Coasting in the Countertransference
Conflicts of Self-Interest between Analyst and Patient
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Money and the Therapeutic Frame

Introduction

Quite a number of years ago, shortly after I began full-time independent practice, I ran into a former hospital-based supervisor of mine whom I had not seen for some time. She was with her lawyer husband, whom I had met, and after she congratulated me for making the bold move to private practice, something that she had always been reluctant to initiate, he asked me bluntly how I deal with the conflict between my patients getting better and leaving, and the loss of income that follows. He implied quite clearly that his psychologist wife, senior to me and more qualified, had chosen the professional higher ground by continuing to see her patients while on a hospital salary basis. His commentary was pithy, but profound and jarring both, and a distinct departure from the normal congratulatory, well-wishing responses to which I had grown accustomed. I had no intelligent answer to his question, and I recall mumbling something about recognizing that this was a problem, and that I hoped my successfully discharged patients would be satisfied consumers and refer others to me. A similar encounter was repeated some 30 years later while I was in Germany for a conference. At a dinner with a few German colleagues whom I had just met, I learned that their national health insurance pays 100 percent of psychotherapy and multiple times per week psychoanalysis fees for prolonged periods of time. I was further told that because of this coverage, virtually every analyst has a full practice and a waiting list for new patients. My envy was palpable, though tempered by their lament that the fees I and other analysts in the United States were charging were roughly two to three times what they
received. Parenthetically, the issue of fees and busyness of practice is a primary subject of discussion wherever I travel, as soon as a drink or two loosens tongues. One of my German colleagues, when learning from me that the practices of the vast majority of U.S. analysts were not full, and that the competition for patients in the marketplace of supply and demand was often considerable, asked the same question put to me 30 years earlier: Essentially, how can you try to help patients when an ultimate positive outcome will lead to loss of income? This time I was more prepared and had a better answer, because I had already coauthored an article (Aron & Hirsch, 1992) identifying economic conflict as the single greatest problem in our profession, and was in the planning stages of this chapter and had been doing some reading on this subject (e.g., Josephs, 2004; Lasky, 1984; Liss-Levinson, 1990; Myers, 2008; Whitson, n.d.). I essentially told my astute German colleague that I believed his system created far better conditions for productive analytic work, and that despite my enjoying much higher fees than they, I think I’d be both less anxious and a more useful analyst in their system.

Economic anxieties plague all but a very few analysts I know, especially in large American urban areas like New York City, where the supply of trained analysts is voluminous and the relative number of potential patients who can afford preferred analytic fees creates considerable competition among analysts. Most colleagues are elated when a new referral comes, and depressed when a patient leaves prematurely. Sadly, even after a successful analytic experience, it is often difficult to feel satisfaction and pride only, without this being tempered by anxiety and regret in relation to lost income. As one colleague responded to my “How’s it going?” after running into him in the street, “It’s been a great month—none of my patients have left.” The degree to which we are dependent on our patients to both exercise our skills and create economic security is powerful, and although this is preoccupying, it is rarely addressed in the literature or as part of formal panels and conferences. Analysts’ economic dependency on patients leads to an inherent and profound conflict between self-interest and patient interest, and this conflict always has the potential to severely compromise analytic work. Indeed, I believe that analysts’ financial concerns reflect the most vivid example of this conflict, and I still suggest that analysts’ anxiety about income is the single greatest contributor to compromised analyses.*

Emotional greed disguised as economic greed undoubtedly has something to do with the degree that analysts ruminate about money, though greed often has its primary source in deprivation and fear of subsequent deprivation. I know of no literature that has studied the psychogenetics of such worries among analysts, though it is plausible to assume that those among us who have greater internal expectations that they will have enough in life are less frightened than their counterparts. However, regardless of inevitable individual differences among analysts, dependency on patients, on multiple levels, is very real and pragmatic. As Singer (1965a, 1971) suggested, we are dependent on our patients, in addition to our need to earn a living, in order to practice a profession that we presumably like and value, and for which we have trained long and hard. He further noted that analysts often grow very fond of and attached to patients, and each separation may hurt along the same lines as separating from friends or family. When patients leave prematurely, this inevitably tells analysts that they have not done very well, and most probably that they were not liked and valued both as a professional and as a person. Independent of the need to earn a living, patients saying hello and goodbye to us bears close similarity to both loving and rejecting experiences in our personal life. Whenever a patient remains with us, the experience lends itself to feelings of being loved (Racker, 1968), and this theme of staying or leaving can be played out multiple times with multiple patients during each workday. Searles (1965, 1979) also appreciated the multiple forms of analysts’ dependency on patients. Searles was one of the early analytic writers to grasp the true nature of a two-person psychology, with both analysts and patients sharing all of the same emotional needs and desires vis-à-vis the other, usually in equal measure (Racker, 1968). As well, both Singer (1971) and Searles (1979) wrote openly about

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* Though I write throughout this chapter as an analyst and about psychoanalytic work, I wish to make clear that I believe similar conflicts surrounding financial self-interest exist in the practice of all forms of psychotherapy (and psychopharmacology). Indeed, though my interests and knowledge base are restricted to the practice of psychoanalysis and psychoanalytic psychotherapy, I believe that such conflicts are likely relevant in all of the professions where individuals earn their income to at least some degree as private practitioners.
analysts’ wishes to be not only loved by their patients but helped by them too. Both authors were sensitive to patients’ inclinations to be of help to caretaking figures, first to parents and then to analysts. If analysts are unreceptive to patients’ helpful strivings, they run the risk of diminishing patients, conveying to them that the analyst is strong and sufficient, and the patient weak and deficient (Goldberg, 2007). Sullivan’s (1953, 1954, 1956) shift from a more authoritarian one-person model to one of co-participation* precipitated the democratization of the psychoanalytic process, the view championed by those identified with the interpersonal school, that the analytic dyad is composed of two flawed individuals (see also Racker, 1968). Relational perspectives in psychoanalysis** begin here, with the view that the personal subjectivity of both analytic participants is visible within the dyadic field, and that each party, at least unwittingly, has some influence with the other. Racker’s (1968) proclamation that the analytic relationship is not one between a well analyst and a sick patient mirrors Sullivan’s declaration of the shared and compromised humanity in every analytic enterprise, and these are the sentiments that have grown into prominence in much of contemporary psychoanalytic discourse, especially those perspectives now under the conceptual umbrella referred to as relational.


The fact that analysts are dependent on patients is not a problem in and of itself. This normal human quality becomes an impediment when it is either denied by analysts or exploited by them. The recognition of our fragility and dependency, economic and otherwise, can be very facilitating of analytic process when such recognition leads to the effort to contain these self states of the analyst. For better or worse, however, analysts’ flawed humanity works to sometimes defensively help deny that dependency on patients is powerful, and at other times to not curb dependency when we can see that exercising this is more in our own interests than in patients’ best interest. Because dependency experienced through economic need is such a powerful force in most analysts’ lives, analysts’ temptation and inclination to choose self-interest in priority to patient interest are woven into the very fabric of professional life.

The tangible and practical need to earn a reasonable living makes anything approaching a relatively objective attitude about which patients to work with, and how long to keep them, nearly impossible. As noted, this dilemma of self-interest versus the interest of clients or patients is not, of course, unique to psychoanalytic practitioners. Based on the laws of supply and demand, professionals and businesspeople are inclined to enlist potentially interested consumers, even when a hypothetical jury of disinterested peers might easily judge that the consumer either does not need the service or would be better served elsewhere. Newman (2006), for example, wrote pointedly of his experience searching for medical treatment for a life-threatening malignant tumor. Each physician consulted seemed convinced that his own specialty was best suited to address this urgent life-or-death matter. None were inclined to refer him to rival colleagues, despite the fact that one well-known specialist colleague in particular clearly turned out to be the most appropriate one to address this unusual cancer. Newman concluded that most of those he consulted for his health crisis were interested in their business primarily, and did not consider with due equanimity if their special skill was the one most likely to save his life. His story confirms the conventional piece of wisdom that suggests that if one is considering surgery, consult first with a physician who is not a surgeon. “First, do no harm” (if applied to psychoanalysts as well as physicians) is a worthy ideal, though this is difficult to adhere to in a context where competition with peers for needed income is a very practical force.
Though greed and competitive feelings toward rival peers* may be powerful motivating forces for many or most analysts, it is needed income that creates the most serious difficulties and conflicts. Greed and competition are luxuries when compared with the desire to support oneself or one's family in a manner that approaches what is anticipated by those aspiring to upper-middle-class or professional-class ways of living, and, as well, what is expected by others in the community whose gaze is evaluative. From what I can see, the considerable majority of psychoanalysts in the United States are quite anxious about earning sufficient money to live comfortably without worrying about their economic future. Because all of our work is referral based, analysts are often anxious even when practices are relatively full, for who can know when the next patient might leave, the next referral call might come, or what might happen the following year, or even 5 years down the road, when children's college tuitions may be due or health insurance fees skyrocket? It is the quotidian and pragmatic nature of financial concern that makes this issue so powerful, and that leads to such great difficulty in placing what might be best for patients in priority to analysts' own interests. It is for these reasons that I reiterate the belief that analysts' economic concerns create a most vivid example of inherent conflict of interest, and represent the most serious problem in any effort toward productive clinical work.

In what follows, I will attempt to state some major consequences precipitated by analysts' anxiety about money, and subsequently discuss these and present clinical examples that are illustrative of such problems. Perhaps the most predominant consequence of analysts' financial concerns is keeping patients in treatment too long, and the development of patients' excessive dependency that inevitably arises from this (Renik, 2006). I have no research data to support this, but my own anecdotal observation is that many patients remain in analysis for a staggering number of years, and that it is more common than it was in other generations for patients, many of whom are analysts themselves, to remain in analysis for 10, 15, 20, or even 25 years with the same analyst. A related effect of analysts' economic interests emerges in the number of times per week that patients are seen. Though, as most analysts, I believe that at least three sessions per week are optimal for analytic work, analysts' motives for seeing patients multiple sessions each week can be unrelated to this analytic ideal. Some patients who are seen many times each week, indeed, are not necessarily being seen in an analytic context with analytic aims. That is, some analysts are doing supportive or maintenance-oriented work, yet seeing patients who can afford this as if they were conducting an analysis. Similarly, many patients who can pay high fees will be seen multiple times per week for many, many years, long after it is easy to rationalize that analytic goals still prevail. One colleague has said to me, without shame, that a couple of his patients are so troubled that he anticipates that they will be "patients for life." Another very well-respected colleague proclaimed at a clinical meeting that she and all of her colleagues have their "lifers," patients who allegedly "need" to be in analysis for literally their entire lives. This statement was not challenged by others at this meeting. In the above situations, "analysis" becomes a vehicle for the creation of mutual attachment and of dependent ties, and the rationales for this may center on biased assessments of patients' degree of psychopathology. The very idea of adhering to the patients' original analytic goals or aims is forgotten. Maintenance of the analytic relationship may become an end in itself (Renik, 2006). A third compromise precipitated by analysts' anxiety about money is the striving to be liked by patients, in order that they remain in treatment. In this respect, analysts may be overly supportive and complimentary; strive to be helpful in ways that do not correspond to the analytic aim of facilitation of autonomy; avoid challenging patients when this would seem to be potentially useful; avoid uncomfortable transference themes, particularly themes related to anger and disappointment; engage too tentatively in order that patients' anxiety, even productive anxiety, be kept to a minimum; and use deliberate self-disclosure in order to gratify patients' wishes (in contrast with self-disclosure being used to open up areas for exploration). I also believe that certain theoretical points of view are sometimes embraced more because they are gratifying than because they are the most likely to effect ultimate separation and autonomy. Both analytic reserve and analytic challenge can be eschewed for fear that these attitudes may provoke patients

* Though the focus of this chapter is on financial needs and economic greed, selfish and harmful competitiveness in helping professions, of course, goes beyond money matters solely. For example, Gabbard (1996) and Gabbard and Lester (1995) addressed the problem of psychotherapists' sexual involvement with patients; and for a powerful description of destructive competitiveness and egreous pursuit of selfish interest in religious circles, see Frawley-O'Dea and Goldner (2007).
to quit, whereas measures that were more traditionally associated with supportive psychotherapy may maintain patients in prolonged attachment. I contend that analysts are more likely to conduct briefer analyses, and analyses that try to create significant independence, when the analyst is more willing to let patients leave and to lose income. Unfortunately, this does not occur enough in our current analytic culture, and when it does, it may readily be a function of an analyst's practice being full, the analyst having new patients waiting, or the patient's fee being low enough that the analyst does not wish to prolong this commitment at a reduced fee. I am not suggesting that the willingness to see patients leave is always good for patients, for this too can easily be based on the wish for a higher fee, or the wish to see someone new, or perhaps more interesting. And, the wish to keep patients for many years and see them as often as possible can be based on what is believed best for patients, or even on a strong and ultimately fruitful attachment. However, as with Newman's (2006) surgeons, our (analysts') financial needs carry much weight in the myriad of judgments and choices we make in our clinical work, and these choices are very often quite conscious on our part. I intend to use clinical examples in this chapter and in the next, to illustrate this delicate and controversial theme, and the often enormous impact that it has on many aspects of psychoanalytic practice.*

Clinical Illustrations

I saw Norman, with him "kicking and screaming," for 11 years, initially twice per week and then three times per week. He complained almost daily, often quite nastily, that this was a profound waste of time and a futile exercise with a profession full of charlatans. He had been in therapy with a nonanalyst, and then in a prior analysis, for the previous 14 years before beginning with me, and concluded that both treatments had been total failures. He lamented that he had "lost his mind" while in college and, though functioning as a successful graduate student and then professional for much of his post-college life, claimed that he has never had full use of his cognitive faculties since. Because of this rather vague complaint, he insisted that he needed to see the likes of me, despite his conviction that psychoanalysis is fraudulent. "What alternative was there?" he argued.

Norman described his prebreakdown self as powerfully focused and astute, brilliant both academically and in his comprehension and awareness of social and cultural phenomena. He was the favorite child and the prized possession of his mother, and he was being groomed by her to follow in the footsteps of her ancestors, many of them esteemed rabbis in pre-Nazi Europe, and more recently in the United States as well. Until his college years Norman was a good boy, a straight-A student, and a serious Jewish scholar with a glorious future in the Orthodox Jewish world of his mother and her ancestors.

Though his nonreligious father mocked his "momma's boy" existence, Norman did not fight him, or push away from mother until his senior year in college. At this point Norman discovered that he was attracted to women and began masturbating at a more frantic pace than during the years that he buried himself in his books and did not notice that he was good-looking and desirable. Simultaneously with this, he realized that he was passionate about science and began to wish that he could pursue a career either in clinical medicine or in medical research. Both his interest in women and his veering away from Jewish studies put him on a collision course with his mother, and at about the time he was graduating he had his "breakdown." After getting to know Norman somewhat, I interpreted that what he called his breakdown was actually the only way he felt could get out of being a compliant boy. This alleged loss of the ability to think straight allowed him to postpone going to seminary, and to take a break from his studies. As part of his recovery he began to travel and to live independently for the first time, and in this context, he began to enjoy women and initiate the active sex life that still characterized his life at the time I met him.

By the time Norman returned to New York City, after 2 years of "recovery" via odd jobs and travel around the world, he had already applied to medical school and was prepared to pursue his career. Although by the time I met him he was a well-respected researcher and teacher, Norman was still insisting that his mind never has worked as sharply as it had earlier, and that he wanted his mind back and needed to be in therapy for this reason. Though I have heard clinically psychotic individuals talk of "not having my mind," Norman was anything but crazy. His professional life was productive,
and his interests were rich. He had no intimate friends and preferred serial monogamy with women to marriage, but he was not certain if this situation troubled him, for he reported liking his space and his autonomy. It did not take very long for me to recognize that what Norman meant by not having his mind was that he was in considerable conflict about having defied his mother, and that he felt that he could never be all present in any career or in relationships that excluded her. In the good old days of mother-son symbiosis, Norman had a unity of mind with mother, and in this partnership, there was no conflict. There was virtually total presence in their relationship, and in the intellectual pursuits that were aligned with her. As an adult performing independently, he was very angry with his mother and maintained a distant physical connection. Nonetheless he was still strongly dependent on and attached with her, and could not feel unambivalent engagement in either his work life or love life.

This same angry dependency characterized Norman’s connection with me, as it had over the 14 years with his two other therapists. He would attend sessions reliably, invariably attacking me in the same mocking and incisive way that his father castrated him while growing up. He was relentless, never giving me any credit for saying anything worthwhile, or for whatever movement existed in at least his professional life. Though I was committed to doing better than my predecessors, whom I assessed as engaging in a mutually constructed symbiotic dependency with my patient, Norman would not acknowledge my superiority to them. His sharp criticism kept me very alert and wired, and I believed that I was both very present with him and attuned to him. I believed that my observations and interpretations were astute, and that I dealt directly with his anger-dominated transference in a way that his other therapists ignored. As much as I experienced that I was my most capable analyst self, I was confronted with my being as much of a charlatan as my rivals, and with Norman’s stated facts that he did not feel fully present in his work, and that he was still cynical about being in loving and intimate relational configurations with anyone. I felt close with him despite his porcupine ways, though he never acknowledged reciprocal feelings. At best, he mocked me with some warm teasing for my girly desire to have him love me. My interpretive emphasis was on Norman’s fear that his loving bond with me would leave him totally subject to my will, and masochistically submissive to me in ways similar to his connection with both his parents. Were I not the object of his castrating aggressions, he would be the good boy of his youth, and forced to abandon any semblance of self-direction and personal freedom. Though he acknowledged to some extent the relevance of these transference themes, he never admitted to caring about me in any way, and we struggled over this theme for what seemed like an eternity. It was only in the 10th year of our work that I began to stop talking with him about love and attachment and shifted to the term dependency. Under manifest protest, Norman visited me for years in spite of his busy schedule, just as he had my predecessors. He earned a good living, but he paid my highest fee, and at the rate of three times per week our time together cost him a great deal of money. Though disguised by consistent aggression, Norman was a very dependent man, and my failure to emphasize his dependency in the transference was, indeed, the same mutual enactment of dependency exploited by his previous therapists. I had early on diagnosed his previous therapists essentially as dependency operations, and because I was so active in addressing transference themes I was able to deceive myself into believing that I was engaging in a distinctly higher-level therapeutic enterprise. Norman’s dependency on me was lived out, and was not sufficiently pointed out. I knew how dependent he had been with his mother, but I did not let myself fully articulate this in his transference to me. We engaged in an extended enactment that reinforced both his dependency and his denial of dependency. Norman did not consciously feel love for me or for anyone else, and he readily could tell me that I was off base in addressing this sort of attachment in the transference. When, very belatedly, I began to speak with him about his dependence on me, and use as evidence the many years he had visited me (and others) and the many thousands of dollars spent on the psychoanalysis he so damningly criticized, Norman was able to relent somewhat and give me credit for finally pointing out something salient to him. He began to see the impact of his dependency and the disguises he used to protect him from feeling this acutely, and this awareness had some salubrious impact on his life, his love life in particular. This also signaled the beginning of the end for our work together, though Norman was angry that it had lasted so long.

It seems awfully clear in retrospect that I exploited Norman’s dependency instead of clarifying this much earlier in our analysis. I felt alive (though battered) in my work with him, and enjoyed my alertness and having my full mind when with him. The years went by
quickly, and Norman’s existence in my life, two to three times weekly, was both emotionally and intellectually stimulating and financially rewarding. Though I did not articulate this clearly to myself, I knew that dependency was at the core of Norman’s involvement with his mother and in his two previous “dead” therapies, and that it had to be, certainly after the years went by, the heart of the matter between us. How could this not be evident? Indeed, it was quite evident, but I did not articulate this to myself beyond fleeting private thoughts, nor did I spell this out with Norman. In an unformulated way I knew that once this theme was worked through, our analysis would end. I was dependent on Norman in a variety of ways, though were I seeing him in a clinic and money were not an issue, I have little doubt that the theme of dependency would have been center stage much sooner in our work together. Though I consider this analysis ultimately a productive one, it should have had a far briefer duration. I believe this illustration is emblematic of all too many of my own and my colleagues’ analytic work, where patients’ dependency is either facilitated or subtly fed in order that we are helped to maintain some economic security.

This analysis lasted 11 years, though for Norman, his total years in therapy added up to 25, and 19 of those years were in multiple times per week analysis. This is not unusual in our current psychoanalytic culture, where it is not only difficult to find patients outside of our profession willing to come for three or more sessions per week, but also hard to find enough people who have the money to pay at least some approximation of analysts’ preferred fee. That is, when analysts are fortunate enough to be referred people who both are interested in attending multiple sessions each week and have the financial resources to do this, it becomes especially conflictual to facilitate their successful termination. Unconsciously and with some consciousness both, analysts find rationales to hold on to such individuals as long as possible, as I did with Norman. I have observed in myself and among supervisees and colleagues that this phenomenon exists even with patients who pay reduced fees, sometimes significantly reduced. My informal discussions with colleagues have supported my private observations about how difficult it has become to attract patients into three or more times per week psychoanalysis in the United States, especially since the stark decline in the numbers of training candidates at analytic institutes. If one’s practice is not full, it may be quite appealing to be in a position to practice the standard analysis one has been trained for, and this may be rewarding despite the lower than preferred fee schedule. As well, reduced fees multiplied three to five times per week still usually add up to substantial income. The combination of this factor and the appeal of working analytically in the optimal fashion often leads also to the co-creation of dependency and to unnecessarily prolonged analyses. For example, analytic candidates in training commonly pay considerably reduced fees, yet remain as highly desired analysands, and from anecdotal observation many spend an inordinate number of years in analysis. In this era of fewer analytic candidates for senior analysts to see as patients, extended analyses have, indeed, become more common.

Mitchell was an economics research scholar who received his doctorate but never worked as an economist, choosing instead to manage his investments and to engage part-time in his family business. When he first came to see me, shortly after achieving his degree, he believed he wanted an academic job and, indeed, searched for one. He found nothing available in New York City, where he wished to live, and after one year he no longer pursued this. However, shortly after beginning four times per week analysis with me, at my full fee, Mitchell did get an offer to teach in a relatively rural town a few hours outside of New York. This was far from his ideal situation, but he was considering it and talked with me a good deal about this. This job was a decent opportunity, and one that could conceivably be a first step to a traditional academic career in perhaps more interesting geographic locations. My patient was single, struggling with his sexual identity, but claimed to wish to settle down with a Jewish woman. At the time, his love life was totally barren, though this had also been the case for virtually all of his life. Indeed, this was primary among his reasons for entering analysis. He acknowledged some conflict about the direction of his sexual desire, though insisted most of his masturbatory fantasies were directed toward women. Already in his late 20s, he had had only the scantiest sexual experiences with women, and he claimed to have had none at all with men. I was quietly skeptical, sensing in him an attraction to me, and a strong prohibition toward homosexuality, which was internalized from his family of origin and from his subculture. Much of his stated reservation about accepting this academic job revolved around the lack of availability of suitable women, though I thought that it also reduced the likelihood of fulfilling his homosexual desires. While
he wrestled with this decision, I was quite clear that I did not want to lose this interesting man who paid my full fee, and even asked for four sessions per week, one more than the three sessions that were the rule of thumb of my own psychoanalytic culture. Though I knew he would not likely find a full-time academic position in New York, and thought the offer he had was a decent place to launch a career, I was quite supportive of the parts of Mitchell who wished to stay here. I did see these pro-New York arguments as credible to an extent, but I knew that I was nowhere close to neutral on this issue, and that I withheld myself from fleshing out some of the talking points in favor of accepting this academic post. Indeed, one of my arguments referred to the absence of trained analysts in easy commuting distance from this college campus, and Mitchell’s early devotion to the analytic process and to the goals he hoped to reach through this commitment. Though his concerns about finding a wife and continuing analysis, and my sense that he wanted homosexual opportunity, all had validity, despite some rationalization, I knew what I preferred. Mitchell was undoubtedly influenced by my desire to keep him as a patient. This set the tone for a long analysis that was fueled, in part, by Mitchell’s dependency on me and unarticulated homosexual interest in me.

Were Mitchell coming once per week and/or not paying my highest fee, I suspect he may very well have taken this academic position. Though after some time he did eventually enjoy managing his family business and his investments, I always believed that he may have had more satisfaction following his scholarly and academic interests. In retrospect, Mitchell clearly sensed that I wanted him around, and though he knew that I was heterosexual, he experienced my wish to be with him as an opportunity for both a dependency-dominated and a sexually intimate involvement with a somewhat older man. Mitchell did begin to acknowledge his dependent attachment to me, but never admitted homosexual interest, despite reporting periodic homosexual fantasies about other men. He insisted that he was heterosexual and wished for marriage and family, and consistently focused on anxiety about sexual performance and feared impotence as reasons for not following up with women after their initial date or two. He linked his previous impotence and heterosexual anxiety to feelings of diminished self-worth, in the context of his relations with his dominating and competitive father. Mitchell believed that his father wanted him to remain his personal castrato, and that he had internalized this. Indeed, Mitchell’s place in the family business, as lucrative as this was for him, kept him attached to his father in a perennially subordinate way. His presence persisted in helping his father feel competitively strong. He hoped that, as his analyst, would offer a new experience that would help make him strong and sufficiently competitive in order to become potent with women. Unfortunately, however, I had already helped steer my patient away from an independent career pursuit, and I was cooperating with his coming to see me once more time per week than my psychoanalytic tradition dictated. In some parallel with his father, my own self-interest took some priority to that of Mitchell. I was perhaps, like his father, getting more from being with him than he was from his analysis with me. I enacted with Mitchell a facsimile of this father–son configuration—like his father, his subordinate position was rewarding to me. Indeed, this was not unknown to me in my conscious reverie.

I was reluctant to be candid with Mitchell and tell him that I believed he was gay, and that he should come to terms with this and allow himself to enjoy sex and companionship, instead of continuing his futile dating patterns with women. I rationalized that I did not know this for certain, for Mitchell kept denying his homosexuality each time I questioned this. By not telling him forthrightly what I believed, he and I lived out a homosexual engagement. I became the relationship that Mitchell denied himself from having outside the transference, and our currency in his staying with me was his wish for me to help him overcome his anxiety with women. He was dependent on me as a lover and as an ostensibly more benign paternal presence. This went on for 6 years, with Mitchell achieving some sense of potency in taking over many of his father’s functions in the business, after some of the latter’s health problems began to limit him. He began to enjoy the business at this point, and I felt less guilty over my having supported this career choice, in part for my own economic benefit. At one point I even confessed to Mitchell that I had wanted him to stay in New York and that I had been biased in my analysis, though I stressed my enjoyment in working with him, failing to mention the economic element. Despite his dependence on me, Mitchell began to feel stronger. I believe that he ultimately sensed how dependent I was on him, and that in some respects I was the economically struggling son to his wealthy father self. It was in this emotional context that Mitchell began to confess to me that he had all along had more homosexual fantasies than he admitted and,
with increasing frequency, had been having brief sexual encounters with men for the past couple of years. He claimed to still want a wife and family, but acknowledged that integrating his preferred sexuality with this would be difficult. He explained that he failed to tell me the extent of his homosexuality because he did not want it to be real, and as well, if I knew, I'd have given up on his efforts to grow comfortable with women. At the time we terminated, Mitchell had grown to enjoy his place in the family business, and developed a knack for investing his money via day trading and other vehicles. His sex life was more open, and he engaged with increased frequency. He had had a few short-term relationships beyond anonymous encounters, though he did not think he wished to develop a serious relationship with a man. He still believed that he might be able to develop a heterosexual marriage and a family, while perhaps maintaining a private homosexual erotic life. He was convinced that there were women out there who would be happy to be married to a wealthy man who was gentle, caretaking, and devoted to his children, and that these women would be able to tolerate a barely existent sex life. I was not in a position to challenge this, and actually believed that Mitchell was probably correct. I knew firsthand how easy it was to be dependent on Mitchell—how willing he was to be a caretaker both emotionally and financially. I was, however, disappointed that I had not helped him be more comfortable in his homosexual skin, and that shame and internalized familial desires continued to constrain him. He, on the other hand, seemed relatively pleased with our work together, and did not have the sense that our 6-year, four-times-per-week arrangement was either excessive or a function of my own self-interest. Mitchell was a sweet and generous man, and he was raised to make others feel good.

Though I am somewhat pleased with the ultimate outcome of this analysis, I am also convinced that it could have been both briefer and equally useful at the three times per week rate to which I am accustomed, and which corresponded with my own experience as an analytic patient. I am also not convinced that Mitchell would have not been better served had he taken his academic job, experienced accomplishment and independence outside of his family business, and commuted to a local analyst an hour or more from his college. Further, I feel certain that if I had been more candid about my belief that he was gay, and that it was a waste of time to keep talking about his wish for intimacy with a woman, we would have saved considerable time.

Though 6 years is not especially long in today's analytic culture, my relationship with him was an enactment of the homosexual, dominance—submission one with his father, and it served to keep him more tentative about pursuing other gay relations. Indeed, I was aware that I believed the fourth weekly session unnecessary, and I felt some ambivalence about my patient embracing his sexuality and moving on from our relationship. Even though I and many of my colleagues have engaged in much longer analyses, even ultimately fruitful ones, the troublesome element of my selfish interest in the economic rewards in my work with Mitchell is unmistakable. I believe that it is more common than otherwise that patients like this one, who pay full fees and are willing to come as often as analysts prefer, have analytic experiences that are prolonged and/or can be facilitated at a lower weekly frequency. Under circumstances like the one I have just described, it is difficult for analysts to avoid the self-deception that long analyses at an optimum* weekly frequency are invariably best for each given patient. There is no doubt that this configuration is invariably beneficial, on an economic level, for each analyst.

Discussion

It must also be noted that there are many circumstances where the obverse is true, that is, where a given patient is seen fewer sessions per week, or for a shorter duration, in order that the patient may be able to afford the analyst's preferred fee. In fact, this is a common dilemma faced by most analysts. As is evident, most analysts, financial interests aside, prefer to work with most of their patients multiple times per week for an extended period of time, the exact preferred number of sessions per week determined by the particular analyst's theoretical identifications. Most every contemporary analyst in the United States is aware of the unfortunate circumstance that only a small percentage of patients are interested in pursuing three or more times per week treatment. Of those, only a tiny fraction can afford these multiple sessions for a significant number of years at our preferred fee scale. When a patient is willing or is interested in pursuing an optimal analytic experience but cannot afford to do this at the

*I wish to reiterate that I saw Mitchell at a weekly frequency beyond what I normally consider optimal.
analyst's preferred fee, the analyst is confronted with the choice of seeing this person under ideal circumstances at perhaps a sharply reduced fee, or seeing the patient twice or once weekly at a much higher rate. Analysts' economic realities make it very difficult, in this frequently faced conflict, to choose patients' interest in priority to their own.

For example, if a particular analyst is low on filled hours, this analyst may be more likely to encourage patients to attend as frequently as possible, inducing them with a sharply reduced fee. Although this structure may be a blessing for the patient, the analyst's offer may have been more related to self-interest (filling unbooked hours) than to the patient's interest per se. If it has not been clear to this point, I wish to underscore that there are, indeed, many instances where analysts' self-interest and patients' self-interest are aligned. However, in the illustration just given, which in practice comes up quite often, there are some potential risks. If, for example, this analyst's practice becomes more busy, he or she may resent this reduced-fee patient and begin to see this individual as a burden. This anger may be subtly communicated, and in extreme, the analyst's unconscious motive might be acted out so as to undo the multiple session-reduced fee arrangement or, even worse, to induce the patient to leave treatment altogether.

Another common resolution to the equation of fee and sessions per week is to agree to see a given patient once per week at the analysts' preferred fee, while in full awareness recognizing that this patient might be both better served and willing to be in a more ideal, multiple sessions per week analysis. This situation is likely to evolve when the analyst in question may have only a few free hours, and/or believes that he or she already sees enough long-term psychoanalytic patients at reduced fees. This matter is complicated by the viewpoint articulated by Gill (1982, 1983, 1984, 1994) that the intrinsic factors, particularly analysis of transference, define what can be called psychoanalysis, and although multiple sessions per week over a number of years are an analytic ideal, they comprise an extrinsic factor in defining psychoanalytic treatment. I have always been in full agreement with Gill's argument, and have often used this to rationalize my choosing to see a patient in once per week psychoanalysis (with the expectancy that this will run for a significant number of years) at my preferred fee, rather than either reducing my fee or referring this person to someone who would be willing to work at a reduced fee for multiple sessions per week. I, and many of my colleagues, are faced with this dilemma on a regular basis—in today's analytic culture, it can be seen as a quotient situation. In some such moments, especially if I find the patient interesting and/or appealing, I will offer a referral to someone who might see him or her more frequently at a reduced fee, but I may not strongly emphasize the potential advantages of such a pursuit. Parenthetically, if, for instance, I were an analytic candidate in need of a patient to meet my requirements, I would likely make a strong effort to sell the patient on the advantages of multiple times per week analytic work. In my current professional situation, if I sense that the patient and I have made a good connection and he or she is someone with whom I'd like to work, I am likely to convey the optimism about our analytic future that I genuinely feel, emphasizing with less enthusiasm the patient's other options, and the potential advantages that may lie in these alternatives. I would be far more reticent about acknowledging this blatant pursuit of self-interest if I did not believe that it is normative among colleagues at all levels of experience.

I might add, perhaps in order to shade my own selfish behaviors, that I know of far more egregious pursuits of self-interest, ones that fall closer to ethical borders. I know of analysts who advise their patients to come every other week, expressly because they can charge double for each session. They explain to their patients (and sometimes rationalize to themselves) that attending every week is not a serious advantage, though privately and to like-minded colleagues they acknowledge that they feel that they do their best and least compromised work when feeling well compensated. I am acquainted with other analysts who see patients for double sessions, implying that this constitutes two times per week psychoanalysis. One common motive for these double sessions reflects an accommodation to some patient's unwillingness to disrupt their schedules by making two trips each week to their analyst's office. However, in condensing two sessions into one longer one, the philosophical basis of multiple visits is largely negated, though the analyst is technically justified in charging for the time involved in two independent sessions. I believe every analyst knows that encouraging patients to commit to the inconveniences of attending sessions is a part of the devotion necessary for productive work, though this shortcut, for obvious economic reasons, may be difficult to resist when offered by patients. One can say the same for telephone sessions, an increasingly common practice among contemporary analysts (Richards, 1999). Though there
are some situations when sessions over the phone may be unavoidable, more frequently I observe this phenomenon to be devolving into a convenience for both parties. Like double sessions, the convenience of the telephone might reflect an absence of full commitment to do the hard work of analysis on the part of the patient. I believe that most analysts would agree that a certain level of commitment is needed in order to maximize the likelihood of success, and the too easy or too convenient way might make the outcome of a treatment more dubious. Nonetheless, when faced with the prospect of a patient leaving treatment because he or she is finding it too difficult to attend, many analysts are tempted to work in a way that is knowingly a severe compromise.

A qualitatively different but also questionable practice is an analyst's willingness to see patients who are related to one another either as family or by close friendship. This has long been frowned upon by psychoanalysts representing all of the major traditions, though once again I observe anecdotally that this is a more frequent phenomenon in today's professional culture. Indeed, a certain percentage of most practitioners' referrals come from current or past patients. When the referral source does not specify that he or she does not wish for the analyst to see the referral, and the referred-to analyst is anxious about the economics of his or her practice, it may be very tempting to see a new patient who has a close relationship with a current or past one. It is not relevant for the purposes of this chapter to review all of the reasons why this has consensually been regarded as poor practice. Were economic needs not a factor, I believe it would be hard to find an analyst who would not agree that referral to a colleague is the reflexively appropriate procedure, and clearly in the best interests of both the old or current and the prospective new patient. It is actually difficult to find a rationale that might support doing otherwise, though I have heard from a few colleagues and supervisees that they believe that it may be an advantage to have knowledge about a patient from information received from a close acquaintance. I think that this very weak rationale can only be an effort to save face, and to cover up an analyst's shame that is inevitable when a thoroughly conscious pursuit of self-interest so obviously conflicts with the prevailing professional culture.

* Unfortunately, I know of some analysts who actively encourage their patients to refer significant others to them (e.g., spouses or children).