3. Money

It is better to have a permanent income than to be fascinating

Oscar Wilde (1854-1900)

Nearly a hundred years ago, Freud (1913) noted that most people approach matters of money with 'inconsistency, prudishness, and hypocrisy' (p. 131). Little has changed since then. It is still difficult for people to talk about their realities, fantasies, feelings, and aspirations involving money in a peaceful manner. This is not only because money is important in external reality but also because it has powerful meanings in the inner world of emotions. Not surprisingly, concerns about money readily become drawn into psychopathology and its treatment. The conceptual and technical knots in the encounter between money and psychotherapy have myriad forms indeed (Krueger, 1986a; Borneman, 1976; Rothstein, 1986).

In this chapter, I will attempt to shed light on these problems and their potential solutions. I will begin with a brief survey of literature on the symbolic significance of money and then delineate the psychopathological syndromes involving money.[18] My focus, however, will be upon how various aspects of our clinical work, including the therapeutic frame, transference, and countertransference are impacted upon by matters of money. Elucidation of these will lead me to explore the technical dilemmas rampant in this realm and suggest some ways of handling them.

PSYCHOLOGICAL SIGNIFICANCE OF MONEY

In a paper titled 'Character and Anal Erotism', Freud (1908) listed parsimony as a major trait of the obsessional personality. He traced the reluctance such individuals show in parting with money to the pleasure felt by the anal-phase child in retaining feces. Invoking illustrations from fairy tales, mythology, language, and dreams, Freud declared that money and feces were equated in the unconscious. He stated that two factors facilitate this equation. First, the striking contrast between a precious and a worthless substance makes the former a perfect disguise for the latter. Second,

> the original erotic interest in defecation is, as we know, destined to be extinguished in later years. In those years, the interest in money makes its appearance as new interest which has been absent in childhood. This makes it easier for the earlier impulsion, which is in the process of losing its aim, to be carried over to the newly emerging aim. (p. 175)

Freud's notions were phenomenologically embellished by his early pupils (Ferenczi, 1914; Jones, 1918; Fenichel, 1938, 1945) though with little addition to their theoretical basis. The feces-money equation thus became the established psychoanalytic dictum and miserliness was firmly ensconced as an anal trait.

However, as psychoanalytic motivational theory evolved from its instinctual foundations to include the ego, object-relational, and self-psychological perspectives, additional views regarding the emotional significance of money were voiced. Klein (1937) saw the origin of greed in the early oral phase and stated that its purpose was a hungry, destructive introjection of the frustrating breast. Money came to symbolize this elusive source of security later in life; children's fears of poverty betrayed the expectation of punishment over unmitigated hostile phantasies towards the mother. According to Klein, the adult depressive's dread of becoming destitute could be traced to this very dynamic of early childhood. Extension of her ideas was evident in Kernberg's (1975, 1976, 1984) descriptions of narcissistic personality that included the intense fervor with which some of these individuals pursue wealth. It was as if having money would provide assurance that one was not unloved and 'bad' (i.e. hostile). However, the goal of such contentment remains elusive and the narcissist keeps chasing it like a mirage.

The self-psychological perspective on money (Krueger, 1986b) emphasized the exhibitionistic aspect of wanting to be wealthy. Showing off one's financial success, with all its colorful accoutrements, provided a way to seek affirmation and applause from others. This helped maintain a positive self-image. It also provided a sense of vitality and coherence to an otherwise fragile self. Yet more psychological meanings of the interest in acquiring large sums of money were discerned over time (Blanton, 1976; Kaufman, 1976; Fuqua, 1986). These pertained to phallic competitiveness with one's rivals, sadistic wishes to triumph over one's 'enemies', and the 'some day...' (Akhtar, 1996) fantasy of leading an effortless and blissful existence by returning to the early infantile merger with mother. All in all, money seemed to acquire multiple symbolic functions and thus became vulnerable to being caught up in conflicts from diverse levels of development.

PSYCHOPATHOLOGICAL SYNDROMES INVOLVING MONEY

The flamboyant overspending of money in manic states and the delusional dread of poverty associated with profound depression (Slater & Roth, 1977; Wolpert, 1980; DSM-IV, 1990) are well-recognized monetary manifestations of psychopathology. Less known are the subtle ways in which psychological conflicts shape attitudes regarding money. The following six conditions stand out in this context.

Chronic Miserliness

That frequent topic of behind-the-back conversation, miserliness, is a Janus-faced problem with considerable intrapsychic and interpersonal ramifications. Before going into them, however, it should be emphasized that miserliness is unrelated to the actual financial state of the individual. Both the rich and the poor can be miserly and both can be generous. Tight-fistedness is the inverse of large heartedness. It is not about lack of money. That said, the problem of miserliness appears to have two faces. Subjectively, the miser is saddled with terrible anxiety; parting with money stirs up in him

the dread of becoming poor and resourceless. Saving money is equated with psychic security and the slightest monetary bleed is felt to be a life-threatening hemorrhage. The miser resorts to all sorts of conscious and unconscious measures to avoid spending. Rationalization especially comes to his rescue; it helps stinginess to masquerade as prudence. Inner tension nonetheless persists.

In contrast to such an anxiety-laden inner world, the miser's object relations are permeated with sadism, even though he is consciously unaware of it. His lack of generosity, his frequent cheating and unfairness in paying his due, becomes a torture to his friends and relatives. The miser seems to be saying to them: 'Why should I give you anything when I myself have not been given much?' This brings up the fact that while anal drive derivatives are clearly discernible in it (Freud, 1908; Jones, 1918), 'monetary constipation' is, at its bottom (pun unintended), a reaction to early oral deprivation. The miser has experienced a profound and traumatizing lack of nourishment from his early caretakers and, in a move typical of 'identification with the aggressor' (A. Freud, 1936), has adapted an ungiving attitude towards others. Yesterday's victim has become today's perpetrator. The miser's self is split; a deprived child weeps inside while a cruel and withholding adult triumphantly parades outside.

Characterological Overspending

Many individuals resort to spending sprees in states of anxiety. Shopping serves as a distraction from inner turmoil and the act of buying becomes a reassurance against passivity and ego-impotence (Benson, 2000). Feelings of inferiority are masked by flashes of financial omnipotence. Depressive affects can also be warded-off.[19]

Besides such 'state-related' financial excesses, there are patterns of overspending that are better viewed as 'trait-related'. Highly repressed, neurotic individuals over-spend money to derive sexual gratification in disguise.

> The spending of money deceives them as to the want of freedom of their libido and thus relieves them for a short time of the painful feeling of sexual insufficiency. In other words, they are under an abnormally strict prohibition, proceeding from the parental imago, against expending their libido freely. A compromise between instinct and repression is made by which the patient, in a spirit of defiance, does expend—not his sexual libido but an anal currency. (Abraham, 1917, p. 301)

The motives for overspending in individuals with narcissistic, hypomanic, and antisocial personalities (Akhtar, 1992) are different. They like to throw lavish parties, give huge tips, buy costly dresses, drive flashy cars, and go on exorbitantly expensive trips. All this is often accompanied by a pretended contempt for money in real life (Jones, 1913). The motivations underlying such behavior include self-aggrandization, defying the limits of resources, dazzling others, buying gratitude, and drawing secondary gains from making an impression. Money becomes an instrument of 'manic defense' (Klein, 1935; Winnicott, 1935).

Inordinate Generosity

In contrast to the exhibitionistic and self-indulgent overspending of money described above, the syndrome of 'inordinate generosity' involves giving excessive amounts of money to others. Such behavior is distinct from genuine philanthropy where a resourceful individual donates money for civic causes. In situations of 'inordinate generosity', the individual often does not have much money himself and the recipient is not needy in reality, only construed as such in the giver's mind. The dynamics of this undue financial indulgence in others is the same as seen in 'pseudo altruism' where

> compulsive caretaking and self-sacrifice cloaks and defends against aggression, envy, and a need to control the object. There is generally little or no conscious pleasure in the behavior, although the analytic observer can detect evidence of sadistic glee in the dramatic exhibitions of suffering that aim, generally unconsciously, at coercing others. (Seelig & Rosof, 2000, p. 948)

Monetary Masochism

This is evident in individuals who display some or all of the following behaviors (i) not asking for a salary raise even when they are deserving of it, (ii) turning down opportunities for making more money, (iii) chronically asking lower than market price for their services, (iv) not being able to spend money on their own selves, (v) not investing their capital in ways that assure its maximal growth, (vi) being unable to firmly conduct financial negotiations, (vii) frequently misplacing and losing money, (viii) not being able to use or enjoy expensive gifts given to them, and (ix) becoming depressed or self-injurious, however subtly, upon receiving a windfall. Such 'monetary masochism' occupies an intermediate place between 'moral' and 'erotic' (Freud, 1924) varieties of masochism insofar as it is highly libidinized, can result in physical suffering, but does not involve overt sexual enactment. The 'beating fantasy' (A. Freud, 1922) typical of erotic masochism lurks just beneath the surface and the 'pleasure' in financial hardship is discernible to the experienced eye.

Bargain Hunting

The tendency shown by some individuals to be irresistibly attracted to merchandise that they do not need but can buy cheaply constitutes the essence of 'bargain hunting'. The object's price is more important here than its usefulness. In Bergler's (1947) words,

> The act of buying is for the bargain hunter not a rational situation but a battle of wits. He tries to outsmart the seller, who, on the other hand, seeks to give him, the involuntary 'sucker', the narcissistic illusion of triumph... bargain hunters behave as if bad reality (mother substitute) wants to refuse and must be outsmarted with aggression which shows up in the tenacity of the bargaining process. (p. 625)

The pleasure of victory experienced by the bargain hunter is, however, short-lived. It is soon replaced by 'buyer's remorse' and doubt about the 'success' of the transaction. 'Could I have gotten the stuff for even less?' the bargain hunter wonders. This anguish is the masochistic counterpart of his oral sadism which fuels his greed.

Pathological Gambling

Closely related to 'bargain hunting' is the syndrome of pathological gambling. Here the wish to get something cheap reaches its zenith. The disproportion between the amount spent (e.g., on lottery tickets, roulette, off-track betting) and the desired reward (in thousands and millions of dollars) creates the illusion that what one is about to receive is free of charge. This constitutes a powerful allure since it secretly gratifies the infantile wish of getting something for nothing. After all, it is only in infancy and childhood that one actually gets free supplies (tangible or emotional); once that period of life has passed, all material acquisition and even all love and respect has to be earned. Gambling, by 'promising' a windfall and a generous gift from the 'mother nature', as it were, creates the possibility of being a carefree child again. At the same time, ignoring the fact that the probability of winning is minuscule (a fact that *is* preconsciously known), prepares the ground for masochistic self-punishment; the guilt over resorting to an unfair and effortless path to success (unconsciously equated with transgression of the oedipal barrier which demands respect for generational boundaries and therefore of time) is thus relieved.[20]

Addiction to gambling has a special connection with masturbation. Both involve arousal, excitement, and climax. Both deploy punishment for the activity per se as a plea bargain for keeping the fantasies involved in them unconscious. And, both are intended as a sort of play.

> Masturbation in childhood and puberty, in this sense, is 'playing at' sexual excitement, acquainting the ego with this excitement, and preparing it for the ability to control it. Gambling, in the beginning, is also thought of as 'playing' in the sense that the 'oracle' is playfully asked how it would decide in a more serious situation. Under the pressure of inner tensions, the playful character may be lost; the ego can no longer control what is has initiated, but is overwhelmed by a very serious vicious cycle of anxiety, violent need for reassur-

> ance, and anxiety about the intensity of this violence. The pastime becomes a matter of life and death. (Fenichel, 1945, p. 373)

Having surveyed the various symbolic functions of money and having briefly gone over the various psychopathological syndromes involving it, we are now prepared to plunge into the discourse about the impact of money upon the practice of psychotherapy and psychoanalysis.

Setting Fees, Billing and Third-Party Involvement

Setting of fees constitutes an important step in beginning the patient's treatment. On the one hand, it establishes, beyond doubt, that the therapist-patient relationship is a professional one. On the other hand, the very act of setting fees can reveal hitherto hidden information about the patient's inner dynamics and actual life circumstances. It is therefore surprising to note that the coverage of this issue differs greatly in books on psychotherapy. Some (e.g. Colby, 1951) do not mention it at all. Others (e.g. Menninger & Holzman, 1973) go over it briefly, using a rather authoritarian tone where the patient is told what to do rather than being made a partner in such decisions. Then there are books (Bruch, 1974; Roth, 1987; Ursano, Sonnenberg & Lazar, 1998) that address the matter in a thoughtful manner, emphasizing the need for candid and thorough discussion of the fee, insurance payments, charging for missed sessions, and, above all, the patient's freedom to decline to participate in the financial arrangements proposed by the therapist and seek help elsewhere.

It is, however, Jacobs (1986) who provides the most lucid and thoughtful discussion of setting fees for psychotherapy. Prominent among the points he makes are the following:

- The amount to be charged for each session should be explicitly discussed between the therapist and patient during the initial evaluation. Such discussion might have to include an exploration of the patient's assets and income from various sources.

- Since dynamic psychotherapy and psychoanalysis are long-term endeavors, the sustained nature of the patient's financial resources should be assessed. Contingency plans in case of the patient's resources drying up should also be addressed at this early stage. Leaving them for later is hardly prudent since at that stage issues of transference and countertransference are likely to muddle the clinical picture.

- The therapist should mention his 'usual' fee only if he is going to stick to that very figure or make only minimal reductions to it. Telling a patient one's 'usual fee' and then accepting a significantly lower amount can puzzle the patient; both narcissistic fantasies of being 'special' to the therapist and a guilty sense of having unwittingly burdened him can arise as a consequence.

- There are exceptional instances where the therapist might deliberately agree to a lower fee than is realistically possible for the patient to pay. This is done for psychodynamic reasons since some (e.g. schizoid and depressed) individuals cannot otherwise be engaged in treatment. 'It is also true for certain patients who have subtle difficulties with ego boundaries and for whom paying less assures them of a comfortable separateness which they may need in order to enter an intensive treatment' (Jacobs, 1986, p. 127). Eissler (1949) had made the same point, long ago, in connection with mildly antisocial individuals.

To these sensible recommendations, I will only add that the fee, regardless of its actual amount, must be realistic for the circumstances of both the patient and therapist. If the patient, for some reason, agrees to pay a higher fee than he can afford, he will sooner or later begin to resent the treatment; this, in turn, will contribute to his resistances. If the patient manages to have his therapist accept a fee that is less than what he can actually afford, he will sooner or later begin to feel guilty; this will cause problems for their work. The same dual dynamics applies to the therapist. If he charges the patient an inordinately high fee, he is prone to feel guilty just as if he accepts a very low fee, he is likely to feel resentment. The lesson from all this is crystal clear: the fee must be realistic for both parties. And, if their realities cannot match without

gross adjustments, the advisability of their working together becomes questionable.[21]

A few other points are important here. First, therapists are accustomed to exploring a patient's declaration that he cannot afford to pay their fee but take another patient's agreement to pay the demanded fee at surface value. Such an attitude overlooks that a quick agreement on the patient's part might be unrealistic. Interview-related anxiety and characterological timidity might cloud the patient's judgment in this regard. Cultural factors might also pay a role here. Negotiations of fee with recent immigrants from Far Eastern countries, for instance, must take into account that their socially-dictated reverence for authority might be making it difficult for them to ask for a lesser and more realistic fee.[22]

The second issue pertains to the frequency of payments. Most therapists bill on a monthly basis but there are some who wish to be paid at each session. This might be financially prudent but it is psychologically insensitive. It carries the potential of conveying that the therapist does not trust the patient or that he is unduly anxious about money matters. Such repeated reminders of the business aspect of the relationship deprive the patient of the much-needed illusion of unconditional acceptance in the setting of which transference can develop and internal objects become mobilized. Moreover, the patient who pays at each session is prone to assess the value of an individual hour separately rather than that of the therapy as an on-going process.

Finally, there is the impact of third-party payers on setting and collecting of fees. Ideally, this variable would not exist. But it does and has to be dealt with. The potential breach of confidentiality, while unavoidable to a certain extent, must be kept to a minimum (Chodoff, 1986; Ursano et al., 1998). In general, the therapist should be available to provide a bill in the format required by the patient's insurance company and/or be willing to sign the needed forms. The current climate of practice, with its provider networks, often makes it necessary to accept insurance payments directly and receive only the 'co-payments' from the patient. However, if there is a choice, it is preferable that the patient be responsible to deal with and submit the bill to the insurance company; this keeps the financial dialogue and its attendant affects and fantasies contained within the therapeutic dyad.

The same policy (i.e. of assuring that the patient deals with the 'third parties'), by and large, applies to very young adults (e.g. college students) whose treatment is being paid for by their parents.[23]

CLINICAL VIGNETTE 10

> Erin Nevin, a twenty year-old college student sought psychotherapy for depression that was making it difficult for her to do the required academic work. During the initial evaluation, she told her psychiatrist that her parents, who owned a highly successful restaurant in a large mid-western city, would pay for her treatment; all he had to do was send them a monthly bill. The psychiatrist declined saying: 'Look, you are an adult, a young adult but nonetheless an adult, and you have to be responsible for paying your bill. Where you get the money is up to you but I will only accept payment from you.' Erin protested saying that the psychiatrist she had previously seen had accepted such an arrangement. Undaunted by Erin's argument, her psychiatrist refused to bill her parents. He felt that doing so would be harmful in two ways: (i) it would make Erin feel as if her treatment was being carried on free of charge and thus fuel a sense of infantile omnipotence in her, and (ii) it would preclude her realizing that her parents were indeed spending hard-earned money on her treatment.

On rare occasions, however, this policy can be reversed if the decision to do so is based on solid psychodynamic reasons. For instance, an older woman analyst seeing a young out-of-town college freshman, who has never felt loved by his mother, might accept to receive payments directly from his parents. She would be doing this in order to provide her patient the much-needed illusion of unconditional love as a preliminary condition for beginning treatment, knowing fully well that sooner or later this would have to become a topic for exploration and understanding.

CHARGING FOR MISSED SESSIONS

Psychodynamic psychotherapy or psychoanalysis requires that the patient come two to five times per week for sessions with his therapist. This needs discipline. While pre-arranged absences that have been realistically discussed and interpretively explored cause less disturbance to the flow of the therapeutic process, it is the unexpected, sudden, and impulsive absence from the session that draws greater analytic attention. Purposes of resistance, acting-out, and transference-based enactments can all be served by such 'missed sessions'. Clearly all this has to be analytically handled—i.e. by confrontation, exploration, interpretation, and reconstruction. However, the aspect that becomes quite 'charged' (pun intended) for the novice is whether to bill the patient for a missed session or not.

In one of his technique papers, Freud (1913) emphasized that the patient 'rents' hours from the therapist and is responsible for paying even if he does not make use of them. This gradually became the standard practice, or at least the practice that has been customarily upheld as desirable. Ursano et al. (1998) have eloquently explicated the rationale for this technical stance, regarding it to be

> the most neutral and fundamentally respectful stance for the therapist to take. Otherwise, the therapist takes the position of making a moral judgment about whether the absence was justified. In such a case, the therapist, in effect, volunteers to make a personal financial sacrifice if an absence is deemed worthy of being excused. If the patient is angered by paying for a missed hour, there is then an opportunity to explore the dynamics of the anger and why the patient feels that the therapist should absorb the exigencies of the patient's life. Similarly, the therapist operating on these guidelines can more appropriately set fees reflecting a known stability of chargeable hours and therefore potentially lower per-session fee. (p. 174)

To me, these 'explanations' and the value system that underlies them appear harsh, self-serving, and devoid of physicianly kindness. I assert the following: (i) Freud's recommendations were developed nearly a hundred years ago when life's pace was slower, analyses were shorter, and authoritarian models of clinical work prevailed. Those recommendations may have little applicability to the changed social and clinical milieu of today. (ii) Freud was a private practitioner with a large number of dependents and no other source of income beside clinical practice; his policy of charging for missed sessions reflected his personal situation and is less relevant to those practicing under different circumstances. (iii) While psychotherapy and psychoanalysis do require a certain asymmetry (with the patient revealing his inner world and the therapist withholding personal information), this asymmetry does not extend to all aspects of their work. Since the 'exigencies' of the therapist's life (e.g. illness, pregnancy, professional meetings) can and do impact upon the patient, it is morally unfair not to have the therapeutic frame accommodate the 'exigencies' of the patient's life. (iv) The assumption that the anger felt by the patient at being charged for a missed session is something that needs 'exploration' is also open to question. It blocks the consideration that the patient's anger at this situation might, at times, be legitimate.[24]

Clearly, there is a dialectical tension between the two positions outlined above; indeed, they represent one particular derivative of what Strenger (1989) has broadly termed the 'classic' and 'romantic' visions of psychoanalysis. The two approaches view human life differently, embody different ethical values, and give rise to different therapeutic strategies. A rigid clinging to either extreme is not useful even though it might provide the comfort of having clear-cut guidelines regarding clinical work. The fact is that most clinicians somehow end up striking a balance between these extremes and this applies to their policy of charging or not charging for missed sessions as well.

Four situations that might suggest not charging include absences due to: (i) developmentally appropriate out-of-town interludes (for visiting parents, study abroad) of college students; (ii) serious medical illness of the patient, and, according to Pasternak (1986) of the patient's immediate family members; (iii) family vacations which the patient, despite earnest effort, could not manage to

match with the therapist's time away; and (iv) natural disasters.[25] This recommendation might invite the criticism of the purists that the therapist is taking a superego position and flaunting moral authority. A rejoinder to this would be that the therapist is actually taking an ego position and showing respect for reality. And, in all fairness, it should be acknowledged that even these four situations can be used for the purposes of resistance and enactment. The recommendation of making an allowance for them is therefore relative and not absolute. While the novice might benefit by erring on the side of caution, with experience one learns that, when all is said and done, charging or not charging is all a matter of tact, empathic attunement, common sense, and analytic understanding of the situation. A far cry from water-tight policies, this stance reminds one of Limentani's (1989) solemn observation that 'psychoanalysis is an art and for this reason it needs discipline' (p. 260).

Money, Transference and Countertransference

The deployment of a monetary idiom in the service of repressed and unresolved infantile desires is far from uncommon. Stated in simpler terms, this means that money is frequently used by patients to express and enact transference wishes (and defenses against them) involving the therapist. A frequent manifestation of this is withholding payments or inordinately delaying them. The therapist, faced with this problem, has to decipher whether it is a characterological pattern or a specific development in the transference. The former might need more active confrontation and limit-setting while the latter needs to be handled in the more customary fashion of interpretation.

A related situation is when the patient loses a job or encounters a financial setback. Regardless of the extent to which such a mishap can be psychodynamically understood, the therapist is faced with a dilemma: terminate the treatment and refer the patient to a low-fee clinic or keep seeing him while extending credit to him in the form of deferred payments. A number of variables come into play here. These include: (i) the therapist's degree of comfort with his own financial situation, (ii) the overall value system of the therapist, especially as it involves matters of money, neediness, dependence, generosity, and so on, (iii) the nature of the financial emergency, especially whether it can be realistically assessed as transient or protracted, (iv) the patient's erstwhile reliability both as an individual and a partner in the therapeutic dyad, (v) the availability of reasonably good low-fee care, (vi) the current state of transference and countertransference, and so on. A complex grid of variables thus guides decision-making for the therapist encountering such a situation. In general, unpaid bills should not be allowed to accrue for a long time and any extension of 'credit' to the patient should be short-term. Collecting interest on delayed bills, however rationally justifiable it may be, seems unkind, contrary to the generative attitude that is integral to being a therapist, and therefore might turn out to be anti-therapeutic. Of course, if the patient feels guilty at not paying interest, his inability to tolerate gratitude can become a topic for exploration.

Yet another manifestation of 'monetary transference' is the patient's spontaneous offer to increase the fee, for instance, in an attempt to 'seduce' the analyst away from potentially painful introspective work, while remaining oblivious to his unconscious intent.

CLINICAL VIGNETTE 11

Dr. Robert Purple sought help when he found himself falling in love with 'yet another inappropriate woman'. A forty year-old internist with a mildly apologetic but earnest and decent way of relating, Dr. Purple had been twice divorced, both times having 'discovered' that he had married far beneath his socioeconomic and intellectual status. The current situation was different only on the surface; the inappropriateness of the choice became readily evident with questioning during the initial assessment.

Dr. Purple had grown up with a father who was preoccupied with his work and a mother who was anxious and clinging to her two sons. Dr. Purple's older brother had been difficult from childhood onwards; local police were often knocking at their otherwise respectable door. Assuming a quiet and passive stance, Dr. Purple grew up to be a kind and industrious man who somehow never blossomed fully, either as a pro-

fessional or as a lover. He accepted a humdrum job and twice married needy and impaired women.

Soon after beginning treatment with me, he offered to raise the amount he was paying me. Since little evidence could be unearthed that he had misrepresented his financial status at the time when we decided the fee, and had not received a salary raise, I was intrigued by this offer. My encouragement for him to elaborate on this idea gradually revealed that he viewed me as an immigrant physician with few well-paying patients; he wanted to help me. I was going to be his next rescue project, it seemed. A transferential re-creation of his needy mother (made more rescue-worthy by the condensation of a realistic perception of her character with the primal scene fantasies of her being beaten by the father) was essentially the motivating force behind Dr. Purple's gesture.

A more dramatic example of such transference-based 'generosity' is provided by Rothstein (1986) who describes a patient's offer to donate a huge sum of money in order to establish a research foundation bearing both their names. Exploration of this wish revealed the desire to remain united with the therapist (to undo the traumatic separation from his mother during childhood). Giving money to the therapist also assured his loyalty and helped bypass the analysis of the mistrust that the therapist would not really be there for him when he needed love and support. Money was to serve as glue between them.

In contrast to such direct allusions to money are situations where the patient strenuously avoids mentioning money when this would appear logically expectable.

CLINICAL VIGNETTE 12

Paul Marcus, a recently married and highly competitive mid-level administrator, was in the process of buying a house while in intensive treatment with me. There were many determinants of this decision and all sorts of fantasies were stirred up by the houses he and his wife saw in the process. Things began to calm

down once they settled on a particular house and made a formal offer. Paul would now talk enthusiastically about this house, describing its pros and cons in painstaking detail. While the transference wish that I be impressed by his thoughtfulness was evident, it struck me as more significant that he never mentioned the price of his forthcoming purchase. I brought this to his attention. He responded by acknowledging that this was difficult for him to do. As we explored further, it turned out that he was worried that I might mock him upon hearing the price of the house since I must own a house that was much more expensive. Empathizing with him, I nonetheless encouraged him to elaborate further. Now a second fantasy emerged: what if his house was more expensive than mine? Would that not be a 'crushing blow' to me? Looking at these two scenarios, it became clear that the price of this house was no longer a matter of external reality; it had become caught up in his hostile competitiveness with me (and, behind that, with his father whom he deeply loved, hated, and feared). By not mentioning the price of the house, Paul could keep these difficult feelings out of our exploratory work.

Yet another manifestation of money's involvement in transference-based anxieties is evident in the following vignette lent to me by a female colleague.

CLINICAL VIGNETTE 13

In the second year of Charlie Kim's analytic treatment, the first explicit exploration of erotic feelings came up. It was when—noting his 'erect' manner of entering my office, associations to fleeting incestuous thoughts about his sister, and his lively flirtation with one of my female patients in the waiting room—I decided gently to unmask the potential transference reference in all this. I said: 'I wonder if you ever find yourself struggling with similar erotic feelings in here, with me.' He responded by saying: 'I have thought about

you, yes, I have. This is so hard to say. This is one of the most difficult things to talk about. I have looked at your boobs a few times, coming in. I can't believe I said that... I have these passing thoughts and fantasies... you probably think I am a horn dog... All these feelings are disgusting.'

As he went on and on, oscillating between sexual confessions and guilt-ridden self-admonishments, I noticed that he made no reference to any potential erotic competitors of his vis-à-vis me. When, in a later session, I pointed this out, he responded with the following: 'I try not to think about your husband... He is probably some good looking, muscular, rich guy. One of these types, who makes four-five hundred thousand dollars a year. See, that's why I never think of him. I avoid it. Yet I have to admit that he has crossed my mind a few times. I would never bring him up though. I could never compare to him. I feel like a total loser. I could never compete with him.' It was clear that Charlie defended against oedipal competition by undue self-diminishment and a neurotic over-exaltation of his rival's prowess. He made it appear that the competition was over before it began. Charlie's estimation of my husband's income was an example of 'denial by exaggeration' (Fenichel, 1945); he put my husband so out of competitive reach that he did not have to bring his hostile feeling towards him out into the open for analytic exploration. Big money served as a shield against phallic competition (and the associative dread of defeat) in the oedipal transference.

Clearly, concerns and fantasies involving money can be used for expressing a variety of transference wishes (e.g. seductive, hostile) and equally varied defenses against them. However, this should not lead one to overlook that matters of money impact upon the therapist's subjectivity as well.

Being human, the therapist brings his own feelings, fantasies, desires, and values regarding money to the clinical situation. The more financially stressed he is and the more his total income depends upon direct clinical work, the greater is his vulnerability to countertransference difficulties in this realm. Such current stressors, at times, come into tantalizing but painful play with the therapist's characterological soft spots (e.g. greed, masochism) on the one hand and the patient's monetary 'seductions' and 'tortures' on the other. Charging different fees to different patients also exposes the therapist to potential countertransference pitfalls. An even greater tendency for the countertransference to become problematic is evident in the treatment of the very wealthy and the very poor.

TREATING PHENOMENALLY WEALTHY PATIENTS

Working with phenomenally wealthy patients poses special challenges. To begin with, such patients, and especially their children, bring along with them an attitude of entitlement. Used to having their wishes and whims quickly gratified, they might find the plodding work of psychotherapy too slow and boring. Their 'superego lacunae' (Szurek & Johnson, 1953) might facilitate the sequestering of impulse-ridden sectors of personality; this might impede the integrative and probing efforts of the therapist.

Even in the absence of such difficulties, there is a great risk of countertransference problems in the treatment of wealthy patients. Feeling 'proud' to have a rich individual in treatment, gossiping about the patient's finances, envy of the patient, defensive contempt, undue deference and, born out of this, a tendency to avoid embarrassing material or excessively to accommodate schedule changes are among the major manifestations of countertransference-based impediment of treatment (Stone, 1972; Wahl, 1974; Olsson, 1986). The risk of such developments increases if the 'state' and/or 'trait' related vulnerabilities of the therapist are painfully stirred up by his wealthy patient's talk of money.

CLINICAL VIGNETTE 14

Pamela Kasinetz, an elderly woman with extreme wealth, sought psychotherapy for depression and anxiety of recent origin. The apparent trigger for this was the worsening relationship with her husband of over three decades. With their children no longer at home, the two had become quite alienated; he was engrossed in his business and she with her social com-

mitments and philanthropic work. Matters became worse when Pamela ran into an 'adorable' seven or eight year-old Cambodian boy in a shopping mall and 'fell in love with him'. She took it upon herself to help him and his financially strained family. The boy gradually became her constant companion. Paying huge sums of money to his parents, Pamela pretty much took over his life. She would pick him up from school, bring him home, shower him with lavish gifts, and indulge all his whims and desires; his friends also were welcome at her house and were treated with similar indulgence. While numerous examples can be given, one instance should suffice, where she spent in excess of thirty thousand dollars over a weekend entertaining her little 'friend' and his four playmates. All this led to frequent arguments between Pamela and her husband who insisted on putting limits on her expenses.

Seeking symptomatic relief, Pamela appeared unprepared to look into the deeper meanings of her fascination with this little boy. Raised in a family of means, she readily dismissed any inquiry into a childhood sense of feeling deprived and thus blocked the therapist's efforts at linking her runaway altruism with potential unconscious issues pertaining to early trauma. It was all 'real' and rationalized in terms of kindness and generosity towards the underprivileged, as far as she was concerned. Soon after starting treatment, she expressed a desire to pay a much greater fee for her sessions, quoting what appeared to be truly an exorbitant amount. The situation was complicated by parallel problems in the therapist's countertransference to her and to the financial glitter of the situation. Having suffered a childhood parental loss at about the same age as the Cambodian boy Pamela so adored, and being financially strapped himself owing to a recent personal crisis, the therapist was made terribly uncomfortable by Pamela's financial seductions. Reacting defensively, he not only made premature transference interpretations but also sternly rejected her offers. He failed to explicate and explore them in a peaceful manner. Pamela soon dropped out of treatment.

This adverse outcome seems to have been the result of a number of factors in the therapist: (i) current financial distress made it hard for him to listen peacefully to his patient's extravagance; it stirred up too much greed, (ii) childhood trauma made it difficult for him to hear about his patient's indulgence in a little boy; it stirred up too much envy; and (iii) not seeking a consultation in what was obviously a difficult clinical situation for him, it led to defensive recoil and over-interpretation. Flying solo under these circumstances was an inappropriate clinical choice. And yet, the vignette has didactic value. It reveals some important variables in pre-empting, precluding, or gainfully using these emergent countertransference feelings, including the therapist's: (i) inner 'good objects' (Klein, 1935; 1940), the presence of which will diminish his vulnerability to greed and envy, (ii) aptitude and skill for learning from his subjective experiences in the course of treatment and (iii) willingness to seek outside consultation in difficult clinical situations.

TREATING INDIGENT PATIENTS AND WORKING GRATIS

Difficulties also arise in working with the poor. Their lives are at the mercy of socio-economic forces and their subjective experience is often riddled with a sense of marginality, helplessness, and resignation. Often the families they originate from are broken beyond repair; there is deprivation of both maternal care and paternal guidance. Lacking hope to escape their economic entrapment, such individuals lack impulse control and become action-prone; Boris' (1976) notion that hope and desire are inversely related is pertinent in this context.[26] They seek dynamic psychotherapy infrequently and their preoccupation with the different realities of their lives have a discouraging effect upon the psychotherapist. Indeed, it has been declared by some (Ruiz, 1981; Sue & Sue, 1977) that dynamic psychotherapy is irrelevant in the context of their lives.

At the same time, it is possible that a discouraged therapist is manifesting a class-related and value-based countertransference reaction which, in a circular fashion, adds to the patient's 'untreatability' by dynamic psychotherapy (Javier, 1996). Viewed from this perspective, the main issue to be examined is that of sociopolitical, aesthetic, and empathic fit between the patient and therapist. Conducting dynamic psychotherapy with the urban poor might indeed be possible if the therapist is willing to:

- Learn the language of the urban poor, not only in regard to its colloquialisms but its overall architecture of urgency, worry, and mistrust.

- Blend some educative measures that actively encourage verbal reformulation of symptoms and 'teach' the patient the importance of their personal dynamic history (Olarte & Lenze, 1984).

- Regard the patient's preoccupation with reality problems as legitimate material for elaboration without prematurely linking them with their potentially deeper meanings and usage.

- Titrate the degree to which 'affirmative interventions' (Killingmo, 1989) are mixed with interpretive work.

- Rely more upon the object-relations model than upon the ego-psychological model; the former permits viewing the patient's complaints about reality problems, pressuring the therapist for action, and frequently missing sessions as interactive and communicative phenomena and not merely intrapsychic events (Altman, 1993).

- Offer interpretations in the context of support rather than in the context of abstinence; in Pine's (1985) words this is 'striking when the iron is cold'.

The clinical flexibility of the therapist, however, must find a willing and able partner in the patient. Sometimes this turns out to be the case and other times not. At still other times, one comes across poor individuals who display considerable resilience, ego strength, and 'psychological mindedness' (see Chapter One) and can benefit from 'unaltered' dynamic psychotherapy and even psychoanalysis.[27]

Contrary to the prevalent notion that the patient must pay a fee for the treatment to be effective, there is evidence that those who cannot pay anything might also benefit from psychotherapy and psychoanalysis (Lorand & Console, 1958; Jacobs, 1986). A growing unease that the benefit of psychoanalytic treatment was available only to the affluent, and the awareness of the long history of philanthropy in medicine prompted Freud to declare in 1918 that sooner or later

> the conscience of the community will awake and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving life; and that the neuroses menace the health of a people no less than tuberculosis, and can be left as little as the latter to the feeble handling of individuals. Then clinics and consultation-departments will be built, to which analytically trained physicians will be appointed, so that the men who would otherwise give way to drink, the women who have nearly succumbed under their burden of privations, the children for whom there is no choice but running wild or neurosis, may be made by analysis able to resist and able to do something in the world. This treatment will be free. (Quoted in Lorand & Console, 1958, p. 59)

Freud's vision led to the establishment of psychoanalytic clinics providing treatment at minimum or, at times, no fee at all.[28] At the same time, it was felt that gratis treatment might create difficulties. Among the expected problems were lessening of motivation, increased dependency, avoidance of negative transference, and countertransference resentment. Freud himself warned that 'gratuitous treatment enormously increases the transference relationship for young women, or the opposition to obligatory gratitude in young men arising from the father complex which is one of the most troublesome obstacles to treatment' (quoted in Lorand & Console, 1958, p. 60). However, he acknowledged that in many patients 'unpaid

treatment led to excellent results without exciting any of these difficulties' (p. 60).

Putting all this together, it seems that if properly handled, gratis treatment can work as efficiently as one with fee. However, the following conditions must be met for such work to take root and proceed meaningfully.

- The financial situation of the patient must be explicitly and 'shamelessly' evaluated before the decision for gratis work is taken.
- Gratis work should not be undertaken by therapists who are themselves struggling with finances.
- Even those who have financial security should not take more than one or two patients on a pro bono basis.
- An attitude of flexibility must be maintained and fees should be introduced if the patient's reality changes.

The fact is that careful investigation almost invariably reveals that the patient can pay at least a small, token fee. The amount of that fee is significant for the patient even if it appears 'low' by all external standards; the patient should not be forcibly turned into a gratis patient and the 'low' fee should be regarded as reasonable.[29] This changes the ambiance of the clinical dyad. Of course the emotional meanings of being treated for a 'low' fee will have to be explored and understood in the course of treatment, especially if direct or disguised associations to it crop up in the clinical material.

Distinct from ongoing treatment done without fee, is the issue of offering one or two session-long consultations gratis. This practice is not infrequent though it is hardly discussed in the professional literature. For many therapists, this is simply a part of therapeutic 'good manners'. They do not charge fees for the initial consultation to patients referred by friends and acquaintances. Others extend a similar courtesy to junior colleagues in the mental health profession and other sundry categories of patients they select on various personal and professional grounds.[30] How many of these gratis consultations turn into ongoing treatments and to what extent the patient's retrospective feelings about those free sessions affect the course of therapy remains unknown. In my own experience, little negative impact of this initial indulgence is evident. In fact, it might add to a strengthening of the therapeutic alliance that evolves later on, even though the consultation is not done gratis for that reason.

Refusing To Take Money From Patients

In contrast to clinical work done on a pro-bono basis due to the patient's lack of resources, there are situations where the therapist might refuse to accept money from patients for ethical and psychodynamic reasons. The treatment of patients whose income is derived from illegal activities constitutes one such situation. To be sure, hardened criminals are not the psychotherapist's frequent clients. Yet sometimes members of the mafia, professional call-girls and prostitutes, and drug dealers and smugglers do end up seeking help. To accept payments from them poses moral dilemmas, only some of which can be solved by consulting a colleague, seeking supervision, or obtaining formal legal advice. Certainly most therapists would not accept money if they knew that it was earned by running a pedophilic torture ring or committing murder on contract. But what about white collar criminals? Are the crimes of those investment bankers who rob the pension funds of the elderly any less sinister? The point here is that, in the end, it might boil down to the therapist's personal morality and judgment.

Less flagrant situations can also pose challenges. For instance, a wealthy patient might offer a huge sum of money to recruit the therapist to provide care only to him and no one else.[31] This, of course, cannot be accepted. Even the milder forms of such perverse enactment have to be dealt with by firm limit-setting.

Clinical Vignette 15

'Richard Lambert' called me three months after his Latin-American psychiatrist had moved back to his country of origin. He said that he was following up on the advice of his psychiatrist to see me. However, he would only come if I accepted three conditions: he would never tell me his actual name; no record of his visits were to be kept, and he would pay my top fee,

cash, at each session, but this transaction must not be recorded in any form. I responded by saying that I could not accept these conditions for the same reason that I could not reject them. He was puzzled at my response and asked me to repeat it. I did so. He, unsatisfied, asked me if I were saying 'yes' or 'no' to his conditions. I told him that I was saying neither since I did not really know what all this was about and could not jump into actions in light of the fact that we had not even met and I knew nothing about him, his life, and his problems. I told him that if he could tolerate such ambiguity and maintain open-mindedness, then he would come and, if not, then he would go elsewhere. He thought for a while and then said that he would like to make an appointment.

Upon arriving in my office a few days later, 'Richard' did not sit down. Instead, he paced through my office, picking up books and commenting upon them, touching knick-knacks. Impeccably dressed, tall, and in his mid-fifties, he cut an impressive figure. Nonetheless, there was an eerie feeling to what was unfolding in front of my eyes. Attempts on my part to engage him in the customary gambits of initial assessment (see Chapter One) failed. He brushed them aside. He would neither tell me his name nor give me an address, phone number, or any identifying information. After this strange 'clinical' dance went on for nearly forty-five minutes, I called the meeting off. Upon this, he, still standing, took out a big wad of dollar bills from his pocket, and asked me how much he should pay me. I responded by saying: 'For what?' He said: 'For the time you spent with me. Shouldn't I be paying for it?' I said: 'No, I don't think so. It is true that I charge money for clinical work but what has transpired here does not qualify as that and therefore I cannot accept this money.' He was taken aback. After one or two repetitions of basically the same exchange between us, he left my office. I never heard from him again.

Accepting money from this 'patient' would have created a misalliance whereby I would have colluded in bringing upon a fundamental distortion of the therapeutic frame. Psychotherapy cannot be practiced and must not be started under circumstances that defy reality, especially when repudiation of consensual truth is so outrageous and violent as it was in this case.

Yet another instance where the therapist might refuse to accept money from the patient is when the offer is based upon a near-delusional idea and taking money conveys an agreement with such distorted thinking.

CLINICAL VIGNETTE 16

During her analytic treatment, Carol Dunson, a thirty-seven year-old unmarried attorney with pronounced depressive proclivities, would frequently be in the throes of a powerful negative transference. At such times, she would become convinced that her therapist despised her; she would feel intensely angry towards him. Empathic holding and transference interpretation which linked her perception of the therapist to her feeling rejected by her mother in childhood would alleviate the affective tension for some time. Then she would become regressed again, losing the clarity she had just gained. The therapeutic work continued in a staccato fashion and then took a downward swing as Carol developed a disturbing physical ailment. Though causing considerable distress, the illness was not life-threatening. Carol, however, felt otherwise. She was convinced that the disease would kill her and, during a dip into her usual negative transference feelings, became nearly delusional in her conviction.

One day, she arrived at her therapist's office with two checks in hand. One was for the last month's fee that indeed was due. The other check was for the few sessions that she had had in the current month and for which the usual monthly bill was yet to be given to her. She offered the two checks to the therapist, explaining that she did not want him to get stuck with

> unpaid bills for the current month since she was going to die within the next day or so. The therapist was taken aback at this 'earnest' offer but soon regained his composure. Declining to take the second check, he insisted that the sources of her certainty about her impending death should be explored. He also noted that his accepting the check would 'confirm' that he too believed that she was going to die; that the patient was unconsciously imploring him to show her that this was not so gradually became explicit as the session progressed.

To summarize, it seems that there are at least three circumstances in which the therapist might refuse to accept money from a patient: (i) when the source of money goes diametrically against the therapist's ethical standards, (ii) when accepting the money would be a collusion to form a perverse alliance, and (iii) when money is offered in the throes of an intense transference regression.

CONCLUDING REMARKS

In this chapter, I have discussed the emotional significance of money and attempted to show the ways in which it impacts upon the work of psychotherapy. The areas I have addressed range from symbolism and psychopathology through the setting of fees and charging (or not charging) for missed sessions to the myriad transference and countertransference reverberations of monetary exchange within the clinical dyad. I have also elucidated, albeit briefly, the special problems that emerge in the treatment of extremely wealthy and very poor and indigent patients. Finally, I have described some unusual situations where a firm refusal to accept money offered by a patient seems the only therapeutically and ethically right thing to do.

Throughout this discourse, I have paid attention to the fact that what we encounter as clinical phenomena are the end products of a complex interplay between reality and fantasy, between the wild lyricism of id and stern admonishments of superego, between spontaneity and falsehood, and, above all, between transference and countertransference exchanges. Locating them in this ever-

shifting complexity does rob one of the opportunity to make up 'rules' that would be correct for all circumstances. It forces one to take a pause, think, reflect upon prior knowledge and experience, read some more, and, if still unclear, seek some supervision or collegial input. It nudges the therapist towards humility. The clinical situation that forms the topic of my next chapter can put the need for such humility to its utmost test.