Despite a burgeoning literature on major analytic boundary violations, there has been little investigation of what might be called analytic delinquencies or misdemeanors—the small and virtually ubiquitous ways in which analysts deliberately withdraw from the therapeutic endeavor. I consider the impact of professional misdemeanors on patient and analyst and compare both with more serious analytic “crimes” and enactments. Professional delinquencies may reflect a therapeutic reenactment, an expression of the analyst's split-off or disavowed need, or an unconscious attempt to self-regulate or to negotiate space within the constraints of the treatment setting. Because the professional ideal leaves so little room for the analyst's humanity, it is often difficult for us to address and work with evidence of our own need when it clashes with what we regard as the analytic contract.

Dr. M, A Supervisee With Whom I Have Been Working for Several years, opened our session with a confession that she made with some difficulty. Before I describe it, let me contextualize things a bit. Dr. M is a sensitive, skilled analyst who has been in the field for nearly two decades. We had worked together for five years, and I knew

Earlier versions of the paper were presented at the Manhattan Institute of Psychoanalysis, December 2000, New York City; Division of Psychoanalysis (39) American Psychological Association, April 2001, Santa Fe, NM; and the Austin Riggs Center, December 2001, Stockbridge, MA.

I thank Glen Gabbard, Adrienne Harris, Sue Grand, Margaret Crastnopol, Ruth Gruenthal, Susan Kraemer, and Kristina Schellinski for their very helpful comments on an earlier draft of this paper.
her to be a serious professional with an impeccable sense of commitment to her patients. For all these reasons, I found Dr. M's confession jarring.

About 10 minutes into a telephone session, Dr. M's patient, Mr. J, interrupted himself to ask about “a weird noise” he heard, saying it sounded like pages in a magazine being turned. Mr. J's guess was correct; Dr. M was, in fact, quietly skimming through magazines and catalogues and giving Mr. J less than her full attention. “On the spot” and feeling intensely guilty, Dr. M said that she was taking notes on the session and had been turning the pages of her notebook. Mr. J seemed to accept her explanation easily and returned to describing other experiences.

Before I address the very complex dynamics embedded in this enactment, let me underscore that Dr. M is far from alone in her secret delinquency. Although rarely acknowledged in public forums, Dr. M's action represents one example of many common infractions of the analytic contract. Yet, despite a burgeoning literature on serious ethical violations by professionals, analysts have not directly taken up the question of how to understand those less egregious, yet still worrying breaches of our professional role. Probably both because analytic misdemeanors seldom disrupt the treatment on a permanent basis and because they are nevertheless unacceptable, these acts are rarely discussed and, to my knowledge, never written about.

This paper has two aims. The first is to identify and attempt to understand the nature and motivations underlying analysts' tendency to commit small delinquencies. The second is to bring these issues into the arena of dialogue with the explicit intention of changing problematic aspects of our professional behavior. In the course of this paper I describe a variety of analytic delinquencies, including my own. I invite you to join me in directly investigating the nature of professional delinquencies, their dynamics, and their consequences for both analyst and patient.

**The Analytic Ideal and the Real Analyst**

It is a paradoxical and yet crucial professional ideal to which we aspire. We aim to be emotionally and intellectually present for our patients, to use our subjective reactions in the service of the work, to attempt
to suspend or, in any case, bracket our self-interest when it is counter or irrelevant to our patient's best interests. This is how we attempt to protect the analytic space and work with a clear focus on our patients' needs. We assume that we will become personally “caught up” with our patients and that we are capable (at least retrospectively) of studying those moments. We use our personhood in the work and endeavor mightily to understand its impact. In line with Winnicott's (1947) conception of countertransference hate, we tend to think of our professional misbehavior in terms of its potential therapeutic usefulness. After all, moments of enactment often deepen the work and the analytic relationship. There is not much room in this model for expressions of self-interest that are not also useful to our patients. How much more difficult it becomes to consider the impact of our real failures (Kraemer, 1996)! Yet I suspect that we are all susceptible to engaging in analytic delinquencies or misdemeanors.

By characterizing some therapeutic actions as delinquencies or misdemeanors, I am deliberately and almost arbitrarily creating a category of professional behavior that is often secretive and usually guiltily enacted. I use the idea of misdemeanors to designate those smaller breaches wherein we relatively momentarily, but with apparently conscious intent, deliberately disengage from the treatment process in the pursuit of a personal agenda. While the bulk of professional misdemeanors are intentionally hidden, committed either when patients are on the couch or during phone sessions, some occur in face-to-face therapy sessions. In minor and more egregious ways, we take advantage of an opportunity temporarily to withdraw affectively, cognitively (or both) from our patients; at the same time, we are aware that we are violating implicit, if not explicit, professional norms.

Let me offer some anecdotal examples of minor and more serious delinquencies. All are uncensored and reported with permission. Some were described by patients; others, by analysts about themselves. They include:

- Making a note to oneself about a forgotten task, adding to a grocery list,
- Planning an event, filing or painting one's nails, combing hair, putting on makeup,
- Surfing the web, searching a dating website, eating a snack, skimming a magazine or journal, checking email, buying airline tickets online, reading correspondence, pumping breast milk, watching a sports scoreboard online, writing patients' bills, deliberately cutting a session short by a minute or two, and charging for a missed session during a vacation that the patient was unaware the analyst
took. Strikingly, in only two of these instances did patients indicate that they were aware of the therapist's breach. One person reported to me that while lying on his analyst's couch, he sniffed several times and then asked “Do I smell nail polish?” He did. Another colleague reported that a patient's previous analyst regularly ate dinner during their sessions until one day the patient exploded with the comment, “What is this, a fucking picnic?”

There is a second group of misdemeanors that are engaged in openly during face-to-face sessions, in full “view” of patients. These include eating or taking long phone calls, using a treatment hour to discuss a matter of personal concern, asking patients to recommend physicians, stocks, discount clothing stores, restaurants, hotels, and so on. In contrast to hidden misdemeanors, these “open” breaches are more clearly located within the relational domain. On one level, they can be understood as a form of indirect communication with one's patient that embodies a reenactment reflective of implicit aspects of the treatment relationship. That we seem to be acting openly may invite, or at least make more possible, the patient's response. Yet these small bits of misbehavior often do not enter the treatment conversation, perhaps because our need to preserve an element of self-interest tends to put enormous pressure on our patients not to notice, or at least address, what we are doing. This silent pressure can exclude our action from therapeutic discourse so that “open” misdemeanors may, in fact, function more like the secretive ones that effectively render our patient silent.

Although both the types of breach and the frequency with which they are committed are variable, it is my sense that only the unusual, or perhaps very young analyst is altogether innocent in this regard. And because both hidden and explicit misdemeanors remain sequestered, if not split off, from the rest of the analyst's self-experience, these kinds of actions frequently seem to go unnoticed or at least unacknowledged by patients. On those occasions when a delinquency is detected, analysts may commit a second breach by lying or rationalizing in an effort to cover up their action.

In my experience, misdemeanors are usually circumscribed moments within a given treatment that stand in stark contrast to the analyst's ordinarily high level of therapeutic engagement. Because our misdemeanors are so often disavowed, their negative effect on our self-image as caring and committed professionals tends to remain sequestered.
Professional misdemeanors represent another dimension of the malignant underbelly of the analytic position that Irwin Hoffman (1998) describes. He focuses on how analysts can exploit their professional role to feed their narcissism or enjoy a sense of control or power. This “dark side” of the analytic frame may be expressed, for example, in an analyst's potentially exploitative request to publish material about a particular patient.

How is it that otherwise conscientious analysts engage in secret delinquencies? Chessick (1990, 1994) has described the insidious impact of such corruption on psychoanalysis as a profession. He suggests that professional corruption reflects a gradual falling away from the individual and group ego ideal, a deterioration that illustrates the demoralizing impact of life itself. Chessick urges analysts to consciously attend to and resist the “inevitable pressure tending to force us onto a line of development of corruption” (p. 394).

Some support for Chessick's assertion may be found in “off the record” conversations I have had with colleagues and supervisees about professional misdemeanors. My younger colleagues in training responded with outrage and shock to the idea that analysts commit these acts. They ascribed misdemeanors to burnout or to a loss of ethical standards, and several declared that they would terminate their analysis were their analysts ever to commit even the smallest of such breaches. In marked contrast, the bulk of the two dozen older analysts with whom I spoke responded with little surprise, and sometimes with amusement, and spontaneously added other examples of professional misdemeanors to my list. And after I presented this paper for the first time, I received several messages from analysts who asked me to include their confessions in my paper. Some analysts seemed to view their “misbehavior” as a rebellion, more or less conscious, against their own theoretical model, while others saw their actions as purely selfishly motivated. Although I surmised that a sense of shame or guilt lay beneath their amusement, I also heard a tendency to rationalize such actions or avoid addressing their dynamics. Perhaps, as Chessick suggests, a layer of cynicism that had infiltrated the professionalism of senior colleagues had not yet compromised the idealism of younger therapists.

It is my impression that analysts are less likely to bring misdemeanors into supervision than more emotionally tinged enactments. When we

1 And during its delivery, there was a great deal of laughter.
sneakily transgress our own professional standards, supervisors and colleagues can seem to be the moral “police” whose judgment must be sidestepped. Indeed, the clash between these minor acts of psychopathy and the analytic ideal can result in a quasi-conscious disavowal of professional breaches. These misdemeanors then remain sequestered from evenly hovering attention, the process of self-examination, and thus from analytic discourse. Ultimately, of course, such disavowal may result in more egregious misdemeanors—acts—that traverse this permeable boundary between delinquencies and serious analytic crimes.

The extent to which misdemeanors are denied suggests that most of us have a difficult time contending with any evidence of our delinquent behavior. Only when we can tolerate this disruption of a positive professional self-image can we easily acknowledge, reflect on, and work with the impact of the breach on our patient and ourselves.

**The Analytic Breach: Crime, Misdemeanor, or Enactment?**

It is difficult to delineate precisely which aspects of professional behavior constitute misdemeanors, for these delinquencies inevitably overlap with both enactments and more serious analytic crimes. Additionally, such distinctions are subjective, contextual, and open to interpretation. The gravity of a given breach is always colored by the particulars of the patient's experience within the therapeutic dyad and the sociocultural context in which the treatment takes place.²

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² For example, in some cultures and at different periods in the history of psychoanalysis, analysts regularly sip tea, knit, crochet, allow their dogs or cats in the consulting room, and so on. It is difficult, if not impossible, to mark an absolute line around the notion of misdemeanors. When such actions are culturally sanctioned, analysts may feel freer to engage in them openly. Whether or not a given action represents a misdemeanor often depends on the meanings of that action for a particular patient and analyst. Is the action openly or implicitly acknowledged by both parties? Is the patient free to express her feelings about the analyst's action? Are even these “acceptable” analytic activities experienced as symbolic thefts by patient or analyst?
It is crucial to distinguish deliberate professional breaches from those moments of wandering attention and emotional preoccupation to which we are all vulnerable. Although the latter may reflect a breakdown of the analytic function, more often these moments carry symbolic meanings that can be studied and used, for example, by exploring our personal reverie (Ogden, 1994). When we can locate our breach within the relational configuration and parse its dynamics, that breach may ultimately be of analytic use; that is, it may stimulate a dialogue that opens up or deepens the work. Yet making such distinctions can be self-serving; by attributing an action to relational dynamics we may avoid confronting unpleasant realities that are discrepant with our self-image as caring and committed analysts. Similarly self-serving may be our attempt to categorize a particular breach as a misdemeanor or enactment; what constitutes a misdemeanor or enactment to us may seem like a crime to our patient or colleague, and vice versa.

Smaller bits of deliberate analytic acting out can be contrasted with more serious analytic “crimes,” enactments, and moments of reverie wherein the analyst's attention wanders inadvertently. Major boundary violations on the analyst's part effectively destroy the treatment relationship and sometimes the analyst as well. These egregious breaches of the therapeutic contract so seriously compromise the treatment that the analyst may be open to ethical censure, legal suit, or both. Gabbard and Lester (1995), detailing the early history of serious boundary violations, beginning with Freud, describe both sexual and nonsexual transgressions.

There is some overlap between major boundary violations and enactments that emerge in the emotional or erotic heat of an analytic encounter, and the line between these two categories is sometimes a fuzzy one. Gabbard and Lester note that boundary violations typically emerge from a slide down a “slippery slope” wherein the analyst's emotional involvement with a patient gradually erodes a clear sense of the boundary between them. They recount a number of contemporary clinical cases in which the analyst's violations of the treatment contract eventually destroyed the therapeutic relationship.

While not all boundary violations reflect countertransference enactments, an analyst who commits serious breaches is frequently under the sway of an intense emotional involvement that overrides awareness of the treatment boundaries. Although enactments can often be addressed in a way that deepens the work, major boundary
violations not only are disruptive of the analytic relationship, they are much more likely to derail it permanently. They tend to be highly exploitative of the patient, are committed with more persistence, and are less easily discussed. In contrast, misdemeanors have a more insidious impact on patient and analyst. On one hand, most misdemeanors are committed with more deliberateness than are unconsciously motivated enactments, which seem to “burst out” between patient and analyst. Misdemeanors also appear not to be powered by a strong affective charge; they emerge during periods of analytic quietude more than under the gun of intense affective pressure. Yet these distinctions are far from pristine, for a purposefully committed misdemeanor may embody other, far more unconscious motivations.

**Hidden Misdemeanors: Relational and Personal Contributors**

Analytic misdemeanors take different forms and have different effects when they are committed secretly, as we saw in Dr. M's secret magazine reading, and when they are open and blatant. Where secretiveness may, in fact, shield a patient from awareness of the analyst's attentional departure, breaches that are openly committed appear to have the patient's tacit and sometimes direct consent. For this reason, explicit misdemeanors tend simultaneously to reflect the analyst's self-interest and a dynamically driven enactment around a core treatment theme.

A patient of mine, Samuel, described his experience in a previous treatment. As an aside, he mentioned that his analyst frequently ate a meal as they talked. Samuel had not been consciously bothered by this behavior, and, probably in response to my surprised expression, added that his analyst had asked if he minded and he had said no.

Over time, Samuel and I were able to understand his analyst's actions on several levels. Samuel consciously enjoyed these dinner sessions because he was left with the feeling that things were “comfy” between them; he enjoyed the “special place” accorded to him through this intimacy. Samuel was initially unaware of any more complex feelings about his therapist's actions.

It only gradually emerged that other, more troublesome meanings were embedded in this enactment. Despite Samuel's having freely
consented to this breach of analytic etiquette, he had, in fact, been quite *unfree* in that interaction. Samuel experienced his analyst's request as an implicit demand that he comply with, and not react negatively to, the analyst's desire to eat. Since Samuel's need to please others was very strong, his response was not surprising. By “not minding” that his therapist ate dinner, Samuel placed himself (and was placed) in a compliant position vis-à-vis the other's needs, a pattern of relatedness reminiscent of Samuel's relationship with both parents. Those experiences had left Samuel with a major difficulty in the area of self-assertion. His analyst's apparent oblivion to the impact of this interaction reinforced Samuel's chronic but still unconscious sense that his needs were less important than those of the other.

Samuel and his analyst both seemed to exclude or deny the reenactment around Samuel's pattern of self-effacement and compliance to the other's needs that was embedded in these dinner sessions. In a sense, analyst and patient together established an emotional context of apparent ease that was contingent on Samuel's participation as a compliant partner and that precluded a dynamic investigation of their interaction.

It is impossible, of course, to ascertain the relative weight of this analyst's conscious self-interest or unconscious participation in a reenactment of Samuel's relational pattern. However, given that the analyst focused on Samuel's needs at other times, I suspect that a key motivational factor involved personal need—in this case, hunger—leading the analyst to override what he knew about Samuel and actually to recreate an exploitative interaction within the treatment context.

On yet another level, Samuel may have unconsciously assimilated a different, equally troublesome message from these dinner sessions. Did his analyst have difficulty meeting his own needs—after all, he regularly deprived himself of a dinner break and “snuck” in time for himself in the context of helping the other. Samuel may well have identified with his analyst's implicit self-deprivation, a pervasive theme in Samuel's own relational pattern.

**Analytic Misdemeanors in a Relational Context**

In contrast to the explicit impact of overt misdemeanors, hidden misdemeanors may actually or merely apparently shield patients from
our actions. It is interesting to note that, although we might assume that analytic breaches are inevitably registered by our patients, most of the analysts with whom I spoke asserted with certainty that their patients were unaware of their temporary withdrawal. It is difficult to ascertain whether or not their patients were subliminally aware of those moments of relative cognitive/emotional absence. Interestingly, in those cases where the analysts' actions were explicit, patients apparently manifested little distress. As Jacobs (2001) notes, patients often suppress, deny, or rationalize their perceptions of their analyst. The result is an unconscious collusion between the two.

How can we understand this collusion? Are those patients with whom analysts “stray” people who are unable to ask for much, who content themselves with a modicum of attention? Are they more narcissistic than not, unaware of the analysts' self-involvement as they are unaware of their own impact? Or do some patients bracket their emotional responses in these situations in order to protect the illusion of analytic attunement (Slochower, 1996)? Yet, even when these experiences are not consciously assimilated, how could they not subtly alter the affective coloring of the therapeutic moment? Certainly, when we parse a misdemeanor retrospectively, we can relocate our action within the interpersonal field (internally at least) and may be able to examine its intersubjective and personal meanings.

Let us return to Dr. M. She told me about her magazine sneaking with much embarrassment and worry about my censorious reaction, but with strikingly little curiosity. Although I agreed that magazines should not be read during telephone sessions, I made it clear that I was not shocked. I wondered aloud if we could look at her behavior with curiosity rather than simply with censure. We knew her patient to be an earnest and rather intellectualized young man, someone who had considerable difficulty accessing his emotional life. He was deeply committed to his treatment and maintained a friendly although aloof stance vis-à-vis Dr. M. Dr. M was aware that she sometimes struggled against boredom during their sessions; this was especially true during telephone contacts. They had agreed to use the phone to maintain continuity during Mr. J's extended business trips, and, consciously at least, Dr. M felt comfortable with this arrangement.

As Dr. M and I considered her actions within the dyadic context, we wondered if she had unconsciously responded to her patient's emotional withdrawal by reading magazines. Did her action reflect an unconscious hopelessness about making contact with her emotionally
disengaged patient? Was Dr. M expressing disowned resentment toward Mr. J for his frequent business trips? As we discussed these possibilities, we realized that Dr. M felt particularly deprived of contact in the absence of the visual stimulation of the “in person” session. Perhaps she had responded to this deprivation by turning to magazines to fill in the missing visual element. It seemed likely that her strong need to make contact, a need already reactive to Mr. J's schizoid style, was further exacerbated during the emotionally remote telephone sessions.

As we discussed these dynamics, Dr. M said, with much embarrassment, that she doubted that her action could be fully explained in this way because she typically looked through magazines when doing phone sessions with many of her patients. Although Dr. M knew that her activity compromised her attentiveness, she looked forward to phone sessions because they gave her a chance to relax a bit. Dr. M had been peripherally aware that she was doing something wrong, but she had never allowed herself to think about her actions.

Thus, despite the unique aspects of Dr. M's response to Mr. J, it was clear that her misdemeanors involved more or less chronic expressions of opportunism. Dr. M took advantage of many telephone sessions and sometimes of patients' use of the couch to look through magazines and, in other small ways, satisfy herself while still “playing the role” of good analyst. As she put it, Dr. M made use of her hidden position to take something for herself. It is noteworthy that Dr. M did not commit these breaches with very difficult patients who “demanded” her attention. Instead, it was with patients whom she experienced as having a less demanding presence that she responded with an eruption of personal desire.

Dr. M expressed intense guilt, shame, and anxiety about what she identified as a failure of professionalism and an abandonment of her patients. As we continued to discuss her experience of herself as an analyst, she became increasingly conscious of a heretofore disowned, chronic sense of depletion and strain that pervaded her working life. Dr. M's need to support her family led her to take on a maximum number of patient hours while counterbalancing that strain in little ways. She began to wonder if patients she found easier to work with had picked up on her strain and, recognizing how much difficulty she had had openly taking what she needed, somehow “allowed” her these periods of emotional respite. Dr. M was also aware that there was not a great deal she could do about the ongoing strain in her life. Ultimately, she decided to guard against the danger of taking advantage
of her patients: she exercised increased vigilance vis-à-vis her own tendency to sneak what she needed and more concretely, decided to stop doing telephone sessions except in real emergencies. Now that Dr. M was conscious of her tendency to withdraw from him, her emotional involvement with Mr. J gradually intensified, and she began to address the subtle enactment that had been taking place between them.3

The Analyst’s Countertransference and the Analyst’s Compromise

In contrast to the subtle, yet pervasive underlying strains that impel some analysts to commit misdemeanors with many patients, some delinquencies are driven by factors unique to particular treatment configurations. We react to a treatment moment or to ongoing relational dynamics with an association to unsettled needs and obligations, a sense of rebellion against our own theory or even against the analytic ideal. Those associations may well emerge in moments of reverie within the analytic third (Ogden, 1994).

When we are able to engage and address these associations (whether privately or with our patients), we have an opportunity to deepen and enrich the work. We may, however, also avoid active self-reflection and instead secretly reward ourselves with small “pleasures.” Many analysts seem especially vulnerable to committing infractions in treatment configurations characterized by ongoing feelings of boredom or emotional disengagement with patients whom they find ungratifying. During my internship training year, I had such an experience.

Ms. R was a pleasant but extremely self-involved woman who spoke virtually nonstop during our sessions. She was uninterested in hearing anything from me and filled our time with vignettes about herself that

3 A colleague who read this paper commented that Dr. M’s willingness to reveal herself to me within the supervisory context was unusual. I agree. I suspect that the fact that this was a private supervisory relationship outside the institute training framework played a large role in creating the open atmosphere that permitted her to take this chance. In addition, such “confessions” are more likely to occur in long-term and intimate supervisory relationships. It is certainly not surprising that these issues so rarely enter the supervisory or peer supervisory processes, for such confessions require a very high degree of trust between colleagues.
seemed devoid of self-reflectiveness. Unable to engage her in exploring either the content or the process of our sessions, I talked to her about how disturbed she became when I entered the therapeutic dialogue. She responded to my interventions with confusion, avoidance, and sometimes disorganization. Eventually my supervisor suggested that Ms. R needed to use much of our time to ventilate in my presence and that I contain my wish to comment on her experience.

Metaphorically sitting on my hands, I became intensely frustrated and bored during these sessions. I was uncomfortable and ashamed of these feelings and avoided discussing them with my supervisor, from whom I anticipated a censorious response. Instead, I sometimes took advantage of Ms. R's prone position to look through my appointment book and make “to do” notes to myself. I expressed my countertransference by “taking” for myself, compensating for a sense of deprivation and irritation (both at her and at my supervisor) during these hours. On one level, it is possible that my withdrawal actually sustained the treatment, giving my patient plenty of room and protecting her from my excessively ambitious wish to intervene. Yet, I suspect that on another level, my cognitive and emotional withdrawal inadvertently supported Ms. R's self-involvement without explicitly disrupting the therapeutic frame. Interestingly, Ms. R seemed oblivious to my inattentiveness, and thus I experienced little pressure from the treatment relationship to address my actions.

In certain respects, analysts who withdraw from the treatment context in relatively small ways paradoxically both breach and protect the analytic frame. For patients who cannot tolerate too much engagement on the analyst's part, the analyst's momentary removal reduces the affective tension between patient and analyst and may allow the patient to experience a needed sense of emotional autonomy (Slochower, 1996). The therapist may resort to small misdemeanors in a quasi-unconscious attempt to restore herself and to sustain her involvement in the treatment. As Frankel (2001) has noted, misdemeanors are potentially protective of the analyst and may thus also protect the treatment.

It seems to me that my behavior with Ms. R had both effects. I created emotional room for her as I turned to my own interests in a secretive way. Yet, despite the possibility that my action represented a compromise that in part protected Ms. R, my inability to examine my behavior or to take the matter up with my supervisor reflected both avoidance and a breach of therapeutic professionalism. It was not until
considerably later in my professional development that I was able to tolerate examining the dynamics underlying this experience, in particular, a disavowed sense of anger about feeling used and unrecognized.

I suspect that most misdemeanors, like my own experience and that of Dr. M, contain an element of inner negotiation on the analyst’s part (Pizer, 1998). Delinquencies may camouflage the analyst's unconscious compromise, reflecting a struggle to balance or regulate conflicting need states (see Aron, 1999). In part, at least, this attempt arises directly out of the nature of analytic work. Although most of us derive considerable gratification from our role, it is equally true that we sometimes feel deprived—concretely or symbolically—as we attempt to be fully present for our patients. The strain of focusing on the other is intensified by the relative sensory deprivation of long days in a still and constant consulting room. Inevitably, the struggle to be present for our patients will at times clash with our own needs. Small bits of analytic “theft” may represent our unconscious attempt to balance these two desires in an unsatisfactory internal negotiation between the wish to be a good analyst and to reward ourselves in one way or another.4

These negotiations may represent, to one degree or another, attempts at self-regulation. Many, perhaps most, of these negotiations are minor. While working on this paper, I observed myself in such a moment. I suspect that it would have gone unregistered by me were it not for the fact that I was writing this paper. I recently found an old photo of my now grown-up daughter. She was about 10 at the time, smiling hugely, and looking utterly adorable. I had slipped the picture into a pile on my desk to await a moment when I would have time to put it into an album. During an analytic session with a quiet and very thoughtful patient who works hard and is engaged with me in a low-keyed way, I pulled out that photo. Smiling at my daughter's aliveness and youthful beauty, I was briefly suffused with a sense of warmth and personal pleasure. This was a “stolen” pleasure; I had briefly but quasi-deliberately removed myself from my patient affectively and enjoyed

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It is interesting that, despite my colleagues' frequent use of “theft” as a metaphor to describe their misdemeanors, only one analyst mentioned a financial delinquency. Is the area of financial theft so profoundly, not to mention legally, unacceptable that analysts do not act out in this way? Or, because of these grave implications, can analysts not acknowledge that they overcharge or otherwise steal from patients?

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a private moment of loving pleasure before returning the photo and turning once again to my patient.  

As I think about my experience, I suspect that I unconsciously used that moment of contact with my intensely affective daughter to counterbalance the very quiet, sad (and, on some level, less gratifying) emotionality between my patient and me. In part, the moment reflected an enactment that repeated aspects of my patient's experience with his own self-involved parents. It may also have contained aspects of what Ogden (1994) describes as reverie, in that my withdrawal resulted in a renewed awareness of my patient's experience with his parents. I want to emphasize, though, the deliberateness with which I turned to that photo in contrast to the unconscious flavor of enactments or the peripheral cognitive/emotional phenomena that Ogden describes, wherein we find our attention wandering elsewhere. In this instance, I briefly withdrew from an intense but difficult emotional engagement and sought a simpler and more joyous affective moment with my daughter. I offer this vignette to illustrate the analyst's often unconscious effort at self-regulation within the treatment frame. It is when those efforts fail in major ways (as they did with my patient Ms. R) that we may find ourselves committing flagrant breaches of the analytic contract.

Analytic Crimes, Misdemeanors, and Object Relatedness

To some extent, the analytic community shares a consensual sense of the nature of the analytic frame. If not psychopathic, analysts who commit smaller or larger infractions of that frame contend with anxiety about being caught as well as guilt when not discovered. That guilt often arises even when the patient remains oblivious to the infraction and when awareness that we are doing something sneaky or wrong is kept at the periphery. Analytic crimes and misdemeanors profoundly affect both our professional self-image and our relationships with our patients. Yet it seems to me that there are important distinctions to be

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5 I chose not to tell my patient about what I had done but instead began to talk with him about where we were emotionally with each other.
made with regard to the quality of the object relationship embodied in analytic infractions versus analytic crimes.

Analysts who commit serious and persistent violations of the treatment contract not only take for themselves while blotting out an awareness of their patients, they also actively reject or deliberately exploit the patient's subjecthood. In this process, they unconsciously or purposefully transform the patient into an object. I believe an important distinction lies here. Whereas the analyst who commits a serious “crime” transforms the patient from subject to object and explicitly takes advantage of the patient's emotional vulnerability, misdemeanors involve the analyst's attentional and affective withdrawal from the arena of the patient's needs. Rather than using the patient to further the analyst's own needs, the analyst withdraws from her patient into a state of solipsistic subjecthood, temporarily losing contact with the reality of her patient as a subject so that the analyst becomes the single subject in the room (Benjamin, 1995, 1998).

Interestingly, all the analysts with whom I spoke commented that they never committed misdemeanors during emotionally intense or demanding sessions, but, instead, during quieter sessions whether on the telephone or in person. I wonder if it is precisely the absence of intense emotional demands on the patient's part that creates room for the analyst to experience her self-interest. During these calmer sessions, the analyst who commits a misdemeanor implicitly turns to her own desire and away from her patient's. She attempts to balance personal need with her patient's by “appearing” to be analytically involved. This retreat from the relational field into a self-involved state is, surely, an abandonment of the patient and the analytic task. Nevertheless, hidden misdemeanors are often less abusive than analytic crimes or misdemeanors committed in face-to-face sessions: the latter actions transform the patient from subject to object in an explicitly exploitative way.

To some degree, analytic delinquencies represent an expression of burnout, overwork, or intensified personal strain. When analysts are driven by professional interest, need, or greed to see more patients and work longer days, a sense of increased inner pressure is nearly inevitable. And when analysts do not allow themselves, or are unable

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6 Sue Grand (2000) has powerfully illustrated the dynamics of such exploitative relatedness in her discussion of human malevolence.

7 The female pronoun refers to patients and to analysts of both genders.
to create, other venues for personal restoration, emotional and physical depletion can become chronic. By committing a misdemeanor, the analyst may unconsciously attempt to recapture something for herself and simultaneously express disowned hostility toward her patients. Thus, an analyst who struggled to earn enough money to support his family complained to me that he often felt that his patients “sucked him dry.” His intense experience of depletion resulted in his hatred of those patients who remained in need even when he felt that he had little left to give. That hatred ultimately found expression in a variety of forms, including (although not limited to) misdemeanors.

**The Analytic Ideal and the Analyst’s Humanity**

This essay was written well before the catastrophe of September 11, 2001. The new context created by the events of that day evoked intense feelings in many of us, and in the New York area many psychotherapists responded to the immense need and crisis with enormous generosity. In the face of that crisis, we set aside personal need in a big way, and I suspect that the kinds of thefts that I describe in this paper had little, if any, place in our work. Yet, I do wonder what the long-term effects of this massive strain will be on us. Will it become necessary to balance that strain by committing professional delinquencies? Or will our refreshed awareness of the preciousness of life and our obligation and desire to be of use support a movement away from the phenomenon I have spoken about here?

There is something ironic about the notion that to do good analytic work we must be present as full and feeling persons in the treatment relationship while always aiming to use our humanity in the service of our patients' needs. Certainly, the past decade has seen a dramatic shift in our view of that analytic ideal. It is now widely recognized that we exist as persons who struggle to function as analysts within the therapeutic encounter and, further, that our subjectivity enriches and deepens analytic work. Yet, while there are a myriad of ways in which we do “get” for ourselves emotionally while we work without committing misdemeanors, at times the press of our own needs may be insufficiently met within the constraints of our analytic role. For despite the potentially therapeutic benefits of our subjectivity, there are times when that subjectivity is transformed into responses that
collide with the professional ideal and override our professional commitment.

Individual analysts may well respond to different dimensions of the professional ideal with a feeling of increased pressure. Some analysts may experience their patients' need for holding or self-preoccupation as a nearly intolerable deletion of their subjectivity and may react by asserting those needs and “stealing” in small ways. Others may find it difficult to respond when the treatment seems to require that they be fully emotionally present, using their experience of their patient to deepen the work. All of us struggle at times with the intensity of emotional demands implicit in this work, particularly during periods of personal life stress, illness, or other crisis.

Winnicott (1947) believed that the analyst expresses her selfishness or hatred of the patient in symbolic ways, for example, in the strict ending of the hour. He suggested that this expression supported the treatment and the analyst, allowing her to work more effectively. But what if these symbolic expressions of personal need are not enough? Are we capable of remaining focused on the patient for much of the working day in a manner far more complete than is required, perhaps, in any other profession? I suggest, that, unless we own and consciously struggle with our greed, sense of deprivation, or selfishness—that is, with our very unideal humanity—it is almost inevitable that those feelings will ultimately become sequestered and thus expressed illicitly. (See Susan Kraemer's [1996] discussion of the mother's nonuseful failures and Slavin and Kriegman's [1998] description of the inherent conflict between the patient's and analyst's self-interests as they play out in the analytic situation.)

The analytic ideal contains within it a disregard for those dimensions of the analyst's humanness that are not integral to the treatment relationship. I believe that this is true across the theoretical continuum. Analytic misdemeanors may thus represent an unconscious rebellion against the ideal analytic position, whatever its shape, and an implicit, symbolic assertion of the analyst's subjecthood. These misdemeanors are virtually ubiquitous precisely because we find it so difficult to acknowledge openly and struggle with the clash between our very human selfishness and the still extraordinary demands of this “impossible profession.”

Analytic misdemeanors at once disrupt and sustain the treatment contract. They represent a real failure of the analytic function and yet also reflect our abiding and immutable humanity, the limits of our
ability to fully suspend personal needs in the context of a requirement that we do so. It is essential that we analysts contend with the paradoxical necessity simultaneously to embrace the analytic ideal, its inevitable clash with our own very real and limiting humanity, and the need to sustain an ongoing and conscious struggle against the abandonment of that ideal.

References


Frankel, J. (2001), Pre-existing and emergent thirds: Play, submission, and suffering in the analytic relationship. Discussion of papers by Sue Grand, Phil Ringstrom, and Joyce Slochower. Presented at Annual Spring Meeting, Division of Psychoanalysis, American Psychological Association, April, Santa Fe, NM.


