A Christian Application of Multimodal Therapy

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Multimodal therapy was developed by Arnold A. Lazarus. His prodigious career has included university faculty appointments at Stanford, Temple, Yale, and finally Rutgers, where he currently is an Emeritus Distinguished Professor of Psychology (Nelson-Jones, 2001). Lazarus has behaviorist roots. Indeed, while completing his doctorate under Joseph Wolpe, it was Lazarus who introduced the terms “behavior therapy” and “behavior therapist” to the literature (Lazarus, 1958). From 1966 to 1967, he was the director of the Behavior Therapy Institute in Sausalito, CA (Nelson-Rogers). It was not long, however, before he began to question pure behaviorist approaches as being too narrow. In 1966, he wrote about what he called “broad spectrum” vs. “narrow-band” behavior therapy (cited in Lazarus, 1989, p. 7). Then, in 1971 he published his book *Behavior Therapy and Beyond* which has been cited as one of the original descriptions of a cognitive-behavioral psychotherapeutic approach (cited in Lazarus, 1989). His motivation for developing his model was connected with follow-up assessments of former clients. As one of the earliest devotees to psychotherapy outcome research, Lazarus observed high relapse rates for many persons exposed only to pure behavioral techniques. As such, he continued to explore the impact of combining behavioral and non-behavioral strategies. Soon thereafter, Lazarus introduced his foundational model, which he initially called *multimodal behavior therapy* (Lazarus, 1973, 1976). Later, because of the erroneous assumption that his approach was primarily behavioral, he simplified this to *multimodal therapy* (e.g., Lazarus, 1989, 2006a). As will become evident below, this model is multimodal not only regarding interventions but also assessment.

Multimodal therapy (MMT), with its roots in behaviorism, has a clear respect for science and data. This model also recognizes, however, that persons can be viewed as more than mere stimulus-response mechanisms. Furthermore, MMT emphasizes the need to view each client as unique, potentially representing various exceptions to any general principles of human function. As such, MMT goes beyond behavioral methods and involves assessment of other modalities. This approach might quickly be confused with cognitive-behavioral interventions, but Lazarus clearly differentiates MMT from cognitive-behavioral and all other therapeutic models. He notes that most therapeutic models have a tripartite focus on behavior, affect, and cognition. In contrast, MMT also emphasizes four other modalities of human experience, resulting in assessment and intervention across seven modalities and their potential interactions (Lazarus, 2006b). In addition to behavior, affect, and cognition, MMT attends to the client’s sensory responses, mental imagery, interpersonal concerns, and biological/physiological issues. The first letters of these seven modalities (behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology) conveniently form an acronym (BASIC I.D.) which is central to Lazarus' assessment and intervention approaches (Lazarus, 2007). Introducing the concept of the BASIC I.D. to the client provides a means of establishing good communication.

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regarding whatever spectrum of problems is presented and also provides the client with a ready means of quickly grasping the concept of personality as it relates to psychological functioning and the problems at hand.

Lazarus is also quick to acknowledge that MMT borrows useful material from other models, particularly behavior therapy, rationale-emotive therapy, and cognitive therapy. He notes several factors, however, which distinguish MMT from these and other models. In addition to the unique seven-modality approach of the BASIC I.D., he notes MMT's use of a second-order BASIC I.D., modality profiles, structural profiles, bridging techniques, and tracking the modality firing order (Lazarus, 2007). These distinctive features will each be discussed below. First, however, it is important to note two of MMT's fundamental principals.

One of Lazarus' central tenets is the concept of technical eclecticism (Lazarus, 2006a). This should not be confused with the more common unsystematic eclecticism, whereby the therapist haphazardly uses components of various theories and their related interventions in a purely pragmatic way. Technical eclecticism also differs from theoretical eclecticism, whereby the clinician combines components of different theories as a basis for using related interventions (Lazarus, 2007). Lazarus consistently opposes unsystematic approaches and also argues that theoretical eclecticism can at times be unprofitable or even counterproductive, particularly when such theories actually posit opposing views (Lazarus, 1996). In contrast, technical eclecticism refers to the process of utilizing techniques derived from various theoretical orientations while maintaining a non-redundant, unified theoretical focus. Lazarus' own orientation is squarely based on social cognitive theory (Bandura, 1977, 1986) while also tapping general system theory (Bertalanffy, 1974; Buckley, 1967) and group and communications theory (Watzlack, Weakland, & Fisch, 1974). He argues that these three influences are not redundant and form a complementary singular approach (Lazarus, 2007). As such, the technically eclectic clinician adopts various techniques while not necessarily ascribing to the theories from which they emerged. Lazarus qualifies this approach by proposing that well-documented, empirically supported treatments should always be the first course of action (Lazarus, 2006a). When such approaches do not prove fruitful or when they are not available, however, the multimodal therapist's technically eclectic approach provides a wealth of interventions from which to choose.

Another foundational concept for Lazarus is the idea of thresholds (Lazarus, 2007). He notes the importance and strength of genetic influences and emphasizes that such factors can be observed physiologically in the form of individuals' differential reactions to negative stimuli (e.g., pain, stress, and other environmental factors). Nelson-Jones (2001) summarizes this position: "People whose autonomic nervous systems are stable, which usually indicates high thresholds to many events, have a different personality pattern and are likely to be less anxiety-prone than those whose autonomic reactions are labile, which usually correlates with low thresholds" (p. 364). Thresholds can therefore necessarily limit the effectiveness of therapeutic interventions. For example, a clinician skilled in pain management techniques may help a client to improve pain tolerance, but if that client has a very low pain threshold, optimal pain management will not be possible no matter how skilled the clinician is. The concept of thresholds provides an important context for understanding each of the distinctive features of MMT, which will now be reviewed.

**Distinctive Features of MMT**

The Structural Profile employed in MMT is clearly tied to the concept of thresholds. An empirically supported Structural Profile Inventory (e.g., Herman, 1993; Lazarus, 2006a) is available for assessing the extent to which clients' personalities can be reflected by variance across the seven BASIC I.D. modalities of human experience. Relating the modalities to the concept of thresholds, Lazarus proposes that different clients will be more likely to react to some modalities than others, and that such different response tendencies will differ from client to client (Lazarus, 2007). As such, he notes that noncompliance issues that often are interpreted as the client's resistance may actually reflect the therapist's resistance (Lazarus, 2006a). For example, attempting to force a client into a cognitive-behavioral framework may prove counterproductive if that client actually scores low regarding the behavioral and cognitive modalities. Similarly, including imagery in relaxation training may render success less likely for a client who assesses her imagination as poor. Conversely, learning which modalities are preferred for a given client and then focusing on interventions in those modalities can help to optimize treatment success.
The BASIC I.D. also serves as the structure for initial problem assessment via the modality profile. This is derived from the 15-page Multimodal Life History Inventory (Lazarus, 2006a). This inventory includes a series of rating scales and open questions organized across the seven modalities. Given its length, it also serves to assess the client's motivation for treatment. After the clinician reviews this information and following initial clinical interviews, a modality profile can be created consisting of a chart listing each modality, problems cited in each modality, and related proposed treatments. This problem list can be reviewed with the client as a psychoeducational tool and it can also be revised as treatment progresses (Lazarus, 2007). Using this assessment tool helps the clinician to avoid missing specific concerns which might otherwise obstruct treatment progress. This multimodal framework then provides a basis for utilizing unique intervention techniques, bridging and tracking.

Bridging is a useful technique which can help clients to access previously blocked modalities of experience. This intervention addresses a client's avoidance of particular modalities (e.g., affect) by first acknowledging the client's preferred modality (e.g., thinking) and then bridging back to the avoided modality through an intermediate, less aversive modality. Thus, for example, a client who responds, "I think that..." when asked, "How do you feel?" is not badgered with persistent refocus on feelings. Rather, the multimodal clinician acknowledges the client's preference for reasoning and allows him to pursue his thesis regarding a given problem. By doing so, the client feels heard and validated. Next, the clinician will gently raise questions in another preferred or neutral modality. For example, if imagery is another of the client's preferred modalities, he might be asked to report whatever images come to mind as he thinks about the problem. Then, while describing the images, the clinician could ask what feelings were aroused by these images, at which point Lazarus proposes it is far more probable that the client will respond affectively (Lazarus, 2006a). Thus, by acknowledging preferred modalities rather than confronting them, and by then invoking other preferred or neutral modalities, this bridging technique can help the client to engage in healthy experience regarding a previously avoided modality. This in turn can reduce the likelihood that clients will appear resistant. In contrast, as previously stated, therapists who insist on client compliance with a given approach may lose the client due to resistance, but this resistance belongs to the therapist!

Tracking is an intervention which also capitalizes on the BASIC I.D. as a multimodal approach. Lazarus suggests that individuals typically have a modality firing order that is generally consistent across situations and thus can help in elucidating the nature of symptoms and problems for which the client cannot readily determine a cause (Lazarus, 2006a). For example, a depressed client whose symptoms cyclically worsen "for no reason" might identify that such symptomatic exacerbation actually begins with bodily sensations (S) of fatigue or muscle soreness upon waking in the morning. These sensations might trigger cognitions (C) such as "This will probably be a really bad day," and/or "I will probably always be depressed." The negative thoughts might then prompt depressive behavior (B) such as remaining in bed all day, which leads to worsening affect (A). By identifying this S-C-B-A firing order, treatment can proceed to address the problem of worsening symptoms at its start. The clinician might suggest exploring possible reasons for morning fatigue or soreness (e.g., poor sleep hygiene, caffeine abuse, bad mattress), and also help the client to counter the negative thoughts with more reasonable ones (e.g., "This day represents an opportunity" and/or "soreness does not equal depression, and stretching helps.") Additionally, suggesting a morning routine of stretching and taking a brief walk before breakfast could serve not only to counteract soreness but also mobilize adaptive behaviors (e.g., not remaining in bed).

The final distinctive feature of MMT involves use of a second-order BASIC I.D., which can be employed when success is not achieved using the standard BASIC I.D. The second-order BASIC I.D. provides a more thorough assessment of an unresponsive problem. For example, if depressed mood does not respond to interventions suggested by the initial BASIC I.D., the clinician can then ask the client to think only about her depressed mood and generate associations in terms of all seven of the modalities (Lazarus, 2007). Possible responses might be as follows: withdrawal (B); sorrow and worry (A); headache (S); image of rain against the window (I); thought of a possible brain tumor (C); loneliness (I); family history of cancer (D). In this hypothetical case, the second-order BASIC I.D. reveals that the client associates depressed mood
with the possible threat of a brain tumor, her headaches, and her family history of cancer. In such a case, recommending referral for a brain MRI might eradicate this block to treatment, and progress can resume once negative results are obtained and the client's fears are allayed.

**Multimodal Psychotherapy**

As should be clear from the preceding conversation, MMT places great emphasis on assessment with respect to personality (e.g., structural profiles), comprehensive problem inventories (e.g., modality profiles), processes underlying symptoms (e.g., tracking of firing orders), and more focused examination of unresponsive problems (e.g., second-order BASIC I.D.s). Thus, the initial sessions are focused on assessment and evaluation, but the intake need not be completed before interventions are used. Indeed, utilizing appropriate interventions during initial sessions, particularly those resulting in symptom relief, can help to build the therapeutic alliance (Lazarus, 2006a).

In addition to initial assessment, “ongoing evaluations of progress are integral to multimodal therapy” (p. 376, Nelson-Jones, 2001). Such evaluations are done within the context of the therapeutic relationship, which emphasizes collaboration and parity. Indeed, in recent years, Lazarus and others (e.g., Lazarus & Zur, 2002) have argued not only for parity but also for the elimination of universal taboos regarding all dual relationships, particularly noting the important difference between boundary crossings and boundary violations: “Boundary violations refer to actions on the part of the therapist that are harmful...[such as]...sexual or financial exploitation of clients. A boundary crossing is a benign and often beneficial departure from traditional therapeutic settings or constraints” (p. 6). While being careful to avoid boundary violations, the multimodal therapist will be flexible in approaching the therapeutic process, taking the unique considerations of each client into consideration (Lazarus, 2006a). As one straightforward example, the multimodal therapist will optimize in vivo exposure techniques with an anxious client by accompanying the client to the specific feared environment in question (e.g., restaurant, shopping mall, car, etc.).

When considering intervention selection and the resulting appearance of the therapeutic process, it is essential to remember the technically eclectic nature of MMT. The *Multimodal Life History Inventory* (Lazarus, 2006a) asks clients their expectations regarding the nature and duration of therapy, as well as the qualities of the ideal therapist. This information helps the therapist to match the style of the client. Given this information, it is possible that the same multimodal therapist seeing four clients in succession might use Rogerian, Gestalt, psychodynamic, and cognitive techniques in the four respective sessions. Lazarus favors interventions with clear empirical support (Lazarus, 2006a), but when these are not available or do not prove helpful, MMT proposes that interventions should be selected in response to the particular client's modality and/or structural profiles. Whereas MMT advocates competence in a wide array of techniques (Lazarus, 1989; Lazarus, 2007), such interventions are to be used “sparingly according to the assessed needs of individual clients” (Nelson-Jones, 2001, p. 379).

Traditionally, MMT typically involved 50 weekly sessions; but with the advent of managed care, Lazarus illustrated that a brief approach (10 to 12 sessions) is completely feasible (Lazarus, 1989; Lazarus, 2006a). Indeed, MMT not only lends itself well to short-term models but also to crisis intervention (Escapa, cited in Lazarus, 2007). In addition, MMT has been shown to be useful with a variety of specific applications, including marital therapy, sex therapy, child therapy, group therapy, and therapy with persistently mentally ill persons (Lazarus, 1989). In short, MMT presents as a very versatile therapeutic model that lends itself well to short-term and/or longer-term treatment models with a broad variety of problems and populations.

**Empirical Support**

Whereas MMT has not yet been named as an empirically supported treatment (EST), there have been numerous case studies over the years documenting its efficacy (e.g., Breunlin, 1980; Brunell, 1978; Keat, 1996; Lazarus, 1985; Lazarus, 2005; Martin-Causey & Hinkle, 1995; Richard, 1999). As noted previously, MMT might be viewed as a flexible expansion of empirically supported cognitive and/or behavioral treatments, given MMT’s focus on seven modalities rather than only three (cognition, behavior, and affect); but formal assessment of MMT as an EST has not yet been published. One study did provide some indirect empirical support for MMT. Herman and Roudebush (1998) found that greater matching between therapist and client
regarding modality orientation preferences led to better therapy outcomes. (For a current review of MMT, see Lazarus, 2007).

One Christian’s Application and Critique of MMT

In my small outpatient private practice, I treat both non-Christian and Christian individuals, couples, and occasionally families. I was first exposed to MMT over 22 years ago, when as a graduate student I attended a day-long seminar taught by Dr. Lazarus. My immediate attraction to his approach may have been partially due to its action-oriented, multi-level, problem-focused approach which was a good fit for my ADHD-prone personality. This approach gave me permission to focus on many things at once, which is actually easier for me than focusing on one thing! Thus, I would note that MMT might not be a satisfying approach for clinicians preferring a slower paced, less active style of therapy focusing much on the relationship and little on techniques. Indeed, Lazarus (2006a) views a primary focus on relationship as necessary but rarely sufficient.

Whereas I do not approach MMT solely from a social cognitive and/or systems theory perspective as Lazarus (2007) does, I concur with him that a unified theoretical focus is crucial. A thorough description of my own theoretical orientation is beyond the scope of this article. In brief, it does include a respect for all the components of Lazarus’ blended theory when considering conscious and/or intentional behaviors. My orientation also encompasses the concept of unconscious processes, however, which I view theologically as manifestations of original sin. Specifically, I would propose that original sin might readily be summarized as the innate desire to perceive oneself as completely sufficient, with no need of God, others, or any self-change. Given that reality continually disproves this desired perception and its concomitant wish to perceive oneself as completely in control, I believe that anxious walls of denial are unconsciously constructed to block out contradictions of self-sufficiency and maintain illusions of control (Bjorck, 1995). From this vantage point, progress in therapy can be measured by the client’s ability to identify these walls, dismantle them (exchanging unrealistic anxiety for reasonable and guilt-free sorrow over the fact that all decisions involve loss), and embrace human limits as God’s gifts. Doing so permits the client to move towards increasing peace, self-acceptance, and dependence on God while maintaining and enhancing reasonable human agency and responsibility as two other gifts from God.

 Whereas my theory diverges from Lazarus’ (2007), I fully value and maintain his technically eclectic approach. I also continue to use the Structural Profile Inventory (SPI; Lazarus, 2006a) with every new client, presenting the scores in a bar chart as a means of providing feedback. Whereas I also use more detailed assessment (e.g., the Millon Clinical Multiaxial Inventory-III; Millon, 1994), I have found that the SPI is often more helpful in communicating to the client that I understand them well. This often helps to engender hope and enhance motivation. It is especially useful when working with couples. Not only can comparison of the two structural profiles provide insights, but asking each partner also to complete a profile for the other can illustrate the degree to which each partner knows the other (Lazarus, 1989).

Lazarus’ technically eclectic, problem-focused approach to therapy fits well with my own views regarding the need to identify functional impairments as treatment foci, with the client and not the therapist as the focus of therapeutic goals (Bjorck, Brown, & Goodman, 2000). Thus, I agree that goals targeting the client’s willingness and ability to progress through mandated steps of a particular theoretical framework may actually be more for the benefit of the therapist than the client. Indeed, clients who fail to comply in such cases may erroneously be characterized as resistant (which itself may be a self-fulfilling prophesy of a given theoretical orientation).

Lazarus’ argument for technical eclecticism also strongly resonates with my own Christian perspective. Indeed, the Apostle Paul noted that he would become “all things to all people” in order to communicate the Gospel most effectively (1 Corinthians 9:22). In doing so, Paul modeled what Lazarus calls being an “authentic chameleon” (Lazarus, 2006a, p. 14). Rather than forcing the Gospel on diverse people with a uniform approach, Paul modified his presentations in accordance with the culture, beliefs, and practices of his audience. Likewise, Lazarus notes, “Effective psychotherapists are constantly on guard against fitting the patient to the treatment. A primary purpose ... is ... to fit the treatment to the patient” (Lazarus, 1989, 63). As such, MMT considers all aspects of diversity, going beyond basic demographics.
Having said this, and noting the American Psychological Association's (1991 2002) call, to consider religious and/or spiritual beliefs as an important diversity issue, MMT's technically eclectic approach is particularly suited to working with Christian clients. Such clients' world views will include a variety of religious premises that may inform a variety of modalities across the BASIC I.D. As perhaps the most obvious example, belief in God as a real, relational being will typically be a primary cognitive premise that has ramifications for all other cognitions. God will probably also be considered with respect to other modalities, for example, as a key figure in the client's interpersonal network (e.g., Fiala, Bjorck, & Gorsuch, 2002). As another example of faith informing the BASIC I.D., imagery exercises might be contraindicated for a client who views imagery as a prohibited non-Christian religious practice. Diversity concerns should also go beyond simply determining whether or not a client is a Christian and include consideration of the wide variety of unique denominational beliefs among Christians. Given that such specific beliefs can influence all aspects of the client's faith and world view (Trice & Bjorck, 2006), precisely tailoring the treatment to the individual can be even more important; and MMT provides a useful means for doing this.

When considering MMT from a Christian (or any spiritual) perspective, one obvious question concerns the lack of a spiritual modality. Tan (1991) has suggested that MMT "ignores the crucial spiritual dimension of human life and experience" (p. 39). To address this concern, Tan proposes that a Christian approach to MMT should thus add "S" to the BASIC I.D. as an eighth modality. In response to such critique, Lazarus argues that adding an eighth modality is redundant. In earlier years, he suggested that spirituality could be accounted for parsimoniously as the combination of strong cognitions and strong affect (A. Lazarus, personal communication, November 1, 1985). More recently, he has proposed that the spiritual dimension is typically a combination of strong cognitions (beliefs), which are frequently experienced together with strong imagery and sensations (Lazarus, 2006a). His description of spirituality is laudable in its avoidance of redundancy, but two rebuttals are possible.

First, given the arbitrary nature of all psychological constructs (Nunnally & Bernstein, 1994), it is important to note that the seven modalities, while meaningful, should not be reified. While very useful, the modalities in MMT have considerable overlap. For example, one could certainly argue that images, as mental representations, are simply a subset of cognitions. Likewise, emotions can be operationally defined as cognitively interpreted sensations and perceptions (e.g., R. Lazarus, 1991). This can explain, for example, why rapid heart beat and shallow respirations can just as readily signal fear as joyful exuberance depending upon the cognitive interpretation. Thus, one might argue for eliminating both imagery and affect, as being subsumed in the combination of cognition and sensation. This ignores the utility of all four modality labels, however, as useful tools for meaningful communication between therapist and client. Similar utility can result in allocating a separate modality for spirituality, however, particularly for Christian clients.

The second rebuttal concerns the Christian world view that God is a real Person, and not simply a projection of one's personality or unmet wishes. For clients with this spiritual world view, the message that spirituality can be reduced to a simple emanation of self (e.g., strong beliefs or sensations) may possibly cause a rift in the therapeutic relationship. Indeed, doing so might be said to be fitting the client to the treatment, the antithesis of MMT.

Clearly, as a Christian psychologist who believes in a Personal God, I have no difficulty avoiding the pitfalls of communicating to a client that spirituality should be relegated to the domain of projected cognition, imagery, affect, and/or sensation. (Conversely, I would not emphasize spirituality to a client who expresses no spiritual interests, and I would make sure to respect any client's world view.) Typically, however, I do not add "S" to the BASIC I.D. when communicating feedback to Christian clients. Whereas this difference from Tan (1991) is almost entirely semantic, I prefer to conceptualize God and the spiritual realm as completely encompassing all seven modalities. To relegate the spiritual to only one modality can potentially communicate that it is not related to the BASIC I.D. (and thus must be added). I do, however, always include a spiritual history as part of intakes (e.g., Bjorck, 1997; Tan, 1996), which has also been endorsed by sources outside Christian circles (e.g., Sue & Sue, 1999).

Before using any therapeutic approach, it is ethically important to consider whether it is appropriate for a given client in a given circumstance. When considering MMT, such questions
are even more central given their relevance to technical eclecticism. As Lazarus notes, "Technical eclectics try to answer the basic pragmatic question: What works for whom and under which particular circumstances" (Lazarus, 1989, p. 5). With this in mind, I would suggest that the flexibility of MMT assures its appropriate use in virtually every instance where the concept of the BASIC I.D. can be cognitively grasped by the client/clients. As such, this approach would require caution when working with those whose intellectual functioning is markedly below average. In addition, given the clinician's active stance and frequently simultaneous attention to multiple areas, MMT might be less effective for clients who are merely seeking solace and a safe place to vent rather than assistance with addressing self-change. As such, those clients who are highly narcissistic and/or otherwise highly defensive can represent greater challenges. It should be noted, however, that the competent multimodal therapist will adjust her/his approach accordingly, perhaps even resorting to the primary utilization of Rogerian (1951) techniques for a considerable interval, in order to enhance the client's comfort levels and willingness to consider tangible constructive changes (Lazaais, 2007).

**Case Example**

To illustrate my use of MMT, I will present a fictional case based on a conglomeration of many cases I have seen over the years. Mike was a 27-year-old African-American male who was referred by an insurance company handling Worker's Compensation claims. He lived with his wife and two sons, ages 2 and 4. When I met him, he had worked at the same bank since graduating from community college and had served as a teller for the past 5 years. Three weeks before his initial visit with me, this bank had been robbed right before closing. The masked robber had run in, jumped Mike's counter, said "how ya doin'?" and then had drawn a gun, pressing it into the side of Mike's head. He first forced Mike to his knees while he ordered all those in the bank to lie down. Then, Mike was told to collect all available money, while the robber (a foot taller than Mike) clutched Mike's collar with his left hand and kept the gun jammed against Mike's head with his right. At one point early on, a customer screamed and the gunman fired a warning shot into the ceiling, immediately and forcefully returning the gun to Mike's temple. After collecting the money, the robber pushed Mike to the floor, told him not to move, and ran from the building to a waiting car that sped away.

Throughout the incident, Mike had continually experienced images of his wife and children and had silently begged God to protect his life. Immediately after the robber had left the building, Mike experienced some relief but also felt somewhat "numb." He felt himself "going through the motions" as he was interviewed by police, who commented on how calm and how "lucky" he was. As Mike drove home, he thanked God for protecting his life but he was troubled by the fact that "it was like the whole thing had been on TV, not real." After dinner, when the children were put to bed, he told his wife about the event, omitting many details "because I did not want to stress her out." He also told her that the bank would be installing bullet-proof glass the next day and hiring an armed guard (which was true). That night, his sleep was interrupted by nightmares in which the gunman repeatedly slammed the gun into Mike's head and forced him to his knees. He awoke tired and "still feeling numb." Upon arriving at work, he was barraged by well-meaning co-workers asking him repeatedly how he was doing. "I kept saying I was OK, but more and more, I didn't even believe myself." Then, when a customer accidentally dropped a laptop with a loud crash, Mike yelled and dropped to the floor "in a cold sweat." Seeing people stare at him as he rose from the floor, he walked quickly out of the front doors, "and I haven't been able to go near the bank since then. I don't feel numb anymore. I just feel lousy."

Mike initially presented with symptoms meeting criteria for a marked Acute Stress Disorder. When assessing his problems with respect to the BASIC I.D., his chief complaints included: (B) avoidance of the bank, inability to button his collar or wear a tight tie, and heightened startle response, difficulty resuming sleep after awaking from nightmares; (A) anxious and depressed mood, guilt, shame; (S) hypersensitivity to anything touching his neck; (I) nightmares of the trauma, flashbacks of the gunman's masked face; (C) repeating thoughts, such as, "I should have disabled him before he drew his gun," "I can't protect myself or my family," "What's to stop him from coming back?" "What did I do to deserve this?" "A person with more faith would be able to handle this;" (I) discomfort around friends due to continual questions and even some discomfort
around his wife, feeling somewhat distant from God; and (D) fatigue and headaches.

As discussed above, I do not add a separate "S" dimension (spirituality), but my conceptualization of any case is permeated by the spiritual. I typically look for ways in which spiritual issues are relevant for the client, however, rather than imposing on the client my premise that spirituality permeates all else. Mike viewed his behavioral problems (B) as spiritually problematic only to the extent that they reflected his current inability to "trust God enough to just go back to work." His avoidance of work compounded his feelings (A) of guilt and shame, which had spiritual overtones as well (e.g., "not having enough faith"). He drew no spiritual connections to his hypersensitivity regarding his neck (S), so this issue was not framed in spiritual terms. His nightmares (I), however, were disturbing in that they involved "no sense that God was with me." Mike's spiritual concerns were most clearly apparent in the cognitive (C) modality, where his troubling thoughts had strong spiritual overtones. Interpersonally (I), Mike's feeling distant from God also caused him distress. Finally, his fatigue and headaches (D) seemed like natural consequences to Mike, and he did not associate these with his spiritual outlook.

Mike's structural profile showed particularly strong preference for imagery and cognition modalities, with medium preference for behavior, affect, interpersonal, and drugs/biology and lower preference for sensation. Whereas he admitted he was uncomfortable about "spilling [his] guts to a stranger," he also reported feeling better knowing that I shared his faith (he had asked for a referral to a Christian psychologist). Because he also quickly confessed guilty feelings for "needing to see a shrink," I assured him that my job was to "work myself out of a job and have you back on your own ASAP." I also reminded him that he was the "expert" on himself and thanked him for sharing his expertise in the form of the detailed and helpful information he had provided me. The parity of this collaborative approach immediately seemed to reduce his embarrassment about being in treatment, and together we worked to prioritize his problems. We also addressed issues of race and culture, especially given that I and the gunman were Caucasian. Mike chuckled and responded, "As long as you don't wear a mask, I won't have any problem." I supportively responded that, beyond having no problem, I hoped that treatment would be a culturally affirming experience. To this end, I invited him to help me fully understand his culture (via instruction, correction, clarification, etc.) and its impact on our work together, as yet another area of his expertise.

Mike identified his thoughts and images to be the most troubling problems. Next in line were his need to return to work and his dysphoric mood. Treatment began with a primary focus on these four areas. First, however, some stop-gap measures were put in place regarding other symptoms. For example, Mike reported that aspirin eliminated his headaches, so his moderate use of this medicine was encouraged. Because he had just had a company physical, no physician referrals were made. I also educated him regarding sleep hygiene and provided him with a relaxation tape to use at home before bed. His aspirin use quickly subsided, and Mike reported that he also found the tape helpful during the day "if I get really antsy." With these interventions in place, treatment proceeded.

With regard to his negative thoughts, I observed that two of his predominant thoughts had clear spiritual overtones ("What did I do to deserve this?" "A person with more faith would be able to handle this."). As such, using Lazarus' (1989) correcting misconceptions intervention, therapy focused on helping him see how his own Christian faith actually did not advocate for an automatic direct link between behavior and misfortune, but rather implied that bad things could simply happen (e.g., the life of Job, the Beatitudes, the martyrs through history). I also educated him regarding how normative his responses were to his life-threatening trauma, noting that even the most spiritual people can experience such symptoms in response to what I termed "such evil events." At the same time, I began to introduce the concept of illusory control (Bjorck, 1997), and helped him to see how his self-blaming statements (e.g., "I should have disabled him before he drew his gun," "What did I do to deserve this?") might serve as attempts to deny his human limitations, which entailed being too hard on himself. Moreover, I guided him to seeing that denial of reasonable limits (e.g., "I should be able to instantly stop a gunman even before I know he has a gun.") comes at an unreasonable cost (e.g., false guilt over the "failure" to stop the gunman). Similarly, regarding his thought that he had insufficient faith in God, I helped him see that most people's lack of fear about going to work is not primarily due to
strong faith in God; but rather is due to the
unstated assumption that they can guarantee
their safety simply by being careful. In this light,
Mike was able to see that his life circumstances
had shattered his illusion of control about being
safe at work. As such, his willingness to return to
work would indeed signify true faith in God,
whereas going to work for most people would
not involve fear or faith and primarily signify the
illusion of presumed safety. Finally, given his
question regarding “deserving” this event, I
tried to encourage Mike to explore his own
God concept regarding the cognitive, affective,
and interpersonal realms. In doing so, Mike was
able to identify that he had “always kind of
viewed God as a distant employer that I was
supposed to please, who would reward me if I
did well but punish me if I failed.”

In addition, Mike came to the awareness that
“God must have loved me to keep me alive that
day.” Whereas I personally believed that God
would have loved Mike just as much even if
Mike had been killed, I did not impose this view
given that Mike’s “life-saving” reframe of the
event was helping him move forward. I did,
however, encourage Mike to consider the 23rd
Psalm’s statement that God is with him even
when he walks through, not around, the valley
of the shadow of death. He found this helpful,
commenting that “I guess I know better now that
God is always with me, even in hard times.”

Over the weeks, referring Mike to other scrip-
tural texts (i.e., bibliotherapy, Lazarus, 1989)
discussing them resulted in his increasingly being
able to exchange his stern view of God for a
more personal God who loved him independ-
ently of his performance. For example, he appreci-
ed Deuteronomy 31:6-8, in which God
couraged Joshua to be strong and not fear
because God would never leave him nor forsake
him. In processing this text, Mike was relieved
and encouraged by the realization that God
would not have needed to encourage Joshua to
be strong if Joshua had already been fearless.
Mike also found comfort in the fact that, whereas
God promised never to leave nor forsake Joshua,
this did not mean that bad things never happened
or that Joshua always succeeded at what he tried.
In response, Mike commented, “I guess God real-
ly understands that we are afraid or else he
wouldn’t remind us to trust Him; and if bad things
still happened to Joshua, then I guess my robbery
doesn’t mean that God doesn’t love me or that I
automatically sinned or something.” In addition,
he found new meaning in Philippians 4:6 regard-
ing the peace that passes understanding. I helped
him explore the implications of God’s peace
exceeding human understanding, suggesting that
this premise implies it is completely understand-
able for humans not to have supernatural peace
automatically. In response, he said, “I guess God
knows that humans have a lot to be anxious
about if we try to make things all up to us! I
guess I was trying to make my robbery all up to
me when there really wasn’t anything I could’ve
done about it.” Finally, the admonition (1 Peter
5:7) to cast all his cares on God because God
cares for him was particularly useful. After pro-
cessing this passage in session, Mike reflected,
“The robbery puts this verse in a whole new light
for me.” Specifically, he was able to see that “cast-
ing his cares” could be restated as “accepting the
robbery as something beyond my control and giv-
ing it to God,” rather than continually trying to
mentally castigate himself for what he could have
or should have done differently.

Mike’s nightmares and flashbacks also troubled
him greatly, and given his preference for the imagery modality, therapy focused here as well.
The concept of illusory control was again incor-
porated, with the suggestion that nightmares and
flashbacks might be his unintentional repeated
attempts to replay the event but do it differently.
Mike resonated with this reframe, and with a
laugh, remarked, “I guess that would be like
watching a movie over and over to see if it ends
differently.” Using backward time projection
(Lazarus, 1989) as an imagery intervention, Mike
was able to go back to the actual event and stay
with “Mike” (himself) through the entire situa-
tion. Mike imagined that only the “Mike” from
the past could see or hear him in this time travel
exercise. Mike imagined himself standing right
next to the robber with his hand gently on
“Mike’s” shoulder, reassuring “Mike” that he defi-
nitely would not be hurt in this situation and that
God had chosen to keep him safe. Mike also
encouraged “Mike” not to blame himself for
choosing not to try disabling the gunman, rea-
soning that “even a gramma with a gun wins.” In
addition, Mike pointed out that “because you
were right next to the robber with your hand gently
on ‘Mike’s’ shoulder, reassuring ‘Mike’ that he defi-
nitely would not be hurt in this situation and that
God had chosen to keep him safe. Mike also
encouraged ‘Mike’ not to blame himself for
choosing not to try disabling the gunman, rea-
soning that “even a gramma with a gun wins.” In
addition, Mike pointed out that “because you
took the stress of doing nothing, your wife and
kids still have a husband and father.” During this
imagery exercise, Mike reported vivid images,
which he experienced “in full color, except this
time, I knew that I would be OK in the end and
that God was with me." Mike also experienced his first tears "in a long time" during this exercise and reported that it was "like a scar was healing." Using self-instructional training (Lazarus, 1989), I suggested that Mike make the following statement: "The more I accept this event as a part of my story, the less I will have to keep re-reading this chapter." Philippians 4:6 (as discussed above) also helped him accept the trauma. In the ensuing weeks, he spoke this statement and/or recited Philippians 4:6 to himself upon waking from nightmares and/or having flashbacks, and both disturbances were reduced and eventually eliminated over time.

Fortunately, and not surprisingly, Mike's emotional symptoms decreased as a result of the interventions described above. His hypervigilance, however, was still an issue whenever he drove near the bank. Thus, behavioral techniques such as in vivo counterconditioning (Lazarus, 2007) were employed midway through treatment, whereby I accompanied Mike on walks that brought him increasingly closer to the bank and eventually into the bank itself (while I waited just outside). This progressed to his making the trips alone while talking to me via his cell phone, and ultimately resulted in his full return to work. Similar counterconditioning exercises helped Mike resolve his aversion to anything being snug on his neck (e.g., his tie). This represented another accomplishment, particularly given the bank's "ties are required" dress code.

Resuming work encouraged Mike greatly, and support from his co-workers served to further bolster his mood. By this time, his relationship with his wife had gotten "back to normal," with the help of two sessions one month apart where I requested that his wife accompany him. During those two conjoint sessions, I focused on normalizing Mike's situation and offered them some strategies for increased communication and mutual support. Given the extant strength of their marriage, these two sessions sufficed. Including these two, Mike's MMT involved 30 sessions, with twice weekly sessions for the first two weeks to address his crisis, followed by weekly sessions for 20 weeks, 5 bi-weekly sessions after his return to work, and a final follow-up session after one month. Given the severity of his trauma and resulting symptoms, it is unlikely that short-term (e.g., 10 to 12 sessions) would have sufficed, although such a time-limited approach can be very useful for more moderate clinical concerns.

Conclusion

MMT is a versatile model for addressing the unique therapeutic concerns of Christian clients (e.g., God concept, spiritual concerns, etc.). Whereas it has not yet been identified as an empirically supported treatment, MMT's emphasis on using empirically supported techniques (e.g., cognitive-behavioral interventions), together with multiple documented MMT case studies, suggest that this model is useful in facilitating positive therapeutic outcomes. It is also sufficiently flexible to lend itself readily to use by clinicians who hold Christian beliefs and values. Whereas Lazarus (2006a) does not view spirituality as a separate modality, it can be argued that a technically eclectic approach must address spirituality when addressing Christian clients or risk forcing a fit of the treatment to the client. Given these qualifications, Christian clinicians seeking therapeutic orientations well-suited to today's short-term treatment protocols should give MMT serious consideration.

References


Author

Jeff Bjorck received his PhD in clinical psychology from the University of Delaware and began as a faculty member at Fuller Theological Seminary’s Graduate School of Psychology in 1999. Currently, he is a professor of psychology and a licensed psychologist in private practice. His research interests include religious support and religious coping. Currently, he is focusing these interests on both Christian adolescents and on adults from various ethnicocultural and faith backgrounds. He serves as an elder at his local church, where he also occasionally preaches and teaches.