

Inadequacy and Indebtedness

No-Fee Psychotherapy in County Training Programs

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The nature of the fee arrangement has significant influence on the psychotherapeutic process even when there is no fee. Given the large number of psychiatrists who receive at least some part of their training in the public system, understanding the no-fee arrangement is vital to the psychodynamic training of future psychiatrists. Following a brief overview of the meaning of money and the fee arrangement, various scenarios are considered under the headings of "inadequacy" and "indebtedness." Although similar dynamics may be present in other public and private settings, attention is given to the county training program, with the intent to assist psychiatry residents and supervisors in their awareness and understanding of the psychodynamics of psychotherapy without fee.

(The Journal of Psychotherapy Practice and Research 2000; 9:142-148)

Now let us assume that by some kind of organization we were able to increase our numbers to an extent sufficient for treating large masses of people. Then, on the other hand, one may reasonably expect that at some time or other the conscience of the community will awake and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving his life. . . . This treatment will be free.¹ —Sigmund Freud

Fee arrangement is a fundamental component of the psychotherapeutic frame and has significant bearing on the therapeutic process. Nearly any introductory textbook, article, or course on beginning psychotherapy recognizes this and considers the management of fee issues to be an essential skill for the successful psychotherapist. Psychiatry training programs, however, often do not involve direct payment from patient to the resident, and sometimes the resident is entirely excluded from the fee setting and billing procedures. In public mental health clinics, not only is the fee set by staff other than the residents, often patients are assigned no fee at all for their treatment. The no-fee status of many clinic patients contributes to a general lack of attention given by residents to the issue of payment in the public system. Moreover, the fact that the residents are not included in the fee determination further removes the dynamics of the fee arrangement from the patient-ther-

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apist interaction. Nonetheless, psychodynamic factors related to fee arrangement (in this case, no fee) still exist and can be expected to affect the patient, therapist, and therapeutic process.

As many therapists and psychiatric educators have advocated, proper training in psychodynamic psychotherapy remains an essential component of general residency training despite the continued influence of managed care and the increasing role of nondynamic therapies.²⁻⁴ Given the large number of psychiatrists who train in public mental health systems or in other settings where fee for therapy is absent or significantly removed from the doctor–patient interaction, the no-fee model of psychotherapy remains an important one. The lessons learned from the dynamics of this model have valuable application to the management of fee issues in general and play a significant role in the overall psychodynamic education of future psychiatrists.

Other models of no-fee psychotherapy include the Veterans Administration, correctional facilities, and training sites where patients are not billed for treatment provided by residents. In addition, some third-party payment settings may be such that there is no direct exchange of bill and fee between therapist and patient. Although similar psychodynamic scenarios may emerge under these conditions, these other settings are clearly distinguishable from the county clinic setting in that the no-fee arrangement is not necessarily a direct reflection of the patient's socioeconomic status.

THE MEANING OF MONEY

The meaning of money itself has had some importance since early in the development of analytic theory. Money has been symbolically linked to feces, penis, and breast; and in various contexts it may represent issues of sex, power, greed, gifts, independence, control, love, or self-worth.⁵⁻⁷ In the vernacular, money often carries a negative connotation, as seen in phrases such as “filthy rich” and “money-grubbing.” It is also worth noting that the verb “to charge,” as in the phrase “to charge the patient,” has a certain aggressive quality. The disreputable nature of money is captured by Freud's remark⁸ that “money matters are treated by civilized people in the same way as sexual matters—with the same inconsistency, prudishness and hypocrisy” (p. 131).

In addition to the analytic meaning of money, the fee arrangement also holds an important place in the practice of psychotherapy. Of all the parameters nego-

tiated early on in the therapy, the setting of the fee often represents the most personal and potentially the most awkward—not unlike dealing with sexual matters. The nature of the fee setting in many ways foreshadows how future sensitive topics will be handled. Thus Freud continues, “. . . in his dealings with patients, [the analyst is] to treat of money matters with the same matter-of-course frankness to which he wishes to educate [the patient] in things relating to sexual life ” (p. 131). Besides the importance of these negotiations, the actual exchange of bill and fee represents one of the few physical exchanges between therapist and patient. Whether it be by mail or by hand, the physical transmission of bill and fee is a real-life phenomenon that allows for poignant expression of conflicts that might otherwise jeopardize the therapy. This may be considered an inherently sanctioned form of boundary crossing and therefore deserving of special attention. Gutheil and Gabbard⁹ write, “Money is a boundary in the sense of defining the business nature of the therapeutic relationship. This is not love; it's work” (p. 192). Thus the fee and fee arrangement are important determinants of the nature of the therapeutic process and the boundary of the patient–therapist relationship.

THE FEE ARRANGEMENT

Some authors have found the management of fee issues to be particularly problematic for residents as beginning psychotherapists.¹⁰ Langs¹¹ writes of the fee setting, “this is usually one of the most sensitive aspects of the ground rules, and thus filled with many pitfalls” (p. 9). Buckley¹² lists fee avoidance, along with other factors related to residents' self-esteem and professional identity formation, as one of the commonest therapy “mistakes” made by residents. Management of fee issues is often difficult for beginning therapists in general because of feelings of guilt and inadequacy, but, as Meyers¹³ points out, there are some factors more specific to the residents' position that present barriers to the handling of fees: “Underlying transference and countertransference conflicts are more directly manifested in the continued aversion to the subject of money. This aversion is augmented by the fact that psychiatric residents can easily rationalize that patients' fees have little to do with their own incomes, material sustenance, or ‘professional concerns’ for the patients” (p. 1460). A similar observation is made by the authors of the book *Money Matters*: “In situations where the therapists' in-

comes are not affected by the patients' payments, fee policies may be quite loose as the therapists merge with patients in fee avoidance. Identification with the patient's point of view comes easily when a therapist feels exploited, and that feeling is relatively common in public agencies or training programs" (p. 129).¹⁴

NO-FEE PSYCHOTHERAPY

Relatively little has been written on the dynamics of no-fee psychotherapy, and what has been written is quite inconsistent. A small number of attempts have been made to assess the impact of the fee on psychotherapy.¹⁵⁻²⁰ In a review of the literature, however, Herron and Sitkowski²¹ conclude that the studies, although methodologically weak, consistently found no evidence that fees have any positive effects on the outcome of therapy. Another review suggests that a wide range of clinicians believe that the presence of a fee does have therapeutic value.²² There is also a history of thought advocating that not only should a fee be present, but it should also be of sufficient magnitude to represent a sacrifice to the patient.²³ Although arguments in favor of a relatively high fee ostensibly draw on concerns about patient motivation, Marmor²⁴ makes this important clarification: "While the amount of money he is willing to pay to get rid of his illness may indeed *reflect* the degree of his motivation, it is not the *source* of it. . . . There is no need to rationalize that [the patient] is being made to sacrifice and suffer for his own good" (p. 203; italics in original).

Nash and Cavenar²⁵ cite several problematic scenarios attributable to the no-fee arrangement, and they conclude, "It is suggested that for the purposes of teaching residents in psychiatry the techniques of insight psychotherapy, all patients should be charged a fee" (p. 1069). Although not explicitly stating that a fee should be charged, Pasternack²⁶ adds the important point that "training in psychotherapy involves knowledge about the setting and collecting of fees just as much as it does the establishment of other boundaries in the therapy." (p. 1066).

Although there exist cogent arguments for the usefulness of fees in the therapeutic setting, the primary goal remains that residents learn how to discuss fee arrangements; and for this purpose, the no-fee arrangement should suffice. Regardless of the presence of fee or the amount of the charge, residents can still address the fee arrangement and engage the patient in an em-

pathic exploration of the patient's views on the matter. Furthermore, the fact that the fee might be determined by someone other than the resident does not preclude a collaborative exploration of fee issues once the patient and resident begin their work together. Such an exploration safeguards against the patient's forming the impression that the no-fee status is a secret unknown to the doctor. Thus the no-fee arrangement presents only a variation on what remains the task at hand: setting the frame and understanding what it means to the patient.

THE PSYCHODYNAMICS

The no-fee arrangement, like other therapeutic parameters, has psychodynamic components that reside in both patient and therapist. These components will present in the usual, albeit complex, way, for example in transference, manifest or latent content, dreams, enactments, or acting out. The overall themes of these psychodynamic forces can be considered under the following headings.

Inadequacy

The no-fee arrangement may produce feelings of inadequacy in both patient and therapist. In such instances the lack of fee is directly translated to mean the therapy is less valuable, perhaps even worthless.²⁷ If this translation meets with preexisting low self-esteem or self-castigation, it might further be translated into "I am worthless" or "I am inadequate." There is no reason to believe, however, that this line of thought is limited to the patient only. Both patient and resident might devalue the therapy or themselves as a reflection of the monetary value assigned to the therapy ("You get what you pay for").

The patient may also experience intense inadequacy associated directly with the inability to pay. In the words of one clinic patient regarding her no-fee status, "It's humiliating; it takes away your sense of dignity!" This factor compounds the already high potential for similar feelings that often accompanies seeking and accepting psychological help, regardless of ability to pay. The county clinic/residency fosters this dynamic. In this setting, socioeconomically disadvantaged patients are often paired with inexperienced therapists (psychiatry residents). At the same time that the patient might feel, "I'm too inadequate to pay for my therapy,"

the resident might reflect, "I'm too inadequate to provide it."

Although feelings of inadequacy pose an initial obstacle, successful psychotherapy is still quite possible. As the resident strives to meet some minimum threshold as a safe and reliable object for the patient, he or she gradually establishes competency. To do this, the resident must attain some sufficient level of acceptance of his or her own limitations. In settings where patients pay full fees to see beginning therapists, there is often an accentuation of guilt in the therapist. This particular potential for guilt in residents may actually be reduced in public training programs, since here full fees are rare. On the contrary, the absence of a fee may help residents justify their discomfort as beginning therapists and thus facilitate some level of initial self-acceptance. This self-acceptance not only reassures the patient of the therapist's competency but also allows the patient to borrow the resident's attitude in order to reassure him- or herself as the patient. In this way the patient's feeling of inadequacy is offset by the resident's self-acceptance and willingness to proceed with the therapy.

One possible variation on this dynamic results from a projective defense, in which the patient defends his or her own self-esteem by devaluing the therapist. In this scenario, the patient might belittle the therapist and wonder, "What's wrong with him that he is willing to (or has to) see me for free?" The therapist also might devalue the patient as a way of deflecting his or her own self-criticism. Making matters worse, the overwhelmed resident may displace anger onto the clinic. This can result in resentment toward clinic responsibilities and a collusion with the disparaging views held by the patient. If the resident holds some primary dislike for the public health care system, a similar collusion may emerge. Perhaps even more menacing to the therapy is the case where the resident holds some primary dislike for the public *patient*. A mutual animosity may erupt, or there may develop a more insidious, devalued impression of one another. Of course, if there is an actual collusion (conscious or not) between patient and resident to defraud the clinic, no therapeutic interaction can occur.

It remains essential for residents to achieve some sufficient level of acceptance, not only of their own inadequacy as beginning therapists, but also of their responsibilities toward the clinic and training program. In addition, the resident must establish sufficient tolerance for the patient's hostile, devaluing projections. One approach might be for the therapist to reframe the pa-

tient's devaluation into a more explicit form, such as, "You seem concerned about the therapy. Maybe you're wondering if I'm qualified to help you." By openly acknowledging and tolerating these early anxieties related to inadequacy, the therapist not only soothes the hostility, but also begins to demonstrate a deeper understanding of the patient.

Idealization may also serve to compensate for feelings of inadequacy. Patients might idealize themselves in narcissistic fashion to defend against underlying disparaging affects, feeling that they must be "special" since they are being seen for free. The pressure to remain special can confine patients to speaking and behaving in a particular way in order to prove their worth to the therapist. On the other hand, patients may feel that they are so despicable it would take someone "special" to want to deal with them, thereby contributing to idealization of the therapist. When paired with a willing resident, the patient faces an immediate conflict between his or her own inadequacy and an idealization of the resident who willingly comes to the patient's aid. In those settings where the patient receives no bill, the perceived "saintliness" of the resident may be intensified even more. Consequently, the patient might assume a more submissive or obsequious attitude. The idealization may also inflate to a point where it becomes "too good to be true," causing the patient to question the true motives of the therapist or the value of the therapy. In exploring his fantasy for a "quick fix," one clinic patient expressed the following ambivalence related to his idealization of the therapist: "I wish you had some magic bullet or wand that could cure me. . . . I don't know . . . you probably do and you're just not telling me . . . but, then if you did, you could market it and make millions, then . . . I wouldn't be able to afford you!"

This saintly quality to the transference in no-fee therapy seems to be the mirror image of the notion that being charged for therapy somehow cheapens the experience. Whereas patients who pay their therapist directly for services may perceive the therapist as analogous to a prostitute, those who receive therapy for free may perceive their therapist as saint or savior. The resident may embrace this idealization in order to satisfy rescue fantasies or to squelch his or her own feelings of inadequacy, taking pride in the notion that he or she is seeing patients that "nobody else would see." Likewise, clinicians may take similar pride in providing therapy where ability to pay (and therefore, fee) "doesn't matter."

The observation by Meyers regarding residents' aversion to the subject of money was noted above. This aversion, in general, reflects the widespread view that money matters are somehow ignoble or petty, having potential to contaminate the purity of the doctor-patient relationship. This attitude may also be the result of some underlying guilt about charging patients, which in turn may go back to feelings of inadequacy in the therapist or fears of harming the patient. Furthermore, such views reveal something of the more primitive, "filthy" or aggressive meaning of money discussed earlier. In any case, an attitude of disregard for the *fee* represents some degree of disregard for the *self* on the part of the therapist and deserves further examination.

Although idealization may distort the initial therapeutic relationship, it may also be a very natural attempt to resolve the initial fears present in both patient and resident. Thus the patient's need to idealize may, in fact, resonate with the resident's need to be idealized. Although both needs might stem from feelings of inadequacy, they may reciprocate in such a way as to allow for progression of the therapy. As long as the resident can maintain some degree of objectivity, this idealization need not be harmful to the therapy and may even facilitate an otherwise fragile dynamic. The awkwardness felt by patient or resident stemming from feelings of inadequacy can be greatly relieved by an empathic and matter-of-fact discussion of the fee arrangement in the opening phase of the therapy. This clears the air of any initial anxiety related to feelings of inadequacy or secrecy and establishes a tone of acceptance and willingness for further exploration.

Indebtedness

Another important theme that may develop in the no-fee arrangement is that of indebtedness. It is not difficult to imagine an attitude of "I owe you one" that might exist in a patient receiving services for free.²⁷ This might manifest as a patient's being overly accommodating or "nice." In this scenario, the patient is very cautious not to "rock the boat" for fear of destroying a good thing or seeming ungrateful. Furthermore, there may be an unconscious attempt to repay the therapist with kindness by remaining a "good" or "interesting" patient. In relation to the training setting, the patient may feel that it is important to help "teach" the resident. A more distressing version of this indebtedness can result from a latent expectation in the patient that he or

she may be asked to return the favor in some sexual way.

In any case, indebtedness creates an imbalance of power. As with idealization, the therapist may unwittingly (or wittingly) exploit this aspect of the transference by asking favors from patients that range from inappropriate rescheduling to frank seduction. When asked how he felt about the frequency of our weekly meetings, a clinic patient immediately responded, "Why? Do you want to cut back?" When I explained that either decreasing or increasing the frequency might be possible, the patient seemed perplexed and said, "I didn't know it was possible to meet more frequently . . . it never even entered my mind. . . . I guess I didn't want to be a drain on the system." Another patient, despite regular attendance, repeatedly declined to reschedule any appointments canceled by the therapist, seeming completely content to meet the next week. Such attitudes are complex but may express feelings of lack of entitlement, fears of burdening the therapist, or a wish to avoid further indebtedness.

The bond between patient and therapist is a complicated phenomenon incorporating factors such as rapport, trust, motivation, and transference. In at least some cases, the fee may be an additional important—even necessary—component. Without it, feelings of indebtedness may be too much for the patient to bear, resulting in missed appointments or therapeutic stagnation. While exploring feelings about his no-fee status, a patient philosophized that society should provide free psychiatric care for all of its citizens and seemed quite comfortable with not being charged for his therapy. Two sessions later, he gave his therapist a painting he had done, simply to "show his appreciation." This example suggests that at least for some patients, payment of some kind may be necessary to reduce the level of indebtedness or imbalance of power they feel toward the therapist—at least until further insight can be obtained.

Moreover, indebtedness and imbalance of power may complicate the termination process. Patients might feel that the resident is making ongoing sacrifices to see them, or that they need to continue the therapy in order to please the resident. This might increase feelings that the actual termination is more of a unilateral decision designed primarily to relieve the resident. The sense of loss for the nonpaying patient may be further compounded by feelings that he or she may have burdened the resident or driven the resident away. Friedman²⁸ states similar concern in his chapter in *Money and Mind*:

“In the public sector it is common for trainees to leave patients after six months or one year in order to rotate to fulfill responsibilities in other areas of their psychiatric educations. Public sector patients, therefore, are frequently exposed to object loss, the loss of the therapist. This is sometimes tolerated, sometimes not” (p. 218). In fact, the entire therapeutic bond may be more precarious in the no-fee setting, since the incentive for the resident to see the patient is never as clear as in fee-for-service cases. Thus the patient may feel at various levels of consciousness that the resident could leave at any time. This is especially true in those clinic settings where ongoing therapy is considered a dispensable or “luxury” service.

As with the defense against inadequacy, patients may react strongly against the feelings of indebtedness. They may become overtly hostile and demanding toward the resident as a result of an intense sense of entitlement—feeling it is not they who owe the resident, but the resident who owes them. Patients may hold the resident or county agency accountable for disappointments in earlier caregivers who failed to provide for their needs in an unconditional way. Thus the transference may take on a quality of “Someone out there owes me, and it might as well be you!”

In contrast to the above examples, some patients may feel the need to *create* a state of indebtedness toward the therapist. In fee-for-service arrangements, when the patient neglects paying the fee for some interval a common response is to interpret this as a retaliation against the therapist. Although this may very well be the case, Gedo²⁹ offers additional insight by considering the withheld payment to serve as a sort of transitional object for the patient. By inducing a financial indebtedness, the patient may actually be attempting to intensify the therapeutic bond (albeit maladaptively) by provoking the therapist to a pursuit or by simply holding on to something that belongs to the therapist. In the no-fee arrangement, the patient is not able to use the withholding of payment as a vehicle to “get back at” or provoke the resident; nor does the no-fee arrangement allow the patient to use the withholding of the fee as a transitional object. These wishes may instead manifest as missed appointments—withholding one’s *attendance* in lieu of withholding the payment in order to punish

the resident or provoke the resident to pursue or punish the patient. At the same time, the resident is unable to rely on the presence of a fee to facilitate the patient’s sense of collaboration and responsibility, which comes more naturally in the more businesslike fee-for-service arrangements.

When trying to explore resentful, entitled feelings in the nonpaying patient, it might be useful for the resident to reflect: Is this patient trying to provoke, reclaim, or hold on? The resident should also consider his or her own reaction to the possible imbalance of power in this setting. Such reactions might include subtle exploitation of the patient’s complicity, an exaggerated sense of responsibility to the patient, or a feeling of being actively or passively attacked.

CONCLUSION

In those settings where the patient is not billed, the issue of payment remains an important psychotherapeutic parameter. These scenarios, considered under the headings of “inadequacy” and “indebtedness,” are not all-inclusive, nor are they unique to the issue of payment. Although the county clinic/residency has served as the primary model for this paper, the psychodynamics of payment in this setting are potentially applicable to any setting where the patient or resident *perceives* the therapy to be free.

Residents are best served to manage such issues as they would any other psychodynamic phenomenon—by careful, honest exploration of their meaning in the residents themselves and in their patients. The long tradition of residents’ receiving psychodynamic supervision, as well as their own psychotherapy, is clearly helpful to the training process in this regard. As many leaders in psychiatric education have pointed out, experience in psychodynamic psychotherapy and proficiency in psychodynamic concepts remain essential components of psychiatric training. This paper has focused on one particular aspect of this training and is based largely on my experience in a county-based training program. It has been my intention in this paper to assist psychiatry residents and their supervisors in their awareness and understanding of the dynamics of the fee arrangement—even when no fee is present.

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