

On Moral Countertransference

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ABSTRACT

This article engages the question and meaning of moral countertransference within analytic space and underscores the primacy of the analyst's moral agency as both an ongoing source of authenticity and hindrance to optimal practice. I specifically explore the relation between the analyst's own moral dispositions that are confronted when presented with patient material that opposes one's own ethical identity. Various case illustrations are presented where my moral countertransference was suspected. Copyright © 2005 John Wiley & Sons, Ltd.

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I have a patient who was regularly physically abused by her mother throughout her childhood, was battered for years by her first husband, having once been kicked in the stomach thereby losing her baby during the third trimester of pregnancy, and forced to divorce her second husband because he sodomized her daughter. During one session she told me how furious she became when a man in a pickup truck passed her recklessly while honking his horn and flipping her the finger as he sped past, visibly rankled that she was driving too slowly. She immediately felt victimized and abused as she had by other men in her life. She was taking a load of debris to the dump. While she was pitching junk out of the back of her truck, as it turned out, the same man pulled up beside her in his pickup to unload his rubbish. There was an awkward moment of strained recognition, but the man had his small son with him, so no words were exchanged. Watching the boy and his father throwing bags of garbage into the pit, my patient asked the little boy if he had a pet. "A dog," he replied enthusiastically. "Well, I hate to tell you this, but your father put your dog in one of those bags and now it's down there." The little boy immediately started to cry as the father became aghast. "That's for that little jewel back there," she said to the man sardonically. Although I never said a word throughout her narrative, she looked up at me and said, "You think that's awful of me, don't you?" I remained silent but my eyes did not. "Yes, I know," she said

remorsefully, looking down in shame. Even in the wake of understanding the dynamic motives that impel human behavior, judgment has already been passed.

Psychoanalysis has generally shied away from passing ethical judgments in the consulting room, instead relegating its moral discourse to clinical and technical practice. Indeed, the role of ethics in psychoanalysis is not a new topic (cf. Lacan, 1959–1960; Rieff, 1959; Hartmann, 1960; Gedo, 1984; Kohut, 1987), and it is garnering increased attention in the literature (see Carnochan, 2001; Koggel et al., 2003; Zeddies, 2005), but it still has yet to engage the question of moral countertransference. When countertransference is discussed in professional space, it is often relegated to the emotional impediments induced by the patient, generated in the analyst, and superimposed onto the therapeutic relationship. These discussions are an indelible part of psychoanalytic lore, but they do not directly address how the analyst's subjective ethical principles and behavioral comportment are confronted, compromised, and introduced in the treatment. In fact, such discussions are readily avoided altogether in classical analytic work, instead emphasizing the underlying motives and needs of the analysand to know about the analyst's subjective states of mind. Even within relational psychoanalysis, where mutuality, analyst self-disclosure, and concessions to the illegitimacy of analytic authority generally predominate contemporary discourse, the frank discussion *in the session* of one's own conflicted motives that inform our moral countertransference has been overshadowed by the need to legitimize countertransference confessions in general. What I am interested in addressing throughout this article is how the analyst's moral agency is an ongoing source of influence and challenge to analytic practice, as well as an inner barometer of detecting countertransference enactments to begin with. I will specifically explore the relation between the analyst's own moral dispositions that are confronted when presented with patient material that opposes one's ethical identity. I will then turn our attention to various case illustrations where my moral countertransference was suspected.

ETHICS AS INNER EXPERIENCE

Freud (1930, 1933) saw morality as a necessary developmental achievement of the psyche responsible for judging, curbing, transforming, and sublimating our more primitive constitutions in the service of our own survival, interpersonal adjustment, and social advancement, a process inherent in the progression of civilization. Although Freud was deeply engaged in the ethos of modern culture, particularly observing how social custom, law, aesthetics, and politics are based on the unconscious transmogrification of primitive mind, he said very little about professional ethics of practice, and said virtually nothing about the personal ethics of the analyst, let alone how they play themselves out within the therapeutic dyad. Despite these omissions, Freud's theoretical corpus is a value-laden enterprise brimming with ethical pronouncements. For example,

when Freud (1912, 1913, 1915) spoke of professional practice in his technique papers, he largely delimited his concerns to what *not* to do in the session, hence evoking an inverse prescription through restriction. Here, value is declared through negation: the proclamation of what one *ought* or *should* do is exemplified through restraint, such as keeping the countertransference in check, or abstaining from gratifying the patient's need for love in favor of neutrality. Freud's rationale was based on a technical methodology or philosophy of practice grounded in prohibition, and in this regard it carries forth ethical imperatives. Perhaps the most well celebrated technical commandment is the ethic of honesty, what Thompson (2004) has recently claimed is the fundamental rule of psychoanalysis. Indeed, when the patient is told to be completely honest and to purely say whatever comes to mind without censoring one's thoughts, this is a demand placed upon the psyche of the analysand, one that disrupts the subject's equilibrium; and it is no less an ethical imperative despite the fact that by implication it encumbers the patient's ego integrity¹, itself a potential ethical infraction.

Do we have an ethical obligation to ourselves in the context of our analytic work with others? I think we do. But even if we concede to this point, to what degree do our obligations to our patients override our own obligations to our moral sensibilities? Perhaps this is merely a contextual conundrum resolved by the analyst's degree of freedom when choosing to express one's own moral inclinations in response to the patient's value assertions. But where do we draw the line? Codes of ethics governing professional conduct are established to respect and protect patients, but how do they bear upon the psychoanalyst's own subjective moral principles? These are but a few dilemmas the clinician faces everyday.

There is a distinction between the analyst's moral sentiments versus how one should act in the consulting room², let alone when our moral sentiments interfere with our clinical judgments and actions. The question and meaning of moral countertransference is a relatively new topic for psychoanalysis, open to exploration, dialogue, and debate; and I must confess up front that I do not

¹ Lacan tells us that any speech act is a demand, for it assaults the subject's desires and imaginary *méconnaissance* with possessing a cohesive ego or sense of self. We may extend this position to include that any linguistic exchange is a process that both opens and potentially expands ego integrity while simultaneously assaulting self-identity and the subject's subjectivity. In this sense, every speech act as direct communication is experienced (either consciously or unconsciously) as a demand, hence a command for responsiveness that assails the ego's inner equilibrium. The mobilization of resistance and defense that is so commonly observed in the speech act of free association is a testament to the felt power of this demand. Although the fundamental rule is not intended as an assault and in fact is employed to open the person up to one's own unconscious processes, desire is fundamentally a one-way relation of libidinal and aggressive channelization experienced as an encroachment because of the felt imposition of the Other's desire.

² For pragmatic reasons, I wish to make a conceptual distinction between 'morality' as a subjective relation the analyst has toward one's felt beliefs and value dispositions versus the 'ethic' of clinical practice established by any mental health discipline governing standards of professional conduct.

claim to have the answers to this complex inquiry, a subject matter that is far beyond the scope of this immediate project. What I do hope to offer, however, is an evocation to this multifarious topic. Philosophers long ago have alerted us to the broad and contradictory array of ethical systems that characterize our moral discourse, valuation practices, and formal axiological categories to the point that one could be easily overwhelmed when determining the right course of moral appraisal. From ancient to modern times, relative, teleological, deontological, and utilitarian perspectives have championed many diverse positions including (but not limited to) ethical absolutism, objectivism, dualism, skepticism, stoicism, egoism, conventionalism, hedonism, consequentialism, nihilism, naturalism, constructivism, pragmatism, intuitionism, eudaimonism, virtue theory, and philosophies of right. There are so many *-isms* that it unavoidably creates a schism in conceptual thought and practice. Although we may perhaps agree that each ethical position promulgates a legitimate kernel of sensibility, it is not so clear that they may have any immediate, discernable degree of clinical utility. Psychoanalytic theory can be applied to any number of ethical positions owing to its inherent value-laden implications, as we have seen in the humanistic, political, and religious commitments of many socially conscious analysts. In practice, however, it may be argued that psychoanalysis largely favors a form of *descriptive* ethics rather than a *prescriptive* one.

Historically, psychoanalytic methodology was designed to analyze internal psychological processes and unconscious motivations. Its intent was to describe the workings of mind, and particularly the internally elaborated dimensions of individual subjectivity, not to prescribe how people should think, act, feel, or behave. From this standpoint, psychoanalysis is a neutral tool of observing, pointing out, interpreting, and articulating internal experience, hence the mentalizing activity of each subject. Yet with any descriptive methodology, it does not dampen or cancel the observer's subjective reaction to what is being observed. Here, psychoanalysis, like the humanities, cannot annul the question of ethical prescriptivism. Each analyst is thrown into ontic³ valuation when a patient introduces material that challenges the analyst's own moral proclivities or way of being.

Perhaps it was Ferenczi (1933) who first advocated for a moral comportment of empathy and compassion for our patients – a theme taken up by the Kohutians, rather than merely trying to understand, formulate, and interpret unconscious material, which Freud largely heralded was the primary purpose of psychoanalytic treatment. Regardless of what telic vision we have of our honorable profession, we cannot escape the fact that each analyst is continually faced with redefining the personal dimensions of conducting authentic therapeutic practice, and this necessarily entails a confrontation with the moral parameters that define the analyst's self-identity.

³ Here I employ the Heideggerian (1927) distinction between the ontic, which applies to human relations, versus the ontological, which applies to the question, meaning, and truth of Being.

I am not concerned here with arguing for the existence of ethical properties, which is the position of moral realism, nor do I wish to advance the notion of ethical subjectivism through the negation of objective moral truth⁴. Rather, what becomes important for psychoanalytic inquiry is how subjective moral agencies within the analytic dyad generate inevitable discord *and* mutual understanding through dialectical therapeutic engagement. Although the notion of agency is once again in vogue, the nature of moral agency within psychoanalysis has been neglected, and more specifically, the question of the analyst's moral countertransference has simply been ignored. Moral countertransference – here defined as the analyst's precipitous emotional reaction to patient material or the patient's way of being that provokes the analyst to act in a negative therapeutic fashion – is constantly evoked in the normative course of our work with patients by the simple fact that patients will inevitably say or do things that accost our ethical sensitivities and characteristic attitudes⁵.

Regardless of the perennial debate surrounding what constitutes ethical identity, such as one's moral obligations, belief systems, duties, and justified actions, all ethical decisions are filtered through the subjective lens of our own personalities, developmental histories, unconscious conflicts, transference proclivities, and emotional dispositions. It is from this standpoint that we must necessarily engage our own internal processes when confronting the ethical. When we engage our moral agency, we have a tendency to suspend other considerations for the primacy of inner experience that speaks to us as an emotional call or summons we feel deep within our interior. Notwithstanding the sober grasp of reason that may inform other ego capacities, we are often drawn to the emotionality of the ideal that, whether based in illusion or reality, captures us within the affective immediacy of our conscience or moral register, including the impulse to take moral action. This is no different in the consulting room, but it comes with a trepidation that may produce the counter-reaction of committing a moral trespass. We are always faced with a calculated risk when it comes to self-expression, for every subjective act communicates some form of self-valuation. We feel compelled to speak authentically even if we remain silent, even if we are self-conscious or ambivalent that such authenticity may negate the authenticity of the other. Who has not become conscientious when speaking openly about one's values to patients?

Our superego visits us in both passivity and activity, that is, whether we disclose our personal views or whether we decide to keep them in abeyance, mindful of the countertransference despite the fact that our mindfulness may

⁴ In the history of western and Anglo-American philosophy, "moral realism" is a metaphysical view committed to the objectivity of ethics such as moral fact and properties that exist independent of consciousness (e.g., people's beliefs about right and wrong); while "ethical subjectivism," sometimes equated with "ethical constructivism," is the belief that moral facts and truths are constituted and dependent upon an individual's state of mind.

⁵ For a lengthy historical discussion and revisionist exploration of countertransference, please refer to my recent article, "Countertransference Revisited" (Mills, 2004).

betray our personal moral principles under the rubric of professionalism. In either case, we are under the sway of internal judgments that guide our actions, which in turn lay down “definitive standards for [our] conduct” (Freud, 1933, p. 78). In this way, ethics obey a logic of the interior based on emotional resonance states and affective truths that reverberate within our souls based on our primordial identifications with the parental agency or its surrogate, including all related derivatives⁶. Morality no longer remains an external presence: it becomes an internal presence based on internalized negation and absence, that is, the dialectic of prohibition and lack as desire for the ideal⁷. Ideality always remains something personal and private, sacred and secret, yet capable of transcending personal subjectivity within a collectively shared identification. But even when ideality is collectively united, it is never devoid of personal ownership or what we commonly refer to as “mine,” for this is the affective invigoration that defines our unconscious soul, what Hegel (1830) refers to as the “law of the heart.”

Ethics is not merely a set of prescribed precepts that inform a procedural code of conduct; it becomes an internalized law – what is both sacrosanct and taboo. Ethics is inner experience – the reverberation of inner truth, even if that truth is transient, dubious, dissolute. When we are attuned to our interior, we seek to express it outwardly in order to make it more real, to validate its presence – to vitalize our immediate self-certainty. But this does not come without consequences, especially when our ethical self-certainty is in response to patient material that draws the truth of our inner experience into question. Here enters the potential for countertransference by virtue of the fact that

⁶ Unlike Klein who views the origins of the superego as sadistic expression, for Freud, the superego (*ÜberIch*) is a developmental achievement based upon the complex divisions and modifications the ego undergoes through maturation, differentiations that originally emanate from the epigenetic transformations of the It (*Es*). The superego is therefore a superior psychic construction based on ethical identifications with otherness, hence truly an agency that stands over the I (*Ich*) and unconscious impulse. Although Freud's views on the superego went through many theoretical modifications, his insistence on its later development out of primitive mind was due to his conviction that the superego was originally conceived as an identification with a set of value ideals internalized and appropriated from parental authority or its cultural signifier. Here Freud wants to preserve the importance of the psychic function of ideality within the moral register we have come to call conscience.

⁷ In Hegel's logic of the dialectic (see Mills, 2002), negation is an act of every movement of thought by entering into opposition with any object we conceive, for oppositions are conjoined and are mutually implicative in all aspects of thinking and being, including unconscious fantasy. At the moment a certain object in thought is negated, it is also preserved within a new state of consciousness, as it is simultaneously surpassed into a higher plane of synthesis. An internal moral stance derived from identification with and internalization of the Other, is based on a dialectical relation that necessarily requires negation of a particular experience (e.g., a value, attitude, etc.) that stands in opposition to its complementary relation, which is incorporated as an implicit yearning of what is absent, hence endowed as an idealized object. Therefore, moral presence within the psyche is conditioned on certain prohibitions as well as coveted value judgments that stand in relation to pursuing an ideal, a doubling effect of the dialectic of desire.

otherness vitiates personal subjectivity by simply being in relation to opposition. When our moral agency is challenged or feels threatened, we feel compelled to assert our interior as a matter of principle, regardless of the cost, perhaps later justified as a heroic stand for championing our ego ideal. Indeed, this compulsion may take the form of a defensive impulse to fulfill our wish to become our ideal ego through the act of self-assertion via negation of the other; hence our ego ideal validated and our ideal ego advanced in that instance of self-posit. It is here when our identification with ideality breaches the ego's other sensibilities and countertransference supercedes.

THE MORALITY OF MORAL COUNTERTRANSFERENCE

Freud (1925) tells us that we have moral responsibility for our dreams despite the fact that certain desires, ideals, and values clash with competing motives in the mind. With this Kantian conviction, Freud alerts us to an ethical absolutism, but he does so with the recognition that certain values are more worthy of support or rectification than other base impulses. Here, Freud is advocating a certain moral stance that may be equated with abrogating countertransference enactments; namely, the need to enlist our superego injunctions.

Some analysts, perhaps more than not, may generally agree that our own moral principles (versus our ethical actions) should remain out of the consulting room in order to keep the countertransference in check and our focus on the patient's process. But what happens when the patient's process, attitudes, beliefs, ideals, character traits, and behavioral actions betray our own conscience? Do we have an obligation – a moral duty – to act? This is Kant's question, the categorical imperative. Perhaps it has no place in the consulting room, but it does. And we even have the legal system impose certain ethical obligations on us to act under certain circumstances for the good of society. This is a utilitarian or consequentialist dictum. But what I have in mind here is the analyst's need to consult his own ideal interiority. This is the domain of virtue theory, namely, what is good, what is right, what is best, what makes for desirable character, what the Greeks call human excellence.

Psychoanalysis proper, that is, an analysis of the psyche, is not adequate unless it engages the question of the moral. I am not merely speaking of examining the patient's superego constellations or functions, but in engaging the patient to undertake his own moral discourse with his interior. This argument is potentially controversial, and I am not unaware of the myriad problems in defining clear ground-rules for when, where, and how to act, not to mention the equivocal epistemological foundation of moral action; but I do nevertheless believe that we have an obligation to ourselves and to our profession to impart the value of self-insight, and in this way psychoanalysis aspires toward eudaimonism, namely, ideality – what the ancients call the good life – contemplative, content, just. Notice here that I say "aspire," for an ideal

may never be fully achieved, only approached. And this always entails the endeavor to lead an ethical life, albeit imperfectly; for the enlightened soul, according to Plato, is the unification of the passions, reason, and morality actualized through leading a good life. But, as Freud reminds us, this necessarily produces a certain degree of *pathos*. For the Greeks, to be human is to suffer. From this standpoint, the pursuit of ideality becomes an infinite, poignant striving⁸ perennially fraught with conflict.

When we decide to utter any ethical communication, we attempt to exert some influence or control over the inner experience of the other by the mere fact that ethical assertion implies an ought, even if that is not what is directly communicated. If such utterances are conveyed in the consulting room, even in abstaining from a direct question, we inevitably pass some form of value-laden judgment. There have been many examples of therapeutic moments where I had been immediately emotionally compelled to say something because the patient's disclosure threatened my moral register. When this happens periodically, it is often a signal to me to bite my tongue, keep my mouth shut, and listen. In these instances, when I am made aware of my immediate negative reaction, such as alarm or condemnation, I attempt to sequester it as silent judgment. But, as I have intimated earlier, silence can be as judgmental as direct communication, despite the fact that it may very well be a projective screen or reflective mirror for the patient's disavowed inner experience. I am particularly reminded of a patient who told me how he murdered his girlfriend's cat by putting it in a bag, suffocating it with duct-tape, and throwing it down the garbage shoot of their apartment complex because he was angry at her. Another patient, in a dissociative blackout, just about drowned his girlfriend's son in the bathtub because he would not allow my patient to wash his hair. Whether feeling disgusted with a pedophile's insipid, rationalized confession of molesting a child, or a psychopathic misogynist's desire to "pound women," silence delivers a very powerful sentence. In these instances, I was told by my patients that they had felt I was judging them. "I'm not here to judge you" I said, "I'll leave that up to you."

⁸ As did the Platonists to the idealists, I am of the opinion that we can approximate an ideal, but there is always a limit to attaining it by virtue of the fact that ideality is an embodied (abstract) perfection, which I believe cannot be fully achieved. When we admire or strive for an ideal, it is because we identify with and covet it, and this is in all likelihood because we lack it. Hence absence is an important attribute because, with qualifications, we would not desire an ideal if we were already in possession of it; and even if we were, we would continue to desire it in order for it to be maintained. When I speak of ideality here, I am generally referring to the greatest valued principles, such as wisdom, truth, justice, beauty, and other virtues. We can approximate these things, but I believe, as well as others, that we always fall short of attaining them in their most pristine forms, for ideals are ultimately abstract formal concepts. But through particular concrete actions, we can nonetheless attain some form of satisfaction or fulfillment in our pursuit or striving toward the ideal.

There are times that the analyst feels compelled to respond to a particular patient disclosure that inevitably communicates an ethical imperative rather than merely describing or interpreting a patient's dynamic process. We may refer to this phenomena as the morality of moral countertransference. I recall working with an exceedingly narcissistic, entitled, and aggressive young man who complained indignantly about his irritation of having to visit his aunt on her deathbed out of family obligation. When he told me she died, he said, "I didn't give a shit," despite that she had always been kind to him. I immediately felt a heavy depletion come over me because his aunt was a former patient of mine who referred her nephew to me for therapy. I continued to ask the patient of the details of her death, which he recounted was tragically sudden yet physically painful during her dying days. At this point, I told him that I felt very sad. We sat for a moment, and he began to discuss how seeing her physical health and appearance deteriorate to the point that her entire system – from her kidneys, liver, and heart – collapsed within days, that he could not bear to see her "doped-up" on pain medication, unconscious in her hospital bed. Upon telling me this, his eyes began to water. His indignation was a manic defense to flee from acknowledging the emotional significance of his loss, which he attempted to preempt with angry-dismissive detachment. My comment appeared to induce guilt followed by a proper appreciation of the lost object. Because therapy indissolubly involves the intersection of competing subjectivities, moral reproach, guilt inducement, and shame may become emergent properties of the analytic milieu.

Our ethical attitudes and sensibilities to which we aspire make us feel justified and content, to the point that we, perhaps unintentionally at times or quite deliberately, foist them upon others under the hubris of our own subjective pretexts for how we live our lives. Here I have in mind Plato's *Apology*, which is none other than a moral defense of how to live one's life authentically. We, as analysts, have a preformed moral position (*praejudicium*) as subjective agents, and have thus consulted our own conscience to bear witness to the justification of our therapeutic actions; therefore, by virtue of this fact we bestow our own prescriptivism through any form of disclosure we wish to introduce into the session, no matter how direct or subtle. For example, a query or question introduces suspicion on the analyst's part by imposing a need to critically evaluate the conditions or motivations underlying the patient's assertions. Even when the analyst offers a narrative, interpretation, or describes the patient's unconscious motivations, he imparts a value judgment through the mere fact that he draws into question the essence of the patient's associations, hence imposing valuation through the act of observation. Whether this be for the patient or analyst to reflect upon becomes inconsequential: the mere circumscription of any aspect of psychic life or intersubjective exchange is itself a value statement for the simple reason that moral intentionality and its consequences become an ingress in all forms of mental phenomena.

THE FUTURE OF A DELUSION

I now wish to turn our attention to the case of Andrea, a characterologically depressed, body-dysmorphic, eating-disordered adolescent. Andrea was subjected to many developmental traumas at the hands of her primary attachment figures, including her mother, father, and aunt. Andrea was raised in a Catholic home environment, but was subjected to many excessive superstitions, fears, and threats of punishment from God by her mother and aunt who were fundamentalist Christian converts. The patient was told from the age of four onward that the Devil exists and looks for souls to possess, that God reads her mind at all times and knows all of her impure thoughts, and that He will eventually punish her for all her sins. As a result, she was terrified as a child, grew up thinking she was innately bad and evil, developed a clingy-dependent insecure attachment to her mother, was phobic of anyone and any situation outside of her immediate home environment, and subsequently became paranoid, obsessional, and depressed during her latency years, only to lead to a suicide attempt when she was 16. The patient had developed many rituals to keep evil spirits away at night, such as surrounding her room with bibles, crucifixes, candles, and religious paraphernalia, but to no avail. Her obsessive-compulsive rituals, prayers, ruminations, and internal methods of warding off evil possession and punishment had led to profound suffering to the point that her belief system concerning the nature and question of God was arguably delusional.

To what extent do our unconscious and preconscious moral principles affect clinical technique? I have been an atheist most of my adult life and can find no justifiable rational argument to believe in a transcendent, supernatural being that has a sense of personal agency, let alone any claim that such an entity possesses omnipotent powers of supremacy, omniscience, and creationism, which is often attributed to a theistic God. My metaphysical beliefs about God oppose most of the world's views on religion and spirituality; and they form the backdrop of my moral dispositions that I bring into the consulting room. But what right do I have to impose my beliefs on my patient? It is generally uncontested that the abuse of any teachings hurt people. We are not neutral when it comes to valuation practices, despite aspiring to observe a neutrality or indifference (*Indiferenz*) when presented with patient material under the rule of analysis. In witnessing Andrea's suffering, I passed a value judgment in determining that the Judea-Christian principles that were inculcated in her, whether accurate or not, were a destructive force in her psyche that needed to be exorcized. Despite this determination, I felt that any conclusions to be drawn needed to be *initiated* by and *spontaneously* come from her own critical engagement and struggle with what she had accepted as unadulterated truth. Here, I speculate, is the first marker of my countertransference; namely, the belief that the patient herself should freely disclose her own reservations without my suggestive involvement. In my view, my *patients* largely suffers from the nefarious, maiming elements and insidious invasions of developmental trauma that her mother and aunt afflicted on her psyche at a young age: these

are damaging, emotionally charged invariants that were internalized as parasitic introjects, mnemonically imprinted, and rigidly laid down within the deep structural configurations of her unconscious mind. She acquired her paranoid epistemology during the preoperational phase of cognitive development years before she was neurologically capable of developing her capacity for critical thinking, and has since remained dominated by austere emotional schemata and unconscious fantasy systems that are recalcitrant to the intervening mediation of reason. After working with Andrea for two years without questioning her religious beliefs, instead focusing on her experience of them and the pernicious impact they have produced on her adjustment, I decided to address the logical premises and propositions of what she actually thought about God in order to bring them into critical therapeutic dialogue with the more healthier portions of her ego. Although we spent several sessions discussing various aspects of her religious beliefs and their negative consequential effects, I will never forget my intervention when she told me that she believed in the concrete reality of the Virgin Mary. "Ah, a virgin impregnated by a ghost. Sounds delusional to me" I replied. She paused in disbelief then immediately burst out laughing, and then said how ridiculous it was that anyone could think such a thing, including herself.

This session opened up a critical space for exploring the conditioned aspects of Andrea's faith and irrational fears based on the uncritical acceptance of religious dogma, which have pervaded her senses as paranoid knowledge because of the ominous threat of punishment, guilt inducement, shame, and persecutory fears ingrained by her attachment figures. We came to understand how Andrea's early affective schemas fueling her paranoid fantasies of persecution and possession were encoded as emotional truths that she as a young child could not possibly combat owing to the toxic introjectory power of internalization. Although I cannot go into every detail of this case here, suffice it to say that this decision to critically engage the grounds and justifications of Andrea's propositional attitudes and beliefs led to drastic changes in her adaptation and social functioning. The question and degree to which this intervention on my part was a countertransference enactment or a moral bid for altering what I perceived to be a pathologically accommodating enslavement of her psyche, I shall leave for the reader to decide, hence an ethical judgment. My own reflections alert me to two decisive events or signals that are grounds for suspect. The first and, in my mind, the most important, is whether my reticence to engage this subject matter more directly for two years based on my self-consciousness to counteract my own value dispositions; and the second involves the spontaneity of the intervention just mentioned. Although I concede that the interpretation itself was an emotional reaction based upon months of disquieted frustration experienced as the concomitant need to introduce a provocative challenge to the patient's religious fixations, I am more inclined to view the former condition to be more telling. The absence of any earlier challenge or intervention questioning the grounds or validity of her

religiosity tells me that I was more worried about allowing my own convictions and conflicts to negatively pervade the treatment, when this omission itself could be viewed as flagrantly remiss. I am still left with self-reproach in thinking that if I had only challenged her illusions and conditioned religious distortions sooner, I may have spared her of excess suffering.

PHILOSOPHICAL AFTERTHOUGHTS

There is a certain ecstasy that comes from intellectual work, but perhaps this is more emotionally accentuated when we feel we have broached the ethical. The self-revelation of our ideal desires can never be fully sheltered from our patients; for surely, as we have ears to hear and lips to speak, we can hardly keep a secret. It has become more permissible among psychoanalysts in recent times to embrace the initiative of not censoring or stifling honest self-representation in session, especially when it naturally and uninhibitedly occurs, thereby exposing one's own bare subjectivity to a subject who is designated to be the object of self-scrutiny, regardless of the fact that analysis is an intersubjective medium. Through the analyst's self-presentation, the patient's self-representation is affected and arguably enhanced, because every self-representation is conditioned on our object relations. This expansion of and permeability in the treatment frame allows the analyst's personality to breathe more freely as a humanistic gesture bearing the fruit of mutual benefit, what may not be inappropriately called "play." But, of course, for Winnicott, play is work, the sum and substance of the most gravest philosophy.

When we embrace psychoanalysis as a moral enterprise, we must mollify the tension between the personal and the professional through some form of unitive conciliatory stance we often call genuineness or authenticity. This especially applies when we feel compelled to live up to a professed self-ideal. Analysts must strive to look at their own moral point of reference in relation to their own superego demands as well as the ideality that governs their self-representations when examining the functions of their patients' minds and lives; and I firmly believe this ongoing process is essential for conducting optimal practice. Here, the personal and the professional coalesce: the analyst's way of being is at once intimately distinctive and e/valuative as he conveys an analytic attitude of determinate inquiry⁹. The analyst bequeaths value in every therapeutic moment as surely as he draws into question the legitimacy of the patient's valuation through the act of analysis itself. Here, analytic engagement is a bid for creativity, freedom, and expressed individuality through volitional self-assertion and repose. It is here that we must surrender ourselves to faith and trust the process. In effect we are communicating, "This is who I am, what I stand for, what you are obliged to recognize in me... and I in you." Two subjects, two subjectivities – interfacing, clashing, championing, and reclaiming the covenant of

⁹ I say "e/valuative" to signify the double nature of valuation as both judgmental and affirmative, an act of every therapeutic utterance

similarity and difference – the evocative dance of discerning and defining value. In this sense, psychoanalysis is not only a moral venture, it is an aesthetic gift to humanity; for what could be more beautiful than value?

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