Bringing the Money Out of the Shadows:
Money and Therapy

by
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Abstract

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There is a limited amount of research in psychology regarding the impact of money on the therapeutic relationship. Although some research regarding clients' transference vis-à-vis money exists, clinicians' countertransference concerning money has been largely ignored. As money and discussion of fees often generate negative countertransference for clinicians, it is likely that this material will not be addressed in the clinicians' personal work, and therefore it risks being harmful to the therapy process. The author's goal is to demystify the subject of money in the clinical setting and make it easier for clinicians to discuss money, fees, and the financial aspects of therapy with their clients, while minimizing the harmful impacts of therapists' countertransference on the therapeutic frame. Using heuristic and hermeneutic methodologies, the author uses his own experiences as a nascent therapist to illustrate some ways for clinicians to address and minimize the negative impact of their money issues on their work.

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Chapter I
Introduction

Area of Interest

Money has always been an important topic of discussion and the main cause of conflict in my family. As I remember, many of my parents' disagreements eventually escalated into arguments about money and ownership of our family assets. Even today, many of our family conversations center on financial matters, including perceived lack of money or sufficiency of income. Although my mother, as a medical doctor, earned enough to support my brother and I as a single parent, she managed money month-to-month. On the other hand, my father, as an attorney, had a lower salary than my mother, but generally knew how to manage money better.

Although the choice of my career prior to my interest in psychology was not solely based on high earning potential, my career in the Silicon Valley did become lucrative, and my value system adjusted accordingly. Discussions in the office often focused on achieving financial goals. Being money-motivated was a primary job requirement for most of my colleagues and myself. Often, bonuses and commissions would appear in our bank accounts without our even understanding what they were for. Our company employed an army of compensation specialists, whose sole responsibility was to keep employees motivated through lavish compensation plans. Although I appreciated the lifestyle, I often felt that money was not a sufficient motivator for me to continue working in the field. As I grew psychologically through my work in therapy, I realized that I was becoming more interested in mental health and helping people than in

making money, so I transitioned out of my career in technology into studying psychology. However, the impact of my experience in the corporate world left an indelible imprint on my psyche and led me to reflect on money issues in a clinical context.

In contrast to my colleagues in the world of high tech, who spoke openly about money and particularly about their financial success, I noticed that many of my peers in the field of counseling rarely spoke about money, and, when they did, they talked about a lack of financial resources in their lives. They also often talked about the shadow of money and consumerism and its negative effects on their clients' lives. I noticed that many of my colleagues struggled to establish sliding-scale payment plans for their clients and reported feeling uncomfortable discussing money with clients. During our supervision groups, conversations about money and clients being behind on their payments seemed to generate much stronger negative feelings than discussions about childhood abuse, incest, sexual practices, or domestic violence.

Guiding Purpose

My main goal is to demystify the subject of money in the clinical setting and make it easier for clinicians to discuss money, fees, and the financial value of therapy with their clients, while minimizing the negative impacts of therapists' countertransference on the therapeutic frame. Because clinicians' unaddressed and split-off complexes, whether regarding family, personal relationships, or money, run the risk of reducing the efficacy of treatment, bringing money out of the collective shadow and especially out of the shadows of counselors' psyches will ultimately be in the best interest of clients.

Rationale

As money and discussion of fees often generate negative countertransference for clinicians, it is likely that this material will not be addressed in the clinicians' personal work, and therefore it risks being harmful to the therapy process. Bringing the money out of the shadow, seeing it as amoral rather than immoral, and recognizing its place as a tool that can be used for good or bad are beneficial for all clinicians' day-to-day clinical work. Rather than being a complex that affects clients as well as their clinicians in unconscious ways, money can be brought into the light so that the associated issues can be effectively explored on a conscious level.

Methodology

This thesis will follow a qualitative methodology by employing a hybrid of hermeneutic and heuristic approaches to this scientific inquiry. As I will be exploring existing research and "reading a text so that the intention and meaning behind appearances are fully understood" (Moustakas, 1994, p. 9), the research will be hermeneutic in nature. However, since I also feel called to this topic and its exploration will seek "to obtain qualitative depictions that are at the heart and depths of [my own] experience" (Moustakas, 1990, p. 38), the research will also be heuristic in nature. Both of these approaches are necessary since the hermeneutic approach allows for finding new connections within the existing body of knowledge, whereas the heuristic approach allows for exploring my personal experiences and for connecting them to the existing research.

In this work, a significant component of the research will be focused on my own experiences surrounding my relationship with money, in general, as well as my

relationship with money in the therapeutic context, in particular. I will explore how the multigenerational influence of my family impacts my relationship with money, how this influence appears in my own psychological work as a therapeutic client, and how this influence appears in the therapeutic setting in my experience as a nascent clinician.

Research problem. There is a limited amount of research in psychology regarding the impact of money on the therapeutic relationship (outside of that produced by the psychoanalytic community, a subset of the broader field of psychology). However, even though the psychoanalytic community has produced a significant body of research regarding transference vis-à-vis money (i.e., unconscious projections of money-related issues on clinicians), countertransference vis-à-vis money (i.e., clinicians' unconscious and unprocessed material that often negatively affects the therapeutic process) has largely been ignored.

Research questions. What are some specific money-related challenges that clinicians have to address in their own work in order to reduce the negative impacts of countertransference surrounding money in therapy? What are some of the strategies that clinicians can use in their own work in order to address these issues? How can a depth psychological perspective regarding the archetypal meaning of money be integrated into therapeutic work in order to further reduce the negative impacts of perceptions of money on the therapeutic process?

Ethical Concerns

Since the research will follow the heuristic tradition, I will be using only myself as a research subject. My experiences discussed in this thesis, whether with family members, colleagues, or clients, are presented as composites rather than as individuals.

Therefore, I am not aware of any ethical concerns that would require additional approval before publishing this document.

Overview of Thesis

The following chapter (Chapter II) locates the research questions inside a historical perspective, including previous research on the topic. The chapter discusses early psychoanalytic thought regarding money and fees in therapy, including the approach recommended by early psychoanalysts to dealing with issues arising from money in the clinical setting. Subsequent development in research and attitudes toward money and collection of fees is presented next, including the resulting needs for better training of nascent clinicians and better processing of therapists' internal conflicts regarding money. The meaning of money for both clients and clinicians is discussed in the second part of Chapter II, including its often-denied influence on the therapeutic container. The chapter concludes with some strategies for clinicians to address and process their own shadow material regarding money and fees in their work.

Chapter III presents this author's experiences and developing attitudes toward money over time: first, as a member of his family; second, as a consumer of psychotherapeutic services; and third, as a clinician. The beginning of the chapter focuses on the author's formative experiences surrounding money and its psychological substitutes, including the role of money as a gift. The next section describes the author's experiences as a psychotherapeutic client and discusses issues of transference that have been evoked by money being exchanged as a part of therapy. The following section of Chapter III discusses the author's first experiences as a clinician, which involved having to confront his unprocessed material surrounding money and manage his clients'

transference (and his own resulting countertransference) surrounding money and the value of therapy. Some of the challenges presented include differences in socioeconomic status, desire to have a financially successful practice while providing services to those who cannot afford them, and impact on the author when clients make decisions that negatively affect the finances of the author's traineeship site. Chapter III concludes with a discussion of the author's experiences during a financial reassessment project at one of his traineeship sites.

The last chapter (Chapter IV) first summarizes the first three chapters, starting with the restatement of the guiding purpose; rationale; and methodology, including the research problem and the research questions. The chapter continues by reiterating the main research from existing literature as well as summarizing the author's personal experiences vis-à-vis the topic of finances, as a part of the heuristic research. The chapter concludes by providing examples of clinical implications for psychotherapists and offering suggestions.

Chapter II
Literature Review

Introduction

This chapter provides an overview of the relevant research regarding fee management in therapy and in particular issues surrounding lack of money-related training of emerging clinicians. This research was largely conducted by the psychoanalytic community, as there has been little focus on this area of study within the broader field of psychology. Stewart Newman (2005), a clinical professor of psychiatry at the University of Michigan in Ann Arbor, stated, "training in psychiatry should explicitly and systematically address the issue of money and its impact in therapy" (p. 21), but Stefan Pasternack (1988), a former clinical professor and a program co-director at Georgetown University, found that "training usually failed to include adequate education regarding the complex interactions between therapist and patient regarding payment, and various financial aspects of health care" (p. 113). David Krueger (1991), a psychiatrist, a psychoanalyst, and an executive coach, observed money "is one of the most emotionally meaningful objects in contemporary life; only food and sex compete with it as common carriers of strong and diverse feelings, fantasies, and striving" (p. 210). However, the issue of money and fees is rarely discussed in the therapist's office or during therapeutic training, often resulting in unprocessed transference and countertransference issues that can have a profound impact on how the therapy proceeds. Kruger indicated that money issues cannot be ignored, although many professionals, and in particular clinicians-in-training, would like to believe that they can. By facing financial issues in a

nonjudgmental and supportive environment, clinicians-in-training could have a unique opportunity to explore these issues and have a profound educational experience (Newman, 2005).

This chapter begins with a discussion of money and fees as understood by classical psychoanalytic thinkers, starting with Sigmund Freud. This is followed by an exploration of clinical issues regarding the payment of fees, the frequent lack of training of nascent clinicians, and clinicians' inner conflicts and resulting shadow material. The chapter concludes with an examination of several frameworks that clinicians might use in mastering money issues stemming from their family-of-origin experiences and culture.

Classical Psychoanalytic Views

There is a limited amount of material available from early psychoanalytic thought on the role of money in therapy, and the majority of subsequent authors who referred to it in their later writings (e.g., Allen, 1971; Blanck & Blanck, 1974; Fuqua, 1986; Gedo, 1963; Lasky, 1984, 2000; Menninger, 1958; Nash & Cavenar, 1976; Pasternack, 1988; Schonbar, 1967, 1986) drew from many of the same sources (Fenichel, 1938; Freud, 1897/1953, 1913/1976) .

Although Sigmund Freud (1913/1976), considered to be the father of psychoanalytic thinking, did not address money issues often, he had strong views about it. He was adamant that the analyst should not dispute that money is "a medium for self-preservation and for obtaining power" (p. 131) for the analyst. He connected money issues to sexuality, not only because sexuality was the main focus of his work but also because money and sexuality shared the same, often unaddressed, feature of being a taboo in the therapy office as much as in society in general. Freud noticed that "money

matters [were] treated by civilized people in the same way as sexual matters—with the same inconsistency, prudishness and hypocrisy" (p. 131), and he tried to bring money to a realm of a frank discussion just as he did with matters of sexuality. In the same volume, Freud wrote that beginning analysts should treat money matters with the same candor, directness, and nonjudgmental stance as they treat sexual matters, therefore allowing clients to experience a reduction in shame regarding money in therapy as well as in the outside world.

Freud (1913/1976) also influenced the creation of a fixed therapeutic frame, including not letting patients significantly fall behind on their payments and advising therapists against providing free treatment. He justified his recommendations based on managing transference for the sake of the patient; however, he did not address any possible countertransference coming from the therapist. He also believed that free treatment was counterproductive to the therapeutic process because it increased patients' neurotic resistance (Fuqua, 1986).

Payment of Fees

Following Freud's work, the majority of research regarding money in clinical practice has focused on therapists' fees and the rules regarding payment amounts, offering therapy for free or at a reduced rate, payments for missed sessions, and late payments. Many psychoanalytic thinkers from the 1920s to the late 1960s (e.g., Fenichel, 1938; Gedo, 1963; Haak, 1957; Kubie, 1950; Loewald, 1960; Menninger, 1958) subscribed to a fixed therapeutic frame regarding fees, therefore establishing strict rules regarding setting and enforcing fees guided by the belief that most if not all issues regarding money that came up in sessions were due to the client's unprocessed material.

However, starting in the 1970s, the fixed-frame guidelines started to be reevaluated (Mintz, 1971; Schofield, 1971), rejected (Pope, Geller, & Wilkinson, 1975), and then reimagined (Blanck & Blanck, 1974; Meyers, 1976; Pasternack, 1988; Schonbar, 1986). Most importantly, these authors started to point out that many issues that come up during treatment could be as much related to the therapist's as a patient's unprocessed material.

Fixed therapeutic frame. John Gedo (1963), one of the most prolific thinkers in the psychoanalytic field and a researcher with the American Psychoanalytic Association, emphatically stated, "when a patient in psychotherapy fails to pay his bill, he has violated an explicit and agreed [upon] responsibility" (p. 368). Gedo's research primarily focused on uncovering clinical reasons for the nonpayment of fees. Gedo reported a rate of about one patient out of seven (36 out of 242 patients) who did not pay him consistently and on time. He considered this to be solely a transference issue that needed to be addressed during treatment, and he did not take into a consideration a wider context of the life circumstances of the analysands as a reason for nonpayment.

Other psychoanalysts (Haak, 1957; Kubie, 1950; Menninger, 1958) also underlined the importance of a fixed therapeutic frame in regard to setting fees. Karl Menninger (1958), a well-renown psychiatrist of the early 20th century and a founder of the Menninger Clinic, warned, "the analysis will not go well if the patient is paying less than he can reasonably afford to pay. It should be a definite sacrifice for him" (p. 32). Nils Haak (1957), a long-term president of the Swedish Psychoanalytical Society, and Lawrence Kubie (1950), a psychoanalyst who brought biology and social sciences into the psychoanalytic sphere, supported Menninger's notion that any flexibility in fee policies would be detrimental to the therapeutic frame and therefore detrimental to the

client. Haak elucidated that if clients have an excuse to miss sessions when therapy becomes difficult, they might opt for that rather than process the resistance with the analyst.

Although Arnold Allen (1971), a psychiatrist and a psychoanalyst in private practice, considered nonpayment as a transferential issue, he assigned the responsibility to the therapist to collect the fees, stating, "when a therapist ignores or fails to properly deal with the whole area of payment or nonpayment . . . , he too is violating an explicit and agreed upon responsibility" (p. 132), and more importantly he stops functioning as a therapist. Even though Allen was still focused on transference, rather than countertransference, regarding payment of fees, he opened up the possibility that therapists might also be responsible for whatever issues arise for the client about fees. Allen's primary focus was on the consequences of the therapist's lack of mastery in properly addressing the collection of fees. According to Allen, one of the main consequences is the client's possible withdrawal from therapy because of the guilt of being behind on payments and the resulting contempt for the therapist. However, the main negative effect of the mismanagement of fees could lead to a "depreciated concept of one's self by the patient" (p. 133). This could occur due to the therapist's unconsciously communicating to the client that the therapist believed the client was too fragile to handle issues surrounding money for the time being. Hans Loewald (1960), a clinical professor in psychiatry at Yale University, in his discussion of the therapeutic action of psychoanalysis, underlined the importance of the therapist's recognizing the client as "something more than he is at present" (p. 27). Through this important recognition, clients would be encouraged to be better versions of themselves and in the

process “establish a new identity with reality” (p. 27). Therefore, according to Allen, the therapist’s reluctance to collect fees has the possibility of injuring clients by reinforcing the idea that they are unable to take care of themselves. Instead, by holding a fixed therapeutic frame in regard to fees, the therapist demonstrates limit setting and provides a place for clients to test limits, thereby allowing them to experience both firmness and selective flexibility inside a safe container of the therapist’s office.

Breaking the fixed frame. Beginning with Norbert Mintz (1971), a psychologist and one of the founders of the Massachusetts School of Professional Psychology, and William Schofield (1971), a professor of psychiatry at the University of Minnesota, the psychoanalytic community started to explore the value of a fixed therapeutic frame, especially regarding fee payment first established by Freud (1913/1976) some 60 years prior. Mintz criticized the belief that a client has to sacrifice something, most often money, in order for the therapy to be effective. He warned against “the practice of routinely using fees as a weapon against the resistance of missed appointments” (p. 4) and provided a counterargument demonstrating that the opposite is true. By forcing clients to pay penance and then by interpreting missed appointments in session, the therapist absolves clients of their responsibility by financially punishing them for their transgression. Therefore, a great opportunity to work on the resulting transference is missed.

In contrast to the anecdotal evidence and opinions of Kubie (1950), Haak (1957), and Menninger (1958), the qualitative study of Pope et al. (1975), researchers at Yale, showed that there was no significant statistical difference in the therapeutic outcomes of treatment that had been provided for free, at low cost, or at a full rate. When taking some

of their research out of context, it appeared that treatment provided at low cost or clients' nonpayment of fees was correlated to a worse clinical outcome. However, once other factors such as socioeconomic status and diagnosis were partialed out, the fee amount had no impact on the clinical outcome. Although Pope et al.'s research was conducted inside a community mental health clinic and Haak's, Menninger's, and Kubie's studies were based on their experiences in private psychoanalytic practice, the former invalidated the long-held idea that clinical outcomes are related to the financial investment of the client.

Flexible frame. Gertrude and Rubin Blanck (1974), experts and textbook writers on ego psychology, believed that policies surrounding the payment of fees should be set based on an individual's pathology. For neurotic patients, they believed it should be rigid. However, for more disturbed patients, they believed it should be flexible because, according to Pasternack (1988), "disturbed patients with [an] ego deficit may be unable to tolerate frustration, enter into a completely reciprocal object relationships with the therapist, or understand the nuances involved" (p. 114). The challenge for the clinician using this approach is to navigate effectively the needs of different clients in order to create "tolerable doses of frustration" (Schonbar, 1986, p. 45). According to Blanck and Blanck (1974), "it [is] the experience of frustration that promotes differentiation of self and object representation" (p. 173). In their view, it is important to require from patients just a little more than what they can handle at the time, while not demanding instant compliance.

Rosalea Schonbar (1986), a 50-year faculty member at Columbia University and one of the first women in the country to lead a clinical psychology program at the doctoral level, critiqued her colleagues (Haak, 1957; Kubie, 1950; Menninger, 1958)

regarding their beliefs toward the fixed frame, stating that this rigidness "[protected] the therapist from his own difficulties concerning money and his own conflicts concerning his entitlement and the meaning of money to him" (p. 38). Barnett Meyers (1976), at the time faculty at New York University Medical School, explained that unwavering rigidness toward fees "serves to protect senior practitioners from dealing with issues that were not resolved during their own training" (p. 1460). Schonbar insisted on full flexibility regarding financial issues and considered all issues regarding fees as clinically relevant and not to be dismissed through the use of fixed rules and financial punishments. In her view, an attempt to create a rigid structure in order to neutralize the chaos in treatment, however rationalized, would inhibit the investigation of issues, thereby rendering the treatment less effective because the needs of the patient were not accounted for when that decision was made.

Lack of Training

Lack of training in regard to fees in graduate and postgraduate programs is one of the most significant concerns affecting beginning therapists (Kipnis, 2013; Shields, 1996). Although Pacifica Graduate Institute offers a course concerning money issues confronting new therapists (taught by Kipnis), many other programs do not. Traineeship, internship, and psychiatry residency programs often lack intentional focus on resolving transference and countertransference issues surrounding money, and they rarely prepare the nascent clinicians to deal with these issues in the future. Many clinicians do not face the issues of fees until forced to when starting their private practice (Meyers, 1976; Newman, 2005; Pasternack & Treiger, 1976). Recognizing this lack of training regarding fees to be a significant handicap of many educational facilities, Newman (2005) strongly

suggested “the subject of fees [be made] an explicit and fundamental part of resident training” (p. 22).

Not facing the issues. The reasons why educational institutions and training clinics do not address financial matters during training are numerous and complex (Lasky, 2000). These reasons might be related to therapists wanting to preserve their sense of dignity. They might be related to the process of the fees being collected by third parties, such as administrative assistants or a billing department. According to Stefan Pasternack and Philip Treiger (1976), at the time director of Central Medical Clinic in Glendale, California, the reasons might be related to the fact that most training clinics do not pass any portion of the collected fees down to the therapists-in-training, as the fees are mostly used to keep the clinics’ doors open for those in need. Due to the therapists’ inexperience and lack of motivation to collect fees, many of them often miss the opportunity to learn how to negotiate transference and countertransference challenges resulting from the collection or noncollection of fees.

Pasternack and Treiger (1976) conducted a research project exploring the reasons behind the minimal collection of fees by the psychiatric residents in a low-cost clinic in which they were supervising the residents. They then created a program including new guidelines for the collection of fees in order to address the problem, followed by the evaluation of the new procedures. Upon the implementation of the new guidelines, the clinic had a fourfold increase in revenue and was kept financially viable.

Prior to the study by Pasternack and Treiger (1976), the fees at their clinic were established by the residents during the initial intake based on the information provided by the clients and were rarely adjusted later on. The residents were expected to ensure that

the clients were compliant in paying the fees consistently and on time. However, Pasternack and Treiger noticed that even though the number of service hours provided by the residents was high, the overall collection of fees was minimal. When asked about the reasons behind the poor collection of fees, the residents reported feeling anxious when discussing fees with clients or feeling guilty for charging for their services or asking money from clients at the low end of the socioeconomic spectrum. According to Pasternack and Treiger, the residents "had colluded with patients and then denied the impact of this collusion on their work" (p. 1064). Instead of addressing the transference and countertransference issues in their work, the residents fell into "neurotic conspiracies with their patients" (p. 1064), the clinic was denied needed revenue, and the residents missed a good learning opportunity to improve their skills.

Although a new framework of checks and balances for effective fee collection was one of the most important contributions to the fourfold increase in revenue, addressing personal countertransference issues with each resident became the most important outcome for the training program (Pasternack & Treiger, 1976). By making the collection of fees a conscious learning experience, the residents were forced to explore their own relationship with money, their feelings of self-worth, and their values regarding social justice. When confronted with a client who asked for a fee reduction, the residents had to address their own feelings of dependency and their unwillingness to be the object of a client's rage. The residents also had to learn to navigate transference and countertransference issues once third parties, such as insurance companies, got involved in fee matters. In terms of the impact on the clients, Pasternack and Treiger (1976) warned "failure to attend to fee-related issues on multiple levels may result in corruption

of the therapy if not its complete destruction" (p. 1065). In terms of the impact on the residents, Ella Lasky (1984), psychoanalyst and lecturer on money issues in therapy, warned "[this] rich source of dynamically significant material is being ignored" (p. 290) by therapists not having an opportunity to address these issues while in training. Since good pedagogy requires effective management of uncomfortable emotions of any sort during training (McKeachie, 1994), it behooves the graduate schools and training clinics to address the problem of money head on (Lasky, 1984).

Unconscious decision making. Krueger (1986) reported that many of his trainees wanted to relegate issues of money to the administrative staff, hoping to avoid bringing up unconscious material based on their as well as their clients' unease of facing these highly activating issues. In Krueger's experience, this came up in particular when the trainees were supposed to negotiate higher fees based on clients' improved clinical and financial situations. Many trainees desperately wanted to avoid this issue.

Other authors (Newman, 2005; Schonbar, 1967) also reported that residents-in-training had difficulties internalizing the fact that they were providing a service for which they needed to be paid. Based on this belief, they often undercharged or provided services for free, without making those decisions consciously and deliberately. By doing so, they often missed an opportunity to deal with their own issues surrounding self-worth; personal and cultural values; and business aspects of their job, including being a clinician who needed to earn money to live.

Therapists' Internal Conflicts

In addition to a lack of training, therapists' internal conflicts often contribute to ineffective management in the setting and collection of fees. Lasky (1984) pointed out

that, in her study, many clinicians were ambivalent about creating a solid framework for setting fees due to their own unprocessed material, and this was true not only for novice, but also for seasoned, clinicians. Krueger (1986) highlighted that in their own personal therapy, many clinicians explored parts of themselves that had been "deleted, omitted, or disregarded, revealing and resolving these powerfully influential aspects of one's development and personal myths" (p. vii). Nevertheless, in these same sessions, practical as well as metaphorical issues surrounding money were neglected, resulting in therapists' emotional isolation regarding their thoughts and feelings toward money.

Society's attitudes creating internal conflict. Lasky (1984) speculated that the neglect of money issues in the personal therapy of nascent as well as of seasoned clinicians is related to general society's conflicting attitudes about money and disapproval of frank and open discussions about it. Money continues to be a taboo topic both for the general public as well as the therapist (Lasky, 1984). Touching on money issues easily provokes strong emotions, including anxiety, depression, shame, resentment, and fear, but many of these feelings are rarely shared with others. According to Lasky, Western society subscribes to two contradictory value systems: altruistic Judeo-Christianity and capitalistic individualism. The former teaches that wanting money is sinful; the latter teaches that having money is superior. Lasky concludes that this contradiction causes people to become wary, affronted, threatened, and anxious when their financial situation is discussed.

Because many clinicians pursue their careers in order to help people in need, many would like to believe that they are beyond the desire for financial rewards (Newman, 2005) and see themselves as "beneficent purveyors of good rather than as

people involved in commerce" (Tulipan, 1983, p. 445). However, at the same time, clinicians in private practice reported that a high income was one of the three most important aspects of their work, just after professional independence and success (Tryon, 1983). Also, many clinicians are concerned that taking money from clients while pretending to give love could be construed as stealing or prostitution (DiBella, 1980), so they try to stay as far away from the issues of money as possible. Yet others reported feeling "excited, powerful, apologetic, or embarrassed when setting a high fee, and guilty, annoyed, or resentful when setting a low one" (Lasky, 2000, p. 6).

Clinicians not taking their own medicine. One aspect that contributes to the presence of clinicians' unresolved inner conflicts is the lack of mandatory participation of clinicians in their own therapy, especially during training. In contrast to psychoanalysts, mainstream clinicians do not always work with therapists themselves, so a significant amount of their unconscious conflict remains unresolved (Newman, 2005). Richard Trachtman (1999), a specialist in money and relationship issues, reported that in his own and his colleagues' experiences, patients would rarely bring up money issues with the therapist unless it was a topic that the therapist was comfortable talking about. Therefore, Trachtman believed that by not dealing with these issues, the therapist deprived the client of working through those same challenges.

Several authors (DiBella, 1980; Krueger, 1991; Newman, 2005) have warned that clinicians often fail to address money issues in their work due to their own insecurities surrounding money matters, thereby greatly increasing the risk of collusion between a client's transference and clinician's countertransference and creating a fertile ground for ineffective therapy. Through their own repressed feelings of inadequacy, clinicians

become drawn into an idealized projection of being saintly; a rescuer for their clients; or above worldly needs, such as payment for their service (Newman, 2005). This unconscious process at times results in clinicians agreeing to a reduced fee even though the client could afford a standard fee.

Another important and often unaddressed aspect of internal conflict and a source of countertransference is therapists' envy of clients' financial or social successes (Olsson, 1986). Charles Wahl (1974), a psychiatrist specializing in treatment of the wealthy, explained that because therapists' education is obtained at a great cost and sacrifice, even after significant work on their own analysis, therapists might continue to experience loathing or envy of wealthy clients. Therapists might be tempted to counteract their feelings of hatred or envy by being more flexible with wealthy clients in terms of cancellation policies or by not offering interpretations to these clients that might be overly confrontive, thus risking rupture between client and therapist (Olsson, 1986). However, for the therapy to be fully effective, clinicians should become aware of these temptations and process them in their own work.

Meaning and Symbolism of Money

Krueger (1986) elevated the meaning of money by stating that "money [is] probably the most emotionally meaningful object in contemporary life" (p. 3). Newman (2005) pointed out that money has a significant meaning for both patients and clients, so it is imperative to explore what that meaning might be for a variety of client types as well as for each particular clinician. The meaning and symbolism of money is often not explored due to the barriers discussed previously, including shame surrounding frank discussion about money, informal societal rules about when money can be discussed, and

general anxiety that money brings up for clients as well as therapists. People's internal representations of the symbolism and meaning of money are also influenced by culture, family values, and experiences surrounding money in childhood and subsequent stages of development (Gallo, 2001; Stone, 1972). Lasky (2000) also believed that people's social class and the ways that their parents handled money also influence their relationship and attitudes toward money and financial issues in general.

Early psychoanalytic writers connected money primarily with feces, but also with penises and breasts (Geistwhite, 2000). Otto Fenichel (1938), an early psychoanalytic thinker and a strong devotee of Freud, expanded this idea, stating that money could symbolize anything that "one can give or take: milk, breast, baby, sperm, penis, protection, gift, power, or degradation" (as cited in Turkel, 1988, p. 525). Ann Turkel (1988), a clinical professor of psychiatry at Columbia University, also reported on Fenichel's view of money as a source of "narcissistic supply originating in an instinctual need for food and for omnipotence" (p. 525).

Krueger (1986) compared the metaphoric emotional value and practical function of money to food and sex. Even after getting to know themselves and their personal myths, most people, including patients and clinicians, tend to omit their relationships to money from those same narratives. Trachtman (1999) conceptualized money as a "projection of emotional concerns" (p. 276), therefore putting the symbolism and meaning of money in the realm of psychodynamic therapies.

For Krueger (1991), money represented many things, including "self-worth, esteem for others, power and potency, contamination, worldliness, and acceptance or rejection" (p. 210). For Allen (1971), money represented feelings of antagonism,

remorse, disdain, seduction, or fear, or a perception of instability. For Newman (2005), money could be used to bribe or pacify others in an attempt to keep away fantasized antagonism. Money could be associated with a source of satisfaction, a source of embarrassment, or amassing or suppressing affection or wanted things. For some people money epitomizes power, whereas for others it embodies "submission to crass materialism" (Pasternack, 1988, p. 113). In today's world, money could be a symbol of competence, stature, manhood, safety, worth, self-determination, and power (Turkel, 1988). For Peter Olsson (1986), a psychiatrist specializing in treatment of the wealthy, money symbolizes immortality, as older generations attempt to achieve it by leaving money to their offspring.

Yet, money brings up conflicting values, especially regarding its accumulation. On the one hand, the accumulation of money is celebrated; on the other hand, the accumulation of money is frowned upon (Krueger, 1986), creating an immense internal clash. "Both money and the lack of money produce guilt" (Krueger, 1986, p. 4) in our society. One who has accumulated a lot of money is viewed as superior, but the aspiration for money is considered to be in bad taste.

Allen (1971) believed that therapists' flexibility or inflexibility regarding the payment of fees could mean different things to different clients as well as different things to the same client at different times of the therapeutic process: "giving or withholding of milk or nourishment, gifts or swearing, a vehicle for control, a phallus, power, or a bribe" (p. 133). Gedo (1963) recognized that the nonpayment of fees serves as a transitional object for a client, therefore keeping the client connected to the therapist—in a similar way that a transitional object keeps a child connected to a mother. Later on, Schonbar

(1986) pointed out that the transitional object also represents *separation* from the mother, possibly invalidating Gedo's theory.

Shadow of Money in the Therapy Practice

Irwin Hirsch (2012), a psychoanalyst and a writer focused on therapists' countertransference issues, was one of several authors who were harshly critical of the psychoanalytic profession for not being willing to admit the extent of the impact of money and greed on the psychoanalytic practice. According to Hirsch, "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" (p. 13). He believed that these uncomfortable feelings needed to be processed in a similar way as any other countertransference-evoking material in order for the analysts to provide effective service. He believed that these shameful and discordant feelings are not the ultimate problem, as we would not be human if we did not have them, but rather therapists' unwillingness to look at them and accept them is what becomes problematic.

One of the main shadow-evoking issues that Hirsch (2012) presented was analysts' worry regarding their self-interest; in his view, "analysts' financial concerns reflect the most vivid example of this conflict [self-interest versus patient interest], and . . . our anxiety about income is the single greatest contributor to compromised analyses" (p. 14). According to Hirsch, many analysts keep some of their high-paying clients in analysis longer than would be clinically justified, and at the same time, these same analysts might encourage premature termination of clients paying a reduced fee. As many of the analysts in major American cities tend to be politically left-leaning, they are often unwilling to admit that they might be making clinical decisions based on self-interest.

Hirsch critiqued the hypocrisy of analysts' obvious preferences for full-paying clients and their concurrent denigration of those same clients for their "greed, mercenary values, and economic ambitions" (p. 18). Hirsch observed that analysts often "split off and deny their own financial and power-related ambitions, while emphasizing, in a condemning and pathologizing way, these qualities in others" (p. 18).

Mastering Money Issues

The discussion in previous sections has focused on challenges that clinicians face regarding the management of fees and other money issues in their clinical practice and some of the consequences of failure to address them effectively. The focus in this section is on some of the ways that clinicians can alleviate possible problems before they become clinically significant and possibly derail the treatment.

Helping clinicians work through their own countertransference. G. Angelo W. DiBella (1980), at the time a director of a psychiatric residency training program in New York City, suggested a multistep process for addressing these issues. Clinicians should start by processing their own conscious and unconscious attitudes regarding money, preferably with a therapist or a trusted colleague because these "conflicted, deep-seated issues are extremely difficult to work on alone" (p. 513). The next step involves becoming more aware when these issues come up in practice and, in particular, reviewing one's reactions to money when these reactions occur. Having a predetermined framework long before the onset of treatment of the fee structure, flexibility, and process for determining levels of sliding scale is bound to minimize countertransference issues for the therapist. Being frank with clients about the cost of treatment before starting treatment is imperative. Having clarity regarding one's own personal values about being

in a helping profession versus personal needs and wants and other external factors is important. DiBella suggested exploring issues such as determining the value of an hour of client-facing contact versus spending time with family; determining the rationale for a sliding scale and how it is set; and having a clear idea of what is involved in being paid for services rendered versus exploiting a person in a dismal situation. DiBella strongly recommended that therapists explore these questions in writing first in order to gain additional clarity and then bring the writing to their own therapist or a trusted colleague in order to fully explore it together.

Lasky (1984) also suggested several steps similar to those by DiBella (1980), but Lasky augmented the process to also include awareness about which patients these issues arise for, and then using the data to identify and address issues that come up for the clinician. She also suggested that therapists review their caseloads to determine whether they can take on more patients and especially if they can afford to see patients at a reduced fee. Another practical approach provided by Lasky was to determine the cost of running the office to have clarity surrounding the fixed costs of running the business.

Money genogram. In order to help clinicians map out multigenerational views and experiences surrounding money, Ellen Gallo (2001), a psychotherapist working with affluent families and individuals dealing with psychological and emotional issues related to wealth, developed a money genogram framework that included specialized symbols that focus on money-related issues. It is based on seminal work by Monica McGoldrick and Randy Gerson (1986), a family therapist and a family theoretician, respectively, who developed a unique way to represent graphically family structures and quality and types of relationships among its members, so the overall approach is familiar to most clinicians.

Gallo's system retains its original family tree structure, but it also augments the nodes of the tree to include dominant money relationships, defined by Gallo as acquisition (A), use (U), and management (M). Gallo also instructs the users of her system to label the dominant money relationship with a plus sign (+) to signify a secure relationship and a minus sign (–) to signify an insecure one. In her view, a relationship is dominant either because it is a "secure and successful part of a person's life" (p. 46) or because it is "a source of insecurity and anxiety" (p. 46). She uses the money genogram approach with her clients in order to map multigenerational attitudes surrounding money and their effect on clients.

Chapter III
Findings and Clinical Applications

Introduction

This work will follow the heuristic tradition, and it will involve a synthesis of existing qualitative and quantitative research, with an emphasis on uncovering innovative ways of helping clinicians resolve their countertransference issues surrounding money in order to reduce its negative impact on their work with clients. The focus is on finding ways for clinicians to develop positive relationships with money that are neither condemning nor idealizing such that they can view money as a tool and a subject matter that can be discussed, addressed, and processed inside the therapeutic setting just like any other countertransference-producing topic (such as sexual abuse, domestic violence, or incest).

Money Genogram

Following Ellen Gallo's (2001) suggestion that therapists should create their own money genograms before helping their clients do the same, I have created one of my family, as shown in Figure 1. Even though I have personally created and also helped my clients create many conventional family genograms (McGoldrick & Gerson, 1986), the process of creating my own money genogram was a challenge and a source of anxiety. Even assigning dominant (and second dominant) money relationship labels to my father (acquisition [–], management [+]) and my mother (acquisition [–], management [–]) was not as simple and obvious as I had assumed it would be. My father was a successful attorney who had the ability to earn and manage money well. My mother, although a

successful physician, was not interested in either the acquisition or use of money, so on the surface she did not seem to be greatly affected by it. However, my mother's focus on retaining property as a symbolic surrogate for money made it clear that both of my parents had similar emotional experiences. They were both focused on the acquisition of money or property, which became a source of insecurity and anxiety. The main difference between them was that my father had a secure relationship with the management of money and my mother did not.

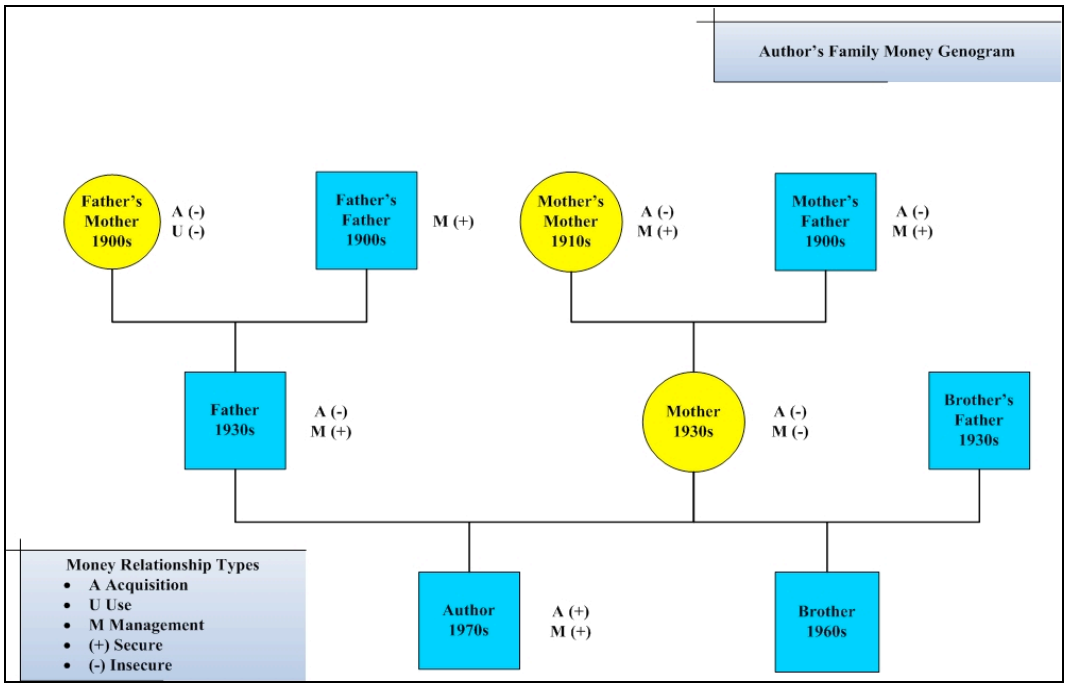

Figure 1. Author's Family Money Genogram. Source: Author.

Although I remember well three out of four of my grandparents, it was difficult to determine their dominant dimensions and relationships to money. The only person who stood out immediately was my father's mother. She was exceptionally focused on the acquisition of money and had an insecure relationship to it. At the same time, her husband, my grandfather, rarely spoke about money and was extremely frugal. At first I labeled my grandfather's management dimension as secure, but after giving it some

additional thought it became clear that it was quite insecure, resulting in extreme frugality bordering on self-deprivation.

The Gift of Money

When thinking of gifts I received as a child, I have only a handful of memories of receiving actual physical items, such as toys or clothing. Almost all of the gifts that I received during that time, regardless of their source, were in the form of money. Although it was not uncommon for children in Croatia to receive money as a gift even at a young age, my family was the only one in the neighborhood who established this practice as a norm. My parents often said that I was best suited to find something for myself that I would like, and not having any other experience, I took this as being commonplace and enjoyed buying the exact things that I wanted without relying on my parents to do so correctly. I never paid attention to this until I came to the United States on a student exchange program and started to receive gifts that did not involve money. On the one hand, I appreciated my friends and partners investing time in finding the items they thought that I might like. On the other hand, I felt disoriented that I did not have much control over choosing what I wanted.

Paying for Psychotherapy

Being around many of my mother's friends who were physicians during my childhood and seeing value in my mother's work in curing physical ailments on a daily basis, I had a front-row seat to the magic and immediate value of modern medicine. I often met her patients who expressed gratitude for the help that they had received from her, and I often received small tokens of appreciation from them on my mother's behalf. My mother was frequently recognized in public, and it was a rare occasion that we went

to a grocery store and did not run into one of my mother's current or former patients. The value that my mother provided to them was visible, obvious, and very much appreciated.

Yet, like so many of my clients later on, I experienced paying for psychotherapy for the first time as strange. From my childhood, I understood the value of medical care in terms of healing traditional physical ailments, but I had difficulty understanding the value of something as abstract as talk therapy. I understood that talking to someone about my life could be useful, but I experienced great resistance to believing that it was a service that only a professional could provide. The title of William Schofield's (1986) book *Psychotherapy: The Purchase of Friendship* succinctly summarizes my attitude at that time.

In addition, growing up in a single-payer medical system that shielded the provision of medical care from its costs, I was not used to having to pay for medical care. This compounded my suspicion of psychotherapy and provided fodder for my resistance to therapy. Since I saw a therapist for the first time while I was still in college, I had difficulty prioritizing its financial cost over my other expenses.

Measurable results. Because of my rigid scientific background and my drive to measure the value and, in particular, the results of the therapeutic process, it was difficult for me to accept that, as a client, it was close to impossible for me to measure objectively the success of the psychotherapeutic process in which I was engaged. In contrast to my professional work, which at that time had predictable results, the value of therapy was not objectively measurable. Rather, I had to depend on my own senses in order to determine whether I was feeling better or making more effective life decisions, with both of these approaches being highly insulting to my scientific sensibilities. The irony of this situation

was that, although my cognitive and emotional functioning might have been impaired at the time, I had to make decisions regarding my own care, and in particular regarding the related financial costs (notwithstanding that the medical insurance companies were footing most of the bill).

Most of my initial experience in therapy was based on a cognitive-behavioral approach that closely matched my previous scientific training; therefore, the results were somewhat easy to measure and the return-on-investment in time and money was obvious. Reviewing and questioning my thoughts, and resulting emotions and behaviors, and then changing these same thoughts, resulted in feeling better and also in making better life choices. The theoretical framework matched the familiar business model: there had been a problem, the problem was addressed and solved in predictable and measurable ways, and the commensurate fee was paid to the service provider.

Triggering transference. However, this model broke down when I was ready to explore deeper issues located in my unconscious. The therapeutic process became slower, its effectiveness harder to track than before, and more transference ruptures between my therapist and I started to occur. As the therapy framework became psychodynamic in nature, largely depending on the interplay of transference and countertransference between my therapist and I, the issue of fees also encroached into the therapy room and became the topic of heated discussions on a regular basis. Looking back over that period of my life, issues surrounding fees flared up most often when I did not feel supported by my therapist and therefore felt angry with him. I often projected onto him my sensations of feeling emotionally stuck and blamed him for my predicament. However, I only became aware of this process when I started to work with my own clients for the first

time, when these same types of ruptures started to happen. I slowly realized that my complexes surrounding money had been constellating in therapy and were part of a much larger context of transferential processes between my therapist and me.

First Experiences as a Clinician

Like many of my colleagues, my first exposure to working with therapy clients was at a low-cost clinic serving socially marginalized and often underserved populations. Being a low-cost clinic, most of our clients were assessed a fee on a sliding scale based on their incomes and household sizes. The financial policy at the time was almost identical to the one reported by Pasternack and Treiger (1976) almost 40 years prior: The fee was determined by the clinician during the first session and was generally not reevaluated unless the client asked for its reduction based on a change in income, which was generally related to a reduction of income or loss of a job.

During those beginning sessions, I felt anxious for a variety of reasons, including being inexperienced and worried about my clients finding out that I was a beginning therapist. I was much more interested in making sure that the clients were willing to continue seeing me than in asking them difficult questions about their finances and possibly triggering an irreparable rupture before the end of our first session. Therefore, I failed to assess many of them at the right level—often assessing them at an unnecessarily low rate. Although I had previous corporate experience and understood that fair assessment of clients is important for many reasons, including the viability of the clinic, social justice, and overall fairness, my desire to see clients and my discomfort in talking to them about money often prevented me from asking all of the relevant questions from the outset of our work together.

However, as I started to feel more comfortable in my new role, gained additional experience, and stopped feeling the pressure of working with new clients, I was able to start asking more specific questions that resulted in fees being assessed correctly more often. I also started to notice how uncomfortable discussions of money were, especially before having developed a good working relationship with a client. Clients fidgeted and attempted to get through the financial questionnaire as soon as possible, mirroring my own emotional fidgeting and internal discomfort.

Confronting My Countertransference

After becoming more comfortable seeing clients and experiencing a reduction in my anxiety about not being an effective clinician and providing immediate value to my clients, I started to become aware of many countertransference-producing issues; some of the money-related ones became pronounced quickly. I became aware of differences in the socioeconomic status between some of my clients and myself. I also started to ponder about the financial viability of my new career and what it meant to have a financially successful practice. I also noticed that I often became emotionally activated when clients lied about their financial situation in order to receive services at reduced rates or were paying for services using money that they had earned working in some aspects of the gray economy.

Differences in socioeconomic status. I quickly became aware of the differences in socioeconomic status between my clients and myself. Working in a low-cost clinic, many of my clients earned about one tenth of what I used to earn working in corporate America. Very often I thought about my clients' situations between the sessions, felt guilty about the discrepancy, and also felt powerless in terms of helping them in any

other way than continuing to see them as their therapist. I also felt angry that my clients, whose presenting issues were quite severe and who were in need of highly experienced clinicians, only had access to services performed by clinicians-in-training due to the clients' socioeconomic class. The guilt and anger toward this injustice became one of the first countertransferential issues that I had to address in the work with my supervisor. I eventually started to understand that I was providing a valuable service even though I was not as experienced as a licensed clinician. I also realized that my role as a clinician was not to save my clients from their particular situation but to provide a milieu for them to grow personally and to develop relationships with other people on their own. Feelings of guilt were not useful, as they would reduce the effectiveness of my work with my clients.

Having a financially successful practice. The first several months of my traineeship was also a time when I started to confront the viability of my own dreams and fantasies of having, among other things, a financially successful practice. Even a definition of a financially successful practice escaped me. Questions surfaced such as "what is an hour of my time worth?"; "how many clients can I help in the same day or week, while providing a high level of service to all of them?"; "how quickly should I be able to pay back the loans that I had to take out in order to pay for my education?"; "as a master's-level clinician with two graduate degrees and over 18 years of education, which socioeconomic class do I deserve to belong to?"; "where is the line between being paid a fair fee for my work and taking advantage of people in need?"; and "how far am I willing to downsize my life and comforts in order to have a more fulfilling career?"

Being early on in my professional development, I do not have clear answers to these questions. I would like to believe that I could do it all: be a good clinician, be

financially successful, and be able to provide some of my services pro bono. I would also like to believe that I could minimize countertransference issues surrounding money and their negative impact on the therapeutic process. At the same time, it has been my experience that most countertransference issues never fully disappear but rather their adverse impact on the therapeutic process diminishes. Nevertheless, for now, my goal is to stay vigilant and willing to confront these issues as they reappear in my future work.

Clients lying about their financial situation. The biggest source of negative countertransference was finding out that my clients had lied about their financial situation during intake and were receiving services at highly discounted rates. This was something that required a significant amount of processing in supervision as well as individual therapy. I was fully aware that my clients' as well as my own complexes could contribute to making decisions or behaving in ways that were not always fully congruent with our value systems. Yet, clients receiving free or almost free services who were able to contribute much more to keeping the clinic's doors open enraged me.

Shortly after discovering their deception, I experienced difficulty being fully present for them. Unfortunately, I was not aware of its impact initially, so the importance of my internal reaction did not enter into my conscious mind until later on. Similarly, to resolve all of the countertransference-producing issues, I needed to become curious about my clients' experiences and certainly my own complexes.

One of the complexes that I became aware of was related to my father, who often attempted to receive items or services for free even though he was financially able to afford them. Whether going to see a movie or an opera, he often lied to and manipulated the theater employees to give him free tickets using elaborate stories and sometimes even

threats if they did not fulfill his demands. While he was engaging in these behaviors, I felt an incredible amount of shame that my own father was behaving in such awful ways. Nevertheless, this complex stayed buried in my unconscious for many years until it started to resurface as a sense of anger toward clients who were trying to receive services at reduced rates although they were able to pay more.

Accommodating higher paying clients. One of the challenges that I discovered over time was my tendency to accommodate clients who were paying a higher rate. Although at the time I was not receiving any financial compensation for my work, my flexibility regarding scheduling was much higher for clients who were paying higher fees to the clinic. Discovering this fact left a sour taste in my mouth and provoked shame. I became worried about if I had a tendency to accommodate clients who were paying higher fees even when I did not directly benefit financially, how this would be when I did benefit financially. Although Hirsch (2012) recognized this tendency of accommodating clients who pay higher fees as being a normal human response, I wished that it were not the case with me. Nevertheless, as I became more aware of this tendency over time, its occurrence started to diminish.

Clients engaged in the gray economy. One challenge that came up during my training was related to receiving payments from clients who earned money while engaging in, according to my value system, unethical or semilegal activities. Whether writing college papers for others for money and promoting plagiarism or more ethically questionable activities, I felt uncomfortable receiving money from them. This created a double bind for me. One of the most important values that I have as a therapist is to have unconditional positive regard for my clients and never risk shaming them in any way. At

the same time, I viewed it unethical to receive money from clients who earned money in ways that went against my personal values.

Although not as obvious at the beginning, I realized that not re-creating the same patterns that my clients experienced in the past when they had been shamed for their behaviors was much more important than imposing my personal ethics. For many, the relationship with a therapist was the first and often only relationship that was free of judgment. If my clients' behavior was egosyntonic, that is their behavior matched their internal representation of their self-image, imposing my values would be dismissed. If their behavior was egodystonic, that is their behavior did not match their internal representation of their self-image, making it explicit would generate additional shame to that they already carried.

Financial Reassessment Project

Introduction. The idea for this master's thesis was solidified during the financial reassessment project that was performed at my traineeship site. This was my first major clinical experience of having to confront strong transference from clients, and my colleagues' and my own countertransference regarding fees. I was asked to be one of the therapists on the team assigned to perform financial reassessments of all of our current clients due to having demonstrated the ability to ensure that my clients made their payments. Although I knew that the project would not be easy, I enjoyed the challenge and especially the opportunity to confront my own countertransference issues when dealing with fees.

Reactions prior to reassessment. Announcing the financial reassessment project to my clients evoked strong reactions on their part and generated useful material that we

addressed in the therapeutic process and, for some of my clients, for several subsequent sessions. The most prominent reaction was anger, which I expected and considered understandable, closely followed by my clients' fear of sharing their personal financial information with me and possibly another person. This was especially true for clients who had been transferred to me from other clinicians. Many of these clients had been assessed fees in the range of $2.50 to $10.00 per session and were alarmed that these amounts might be increased in the near future.

One of the reactions that I did not predict came from clients who had been financially assisted by others—most often family members or life partners. They reported a strong sense of shame for not being able to support themselves and for not being financially independent. They were also the most reticent in sharing their entire financial situation and needed a lot of prompting in order to do so. On the one hand, they were utilizing the assistance provided by their families for their life expenses; on the other hand, they did not consider that assistance as a part of their finances.

Reactions during reassessment. However, the strongest emotional reactions occurred during the financial reassessment appointments when a third person was performing the reassessment and new amounts were assessed. Regardless of the outcome of the process, the underlying anxiety of all three parties present in the room was palpable, and there was a strong sense that everyone wanted the process to be over as quickly as possible. The client yearned for clarity. When I was the primary clinician, I hoped to avoid the shame of not having assessed the client correctly in the past. And when I was the one performing the reassessment, I hoped that a client who was unknown

to me would not fully decompensate in the room or provoke my feelings of incompetence.

For clients who were assessed at the same level as before, I primarily felt a sense of relief coming from them and a sense of gratitude that they were not facing another financial hurdle in their lives. At the same time, they reported feeling shame that their financial situation had not improved over the months (or even years) of receiving services from the clinic, and they wished that this were not the case.

About half of my clients were facing four- to eightfold increases in fees, and they were the ones who had the strongest emotional reactions to the financial reassessment process. Some of them started yelling at the colleague performing the reassessment and me. Some of them started crying when faced with a possible loss of services. And some of them were resigned that they would be unable to continue therapy. However, some of them were accepting of the change, as the increase in fees also signaled that their financial situation had improved since starting therapy.

Long-term impact of reassessment. The effects of the financial reassessment project permeated my work with clients for months to come. The most common reaction of my clients was to reevaluate the benefits of therapy in general and of their work with me in particular. When several clients announced that they were considering terminating treatment or at least finding a more affordable clinician to work with, I started to panic and to question my own skills and relatability to my clients. Their seeming tepid appreciation for our work partially destabilized my own sense of self and my value as a clinician.

In the end, all of my clients decided to stay on for another 6 months even with the increase in fees, which relieved some of my anxieties. I wish that my sense of self were not influenced to that degree by my clients' perceived value of my work with them. However, during this first phase of my work as a budding clinician, I have a sense of acceptance regarding it.

Change in policy. After the financial reassessment project was completed, some of the experiences were incorporated into new policies. Similar to Newman's (2005) recommendations, the patients' financial reassessments were no longer performed by the primary clinicians, but rather by an administrator or another clinician not directly involved with the client. On the one hand, this change reduced my own anxiety about determining the correct fee structure for my new clients based on their level of income. On the other hand, it eliminated opportunities to further develop my skills in setting fees.

Clinical Applications

Bringing any material out of the shadows of a clinician's unconscious in order to be processed on a conscious level has a significant clinical application, as it reduces the risk of psychological injury for clients. Clinicians have an ethical obligation to keep the main instrument of their work, which is their psyche, as close to being perfectly attuned to their clients and as healthy as possible. Addressing their negative countertransference surrounding money becomes paramount in their work with clients, especially with clients who have wounds surrounding the meaning of money and their relationship to it. By demystifying and normalizing these issues in one clinician's personal life as well as in his clinical work, this chapter has attempted to demonstrate some helpful ways for clinicians

to first develop a healthy relationship with money themselves and then be able to process consciously the transference and countertransference challenges that arise in their work.

The beginning of this chapter focused on the clinician's experiences in his family of origin, the multigenerational transmission of values, and his parents' and grandparents' attachment to money and its resulting impact on the clinician. It was followed by a presentation of the clinician's own experience of paying for therapy for the first time and the resulting activation of feelings and complexes. The issues surrounding the clinician's early work with clients, including countertransference and the ways that the countertransference had been addressed, followed. The chapter concluded with the presentation of a financial reassessment project with which the clinician was involved during his traineeship and the impact of the project on the clinician.

Chapter IV
Summary and Conclusions

Summary

An exploration of the existing literature was the main focus of Chapter II. Although the amount of both peer-reviewed journal articles as well as mainstream literature has been limited within the general field of psychology, the psychoanalytic community has produced a significant body of work that underlines the importance of addressing money exchange between clients and their therapists, including both as a transference- as well as a countertransference-producing clinical issue.

Early psychoanalytic thinkers (e.g., Fenichel, 1938; Gedo, 1963; Haak, 1957; Kubie, 1950; Loewald, 1960; Menninger, 1958) regarded payment or nonpayment of fees primarily from a transference perspective, rarely, if ever, acknowledging unprocessed clinicians' material as a possible threat to the therapeutic process or a source of failure of therapy. Following Freud's (1913/1976) unbending ideas regarding payment of fees, these thinkers underlined the importance of always charging for therapy, believing that a positive clinical outcome required a patient to have financial investment in the therapeutic process (Freud, 1913/1976; Menninger, 1958). They also believed in charging for missed sessions and interpreted ruptures due to the payment of fees in the therapeutic process as originating solely from the patient's psyche.

However, following the period of strict adherence to a rigid therapeutic frame, the next phase of discourse started to question whether the clients' strong reactions regarding money and fees were only attributable to their unprocessed material or whether

therapists' unprocessed material was also causing these reactions (Allen, 1971; DiBella, 1980; Meyers, 1976; Mintz, 1971; Nash & Cavenar, 1976; Pasternack & Treiger, 1976; Pope et al., 1975; Schofield, 1971; Schonbar, 1967; Tryon, 1983). During this period, the psychoanalytic, as well as the general therapeutic, community started to realize that clinicians' unacknowledged and unprocessed material surrounding money could also provoke strong client affect.

Many of the thinkers of the following 40 years (e.g., Krueger, 1986, 1991; Lasky, 1984, 2000; McGoldrick & Gerson, 1986; Newman, 2005; Pasternack, 1988; Schonbar, 1986; Shields, 1996; Trachtman, 1999; Tulipan, 1983) agreed that the processing of clinicians' countertransference regarding money was essential for the success of therapy and, if not processed in the clinicians' own work, could significantly impede if not completely destroy the therapeutic relationship between clinicians and clients. Some authors (e.g., Hirsch, 2012) were even more confrontative, pointing out that clinicians' own shadow material might even prevent them from wanting to explore their money issues, although these clinicians also exhibit unprocessed contempt for clients whose lives are motivated by financial gain.

Having established that clinicians had to do their own work in order to minimize the impact of their unprocessed material, Chapter II continued with the discussion of issues and challenges that arise. Many authors (e.g., Kipnis, 2013; Meyers, 1976; Newman, 2005; Pasternack & Treiger, 1976; Shields, 1996) considered a lack of clinicians' training as one of the main contributors to the existence of unprocessed material. Others (e.g., DiBella, 1980; Krueger, 1986; Lasky, 1984; Newman, 2005; Tulipan, 1983) explored possible reasons for clinicians' unwillingness to address the

issues surrounding money in their own work, including clinicians' internal conflicts as well as society's general and often negative attitudes toward money and wealth.

Chapter II concluded with a discussion of possible strategies for clinicians to master their own relationship to money. DiBella (1980) offered a framework for clinicians to work through their own countertransference outside of their work with clients, Lasky (1984) added suggestions regarding how clinicians can address their countertransference during the sessions, and Gallo (2001) provided a framework of money genograms to help clinicians map their own and their families' relationships with money.

Chapter III used this author's own experiences as a nascent therapist to demonstrate some of the challenges facing clinicians when dealing with issues surrounding money and fees in therapy as well as this author's efforts to address them. The chapter began with a short autobiographical sketch of the author's family using Gallo's (2001) framework for the creation of multigenerational money genograms as well as a narration of early memories of money and its meaning for the author during childhood. Familial attitudes toward money, its meaning and importance for the author's parents and grandparents, in addition to the role of money as a gift were discussed next.

The following section of Chapter III focused on the author's own experiences of engaging with challenges posed by the exchange of money in a therapeutic relationship from the point of view of a client. The section discussed challenges in terms of objectively measuring the value and results of therapy as well as this author's challenges in bridging his previous academic training and work experience with the field of psychotherapy.

First experiences as a clinician were shared next, including an account of initial confrontation with negative countertransference and the author's attempts to minimize its impact using his own work in therapy. Some of the countertransference-generating clinical experiences included managing feelings of guilt due to differences in socioeconomic status between the author and his clients and questions of appropriate financial remuneration of the author's work. Other countertransference-generating experiences included clients lying about their financial situation in order to receive services at reduced rates as well as the author's internal reactions when accepting payment from clients engaged in the gray economy.

Chapter III concluded with a discussion of this author's experiences while being involved in a financial reassessment project at his traineeship site. The preexisting policies regarding the establishment and collection of fees were presented followed by the author's experiences of assisting the site with a fair assessment of sliding-scale fees based on clients' financial situation. The author's handling of transference and countertransference before, during, and after the reassessment was presented including attempted approaches to address these issues.

Conclusions: Clinical Implications

One of the main goals of this thesis has been to educate and to persuade the reader on the importance of therapists' processing their own attitudes and relationships to money in order to reduce the possible negative impact on the therapists' clinical work. The topic of money as a clinical issue for clients and therapists continues to be a taboo that is often unaddressed during training and continues to be avoided in clinical practice.

The author's attempt has been to demystify the topic and surrounding issues by presenting one person's account of the journey in partnering countertransference resulting from money and fees in therapy. Although the research represents only a single-person account of the possible issues, it is clear that these issues exist and it is prudent for any therapist, whether in training or in a successful practice, to explore them. Since the risk of clinicians' unprocessed material negatively affecting clinical outcomes is always high, clinicians' willingness to explore these issues supports the creation of a safer therapeutic environment.

Recommendations for Further Research

As stated previously, the amount of academic research on the topic of money and fees in therapy has been limited from the broader field of psychology, although the psychoanalytic community, as a subset, has created a significant amount of peer-reviewed research on the topic over the past 100 years. Unfortunately, even psychoanalytic research has been skewed toward handling patients' transference rather than processing clinicians' countertransference in relation to fees. The efficacy of the presented attempts (DiBella, 1980; Gallo, 2001; Lasky, 1984) to formulate ways for clinicians to identify and address their own countertransference needs to be evaluated in addition to finding other strategies for confronting clinicians' negative countertransference in practice.

Furthermore, building awareness within the therapeutic community of the problem and its effect on their work is also required. Therapists claim that all clinical interventions have to be in the best interest of their clients. Ironically, one of the best

interventions for their clients is for therapists to work on their own unconscious and unprocessed material concerning money and how it affects their work.

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