suggestions may be presented in any order and repeated with appropriate variations in content. Each suggestion may contain elements of the others, in which case the label applied to describe the modality refers to the element given the greatest emphasis (Gibbons, 2004).

Multimodal suggestions may be used in an induction procedure in the formulation of therapeutic suggestions and in the conclusion of the hypnotic or hyperemipic session.

Multimodal suggestions in inductions may be worded so as to emphasize one or more categories (e.g., beliefs, sensations), according to the experiential orientation of each participant.
A clinical test revealed that clients who came to therapy seeking a procedure such as hypnosis but did not receive it, were apt to respond less well than those whose requests were granted (Lazarus, 1973b). Multimodal therapy, (MMT), an outgrowth of behavior, can incorporate hypnotic methods at several strategic junctures. I was the first to use the terms behavior therapy and behavior therapist in a scientific article (Lazarus, 1958) of action over insight. Follow-up concludes that more durable results would ensue from applying behavioral plus cognitive methods.

Cont...

...may bridge into affect by asking, “Beneath the sensations, can you find any strong feelings or emotions? Perhaps they are lurking in the background.” Starting where the client is, is a fundamental principle of many hypnotic approaches. Notably, a hypnotic technique, the affect bridge, can be helpful in this context. In this technique, clients imagine that feelings they identify are a bridge they cross to foster a connection with similar or other feelings, cognitions, and behaviors in everyday life or in the past. A fairly reliable pattern may be discerned behind the way in which people generate negative affect.

Clinical findings suggest that it is often best to apply treatment techniques in accordance with a client’s specific chain reaction. A rapid way of determining someone’s firing order is to use hypnosis to foster an altered state of consciousness-deeply relaxed with eyes closed—contemplating untoward events and then describing his or her reactions.
The outcome showed that, in the main, those individuals who requested hypnosis and were given the hypnosis script obtained better results than those who received relaxation. Subsequently, when those who had derived little or minimal benefit from relaxation were treated by the hypnosis script, significant gains accrued. People’s expectancies must often be honored, and the power of the proper word can be of inestimable value.

Clinically speaking, the use of the word hypnosis and the application of various hypnotic techniques appear to enhance the impact of imagery methods on susceptible (high hypnotizable) clients. These steps also appear to augment the power of most suggestions. There seems to be a greater veridical effect when suggestible (high hypnotizable) clients picture various scenes under hypnosis.

Routinely inquire about clients’ attitudes toward hypnosis. I do not waste time endeavoring to persuade skeptics. Those who say they do not believe in hypnosis or who claim to be non-hypnotizable are treated without hypnosis. Given that virtually everyone is suggestible (to a greater or lesser degree), one may wonder to what extent hypnosis is nevertheless often part of the variance.
High Hypnotizables
(Hypnotically susceptible)

- The multimodal therapist then uses the required imagery methods (especially coping imagery, various past and/or future-oriented time-tripping techniques) to challenge faulty cognitions and to offer self-statements that enhance self-assurance and self-worth. What are often referred to as ego-strengthening suggestions (e.g., “You can feel your own power,” “You can develop a sense of independence”) are also often worth pursuing.

Major elements of hypnotic imagery rests on an assumption that before one can accomplish something in reality, it is often essential first to be able to perceive or picture oneself doing it in imagery.

Hypnotic suggestions can play a role to alter significant behaviors; enhance different affective states; augment pleasant sensations while diminishing unpleasant ones; intensify positive and coping imagery; attenuate dysfunctional beliefs and replace them with prudent, insightful and discerning ideas; heighten assertive behavior and develop social skills; and persuade them to picture themselves adhering to health promoting activities: exercising, eating sensibly, avoiding noxious substances, and taking prescribed medication when indicated.
Suggestions can be described to clients as self-hypnosis. Framing hypnosis in this manner can counter prevalent, yet inaccurate, cultural beliefs that hypnosis somehow robs individuals of their volition or sense of control.

Hypnotic suggestions often target and call for changes in sensations, perceptions, cognitions, and behaviors. Accordingly, hypnosis can rightfully be considered a multimodal approach that can expand the breadth of psychological interventions.

It is not necessary that clients actually achieve a state of consciousness dramatically or demonstrably different from waking consciousness. Rather, it is more important that clients become immersed in the therapeutic suggestions that follow the induction, which are crafted to meet their needs and achieve their unique therapy agenda. Hypnosis is almost always used in combination with other treatments.
Bibliography


Multimodal Therapy

Some Slides in this Presentation Created by Barbara A. Cubic, Ph.D.
Associate Professor
Eastern Virginia Medical School

To accompany
Current Psychotherapies &
California State University-bhartsell
661-654-2106 bhartsell@csub.edu

Case Presentation and Practice