*Psychotherapy with Psychotherapists*

# The Therapist in Behavioral and Multimodal Therapy

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# THE THERAPIST IN BEHAVIORAL AND MULTIMODAL THERAPY

*Allen Fay, M.D. Arnold A. Lazarus, Ph.D.*

Starting from a traditional psychoanalytic perspective, we gradually shifted our orientations in a more behavioral direction and subsequently evolved a multimodal approach to assessment and treatment (Lazarus, 1981; Fay & Lazarus, 1981). It is not the purpose of this chapter to discuss in detail the practice of behavior therapy or multimodal therapy; the purpose is rather to indicate what might be distinctive about therapy with professionals, particularly from a behavioral or multimodal perspective. For readers unacquainted with behavior therapy, we define it as:

1. A philosophy that stresses learning as a major factor in the development and/or alleviation of a large proportion of dysfunctional behaviors, thought patterns, and feeling states, and

2. A set of techniques basically derived from and utilizing learning principles.

A close relationship to scientific methodology has been an intrinsic part of behavior therapy since its inception. The approach is essentially direct and problem focused.

The fundamental assumptions and distinguishing features of multimodal therapy have been summarized as follows (Lazarus & Fay, in press):

1. Psychological disorders represent some combination of biological determinants and learning factors.

2. Abnormal behavior that is a product of learning factors is acquired and maintained according to the same principles as normal behavior.

3. Dysfunctions attributable to faulty or inadequate learning, and even many disturbances with strong biological inputs, may be alleviated by the application of techniques derived from learning principles.

4. Presenting problems are viewed as real problems, and are investigated on their own merits, rather than being regarded as symptoms of some underlying problem or process.

5. The focus is on the present rather than on remote antecedents or unconscious processes. Immediate antecedents and current factors maintaining behavior are emphasized.

6. Assessment involves investigation of all areas of behavioral, cognitive, and interpersonal functioning to discover dysfunctions or deficits that are not immediately presented.

7. Simple behavioral descriptions are preferred to diagnostic labels.

8. Though recognizing that therapy, to some extent, involves transmission

of values, behavior therapists minimize value statements. Rather than behavior being labeled as good or bad, its consequences are specified.

9. The therapist is active and interactive, often assuming the role of teacher and serving as a model.

10. The locus of resistance is primarily in the therapy and the therapist rather than in the patient.

11. Emphasis is on self-management. Patients are taught specific self-management techniques so that the likelihood of autonomous functioning in problem areas is maximized and dependency on the therapist is reduced. Assigned homework is an essential part of the behavioral approach.

12. Involvement of the identified patient's social network is desirable and often necessary. It permits the therapist to structure an optimal reinforcement environment and to resolve interpersonal conflicts through such approaches as communication training and contracting. (For details of specific behavioral techniques, see Bellack & Hersen, 1977; Goldfried & Davison, 1976; Rimm & Masters, 1979; Wilson & O'Leary, 1980.)

The multimodal approach is broader and deeper than traditional behavior therapy. In addition to overt behavioral responses, it delves into affective processes, sensory reactions, images, cognitions, and the subjective nuances of interpersonal relationships. There is significant overlap between behavioral and multimodal theories and techniques (Wilson, 1982), but

there are also important points of departure (Lazarus, 1981, 1983). In most instances, when colleagues have sought our counsel, they were drawn to us partly for what we represent, as well as for what we oppose—psychodynamic psychotherapy (Lazarus & Fay, 1982; Fay & Lazarus, 1982).

In a much misquoted paper, Lazarus (1971a) observed that many behavior therapists were apt to seek treatment from nonbehavioral practitioners. This was *not* because these therapists had little confidence in behavioral techniques and considered psychoanalysis or Gestalt therapy or any other nonbehavioral system superior. Rather, since traditional behavior therapy has little to offer the person who functions well (i.e., is not phobic, obsessive-compulsive, unassertive, sexually dysfunctional, depressed, obese, or beset by maladaptive habits), it is logical to consult nonbehavioral clinicians when the object is to attain insight, to explore the "collective unconscious," to experience existential encounters, to enjoy an excursion in guided imagery, and so forth.

Our colleagues—psychiatrists, clinical psychologists, psychiatric social workers, counselors, and other mental health workers—have usually consulted us only after receiving more traditional therapy without success. The majority were self-referred, having read our writings or having attended lectures, seminars, or workshops that we presented. Their range of problems has covered the gamut from organic disorders, through substance

abuse, schizophrenia, and major affective disorders, to anxiety, psycho-sexual dysfunctions, and family relationship issues. Rarely have we had the experience of treating a colleague who simply wished to get in touch with his or her feelings, or understand his or her dreams. In terms of *DSM-III* nomenclature, the most benign subsets were comprised of colleagues with "adjustment disorders with work or academic inhibition," with specific "marital problems," and with "other specified family circumstances."

The vulnerability of mental health professionals to psychological-psychiatric ills is well documented and the high suicide rate among psychiatrists well publicized (Freeman, 1967; Rich & Pitts, 1980). Still the idea persists in the public mind, and even among professionals, that therapists have, or at least should have, a high level of psychological wellness. This attitude tends to make it difficult for some therapists to seek assistance, and it may complicate therapy as well.

During the first year of psychiatric residence one of us (A.F.) recalls how anxiety-producing it was when on several occasions a psychiatrist was admitted to our inpatient service. Although a senior attending psychiatrist was usually the principal therapist, a resident was involved as well, and on occasion a resident *was* the therapist. How does one talk to such a patient? How does a tyro talk to a seasoned clinician, let alone be therapeutic? Fortunately, the therapist-patients were usually not as forbidding as the

residents had anticipated. Admittedly, this situation is somewhat unusual in that therapists generally seek help from equally or, often, more experienced therapists than themselves.

Another trauma occurred when a fellow resident had a psychotic episode. Twenty years ago it was de rigeur for residents to be in psychoanalysis, and somehow if you were accepted for treatment by a training analyst at a major institute, it seemed to offer some kind of assurance that psychosis was not in your future. Being in psychotherapy as opposed to analysis was a mark of inferiority. Behavior therapy was not even accorded the status of heresy; it was simply superficial nonsense. As time passed, it became more apparent that therapists were as vulnerable as anyone else to psychiatric disability, and possibly more so. In fact it became clear that some enter our field seemingly in search of help, whereas others do so in an attempt to demonstrate that they are not disturbed.

In our first year of training, a junior staff psychiatrist made the astounding statement that he never saw a patient whose symptom he did not have himself to some degree (Fay, 1978). What seemed like a shocking and inappropriate revelation of gross psychopathology was seen subsequently as one of the central truths in the practice of psychological therapy. What this young psychiatrist meant was that most individuals, at some time or another, have irrational fears, depressive ideation,

superstitious ruminations, compulsions, thoughts of suicide, and paranoid notions. One of the senior supervisors, who was a faculty member of an analytic institute, commented that when candidates came for a training analysis, one of the most important aspects of the therapy was to convince them that they were neurotic and not simply satisfying a perfunctory requirement.

In most essential respects, our therapy is identical for professionals and nonprofessionals. Assessment procedures are no different, the technical armamentarium is basically the same, and relationship factors are crucial to both. But there are significant differences although we cannot generalize about therapy with "therapists." Therapists have different theoretical orientations and styles in their practices, and they have different expectations and beliefs about therapy for themselves. Some therapist-patients (we refer to them as t-ps for convenience) are absolutely committed to therapy as a way of life and seem totally comfortable consulting a colleague. Others are embarrassed and feel less worthy as a result of their excursion into therapy. Still others who had therapy or psychoanalysis earlier in life feel that it is a defeat to seek help again.

Initially, our major thrust of therapy is usually in the cognitive sphere; there are certain basic beliefs and attitudes that require examination and modification. For example, we regard the idea that therapists are, or should

be, better than their clients as highly dysfunctional (Lazarus & Fay, 1975). The basic difference between therapists and nontherapists is *not* pathology, neither the fact nor even the degree; the basic difference is training and experience in their vocational area. Consider the following dialogue between Fay (A.F.) and a 41-year-old female T-P:

T-P: Yesterday I saw a patient who was so much like me, it was scary. It's really a joke, the blind leading the blind.

A.F.: Who's more appropriate?

T-P: Who? A normal person.

A.F.: What's a "normal person"?

T-P: You know.

A.F.: You mean someone well-adjusted who sailed through the best schools without a care, someone with a great marriage, fabulous sex life, two normal children who never had a problem, makes $200,000 a year, someone who is never anxious and never depressed and never has self-doubts? Is that what you mean?

T-P: Yeah, something like that.

A.F.: I'd be terrified to see someone like that. I don't think I could learn anything—or relate to such a person.

T-P: But I'm a far cry from that.

A.F.: Tell me, how many patients have you destroyed with your problems?

T-P: (*Laughs*) I hope not too many.

A.F.: Do you know what to do for this patient who is so similar to you?

T-P: I think so.

A.F.: Are you interested in helping her?

T-P: Sure!

A.F.: Does she seem to trust you?

T-P: I guess so.

A.F.: Are your problems bothering her?

T-P: Not that I know. Actually, when I told her how devastated I was when Bill left me, she was relieved.

A.F.: (*Paradoxically*) Well, then, it seems that you have all the ingredients of a terrible therapist.

T-P: (*Laughs*)

A.F.: Apart from the fact that you're not quite as dilapidated as you think, did it ever occur to you that mental health might not be the most important quality in a good therapist? You know, Freud was a complete fruitcake.

The type of problem and the intensity of symptoms certainly may be a factor in a therapist's ability to conduct a practice. For example, one must be able to tolerate criticism from patients and be reasonably comfortable when discussing sex. Depression in a therapist may make it more difficult to communicate than would a circumscribed phobia or hypochondriasis. On the other hand, the latter symptoms might preclude the behavioral

technique of in vivo exposure with participant modeling (i.e., the therapist takes the patient into the feared situation and demonstrates exposure or contamination exercises).

Among the unique relationship factors with T-Ps is the fact that more experienced therapists who work with less experienced T-Ps are not only communicating messages about problem solving but are also transmitting therapeutic skills. A large segment of our T-P population has consisted of graduate students in psychology. Here we are often seen as teachers as well as therapists, especially by those students in programs with a cognitive-behavioral orientation. A subset of this group consists of students who have been in our classes.

Another significant feature of our relationship with T-Ps is that we will sometimes refer a patient to our T-P. Although some might think that this would complicate the "transference," even orthodox analysts have engaged in this practice since Freud's time. In fact, many years ago one of us (A.F.) was treating a patient jointly with his analyst, an orthodox Freudian on the faculty of the New York Psychoanalytic Institute. Referring patients to T-Ps might create problems if you are known to engage in it with some T-Ps and not others. More than one of our T-Ps has said "If you didn't think I was too sick, you would have referred a patient to me" or "*You* wouldn't send me a patient, would you, and take the risk that I would louse it up?"

Sometimes the converse occurs, that is, our T-P refers a patient to us, either someone he or she is having difficulty with or perhaps a relative or friend.

A couple of T-Ps have asked us to arrange our schedules so as to avoid waiting-room encounters. We can recall two occasions over the years when patients showed up at the wrong times. In one case it was assumed that the T-P's session was a conference between colleagues, and in the other case it was not mentioned. As an aside, it is obvious that many professional psychotherapists who seek personal psychotherapy are even more sensitive than "ordinary patients" about matters of confidentiality. Some of our psychoanalytically oriented confreres particularly have been concerned that nobody should discover that they sought our professional counsel.

Behaviorally oriented T-Ps will often know the techniques we suggest, so that the major task is to get them to implement what they already know; whereas with nonprofessionals we must explain the basic approach as well as describe and illustrate the techniques.

In our experience, one of the most essential factors in therapy is therapist self-disclosure. It is particularly important with T-Ps, because we are even more likely to be role models for such patients. As mentioned earlier, behavior therapy rests on learning principles and the techniques

derived therefrom, and modeling is one of the major mechanisms of learning (Bandura, 1969). It is a tenet of social learning theory that the closer the resemblance between the subject and model, the easier it is for learning to occur. T-Ps are sometimes encouraged to be more disclosing to their own patients for the dual reason that it is often beneficial to themselves and their patients. Although there is some controversy in this area, coping models are probably more effective than mastery models, so that telling patients about our great successes in life and our sterling achievements will not be as effective as discussions about our own struggles with some of the issues with which they are dealing. We disclose our own symptoms, limitations, and life problems, not compulsively but selectively, when we feel it would serve a constructive purpose for the patient.

There is a tendency for many patients to put therapists in a one-up position; T-Ps may do this also, even while trying to convince us of their adequacy. It is critical for the therapists of professionals not to feel competitive, or act in a competitive way, or derive satisfaction from the plight of their colleagues, or feel superior to them.

Two patients expressed concern that we would steal their ideas and publish them. Trust may be even more important when working with T-Ps than with others, since betrayal can have professional as well as personal repercussions.

Some feel that professionals in therapy know too much and that their expertise fosters "resistance." We have discussed the concept of *resistance as rationalization* elsewhere (Lazarus & Fay, 1982; Fay & Lazarus, 1982). Some years ago, a very scholarly confrere was told by his world-renowned analyst that if he continued reading the analytic literature his therapy could not continue. In behavior therapy, as a rule, the more you know, the *better* it is. Although in some instances this attitude may foster intellectual discussions about therapy, it also makes it easier to discuss basic issues and implement techniques. Frequently, a therapy session is a combination of therapy and supervision. In fact, we believe that supervision is often part of the therapy, since discussions about therapy and specific issues in case management can be personally helpful. In general, supervision may be therapeutic, provided the supervisor has the appropriate personality and style. T-Ps may feel better and develop greater self-confidence and self-esteem by improving their technical competence.

One patient reported that work inhibition was one of her major problems. She mentioned that she had been thinking about writing a book, but had procrastinated for several years. We talked about her most important and interesting topic for a while, and then she was asked to mail an outline to us before the next session, which she did. This occurred at the same time that one of us was working on a book. He commented that his way of writing was to take a week off several times during the year and devote it

to fulltime writing. The patient thought that was a good idea and called a couple of days later to say that she would be taking the following week off. At the end of the period she came in with about 45 pages of typed material. We sometimes make specific content suggestions and even edit the writings of some of our patients. Occasionally we have asked a patient to do the same for us.

Sometimes therapists feel that it is a sign of weakness to be in therapy more than other patients do. Analytically oriented individuals are particularly harsh with themselves, making negative judgments about their behavior and labeling themselves immature, narcissistic, infantile, regressed, or acting out. The following dialogue between a 36-year-old clinical psychologist (C.P.) and Lazarus (A.A.L.) illustrates this point:

C.P.: I'm so damn immature and controlling. So needy.

A.A.L.: Can you give me some examples?

C.P.: All right, let's talk about the set-up at work. When I joined the hospital, the Adolescent Unit was losing money. So I was put in charge, and within six to seven months they were out of the red and showing a nice profit. Well, the chairman never said anything about it, and I kept waiting to see if he would say, "Nice work!" or something like that, some acknowledgment. Now, why the hell do I need his approval? I should be more mature and secure instead of looking for strokes from Big Daddy. Why do I have to suckle the breast?

A.A.L.: I don't see anything wrong with a desire for recognition and reward for one's efforts. Why is that a symptom of immaturity?

C.P.: Well, when he said nothing to me about the—if I say so myself—fantastic job I had done, I got pissed and asked for a raise. It's the same theme—give to me, nurture me, stroke me. I see the patients exploiting, controlling, manipulating all the time, but I'm no different. I'm just as regressive and immature.

A.A.L.: So in your book, a mature individual wouldn't desire rewards or recognition?

C.P.: Self-satisfaction should suffice. I know I did a hell of a good job. I pulled them out of a hole. I feel good about that. So why be so hung up on whether or not others applaud or appreciate my efforts or achievements? It's this damn dependency.

A.A.L.: You seem to put negative labels on everything. Self-satisfaction is sweetened by acknowledgment and reward from others.

C.P.: Yes, but wait till you hear the rest of it. My request for a raise was turned down. Well, when I learned this bit of information I was really down.

A.A.L.: Depressed?

C.P.: You bet! I just sulked around the place all day, behaving exactly like any of the adolescents on the ward.

A.A.L.: Weren't you angry? Didn't you feel that you deserved the raise?

C.P.: Who can figure out who deserves what? The point is that if the chairman would have noticed or praised my efforts, I wouldn't have asked for the raise—it was only when he didn't give me the strokes that I asked for the money.

A.A.L.: Would you rather have received the strokes or the money?

C.P.: My immediate impulse was to say "both"! That's what I mean about being needy.

A.A.L.: Are you implying that if you had received both lavish praise and a raise, you still would have felt deprived or shortchanged?

C.P.: Well, when people start gushing, I question their hidden agendas.

A.A.L.: Let me rephrase the question. If you had received both acknowledgment for your achievements and a salary increment, would you still complain that you wished for more?

C.P.: No, that would be great, but my point is why be so put out when it's not forthcoming?

A.A.L.: I think you have unrealistic expectations for yourself. Moreover, your psychological orientation leads you to fall back on global pejorative labels when your idealistic standards are compromised. Self-reward can go only so far, and when appreciation from significant others is not forthcoming, I maintain that there is nothing pathological in feeling let down. What also strikes me about your account is that you made no assertive responses. You did not approach the chairman and ask him if he was aware of the fact that your efforts had changed the ward from veritable bankruptcy to one of financial profit.

C.P.: But that would be so controlling!

C.P.'s deprecatory talents seemed unlimited. He was able to pull "primitive impulse gratifications" out of thin air the way magicians pull cards, coins, and rabbits from hats. The outcome was inevitable self-condemnation. (The corollary is that such a therapist might be apt to engender guilt and self-belittlement in his clients.)

Whereas many of our psychoanalytically oriented patients tended to dwell on putative complexes and would often allude to intrapsychic dynamics (thereby retarding the course of therapy), the same tendencies, but with different words, were prevalent in other nonbehaviorally trained clinicians. For example, those with a systems orientation tended to perceive double-binds, hidden agendas, sabotaging maneuvers, and various triangulations and collusions. It was often impossible to detect precise behavioral referents for these inferred constructs. We are not denying that

nonconscious processes may determine certain behaviors, that defensive reactions may lead to various perceptual distortions, and that some communication patterns are governed by manipulative ploys and unhealthy collusions. Our point is that many of our colleague-patients tended to perceive pathologies in themselves that appeared to have no basis in fact.

Psychiatrists or other physicians, when treated by a clinical psychologist (or any nonmedical therapist), sometimes present barriers pertaining to the medical hegemony. Psychiatrists wield more power and authority than psychologists, and it is not uncommon for physicians to "pull rank" when treatment issues prove threatening. One of us (A.A.L.) was treating a psychiatrist who manifested persecutory trends, a distinct loosening of associations, and signs of inappropriate affect. The advisability of consulting another psychiatrist to determine if psychotropic medication might be indicated was tactfully broached. The following dialogue (reconstructed from memory) ensued:

client: What gives you the right to talk about drugs to me? Do you like to play doctor with all your patients? I've a good mind to have your license revoked. Let me remind you that I majored in psychology at college, after which I went to medical school, and then I went through a residency in psychiatry. And you have the gall to come on to me like some wise and seasoned physician when you know nothing about medicine! If I needed medicine, I sure as hell would be able to recognize it before you would.

A.A.L.: It's difficult to be objective with oneself. As you know, the right medication can often potentiate important behavioral changes.

client: I can prescribe my own medication. I don't need you to tell me about that.

A.A.L.: I'd be happier if you were willing to give over that responsibility to another psychiatrist. It's like a dentist refusing to see a colleague and insisting on filling his own teeth.

In the foregoing excerpt many issues other than the medical versus nonmedical emphasis are present, among which the client's anxieties and unwillingness to recognize the extent of his own limitations are perhaps uppermost.

When working with a thirty-four-year-old psychiatrist who referred himself for the treatment of "anxiety-hysteria," Lazarus (1971b), during the second interview, asked him to project himself into the following scene: “Imagine that you and I are on a deserted island for six months with two beautiful women, one of whom will be attracted and responsive only to you, whereas the other will be turned on only by me, so there is no risk of rejection or any need for competition." The following dialogue shows how productive this fantasy test can be, both diagnostically and therapeutically:

pt: Oh, God! The four of us will be there for six months?

A.A.L.: Uh huh.

pt: Ummmm, uh. Gee! Well, I will obviously be in charge of our physical well-being, you know. I'll obviously be the doctor.

A.A.L.: That's taken care of. I mean it's a magic island, and we are all going to be well and healthy for the entire period. We won't require your medical services, just you as

a human being.

pt: Well, somebody has to be in charge of the place. We won't let the women take over, so obviously you and I will have to compete for leadership.

A.A.L.: Why? I mean, why can't we just all be together as four human beings—sharing, experiencing, confiding, relating? Why must someone be in charge?

pt: I just know you'll tell me what and what not to do. And I'll kick you in the balls.

A.A.L.: Would requests or suggestions be tantamount to telling you what to do?

pt: I can be awful touchy. But let's face it. Even though you have ruled out competition between us and the women, I might still feel that your woman was closer and more loving to you than mine was to me. This would cause friction between my uh . . . girl and myself, uh . . . and also lead to jealousy and resentment toward you.

A.A.L.: It sounds as if you are just determined to look for trouble and to find deficiencies in yourself. You set yourself up so that everything becomes a competition. Couldn't you just enjoy your relationship and not even notice if I was a little closer or perhaps a little more distant from my woman? Obviously, if there was a big difference, if my woman was much more loving and attentive to me than yours was to you . . .

pt: How much is "much more"? Look, frankly, I'd be afraid that I wouldn't be as adequate sexually as you would be.

A.A.L In what way?

pt: Well, in real life, my wife has only slept with me, so she has no means of comparison. But maybe the girl on the island has had many lovers, and I wouldn't measure up.

As the dialogue continued, the focus of therapy centered on his anxiety, extreme competitiveness, and sexual insecurity. The course of therapy was

surprisingly smooth, although from time to time his competitive proclivities intruded into the therapeutic relationship, calling for frank yet tactful management. Whenever he felt threatened, he tended to fall back on his M.D. degree.

We have seen many couples in marital therapy where one or both partners were mental health professionals. It is our clinical impression that when *both* were therapists, with few exceptions, marriage therapy was more easily conducted than with nonprofessionals. On the other hand, where one party was a therapist, couples therapy tended to prove more difficult. One of the most prevalent tactics in the latter instance was the use of jargon by the T-P against the partner. This called for considerable clinical skill in recognizing the professional credentials of the T-P and simultaneously supporting the nonprofessional partner against unfair onslaughts.

Some of the most challenging treatment situations arose when multimodal assessment dictated the need for family retraining and where one or more family members were themselves professional therapists. The family setting tended to bring competitive strivings into the open. In some instances, the therapist family member was inclined to demonstrate for his or her family that he or she was "the best therapist in the room." In other families, the primary allegiance of a sibling, or especially a child of the therapist family member, led to combative tactics whenever we made

observations or suggestions. When recommending homework exercises to enhance communication in one family, the eleven-year-old son of the T-P (a prominent psychotherapist) said: "I don't have to listen to you. My dad knows more than you do!"

A few colleagues have consulted us to confirm their allegiance to the safe confines of the couch. They labeled our educational orientation as "mechanistic" and retreated to the introspectionistic realms of psychoanalysis. We have found this especially frustrating when we felt fairly certain that if only the T-P would be willing to modify certain behaviors, positive benefits would accrue. In many instances, this apparent "resistance" proved to be a function of the T-P's a priori belief that all overt behavior is an insignificant part of a more basic unconscious conflict. Elsewhere (Lazarus & Fay, 1975) we have emphasized that "many people waste inordinate amounts of time struggling to change by delving into their early life, by analyzing their dreams, by reading ponderous tomes, and through philosophical reflections about the meaning of life. Life is too short and that struggle too long."

Behavior therapy and especially multimodal therapy are freer from the taboos and proscriptions that typify some approaches to psychotherapy. For example, when one of us had just started analysis, he grew tense at the sight of his analyst sitting a few rows away at a professional meeting, because he

did not know whether he would be greeted cordially or viewed as complicating the transference. We are generally delighted to see T-Ps at meetings and sometimes exchange information about interesting conferences and workshops either of us may not have heard about. At times, T-Ps attend presentations where we are the speakers.

Modern behavior therapy and multimodal therapy are, above all, humanistic endeavors. Theodore Kheel, the well-known labor negotiator, said that "some people think in terms of problems and some in terms of solutions." Our treatment orientation is essentially one of *problem solving*, and no matter who the client or patient turns out to be, we do our best to ensure that he or she will acquire a more adaptive repertoire of coping skills.

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# EDITOR'S COMMENTARY
# THE CLARITY AND DEFINITIVENESS OF MULTIMODAL THERAPY

*Florence Kaslow, Ph.D.*

Fay and Lazarus succeed in elucidating with great specificity some often-murky areas. Like N. Kaslow and Friedman (Chapter 3), they deal with a client population that includes a subset of graduate students. Although their trainee populations were drawn from somewhat different geographic areas and although they discuss different treatment approaches (mainly psychodynamic and behavioral/multimodal), both pairs of authors indicate that the students may well receive from some clinicians therapy that includes a component of supervision. This marks quite a departure from a purist stance of a clear demarcation between these two functions.

In this chapter, Fay and Lazarus highlight how often the therapist becomes the prototypical "role model" of how therapy is done—and even, perhaps, how it should be done. Training and training issues may become intertwined with treatment and treatment issues; thus a complex tapestry emerges as these roles overlap. When the patient/trainee is also a student in the therapist's classes, apparently a not uncommon happening in small communities with a shortage of fine therapists who are not also on the faculty of the graduate or medical school, great caution must be exercised in

keeping their roles and functions separate but integrated. For example, how does the therapist's knowledge of a student's deep deprivation impinge upon how he or she grades the student in a course? Does the patient as student exploit the sympathy of the therapist as professor? Does the therapist's power cross roles and intimidate the student in some subtle ways or inhibit his or her self-disclosures?

Given the therapist/professor's multidimensional influence, the process of selecting graduate students and faculty becomes compelling. Well-designed research to determine the impact of this multiplicity of roles on the student's therapy and training certainly seems crucial if we are to derive answers to these important questions.

Several additional aspects of the material presented by Fay and Lazarus initially seem unusual, yet on further consideration are probably not so atypical. They indicate that they sometimes refer potential patients to their own patients who are therapists, implying that they have confidence in their competence. Certainly this may give a boost to the latter's self-esteem, yet one wonders if it also heightens feelings of dependency and competitiveness. They also indicate that they sometimes edit patients' writings and have collegial relationships with patient/therapists at professional conferences.

Given that in analytic circles, analyst and analysand are cautioned that contact outside of the analytic hour will impede the transference and is definitely contraindicated (see Chapter 2), this work by Fay and Lazarus serves to highlight the diversity of ideas about what is tenable, feasible, and appropriate in the field.