

## Hope as Inspiration in Psychoanalysis

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In this paper, hope is explored as a motivating force in analysis. To see the patient's and the analyst's hopes in terms of changes they expect the treatment to accomplish emphasizes the cognitive aspect of hope. While touching on these cognitive expectations, this paper focuses on the emotional, rather than the cognitive, function of hope in treatment. It addresses the question of how hope can inspire analytic participants to have the strength and stamina that analysis requires.

HOW MANY TIMES HAVE YOU ATTENDED an analytic conference that proceeded with due gravity until a venerable older member offered a pithy, utterly direct comment that sent the group into gales of relieved laughter? Why do her words, delivered with the straightforwardness of a child, carry the authority of an oracle? Amusement aside, why do we also feel stirred?

I believe it is partially because the older analyst has spoken passionately, without doubt, without equivocation, as though it were obvious that some things are right and others wrong, that some things matter and others don't. This spirited relationship with good and bad is something that we all have as children but, particularly in the current climate, come to question as adults. We live in "a universe in which truths are replaced by opinions," a universe in which, as the literary theorist and professor of law Stanley Fish (Quoted in *The New York Times*, January, 28, 1994), suggested, the death of objectivity "relieves me of the obligation to be right" and "demands only that I be interesting." Some of us seem, in our last years, to recapture the simplicity of earlier convictions.

Emotional investment in a truth isn't just comforting, it's inspiring. It elicits acts of courage and fortitude. In war, in illness, in distress, if we

feel we're fighting for life, for something that is indubitably right, good, and worth it, we can go on fighting.

In *Hope and Dread in Psychoanalysis* (Mitchell, 1993) asks what can inspire both participants in the analytic dyad in this perspectivist age. How do we sustain our own passionate engagement and elicit it in our patients, in a process shorn of its 19th-century certainties? As Mitchell succinctly states the problem:

The shift from the view that the analyst knows the Truth to the view that the analyst knows one (or more) among various possible truths about the patient's experience has created a crisis of confidence in psychoanalytic theorizing and a crisis of authority in the psychoanalyst's self-image. The certainty and its consequent hopefulness that pervaded traditional psychoanalytic theorizing have become inaccessible to contemporary analytic theorists or clinicians. Is this a problem? Is uncertainty a cause for nihilism and dread, or the basis for a different sort of knowledge? If the content of what analysts know is not the Truth, is the authority that analysts can claim diminished? [pp. 47-48].

Freud's clear convictions about what the patient needs, and what the analyst knows, are impossible to recapture in this age of theoretical diversity. The eye of the beholder significantly affects what the patient seems to need. Political and intellectual allegiances shape what the analyst thinks he can contribute to the process of the patient's growth.

The traditional analyst had a clear sense that what needed to be achieved in treatment was the patient's overcoming of the force of infantile, instinctual pulls. What the patient needed was this increasing mastery; what the analyst provided was a clarity of goals and a method for their attainment.

Contrast this with our current diversity of opinion about the goals and methods of treatment. In *The Actor's Nightmare*, Christopher Durang (1980), that puckish escapee from Catholic dogma, created the perfect expression of what the unmoored modern analyst may feel. Durang's play has the protagonist caught in a script whose plot he can't quite fathom, desperately trying to figure out his lines as he goes. Hopeless muddles result from his efforts to take his cues from the other

players, since the protagonist's sense of where the script is headed keeps evolving.

These observations raise fundamental questions about the psychoanalytic endeavor and, even more broadly, about human nature. If hope is an emotion, what gives it its motivating force? Is hope equivalent to the strength of an expectation? Is it a product of certainty about the value and attainability of a goal? How are these (cognitive) qualities related to the emotional experience of being inspired by hope? Can we sustain emotional hope without cognitive certainty? Is such hopefulness contagious in psychoanalysis? How is hopefulness in one partner communicated, or engendered, in the other? How do we understand hope's absence and its sometimes unfortunate coalescence in the lives of some psychoanalyses?

A survey may astound the reader with our vast neglect of these topics. We have yet to achieve clarity about the nature of emotion (Spiegel, 1980; Buechler, 1993a) and its relationship to cognition (Barnett, 1968, 1980) in treatment. The literature on emotions in psychoanalysis is curiously consistent in its attention to feelings that disrupt the work, such as anxiety, but its relative silence about what can sustain the effort. Recent contributions (Stern, 1989, 1990) have suggested the importance of curiosity in keeping the inquiry alive. Along with curiosity, hope must surely be among the motivating forces that propel the participants in an analysis.

Defining the psychiatric interview, Sullivan (1954, p. 4) considers it essential that the patient expect to derive benefit from revealing his characteristic patterns of living. Bion's oft-quoted injunction to the analyst to enter every session without memory or desire is not usually prescribed as a goal for the *patient*. The patient enters each session, one hopes, with increasingly elaborated memory and an unquenchable desire to lead, as a result of the process, an enriched life.

In addressing the nature of hope in psychoanalysis, we must ask how what goes on in our heads affects what happens in our hearts, and vice versa. If hope is seen as an expectation, with a particular degree of certainty or uncertainty, its cognitive aspect is emphasized, but this understanding of hope does not, I believe, fully account for its motivational power. When we refer to what the patient expects to derive from treatment, or what the analyst expects to offer, we are focusing on an

appraisal that is the cognitive aspect of hope. We are explaining only part of the phenomenon of hope. We are not yet comprehending what it is about an expectation that sometimes gives it the emotional force to drive us forward.

Schachtel (1959) supplies a framework for the study of hope as an emotion. As background, Schachtel distinguishes all affects into two categories: the embeddedness affects, which have as their goal the discharge of tension, and the activity affects, which are our eager, directed strivings. Hope, in his view, can be either an embeddedness affect or an activity affect. As the former, it is wishful expectations that things will change for the better in the future. Tomorrow someone, or an event, or time itself will bring happy fulfillment. In contrast, in the activity affect of realistic hope,

the present is not experienced as a desert through which one has to wander in order to arrive at the future. It receives significance from the activities which make one's life meaningful and/or through which one tries to help bring about hoped-for change. While realistic hope, too, is directed towards the future it does not shift the emphasis from the present to anticipation of the future [p. 39].

Thus we have a contrast between an essentially passive expectation of something in the future and an active striving that gratifies in the present, as it prepares for the future. Behavior that is motivated by hope as an activity affect should be gratifying both as means to an end and as an end in itself.

If we apply this distinction to analytic participants, we can see that their expectations might not result in a galvanizing activity affect, no matter the degree of certainty with which they are held. Our 19th-century Freudian's certainty about the Truth may not be enough to give him *mobilizing* hope, though it would provide an expectation of success, under the right circumstances (with an analyzable patient). To provide the power to propel, his hopefulness would have to embody an active attitude, a focus on the process as well as its intended results, an eagerness to expend effort. The same can be said of his patient, whose hope would have to include these attitudinal factors to sustain his active engagement.

In a similar vein, writing of hopeful expectations for a fuller life, Fromm (1968) says, "Indeed this kind of expectation could be hope; but it is non-hope if it has the quality of passiveness, and 'waiting for'—until the hope becomes, in fact, a cover for resignation, a mere ideology" (p. 6).

It should be clear that, like all other human emotions, hope cannot be understood outside the context of the other emotions it joins (Buechler, 1992, 1993b). The emotions form a system in the human being (Izard, 1977) with the experience and expression of each modified by the levels of all the others. We cannot speak of the hope of the analyst and patient without reference to what is, or is not giving them joy, and what is, or is not, creating anxiety, anger, shame. Their hope is shaped, partially, by their capacity to be surprised and by their eager curiosity. As an emotion, hope is modified by the other motivating forces it accompanies.

Thus, in Schachtel's (1959) language, we could probably predict the strength of the embeddedness affect of hope from knowing the degree of certainty of the individual's expectations, for this type of hope is close to a cognitive appraisal. But to understand the motivating, activity-inspiring power of hope, we need to look beyond expectations, regardless of their certainty, to a complex array of other emotions and attitudes that shape these forces.

In the realm of expectations, the hopes of the two participants may diverge significantly, creating discords familiar to any clinician. Mitchell (1993) underscores difficulties we all face when he writes of the neurotic patient who enters treatment with an agenda that for the therapist amounts to a perfection of the neurosis rather than an overcoming of it. He raises other clinically complex issues, such as the difficult judgment calls we make in assessing whether what the patient wants from us is a legitimate need, which should be granted, or a regressive wish, which should be denied. He also cites instances when the patient hopes the treatment will not result in real change or resolution and prefers instead to use the therapy in the service of stasis.

In all these situations, the clinician is called on to wear the mantle of the expert, in some sense equipped to bring to the treatment a separate vision of what would be good for the patient. These situations remind us that we are not mere facilitators of a naturally unfolding process in the patient. We actively contribute to the process by lending our own

vision of what is potential for the human being we are treating. As analytic instruments, we have more to offer than a method for the patient's self-examination. We must bring more to the table than a knowledge of the "how" of analytic exploration. We must provide more than merely a self-observant "other" available to the patient for mutually reflective interactions. We need a map of the territory, not just a knowledge of how to drive the car. We cannot fully operate without the theories that lend us a sense of where we should be going.

Theory can provide the cognitive aspect of hope, the expectations the analyst brings to the interaction. This is a type of hope that guides, but it is not enough to inspire. It is necessary, but not sufficient. It can tell us much about where we are going *after* we have mobilized the strength to continue our efforts. For both patient and analyst, something else, closer to the essence of hope as an emotion, or in Schachtel's (1959) phrase, an activity affect, is also needed. Though difficult to define, the presence of this active hope may sometimes differentiate the analyst from the patient and form a significant aspect of the analyst's contribution to the process. I suspect that, although the expectations patient and analyst bring have changed from Freud's time to ours, cultural shifts may not have altered what inspires.

For some analysts, treatment must address specific unmet developmental needs. Others, believing that if the patient can profit from all that life can teach, healing will occur, focus more on the patient's capacity for new experience. If only the patient could fully experience what is now "inattended," the patient would progress. A strong belief in either of these paradigms, or in any other conception of growth, will give analysts a sense of what their mission is. But will it make us the long-distance runners we all need to be? Will it carry us through the bleak, lifeless periods where no movement seems possible, let alone evident?

This is not meant to devalue the importance of theory. Clarity of purpose is a vital ingredient of hope. As Viktor Frankl often repeats, in his moving autobiographical tale of survival during the Holocaust, Nietzsche captured an essential truth when he said that "he who has a *why* to live can bear with almost any *how*" (Frankl, 1985, p. 97). It would be difficult to mobilize the emotion of hope without a sense of conviction about the purposes of analytic effort.

I feel that Mitchell (1993) may be alluding to the gap between expectation and inspiration when he says, "Analytically useful forms of meaning and hope do not lie preformed in the patient; they are generated when the analyst has found a way to inspire personally meaningful forms of growth and expansion from the inside out" (p. 225). It is, I believe, as difficult to define this gap as it is to fill it, although in my attempts to define hope as a component of the emotion system and in what follows, I try to do so.

In an effort to apply Frankl's insight to analytic participants, it may be useful to look, again, at the "why" of their efforts, that is, the purposes analysis is currently thought to serve, so that we may understand what inspires analysts to bear with the "how" of analysis. These purposes of analytic effort are inextricably interwoven with our current understanding of the nature of the self, the ultimate subject of the analytic process. In Mitchell's (1993) vision, treatment strives toward the goal of continuity and diversity of self-experience. While I need an ongoing sense of "I," my growth is equally dependent on an expansion of what can consciously constitute "myself." I must come to hear the theme, and recognize its variations. I am reminded of a definition of the creative process that describes it as a method of "making the strange familiar" and "making the familiar strange" (Gordon, 1966). The growth of a sense of self entails recognition of personal consistencies in my approach to life. I must contact a familiar "me" in my seemingly strange moments. Reciprocally, I must recognize and tolerate my own diversity, appreciating nuances of difference in who I become in varying contexts.

In contrast to a drive-centered understanding of self-experience, Mitchell suggests that

psychoanalytic theorizing will have more to contribute to our understanding of personal individuality if we can get away from a search for presocial or extrasocial roots of the core or true self and focus on what it means at any particular moment to be experiencing and using oneself more or less authentically [p. 150].

The search for a bodily based core comes to naught, since the meaning of any experience is always inextricably interwoven with its interpersonal functions.

Thus, the issue, "What is the purpose of psychoanalysis?" leads to the question, "Who is the self we are trying to affect?" To know this "self" requires us to raise, once again, the thorny issue of the nature of human motivations and, in particular, aggression and how it arises as part of self-experience. Is aggression a prewired drive, an inborn push seeking an outlet regardless of interpersonal contexts? Is it something I can, therefore, recognize has always been a part of me, no matter what the circumstances? If so, does that lend it the quality of "depth," or a sense of being "true" and basic to who I am? Did I enter this world "leading with my chin," looking for a fight? If so, I am motivated to *impose* an aggression-releasing meaning on some of my experience, and the recognition of this ongoing aspect of my motives would enhance my acquaintance with myself. The contrasting position holds that aggression is a response that is within our capacity but that its expression is not an inner yearning. I would know myself better if I understood what *evokes* an aggressive response from me.

Rejecting the idea of an aggressive drive, Mitchell's (1993) vision takes from the traditionalists their sense of the centrality of aggression in human experience, but focuses on aggression as a response to an endangered sense of self, rather than as an inborn push. For me, this perspective raises two questions:

1. Are aggression and assertion as separable as this point of view suggests? If they are not, as, for example, Thompson (1950) indicates, it will be more difficult to exclude the possibility of a prewired assertive/aggressive push.

2. Do we bring prewired emotions (rather than drives) with us into the world? On the theory that all that is prewired strives for expression, this would suggest that each fundamental emotion, each of the universally experienced human feelings' is a bodily and interpersonally based given and crystallizes an aspect of self. That is, I come into the world with some propensity to experience, for example, fear. I develop a history of who I am as a fearing person. This history, of course, is interpersonally and contextually shaped. But it is inevitable that I have some fear-inspired experiences, and these form part of who I am to myself. I do come into this world with a tendency, a pull, toward fearing, and this imposes meaning on some of what happens to me. I feel fear, anger, shame; therefore, I am. I would not be me, to me, without my sense of who I am as a fearing person. A long history of empirical/



developmental, and cross-cultural research (Izard, 1971; Buechler and Izard, 1983) supports such a view. Notions such as Tomkins (Izard and Tomkins's, 1966) belief in the "socialization" of emotions suggest that each fundamental emotion is both catalyst and organizer of self-experience.

To add to the complexity, we might see Kernberg's (1992) more recent contributions as suggesting that prewired emotion components are the constitutionally based constituents of the drives. Here emotions are seen as the primary building blocks of the drives. This view retains body-based, constitutional imperatives, but, with the emotions rather than the drives in the primary place, it leaves room for more possibilities of individual differences in makeup.

What difference would these viewpoints make in what is hoped for from treatment? I am reminded of the prayer that is so central to the tenets of Alcoholics Anonymous, asking for the ability to accept what cannot be changed, to change what can be changed, and to have the wisdom to distinguish the two. We cannot hope to change bodily based givens. Patients entering treatment often ask to be made less angry, or fearful, or ashamed. It is certainly not that these hopes are unreasonable. Just because we, as human beings, are born with propensities to feel these emotions does not mean we should passively accept whatever comes to be our experience of them. But the simple recalibration often implicit in the patient's hopes is impossible. We as analysts cannot, directly, make anybody less anything. Emotions cannot be turned up or down, like a thermostat.

The question is, rather, what kind of interchange in treatment can result in the patient's enjoying a healthier emotional life, given that *some* experience with each of the fundamental emotions is essential to being human. The patient may well leave treatment more curious, hopeful, and joyful, and less angry, fearful, or ashamed; but I don't believe these changes can be approached directly as goals. Like happiness, these emotion-system changes are, I would suggest, by-products of healthy relating.

This theoretical position has implications for how hope, as an active emotional motivator, evolves in treatment. Is it contagious (in Sullivan's sense of early experiences of anxiety as passed from mother to child)? Is it modeled, learned by example? Does the analyst's hope for

the patient, or for himself, somehow communicate itself to the patient, infecting or instructing him?

I don't believe it is, specifically, the analyst's hope that engenders hope in the patient, but the analyst's whole relationship to life. The patient observes the analyst's struggle to make sense of things, keep going in the face of seemingly insurmountable obstacles, retain humor and courage in situations that seem to inspire neither. The analyst stumbles, reacts without self-hate, works to recover. The analyst is willing to work hard. She is honest without being crippled by shame. She wants to live even the most difficult moments. She doesn't shrink from what is ugly in herself or the other. She is more interested in growth than in being right, more curious than self-protective. She can be wounded but refuses to be made dead. While in part this attitude may provide a model, and it may be contagious, I think that what mainly creates hope is the patient's experience of finding a way to relate to such a person. For many, this task requires substantive changes, alterations in all components of the emotion system. The deepened curiosity and joy, the lightened envy and hate that results engenders hope.

Mitchell's (1993) title also refers to "dread," an emotion I feel may have an important anxiety component. It is difficult to say whether dread is merely hope's absence or a more complicated array of emotions. It is surely true that trying to face life without much hope should engender anxiety. The patient who does not retain, or gain, an active sense of hope in treatment may leave more damaged than helped.

To return to our venerable, show-stopping analyst, her power derives from the commitment to life that is the palpable context of her expectations. As Fromm (1968) suggested, hope may be defined as "a psychic commitment to life and growth" (p. 13).

The aspect of active hope that affirms a commitment to life is probably not generally communicated in the content of what is said but, rather, in the fervor of the tone, in the strength of conviction that may be signaled by directness and forcefulness of speech. In analysis, this is probably conveyed to the patient more fully by personal and professional attitudes the analyst reveals unwittingly. Love of the work, a passion for promoting life and growth, an empathic stance toward herself and others, a willingness to struggle, joy in the humor and challenge of life are some of the intangibles that make themselves known

in the subtle timing and gestures of the music, rather than in the words. What the analyst focuses on, responds to, is willing to break the frame for, lets pass in silence, meets with passion, expresses in the first person, tires about, is willing to fight, says a great deal. The same can be said in supervision, where the supervisor's and the supervisee's attitudes about treatment and life are often explicitly, as well as implicitly, studied.

The relationship between author and reader also provides avenues for the inspiration of hope. We probably absorb more from who the author is, in front of us, and how we are treated than from what is said to us. For example, in his last pages, Mitchell (1993) expresses his hope that his work will be "valued without being sanctified" (p. 230). As his readers, we have been allowed access to the personal and professional experience of a profoundly thoughtful analyst. We have watched him work hard to make sense of his treatment experiences. We have heard about how his struggles as a father inform his analytic understanding. We have witnessed the cross-fertilization of his private and public lives. We have experientially understood the values essential to his clinical work, partially by living with his approach to us as a writer. We have sensed his passion about growth and life. We have had the opportunity to gather hope.

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