MONEY TALKS
in therapy, society and life

Edited by
BRENDA BERGER
STEPHANIE NEWMAN

SAMPLE CHAPTER
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Chapter 2

It was a great month: None of my patients left*

Irwin Hirsch

In this chapter, I will attempt to expose my psychoanalytic profession and myself as simply human when it comes to money and to greed. I believe that an analyst’s awareness and acceptance of his own disquieting characteristics are likely to lead to more productive use of these feelings in our everyday analytic work. When we analysts deny our shameful or personally discordant feelings and strivings around money and project them into patients, we lose touch with them and are at risk for doing harm in our work.

A number of years ago, shortly after I left my hospital job and began full-time independent practice, I ran into a former supervisor of mine who I had not seen for some time. She was with her lawyer husband, and after she congratulated me for making the bold move into private practice, something she had been reluctant to initiate, her husband asked me bluntly how I dealt with the conflict between my patients getting better and leaving and the loss of income that followed. He implied quite clearly that his psychologist wife, senior to me and more qualified, had chosen the professional high ground by continuing to see her patients on a hospital salary basis. His commentary was not only pithy, but also profound and jarring. It was 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.

I had a similar encounter some 30 years later while I was in Germany for a conference. At a dinner with a few German colleagues I had just met, I learned that national insurance paid 100% of psychotherapy and multiple times per week psychoanalytic fees for prolonged periods of time. I was further told that because of this coverage, virtually every analyst had a

*This is a revised version of Chapter 7 from Coasting in the Countertransference: Conflicts of Self-Interest Between Analyst and Patient (Routledge, 2008). Reprinted with permission.
full practice and a waiting list for new patients. My envy was palpable, although tempered by their lament that the fees that I and other American analysts 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 whenever 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 American 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. He wondered how I could try to help patients when an ultimate positive outcome would lead to my losing income. This time I was more prepared and had a better answer. I had already coauthored an article identifying economic conflict as the single greatest problem in our profession (Aron & Hirsch, 1992), and I was in the planning stages for a book dealing with issues such as these (Hirsch, 2008). I essentially told this man that I believed his system created far better conditions for productive analytic work, and that despite my enjoying much higher fees, that I thought I personally would 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. This is best captured by an interchange I had with a colleague. “How’s it going?” I asked him when I ran into him one day in the street. “It’s been a great month—none of my patients left,” he responded.

The degree to which we are dependent on our patients both to exercise our skills and to 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 dependence 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 believe that our anxiety about income is the single greatest contributor to compromised analyses.

There are many and often major consequences of this worrying about money. Perhaps the most common one is the problem of keeping patients in treatment for too long and the excessive mutual dependency that inevitably arises. I have no actual research data to support this, but my own
anecdotal observation is that many patients remain these days in analysis for a staggering number of years. This appears to be more common than it was in previous generations. Modern patients (many of whom are analysts themselves) seem to remain in analytic treatment 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. With most analysts, I also believe that at least three sessions per week is optimal for good analytic work. But analysts’ motives for seeing patients multiple times each week are sometimes unrelated to this analytic ideal. Some patients who are seen frequently are not necessarily being treated in an analytic context with analytic aims. That is, some analysts do supportive or maintenance-oriented work with patients who can afford this, and they behave as if they were conducting an analysis that actually requires the frequent sessions. Similarly, many patients who can afford high fees will be seen multiple times per week for many, many years, long after 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 well-respected one proclaimed at a clinical meeting that she and all of her colleagues have what she called their “lifers,” patients who allegedly “need” to be in analysis for literally their entire lives. Shockingly, this statement was not challenged by others at the meeting.

In these situations, “analysis” has become a vehicle for the creation of mutual attachment and dependent ties, and the rationale for this centers around biased assessments of patients’ psychopathology. The very idea of adhering to the patients’ original analytic goals or aims is forgotten too often. Maintenance of the analytic relationship can, and frequently does, become an end in itself.

Another compromise precipitated by analysts’ anxiety about money occurs when the analyst strives to be liked by his or her patients so that they remain in treatment. This takes the form of analysts being overly supportive and complimentary or striving to be helpful in ways that do not correspond to the analytic aim of facilitating autonomy. They may avoid challenging patients when this would be potentially useful, or they may duck uncomfortable transference themes, particularly those related to anger and disappointment. Analysts may be too tentative so patients’ anxiety, even productive anxiety, is kept to a minimum. They may use deliberate self-disclosure to gratify patients’ wishes.

I also believe that certain theoretical points of view are sometimes embraced more because they are gratifying than because they are likely to effect ultimate separation and autonomy. Both analytic reserve and analytic challenge can be eschewed for fear that these attitudes may provoke patients to quit, while measures that are more traditionally associated with supportive psychotherapy serve to maintain patients in prolonged attachments.
It is my view that analysts will be more likely to conduct briefer analyses, and analyses that foster independence, when they are more willing to let patients leave and bear the loss of income. Unfortunately, this does not occur enough in our current analytic culture. When it does, it may be a function of an analyst’s practice being full, the analyst having new patients waiting, or the patient’s fee being so low that the analyst does not wish to prolong this commitment at such a reduced fee. I am not suggesting that the willingness to see patients leave is always good. This also can easily be misguidedly based on wishes for higher fees or to see someone new or perhaps more interesting. Keeping patients for many years and seeing them frequently can of course be appropriately based on what is genuinely best for patients or be evidence of a strong and ultimately fruitful attachment. However, analysts’ financial needs carry much weight in the myriad judgments and choices we make daily in our clinical work. These choices are often quite conscious on our part.

There are several other money-driven practices that have become somewhat common even among the most ethical and respectable among us. They concern the ways in which the modality of psychoanalysis is often compromised and other treatment modalities are collapsed into each other in confusing and potentially damaging ways. For example, when an appealing patient who is highly motivated (someone with whom an analyst wishes to work) can afford to pay only a demarcated amount of money, the analyst often opts for a higher fee to see this individual once or twice weekly. This is selected over dividing the dollar amount by three or more sessions per week or referring the patient to someone whose fees are lower, an analyst who could provide a more optimal psychoanalytic experience. Another example of this occurs when it is difficult for a patient in analysis three or more times weekly to commute to an analyst’s office. Such a patient might be offered a double session at double the fee, thereby defeating some of the original aim of psychoanalytic frame that occurs multiple times per week. This coconstructed “deal” between analyst and patient maintains for the analyst the advantage of receiving payment for an ideal number of sessions.

More recently, telephone sessions have also attacked the analytic frame. They have become a way to reduce inconvenience for busy patients while maintaining the patient’s consistent willingness to stay in therapy. An analyst may cooperate with this to maintain the patient in therapy or to secure optimal income. Finally, although it has long been recognized as poor practice, analysts might accept referrals from patients who are either close friends or family members of their patients. They may also see a patient while regularly doing couples therapy with that same person and the person's significant other.

It is clear to me from all that I have struggled with personally and seen practiced in my field that we psychoanalysts are no more noble as a group.
when it comes to financial greed than are our counterparts in the financial sector, the “business world,” law, and medicine. In denying to ourselves our own financial ambitions, psychoanalysts often have little to offer by way of understanding to people in other fields who make headlines for their so-called disregulated affect or compulsive irrationality.

Fundamentally, I do not believe that these criticisms veiled as semidiagnostic designations are warranted. I think that the wish to earn maximum money and to be recognized as successful or powerful is but a variant on normative ambition. Any human quality, like ambition, that can be seen as productive for individuals and for society at large can also in extremis cause harm. The desire for recognition, power, and status is normal across disparate cultures, and the degree to which any individual possesses these qualities lies on a bell-shaped curve. Because many psychoanalysts and others in the helping professions deny having such personal needs to any significant degree, strong ambition and greed are often projected onto those “bad” others in different professions. These “others” then become demonized in the best way that psychoanalysts do this—the designation of diagnostic labels that conveniently lead to a “good me and bad them” binary.

In private conversations, at committee meetings, in published articles, and in the context of clinical presentations of patients, those others outside our profession are often discussed as living on a moral low ground in comparison with the prototypical psychoanalyst, allegedly in aggregate embracing higher moral standards with respect to money and other forms of ambition. Because psychoanalysts belong to a helping profession for which fees and income may on average be lower that those of other professionals mentioned, and because most psychoanalysts, at least in large urban centers in America, lean leftward in their political beliefs, analysts may readily deceive themselves and deny that ambition for status and money plays a role in their aims. This superior moral attitude, indeed, often disguises what is actually a sense of weakness and inferiority toward those who earn appreciably bigger incomes or have more social power and stature, including many of the patients whom psychoanalysts treat.

There exists a clear irony in the fact that psychoanalysts invariably prefer to see patients who can afford what we call a “full fee” (the analysts’ maximum fee), and that this fee, often barely or not at all covered by insurance, is more than the vast majority of people can afford. Without considerable income, family money, or rarely available terrific health insurance coverage, only a very small percentage of people can engage in a psychoanalytic process once weekly. Once-weekly treatment, however, is only one third to one fifth of what psychoanalysts desire. And, as is well known, these sessions one to five times weekly often last for many years. It is rare that an analytic patient who is productively engaged in treatment and who can afford to keep coming will spend less than 5 years “on the couch.” Of
course, 10 to 20 or more years are not at all uncommon. Although many analysts may reduce their fee from their full fee to a lower one to accommodate analyses multiple times per week, the total income accrued from such therapy is likely quite significant. And yet, with all the education and years of study and personal analysis, analysts’ income is often less than counterparts in other professions like medicine and law. It is especially less when compared to those earning in the world of finance, banking, and private business.

I see great hypocrisy in analysts’ distinct preference for patients who are wealthy enough to help support them and simultaneous denigration of those patients with their colleagues for their greed, mercenary values, and economic ambitions. Most contemporary analysts have integrated Harry Stack Sullivan’s now-famous phrase, “We are all more simply human than otherwise,” (Sullivan, 1940, p. 16) and have embraced the value that Racker articulated so well: “The first distortion of truth in the analytic situation is that analysis is an interaction between a sick person and a healthy one.” (Racker, 1968, p. 132). The best analysts are those who readily acknowledge their subjectivity and their personal flaws, and view themselves as neither objective observers of specimen patients nor inherently more psychically healthy because of being in the role of healer. The term wounded healer has been widely embraced by modern analysts, who largely have been increasingly free to speak and to write publicly of their most intimate feelings and foibles.

Although economic greed is a shortcoming analysts share with many others, I have observed, paradoxically, that this remains one area wherein analysts commonly differentiate themselves from their patients and in their remarks about public personalities. That is, I have observed that when speaking or writing about them, analysts often split off and deny their own financial and power-related ambitions, while emphasizing, in a condemning and a pathologizing way, these qualities in others.

I do not have many speculations regarding why this happens. I previously suggested that analysts often feel inadequate in comparison with patients whose ambition has led to far greater material success and comfort than that available to the purportedly stronger person in the analytic dyad—the analyst. An analyst’s ambition for, or envy of, wealth and power may be quite painful in this context, so these uncomfortable emotions may be attributed to belonging to the patient only and then be regarded as bad or pathological characteristics. Such attribution not only pathologizes a patient (or a public person), but also pumps up the analyst so that he or she may then feel more like a powerful healer. In the analyst’s eyes, he or she is now in a position to cure the allegedly sick patient of the latter’s pathological greed and ambition—moral and personal failings, allegedly inferior to the qualities of the allegedly healthy analyst. Here, the analyst positions

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him- or herself not only as more powerful by virtue of heartier mental health but also as stronger through an attribution of moral superiority. This positioning, clearly not useful to patients, is supported often by left-leaning political beliefs shared by a majority of psychoanalysts, beliefs that often encourage a suspicion of dishonesty toward almost anyone whose ambitions have led to an accumulation of wealth and power.

It is my view that those analysts who are most successful in achieving either relatively high income or public professional recognition have ambitions quite parallel to others outside this profession. I further argue that many analysts who do not feel successful along these dimensions are soothed in their disappointments by denying their thwarted ambitions and attending to the ambitions of others only as pathologically excessive.

For example, the term *mania* is often used in our field to describe people who work long and hard and with much energy to reach very high aims or reap strong economic rewards. Other designations, such as *type A personality* or *workaholic*, are also common. Mania comes from the colloquial *maniac* or, more respectfully, from the severe psychiatric diagnosis, manic-depressive. The connotation of these terms is most negative, although I believe personally that when harvested productively, a fair touch of mania is often highly productive both for the individual and for what the results of this mania may produce for society. I have long believed that many people who have contributed greatly to the human race have been driven in ways that could be called manic. This designation could be viewed as either “healthy” or pathologic depending on the eye of the beholder and his or her motives, conscious or unconscious. Leaders and pioneers in the arts, the sciences, philosophy, business, politics—and yes, even psychoanalysis—have been motivated by ambition for recognition, power, and sometimes wealth. They could be called workaholic, manic, or both in either the productive or the pathological sense of the words.

In conclusion, the economic realities of psychoanalytic practice in America create choices that I believe very few of us would make were we working for a salary at a clinic or under the German national insurance system. Some analysts opt for therapeutic configurations that constitute, or come close to constituting, unethical conduct. I believe that almost every analyst makes some decisions about the basic physical structure of the analytic relationship that reflects compromise that falls short of analytic ideals. Such decisions can only be controlled when they are acknowledged and made without self-deception. However, even in full consciousness, I suspect that most analysts will make some basic frame decisions that are affected by financial self-interest. The more that these realities are embraced, the less they will be projected onto ambitious or wealthy patients such that these patients become demonized or pathologized for qualities that we analysts share with them.
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