

Coasting in the Countertransference

Analysts' Pursuit of Self-Interest

I have had, over the years, many informal conversations with psychoanalytic colleagues who are also close friends that focus on some of the selfish motivations both for our work with patients and in our broader professional pursuits. These conversations are often in a humorous vein, sarcastically tweaking both our own self-serving interactions and the myth that those of us in the helping professions are possessed by especially altruistic spirits. In the candor of friendship we have teased one another about a variety of familiar themes; for example, the joys of being the object of sexual desire, especially in the eyes of patients toward whom we are physically attracted; the pleasures of being admired in a myriad of ways, in contrast with being the target of hurtful criticism or scathing anger, even though it is clear to all in the field that anger in the transference is an essential part of any depth analysis; the high that comes from the affirmation of receiving new referrals, having most of our available hours filled, and earning a satisfactory living; and the ever present specter of boredom, and the frequent temptation to not listen carefully to patients. I recall one specific moment of shared laughter and recognition when a colleague quipped to a small group of us that, by far, his favorite form of transference was idealization.

Though conventional wisdom dictates that self-interest is a significant, though not exclusive, motivation for much of what all living creatures do (Slavin & Kriegman, 1992, 1998), psychoanalytic literature has, for the most part, avoided addressing the degree to which this impacts analytic therapy in ways that are sometimes helpful but sometimes harmful to patients. Analysts' pursuit of money, or, put more colloquially, the need to earn a living, has received more attention in the literature than other dimensions of analysts' selfish

pursuits (see, e.g., Aron & Hirsch, 1992; Josephs, 2004; Lasky, 1984; Liss-Levinson, 1990; Whitson, n.d.), and I intend to address this important question again in chapters 7 and 8. Recently, Maroda (2005) has emphasized the importance that analysts recognize that, inevitably, they seek gratifications from patients, and that this should be seen as normal and inherently human (Slavin & Kriegman, 1992, 1998). Maroda referred, for example, to desires to be important and effective as virtually standard features of all interpersonal engagement, though she was aware that pursuit of these "normal" gratifications can become overly narcissistic, excessive, and ultimately harmful to patients. In an earlier generation, iconoclastic analytic writers like Singer (1965a, 1965b, 1968, 1971, 1977) and Searles (1960, 1965, 1979) both suggested the ubiquity of analysts' self-interest, and the need to be aware of it, so that the analytic process is neither a sham (i.e., analysts' portrayal of themselves as selfless and as caring only about what is best for patients) nor a vehicle for unrestrained pursuit of this self-interest. Singer implied what is essentially a capitalist ideal—the pursuit of financial compensation and professional recognition is best served by being an optimally competent analyst for patients. Searles suggested that vigorous enjoyment of one's interaction with patients is likely to lead to more authentic and passionate engagement with them. Needless to say, past a certain, difficult-to-determine point, an emphasis on self-interest usually involves at least a measure of disregard for the other.

In this volume I write about the kind of analyst self-interest that is not an aspect of the analyst's character alone, nor simply an expression of a wish to be successful in one's work. My interest lies in pursuits of self-interest that emerge as potentially useful data from the transference-countertransference matrix, though are not necessarily used to further the analytic work. Instead, the analyst can be said to coast in the countertransference, choosing comfort or equilibrium over creating useful destabilization (Mendelsohn, 2002; Slavin & Kriegman, 1992). In this chapter and in what follows, I plan to address a variety of ways that, with at least some consciousness, analysts commonly pursue their own interests at some cost to patients. The first issue I address in this chapter reflects momentary indulgences, the countertransference implications of which the analyst does not use to deepen the analytic process. Lapses in attention and daydreaming are quotidian examples. The second theme in this chapter refers to the way analysts structure their practice, including

the length of the workday, spacing between analytic sessions, and competing professional activities. In subsequent chapters (chapters 2, 3, and 4), my attention focuses upon analysts' unique personalities and the situational factors in analysts' lives. These enduring and/or transient states generally lead analysts, usually unwittingly at the start, to shape the analytic relationship to conform, more or less, to their most comfortable and preferred relational states. At some point these interactions inevitably become conscious to the analyst, and the choice presents itself whether to create a disquieting disequilibrium by using these interactional data to productively address the transference-countertransference theme, or, conversely, whether to coast with the status quo and maintain what might be a mutually comfortable equilibrium between patient and analyst. I am suggesting that it is more common than one would suspect from the psychoanalytic literature for analysts to consciously choose to maintain personal and/or mutual states of equilibrium with patients over the promotion of therapeutically useful mutual destabilization. Perhaps the most common example of this can be seen in many long analyses, where a dependent patient wishes to remain eternally, and an analyst, gratified by both a sense of importance and an economic annuity, chooses not to address the mutually gratifying nature of the transference-countertransference relationship (Renik, 1995, 2006). Along the same lines, a situational factor of analysts' loneliness (Buechler, 2004; Fromm-Reichmann, 1959) may readily lead to efforts, unconscious at first, to facilitate patients' excessive dependency and to discourage separation and autonomy.

In chapter 5, I address the often powerful role that any analyst's cherished psychoanalytic theory may have in both structuring and understanding the therapeutic dyad. Analysts' respective theoretical heritages provide comfortable and familiar homes for them, and patients are commonly shoehorned into a conceptual space that is designed to reinforce analysts' sense of stability. In chapter 6, I discuss the rarely addressed issue of male analysts' and/or patients' baldness, and the enormous anxiety that either state may create within the analytic dyad. I argue that analysts' avoidance of dealing with this issue is more characteristic than otherwise, for it may readily create in both parties what could be experienced as a premature confrontation with mortality. In my final two chapters (7 and 8), I emphasize the degree to which analysts' economic needs may influence every aspect of the analytic relationship. I underscore that the

impact of therapists' economic concerns reflects the single biggest dilemma in any of the helping professions.

Slochower (2003, 2006), referring to what she called everyday "crimes and misdemeanors," wrote with unusual candor of the inherent conflict that may exist at any moment of analytic work between attention to patients' and analysts' wishes and/or interests. Though it seems so obvious after it is noted, Slochower highlighted what has rarely been acknowledged in the literature—the difficulty of suspending attention to one's interests and listening carefully to others for even one analytic session, much less all day long. The joke that ends in the analyst's shrug of his shoulders and his question "Who's listening?" is a reflection of how well most analysts know privately that they do not always listen to patients, choosing instead, at any given moment or for much longer, to attend to themselves in priority. Slochower argued that pursuit of self-interest of any kind is most harmful when analysts fail to acknowledge this phenomenon as a powerful force in any given analytic experience. Needless to say, analysts who face themselves and embrace their deficiencies with a good measure of honesty are less likely to *persistently* pursue selfish interests to the severe detriment of patients. For instance, because most lapses in attention by the analyst have something to do with the patient or with the analytic interaction, each instance of this becomes an opportunity for analytic inquiry. Few of us use productively *each* such instance. However, though no analyst can operate with this degree of presence all of the time, some approach this ideal more consistently and, of course, with some patients more than with others.

Self-awareness, however, is not a guarantee that any given analyst will change the way he or she is relating to a particular patient, either at specific moments or over extended time periods. The power of the quest for personal comfort and equilibrium, with each unique individual patient, is always potent. In the dyadic work of analysis, it is quite common that analysts' self-interest and patients' comfort levels dovetail, and persisting in perhaps stagnant but relatively anxiety-free enactments or mutual configurations is compelling for both parties (Feldman, 1997). For instance, think of the schizoid patient who is quite comfortable with the analyst's withdrawal, the overdependent patient who relishes the analyst's infantilization, the sexually provocative patient who enjoys the analyst's flirtations, or the masochistic patient who expects to be ignored. Analysts' awareness of such engagements or enactments has the potential to lead to

a useful deconstruction of them, but because they can be so mutually gratifying, this is often not the case. On a conceptual level, most contemporary analysts agree that the analysis of a mutually constructed configuration is the sine qua non of the process and that such interactions are hard to meaningfully address unless they have been enacted within the transference-countertransference matrix (Black, 2003; Bromberg, 1998, 2006; Gabbard, 1995, 1996; Greenberg, 1991, 2001; Hirsch, 1996, 1998a; Jacobs, 1986; Levenson, 1972, 1981, 1992; McLaughlin, 1991; Mitchell, 1988, 1993; Poland, 1992; Renik, 1993; Sandler, 1976; Stern, 2003, 2004; Varga, 2005; Wachtel, 1980). The issues addressed here, however, focus on analysts' conscious disinclination to assert the effort to put these interactions (unwitting enactments) into words, choosing instead to remain in a comfortable moment, or in a long-standing equilibrium of what may perhaps be either free of anxiety for the analyst singularly or a familiar and therefore comfortable mutual enactment for both analytic participants. Implicit in this exegesis are the ideas that analysts often fail to use countertransference productively and that the thoroughgoing embrace of countertransference experience in much of contemporary two-person psychology theorizing may not be sufficiently thought out. A more genuine two-person relational psychology cannot assume optimistically that each unique analyst will engage countertransference experience to good end. Analysts' idiosyncrasies dictate that each individual analyst will at times indulge his or her countertransference, and that patients will be the worse for this. If the examination of the experience and participation of both parties in the dyad is to be as thorough as interpersonal and relational writers suggest it should be, there will have to be added a focus on how often patients' progress is limited by analysts' failures to translate what they know about their countertransference experience into helpful shifts in analytic relatedness. That is, the inclination to pursue self-interest must be included as a feature in any conception of a mutually subjective (Aron, 1991, 1996; Benjamin, 1995; Hirsch, 1990; Levenson, 1972, 1981, 1992; Renik, 1993, 1995; Singer, 1977; Stern, 1997; Wolstein, 1954, 1977, 1997), two-person psychology of psychoanalysis. Though I do believe that analysts' unwitting participation is inevitable and virtually always potentially productive, I also believe that analysts too often are willing to coast with comfortable modes of participation after they become witting. What Buechler (2002, 2004) has called "effort fullness" reflects her recognition of

how counterintuitive it is for anyone to choose discomfort and disequilibrium in preference to their opposite states (Slavin & Kriegman, 1992, 1998). Theories of therapeutic action are based on ideals and on analysts behaving ideally, though each individual analyst is, indeed, a flawed human being who operates selfishly and falls short of analytic ideals very often.

In what follows throughout this volume, I will address a variety of ways and contexts that reflect analysts' at least somewhat conscious choices to maintain self-interest, or to coast, and to make less than optimum effort to use immediate experience to help patients progress to satisfactory termination (Renik, 2006). Though, as noted, I will try to separate these pursuits of self-interest and personal equilibrium into discrete categories, inevitably there is much overlap between categories, and they are not at all independent of one another. In the remainder of this chapter I address the particular theme of analysts' lapses of involvement and attention, and the often selfish way analysts structure their workday and integrate their range of professional commitments. Implicit throughout all chapters is the concept that analysts need to tolerate disequilibrium and to personally change in relation to patients, if patients themselves are expected to change (Buechler, 2002; Mendelsohn, 2002; Slavin & Kriegman, 1992, 1998; Wolstein, 1954, 1959).

The Analysts' Lapses

It is worth restating Slochower's (2003, 2006) obvious but rarely addressed acknowledgment of how difficult it is to suspend attention to one's own concerns, and intently listen to another person for 45 or 50 minutes, much less do this repeatedly over the course of an entire workday. Indeed, this seems to me quite impossible, and I believe every analyst has lapses in attention for some fractions of time in every session. When these periods of inattentiveness occur, of course, are crucial data, because analysts' boredom or affective withdrawal is usually related to the patients' participation and to elements of the analytic interaction. As well, the content of analysts' ideation during periods of inattentiveness may be highly informative about patients and about the analytic interaction. Ogden (1994) and Wilner (2000), from very different analytic perspectives, both suggested that *all* of analysts' fantasies or reveries are related to the

analytic interaction not only in form, but in content as well. In a sense, they imply that analysts never really withdraw from patients, because every withdrawal and how it is spent are actually just other forms of being involved with patients.

Though I agree that this often is the case, this conception seems to me somewhat idealistic, and a denial of the flawed humanity of all of us who practice analysis. It suggests that analysts never retreat into privacy and self-involvement for reasons that are largely narcissistic and selfish, and that are more often than acknowledged independent of patients' participation. I do believe that every act, when with another person, indeed does have *some* interpersonal meaning. However, this meaning could be far secondary, for instance, to an analyst's communication of the wish for privacy or respite, or a statement, for example, of analysts' fatigue, preoccupation, worry, or looking forward to what lies ahead in the day or evening. Most analysts will acknowledge privately that boredom is an occupational hazard, and that this experience is not *always* primarily related to a particular interaction with a given patient. I will say more about this later in this chapter, but boredom is often related to how many patients are seen in a day, how they are spaced, the time of the day, and competing activities. I suggest that although analysts are, of course, more likely to withdraw into boredom and self-involvement with some patients more than with others (and that this is always of informational value), the reverie involved in these withdrawals sometimes reflects exclusively analysts' narcissistic concerns (Bach, 1995; Blechner, 2005b; Fiscalini & Grey, 1993; Hirsch, 1993), and may not at all be of informational value in understanding patients.

Although some analysts are better able than others at suspending attention to their own concerns during sessions, and most analysts can do this best when not especially busy or fatigued, or when their personal lives are relatively smooth, I do not believe that anyone does not use his or her workday, in some degree, to retreat into privacy. Indeed, the structure of the analytic situation lends itself to this. Psychoanalysts are expected to be quiet and reflective, and patients quickly learn not to expect very much verbal interaction. When patients lie on the couch, they face away from the analyst, and the analyst probably speaks less often, so that both visual and auditory cues about the analyst's experience are less available to patients than when they sit up. I am not sure, though, that patients on the couch know as little about the analyst's ongoing experience

as analysts often seem to think. I have always believed that patients *are* able to read our sentiments, attitudes, and levels of engagement despite even lengthy silence and/or not seeing us. However, because analysts' roles, even in current times, are defined by at least reserved or infrequent verbal and nonverbal expressiveness, it is difficult for patients to entirely trust their perceptions about analysts' momentary, or sometimes even long-term, disengagements. Indeed, analysts often do not encourage patients to challenge them about their withdrawals, preferring instead to remain in such states, often protected by patients' unwillingness to be overly critical and to lose analysts' affections. Because analysts' work is defined more by listening than by speaking (we are supposed to be "good" listeners), we can usually get away with brief or even extended periods of listening to ourselves more than to our patients. Obviously, this is more likely with patients who do not expect and/or demand a great deal from us, or from relationships in general. Independent of particular transference-countertransference interactions, I believe that the use of the analytic couch lends itself to analysts' taking selfish leave from patients. Designed to minimize analytic influence on patients and to provide analysts optimal freedom to use creative reverie in the service of helping patients, this freedom, unfortunately, extends to greater latitude to be absent without detection—to be self-involved, and "missing in action." Slochower (2003, 2006), with some self-effacing humor, cited a variety of ways that she and/or her colleagues have taken leave from patients, aided by the absence of visual cues afforded by the couch or, even more extremely, in the context of telephone sessions. Indeed, this latter phenomenon has become more common in recent years (Richards, 1999). Slochower's examples include making shopping lists and schedules, paying bills, scanning the Internet, and looking at personal photographs. The humor involved in noting such unabashedly selfish pursuits is the humor of recognition—each analyst feeling some personal exposure to what Slochower called analytic "crimes and misdemeanors." In face-to-face analyses, one must learn to be more subtle, to scan the Internet of our mind, so to speak. Paying attention to oneself and not to patients will never be eliminated by any of us—it will only at best be controlled when analysts fully acknowledge this to themselves and encourage patients to make us uncomfortable by expressing, not containing, their transference-related perceptions of us (Aron, 1991, 1999; Blechner, 1992; Fiscalini, 1988; Gill, 1982, 1983, 1984, 1994;

Goldstein, n.d.; Greenberg, 1986; Hirsch, 1998a; Hoffman, 1983, 1987; Singer, 1968; Stern, 1987; Wachtel, 1982).

Later in this chapter I refer to circumstances that make analytic disengagement more likely, independent of particular transference-countertransference configurations. Nonetheless, as noted earlier, analysts' boredom, retreat into privacy, and the like are usually related to the person of the patient, and to the nature of the interaction at any given moment. I want to emphasize that I do not consider experiences like boredom, lapses in attentive listening, and affective retreat and isolation as unmediated expressions of the analyst's character or personality, and therefore as countertransference in the one-person sense described by writers such as Reich (1951). Instead, I view such states as intrinsic to any interpersonal situation that endures for even a modest period of time. What is problematic (albeit universal), and reflects my emphasis throughout, is analysts consciously choosing to remain in these states because this represents the most comfortable place to be situated at any given moment for the analyst, and often for the patient as well. Analysts' failures to make the effort to return from lapses in attention and pursuit of personal reverie, and/or to use these retreats for therapeutic ends in order to expose mutual enactments, comprise the countertransference theme most unaddressed in our literature. Here is a brief illustration.

Hillary* has been in analysis for some time, and has made only modest gains in her original presentation of herself as depressed in a "low-grade" (her words) way and passionless in both her marriage and career pursuits. She reports "the blahs" and, indeed, relates to me with a flatness and absence of verve or of urgency, virtually regardless of the seeming importance of the issue she brings to me. This was so when she told me of uncovering her husband's sexual infidelity, as it was true of her recent report of the acute mental collapse of her elderly mother. Our interaction follows a pattern. I usually tell her that she is speaking in a flat and disinterested tone about something I know that she has strong feelings about. She takes note, though continues in the same vein. I begin to become bored and retreat into my own private world, and then mobilize, and convey to Hillary that she still sounds like she's deadening her feelings. Hillary agrees; yet continues true to form. I resort to interpretive comments, reminding

* In this and other clinical examples used throughout the book, names and other identifiers have been changed to protect confidentiality.

her of the origins of her retreat. In capsule, the origins to which I refer are largely the loss, in her early teens, of her romantic fantasies with, and strong sense of being special to, both her father and her brother, a loss brought on by her mother's success in "stealing back" her father, and the beginning of her brother's relationship with a girl who eventually became his wife. Until her acquiescent father withdrew profoundly, Hillary describes herself as having felt special to him and, as well, felt vivacious and excited about life. Subsequent to this period, she usually chose safety, including a marriage to a man she knew she was not in love with, but whom she perceived as steady and potentially a good provider economically. This combination of safety and dependency has characterized our relationship, and in an effort to emerge from an incipient boredom and retreat that I know will soon intensify, I interpret to Hillary that she is playing it safe with me and, as well, isolating what she might be feeling about her mother's deterioration. My patient agrees, genuinely I believe, but very soon again returns to pattern. In this context, my retreats and my private reverie become longer. Depending on the day, my reverie could be about anything from phone calls I must make, to what I am doing that evening, to worries about one of my adult children, or even to all of the above and more in the course of one session. What I wish to emphasize is that, with Hillary (and others), for periods of time I desist from making the effort to return to the key issue of her emotional retreat and its impact on me, and I just coast with this impact. During these periods I am pursuing my own self-interest, soothing myself and ignoring my patient, as I feel she is ignoring me. Though I am not these days usually conscious of feeling hurt, angry, or retaliatory, indeed I have often used this obvious instance of projective identification, in the form of an interpretation to Hillary, as an additional way of combating my withdrawal. Earlier in our work together I had made much of her passive-aggressive withdrawal as a reflection of her transference and her usual retaliatory anger, and conceptualized my own affective retreats from her as reflections of my anger in relation to Hillary's deprivation of me. These interventions were seemingly accepted and understood, but I found that they did not advance our situation. Indeed, were I to have been making a consistent and persistent effort to be optimally present, there would have been much process and content to address with Hillary. Unfortunately, she evokes my withdrawal by her flatness and

absence of excitement about me, and then is content to let me stay there, leaving herself with the considerable safety of emotional distance in a context where she feels certain that I will not abandon her entirely. Part of Hillary wishes to remain this way with me forever, dissociated from her emotional dependency on me, though part of her also wishes to risk being more vulnerable and alive. I depend on my initial comments and transference observations and interpretations to energize me, and when she rejects them by returning to her withdrawn pattern, I may disappear, in part hoping that Hillary will bring me back. We are, however, in a state of mutual equilibrium. My patient almost never challenges my withdrawals. I know that it is solely my responsibility to make the requisite continuous effort to emerge from the safety and comfort I often feel when I coast in my own self-absorbed and self-enclosed rumination or reverie.

Related to the theme of effort is the question of analysts' memories about patients' life history, significant details of current life, and dreams. Bion (1967), in his well-known directive, recommended that analysts do best when free of memory or desire. He suggested that this position allows patients to be uninfluenced by analysts' wishes, and enables them to address only what is of most urgency to themselves at any given moment. In addition, analysts' knowledge of history or of previous dreams readily leads to interpretive bias on analysts' part. That is, there is risk that immediate experience is seen less as something fresh, and to be examined with naïve curiosity, than as something that fits into a schema that is based on past knowledge. In Bion's eyes, analysts' attention to immediate experience reflects the heart of the process.* Indeed, analysts' attempts to not make the effort to recall data about patients, for the reasons Bion advised, seem to me like one reasonable view of ideal analytic process. This corresponds to a traditional classical Freudian perspective, in which meticulous care is exerted to avoid influencing patients with analysts' subjectivity. Though central to the relational turn in

* Though it is not my intention to discuss Bion's significant contributions beyond the one segment that is relevant directly to the issue of analysts' memory, it is worth noting that Bion has developed an intricate theory of therapy. In contradiction to his care to avoid analysts' influence on patients, looking at analytic process through his theoretical lens creates a distinctive perceptual set of biases (Hirsch, 2003a).

psychoanalysis* is the argument that analysts' subjectivity is irreducible (Renik, 1993) and must be examined in the analytic process, it is the rare analyst who advocates purposeful attempts to influence patients, or influence the material that patients present. That is, analysts' subjectivity is viewed as unwitting, and not consciously designed to bias either the analytic data or the patients' choices. In fact, analysts' unwitting influence on patients ideally is to be carefully analyzed, in a verbal forum (Aron, 1991, 1996; Blechner, 1992; Friedman, 1988; Gabbard, 1995; Gill, 1982, 1983, 1984; Greenberg, 1995; Hirsch, 1987, 1996, 1998a; Hoffman, 1983, 1987; Levenson, 1991, 1992; Mitchell, 1988; Sandler, 1976; Stern, 1987, 1996a), in part as a means of trying to neutralize analytic influence and the power of the analyst as a person.

Returning to the question of analysts' memory, I suggest that although some analysts may try to not remember material in order to keep the analysis optimally pure, most forgetfulness exists for less noble reasons. Indeed, depending on how many patients a given analyst sees, it is often very difficult to recall, in particular, many details of life history. I believe that the majority of analysts value remembering as much as possible about each patient, though there is much individual difference in how much effort is expended in remembering. The most vigilant analysts may keep detailed notes of history and of each session, and review the former periodically and the latter prior to each session. This, of course, is very time-consuming, and dramatically so when one sees many patients. Nonetheless, this does seem like the most responsible approach if an analyst is to maintain an optimal presence in the effort to know a patient as thoroughly as possible. It reflects a commitment to patients at the considerable expense of analysts' time—a choice of interest in the other in priority to self-interest. Though I believe this last statement to be true, I do not routinely review patients' life historical data, nor do I keep

* For example, Thompson (1950), Sullivan (1953), Wolstein (1959), Schachtel (1959), Tauber and Green (1959), Fromm (1964), Searles (1965, 1979), Singer (1965a), Levenson (1972), Barnett (1980), Wachtel (1982), Hirsch (1987), Mitchell (1988, 1993, 1997, 2000), Greenberg (1991), Davies (1994), Benjamin (1995), Josephs (1995), Aron (1996), Slochower (1996), Stern (1997), Rucker and Lombardi (1997), Bromberg (1998), Hoffman (1998), Layton (1998), Frankel (1998), Pizer (1998), Cooper (2000a, 2000b), Grand (2000), Knoblauch (2000), Bass (2001), Berman (2001), Fonagy (2001), Crastopol (2002), Beebe and Lachmann (2002), Dimen (2003), Fosshage (2003), Safran (2003), Seligman (2003), Bloland (2005), Bonovitz (2005), Harris (2005), Skolnick (2006), and Aronson (2007).

detailed notes of sessions in order to review them prior to any given appointment. I believe that in this regard I am in the majority, especially among analysts who have at least a reasonably large practice.

It is difficult to rationalize the many lapses in memory that I think exist in most analyses. Clearly, some analysts listen more carefully than others, are more passionately involved, and are likely to keep in mind a considerable amount of data about their patients. It is equally apparent that some patients' lives are more compelling, and/or their presentation more demanding, making their analysts' memory for details about them better than it is with other patients. And, when patients are seen multiple times per week and/or over a number of years, analysts tend to remember more historical detail as time goes by. Though these features are all highly relevant transference-countertransference data to explore with patients, the fact remains that I and most of my colleagues, especially those with large practices, do not always make the maximum effort to know our patients in full by having life historical details at hand to use in any given session.

Murray has a very spare personal life, and spends much time in fantasy and in intellectualized ideation. He speaks to me in a manner that is stilted and impersonal, barely above a whisper, and maintaining attention to him takes much work. This is, of course, is a key transference-countertransference theme, and Murray has a long history of being relatively ignored. He has developed a marked passive-aggressive character in response to this, and has become a master of ignoring and thwarting others. Despite how little he gives me on a manifest level, I am sure Murray is both attached to me and dependent on me. He has opened up with me more than he has ever done with anyone, and I am his most intimate contact except for his dog. I try to stay alert by challenging him about his passive-aggressive retreats, but all too often I withdraw into my own ideation. Murray never challenges me, and I feel that I could get away with entire sessions of not listening to him, or literally not even hearing him. He demands nothing from me. Murray comes from a large family in a small town, where grandparents, aunts and uncles, pastors, neighbors, storekeepers, and others played important roles in his own and his siblings' development. Though Murray's interest in history (his own as well as American history) is among the most interesting things about him, I have an awful time remembering which brother is which, and which grandparent was warm and caring, and which was neglectful and harsh. I have a very good sense of the doings in

his current life, and about the way he relates to me and to others, but there is much in his life history that he has told me, and that is clearly significant, that I do not hold on to. I never take a detailed history when I begin with patients, and I learn about history as the work proceeds. I do take notes early in the analysis, but as treatment proceeds my notes become perfunctory, more for legal requirements than for information. I can consult my notes and study Murray's history, but I usually do not. I ignore aspects of him, passive-aggressively, as he can ignore me. I rationalize that if I help him come alive in the here and now of our exchange, I will naturally recall his history in more detail. I tell myself that transference and attention to the immediacy of process are far more central than historical detail per se, and though I do believe this to be true, my failure to remember is *part* of a transference-countertransference enactment, and I do not make the full effort to pull myself out of it. As I write this, I resolve to examine my notes and get Murray's life history straight, prior to each session if need be. This will take time and effort, and perhaps interfere with the number of patients I can see in each day, for Murray is not the only person whose historical data elude me. This would represent a financial sacrifice. Murray wants to emerge from his state of withdrawal, and he wants to be loved and attended to. He is, however, too comfortable and too familiar with both receiving and giving less than full attention. We both can live with our situation the way it is, but it is my place to make the effort and the sacrifice, and to create a situation of greater discomfort and disequilibrium for both of us.

Rory is young, exceptionally handsome, athletic, and successful; he is charismatic and charming and seductive. He has many close friends, and was always very popular and a leader throughout school. He feels special and central to both his parents. Though his divorced parents are both very troubled people, Rory has never doubted their love and commitment to him. Rory initiates analysis because *he* cannot commit. He has so many career opportunities and is so heavily recruited that he does not know what to pursue. Similarly, he is involved with a young woman who is desperate to marry him, but other women are constantly falling into his lap. He fears that he is similar to his father—never able to love anyone but his son. Though I have seen Rory for a much briefer time than Murray, I remember everything Rory tells me. I am always on my toes and never tempted to wander. Though I do not think he would tolerate my lack of attention or absence of memory, my near perfect recall

of Rory's history and our previous sessions is effortless. It is not so much that he is particularly involved with me—he commands my total attention without reciprocating. Rory's narcissism and absolute sense of entitlement comprise our central transference-countertransference theme, yet I have been reluctant to address it in the extratransference, much less in the transference. The issue of forgetting or remembering details of patients' lives merges at this juncture with a theme to be discussed next—analysts' inclination to avoid uncomfortable transference themes (Gill, 1982; Goldstein, n.d.). This latter factor is yet another way that analysts may maintain a mutually constructed equilibrium and fail to make the effort to promote potentially productive discomfort.

Whereas I am quick to challenge and confront Murray about almost anything (when I am not withdrawn from him), I am very careful with Rory. Not only am I on my best behavior with regard to an almost photographic memory about his life and life history, but also I am never inattentive even when he obsesses endlessly about which job offer to consider. Rory is often late for sessions and in paying his bills, and on a few occasions he has forgotten to come altogether. He is very well bred and is always apologetic, though he has little awareness of his degree of self-centeredness. His looks, charm, and considerable intelligence have always given him much latitude with others, and I find myself reluctant to address his palpable narcissism in the transference. In contrast with Murray, I feel lucky to have him as a patient, and I, along with everyone else he knows, offer him my royal treatment. To the extent that I recognize a highly significant transference-countertransference enactment and do not address it, of course he actually receives very poor treatment from me. Rory is comfortable with being special, and even though I am not comfortable with my role in this mutual configuration, I avoid the greater discomfort of raising his ire and his disapproval. Rory reports that he has a short fuse, and is quick to walk away from situations that get what he calls "too sticky." I know what I must do in this situation, and I trust that I will be more courageous at some near point, and risk losing him.

I wish to highlight that it is quite common for analysts to withdraw in this way. Though this is a very different sort of withdrawal than retreat into boredom, or forgetfulness, it is also similar. Conscious avoidance of a palpable and key transference theme (Aron, 1991, 1996; Friedman, 1988; Gabbard, 1995, 1996; Gill, 1982, 1983;

Greenberg, 1995; Hirsch, 1996, 1998a; Hoffman, 1983; Jacobs, 1986, 1991; Mitchell, 1988; Renik, 1993) reflects being less than present in a social context, and suggests an analyst's preference for the maintenance of mutual equilibrium and minimal anxiety. Freud (1912/2000) long ago observed that transference is both the heart of analysis and the hardest part of analysis. Gill (1982, 1983, 1984, 1994) supported analysis of transference as the *sine qua non* of the process, while noting that examination of transference is commonly avoided by many or most analysts who adhere to this principle in theory (see also Goldstein, n.d.; Hirsch, 1987; Hoffman, 1983, 1987; Stern, 1987, 1997). As reflected in my work with Rory, transference is often consciously avoided when it creates anxiety in the analyst. Addressing transference themes in the context of extratransference content shifts the focus to a you-me, here-and-now engagement, a level of interaction far more intense than most other analytic data or content. The intimacy involved in dealing with immediate interpersonal experience, regardless of the feelings involved, is in and of itself potentially difficult to endure with some patients more than others, and/or with multiple patients per day. As well, different analysts are more or less comfortable with different affective states, and it is quite common for analysts to consciously avoid some and encourage others. Among the feeling states commonly avoided in the transference are disrespect, disappointment, disinterest, anger, sexual interest or disinterest, and dependency (often reflected and enacted in overly long analyses). In my work with Rory, I fear his disrespect, and I fear direct confrontation with his disinterest. For Rory, being angry usually means walking away—there are plenty of others who want him. In listening to his extratransference content and not taking him up on his narcissistic entitlements and his forgetfulness, I am consciously retreating from him and depriving him of proper psychoanalysis. I suggest here, with Gill (1982, 1983, 1994), that analysts generally are comfortable (though often bored) listening to excessive extratransference reporting, in which patients may express affect about parents, lovers, colleagues, and so on. When we are relatively at ease with the affects expressed, we are more likely to introduce transference implications and/or parallels. As reflected in my work with Rory, analysts are often quite conscious of transference themes they are not addressing, although they often rationalize this by claiming that the patient is not ready to hear something (Coen, 2002; Fromm, 1964; Hirsch, 1987, 1998a; Mitchell, 1988;

Searles, 1979; Singer, 1965b, 1968, 1977; Thompson, 1950; Wolstein, 1954, 1959). Though I believe that addressing uncomfortable transference themes often raises anxiety in patients, this often evokes even greater anxiety in analysts. My most frequent intervention, when I supervise others, is to point out reluctances to address transferences. It is relatively easy and anxiety-free, if sometimes tedious, to listen to patients' reports of their extratransference interactions, though the power of the analytic process, and the part of the work that is much harder for analysts, lies in making use of the ways in which what the patient says and feels shapes the experience and interaction of analyst and patient. I always encourage supervisees to allow themselves to become uncomfortable and to deconstruct mutual equilibrium (Levenson, 1972, 1983, 1988, 1991), whereas I, in full consciousness, may choose a path of self-interest and self-preservation with Rory, and with all too many others with whom I am anxious. Analysis of transference is usually in direct opposition to coasting in the countertransference, and forcing oneself to use countertransference experience to address destabilizing mutual patterning is, I believe, the best analytic hedge against a comfortable status quo. Excessive focus on extratransference material reflects a very common lapse, one that is invariably fueled by avoidance of anxiety related to expected transference affect.

The Structure of the Analytic Setting

Our psychoanalytic literature, with some exceptions (e.g., Abend, 1982; Basescu, 1977; Blechner, 1993, 2005a, 2005b; Boulanger, 2007; Buechler, 2004; Cole, 2002; Crastnopol, 1999, 2001; Drescher, 2002; Frawley-O'Dea & Goldner, 2007; Frommer, 1994, 2006; Gartner, 1999; B. Gerson, 1996; Goldman, 1993; Hoffman, 2004; Hopkins, 1998, 2006; Kantrowitz, 1992, 1993; Lasky, 1993; Leary, 1997; Nachmani, n.d.; Newman, 2006; Pizer, 1997; Richman, 2002, 2006; Singer, 1971, 1977; White, 2002), has not attended to the myriad of personal and professional variables that impact the way analysts work with patients during any given hour or day, or over extended periods of time. Prominent among these unaddressed professional variables is the way analysts structure their working day. The personal and professional are inseparable. For example, if one is worried about personal health issues or a breakup of a love relationship, does this

lead to throwing oneself into work, or being unable to concentrate on work? In either case, if there are preoccupying factors in an analyst's personal life, does this lead to being intensely consumed with patients as a way of casting worry aside, or to considerable distraction from patients?

Though most professionals are aware of this and would not deny it, I believe it is fair to say that self-interest is the first consideration in choosing the length of sessions, which hours to hold sessions, how many hours to work each day or week, the spacing between analytic sessions, and what other professional activities compete with commitment to one's patients. If patients' interest was analysts' primary concern, we would conduct longer rather than shorter sessions, work during hours most convenient to patients, work only a modest number of hours each week in order to maintain optimal involvement with each patient, space our sessions sufficiently far apart so as to be able to reflect on each patient hour and prepare for the next, and orchestrate our workday and schedule in a manner that maximizes what physicians like to refer to as *patient care*. Though I do not think of psychoanalysis or psychotherapy as at all part of a medical model, and the term *care* in this context has always struck me as cloying and insincere, I do think a concept of *optimal patient involvement* is relevant for analysts to reflect upon.

I will rather quickly refer to the matter of length of sessions and the time of day they are scheduled—I think that there is only a little bit to say about this. Analytic sessions used to be 50 minutes, with a 10-minute break built in, in order to add up to a legitimate "hour." Currently for me and most colleagues, the "hour" lasts 45 minutes, usually without a break scheduled between any given sessions. One thing that happened to the 50-minute hour was that the break in between disappeared, and sessions were commonly scheduled in succession. Given this purely economic-based practicality, 50 minutes became an odd and arbitrary number, and scheduling times emerged at awkward and difficult-to-remember times (e.g., 2:50 p.m.). Thus, with the loss of the between-session break, the more sensible number of minutes to be with patients was rounded *down* to 45 minutes, which is easier to keep track of. It could have been rounded up to 60 minutes, a true "hour," and even easier to remember. Though I know a number of analysts who still meet for the traditional 50 minutes, I know of no one who holds full-hour sessions, and hardly anyone who *tries* to schedule a 10- or a 15-minute break between sessions. I

am not here challenging the importance of maintaining boundaries and structure with patients—of choosing a set amount of time and working strictly within this. I do think, however, that it is impossible to avoid the conclusion that seeing patients back-to-back, *and* reducing analytic time by 5 minutes, works strictly for analysts' benefit in priority to patient interest. Who would argue that for the same fee, 50 minutes would not be more beneficial to patients, or that rounding up to 60 minutes would not have been more of a patient-oriented choice for our analytic culture to have adopted?

The time of the day analysts choose to work is a complex variable, because it combines analysts' preference with the question of when patients are available, as well as how busy any given analyst may be. There is little to say about this except that it is usually ruled by the capitalist law of supply and demand. Those analysts who are in sufficient demand can work whatever hours they choose, and need not take into account what is convenient for patients. Most patients with full-time jobs prefer to come either before or after work hours, though analysts who are in great demand often prefer not to work during the evening. Analysts who are more "accommodating," for example to patients' wishes for evening hours, usually do so because their preferred daytime hours are not sufficiently filled up. In order to earn a reasonable livelihood, most analysts feel they have no choice but to work at times they would prefer to be at leisure. Indeed, much analytic work is conducted in the evening, a time of day when one's concentration may be less than optimal and one's wish to be working at low ebb. I recall many years ago a colleague who was in analytic training, which required him to be in analysis four times per week with one of a number of training analysts, all of whom practiced in Manhattan. My colleague lived in Manhattan but worked in a nearby suburb, and commuted back and forth from his place of work for each session, in the middle of the day. I remember thinking he was either crazy or masochistic, and that this senior analyst must be an absolute monster to not even see him *once* each week in the early morning or in the evening, when my colleague was already in Manhattan. Now, in my own more senior status, I think I would do my best to move such a patient into an early morning or late afternoon hour, or 2:00 or 3:00 p.m. if they became available. But maybe I would not, and in that case I would be as selfish as this sadistic analyst of yore. My colleague *was* an accommodating (masochistic?) man, and he was willing to take analytic hours totally convenient to his analyst. Am I sure

I would give up a harder-to-fill, middle-of-the-day hour and transfer him to a more precious time, given his willingness to come at my behest? What if I did this and someone interesting came along who *claimed* he could come only early or late in my day, and I now had no such available time? In such an instance, I would probably have been the masochist. If this new patient were Rory, would I do everything possible to accommodate him—perhaps start my day earlier, or end later? I know that I would more likely do this for Rory than for Murray. In any of these situations, would I use the scheduling issue to deepen the analysis? Would I address with my masochistic colleague (were he my patient), or with Murray, his pathological compliance and his passivity, thereby placing my comfortable schedule in jeopardy? Would I address in any way with Rory how desirable he was to me, and how much I accommodate him? In these situations I speculate about, I think that many analysts would be likely to continue engaging in ways that are both practically and emotionally comfortable, choosing consciously not to address themes that would be too disruptive to the respective psyches and/or selfish conveniences of perhaps either coparticipant, and to the enactments that evolve from these configurations.

In the realm of the structure of the analytic setting, perhaps the purest illustration of analysts' self-interest can be seen in the choice of how many patients (and/or supervisees) are seen on any given day, and how these sessions are spaced. Given the choice, for economic purposes I believe most analysts will see as many people as possible, short of mental exhaustion. If referrals are plentiful, it is likely that many of these sessions will be conducted back-to-back, perhaps in clusters of 3, 4, 5, or more hours in succession. Speaking personally, when I have the choice my ideal day consists of seeing 11 people, starting at 7:15 a.m. and ending at 6:30 p.m., recently with a one-half day on Friday. There are days when I will see 12 individuals, sometimes even 13, though I prefer not to do this. Again, when I can choose, I will see individuals in clusters of three to a maximum of six sessions with no break (I prefer no more than four consecutive sessions), though I have seen as many as eight people in succession. I am taking the liberty of assuming* that, with regard to scheduling, most analysts place economic concerns in higher priority to patient

* This is not simply an assumption, for I have both observed and spoken with many colleagues about these matters.

concerns. That is, as a group we are quite conscious that seeing fewer patients, and not seeing them back-to-back, generally allows us to devote more affective and cognitive energy to each individual. There is no benefit to our patients to be one of many, or to walk in and sit or lie down in a warm chair or couch just vacated by a "sibling." Of course, this issue is ripe for analytic exploration and should be used to this advantage, but analysts' motivation is clearly to maximize income. Though I have developed the ability over the years of quickly shifting attention from one person to another, and of keeping in mind who each of my patients is, can there be any doubt that my concentration would be more acute if I saw fewer people and took a break between each one? If I had 10 or 15 minutes between patients, I *could* look back to the last session to refresh myself about an important dream, or I could look at my notes and try to get straight some details about siblings or grandparents. A near ideal commitment and passion to patients cannot exist under the conditions I describe as my own, and those of virtually every colleague I know who has the same opportunity or luxury.

The impact of analysts' busy schedules and selfish use of time will invariably affect interaction with different patients in different ways. Rory will get my attention no matter how busy I am and regardless of when in the day or in a sequence of patients I see him. I will remember his siblings and his recent dreams without checking notes. When I am tired or in the midst of a demanding day, Murray's interests are not well served by my relative inattentiveness. Murray is comfortable in his schizoid isolation, and will allow me to relax, to be less intent on his every word or gesture—actually, even to ignore his nonverbal *and* his verbal communications. When I see patients back-to-back, or if I see Murray at a time of day when I seem most sleepy (early afternoons, around 1:30–2:30, just before my lunch/gym break of 2 hours), I will often take a respite from listening and escape into daydreams, reverie, and the like. When a patient who asks for little follows someone who is demanding, or where the former session has been particularly affectively intense, the second patient is likely to be *used*, at least to some degree, as a vacation—a respite. I now schedule Murray early in my workday, when I am most alert, and his analysis has benefited from this timing.

However, I do see Jack three times per week in the early afternoon, and this is far from ideal for him. Jack is not employed, lives off of a trust fund, and can come at any time of the day. He is very

dependent on me, for I am one of the few people who populate his life. I am his primary human contact, and if I permit this, I will be able to see him interminably and use him as a financial annuity.* Jack is most ambivalent about restarting his career ever since he lost his high-tech job during the recession. Similarly, he refuses to risk loss of any kind in his personal life, and allows no sexual or personal intimates. His personal contacts are restricted to the bar where he hangs out each night (reminding me of the television series *Cheers*), and the musicians he sometimes jams with. He spends much time with pornography, and is quite used to taking care of himself and living a life of solitude. One might think that Jack is psychotic, or near this, by the way he lives, but I know that he is not. He is very lucid and clear thinking and articulate, and is by now conscious of many of his motives. Jack is clear that he wants to play it safe in life, and he sees the historical antecedents that have brought him there. He also sees that he rejects anyone who comes too near to him, doing to them what his caretakers did with him. Jack has let me into his life and does not want to lose me. He will come to see me whenever I wish, for as long as I allow him. Where I place him in my daily schedule takes advantage of his dependence on me, and his compliance toward me. If I am fatigued, or if I had a trying session prior to his, he will allow me to coast, to listen to him with one-half an ear. He teases me when I forget things, but his anger does not intimidate me, and there is no threat of losing him. I do, of course, address his dependence and his wish to be with me forever. However, at least one of his sessions should be at a time of the day when my alertness is optimal, and I have not facilitated this, nor have I addressed *this* element of his compliant dependency with him. I reserve my early morning times for those patients who cannot come during their workday, and I do not risk Jack demanding that I give this up for his benefit. It might benefit both patients if I attempted to trade Jack's time slot with Rory's. However, at the point of this writing my self-interest and my mutual equilibrium with each of these patients stand in place.

Analysts' self-interest and the practice of less than optimal analytic treatment can also be seen in the way patients' lateness and/or

* I will address this issue in more detail in two ensuing chapters. I will at this point only note that long analyses are very often driven by analysts' economic needs (Aron & Hirsch, 1992; Renik, 2006).

absence may be handled. It goes without saying that both lateness and absence invariably reflect transference feelings of some sort, and *always* should be examined, with an eye to minimize this form of acting out a particular affective expression. However, in the context of a busy schedule, especially when seeing patients in succession, I sometimes find myself wishing that my next patient will either be late or not show up at all. Because analysts are not penalized economically by lateness or by last-minute cancellations, there, indeed, is something to be desired about being paid for taking a break and relaxing in the midst of a demanding workday. It is difficult to avoid wishing for free time, even though lateness and absence might reflect some problem in the analysis. Given this selfish desire, it is quite likely that we sometimes communicate encouragement to our patients who are anyway inclined toward lateness or absence. The most likely way to encourage patients in this way is to avoid *diligent* exploration of each late minute and absence. When analysts too readily accept excuses that are, on the surface, quite reasonable, this is likely to convey to patients that lateness or absence represents a comfortable state for both parties, albeit perhaps for very different reasons. Although the patient, for example, may be characterologically conflicted about engaging with emotional intensity, the analyst may be conflicted more situationally, based on the analyst's heavily loaded schedule. Of course, it is quite possible that either the analyst or the late or absent patient is conflicted about consistent and intimate relatedness.

Terence drives from the suburbs to see me in Manhattan at 9:30 a.m. The traffic is awful and not entirely predictable. It is clear that to make this trip is effortful for him, and that it reflects a strong commitment to analytic work. He is not someone who finds such emotional commitments easy, and he tends to live more in his head than in a world of emotional mutuality. I find him quite interesting to be with, yet I am often relieved if he is 5 to 10 minutes late, for he is the fourth person I see in succession, and I can use a break by the time he arrives. Terence always seems troubled and apologetic when late, and he seems to believe that his tardiness is all traffic related. I, of course, have challenged this, suggesting that leaving earlier would provide a hedge against unpredictable traffic, and that his lateness has personal more than practical meaning. He groans that he knows this, but already wakes up so early to see me. I let Terence off relatively lightly, and I do not press the issue for meaning nearly as much as I could. I know that there must be a subtle communication that

this equilibrium suits both of us, if not on a deep emotional level (for me), then at least on a practical one.

Dorian is a banker, earns a great deal of money, and works very long hours. He has always been a very high achiever and a thorough, if not compulsive, worker. He has great emotional investment in his career, and in the considerable stature this brings him. Dorian has never been comfortable within the confines of intimate personal relationships, and he began analysis at his wife's behest for this reason. I have been pleasantly surprised at how well he has taken to analysis, and the degree to which he has been willing to examine himself. He appears fond of me and attached to me, though often he is called on to address some important business deal with very little notice, and he cancels far more sessions than most other patients. I have worked with a number of individuals in his field, and I know that many such absences are unavoidable. Dorian, however, has more than his share of last-minute cancellations, and I often cannot discern what is necessary and what is avoidable. He is unusually compulsive about his work, and he is probably unusually prone, even for someone in his field, to give work priority over other activities. We have discussed this theme often and in great detail, and Dorian acknowledges how much easier work is for him than the "personal stuff" we do. Besides, he argues, the way he goes about his career has worked for him, and he loves his success and the financial rewards and prestige it brings to him and to his family. Despite how much we have focused on this issue, and on the cancelled sessions that are so emblematic of it, as with Terence I sometimes find myself anticipating with relief Dorian's last-minute call to tell me that he cannot get out of a meeting. The reason for my relief is not that I find Dorian difficult to be with. Actually, I feel quite the contrary. My relief is based on the free time his cancellation affords me, again somewhere in the midst of a number of successive sessions. My patient's cancellations represent crucial data about who he is as a person, yet my anticipation of these cancellations must communicate to him conflicting messages. On the one hand, I convey to him that I wish his intimate presence, yet on the other, I tell him that I am all too comfortable with his emotional disconnection. The latter state represents what has come to be a comfortable equilibrium for both of us.

Summary

I have used examples from my own clinical work to illustrate some fundamental ways that self-interest influences the quotidian elements of my engagement with patients. Some of the particular ways that self-interest enters and impedes my work are unique to me, and reflect my particular character structure. These factors will be more dramatically illustrated in subsequent chapters. Other forms of the pursuit of self-interest, like the way I structure my workday, seem less idiosyncratic. Were these clinical illustrations simply confessionals, it would be safe to say that the sole purpose of this volume would be geared to some expiation of my crimes. Though I believe that I may be more narcissistically engaged than many of my analytic colleagues, I do believe that largely unspoken conscious pursuit of self-interest exists in different ways, and to different degrees, for everyone who practices this work. All of us analysts coast with our countertransference experience to some degree or another, and we do this in ways that reflect who we are as unique individuals, the situational factors that may be dominating our lives, and how these intersect with each idiosyncratic patient we see. At this juncture I feel compelled to say, albeit defensively, that though I am concerned that the interactions I have delineated in this section (and will in subsequent chapters) may reflect egregious behavior to some, if one were to secretly videotape a large sample of practicing analysts, I believe the findings would suggest that situations parallel to those I have described and illustrated might be closer to the norm than the exception.