A Multimodal Behavioral Approach to Performance Anxiety

Arnold A. Lazarus
Rutgers University

Arnold Abramovitz
University of Cape Town

Cognitive-behavior therapy (CBT) stresses a trimodal assessment framework (affect, behavior, and cognition [ABC]), whereas the multimodal approach assesses seven discrete but interactive components—behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors (BASIC I.D.). Only complex or recalcitrant cases call for the entire seven-pronged range of multimodal interventions. Various case illustrations are offered as examples of how a clinician might proceed when confronted with problems that fall under the general heading of performance anxiety. The main example is of a violinist in a symphony orchestra whose career was in serious jeopardy because of his extreme fear of performing in public. He responded very well to a focused but elaborate desensitization procedure. The hierarchy that was eventually constructed contained many dimensions and subhierarchies featuring interlocking elements that evoked his anxiety. In addition to imaginal systematic desensitization, sessions were devoted to his actual performance in the clinical setting. As a homework assignment, he found it helpful to listen to a long-playing record of an actual rehearsal and to play along with the world-renowned orchestra and conductor. The subsequent disclosure by the client of an important sexual problem was dealt with concomitantly by using a fairly conventional counseling procedure. Therapy required 20 sessions over a 3-month period. © 2004 Wiley Periodicals, Inc. J Clin Psychol/In Session 60: 831–840, 2004.

Keywords: cognitive-behavior therapy; multimodal behavior therapy; impostor syndrome; performance anxiety; elaborate desensitization hierarchy; sexual concern

Correspondence concerning this article should be addressed to: Arnold A. Lazarus, Ph.D., ABPP, Rutgers University, 56 Herrontown Circle, Princeton, NJ 08540; e-mail: aalaz@aol.com.

JCLP/In Session, Vol. 60(8), 831–840 (2004) © 2004 Wiley Periodicals, Inc.
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20041

When the Association for Advancement of Behavior Therapy (AABT) was launched in 1966 with Cyril Franks as its president, it was called the Association for the Advancement of the Behavioral Therapies. Soon thereafter, some argued that a behavioral approach revolves around a unified attempt to bring the impetus of experimental psychology to bear on clinical problems, with special reference to the application of established principles of social learning theory. In recognition of the monolithic scientific structure that was said to subsume it, the name was changed to the singular form. More recently, it has become apparent that there are many different approaches within "behavior therapy"—for example, radical behavior therapy, clinical behavior therapy, dialectical behavior therapy, rational-emotive behavior therapy, multimodal behavior therapy, and various forms of cognitive-behavior therapy. Despite their differences, they all offer due respect to data-driven findings and empirically supported methods.

The various forms of "behavior therapy" and "cognitive-behavior therapy" are *trimodal* in that they emphasize the need to assess and address problems within affect, behavior, and cognition (ABC). An exception is the multimodal approach, which underscores seven interactive modalities. In addition to evaluating affect, behavior, and cognition, multimodal behavior therapy emphasizes the need to take account of sensory responses, mental images, interpersonal factors, and biological considerations, thus yielding a seven-point perspective in which to operate (behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors); the mnemonic acronym BASIC I.D. is taken from the initial letters of the foregoing modalities. Multimodal behavior therapy examines the discrete and interactive impact of these seven dimensions (Lazarus, 1997, 2003, 2004).

The elements of a multimodal assessment involve the following range of questions:

B: 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/she stop doing and start doing?

A: What emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, or combinations thereof, and to what extent (e.g., irritation versus rage, sadness versus 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: 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 required, the enhancement or cultivation of erotic pleasure is a viable therapeutic goal.

I: What fantasies and images are predominant? What is the person's "self-image"? Are there specific success or failure images? 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, and the like?

C: 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: 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 and do for them? What relationships give him/her particular pleasures and pains?

D: 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 alcohol and drug use?

The multimodal approach does not recommend rigid adherence to the BASIC I.D. There are cases in which it is clear that a focused bimodal or even unimodal approach is all that is indicated. Our main case illustration of a violinist whose career was in serious jeopardy caused by his extreme performance anxiety is a case in point. He responded very well to a focused but elaborate systematic desensitization procedure. In cases in which a specifically targeted approach is not yielding sufficient progress, traversing the entire BASIC I.D. in search of subtle or concealed problems that call for remediation is often clinically useful.

Varieties of Performance Anxiety

Many surveys have suggested that the fear of public speaking is the most common form of performance anxiety. This fear may affect those who are terrified to speak formally to only two or three people as well as those who only feel anxious in front of a large audience—50 to100 or more. A behavioral assessment may reveal different underlying issues, such as a fear of being scrutinized or of making mistakes, looking foolish, miss-peaking, displaying untoward emotions, or fainting. Actors are frequently afraid they will forget their lines, musicians are primarily afraid of making mistakes, and athletes are impaired by the thought of being trounced. Performance anxiety also includes those who are afraid of not doing well on their job or of failing to make a good impression on someone by whom they would like to be positively regarded. Perhaps it should be said at the outset that it is most difficult to help those people who harbor an "impostor syndrome." These individuals are highly talented, competent, and knowledgeable but regard themselves as inept and as impostors and constantly fear being found out and exposed for their "true" incompetence.

In many instances, some simple methods prove effective in remediating performance anxiety. Thus, with regard to public speaking anxiety, many have managed to contain their fears by picturing members of the audience as sitting in their underwear or being naked. Others have found that they feel less anxious if they do not look out at the crowd but make eye contact with and focus on only one or two people.

When these obvious tactics prove ineffective, one invokes more creative solutions and applies alternative strategies. For example, one man whose work required him to make many public speeches in various locations was completely unresponsive to several standard suggestions and maneuvers. After close questioning, his therapist recommended an unusual ploy. He was advised to inform his listeners that he had an inner ear condition that occasionally caused him to black out, and that if this occurred, he did not want anyone to become needlessly alarmed. Having thereby transferred the burden of anxiety to the audience, he was enabled to go on calmly with his presentation.

Another man, who worked for a very large corporation and whose job entailed frequent talks to new employees, felt extreme anxiety when so doing. A BASIC I.D. assessment soon identified a generalized anxiety disorder caused by his overzealous desire for approval and affection from his coworkers. He often imagined them as making disparaging comments about him behind his back. He attributed their possible negativity to his overall interpersonal deficits—he was shy and tended to be rather detached and aloof. Accordingly, cognitive restructuring was employed to enable him to minimize the impact or importance of rejection, especially by his subordinates. His mantra became "So what, no big deal if someone dislikes me" instead of "That would be terrible!" Role-playing

techniques were selected to deal with his possible interpersonal ineptitude. Thus, instead of withdrawing from people, he acquired better conversational skills. Various diaphragmatic breathing exercises and relaxation techniques coupled with self-calming statements were added to his arsenal. Although he reported a general improvement in his overall level of anxiety, his stage fright when giving talks to the new employees had not lessened. He consulted his family doctor, who prescribed 0.25 mg of Xanax to be taken about an hour before a meeting.

Many have found this to be quite helpful, but not this patient. A more detailed review of his BASIC I.D. suggested the reason. When a more intense focus was directed to his sensory modality and he was asked to zoom in on his main reactions when anxious, he realized that what seemed to stand out was intense tachycardia. Accordingly, his physician was asked to prescribe a beta-blocker in place of the benzodiazepine. The ingestion of a small dose of propanolol (Inderal) coupled with self-calming statements before his presentations proved to be enormously helpful.

Another common area of performance anxiety revolves around sexual prowess. With the introduction of sildenfil (Viagra), straightforward cases are often easily resolved, but for many people whose sexual performance anxieties rest on more intricate and subtle forces. Perhaps we all have a complex mosaic that underlies what it means to be "a sexual being." In some cases, bedroom anxiety caused by a fear of being unable to satisfy one's sexual partner fully calls for an extensive reeducation. Not only must the therapist be highly skilled in explaining lucidly and without personal embarrassment the nuances of foreplay, erogenous zones, individual differences, and specific preferences, but he or she must also be able to dispel myths and convey accurate information.

A simple case in this regard concerned a young man who believed that only those men who were endowed with a very large phallus could satisfy a woman. He feared that his penis was too small and thus had avoided sexual contact. At age 22 he was a virgin. He was referred to a urologist to determine whether he was undersized. The doctor assured him that he, in fact, possessed a larger than average penis. After he was disabused of his dimensional myth, he was given books to read about manual and oral foreplay so that he would understand that deep penetration is often less important to female satisfaction than direct clitoral stimulation. It is noteworthy that when a colleague, upon hearing the straightforward manner in which this case was treated and resolved, said that success would probably be short-lived. He claimed that potential underlying homosexual fears should have been explored, and the likelihood that the client was antagonistic to women also should have been examined. This client was seen in 1993, married in 1995, has two sons, and is doing well in general.

Finessing a Positive Outcome

There are many instances in which performance anxiety reflects a contextual misalliance. Consider the example of an 11-year-old boy who was extremely anxious whenever he had to play sports. His father and two older brothers were athletically inclined, whereas he was rather awkward and gangly. The boy was most anxious during gymnastics. A graduate student was assigned to observe the boy on the playing fields and in the gym. The student concluded that the lad's "performance anxiety" stemmed from the fact that he was genuinely inferior to his peers gymnastically and at a disadvantage in games that called for good eye–hand coordination (e.g., baseball and tennis). Nevertheless, he was an extremely fast sprinter. The family was counseled to encourage him to follow that path and to concentrate on the game of chess, at which he excelled.

A similar contextual misalliance emerged with a young woman who aspired to be a professional ballerina. She entered therapy because she was exceedingly anxious when called upon to perform for the class. Her BASIC I.D. assessment did not bring to light any clear-cut response deficits to account for her anxiety. It was unclear what reasons were responsible for her problems, what lay behind her apparent self-consciousness or stage fright.

One trick of the multimodal approach is to seek solutions from many sources within and outside the profession. In the aforementioned case, the graduate student's observations pointed the way to a viable solution for the gymnastically challenged young man. Similarly, while assessing the aspirant ballerina, instead of relying solely on her self-reports, it seemed necessary to venture outside the office. Thus, the therapist obtained her permission to discuss the matter with her dancing instructor. The teacher claimed to have tactfully told the young woman that she did not have the physique or the talent to become a prima ballerina, but she nevertheless insisted on continuing to torture herself. A logical treatment trajectory became apparent. The teacher affirmed that although she did not possess the right material to excel as a ballerina, the young woman was a most talented dancer, who had much grace, poise, and balance and had an excellent musical ear. Armed with this information, and using considerable diplomacy and skill, the therapist managed to persuade her to move in a different direction. She branched off into ballroom dancing and won several national contests. She also did extremely well at other types of dancing from adagio to tango.

Failure

Nothing works with everyone, and clinical failures are inevitable. As mentioned previously, when an "impostor syndrome" is the mainstay of the specific performance anxiety, outcomes are often less than positive. Here is a case in point:

A brilliant, highly respected, and internationally famous professor, 52 years of age, sought psychotherapy because of his performance anxiety. His peak anxiety level was usually manifested at the start of any semester when he was talking to new groups of graduate students. His fear was simply that he would be exposed as a fraud. One never knew, said he, when a truly gifted student would show him up and reveal him to be deficient—the impostor he believed himself to be. As the semester wore on and nobody exposed or humiliated him, the intensity of his anxiety would diminish, but it was always lurking in the background. He clung to the opinion that he had managed to hoodwink everyone into viewing him as a superstar and treating him as a luminary, despite his basically flawed and limited intellect and the huge lacunae in his knowledge base. Thus, he was worthy of none of the many honors and awards that had been bestowed on him.

The reasons behind his self-denigration were inexplicable. Had he been belittled and degraded as a child, had he been ridiculed or scorned by significant others, had he failed at important tasks, one might assume that he had bought into these derisive scenarios and hence saw himself as intellectually defective. Conversely, had he been raised in a household in which too much had been expected of him so that he always fell short of parental expectations, one might also be inclined to assume a causal connection. Yet he reported a conventional upbringing as the eldest of three sons, all fairly close in age, with affectionate parents and an unremarkable adolescence and early adulthood. He was an A level student in high school, in college, and in graduate school, in which he developed a passion for a subject in which he specialized and in which he received the top honors. He was a prolific writer and his publications were widely cited. He was sought after by several

universities and accepted an associate professorship at a prestigious institution and was soon promoted to the rank of full professor.

Our therapy ranged from formal cognitive disputation to paradoxical intention, but all attempts to disabuse him of his impostor syndrome were to no avail. His levels of anticipatory and ongoing anxiety were not mitigated. Several colleagues opined that prescribing selective serotonin reuptake inhibitor (SSRI) might improve his response to ongoing therapy. A psychiatrist prescribed Prozac, and the client agreed to take the medication. After several weeks, apart from some statements about feeling somewhat less oppressed, no discernible gains related to his performance anxiety occurred. Providing a glimpse into his mode of thought, he arrived for one of his sessions feeling deeply depressed when he found out that his son had been accepted by Columbia University and Princeton University but not by Harvard University. The multimodal arsenal might prove ill equipped to overcome problems associated with an impostor syndrome, whereas some other approaches might be more effective.

Case Illustration

Presenting Problem and Client Description

A most instructive case of performance anxiety dates back to 1960, when we served as cotherapists in treating a professional violinist. The client, whom we will call Mr. DeAngelo, had been referred to Arnold Lazarus (AL), who, at that time, was working closely with Arnold Abramovitz (AA) on various projects. AL was well aware that AA had long been a lover of classical music and used to marvel at the dedication and effort that went into becoming a skilled orchestral player. AL suggested a cotherapy format, and AA agreed, provided that DeAngelo also agreed to it.

DeAngelo had emigrated with his family from Italy when he was 3 years old. The elder of two children, he also had a sister who was musically inclined; by the time he was 6 years old, it was evident that our client was extremely gifted. He played piano, clarinet, and violin, and soon showed a strong preference for the latter. His parents recognized his talent and enrolled him in a prestigious school of music. He started giving public performances before the age of 10 and his talents were widely acclaimed.

In general, there was no untoward event in his history that foreshadowed the fact that at age 30, having enjoyed a successful career, he would suddenly experience a crippling performance anxiety that threatened his livelihood and could end his career as a violinist. Married and having two young children to support, Mr. DeAngelo was first violinist in a large symphony orchestra.

Case Formulation

Upon meeting DeAngelo, we were struck by his deferential manner and his "smiley-anxious" facade, which suggested an overall uncertainty of which "self-presentation" to "produce" or "perform." It seemed that because of his very lack of spontaneity, he acted pleasant and adopted an easygoing manner, but it was obviously phony. He appeared deeply ashamed of being where he was—seeking relief from his desperate situation in a psychologist's office. But he soon began to trust us; he seemed much less distressed by the process and dropped most of his bogus composure. He was quick to inform us how widespread performance anxiety is among professional musicians. He was pleased when we explained that our goal was not to render him totally free of anxiety before or during his performances—that insufficient anxiety could impair performance just as excessive

anxiety could. We agreed that being "screwed up to concert pitch" would be a *focused arousal* that would be adaptive—indeed essential—in the concert hall or recording studio.

Course of Treatment

After taking a case history and conducting a functional behavioral assessment we believed that a course of systematic desensitization held considerable promise. The next step was to determine whether DeAngelo was a candidate for this method. There is no point in applying imaginal desensitization to clients who experience little or no anxiety when vividly picturing themselves in anxiety-generating situations. Likewise, those who lack the ability to conjure up clear images need a different approach. In vivo exposure is often the treatment of choice in such instances. DeAngelo was asked to close his eyes and picture himself walking onto the stage and taking his seat. "Can you imagine that clearly?" After a few moments DeAngelo opened his eyes and said, "I feel it right here," pointing to the pit of his stomach.

We then explained the desensitization procedure and rationale. The three of us would construct a full account of the nature and circumstances of his anxiety responses and then arrange them in a carefully graded hierarchy from the least feared aspect at the bottom to the most intensely feared situation on the top. During the course of developing the hierarchy, we would show him how to use deep muscle relaxation and diaphragmatic breathing to calm himself. (He mentioned that he had tried to relax and breathe deeply and calmly when actually on stage but that it had little impact. We explained that the art lay in extinguishing the anxiety step by step—hence the method we were advocating.)

Developing the hierarchy proved challenging. It seemed logical to commence with "nonperformance" or "still-life" events. For example, "You walk into your room and the first thing you spot is your closed violin case on the table." What seemed to be the least anxiety-evoking stimuli included the following: violin case, violin, bow, music stand, score. That is what we *thought*. In fact, these stimuli proved to be "iconic" or "redintegrative" in that they tended to represent or summon *all* his conflicts around playing the violin.

The bow (by itself) evoked a very strong measure of anxiety. After relaxing him, we questioned him about that, whereupon he explained that of all those "static" stimuli the bow was his most relentless "enemy." It required his major concentration and control; it was more of a pitfall than "stopping" (with his left hand) to achieve correct intonation (i.e., keeping in tune). We thereupon changed the order of various hierarchy items. As we dealt with other aspects of the hierarchy, several interactive events and dimensions were involved: loudness/softness (piano/forte), tempo, passages involving the entire orchestra (tutti), strings and wind instruments in segments that called for accurate timekeeping and ensemble, violins only (first and second desks), first violins only, and, finally, the top of the hierarchy—solo violin in an orchestral context.

DeAngelo alerted us to other dimensions, such as the importance of the audience and occasion. These ranged from uncritical schoolchildren in an outlying township to a gala occasion with cognoscenti in the audience and important critics present. Also, some conductors posed various threats. The most taxing item that headed the list was playing pianissimo as a solo performer under the direction of a feared and fearsome conductor, at a gala event, in front of critics who would name names in influential publications.

It may be evident that we were dealing with a somewhat unwieldy multidimensional hierarchy that was difficult to rank order. We sometimes jumped from one dimension (e.g., type of musical passage) to another (e.g., which dreaded critic was spotted in the

audience). Deliberately introducing a "surprise" stimulus became part of the therapeutic strategy. (Life's vicissitudes arrive haphazardly.) Initially, progress was slow but reasonably steady. We soon reached a point at which it seemed necessary to introduce actual musical performance into the clinical situation. DeAngelo was asked to take his fiddle to the next appointment and play pieces of his choice for us (graded, this time, by him, from easiest to most difficult). Fortuitously, one of us (AA) had a long-playing (LP) record of the late Bruno Walter *rehearsing* the CBS Symphony Orchestra in a performance of Mozart's symphony no. 36 (the *Linz*). DeAngelo was asked to procure the first violin score for this piece and play it as though he were at the rehearsal itself. This turned out to be a key tactic in the treatment. As a homework assignment, DeAngelo played along with the orchestra at least once a day. Our therapy was now coalescing into a robust antianxiety pattern "inside and outside," as DeAngelo put it.

An interesting and unexpected episode occurred when we were more than three-quarters of the way through the treatment process. DeAngelo had been making excellent progress, both in the desensitization procedure and in real-life situations, and appeared to be in a buoyant mood about his professional prospects. Then, without warning, he appeared at a session wearing an expression of the deepest gloom. Inquiries served only to rule out any retrogression in the gains he had made. It was *not* the playing of his violin that was on his mind. It was something unrelated. But he would not or could not talk about it. Eventually, as the result of much coaxing, he was able to murmur a word that sounded like *onani*, which we understood to refer to masturbation. Bingo! With delicate and sensitive questioning, we ascertained that he experienced the most intense, debilitating guilt about the fact that he, a married man who enjoyed sex with his partner, was given to the sporadic practice of masturbation.

English was probably DeAngelo's second language. Nevertheless we found it significant that he knew that we would understand both the meaning of the outdated term *onanisme* (apparently coined in the 18th century for both coitus interruptus and masturbation) as well as the enormous load of guilt and shame that has been associated with it. Some readers might need to be reminded of its origin in Genesis 38:1–10, in which Onan, the son of Judah, was ordered by his father to impregnate his late brother's wife, Tamar, as a religious duty. Onan outwardly complied but covertly "spilled his semen on the ground" whenever they had intercourse. "What he did was displeasing in the sight of the LORD, and he put him to death." Conservative religious teaching to this day condemns both masturbation and recreational sex as mortal sins.

Consequently, we explored his sexual background and training in greater detail than we had during our routine history. Well aware that many psychodynamic thinkers would consider this a pivotal symptom, we tactfully suggested that perhaps his masturbatory guilt led him to imagine that audience members could see right through him when he was on display. He denied this connection. When asked why he had not discussed this sooner, he said that although it had long bothered him, it was on a back burner. However, 2 days previously while dining with a friend, he learned something disquieting about a mutual acquaintance of theirs. He was informed that this man, after imbibing too much alcohol, had mentioned that he frequently masturbated while looking at pictures of nude women he had purchased illicitly. During this conversation DeAngelo's friend commented, "There's nothing wrong with single men who masturbate, but when a married man does so, it is a disgusting perversion."

We delivered a persuasive discourse designed to exorcise these negative attitudes. Emphasis was placed on the view that sexual pleasure, irrespective of whether attained with one's partner or by self-stimulation, is both "normal" and fully acceptable. What ensued was the revelation that his sex life was rather circumscribed—some kissing,

fondling, and then penile–vaginal stimulation in the missionary position. At our behest, he extended his repertoire to include additional manual stimulation, the use of different coital positions, and finally even fellatio and cunnilingus. He volunteered that his wife and he were "very pleased about these things."

We discerned no evidence that his sexual concerns were connected to his performance anxiety but saw them as two separate issues. Consequently, when addressing his sexual distress we did not put the desensitization procedure on hold. The top of his anxiety hierarchy—playing pianissimo in an orchestral context—was successfully presented before the final resolution of his sexual concerns. We were still in the middle of applying cognitive restructuring apropos his sexual guilt when he told us about having effortlessly performed at two concerts that before therapy would have occasioned extreme anxiety.

Outcome and Prognosis

Therapy lasted about three and half months. We met three times weekly for a month and tapered off to once a week and then once a fortnight for a total of about 20 sessions. After 6 or 7 weeks post therapy, we had a follow-up meeting and ascertained that he was, in his words, "totally cured." He went on to explain the reason behind his "cure" (which differed from any mechanisms or attributions that we might have endorsed). "Before I met with you, my music and I were one. I was too close to it. Any mistake felt like a serious imperfection in me. Your treatment enabled me to distance myself from my music. So a mistake was no longer about *me* (M. F. DeAngelo) but about *it*—merely the music. Now I can perform a solo pianissimo onstage and enjoy doing so."

Bravo, maestro!

Clinical Issues and Summary

The multimodal approach underscores the notion that treatment should be "custom-made" for the client. The client's needs are more important the therapist's theoretical framework. Instead of placing clients on a Procrustean bed and treating them alike, multimodal therapists look for a broad but tailor-made panoply of effective techniques to bring to bear upon the problem. The methods are carefully applied within an appropriate context and delivered in a style or manner that is most likely to have a positive impact. The option exists to assess seven discrete but interactive modalities—behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs or biological considerations—especially when making therapeutic inroads proves difficult.

Flexibility is the major impetus. Thus if an assessment reveals the need for attentive listening and reflection, a multimodal therapist uses those methods. If the situation calls for active advice, directive role playing, extensive desensitization, or any other specific intervention, that is what is implemented. In searching for the best match in terms of the therapeutic alliance and the specific treatment trajectory, a multimodal practitioner is quite willing to refer a client to someone else—a colleague who may be a more effective resource. The therapist also seeks input from informed people in the client's network, especially if there are gaps in understanding the main issues pertaining to a client's problems. This method is in stark contrast to many clinical schools of thought, in which the client receives what the therapist offers—whether or not that is what the client requires. In essence, instead of treating all clients with the same technique, multimodal therapists look for specific methods that are likely to have the most positive impact (Lazarus, 2002).

In this article we cite simple and obvious tactics that may overcome several types of performance anxiety, and we describe instances in which positive gains called for shifts in environmental foci. Difficulties in overcoming problems associated with the "impostor syndrome" are discussed, and finally, a somewhat complex case, that of a professional violinist whose crippling performance anxiety called for a mixture of "common sense" and behavior therapy is presented.

Select References/Recommended Readings

Lazarus, A.A. (1997). Brief but comprehensive psychotherapy: The multimodal way. New York: Springer.

Lazarus, A.A. (2002). The multimodal assessment therapy approach. In F. Kaslow (Series Ed.) & J. Lebow (Vol. Ed.), Comprehensive handbook of psychotherapy (Vol. 4). New York: Wiley.

Lazarus, A.A. (2003). Multimodal behavior therapy. In W. O'Donohue, J.E. Fisher, & Steven V. Hayes (Eds.), Cognitive behavior therapy. Hoboken, NJ: Wiley.

Lazarus, A.A. (2004) Multimodal therapy. In R.J. Corsini & D. Wedding (Eds.), Current psychotherapies. New York: Wadsworth.