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# A Study of the Interrater Agreement of Therapists Using the Basic I.D. Profile as an Assessment Tool

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Mann,

Jimmy Paul

1985



A STUDY OF THE INTERRATER AGREEMENT OF  
THERAPISTS USING THE BASIC I.D. PROFILE AS AN  
ASSESSMENT TOOL

A Thesis

Presented to

the Faculty of the Department of Psychology

Western Kentucky University

Bowling Green, Kentucky

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

Jimmy Paul Mann

November, 1985

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A STUDY OF THE INTERRATER AGREEMENT OF  
THERAPISTS USING THE BASIC I.D. PROFILE AS AN  
ASSESSMENT TOOL

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I would like to dedicate this work to my parents as a token of my gratitude for their support. With their encouragement I found the endurance to persevere, and with their faith in me I found the courage to grow.



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I wish to express my appreciation to the members of my Thesis Committee. While all of the members provided me with invaluable suggestions about the physical content of my thesis, each member also shared with me a piece of their personal wisdom. When a specific obstacle appeared to be insurmountable, Doris Redfield sparked my sense of adventure and challenged me to go beyond the textbook and create my own solution to the problem. Bill Pfohl supplied not only his suggestions, but also participated in the research by being one of the interviewers. His professional expertise in the subject matter of my thesis was most helpful. As my Chairman, John O'Connor was always available to serve as my sounding board. If I began to drift off course, he would gently steer me in the right direction.

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## TABLE OF CONTENTS

	Page
LIST OF TABLES . . . . .	viii
ABSTRACT . . . . .	ix
Chapter . . . . .	
I. INTRODUCTION . . . . .	1
II. REVIEW OF LITERATURE . . . . .	4
Definition of Assessment . . . . .	4
Approaches to Assessment . . . . .	6
Psychoanalytical Approach . . . . .	6
Traditional Approach . . . . .	6
Behavioral Approach . . . . .	8
Cognitive Approach . . . . .	10
Cognitive-Behavioral Approach . . . . .	13
Cognitive-Social Learning Approach . . . . .	14
Eclectic Approach . . . . .	16
Multimodal Therapy . . . . .	18
Description of the	
BASIC I.D. Modalities . . . . .	20
Rationale for the	
BASIC I.D. Profile . . . . .	24
Applications of the	
BASIC I.D. Profile . . . . .	25
Criticisms of the	
BASIC I.D. Profile . . . . .	30
Statement of the Problem . . . . .	36

III. METHODS . . . . .	40
Participants . . . . .	40
Raters . . . . .	40
Subjects . . . . .	40
Interviewers . . . . .	40
Procedures . . . . .	41
Preparation of Videotapes . . . . .	41
Training of Raters . . . . .	42
Rating the Subjects . . . . .	44
Analysis . . . . .	46
Kappa Coefficient . . . . .	46
Pearson Product-Moment Correlation Coefficient . . . . .	49
IV. RESULTS . . . . .	50
Kappa Coefficient . . . . .	50
Pearson Product-Moment Correlation . . . . .	50
V. DISCUSSION . . . . .	54
Differences Among Modalities . . . . .	54
Differences Between Interviewers . . . . .	59
Sources of Variance . . . . .	59
Rater Variables . . . . .	59
Target Variables . . . . .	61
Rater's BASIC I.D. Profile . . . . .	63
Limitations of the Study . . . . .	64
Conclusions . . . . .	67
REFERENCES . . . . .	71



Appendixes

A.	AN OVERVIEW OF THE BASIC I.D. . . . .	77
B.	BASIC I.D. ASSESSMENT CHART . . . . .	80
C.	PROBLEM AREAS SHEET . . . . .	89
D.	STRUCTURAL PROFILE SHEET . . . . .	91
E.	TRAINING INSTRUCTIONS . . . . .	94
F.	VIGNETTES . . . . .	106
G.	RATINGS ASSIGNED TO MODALITIES PER SUBJECT . . . .	128
H.	RATINGS ASSIGNED TO SUBJECTS BY MODALITY . . . .	136

LIST OF TABLES

	Page
I. BASIC I.D. ASSESSMENT CHARTS: KAPPA COEFFICIENTS BY MODALITY . . . . .	52
II. PEARSON PRODUCT-MOMENT CORRELATION COEFFICIENTS FOR PROBLEM AREAS IDENTIFIED and RATER'S STRUCTURAL PROFILE . . . . .	53
III. BASIC I.D. ASSESSMENT CHARTS: KAPPA COEFFICIENTS BY INTERVIEWERS . . . . .	60
IV. DESCRIPTIVE STATISTICS: PROBLEM AREAS IDENTIFIED by the RATER . . . . .	65
V. DESCRIPTIVE STATISTICS: STRUCTURAL PROFILE of RATERS'S SELF-RATING of OWN MODALITY . . . . .	66



A STUDY OF THE INTERRATER AGREEMENT OF THERAPISTS USING THE  
BASIC I.D. PROFILE AS AN ASSESSMENT TOOL

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In using the BASIC I.D. profile as an assessment tool, seven modalities of the client are assessed: Behaviors, Affect, Sensations, Imagery, Cognitions, Interpersonal relationships, and Drugs (physiological condition). The purpose of this study was to assess the interrater agreement of the BASIC I.D. profile when used as an assessment approach in psychotherapy. The raters were 15 graduate students in clinical and school psychology at Western Kentucky University. Six actors served as subjects who simulated clients coming to a psychotherapist for his/her initial interview. Two experienced interviewers portrayed therapists conducting the initial interview with the subject. The interviews were videotaped and, after a training session explaining the use of the BASIC I.D. approach, the raters prepared BASIC I.D. profiles for each of the subjects. The seven BASIC I.D. modalities yielded kappa coefficients ranging from .59 for Sensations to .42 for Affect. The correlation between the raters' own BASIC I.D. profiles and the number of problems they identified in the BASIC I.D. profiles of the subjects was nonsignificant. In conclusion, interrater agreement for the BASIC I.D. profile method of clinical assessment appears to be



acceptable. Furthermore, it does not appear that the personal BASIC I.D. profile of a therapist influences his/her assessment of others.

## CHAPTER I

### Introduction

A primary concern of psychotherapists is the psychological assessment of their clients. Assessment seeks to provide an in-depth description of the individual (Deinhardt, 1983). Therapists must know who their client is before they can decide what must be done. Knowing the client requires the therapist to understand how that individual functions in his or her environment; what strengths and weaknesses the client possesses; when and where problems arise; and when and where they are absent. Such an understanding requires an objective and comprehensive view of the client. Only then can the therapist begin to sift out pertinent information and focus upon particular aspects of the client's life that can be shaped into meaningful treatment goals (Nay, 1979).

In choosing an assessment system, the therapist may be well advised to look beyond the goal of merely describing the client. According to Robert Nay (1979), the assessment system should provide insight to the causes behind the problems. In addition, it should develop information useful for deciding what treatment methods to use, and provide a data base for evaluating those methods against the progress of the client.



Furthermore, any assessment system designed to be used by a large number of therapists should be capable of being applied in a reliable fashion. In other words, one therapist should be able to duplicate the judgment of another therapist (Woodly, 1980).

An assessment system that appears to meet these goals is encompassed in the BASIC I.D. profile developed by Arnold Lazarus (1976, 1981). Lazarus described human beings as people who move, feel, sense, imagine, think, and relate to one another. According to Lazarus, one's identity can be summed up by his or her Behaviors, Affective processes, Sensations, Imagery, Cognitions, Interpersonal relationships, and biochemical/ neurophysiological processes (Drugs). The first letter of each of these seven areas provide the acronym for the BASIC I.D. profile. In using the BASIC I.D. profile, each of the seven modalities is explored in order to map out a style of living for each client. Thus, Lazarus has categorized human personality into seven basic dimensions or modalities. These modalities provide the foundation for Lazarus' conception of Multimodal Therapy (Lazarus, 1981). Multimodal Therapy differs from unimodal approaches in that seven personality dimensions are comprehensively explored and treated instead of one or two. After the therapist examines the strengths and weaknesses in each modality, a treatment plan can be developed which addresses the problems in each modality. Even with such a comprehensive approach, Lazarus (1981) believed the BASIC

I.D. profile was cost-effective because it provided a system that was (1) easy to understand, (2) easy to remember, and (3) easy to administer. When properly prepared, the BASIC I.D. profile should provide information relating to causal factors, treatment goals, and data for future evaluation of the client's progress, thereby satisfying Nay's goals. However, can the system be applied in a reliable manner from one therapist to another? Is it, in fact, as cost-effective as Lazarus claims? Can therapists easily learn and apply the BASIC I.D. profile when assessing a client? If so, then one would assume that its reliability would be enhanced because errors associated with misunderstanding the concept would be held to a minimum. While many therapists, and in some areas entire clinics, use the BASIC I.D. profile, no empirical evidence has been provided to show that the BASIC I.D. can be used in a reliable manner.

If novice therapists can be instructed in the concepts and application of the BASIC I.D. profile such that they can obtain reliable and accurate results across therapists, then one may assume that Lazarus has developed a cost-effective approach to assessment. The rationale for this study was to provide an evaluation of the BASIC I.D. profile as an assessment tool. Specifically, the goal of this thesis was to provide empirical evidence for the reliability of the BASIC I.D. profile by evaluating the amount of agreement therapists achieved when assessing the same clients across the seven modalities of the BASIC I.D. profile.



## CHAPTER II

### Review of Literature

Over the years, psychological assessment has grown from a simple personal history interview into systems which include a wide assortment of specialized techniques to gain very specific information about the client. Various psychological theories and orientations have approached assessment from their areas of speciality. Personality, intellectual, behavioral, cognitive and social skills assessment have developed into broad independent models separate from the others. Nevertheless, there has often been overlap from one model to another. For purposes of this investigation, the term psychological assessment will be used to address the many forms of assessment involved in psychotherapy. The following review of literature will examine the major forms of psychological assessment currently being utilized.

#### Definition of Assessment

Psychological assessment may be defined as a systematic use of a variety of special techniques in order to better understand a given individual (McReynolds, 1968). The methods one uses depends largely on the therapist's theoretical and professional orientation. What is important to a psychoanalyst may be of little interest to a



behaviorist. As a result one's investigation into the problems of the client will vary from one orientation to another. However, the final goal remains the same across all theoretical boundaries, that is the improvement of the client. Treatment must also provide visible results which are satisfying to the client. If important aspects of the client's life situation have not been detected or incorrectly interrupted, then the therapist cannot be in a position to select the forms of treatment that will be best suited for the client (Nay, 1979). For this reason it is important that the therapist adopt a means of psychological assessment that comprehensively covers all the psychological factors germane to his/her style of treatment. Many therapists follow their own intuition during this assessment period, while others follow structured guidelines and/or detailed classification systems developed to meet the information needs of various theories. Moreover, assessment systems have been developed to meet the requirements of particular agencies. When developing an assessment system, one must remember that its use is justified only if it increases the efficacy of the professional services offered on behalf of the client (Woodly, 1980). As McReynolds (1968) stated in the first volume of the Advances in Psychological Assessment, "Ultimately, both successful practice and fruitful research depend upon adequate understanding, and this in turn depends in large part upon

the availability of satisfactory methods of assessment" (p. 1).

### Approaches to Assessment

#### Psychoanalytical Approach

Psychoanalytically oriented therapists often have relied on intuitive inferences about the symbolic and dynamic meanings expressed by their clients (Mischel, 1981). There has been a tendency in psychoanalysis to mistrust the client's self-reports because of the emphasis the therapist places on unconscious distortions and defense mechanisms (Genest & Turk, 1981). Founded by Freud almost a century ago, psychoanalysis provided the field of assessment with its most fundamental technique. Psychoanalysis demonstrated the value of providing a setting in which the client can express his/her thoughts and feelings spontaneously and freely to an uncritical, receptive observer (Arlow, 1984). Many therapists, regardless of their theoretical orientation, have adopted an uncritical and nonjudgemental approach while conducting their assessment.

#### Traditional Approach

Over the years the intuitive approach of psychoanalysis has been supplemented by more objective measures. Psychologists have applied the scientific method to assessment and have developed numerous tests designed to explore the many dimensions of the client's personality. Because these personality tests, combined with interviewing skills, are standard courses in counseling and clinical



psychology curriculums, they will be referred to as traditional methods of assessment. Traditional methods of assessment usually have involved an intake interview to explore the presenting problem followed by a case history and a battery of tests including an objective personality test (e.g. Minnesota Multiphasic Personality Inventory), projective personality test (e.g. Rorschach), and a measure for intellectual ability such as one of the Wechsler Intelligence scales (Nay, 1979).

One of the major goals of traditional assessment has been to uncover the cognitive and personality traits of the client. The underlying assumption was that personality consisted of certain relatively stable and interrelated motives and characteristics that were responsible for one's behavior (Goldfried, 1977). Therapists using the personality trait theory further assumed that behaviors were enduring products of early experiences and therefore their behavioral manifestations should be consistent over time (Cone and Haskins, 1977). It has been assumed that personality traits manifest themselves in certain ways in certain situations. Therefore, observable behavior was only a sign of underlying causes and effects. Operating from the above assumptions, traditional assessment methods have looked for underlying personality characteristics by observing behavior, evaluating self-reports (including psychological tests) and developing a case history of the client in order to investigate the client's past experiences.

### Behaviorial Approach

In contrast to traditional assessment, behavioral assessment was not concerned with underlying causes or past experiences. Behaviorists looked for observable physical and social stimuli currently being demonstrated in the client's life (Cone and Haskins, 1977). To behaviorists, "personality" was merely an abstract label for summarizing the total of an individual in his or her social environment (Goldfried, 1977). The emphasis was on the specific behaviors and their antecedent stimuli that caused problems for the client. Unlike traditional assessment which often employed psychometrically designed tests to deduce personality characteristics, behavioral assessment introduces the client to specific situations and observes the client's resulting behavior. Specific situations were presented through role-play exercises or situational tests (Cone and Hawkins, 1977; Goldfried, 1977). During situational tests the client was in a situation, through mental imagery or in actuality, and asked how he/she would normally act. The intent of behavioral assessment was to sample the areas of the client's behavior patterns that seem to be most relevant to maintaining the presenting problems.

One behavioral assessment tool that labeled behavioral patterns was the Behavioral Coding System (Cone & Hawkins, 1977). It functioned as a classification system which provided the therapist with a numerical code that labeled principle problem behaviors. Twenty-one general behavioral



categories were listed (e.g. "fears", "sex"); this listing was then divided into subcategories which named specific problem behaviors (e.g. transvestitism would be under the broad behavioral category of sex). In all, 283 behaviors can be coded.

Another example of a behavioral assessment system that focused on specific variables within the client's life is the SORC system (Goldfried, 1977). SORC stands for

S - situational antecedents.

What specific situations cause problems?

O - organismic variables.

Genetic and physiological factors are examined.

R - response variables.

How does the client respond in actual situations?

C - consequences of certain behaviors.

Are behaviors being maintained by their consequences?

With the SORC system, information relevant to possible treatment interventions can be generated. For example, the therapist may decide to attempt a change in the client's environment that causes a problem situation, or may conclude that a change in the consequences of behavior will affect a positive change.

A comprehensive assessment paradigm, based on behavioral theory, was offered by Kanfer and Saslow (1969). They developed a "behavioral diagnosis" system that analyzed the client's behavior in various situations and provided



information on how well the client was able to control his/her life. Once the problem areas were found, the client was taught how to develop skills in these areas. This comprehensive approach could be broken down into seven steps. First was the definition of the problem which identified excesses and/or deficiencies in behaviors. The second step involved locating where problem situations existed. Third, a motivational analysis was conducted to discover what incentives currently motivate the client. Fourth was a developmental analysis. In this step the behaviorist looked at past and current methods that the client had tried in dealing with his/her problems. Also, physical development, medical history, and sociological changes during the client's life were examined to see if past events were affecting current functioning. The fifth step analyzed the degree of self-control that the individual had developed in various situations. An analysis of social relationships was the sixth step, including who influenced the client the most and what expectations did the client have for others? The last step involved viewing the client in relation to his/her social-cultural-physical environment, focusing on how well the person's behavior fit into his/her community.

#### Cognitive Approach

One may view behaviorism as being concerned with one's overt behaviors and environmental stimuli. Problems result when the person's behaviors are inappropriate for the

situation at hand. Cognitive therapists, however, believe that problems are caused by what goes on within the person. Emotional problems such as depression and anxiety are the result of inappropriate cognitive or thought processes. Cognitive processes refer to the way one perceives and interprets his or her world and thereby organizes the world into specific thoughts, attitudes, beliefs and values (Burns, 1980; Sandberg, 1981; Mischel, 1981).

Psychological problems occurred when cognitive perceptions and interpretations lead to incorrect assumptions, irrational beliefs, and unreasonable attitudes (Beck, 1976; Ellis, 1962). One of the fundamental principles of cognitive therapy was that all moods and emotions were created by one's cognitions (Burns, 1980). Aaron Beck, a pioneer in cognitive therapy, claimed that, "Man has the key to understanding and solving his psychological disturbance within the scope of his own awareness." (1976, p. 3). Therefore, the procedure in cognitive therapy has been to help the client identify his/her unrealistic thoughts and to teach the client how to apply problem-solving techniques to correct previous misconceptions. The nature of cognitive assessment followed the path of searching for these unrealistic thoughts and cognitive misconceptions. This search was primarily accomplished by getting the client to "think-aloud." Such methods may have involved the client in open-ended interviews, self-report inventories (e.g. Beck Depression



Inventory), or thought listing exercises by the client (Meichenbaum, and Cameron, 1981; Beck, 1976; Genest, and Turk, 1981). Cognitive assessment relied heavily on the client's self-reports. For this reason, it has been criticized by noncognitive therapists (Genest and Turk, 1981). Self-reports were limited by the constraints of the client's own awareness. Furthermore, self-reports may be incomplete or reactive to environmental and social influences such as the desire to seek approval from others. What the client says may be different from what he does. Furthermore, self-reports can be confounded by the therapist's bias. Nevertheless, people can be excellent sources of information about themselves. Researchers have found that client's self-descriptions compared favorably with projective tests and therapist's clinical judgments (Mischel, 1981). Also, self-reports may be the best vehicle available to gather certain information such as the client's self-concept.

Imagery was one area of importance in cognitive therapy. Imagery involved the mental pictures and other sensory stimuli that one created without the aid of environmental cues (Anderson, 1981; Lazarus, 1977). Images such as daydreams, fantasies, and one's creative imagination can supply pertinent information about the client's personal needs and motivations. Cognitive therapy utilized imagery in therapy to supply the client with a mental experience that led him/her through a problem area and toward a

successful resolution of the problem. The goals of imagery assessment were to examine the naturally occurring imaginal processes of the client, to assess the person's ability to generate images, and to evaluate the accuracy of therapeutic images presented by the therapist (Anderson, 1981). Some approaches to imagery assessment have been in the form of performance tests where the client was instructed to image some event and the client was evaluated on his/her success. Lazarus (1977) had used an Image Vividness Scale to see if a client may benefit from imagery exercises. The client was asked to imagine 20 different events and rate the clarity of each on a scale of 1, unclear, to 4, very clear. Another content analysis system for assessing imaginal detail was developed by Anderson (1981). Under this system the amount of detail or information included in the individual's self-report of an imagery experience is evaluated. The client was asked to imagine a scene and then describe it in detail. These imagery details were then coded. The coding categories included 12 stimulus propositions (e.g. physical setting and temporal relations) and 12 response propositions (e.g. outcome of own behavior and emotions).

#### Cognitive-Behavioral Approach

To behavioral therapists, mental processes -- such as cognitions and imagery -- were secondary to behaviors. Behavioral therapists were primarily concerned with what the client does or does not do that eventually cause him/her problems. Cognitive therapists, on the other hand, worked



from the premise that what the client thinks, feels, and believes can create and resolve problems. During the past few years, a compromise between these two theoretical camps has developed that recognized the importance of both behavioral and mental processes. The result of this compromise produced cognitive-behavioral therapists. Cognitive-behavior therapists did not study behavior or cognitions in isolation, but observed how the two interrelate to affect each other. The theoretical basis for the cognitive-behavioral approach was that maladaptive cognitions contribute to maladaptive behaviors (Genest and Turk, 1981; Meichenbaum and Cameron, 1981).

Cognitive-behavioral assessment utilized the techniques of cognitive and behavioral therapists alike. Self-reports were critiqued against the client's observable behavior. How a person feels and what he/she thinks about certain behavioral situations were examined to provide the therapist with a composite view of the internal and external forces impinging on the client.

#### Cognitive-Social Learning Approach

Similar to the cognitive-behavioral approach was the cognitive-social learning approach to assessment. The cognitive-social learning approach operated from the belief that the individual's cognitive activities and behavior patterns were evoked, maintained and modified by specific conditions and/or social events (Mischel, 1981). The focus was on "analyzing the specific interactions between

conditions and the cognitions and behaviors of interest" (p. 484). The assessment goal was to establish the relationship between a situation and the psychological construct - cognitive, emotional, and behavioral - that the person brings to it. Mischel described five variables that were of particular importance in cognitive-social learning assessment. The first variable was one's competency to construct a variety of behaviors under appropriate conditions. To assess the client's competencies in personal and social skills, it was important to discover what the person was capable of doing (maximal performance) as well as what he/she usually did (typical performance). The second variable was the manner or style in which the client encoded and categorized events, him/her self, and other people. To understand this encoding style the therapist needed to assess how the individual perceived, interpreted, and experienced the world. A third variable of special interest in cognitive-social learning assessment was one's "behavior-outcome expectancies." What a person expected to happen if he/she behaved in a certain way could be a powerful tool for predicting how a person will behave. The person's expectation was largely predicated on the subjective value, good or bad, that the person placed on the outcome. Assessing the person's subjective value of certain outcomes of behaviors was the fourth variable of investigation. Subjective values were assessed by questionnaires and verbal reports from the client, as well



as by observing his/her actual choices in lifelike situations. The final variable examined in cognitive-social learning assessment was one's self-regulatory systems and plans. The degree of self-control the client had over his/her actions and emotions, even in the absence of external constraints, was examined.

#### Eclectic Approach

Despite the variety of theoretical positions offered in the field of psychotherapy and assessment, some therapists have not been satisfied with any one school of thought. Instead, they elected an eclectic approach. This was the process of selecting or choosing the best systems and techniques from the various theories at large (Patterson, 1973). Eclecticism differed from the theoretical approaches in that it attempted to integrate and synthesize the valid elements of several theories into an open-ended but comprehensive approach that met the needs of the therapist. Patterson noted that the eclectic approach has been criticized because there was no consistent pattern for choosing particular elements from one theory to the next, but rather the elements chosen were individual choices sometimes made out of expediency instead of validity.

In order to provide validity for the eclectic approach, several systematic eclectic approaches have been pursued by leaders in psychotherapy. Nay (1979) suggested that a comprehensive psychological assessment should be thought of as emerging from a systems view of human behavior similar to

that proposed by the natural sciences. In arriving at his own multimethod approach to assessment, Nay first identified the most prominent errors psychotherapists made in psychological assessment: (1) detection errors made either by failure to gather the information available or by receiving inaccurate information; (2) inadequate choice of modality or area of investigation may restrict the type of information one receives; (3) inadequate choice of methods could likewise restrict information; (4) methodological errors within the assessment methods, e.g. how reliable and valid are they; and (5) sources of bias in the manner in which clients present themselves and are perceived by the therapist.

With these errors in mind certain assumptions about the process of assessment may be made (Nay, 1979; Lazarus, 1976, 1981). As the number of modalities included in the assessment process increases (e.g. assessing behavioral patterns, cognitive processes, underlying personality traits, etc.), one can assume that the likelihood of detecting relevant information also increases. Likewise, if several independent methods are used to investigate these modalities (clinical interview, role play exercises, psychometric tests), the therapist will obtain a more comprehensive view of the client. Several investigative methods should also balance methodological errors with information from other tests to collaborate one's conclusions. Another assumption of therapists using



systematic eclecticism approaches to assessment was that multiple methods of assessment across several modalities will yield several treatment strategies that can be tailored to meet the client's individual needs. Finally, assessment was assumed to be an ongoing process. Once treatment interventions have been implemented, the assessment process continues to evaluate the client's progress and to observe any new problem conditions that may arise.

To take advantage of these assumptions, and to provide a systematic eclecticism approach to assessment, Nay (1981) developed a multimethod form of assessment. He described four modalities which should be examined in detail in order to obtain a comprehensive assessment (p. 275):

(1) description of the problems; (2) conditions under which they occur; (3) client resources, both internal and external; (4) client motivation.

#### Multimodal Therapy

Another attempt at systematic eclecticism, which will be the focus of this thesis, was Multimodal Therapy developed by Arnold Lazarus (1976, 1981). Multimodal therapists do not subscribe to any single theory or technique. From Lazarus' viewpoint, to identify with a particular theory would compel the person to gain a "vested interest" (1976, p. 3) in that line of investigation. Lazarus believed that this singularity of thought practiced by unimodal therapists was one of the greatest impediments to learning and progress. Lazarus applied a broad

theoretical framework of social learning, cognitive processes, and behavior principles to in Multimodal Therapy. In order to combine several theories in a comprehensive yet systematic approach, Lazarus devised the BASIC I.D. profile. Each letter of the BASIC I.D. acronym represents a separate dimension of functioning, or modality, to be assessed and treated. The BASIC I.D. modalities include BEHAVIORS, AFFECT, SENSATIONS, IMAGERY, COGNITIONS, INTERPERSONAL RELATIONSHIPS, and DRUGS. While the first six modalities are psychological in nature, Drugs is concerned with the medical and physiological nature of the client. According to Lazarus, it is the "precise and systematic perusal of the BASIC I.D." (1981, p. 68) that sets Multimodal Therapy apart from other single theory systems or general eclectic approaches. In assessing these modalities, any number of methods may be utilized including self-reports, personality tests such as the Minnesota Mutliphasic Personality Inventory, and behavioral observations. Likewise, treatment techniques from several theoretical backgrounds may be combined to provide interventions across all seven modalities as needed. Multimodal Therapy emphasized flexibility and versatility in order to meet the individual needs of each client. The aim of Multimodal Therapy was to reduce the client's suffering and promote personal growth as rapidly and durably as possible (Lazarus, 1981). Lazarus believed that by addressing as many of the problem areas as possible that were discovered when examining the BASIC I.D.



profile, a therapist would accomplish the aim of Multimodal Therapy. Once the various aspects of the client's problem were assessed through the BASIC I.D. profile, specific treatments could be presented to deal with each modality. Therefore, the treatments were fitted to the client instead of forcing the client into a favorite treatment technique of the therapist.

A fundamental assumption underlying the BASIC I.D. profile was that it comprised the entire range of human personality (Lazarus, 1981). Everyone has a BASIC I.D. profile that is unique to that person. Therefore, Multimodal Therapy consisted of assessing the seven basic elements of an individual's personality and treating the areas of dysfunction. In order to see how the BASIC I.D. profile facilitated assessment and treatment, one needs a clear understanding of each of the modalities.

#### Description of the BASIC I.D. Modalities

Behaviors include any actions on the part of the client that can be observed and/or counted. Of greatest interest to therapists are the problem behaviors (e.g. compulsive hand washing) and coping behaviors (e.g. withdrawal). Questions that Multimodal therapists would be interested in answering include the following. What behaviors does the client need to increase or decrease? What behavioral skills or strengths does he/she have with which to work?

Affective processes describe the emotional state of the client. Anger, anxiety, loneliness, joy and sadness express

how a person feels. But it is important to know under what conditions these emotions are present. When is the client anxious and when is the client not anxious? What elicits these emotions? Do they contribute to the presenting problem? Also, it is important to know how the client's emotions affect his or her behaviors. Does the client hold in emotions and walk away from an upsetting situation, or does he or she strike out angrily?

Sensations encompass the sensory reactions one has to various stimuli and events. Sight, sounds, touch, bodily sensations such as pain, cold hands and feet are included in this modality. To what degree does the client focus on sensory messages? Which of the senses are predominant in his/her life? How does the client respond to these sensations? The field of behavioral medicine has brought special attention to the modality of Sensations. Headaches, back pain, tension, chemotherapy reactions, and some sexual disturbances all involve the modality of Sensations.

Imagery deals with the "pictures" one sees in the mind's eye. Does the client picture him/herself being successful or failing, being in charge or being laughed at? Is there any one picture that comes to mind most often (Lazarus, 1976)?

Cognitions refers to the covert thoughts, beliefs, and values the client generates. "I am a worthless, undesirable person." "My life is empty; there is nothing to look forward to." "All men are the same." Because these



cognitions may influence one's subsequent behavior and/or affect, it is important to look for irrational thoughts that may be providing misinformation or overly rigid beliefs. "I am too old to change." An inventory of the client's shoulds can be made to undercover these irrational beliefs (Lazarus, 1968). Examples of irrational "shoulds" include, "I should not make mistakes," and "I should strive for perfection." (Lazarus, 1981).

The Interpersonal Relationships modality is concerned with one's interactions with others. This modality is closely related to Behaviors because the therapist is interested in how the client acts around other people in his or her environment, and how those people react in turn. This includes people at work, in marriage, play, or at social gatherings. Whenever the client is with another person, social pressures are being formed. How the client copes with these pressures is an important indication of the level of social adjustment the client has made. One of the best ways to assess this modality is to examine the client's person-to-person communication. Verbal and nonverbal cues alike are examined to discern a pattern of interaction between people. Learning who the client feels most comfortable with, loved by, or who is seen as interfering in his or her life can be important in future treatment. After knowing what value the client has for various people, the therapist can develop a hierarchy of his or her interpersonal priorities. One of the basic principles that

influenced Lazarus's (1981) concept of interpersonal relationships was parity; everyone is essentially equal to one another. Believing that some people (including one's self) are superior or inferior to others will adversely affect one's interpersonal interactions.

Drugs is the final modality. This refers to the physical well being of the client. Does he or she have medical problems, physiological disorders, or physical handicaps? What kind of drugs, prescribed or illegal, is the person using? How much alcohol is consumed during the week? What does the client do to enhance his/her physical condition? Exercise, diet, and recreational activities would be included in this category.

A BASIC I.D. profile may look like the following example of a man who has trouble relaxing:

- B - Overworks, snaps at others when angry, overeats.
- A - Angry, anxious, depressed, fears not getting promotion.
- S - Tension headaches, upset stomach, muscle tightness.
- I - See myself getting fired.
- C - Not good enough, must be perfect to get ahead, nobody at work likes me. I am no good.
- I - Cranky with family and peers at work, avoids social functions.
- D - Overweight, high blood pressure, takes aspirin often, drinks after work regularly.

While the modalities are assessed independently as



separate dimensions, their influence upon one another cannot be overlooked in therapy. All of the modalities are interrelated. What affects one modality affects the others as well and each sheds some light on the others. For example, thoughts often reveal the meanings behind mental pictures. "I see myself getting fired." This image may reflect fear and anxiety about one's competency to do what is required in the job. It may also suggest that the above client thinks he is not a worthwhile individual. When he "snaps" at people when angry, it involves the behavior, interpersonal relations, and affective modalities simultaneously.

#### Rationale for the BASIC I.D. Profile

The goal of Multimodal Therapy is to examine the seven modalities that comprise the client's BASIC I.D. profile, determine how they interact and perpetuate the presenting problem(s), and determine which therapies are most appropriate for each modality. By taking this holistic approach to assessment, more of the client's strengths and weaknesses may be uncovered and later acted upon in therapy.

Likewise, when only the problems of one modality are treated, the problems in the other modalities remain and continue to contribute to the original problems. Without accounting for the influence of each modality on the other modalities, an effective, long lasting solution cannot be achieved (Lazarus, 1974). Therefore, by treating each modality, the client as a whole improves more quickly and is

better able to care for him/herself in the future than by treating only one modality. The underlying premise of Multimodal Therapy is that the more clients take with them from therapy, the more likely a lasting resolution to their problems can be made.

#### Applications of the BASIC I.D. Profile

Multimodal Therapy has been applied to a wide variety of problem areas. In his book, The Practice of Multimodal Therapy (1981), Lazarus gave examples of how to use this approach in marriage and sex therapy, treating alcoholism and drug abuse, as well as providing services for psychotics. In 1974, he described how the therapist can mobilize a variety of reinforcers across the entire spectrum of the BASIC I.D. profile to successfully treat clients with depression. Beaty (1980) applied the Multimodal approach to eliminate stuttering. He presented the case of a 15 year old stutterer to illustrate how Multimodal Therapy can integrate several separate procedures that have been effective in previous cases. Beaty noted that there was a wide variety of treatment interventions to eliminate stuttering, but they were usually very specific in scope. For example, some focused entirely on behavioral reinforcement, others involved only cognitive restructuring techniques, while still others were only concerned with changing the client's level of tension through biofeedback. The weakness he saw in these techniques was their lack of a systematic overall stratagem. By preparing a BASIC I.D.



profile on his 15 year old client, Beaty was able to assess the effect stuttering had on this young man across the seven BASIC I.D. modalities. In doing, so he identified several specific problems that could be treated by specific treatment procedures within each modality. The result was that the client eliminated his stuttering after seven weeks of Multimodal Therapy. Beaty claimed that a considerable amount of therapeutic time could be saved and a more structured knowledge of the problem could result from the use of the BASIC I.D. profile. Because Multimodal Therapy incorporates empirically proven techniques in a specific systematic and organized framework, Beaty argued that this model can eliminate the "hit and miss" approach to therapy.

The use of the BASIC I.D. profile in behavioral medicine was supported by Richard (1978) as a means of addressing the nonphysical factors involved in hypertension and migraine headaches. The advantage Richard saw in using the BASIC I.D. approach was that it reduced the possibility of overlooking important data and provided greater flexibility in selecting treatment interventions. To support this belief, he cited the case of a 57 year old man with hypertension. While developing the man's BASIC I.D. profile it was learned that there was a Cognition - Drugs - Affect interplay. The thoughts he had about his wife's criticism resulted in increasing his blood pressure which reinforced his fear of having a stroke. To counter this pattern, cognitive therapy was coupled with biofeedback to

successfully reduce the man's hypertension. Richard described a second case of a 43 year old woman suffering from migraine headaches. Prior to undergoing Multimodal Therapy, she was averaging three to four headaches a month. After 15 sessions, she reported having about one headache a month and was continuing therapy.

Implications for applying the BASIC I.D. profile to phobias have been presented by Popler (1977) and Edwards (1978). Popler detailed the effectiveness of the BASIC I.D. profile in identifying the myriad of symptoms pervasive in an agoraphobic's life. Edwards described a case of a 4 1/2 year old boy with an insect phobia that was successfully treated after assessing his symptoms with the BASIC I.D. profile. Two years after treatment there had been no recurrence of the phobic reaction.

Further uses of the BASIC I.D. profile include career counseling. Smith and Southern (1980) stated that the BASIC I.D. profile can be helpful in career counseling by identifying factors which may prevent individuals from succeeding in their jobs. Likewise, Seligman (1981) encouraged school counselors to use the BASIC I.D. profile when counseling high school students. Because Multimodal Therapy emphasizes personal growth and education of the client instead of pathology, Seligman believed that this approach was consistent with the accepted goals and philosophies of school counseling. She cited the case of a 16 year old high school sophomore who was successfully



treated for obesity and interpersonal relationship problems.

The BASIC I.D. profile also has been applied to treating mental health problems in children (Keat, 1976), the aged (Zgliczynski, 1978), and minorities (Slowinski, 1978). In each case the ease in which the BASIC I.D. profile systematically organized the assessment process was supported.

The popularity of Multimodal Therapy has transcended the individual therapist and has been adopted as the therapy of choice by mental health agencies. In such cases the BASIC I.D. profile has been used for assessment by all the members of the clinical team for large numbers of patients in institutional settings (Roberts, Jackson and Phelps, 1980; Brunell, 1978).

Brunell introduced Multimodal Therapy and its BASIC I.D. assessment approach to a 1,500 bed psychiatric hospital in New Jersey. She stated that the major advantage of the BASIC I.D. profile was that it avoided the hit and miss "shotgun" approach to treatment found in many traditional hospital settings. Under Brunell's direction, the Multimodal Intensive Treatment Program (MITP) was instituted in two wards of the hospital. Each ward averaged about 15 patients each. The professional team for each ward consisted of a psychologist, psychiatrist, social worker, psychiatric nurse, activity therapist, and auxiliary personnel such as the ward attendants. All members of the team were trained in the concept and use of the BASIC I.D.

profile. When a patient was admitted to the hospital, a psychologist developed an initial BASIC I.D. profile. After the patient arrived at the MITP ward, a more in-depth BASIC I.D. assessment was collectively conducted by the team. Each member provided input to both the problem list and the assigned treatments. The profile that emerged was the central focus for planning treatments and evaluating progress. As a result of team assessments, the need for specific treatments not currently in use at the hospital was recognized and established. Brunell concluded that the BASIC I.D. profile was ideally suited for a hospital setting.

Another application of the BASIC I.D. profile within an institutional setting was presented by Roberts, Jackson, and Phelps (1980). In a day treatment center servicing between 22 and 35 psychiatric outpatients, the BASIC I.D. profile was used as the primary assessment and treatment tool for all clinical functions. The staff consisted of three treatment teams, the director, and a psychiatrist. Each treatment team included both a caseworker and a social worker or psychiatric nurse. All staff members received training in the BASIC I.D. profile. Team meetings were held weekly with the director, during which the current updated BASIC I.D. profile of each patient was presented. At this time treatments would be assigned for each modality in new cases. For ongoing cases, treatments would be evaluated for their progress and modified as needed. In this way the



authors felt that the BASIC I.D. profile provided a means of systematically and consistently reassessing the patient at least weekly and adjusting the patient's treatment goals in line with his or her progress. From an administrative point of view the strength of this model was seen in its power to generate well informed decisions about the center's service delivery system. Like Brunell, these authors found problem areas that were not being addressed by any treatment interventions currently in use at the center. Therefore, with the aid of the weekly BASIC I.D. profile updates, treatment programs were initiated, eliminated or revised on the basis of the needs of the current patient population.

#### Criticisms of the BASIC I.D. Profile

While assessment and treatment approach of Multimodal Therapy and its BASIC I.D. profile appears reasonable and logical, its effectiveness has only been evaluated through case studies without empirical data to support its utility. Lazarus (1976, 1981) cited numerous examples of case studies covering a wide range of problems to demonstrate the effectiveness of the BASIC I.D. profile in assessment and treatment. As mentioned above Popler (1977), Beaty (1980), Richard (1978), Edwards (1978), Seligman (1981), and Smith and Southern, (1980) supported the use of the BASIC I.D. profile with successful case studies of their own. While case studies have identified individual successes, they often have neglected the failures. Furthermore, case study results have not provided an answer to the question of

whether or not other therapists would have had similar success if they had been in charge of the case. As such, case studies have not provided an accurate picture of the overall effectiveness (or ineffectiveness) of the BASIC I.D. profile. One way to examine its effectiveness is to conduct follow-up evaluations of clients who have been treated with the BASIC I.D. profile. Lazarus (1981) conducted a three year follow-up of "complex cases" and found that 70% had maintained their gains or continued to improve after completing therapy. Overall, Lazarus calculated that 75% of his clients had achieved their major treatment goals and three year follow-ups had revealed less than a 5% relapse rate. As another example of the efficacy of Multimodal Therapy and the use of the BASIC I.D. profile, Lazarus cited the 70% to 80% success rate of the Multimodal Therapy Institute in Kingston, New Jersey. However, Wolpe (1976) disputed the effectiveness of the BASIC I.D. profile. Conducting his own follow-up analysis of 122 cases treated with the BASIC I.D. profile, Wolpe found that 41 cases relapsed between one week and six years after therapy. That consisted of a 36% relapse rate which Wolpe claimed was ten times higher than that of behavior therapists.

Lazarus (1976) recognized the need for empirical research. He welcomed researchers to test his claims of efficacy of the BASIC I.D. profile in assessment and therapy through controlled studies. Those who have successfully used the BASIC I.D. profile with their clients also have



supported further research beyond subjective case studies (Popler, 1977; Smith and Southern, 1980; Brunell, 1978). Despite these calls for research very little empirical work has been done on the BASIC I.D. profile.

In fact, this lack of empirical research has been a major criticism of the BASIC I.D. profile as an assessment tool. Beck (1977) noted that Lazarus only offered his clinical reputation as proof of the efficacy of the Multimodal model. He took further exception with three assumptions he saw in the BASIC I.D. profile. For example, Beck did not fully agree with the assumption that more information is always better information. In the process of preparing the BASIC I.D. profile during a clinical interview, the therapist is directed to gather information for all seven modalities. The goal is to acquire a comprehensive set of facts about the client. Therefore, if any modality is left unexamined, it is assumed that an incomplete, and thereby, inaccurate picture of the client will result. However, Beck noted that in this zeal for thoroughness, some important information may be overlooked in one modality in the pursuit of gathering data from another modality. While completeness is a worthwhile goal, real world constraints limit the time a therapist will have to examine a client. A therapist's time may be better spent assessing two or three modalities in depth than all seven superficially.

Beck (1977) also took exception to the assumption that

an atheoretical position is the best approach to assessment and treatment. While he agreed that strictly abiding by one theory may not be justified, an atheoretical position leaves the therapist with "no guide as to what therapeutic tools to use and when to use them" (p. 294). As Genest and Turk (1981) pointed out, "how people work" models used in assessment are only as accurate as are their theories (p. 240).

Finally, Beck noted that Multimodal Therapy assumed that the BASIC I.D. modalities were not only independent of each other, but also carried the same degree of relevance. Beck dubbed this the "separate but equal" assumption (p. 293). In his analysis of the modalities, Beck found that many aspects of one modality overlapped with aspects of other modalities. For example, cognitive therapists traditionally considered imagery a form of cognition. Yet, in the BASIC I.D. profile imagery was a separate modality. Distinguishing between mental images and mental thoughts can be quite confusing for the therapist. Likewise, where does interpersonal behavior end and interpersonal relations begin? Instead of these modalities being equivalent, they appeared to Beck to represent varying degrees of abstraction. Sensations was a more abstract means of assessing the physical being than drugs. Imagery was more abstract than Cognitions, and Affect was more abstract than either one. Therefore, Beck argued that the therapist was looking at the same problem from different vantage points.



As a result the therapist was covering the same ground twice which may not make the model as cost-effective as Lazarus believed. In short, by assuming distinct separations among the modalities, Beck criticized that the BASIC I.D. profile obscured rather than promoted insight into therapeutic questions.

Others have criticized the BASIC I:D. profile for similar reasons. In their examination of the BASIC I.D. profile, Wilkins and Thorpe (1978) found that the modalities were inconsistently defined which resulted in confusion about which modality is responsible for what type of problems. For example, Behaviors (such as criticizing others or flirting) could be classified as elements of Interpersonal Relationships. Likewise, Imagery (seeing myself being fired from my job) and Cognition (I think I will be fired) are often too close in meaning to be separated into one modality or another. Lazarus answered this attack by stating that it is not necessary to make "perfect fits" so long as the problem area is identified. Once identified anywhere in the BASIC I.D. profile, it will receive treatment (Lazarus, 1981). Therefore, a rigid definition of the criteria for each modality was not necessary.

However, as Wilkins and Thorpe pointed out, the inconsistency found in therapists independently defining the criteria for each modality had resulted in distortions and embellishments of the modalities. Seligman (1981) expanded

the Cognition modality to include poor study habits in high school students. A further embellishment of the modalities was made by Keat (1976) when he added the school environment to the Sensation modality. Another departure from Lazarus's original BASIC I.D. profile was initiated by Slaikeu (1984) when he adapted the BASIC I.D. for crisis intervention assessment. He reduced the acronym to a five modality BASIC personality. In Slaikeu's version Drugs was eliminated. Health related habits (proper diet, smoking, exercise) were identified under Behavior and physiological well-being and physical sensations were coded under the Somatic modality which replaced Sensations. Imagery was combined with Cognition as an all inclusive mental functioning modality which left Interpersonal relations as the only "I." While these embellishments may attest to the flexibility of the BASIC I.D. profile in providing assessment and treatment, they do not add consistency or uniformity to its use. As such, elements of the BASIC I.D. profile may not have the systematic integrity that its supporters have claimed.

Wolpe (1976) attacked Lazarus as being a behavioral therapy malcontent. When Lazarus advocated "going beyond" behavior therapy by adding other "effective techniques," Wolpe complained that these other techniques often had not been supported by sufficient data to justify their use. In addition, Wolpe stated that the BASIC I.D. modalities were simply background knowledge evident to every psychologist. The behavioral therapist routinely assessed such



"personalized" knowledge about the client's overall strengths and weaknesses and did not need to be reminded of them with a format like the BASIC I.D. profile. In short, Wolpe implied that the BASIC I.D. profile was a waste of time. Without empirical data to support Lazarus's claims, Wolpe could not recommend the use of the BASIC I.D. profile.

While Wolpe saw no benefit in the BASIC I.D. profile and Beck suggested that the seven modalities may be too many, Nay (1979) stated that the BASIC I.D. profile fell short of being complete. Because the BASIC I.D. profile focuses heavily upon the person, it may be easy to neglect the socio-cultural influences on the client. Nay advocated that more emphasis should be placed upon the cultural milieu and physical setting in which the client functions.

#### Statement of the Problem

The purpose of the BASIC I.D. profile as an assessment tool is to develop a profile of the client which highlights the areas of discord and identifies his/her strengths. The question is, can two or more therapists look at the same client and develop a similar profile? Because of the lack of empirical evidence about the perceived strengths and/or weaknesses of using the BASIC I.D. profile, it is uncertain how reliable this assessment approach is. Two or more therapists may view the same client and develop entirely different BASIC I.D. profiles. Or, they may agree in the identification of strengths and weaknesses in some modalities but not others. The purpose of this study is to

provide empirical data about the BASIC I.D. profile.

Because the validity of an instrument is limited by its reliability, the first question to be empirically answered about the BASIC I.D. profile should be its degree of reliability. Interrater agreement has been considered a satisfactory measure of reliability in diagnosis and assessment approaches (Kazdin, 1977). When applied to psychotherapy interrater agreement involves the amount of agreement among therapists' observations and clinical judgments. Therefore, interrater agreement can be referred to as the amount of agreement among raters who independently assess the same clinical aspects of a subject (Kazdin, 1977). For the BASIC I.D. profile interrater agreement would include the amount of agreement several therapists would have in observing and noting characteristics within the seven modalities.

Specific areas of concerns in this study include the following questions. Can several raters notice the same characteristics in the same subject? If significant disagreements occur, do they occur most often in certain modalities?

The answers to these questions are important because an accurate and dependable assessment technique is needed for the best treatment to be rendered. Lazarus (1976, 1981, 1984) assumed that the seven modalities of the BASIC I.D. profile provided a systematic and comprehensive means of identifying problems. However, if different therapists were



to see different problems in the same client when developing their BASIC I.D. profiles, then Lazarus's method of assessment may be no more useful than any other personalized assessment style as Wolpe (1976) suggested. On the other hand, if raters can notice the same characteristics while assessing the client's modalities, one can conclude that the BASIC I.D. profile does provide a consistent framework for developing a comprehensive assessment for therapy planning.

Another area of concern is the amount of influence the therapist's own BASIC I.D. profile plays in assessment. If the BASIC I.D. profile is a map of one's personality, as Lazarus (1981) claimed, certain modalities may be stronger and more influential in one's life than in that of others. These influences could have significant repercussions during the assessment process. Can a therapist objectively look at a client and develop an accurate profile, or will he/she unknowingly be more cognizant of aspects in the client's modalities that are also strongest in the therapist's profile? If the therapist's stronger modalities color his/her perception of the client, the therapist may tend to "personalize" the client's BASIC I.D. profile after his/her own. If this is the case, the therapist's objectivity would be hampered and interrater agreement could be greatly reduced.

Therefore, the objectives of this study will be to provide empirical data about the BASIC I.D. profile as an assessment tool by (a) measuring the amount of interrater

agreement among therapists examining the same clients; (b) determining which modalities (if any) have the most and the least amount of interrater agreement; and (c) investigating the relationship between the therapist's BASIC I.D. profile and his/her assignments of problems to the clients' profiles.



## CHAPTER III

### Method

#### Participants

##### Raters

Fifteen graduate students in clinical and school psychology at Western Kentucky University volunteered to serve as raters for this study. As students, their coursework in psychotherapy exposed them to a wide variety of therapeutic approaches, but they had little practical experience in implementing these approaches. A reason for selecting graduate students as raters was their lack of experience. It was hypothesized that if graduate students could grasp the concepts of the BASIC I.D. profile and apply them, then experienced therapists should be able to do the same.

##### Subjects

The subjects consisted of seven individuals who agreed to play the part of a client during a simulated, videotaped assessment interview. Five of the subjects were university students majoring in drama and theater, ages 18 to 28. The other two subjects, 33 and 40 years old, worked at the community theatrical arts center.

### Interviewers

Two interviewers served as therapists during the simulated, videotaped assessment interview. Five subjects were interviewed by the experimenter and four subjects were interviewed by a licensed psychologist having extensive clinical experience with Multimodal Therapy.

### Procedures

#### Preparation of Videotapes

Seven "initial interview" videotapes were prepared which would be viewed by the raters. These "initial interviews" simulated the interaction between a client (subject) and a therapist (interviewer) during their first meeting. In this experiment, the interview was designed to elicit information from the subjects about themselves. The interviews were videotaped by technicians at the Western Kentucky University Audio-Visual Center and dubbed onto a VHS videotape capable of being played on a VHS video recorder. In preparation of the interview films, each subject was given a short vignette describing a client with a particular set of problem areas. Appendix F contains the vignettes used in this study. From this brief description, the subject was free to develop the character of the client as realistically as possible. To avoid biasing the subjects' portrayal of their characters, none of the subjects were trained in the concepts of the BASIC I.D. profile. The subjects were only told to play their parts as realistically as possible. Because the vignettes used by



the subjects to develop their role addressed each modality, it was not necessary for the interviewer to directly mention the modalities during the interview. The interviewer conducted the interview in an open ended manner, reflecting on the subject's feelings and experiences. The primary task of the interviewer was to encourage subjects to talk until most of the strengths and weaknesses of the client listed on the vignette were presented. In this manner each modality of the BASIC I.D. profile was presented without referring to it specifically. To enhance the realistic quality and spontaneity of the interviews, they were not rehearsed ahead of time. Instead, the interviews were videotaped at the first meeting between subject and interviewer. Furthermore, the experienced interviewer was not briefed about the type of clients he would be seeing before the interview, which added to realism of his interviews. While the subjects were acting out the characteristics of the client depicted in the assigned vignettes, they seemed to embellish the parts they played to fit their own personalities. These embellishments increased the realism of the interview and provided another source of personal data in addition to the data found on the vignettes. The interviews with the subjects ranged from eleven minutes to nineteen minutes in length, resulting in a total viewing time of about two hours for the seven interviews.

#### Training of Raters

As a group the raters were trained by the experimenter

in the concepts of the BASIC I.D. profile and its implications for assessment. Appendix A provides an overview of the BASIC I.D. profile and definitions of each modality as presented to the raters during training. In order to present Lazarus' conception of the BASIC I.D. profile as accurately as possible, the training was heavily influenced by his book The Practice of Multimodal Therapy (1981). To illustrate his point of view, Lazarus's videotape, "The Assessment/Therapy Connection" by Multimodal Publications, Inc. (1981), was shown during the training session. After the raters were trained in the structure and purpose of the BASIC I.D. profile, they were instructed in how to fill out the BASIC I.D. Assessment Chart and Problem Areas Sheet which would be used to evaluate interrater agreement. Appendix B is a copy of the BASIC I.D. Assessment Chart and Appendix C contains a copy of the Problem Areas Sheet. To insure that all the raters understood the concepts of the BASIC I.D. profile, one of the seven "initial interview" films served as a practice film during training. After viewing the practice film, the raters completed a BASIC I.D. Assessment Chart and Problem Areas Sheet and discussed the results. Any misunderstandings or ambiguities of the BASIC I.D. process were clarified at that time. Also, any procedural mistakes made in filling out the forms were corrected. The training was completed within two and one half hours. The goal of this training was to provide all the raters with a common



base of knowledge in the BASIC I.D. profile.

### Rating the Subjects

At the end of the training session the raters were asked to view the remaining six "initial interview" films and complete the BASIC I.D. Assessment Chart and the Problem Areas Sheet for each client (subject) portrayed in the films. The BASIC I.D. Assessment Chart required the rater to identify a maximum of four (4) personal characteristics for each modality per subject from a list of thirty characteristics that described that modality. Because the list of all possible personal characteristics that could describe a specific modality would be infinite, thirty characteristics were arbitrarily chosen to represent each modality of the BASIC I.D. profile. If the raters observed less than four characteristics, they were to circle only those characteristics. If they noticed more than four, the raters were instructed to circle the four characteristics that best described that modality for that subject. The Problem Areas Sheet was used to record a frequency count of the number of problem areas found in each modality per subject. To complete the Problem Areas Sheet, the raters were asked count the number of problems they identified in each modality for each client regardless of whether or not it was listed on the BASIC I.D. Assessment Chart. A problem area was defined as any behavior, emotion, physical sensation, image, thought/belief, inadequacy in interpersonal skills, or physiological disturbance that had

a negative influence on the psychological well-being and day-to-day functioning of the client. Problem areas, therefore, were those areas that would have been targeted for treatment if the raters had been therapists responsible for the case illustrated in the videotape. The major difference between the Assessment Chart and the Problem Areas Sheet was that the Chart restricted the rater to finding a maximum of four specific characteristics, positive or negative. The Problem Areas Sheet on the other hand allowed the rater to identify all the negative characteristics influencing the client.

When developing BASIC I.D. profiles for clients, a list the strengths and weaknesses in each modality is made. However, it is possible that the raters, and therapists in actual practice, may be influenced by the structure of their own BASIC I.D. profiles. For example, a rater with a strong ability to form mental pictures may be inclined to notice more strengths and weaknesses in a client's imagery modality. In order to evaluate the effects of the raters' BASIC I.D. profile on their assessment observation, the raters were required to prepare a Structural Profile (1984) on themselves. Appendix D provides a copy of the Structural Profile. Raters rated themselves on a scale of 1 (very low) to 10 (very high) for each of the seven BASIC I.D. modalities. To determine whether there was a correlation between the raters' personal BASIC I.D. profiles and the problems they saw in the subjects,



their Structured Profiles were compared with their Problem Areas Sheets.

### Analysis

#### Kappa Coefficient

A modification of the kappa statistic, which corrects for chance agreement, was employed to compute the level of agreement among the raters for each modality based upon the BASIC I.D. Assessment Charts. Kappa was originally designed for measuring agreement between only two raters who are rating the same subjects (Cohen, 1960). Fleiss (1971) modified kappa for use by multiple raters. Fleiss's procedure is useful when each rater is restricted to assigning the subject to the same number of categories or characteristics. However, when raters assign subjects to varying numbers of categories, then Fleiss's procedure is inadequate. That is, Fleiss does not account for multiple assignments or missing data in the calculation of kappa across multiple raters. The present study required that each rater assign the subject to one to four characteristics for each modality. If a variable number of ratings assigned by raters across subjects per modality were applied to Fleiss's formula, the result would be artificially low kappa values. This underestimation of kappa results from using the total possible rather than actual total number of ratings assigned. For example, using Fleiss's formula (see equation 1),  $n$  equals the number of ratings per subject.

$$P_i = \frac{1}{n(n-1)} (\sum n_{ij}^2 - n), \quad (1)$$

where  $P_i$  represents the proportion of agreement among the raters and  $\sum n_{ij}$  is defined as the number of raters who assigned the  $i$ th subject to the  $j$ th category. If 15 raters assign one rating per subject, then  $n = 15$  and Fliess's formula may be used. However, if the 15 raters may assign from one to four ratings per subject, then  $n = 15$  to 60. The appropriate  $n$  to use, then, is the average number of ratings assigned by each rater. If 45 ratings were assigned by 15 raters, then  $n = 45/15 = 3$ , resulting in a weighted formula as shown in equation 2.

$$P_i = \frac{1}{n(n-1)} [n/n' (\sum n_{ij}^2) - n], \quad (2)$$

where  $n$  is the actual number of ratings per subject and  $n'$  is the number of raters participating in making assignments. The weighting does not affect the integrity of Fliess's procedure. If each rater assigns only one rating, then  $n/n' = 1$  and Fliess's procedure remains unchanged.

The other modification necessary to the present study involved a reconsideration of the error term ( $P_e$ ) in Fliess's formula as shown in equation 3.



$$P_e = \sum p_j^2, \quad (3)$$

where  $P_e$  represents the mean proportion of agreement one would expect if the raters make their assignments purely at random;  $p_j$  is the proportion of all ratings assigned to the  $j$ th category. Under Fliess's procedure,  $p_j$  was simply the number of assignments per category divided by the total number of assignments. Because each rater made the same number of assignments, the total number of assignments remained constant for each category. However, in this study the total number of assignments ranged from 15 to 60 (each of the 15 raters could assign each subject to 1 to 4 categories). One could arrive at  $P_j$  by dividing the total number of ratings per category for all the subjects by the maximum number of assignments possible by the raters (15 raters X 4 assignments X 6 subjects = 360). Unfortunately, two difficulties are encountered if the maximum number of assignments possible is used. First, some studies may not wish to limit the raters to a certain number of assignments, but prefer to allow them to make assignments into as many categories as they deem necessary. Theoretically, a rater could make an infinite number of assignments. Therefore, if raters are not restricted to assigning a maximum number of ratings per subject, there is no ceiling number to determine a possible total. Second, if the maximum number of assignments possible is used, then a smaller error term

results. This smaller error term would then provide a higher kappa coefficient. By computing the error term ( $P_e$ ) using the actual total number of ratings given, a larger error term results and provides a more conservative estimate of kappa. For these reasons the experimenter used the actual number of total ratings given by all the raters in this study.

The modified kappa coefficient based on the average number of actual ratings assigned by each rater (see equation 2 for the formula) was used to measure the degree of agreement among the 15 raters in each modality of the BASIC I.D. Assessment Chart.

#### Pearson Product-Moment Correlation Coefficient

To determine the degree of relationship between the raters' Structural Profiles and their Problem Areas Sheets, the Pearson Product Moment Correlation coefficient was calculated. The purpose of this analysis was to account for the influence, if any, on the raters' agreement due to individual differences among raters' own BASIC I.D. profile.



## CHAPTER IV

### Results

#### Kappa Coefficient

Table 1 contains the kappa coefficients for the BASIC I.D. Assessment Charts indicating interrater agreement for each modality of the BASIC I.D. profile. Kappa coefficients ranged from a high of .59 for Sensations to a low of .42 for Affect.

#### Pearson Product-Moment Correlation

To determine the degree of relationship between the raters's personal BASIC I.D. profiles and the raters's perception of problem areas within the subject's BASIC I.D. profile, a Pearson product-moment correlation coefficient was computed for each modality. The raters' Structural Profiles, which displayed the rater's personal BASIC I.D. profile, was compared to their Problem Area Sheets which identified the total number of problem areas discovered in each modality. Three raters failed to correctly complete these forms and were dropped from the correlation analysis, leaving a total of 12 raters. The Pearson correlation coefficient was computed for each modality to show whether or not the rater's own highs and lows within his/her BASIC I.D. profile significantly influenced his or her judgment in assessing the BASIC I.D. profile of the subject. The

results are shown in Table 2. Pearson correlations coefficients ranged from .48 for Behavior to  $-.16$  for Cognitions. No coefficient was significant at the  $p \leq .05$  level.



TABLE 1  
BASIC I.D. ASSESSMENT CHARTS:  
KAPPA COEFFICIENTS BY MODALITY

<u>MODALITY</u>	<u>k</u>
Behaviors	.54
Affect	.42
Sensations	.59
Imagery	.48
Cognitions	.43
Interpersonal Relations	.46
Drugs	.53
N = 15	

TABLE 2  
PEARSON PRODUCT-MOMENT CORRELATIONS BETWEEN  
PROBLEM AREAS IDENTIFIED and RATER'S STRUCTUAL PROFILE

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MODALITIES	r
Behaviors	.48
Affect	-.12
Sensations	-.12
Imagery	.34
Cognitions	-.16
Interpersonal Relations	.06
Drugs	-.07
N = 12	

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## CHAPTER V

### Discussion

The purpose of this study was to evaluate the interrater agreement of the BASIC I.D. profile when used for clinical assessment. Because interrater agreement can be affected by a number of variables, accounting for the variance in interrater agreement is important in evaluating the usefulness of the BASIC I.D. profile. One variable that could severely limit the usefulness of the BASIC I.D. profile, by influencing the objectivity of the rater, is the rater's own BASIC I.D. profile. Therefore, the correlation between the rater's own personal BASIC I.D. profile and his/her assessment of the problems areas of the subjects was established to determine if this relationship significantly affected the rater's objectivity in assessment.

#### Differences Among Modalities

The kappa statistics yielded for the BASIC I.D. Assessments Charts suggest that the raters did notice with consistency similar characteristics within the same subject.

Sensations was the modality with the highest interrater agreement. The reason for this appears to lie in the fact that Sensation ratings are largely based upon the subject's self-report. During the interview, as the subjects discussed their problems, the subjects often stated whether

they had headaches, queasy stomachs, or other aches and pains. Because of these specific admissions, little was left for inference on the part of the raters. Nevertheless, some subjective evaluations occurred. For example, not all subjects directly mentioned being tense. However, the characteristic "tension" was observed in all subjects, resulting in its being the most frequent characteristic assigned in this modality. Therefore, the raters may have inferred from other sources (e.g. body language or manner of speech) that the subjects appeared to be tense. The tension exhibited by the subjects was most likely genuine. Prior to the interviews several of the subjects stated they were "nervous" about being videotaped.

Behaviors was the modality producing the second greatest kappa coefficient. Behaviors involved not only what the rater could directly observe (e.g. hand wringing and other nervous gestures), but also what the subject reported doing (e.g. suicidal attempts, compulsive acts). These self-reported behaviors provided objective data for the raters to make decisions about what assignments to make under the Behavior modality.

Drugs resulted in the third highest proportion of interrater agreement as measured by the kappa coefficient. Raters made the least number of assignments in the Drugs modality, but they were consistent in which characteristics they made their assignments. The specific nature of the Drugs modality may have provided clearer choices for the



↑

raters than other modalities containing a greater number of ambiguous choices. For example, the Drugs modality was concerned with descriptive choices such as "Physical handicap" and "Sleep irregularities" which were often reported directly by the subject. If the subject did not mention a specific characteristic listed among the Drugs modality choices in the BASIC I.D. Assessment Chart, most raters did not make a choice. In other modalities the raters appeared more likely to make choices based on indirect data from the subject (e.g. body language, tone of voice, and verbal reports suggesting a choice but not directly stating a choice). In other words, the raters appeared more conservative in rating information about the Drugs modality. Reasons for this conservatism could be that the Drugs modality was concerned with the subject's physical well-being instead of his/her psychological well-being. As such, the raters may have felt less competent in this area to make a choice without direct confirmation from the subject. Or, they may have been less receptive to the cues given by the subject for the Drugs modality due to its nonpsychological nature. Nevertheless, the Drugs modality obtained a kappa coefficient of .53 indicating that the raters were consistent about what they were willing to commit themselves to. Their consistency may be accounted for by the fact that the raters more often chose characteristics describing behaviors which indicated the subject's concern for his or her physical well-being instead

of choosing characteristics describing physiological traits. As such, "regular exercise" was the most common choice among raters in the Drugs modality. Relying on a physician's judgment became the second most preferred choice: "Taking medication prescribed by physician" and "Currently under physician's care." Items calling for a subjective judgment about the subject, such as being overweight or susceptible to illnesses, were chosen less often. Interestingly, 13 of the 15 raters rated one the subjects to be psychologically addicted to a drug, while 4 rated her as physically addicted (two raters rated the subject as being physically as well as psychologically addicted). Therefore, the raters may have been more comfortable operating in a psychological mode.

The remaining four modalities required a greater degree of subjective judgment on the part of the rater. Occasionally, the subject would directly pinpoint an characteristic by saying that "I feel angry" or "I have trouble making friends." Overall, however, emotions, images, cognitions, and interpersonal skills had to be inferred indirectly by what the subject said and the way he/she acted.

In examining the data, it was of interest to note the characteristics in the BASIC I.D. Assessment Chart that received the most assignments by the raters. Appendix G provides tables displaying the frequency of assignments by the raters in each modality. Under the Behaviors modality, "nervous gestures" was observed by at least one rater in



five out of six subjects and represented about 19% of the total assignments. A "lack of involvement in activities" was the second most frequent Behavior characteristic with 13% of all assignments. "Appears anxious," "fearful," and/or "depressed" were the most frequent Affect characteristics noticed. In Sensations, "tensions" accounted for 28% of the total assignments. "Being an outsider/not fitting in with others" and images of "failing" were the most frequent assignments under Imagery. The frequently assigned Imagery characteristics were similar to the most frequently assigned Cognitions characteristic, "I am different; not like other people." Other frequently assigned Cognitions were "obsessions," "suicidal thoughts," and "The future is bleak/ nothing to look forward to." "Having difficulty in making and keeping friends" was the most frequent Interpersonal Relations characteristic cited. Under the Drugs modality references to exercise and/or medical treatment were the most common assignments.

In conducting the analysis, there was a concern that one subject may skew the results by having unusually good or unusually poor agreement among the raters. Appendix H provide tables showing the BASIC I.D. Assessment Chart ratings assigned to each subject. There does not appear to be one subject that was unusually easy or difficult for the raters. None of the subjects appeared to provide unusually good or poor agreement across all seven modalities.

### Differences Between Interviewers

In order to see if one interviewer had a greater effect on the amount of agreement than the other interviewer, kappa coefficients were computed for each interviewer. The licensed psychologist was considered the experienced interviewer. Of the subjects used in the analysis, the experienced interviewer talked with subjects numbers 1, 3, and 5. This experimenter was considered the inexperienced interviewer who talked to subjects 2, 4, and 6. Table 3 shows the kappa coefficients for each interviewer by modality. The raters do not appear to have been biased by the interviewer. The experienced interviewer had a higher kappa coefficient in four of the modalities and the inexperienced interviewer had a higher kappa coefficient in three of the seven modalities. However, it is difficult to infer meaningful conclusions from the data on Table 3 because the kappa coefficients are based on only three subjects per interviewer and each interviewer talked to different subjects.

### Sources of Variance

#### Rater Variables

In attempting to account for sources of variance in the kappa coefficients for each modality, one needs to examine the individual differences of the raters. The raters' differing abilities to interpret body language may have influenced the amount of agreement obtained in each modality. Raters may have perceived events differently or



TABLE 3  
BASIC I.D. ASSESSMENT CHARTS :  
KAPPA COEFFICIENTS BY INTERVIEWERS

MODALITY	EXPERIENCED INTERVIEWER	INEXPERIENCED INTERVIEWER
Behaviors	.51	.54
Affect	.42	.40
Sensations	.52	.64
Imagery	.51	.43
Cognitions	.37	.47
Interpersonal Relationships	.52	.39
Drugs	.59	.42
N = 3		

placed different importance on different modalities. Another source of variance associated with the individual differences of the raters would be the level of understanding each rater had about each modality. A rater may have understood one modality more fully than another modality through training or previous experience. However, one study examining the interrater agreement of diagnoses made by physicians, psychologists, and social workers revealed no difference with regard to professional background or years of experience (Andreasen, McDonald-Scott, Grove, Keller, Shapiro, Hirschfeld, 1982).

Other variables that account for disagreements in the choices made by the raters include individual bias and observer drift (Wildman & Erickson, 1977, Kazdin, 1977). There is a possibility that a rater may unknowingly develop a bias for or against one of the modalities. If a rater did not understand the function of one modality, he/she may have passed over those characteristics more quickly than others. There is also the possibility that a rater may redefine the characteristics in the BASIC I.D. Assessment Chart as the rating period continues. This redefining process, known as observer drift, may result from increased familiarity with the characteristics being observed. Fatigue may also cause observer drift by the raters oversimplifying the definitions of each characteristic as the number of ratings increases.

#### Target Variables

The number and type of characteristics targeted for



ratings will influence the amount of agreement among raters. In situations having a large number of behaviors to be observed and rated, Kapust and Nelson (1984) found low interrater agreements. Likewise, researchers have found a significant negative correlation between interrater agreement and the complexity and diversity of the characteristics being rated (Nay, 1979; Kazdin, 1977). In completing the BASIC I.D. Assessment Chart for the present study, the raters were required to rate thirty characteristics across seven different modalities for a total of 210 characteristics. Yet, with all these characteristics to keep in mind, they demonstrated kappa coefficients ranging from .42 to .59 among the modalities.

Andreasen, et. al (1982), in their study of the sources of variance affecting diagnostic reliability, noted that characteristics with the lowest interrater agreement tended to be those that were difficult to define precisely or that involved continuous phenomena. As might be expected, the two modalities yielding the lowest rates of agreement in this study were Affect and Cognitions. Both dealt with abstract concepts such as "feeling annoyed" and "striving for perfection." Perhaps, the low level of interrater agreements for Affect and Cognitions was due in part to the individual definitions that the raters attached to these characteristics. Another source of variance could be what Andreasen et. al called "threshold variability." Individual raters will vary in the threshold, or degree of strength, a

characteristic must demonstrate before he or she decides to include the characteristic in the ratings. Therefore, several raters may have noticed the same strengths and weaknesses in the subject, but some would have deemed them too weak to be counted.

Disagreements among the raters about which characteristics should be chosen during the ratings may be accounted for by differences in the ways the raters viewed the subjects. For example, individual observation styles in viewing videotapes may have accounted for some of the variance. In order to reduce this variance in the present study, the raters shared the same training program and participated in rating a practice film during training. With this common training the raters may have developed similar observation styles.

#### Rater's BASIC I.D. Profile

One possible source of variance that does not appear to have significantly influenced interrater agreement was the raters' own BASIC I.D. profiles. The correlations between the raters' Structural Profiles and the Problem Areas Sheets for each modality were not significant, indicating that the raters maintained an objective view of the subjects during their ratings. Although not reaching significance, the greatest positive correlations were in the Behaviors and Imagery modalities. In psychotherapies which focus on behavioral or imagery techniques, therapists who are inclined to be "doers" and "dreamers" (refer to the



Structural Profile form in Appendix C for definitions) may notice the actions of others or be sensitive to the images of others more than other therapists. However, the data in this study did not substantiate that conclusion. After examining the data it was noticed that one rater identified much larger numbers of problem areas for each of the modalities than the other raters. Table 4 provides the mean, mode, standard deviation, minimum and maximum number of problem areas identified by the raters. Descriptive statistics for the raters' self-ratings of their own BASIC I.D. profiles are provided in Table 5. None of the raters deviated widely from the rest of the raters in their self-ratings. Overall, the raters appeared to maintain an objective view of the subject despite the strengths and weaknesses of the raters' personal BASIC I.D. profiles as defined by the Structural Profile form.

#### Limitations of the Study

A caveat should be mentioned about the levels of agreement in this study. The raters were passive observers, not participants in the interview. They were limited to the assessment style of the interviewer in the film. This style was deliberately kept vague so as not to provide the raters with direct information about the subject's BASIC I.D. profile. The purpose behind this interviewing approach was to let the majority of the information about the subject come from the subject. Furthermore, the subjects were encouraged to present their problems in their own words. As

TABLE 4DESCRIPTIVE STATISTICS:PROBLEM AREAS IDENTIFIED by the RATER

MODALITY	MEAN	MODE	SD	MIN	MAX
Behaviors	21	12 & 21	14.02	5	59
Affect	21	8 & 20	10.03	8	41
Sensations	11	8	4.22	3	18
Imagery	17	14 & 17	5.52	6	26
Cognitions	21	19	2.99	8	41
Interpersonal Relationships	19	18 & 24	8.17	6	33
Drugs	9	3 & 16	5.25	2	16
N =12					

Note. SD = Standard Deviation; MIN = minimum number of problem areas noticed by a rater; MAX = maximum number of problem areas noticed by a rater.



TABLE 5DESCRIPTIVE STATISTICS:STRUCTURAL PROFILE of RATER'S SELF-RATING of OWN MODALITY

MODALITY	MEAN	MODE	SD	MIN	MAX
Behaviors	7.08	8	1.71	4	9
Affect	7.00	6	1.58	5	10
Sensations	6.08	5	1.61	3	8
Imagery	7.25	9	1.69	4	9
Cognitions	7.67	9	1.69	4	9
Interpersonal Relationships	7.83	7	1.14	6	10
Drugs	7.25	8	1.36	4	9

N = 15

Note. SD = Standard Deviation; MIN = level of self-rating by a rater; MAX = maximum level of self-rating by a rater.

a result the raters were provided with brief statements about the subject's problems and some general background information. In actual therapy sessions the therapist would have the freedom to spend more time exploring specific problems and assessing each modality as needed. The limited amount of information provided to the raters and the fact they could not control the interview provided a conservative parameter within which to reach agreement.

It should also be noted that the Structural Profile, like the BASIC I.D. profile, suffers from a lack of reliability and validity studies. Therefore, the results of the correlation between the results of the raters' Structural Profiles and their identification of problem areas should be viewed with caution until a more standardized measure of one's BASIC I.D. profile is developed. However, until a standardized measure is developed, this experimenter considers the Structural Profile the best numerical measure of a person's BASIC I.D. profile.

#### Conclusions

Overall, considering the complexity of the task facing the raters and the conservative nature of the kappa statistic, the range of kappa coefficients from .42 to .59 among the seven modalities was acceptable. When reviewing a BASIC I.D. profile prepared by a therapist, one can conservatively assume that another therapist looking at the same client would probably identify the same characteristics



between 42% and 59% of the time. The raters were able to notice specific targets of behaviors, emotions, sensations, mental pictures, thoughts and values, interpersonal strengths and weaknesses, and physiological factors with reasonable agreement. From a practical standpoint it appears that therapists using the BASIC I.D. profile for assessment would be able to agree upon the most predominate strengths and weaknesses presented by the client.

In evaluating the BASIC I.D. profile, one must also consider the degree of disagreement among the raters' judgment. However, this disagreement may not be undesirable. Lazarus (1981) intended the BASIC I.D. profile to be an approach that facilitated assessment, not a mechanistic system that left no discretion to the therapist. Likewise, Nelson (1983) stated that a standardized set of behavioral assessment techniques with high degrees of psychometric accuracy are not only impractical to develop, but are also undesirable. She believed that it was important to notice separate behaviors (and one can expand her belief to include the other six modalities of the BASIC I.D. profile) for their individual significance. In other words, assessment strategies should be evaluated for their functional benefits rather than their structural soundness. If Nelson is correct, the BASIC I.D. profile offers a sound functional approach to assessment. It may be modified to be applicable to almost any type of client. Additionally, the results of this study indicate that the BASIC I.D. profile offers an

acceptable degree of structural soundness with regard to interrater agreement.

While the agreement about characteristics noticed in the seven modalities by the raters was acceptable, there was not perfect agreement among the raters. In order to maximize the assessment quality of the BASIC I.D. profile, it may be most useful in an inpatient hospital setting where a team approach to assessment and treatment is used. With each member of a treatment team developing a BASIC I.D. profile that is later merged into a composite profile at staff meetings, a detailed and comprehensive assessment can be achieved.

Future studies of interrater agreement of the BASIC I.D. profile need to examine the effects of professional orientation and experience in using the BASIC I.D. profile. Also, intrarater stability needs to be established to see if a rater can develop a similar BASIC I.D. profile for the same initial interview over time.

Being able to accurately identify and later treat as many problem areas as possible across the seven modalities was one of Lazarus's major assessment goals for the BASIC I.D. profile (1981). While the present study focused on the ability of a rater to notice specific characteristics within the seven modalities of the BASIC I.D. profile, further studies are needed to replicate this study and examine the ability of therapists to accurately address all the problems presented in the videotapes. If the BASIC I.D. profile is



shown to reliably and accurately identify the strengths and weaknesses of the client's personality and lifestyle, then studies examining its usefulness in assigning appropriate treatment plans and its effectiveness in evaluating treatment progress should be conducted. It would be interesting to compare the use of the BASIC I.D. profile with the SORC or Nay's Multimethod approach to assessment to see which approach is most effective in arriving at a detailed diagnosis.

One of the major criticisms about the BASIC I.D. profile has been its lack of empirical support. This study has generated data which therapists can use to empirically evaluate the effectiveness of the BASIC I.D. profile.

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APPENDIX A



## AN OVERVIEW OF THE BASIC I.D. PROFILE

<u>MODALITIES</u>	<u>DESCRIPTION</u>	<u>EXAMPLES</u>
BEHAVIOR	This modality limits itself to specific behaviors, actions and responses that can be observed, counted, and measured. It is what people do and do not do.	Gestures Avoidance Rituals Overeating Yells at spouse.
AFFECT	This is the emotional realm of the client. Its purpose is to gauge the strength of his/her feelings and to connect them to their precipitating event.	Anger Anxiety Depressed Fear, Panic Frustration Pride
SENSATION	All of the bodily sensations are included in this modality. Visual impressions, auditory reactions, pleasant odors, as well as tactile responses such as pain, cold, and pressure.	Sweaty plams Tremors Aches and pains Blurred vision Dizziness
IMAGERY	This refers to the various mental pictures that influence the client's life. They may be visual and/or auditory.	Self-image Imagine of being laughed at. See self failing.

COGNITIONS	Thoughts, ideas, beliefs, attitudes and values make up this modality.	Sex is dirty. I should be nice to everybody.
INTERPERSONAL RELATIONSHIPS	This is concerned with how a person relates to others and how they in turn respond. It involves person-to-person communication in not only the spoken word but in "body language" or "paralinguist cues."	Makes friends easily. Timid around the opposite sex. Hermit-like
DRUGS	The physical aspect of the person including the medications being taken, diet, exercise habits, and general physical shape and physiological condition.	Overweight Alcoholic Takes valium. Plays tennis regularly.



APPENDIX B

## BASIC I.D. ASSESSMENT CHART

Client's Name:

BEHAVIORS: Please circle one to a maximum of four (4) numbers that describe the client's most descriptive behaviors. These may be observed directly or related by the client.

- |   |   |
|---|---|
| 1. Eating problem (eats too much or too little) | 16. Avoids responsibilities                 |
| 2. Lack of involvement in activities            | 17. Overcautious/ avoids risks              |
| 3. Procrastinates                               | 18. Rapid speech                            |
| 4. Takes too many risks                         | 19. Labored breathing/ sighing              |
| 5. Drinks alcohol excessively                   | 20. Phobic avoidance                        |
| 6. Takes drugs (legal/illegal)                  | 21. Poor work habits                        |
| 7. Poor posture                                 | 22. Works well at job                       |
| 8. Smokes                                       | 23. Violent behavior                        |
| 9. Poor study habits                            | 24. Temper tantrums                         |
| 10. Suicide attempt(s)                          | 25. Crying                                  |
| 11. Compulsions                                 | 26. Withdrawn                               |
| 12. Criminal behavior                           | 27. Starts more tasks than can be completed |
| 13. Impulsive behavior                          | 28. Poor grooming and careless dress        |
| 14. Plans activities ahead of time/organized    | 29. Makes excuses for problems              |
| 15. Nervous gestures                            | 30. No behaviors presented                  |



AFFECT: Circle up to four (4) numbers that correspond to the client's most significant emotional states.

- |                                |                         |
|--------------------------------|-------------------------|
| 1. Angry                       | 16. optimistic          |
| 2. Annoyed                     | 17. Apathetic           |
| 3. Self-conscious              | 18. Oversensitive       |
| 4. Depressed                   | 19. Jealous             |
| 5. Anxious/<br>worried         | 20. Dissatisfied        |
| 6. Afraid of losing<br>control | 21. Insecure            |
| 7. Fearful/Panicky             | 22. Contented           |
| 8. Bottles up feelings         | 23. Paranoid            |
| 9. Frustrated                  | 24. Lonely              |
| 10. Embarrassed                | 25. Bored/restless      |
| 11. Guilty                     | 26. Proud               |
| 12. Happy                      | 27. Energetic           |
| 13. Confused                   | 28. Discouraged         |
| 14. Regretful                  | 29. Ashamed             |
| 15. Hopeless/helpless          | 30. No affect presented |

SENSATIONS: Circle a maximum of four (4) numbers that correspond with the client's sensations.

- |  |                                     |
|--|-------------------------------------|
| 1. Headaches   | 16. Relaxed                         |
| 2. Dizziness/<br>light headed                                  | 17. Fainting spells                 |
| 3. Tics  | 18. Ringing in ears                 |
| 4. Back pains  | 19. Watery/burning eyes             |
| 5. Chest pains   | 20. Easily startled by<br>noises    |
| 6. Visual sensations/<br>(hallucinations to<br>blurred vision) | 21. Sensitive to light              |
| 7. Body feels hot  | 22. Dry mouth/thirsty               |
| 8. Tingling sensations   | 23. Generalized aches<br>and pains  |
| 9. Cold hands or feet  | 24. Rapid heart beat                |
| 10. Often hungry   | 25. Excessive sweating              |
| 11. Stomach trouble  | 26. Numbness                        |
| 12. Tension  | 27. Does not like<br>being touched  |
| 13. Fatigue/tired  | 28. Enjoys a hug                    |
| 14. Sexual disturbances  | 29. Body feels good/<br>comfortable |
| 15. Blackouts  | 30. No sensations<br>presented      |



IMAGERY: Please circle a maximum of four (4) numbers that most accurately depict the mental pictures of the client.

- |   |                                  |
|---|----------------------------------|
| 1. Pleasant memories                              | 16. Being the best               |
| 2. Unpleasant memories                            | 17. "Bad" person                 |
| 3. Escaping/getting away                          | 18. Flashbacks                   |
| 4. Helplessness images                            | 19. Succeeding                   |
| 5. Being aggressive                               | 20. Losing control               |
| 6. Being followed                                 | 21. Being a coward               |
| 7. Being talked about                             | 22. Failing                      |
| 8. "Tough guy" image                              | 23. Being trapped                |
| 9. Being laughed at/teased                        | 24. Getting older                |
| 10. Being an outsider/Does not fit in with others | 25. Daydreams often              |
| 11. Having an accident                            | 26. Frequent nightmares          |
| 12. Images of death                               | 27. Has pleasant dreams          |
| 13. Being ill                                     | 28. Has difficulty using imagery |
| 14. Positive self-image                           | 29. Can image something easily   |
| 15. Negative self-image                           | 30. No images presented          |

COGNITIONS: Circle up to (4) numbers that best describe how the client thinks about him/herself and the values he/she holds.

- |   |   |
|---|---|
| 1. Can not do x,y,z   | 16. Obsessions                                    |
| 2. I am stupid/<br>incompetent  | 17. I don't care<br>attitude                      |
| 3. I like myself  | 18. Suicidal thoughts                             |
| 4. Stereotyped thinking/<br>rigid ideas about roles<br>people should play | 19. Sinful thoughts/<br>I am an immoral<br>person |
| 5. I am different; not<br>like other people                               | 20. Rationalizes<br>mistakes/Denies<br>problems   |
| 6. The future is bleak/<br>Nothing to look forward to                     | 21. I am intelligent                              |
| 7. Mind goes blank/can not<br>concentrate                                 | 22. Thinks life is<br>boring                      |
| 8. I make too many mistakes/<br>Can't do anything right                   | 23. Others know what is<br>best for me            |
| 9. Should strive for perfection   | 24. No direction in<br>my life                    |
| 10. Should be nice to everyone  | 25. I am sensitive/<br>loving/compassionate       |
| 11. Has memory problems   | 26. Some people are<br>plotting against me        |
| 12. A victim of circumstances/<br>Life controlled by<br>outside forces    | 27. Have to look out<br>for yourself first        |
| 13. Can not be as happy<br>as other people                                | 28. Nobody understands<br>me                      |
| 14. Life is not fair  | 29. I am hard-working                             |
| 15. "Have to..." statements   | 30. No cognitions<br>presented                    |



INTERPERSONAL RELATIONSHIPS: Circle a maximum of four (4) numbers that best correspond with the client's ability to interact with people.

- |  |   |
|--|---|
| 1. Makes friends easily  | 16. Rebellious/<br>nonconforming                                      |
| 2. Uneasy around opposite sex                                  | 17. Critical of others  |
| 3. Unsatisfactory sex life                                     | 18. Shy, timid  |
| 4. Has many casual friends but<br>no close friends             | 19. Does not like to be<br>left alone/needs<br>company of others      |
| 5. Limits self to only one or<br>two close friends             | 20. Mistrusts others  |
| 6. Has difficulty making<br>and keeping friends                | 21. Defensive   |
| 7. Poor relationship with one<br>or both parents               | 22. Overprotective  |
| 8. Avoids getting too close<br>to anyone                       | 23. Needs to impress<br>others  |
| 9. Problems relating to spouse                                 | 24. Competitive   |
| 10. Must have significant<br>other's approval before<br>acting | 25. Has trouble talking<br>to others (nothing<br>in common with them) |
| 11. Avoids people/prefers<br>to be left alone                  | 26. Unassertive   |
| 12. Problems with employer                                     | 27. Socially outgoing   |
| 13. Manipulative, tries to<br>control others                   | 28. Puts needs of others<br>before own                                |
| 14. Feels uncomfortable<br>around strangers                    | 29. Selfish/<br>Self-centered   |
| 15. Intimidated by authority<br>figures                        | 30. No interpersonal<br>relationship factors<br>presented             |

DRUGS: Circle up to (4) numbers that identify the factors that have the most influence on the client's physiological functioning and best describe his or her health.

1. Taking medication prescribed by physician
2. Takes over-the-counter drugs frequently
3. Dislikes taking any drugs
4. Physical addiction to a drug(s)
5. Psychological addiction to a drug(s)
6. Smokes
7. Drinks socially
8. Alcoholic
9. Dental problems
10. Catch colds easily
11. Physical handicap
12. Suffers from a chronic disease (not including alcoholism)
13. Suffers injuries sustained in an accident
14. Recent surgery
15. Poor vision
16. Hearing problems
17. Exercises regularly
18. Plays a sport occasionally
19. Allergies
20. Ulcers
21. Poor eating habits
22. Skin problems
23. Currently on a diet
24. High blood pressure
25. Currently under physician's care
26. Overweight
27. Seriously underweight
28. Sleep irregularities
29. Considers self very healthy
30. No health related factors presented



## BASIC I.D. PROFILE

This sheet may be used for note taking before filling out the other forms. It does not have to be handed in with the rest of materials.

B-

A-

S-

I-

C-

I.-

D.-

NOTES:

APPENDIX C



## PROBLEM AREAS SHEET

Client's Name:

Please identify the sources of problems or maladjustments in each modality. You are not restricted to the ones listed on the BASIC I.D. Chart, rather you are encouraged to count all the problem areas you observed. You do not have to write down the specific problems, just write down the total number of problem areas you noticed within the each modality. To help clarify what a problem area is, view it as an aspect in the client that you would provide treatment for if you were the therapist in charge of this case.

BEHAVIOR:

AFFECT:

SENSATIONS:

IMAGERY:

COGNITIONS:

INTERPERSONAL RELATIONSHIPS:

DRUGS:

APPENDIX D



## Structural Profile

Multimodal Publications, Inc.

## \_\_\_\_\_ BEHAVIOR

How much of a 'doer' are you? Are you action-oriented? Do you like to deep busy, get things done, take on various projects. Rate yourself from 1 to 10 as to how much of a 'doer' you are.

## \_\_\_\_\_ AFFECT

How emotional are you? How deeply do you feel things? are you inclined to be impassioned or have soul stirring inner reactions? Rate yourself from 1 to 10.

## \_\_\_\_\_ SENSATIONS

Some people attach a lot of value to sensual things from sex to food, music, art, and other sensory delights. They are very turned into their sensations. How much do you focus on the pleasures and pains from your senses? How tuned in are to your bodily sensations? Rate yourself from 1 to 10.

---

### IMAGERY

How much fantasy, or daydreaming do you engage in? This is separate from thinking or planning. Here I am asking you about "mental pictures". Do you have a vivid imagination? Do you "think in pictures"? Rate yourself from 1 to 10.

---

### COGNITION

How much of a "thinker" are you? Do you like to analyze things, make plans, reason things, through? Rate yourself from 1 to 10.

---

### INTERPERSONAL RELATIONSHIPS

How important are other people to you? This your rating as a social being. We are talking about close friendships, the desire to gravitate toward people, the desire for intimacy. Rate yourself from 1 to 10.

---

### DRUGS/BIOLOGY

I would you to rate your health. Here I am talking about the avoidance of bad habits like smoking too much, too much alcohol, drinking a lot of coffee, overeating, and so forth. Do you exercise regularly? Get enough sleep? Avoid junk foods? Are you healthy and health-minded? Rate yourself from 1 to 10.



APPENDIX E

## TRAINING INSTRUCTIONS

Assessment takes many forms. There is the behavioral approach where you observe the actions of the client and obtain a baseline of functioning. Cognitive assessment attempts to identify thoughts, beliefs or values that hinder the client. In psychoanalytic circles, assessment emphasizes the person's past and symbolism. However, the common theme in all forms of assessment is to gain an understanding of the client. Norman Sundberg, in his book Assessment of Persons stated that assessment has 3 purposes:

- 1st, to develop a description or image of the client.
- 2nd, to provide information for decision-making.
- & 3rd, to provide means by which you can test your hypotheses about the client's personality.

The question is not so much what we want to accomplish during assessment. The confusion comes when we try to decide how to go about it. What means of information gathering is most efficient, accurate, and reliable? That system must provide you with a "comprehensive understanding of the total context in which behaviors occurs."

Dr. Arnold Lazarus has formatted a means to do just that. As the leader in the field of Multimodal Therapy, Dr. Lazarus does not rely on any one or two aspects of a client's personality to make a clinical assessment. He



views the client, and people in general, as a multifarious human being with seven major dimensions, or modalities as they will be referred to later. Each of these dimensions interact and affect the others with the result being more than the sum of their parts. Therefore, Dr. Lazarus takes a holistic approach to assessment. However, the complexity of human personality prevents us from seeing everything at once. The challenge is to be open to the cues given to us by the client and to be able to put the cues together. Like piecing together a puzzle, in such a way as to develop an accurate description of the client and his or her problems.

In order to help us to organize the information we receive from the client, Lazarus has developed the BASIC I.D. profile. This is an acronym for:

BEHAVIOR  
AFFECT  
SENSATIONS  
IMAGERY  
COGNITIONS  
INTERPERSONAL RELATIONSHIPS  
& DRUGS

Each of these seven modalities represent a separate area of investigation. However, it is not as complex as it sounds. Once you learn how to recognize which items belong to which modalities, it becomes quit simple.

Let's go down the list and get an idea of what each modality is concerned with. {Pass out "An Overview of the BASIC I.D."}

This handout is yours to keep. It gives a basic description of the BASIC I.D. profile.

{Explain handout}

Now that you know what the BASIC I.D. consists of, let's focus on each modality again and look at them from Lazarus's point of view.

{Show film, "The Assessment/Treatment Connection"}

What kind of information was Lazarus trying obtain?

{Discuss film}

With this basic overview in mind let's look at how the BASIC I.D. profile can be applied to an actual case:

{Pass out CAROL handout.}

Your client's name is Carol. She has come to you because she has been suffering from severe anxiety attacks. Carol is a 29 year old white female finishing her 2nd year in a local college. She has returned to school two years ago, after working for several years as a dental technician. Carol came from a working-class background and has a strong upwardly mobile orientation. She wishes to continue her studies until she receives her masters degree, and is being encouraged to do so by a number of her professors.

While wanting to continue her studies and improve herself, she feels helpless in the face of these anxiety attacks. When Carol finds herself in an uncomfortable situation, her heartbeat accelerates and she experiences difficulty in swallowing (sensory). These Sensations occurs in such situations as parties and college examinations, and immediately trigger the fear that she would suffer an anxiety attack (affect). She would then think about how



inadequate and unprepared she is to handle the situation (cognitions). Her preoccupation with these thoughts and fears often result in interpersonal clumsiness (interpersonal relationships). To compound matters, these cognitions are often accompanied by the physical sensation of nausea (sensation). The nausea is especially noteworthy as Carol often imagines herself getting sick and vomiting in public when an anxiety attack occurs. This image adds to her anxiety (affect) which in turn strengthens the power of the image starting a new cycle of panic. Her fear of anxiety attacks has led her to avoid numerous activities she might otherwise have enjoyed (behavior). Over the years this anxiety reaction has been generalized to more and more situations, resulting in an increased number of attacks. This has caused her to lose her appetite and eat very little during meals. She is also afraid that if she eats a big meal, it will make it easier for her to vomit if an attack occurs (behavior). As a result Carol is underweight and suffering from certain nutritional deficiencies (drug). To avoid as many stressful situations as possible, she has moved back home to live with her mother, thus not having to worry about supporting herself, and has stopped dating men entirely. However, this has set up a new set of problems in that she and her mother often fight about what "Carol should do". This is causing an increased hostility towards her mother (behavior and affect and interpersonal).

From this background we can construct a BASIC I.D.

profile. Let's start with BEHAVIORS; what is Carol doing or avoiding that causes her problems?

(Discuss each modality with class members developing a profile. Then pass out CAROL'S PROFILE handout.)

Carol's Profile:

B- Avoids stressful interpersonal situations  
Under eats  
Fights with mother

A- Frequently anxious  
Fear of anxiety attacks and vomiting  
Hostile feelings toward mother  
Test anxiety

S- Tension  
Nauseous  
Heartbeat fast  
Swallowing difficult

I- Sees herself unprepared to handle situation  
Imagines herself vomiting in public  
Low self esteem

C- Must move up in the world  
perfectionistic standards  
"Not good enough; unprepared"

Ip- Excessive distancing from others  
Hostile relationship with mother  
Unsatisfactory relationships with men

D- Underweight  
Nutritional problems  
Probably takes medicine for nervous stomach

As you can see, one of the difficulties (or advantages depending on how you look at it) is that some items can be justifiably placed in more than one modality. For example, the Behavior of avoiding stressful interpersonal situations, could be seen as an Interpersonal problem more than a Behavior problem. Likewise, hostile feelings toward mother and hostile relationship with mother are almost identical. Can you see any others?



The point to remember is each modality affects the others. Problems in one modality has either a direct or indirect effect on the rest. For example, the Behavior of undereating directly contributes to Carol being underweight. Feeling anxious about vomiting leads to seeing herself vomiting at a party. This imagine in turn maintains the anxiety in a vicious circle. The anxiety and images cause Carol to have thoughts like "I'm no good. I can't handle anything." The combination of anxiety, images, and negative thoughts prevent Carol from behaving socially and engaging in interpersonal relationships. As you can see the different modalities of the BASIC I.D. combine to make up a profile. It is their cumulative effect that makes that person unique. Clinically, Dr. Lazarus stated that it is counterproductive to waste time over "perfect fits." As long as a relevant problem appears somewhere on the profile, it will receive the necessary therapeutic attention (1981, p. 127). Are there any questions?

One of the criticisms of the BASIC I.D. is that the modalities are ill-defined and ambiguous. Opponents of Lazarus have stated that the BASIC I.D. is no better than a personal record keeping system for the therapist. As such there is no guarantee that one therapist's profile will mean the same thing to another therapist. In short, no one has proved whether or not the BASIC I.D. profile is reliable. The purpose of this investigation is to evaluate the interrater reliability of the BASIC I.D. profile.

Specifically, can beginning therapists like yourselves identify the same or similar items in each modality after observing the same client? Additionally, can therapists identify a similar number of problem areas in each modality. In order for this study to be accurate, you must work alone; please don't talk to anyone about the profiles you develop.

In order to cut down on some of the confusion about what items belong in which modality, I have developed the BASIC I.D. Assessment Chart.

{Pass out BASIC I.D. ASSESSMENT CHARTS.}

For each modality, there are 30 items to choose from. I will ask you to watch 6 short films depicting the initial interview with a new client. On a sheet of paper develop your own BASIC I.D. profile. Then transfer your profile onto the BASIC I.D. Assessment Chart. Some modalities may have several factors listed, while others may have only one or two. For statistical purposes limit the number of factors within each modality on the the Chart to a maximum of 4. Include the 4 factors which best describe the client in that modality. Let's go down the items and see if there is any you don't understand.

{Point out that some items are positive as well as negative. Call attention to item 30 for each modality which states that the client did not exhibit a factor in that modality.}

The Problem Area Sheet is different from the Assessment Chart. Here you are not restricted to a list of 30 items.



The purpose here to identify all of the total number of problem areas you find in each modality. You don't have to write down the problem, just mentally identify it & make a tally mark on the sheet. Or if you prefer write down the total number corresponding to each modality. All I am after is a frequency count. A problem will be anything you notice that is significantly interfering in the client's well being. In other words, as a therapist you would want to eliminate or modify this factor during treatment.

Do you have any questions about the forms?

OK. Let's watch a film and make a practice run.

{Discuss raters's profiles. Answer questions and correct procedural errors.}

## CAROL

Your client's name is Carol. She has come to you because she has been suffering from severe anxiety attacks. Carol is a 29 year old white female finishing her second year in a local college. She has returned to school two years ago, after working for several years as a dental technician. Carol came from a working-class background and has a strong upwardly mobile orientation. She is competitive and thinks that one should always be the best they can be no matter what they are doing. These attitudes fall under what modality (\_\_\_\_\_)? She wishes to continue her studies until she receives her masters degree, and is being encouraged to do so by a number of her professors.

While wanting to continue her studies and improve herself, she feels helpless in the face of these anxiety attacks. When Carol finds herself in an uncomfortable situation, she feels her heartbeat accelerates and she experiences difficulty in swallowing (\_\_\_\_\_). Usually these feelings occur in such situations as parties and college examinations, and immediately trigger the fear that she would suffer an anxiety attack. This fear of an anxiety attack would go under what modality? (\_\_\_\_\_) She would then think about how inadequate and unprepared she is to handle the situation (\_\_\_\_\_). Her preoccupation with these thoughts and fears often result in her appearing socially awkward or clumsy (\_\_\_\_\_). To



compound matters, these cognitions are often accompanied by nausea (\_\_\_\_\_). The nausea is especially noteworthy as Carol often imagines herself getting sick and vomiting in public when an anxiety attack occurs (\_\_\_\_\_). This image adds to her anxiety (\_\_\_\_\_) which in turn strengthens the power of the image starting a new cycle of panic. Her fear of anxiety attacks has led her to avoid numerous activities she might otherwise have enjoyed (\_\_\_\_\_). Over the years this anxiety reaction has been generalized to more and more situations, resulting in an increased number of attacks. Over time, this has caused her to lose her appetite and eat very little during meals, because she is afraid that if she eats a big meal, it will make it easier for her to vomit if an attack occurs. Here we have an (\_\_\_\_\_), fear of eating, influencing a (\_\_\_\_\_), loss of appetite, which in turn modifies (\_\_\_\_\_), eating less. As a result Carol is underweight and suffering from certain nutritional deficiencies (\_\_\_\_\_). To avoid as many stressful situations as possible, Carol has moved back home to live with her mother, thus not having to worry about supporting herself. Also, she has stopped dating men entirely. However, this has set up a new set of problems in that she and mother often fight about what "Carol should do". This is causing an increased hostility towards her mother (\_\_\_\_\_) and (\_\_\_\_\_) and (\_\_\_\_\_).

## Carol's Profile:

- B- Avoids stressful interpersonal situations
  - Under eats
  - Fights with mother
  - Stopped dating men
  
- A- Frequently anxious
  - Fear of anxiety attacks and vomiting
  - Hostile feelings toward mother
  - Test anxiety
  - Fear of eating
  
- S- Tension
  - Nauseous
  - Rapid heartbeat
  - Swallowing difficulty
  
- I- Sees herself unprepared to handle any situation
  - Vomiting in public
  - Negative self-image
  
- C- Must move up in the world
  - Should be the best
  - Perfectionistic
  - "Not good enough; unprepared"
  
- Ip- Excessive distancing from others
  - Hostile relationship with mother
  - Unsatisfactory relationships with men
  
- D- Underweight
  - Nutritional problems



APPENDIX F

## WAR TORN

(Jerry)

As a Vietnam veteran you have come for counseling after attempting suicide with an overdose of sleeping pills. You have been experiencing depression, insomnia, and "flashbacks" about the war. At times you feel like you are back in Vietnam.

Receiving an honorable discharged about the time the war ended, you say that the war still is being fought in your mind. One day in the backyard a low flying airliner flew over and you immediately threw yourself to the ground seeking cover, thinking that it was a bombing run close to your position. Although never wounded by enemy fire, you occasionally have a burning sensation in you chest, which you attribute to Agent Orange. The lack of support from the Veterans Administration about this problem is extremely frustrating to you. After the war, you had only minimal difficulties in returning to civilian life, resuming college studies, and then marrying within six months after returning home. While overqualified for your present job as a store clerk, you are afraid that you will be fired. Since graduating from college, you have been unable to keep a job longer than six months at a time. You have trouble making friends at work and when someone makes you angry, you quickly walk out the store, often going to a bar. You have



difficulty expressing your emotions, because you are afraid that you will lose control of yourself if you do. This goes back to your days in Vietnam where in the heat of combat you felt an almost emotional relief from the constant tension by firing at the enemy. This, combined with the fact that you survived when several of your buddies did not, has caused some deep seated guilt. While the flashbacks are rare, you suffer from a recurring nightmare about the time your best friend was killed by a land mine. As your thoughts about Vietnam begin to increase, you have turned to drinking more heavily. This has put an additional strain on your already shaky marriage. You never talk to your wife about your experiences in Vietnam, claiming that she could never understand. She, in turn, feels alienated from you.

You say that the war has killed you emotionally, so maybe you are better off finishing the job by taking your life.

## WAR TORN SYMPTOMS:

Avoids eye contact; withdraws from conflict; attempted suicide.

Guilt; depression; angry at government and self; afraid of emotions (fear of loosing control).

Tired and runned down; unable to relax; burning sensation in chest.

Unpleasant war memories; nightmares; flashbacks.

Thoughts of Vietnam; should not get close to others; no one understands what I've been through.

Avoidant of others (especially crowds which make you nervous); untalkative to wife; marital problems; makes few friends.

Sleep problems; drinks alcohol excessively in order to forget the war and work problems.



## Compulsive

(Rose)

A 20 year old junior is having difficulty studying because, over the past six months, you has become increasingly preoccupied with thoughts that you could not dispel. You now spends hours each night "rehashing " the day's events, especially interactions with friends and teachers, endlessly making "right" in your mind any and all regrets. You likened the process to playing videotape of each event over and over again in your mind, asking yourself if you had behaved properly and telling yourself that you had done your best, or had said the right thing every step of the way. You would do this while sitting at your desk, supposedly studying, and it was not unusual for you to look at the clock after such a period of rumination and note that, to your surprise two or three hours have passed. You admit that you had a two-hour grooming ritual when getting ready to go out with friends. Here again, showering, combing your hair, and putting on your clothes all demanded "perfection." When you sit down to study, your books, paper, and pens have to be alined in a certain way before you can begin to study. This demand on your time and concentration has caused your grades to decline which worries you greatly. When any of these rituals are interrupted or not followed, you became extremely anxious - your heart races, start sweating, feel all tensed up, and your face would become flush.

You do not like this life style, but do not know how to break it without undergoing these anxiety attacks. You blame these perfectionistic tendencies on your parents, who you describe as overly strict and demanding. No matter what you did, it was never good enough. Therefore, you are always nervous when dealing with authority figures such as your parents, teachers, and employers. You continually wonders what they think of you and have an overpowering need to impress others.

You consider yourself attractive but your figure could be improved. To keep in shape, you run several miles a day and eat only the healthiest of health foods and avoiding all drugs of any kind including aspirin. You apply your perfectionism to your food as well, counting the calories on everything. Lately, you have decided that you are too fat and have begun to diet excessively. This leaves you hungry most of the time, but think it will be worth it when you get to the right weight. When asked what the right weight is, you are uncertain.



## COMPULSIVE SYMPTOMS

Compulsions; perfectionism; overcautious.

Extreme anxiety when unable to perform rituals (heart races, sweats, face becomes flush); fear of losing control; insecure; worries about grades.

Reviews and corrects daily events in mind; negative self-image; see yourself losing control if rituals are not performed.

Thoughts: "I must be perfect." "Many regrets in my life."  
"I think I'm good looking, but could be better." "What do other people think about me?"

Problem with parents and authority figures. Need to impress others.

Runs daily; excessive dieting; eats only health food and uses no drugs; often hungry

## DEPRESSED ADOLESCENT

(Lisa)

You are a 16 year girl who has been referred by the court for an evaluation, pending charges of grand theft auto. According to your parents, you were without emotional difficulties until, at age 13, you became involved in drugs, primarily marijuana and speed. After that your grades dropped drastically and arguments with your parents increased, especially about the kind of weird friends you were hanging around with. Occasionally, after these arguments you would run away from home and stay with a friend for a couple of days or until things "cooled down." About a year ago you were expelled from school following an argument with the principal over some "minor infraction." About this time your use of drugs also increased, experimenting with a wide variety including cocaine and PCP. While your parents suspected you were using drugs for some time, it was not until you were expelled that they found some pills in your locker, confirming their suspicions. They sent you to a drug rehabilitation center for adolescents for six months. Although outwardly angry, you were secretly glad that something had been done to stop your escalating drug use. You found other teenagers like yourself there, and for the first time found it easy to make friends without being stoned. Your work at the center was good and through counseling, you learned how to deal with your parents in more appropriate ways. In fact, you could



not remember being closer to them than at this time. After you returned home, things were better than they had been for several years. Your grades improved, you made new friends, and physically felt great. However, about a month ago you started seeing some of your old drug friends. You felt like you could take drugs or leave them now. After all, you had kicked the habit. One night last week at a party, you and group of friends got stoned and impulsively stole a car just for the thrill of it. The driver was just as stoned as the rest of you and drove the car into a ditch. No one was seriously hurt, you received some minor cuts and bruises. The police were called and you were arrested two days ago. Since that time, you have felt extremely depressed, your stomach is all knotted up, and you feel like you have let your parents down. Just when things were beginning to work out between you and them, this has to happen. It is difficult for you to talk about this without getting tearful. Your self-image has dropped to an all time low. You keep seeing yourself going to prison, and being a failure for the rest of your life. Asking yourself, "Why can't I be like everyone else?", you secretly wish you could die. You wonder, "What's going to happen to me now?"

## DEPRESSED ADOLESCENT SYMPTOMS

Illegal behavior (stole a car and drug use);  
argumentative; runs away from home after fights with  
parents; impulsive behavior.

Depressed; feels guilty about car theft and letting parents  
down; worries about going to jail.

Stomach trouble; nervous; teary eyes.

Negative self-image; pictures self as a failure.

Tells self that "I'm a crook," "I ought to die," "I'm no  
good to anyone," "Why can't I be like everyone else?"

Poor relationship with parents; usually shy and has  
difficulty making friends except when high.

Uses drugs; has minor injuries from accident.



## AGORAPHOBIA

(Pat)

Over the past three years you have had recurrent episodes of "nervousness," light-headedness, rapid breathing, trembling, and dizziness when going out in public alone. Formerly active and outgoing, over the past six months you have become afraid to leave home unless in the company of your husband. This corresponds with the time of your husband's promotion and transfer to this city. Before the transfer you had lived only a couple miles from your parents home where you had grown up. Now you feel like they are too far away to help if you need them. This has lead you to become more and more dependent on your husband for emotional support. When he is at work, you constantly worry about his safety, sometimes imaging him various kinds of accidents. Before he leaves in the morning, you warn him to drive safely and call home as soon as he gets to the office. Also, you immediately check and then double the locks on all the doors and windows when your husband leaves and before going to bed at night. This clinging and overprotectiveness has begun to put a strain on your marriage. He does not understand your fears, and you do not understand them well enough to explain it him. You just feel confused and helpless. Now you avoid supermarkets and department stores and state that any crowded place makes you uneasy. When unable to avoid such situation, you try to get near the doorways and always check for windows and exits. The

farther you get from home, the more panicky you feel. At times you feel like you will die if you do not return home immediately. Last summer you told your husband that you did not feel up to the usual country vacation because, "I wouldn't feel safe so far away, it would make me a nervous wreck."

At the request of your husband, you gathered enough courage to see a doctor for a checkup. He found you to be physical well except for a little high blood pressure. Your doctor prescribed some medication for the high blood pressure and referred you to me for counseling about your other problems.



## AGORAPHOBIA SYMPTOMS

Avoids leaving home; puts off shopping until the last moment; compulsively checks locks doors and windows.

Fearful; anxious; helpless; worries about husband.  
Light-headedness; rapid breathing; trembling; dizziness.

Has images of dying; being helpless, sees husband in an accident.

Thoughts center around being worthless; "I'm going to die unless I get home."

Dependent on husband; clings to him and is overprotective of him. Avoids social gatherings unless they are held in her home.

High blood pressure; currently taking medication.

## MOTHER'S BOY

(Larry)

You are a 28 year old single man [blinking frequently] who lives with your mother and work as a draftsman. You request counseling to discuss your feeling of unhappiness after breaking up with your girl friend. Your mother disapproved of your marriage plans, ostensibly because the woman was of a different religion. You feel trapped and forced to choose between your mother and girlfriend, and since "blood is thicker than water," you decided not to go against your mother's wishes. Nonetheless, you are angry at yourself and at your dominating mother and believe that she will never let you go. It is obvious that your mother "wears the pants in the family" and is use to getting her way. You are afraid of her and criticize yourself for being weak, but also you admire and respect her judgment - "Maybe Carol wasn't right for me after all." You alternate between resentment and a "Mother knows best" attitude. After all, you do not have much faith in your own judgment and avoid making decisions whenever possible.

In your job you have turned down several promotions because you do not want the responsibility of having to supervise other people. Being basically shy and unassertive, telling other people what to do frightens you. You have worked for the same boss for several years, who describes you as one the best employees he has - hard working and loyal. You have two very close friends at work



who eat lunch with you everyday. If one misses work, you feel lost.

You were the youngest of four children and the only boy. Being the baby of the family you were smothered with attention. Even now, when you have one of your frequent headaches, your mother massages your temples until you feel better.

You have lived at home all your life except for one year of college. You returned because of homesickness. Whenever you have to spend a night away from home, you have trouble falling asleep.

## MOTHER'S BOY SYMPTOMS

Avoids responsibility and making decisions; hard working and loyal to boss.

Unhappy; angry at self and mother; afraid of mother but respects her at the same time.

Has a blinking tic; frequent headaches.

See yourself being a bachelor for the rest of your life; negative self-image.

Think you are trapped; "Mother knows best."

Problem with domineering mother; dependent on others; makes few friends, lack of assertiveness.

Trouble sleeping away from home; smokes.



## FROZEN

(Greg)

You are an eighteen year old college freshman. During your first test in biology, you "froze" and spent the entire hour just staring at the exam paper. You knew the material. After all, you had studied all weekend for it. The night before you had recited definitions and explained biology concepts so many times in your head that you dreamed about them in your sleep. But, when you got to class, you were so nervous that your mind went blank as soon as you got your test. The harder you tried to remember the answers, the more anxious you became. In the end you were the last to leave and had nothing to show except your name at the top of the exam. Walking out of the classroom you felt angry, frustrated, and like a total failure. You say to yourself, "It's not fair. I study all the time. I'm a hard worker. Why do I always freeze up at test time?" Tests have always given you trouble, even in high school. The SAT and ACT Exams were extremely hard on your nerves (which were reflected in your scores). Term papers are not as bad, but they cause you a lot of anxiety as well. Public speaking is frightening because you are afraid you might make some foolish mistake and cause others to laugh at you. In fact, anything that causes you to be graded, evaluated by others, and possibly criticized makes you very anxious. At such times you feel tense and unable to relax, your palms get sweaty, and your mouth becomes very dry. If you are

criticized, you almost always offer some excuse for doing what you did. Sometimes, you tell little "white lies" to avoid blame. You now have images of being a failure and letting your parents down. They never went to college and their dream has always been to see you become a college graduate. Now it looks like you are going to be a college failure.

Everything else in your life is doing fine. You are outgoing, make friends easily, actively participate in intramural sports, and feel great physically.



## FROZEN SYMPTOMS

Freezes during test; studies all the time; avoids situations that might lead to being criticized; becomes defensive if criticized; tells white lies.

Fearful; anxious; afraid of looking foolish; worries about grades.

Tense; sweaty palms; dry mouth.

Imagines self becoming a failure and disappointing parents.

Values hard work; intolerant of mistakes; sensitive to other's comments.

Outgoing; makes friends easily; becomes defensive when criticized.

Enjoys intramural sports; feels healthy.

## BOOZER

(Practice tape)

You have been referred to the clinic by the court for evaluation of a drinking problem after being arrested for DUI. You started drinking in high school to fit in with the crowd, but later you drank because you liked the "buzz." Problems at home started when your parents noticed attitude changes (more disrespectful and rebellious) and a general lack of communication. Later at school teachers reported that your grades were slipping because of your lack of concern and sleeping in class. You are now out of school and working. Your boss has warned you about coming in late to work and taking too many sick days. These are caused by frequent hangovers, usually on Monday mornings. Among your peers you have a reputation of being a real party animal, someone who can really handle the booze. In fact, you have been given the nickname, "Boozer."

You deny that you have a problem and call the arrest illegal - you were only sitting in the car with the motor running, not driving. Being questioned about your drinking is upsetting. You are very defensive and vague about your the amount of alcohol you drink. 5 or 6 drinks gives you a good buzz. You say that you can't be an alcoholic because, while you drink occasionally during the week, you only get drunk on the weekends. Your father was an alcoholic and stayed drunk all the time, so you know what alcoholics are like and you aren't like that. You admit to having frequent



blackouts, but that does not concern you because many of your friends have them too. Besides, you could stop drinking tomorrow if you wanted to, but you just don't want to.

## BOOZER SYMPTOMS

Drinking problem, occasionally smokes marijuana but avoids other drugs; work efficiency is dropping; needs a drink in the morning when hangover occurs; easily annoyed by others when sober (short temper).

Angry about being arrested and having to undergo counseling; defensive about drinking habits.

Hangovers; blackouts; loss of appetite.

Images self as life of the party; sees life as boring when sober.

A victim of circumstances; all the bad breaks come my way.

Personality and reactions towards others changes when drunk.

Suffers from frequent colds; smokes excessively; physically dependent on alcohol.



APPENDIX G

APPENDIX G: RATINGS ASSIGNED TO MODALITIES PER SUBJECT  
 TABLE G-1  
 BEHAVIOR RATINGS TO SUBJECTS USING THE BASIC I.D. ASSESSMENT CHART

SUBJECT	CHARACTERISTICS ASSIGNED BY RATERS																														Σ			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				
1			3*	4		15	2	1			12	1	14	3		2										1						2		60
2	1	4						1		14		1	14	7		1										4	1							48
3			13							7		1	13		8	1	2	7								2			1					55
4	5				4	2		1		14			6	1						7					3				1				45	
5							2			3			2	12		1	1											4			1			27
6			10			1							6	3											1	10		2					46	
TOTAL	1	35	4	4	5	17	2	3	2	14	24	12	3	16	52	10	11	5	4	7	7	14			1	20	1	4	6	1		281		

\* Represents number of ratings assigned.



TABLE G-3

## SENSATION RATINGS TO SUBJECTS USING THE BASIC I.D. ASSESSMENT CHART

SUBJECT	CHARACTERISTICS ASSIGNED BY RATERS																																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					
1	12*										12	14	4										1												43
2	1	1					1				11	13													12									39	
3	4	15									12	12				7			6					2									46		
4					13	1					6	6										1										2	23		
5										2	7	7	1																6	5			21		
6	15										2										7												24		
TOTAL	32	16	0	0	13	1	1	0	0	2	23	54	4	0	1	0	7	0	0	6	7	0	2	2	12	0	0	0	6	6	7	196			

\* Represents number of ratings assigned.

TABLE C-4  
 IMAGERY RATINGS ASSIGNED TO SUBJECTS USING THE BASIC I.D. ASSESSMENT CHART

SUBJECT	CHARACTERISTICS ASSIGNED BY RATERS																														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
1				1*	7	7			9				6		2				2			2	4							1	41
2				2	2			1				7	8				1	4	9			6									40
3				1	2	4			6	8	3		2						6			1	6	2				5		46	
4				8	13	1	1		5	2			1				14		2						12					60	
5				1	1	5							4	1				1				13					1	5		31	
6				1	4	3			8					7						4		6	2	3			1	4		43	
TOTAL	9	10	14	22	1	0	0	0	29	8	5	0	4	24	0	2	15	5	19	4	28	12	5	12	0	2	14	1	261		

\* Represents number of ratings assigned.



TABLE G-5

## COGNITION RATINGS TO SUBJECTS USING THE BASIC I. D. ASSESSMENT CHART

SUBJECT	CHARACTERISTICS ASSIGNED BY RATERS																																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				
1	2*	1		1	13	9	6				2	2				3	12							4				1						56
2				3			3	3	15		1			9	13					1									4				52	
3	3	1		2	5	1	1	1			4	3		1	9				3				1				1	3					39	
4	1				5	0					2	1	3		1	1	11						2					3	11				49	
5	3			2			12	1			2				6						4			1				6	1				30	
6	2	1		3	4	5				1		2			4				1			1	9	9				6					48	
TOTAL	11	3	2	9	27	23	15	10	17	1	2	8	9	3	20	23	4	23	0	4	5	1	9	17	0	0	4	15	16	1		282		

\* Represents number of ratings assigned.

TABLE G-6

## INTERPERSONAL RELATIONSHIP RATINGS TO SUBJECTS USING THE BASIC I.D. ASSESSMENT CHART

SUBJECT	CHARACTERISTICS ASSIGNED BY RATERS																															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
1				4	3		15	1			1			10	1	6									8							49
2				2	2	9	12	6			6			2	8							1	5	1	1							55
3						9		1	7		9			9				8	1			2		6	3							55
4					2	6		5	7		4	6		1		4				7	1			4	1							50
5	12															5							2	1			11	2				33
6					4	3	7	2		10	1			1	1			6			1			2	12			3				58
TOTAL	12	5	6	10	10	31	29	13	14	10	21	8	8	23	15	6	4	14	1	7	2	2	3	6	21	17	11	5			300	

\* Represents number of ratings assigned.



TABLE G-7

## DRUGS RATINGS TO SUBJECTS USING THE BASIC I.D. ASSESSMENT CHART

SUBJECT	CHARACTERISTICS ASSIGNED BY RATERS																															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
1	1			4	13	5	2	1																		1		10			1	38
2			10													15						11							8			44
3	14												2									11	8									35
4	1	1			1	1	1	1																	4	1		6			5	29
5																10	8												11	2		31
6																										1		6				16
TOTAL	16	2	10	4	14	6	10	2	0	0	0	0	0	0	2	25	8	8	0	0	0	0	11	11	13	2	0	22	19	16	193	

\* Represents number of ratings assigned.

APPENDIX H



## APPENDIX H: RATINGS ASSIGNED TO SUBJECTS BY MODALITY

TABLE H-1

## RATINGS ASSIGNED TO SUBJECT #1 (LISA) USING THE BASIC I.D. ASSESSMENT CHART

MODALITY	CHARACTERISTICS ASSIGNED BY RATERS																														Σ				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					
B			3*	4		15	2	1			12	1		14	3		2									1			2						60
A	1		1	3	11	1	4	1	6			6		6		1			3											4					48
S	12									12	14	4									1														43
I		1	7	7					9					6			2		2			2	4									1			40
C	2	1		1	13	9	6			2	2					3	12												1						56
I.				4	3	15	1			1			10	1	6																				49
D.	1			4	13	5	2	1																		1			10						38

\*Represents number of ratings assigned

TABLE II-2  
 RATINGS ASSIGNED TO SUBJECT #2 (ROSE) USING THE BASIC I.D. ASSESSMENT CHART

MODALITY	CHARACTERISTICS ASSIGNED BY RATERS																														Σ		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30			
B	1*	4						1		14		1	14	7				1								4	1						48
A	1		4	5	11	11	3	4	1					1				2	4	4			3				1					55	
S	1	1								11	13												12									39	
I	2			2					1					7	8			1	4	9		6										40	
C	3						3	3	15			1		9	13						1								4			52	
I.	2	2	9	12	6					6			2	8											1	5	1	1				55	
D.			10														15						11						8			44	

\*Represents number of ratings assigned



TABLE II-3  
 RATINGS ASSIGNED TO SUBJECT #3 (PAT) USING THE BASIC I.D. ASSESSMENT CHART

MODALITY	CHARACTERISTICS ASSIGNED BY RATERS																														Σ	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
B			13*							7		1		13		8	1	2	7							2			1			
A					14	2	14						1						1	7		6	10						1			
S	4	15									12					7			6				2									
I	1		2	4					6	8	3			2					5		1	6	2						5			
C	3			2	5	1		1	1		4	3	1	9					3				1		1	1	3					
I.					9			1	7	9			9					8	1		2				6	3						
D.	14												2										11	8								

\*Represents number of ratings assigned

TABLE II-4  
 RATINGS ASSIGNED TO SUBJECT #4 (JERRY) USING THE BASIC I.D. ASSESSMENT

MODALITY	CHARACTERISTICS ASSIGNED BY RATERS																															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
B		5 <sup>a</sup>			4	2	1	14						6	1			1		7						3			1			45
A	13		10		5	1	5	7		10		2	1	2					1									2			59	
S					13	1					6								1										2			23
I	8	13	1	1				5			2			1			14		2						12						60	
C	1			5	8						2	1	3	1	1	11			2								3	11			49	
I.				2	6	5	7			4	8	1			4				7	1						4	1				50	
D.	1	1		1	1	8	1																		4	1		6			24	

<sup>a</sup>Represents number of ratings assigned



TABLE II-5

RATINGS ASSIGNED TO SUBJECT #5 (GREG) USING THE BASIC I.D. ASSESSMENT CHART

MODALITY	CHARACTERISTICS ASSIGNED BY RATERS																														Σ	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
B							2*				3			2	12			1	1			1						4			1	27
A			4	2	9	1	6	1	10	2	1	1	1					1		3							1	2			45	
S										2		7			1													6	5		21	
I													4	1					1			13						1	5		31	
C	3		2				12	1		2				6						4				1				6	1		38	
I.	12													5									2	1			11	2		33		
D.																	10	8										11	12		31	

\*Represents number of ratings assigned

TABLE H-6  
 RATINGS ASSIGNED TO SUBJECT #6 (LARRY) USING THE BASIC I.D. ASSESSMENT CHART

MODALITY	CHARACTERISTICS ASSIGNED BY RATERS																														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
B					10*	1										6	3					13			1	10		2			46
A			1	11	2		6	5	2			6			2				6	4			4					1			51
S											2									7											24
I			1	4	3					8						7				4			6	2	3			1	4		43
C			2	1	3	4	5			1		2			4					1			1	9	9			6			48
I.			5		4	3	7	2		10	1			1	1			6				1				2	12	3			58
D.																									1			6			16

\*Represents number of ratings assigned