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The Therapist's Hope for Healing

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As a fundamental aspect human existence in both psychotherapy and Christianity, hope is a natural point of integration for the often disparate fields of psychology and religion. Hope is recognized in psychological research as associated with greater psychological functioning (Chang & Banks, 2007, p. 94) and it is also recognized as one of the top three priorities (along with faith and love) for Christians in I Corinthians 13:13 (Revised Standard Version). However, the importance of hope, at least within the psychological community, is almost unanimously focused on the client. This paper will define hope and explore its importance for therapists. Finally, hope will be challenged as a viable and sustainable option for all therapists in all contexts. Are there suffering individuals or broken relationships that are actually hopeless? How is the therapist to cope with the client or prognosis that seems beyond hope?

Hope Defined

Historically, philosophers have viewed hope in two different ways. Sophocles and Nietzsche asserted that hope is essentially false, something which merely prolongs human torment. Others, such as Saint Paul and Martin Luther, elevated hope to the same status as love (Snyder, 2000, p. 205). Dictionaries typically describe hope as the perception that “something desired may happen” (Snyder, 2000, p. 207). However, Christian theologians have a slightly more discriminating view of hope. Oswald Chambers (1963) journaled of the “delight of despair,” or the recognition that if he was “ever to be raised up it must be by the hand of God” (May 24, para. 1). Tillich writes, “[e]verybody can lose himself into foolish hope, but genuine hope is something rare and great” (1990, p. 1065). Biblical hope is not wishful thinking; it acknowledges our inescapable limits (Myers, 1980, p. 149).

Psychoanalysts, too, have taken different theoretical approaches to hope. Some viewed hope as primarily a regressive tendency, similar to fantasy and illusion. This view stems from Freud, who believed that religion was “the institutional embodiment of infantile hopes and illusions” which was pitted against science or rationality (Mitchell, 1993, p. 205). Following Klein and Bion, Harold Boris (1976) saw the analytic process as the purposeful relinquishment of hope and the precipitation of a “crisis of despair” in which the therapist would walk alongside the client (Mitchell, 1993, p. 205). Erickson saw hope as constructive, the most basic of the “‘vital virtues’ to connote certain qualities which begin to animate man pervasively during successive stages of his life” (1968, p. 233). Winnicott also viewed hope as constructive, as an embodying of “a new opportunity for an unfreezing of the frozen situation” (1954, p. 283). Kohut and Friedman follow Winnicott, seeing hope as a “necessary illusion that vitalizes self-experience, providing the motivation to persist in the face of despair” (Levine, 2007, p. 297).

Finally, psychological researchers have nuanced what hope is in terms of what effect it has on an individual’s cognitive and social functioning. Snyder and his colleagues offer an extensive model of hope. They note that enhanced self-evaluations or perceptions of control are related positively to psychological and physical well-being (Snyder, 2000, p. 206). They have shown that hope, as measured by their Hope Scale, can be taken to represent a cognitive set composed of two relatively distinct ways of thinking about a goal (Chang & Banks, 2007, p. 95).

If we apply Snyder’s concepts to the hopeful psychotherapist, we may describe a professional who has specific and measurable goals for his/her practice. Of course, the goals may vary. Some psychotherapists may simply hope for a lucrative practice. If this is all they hope for, then they are not particularly vulnerable to feeling hopeless about a client’s problems or the social circumstances which contribute to those problems. However, if the therapist’s goal is to

help every client in ways that can be measured directly, then difficult clients may more easily affect a therapist's outlook. Perhaps with such cases the therapist will reevaluate his/her therapeutic goals. Beyond this, however, a therapist may become hopeless about the possibility of change or about any type of healing.

Clinical Vignette

I worked with “Lizzy” as a floor time therapist—a technique used to help children on the autistic spectrum. Lizzy was quite different from my other floor time clients. To begin with, she was 16 years old and had been receiving services for years, so her parents were no longer participating or learning new ways to engage her. She was also much more challenged developmentally. Her autism diagnosis was substantiated by the fact that she could not speak at all and had difficulty staying engaged, but she also suffered from extremely poor proprioception. Still, her parents informed me that she could understand everything I said. Conversations in her midst were typically about her, with the speaker interjecting every so often with, “Isn't that right, Lizzy?” to which she would not or could not respond.

She walked constantly, did not stop until someone guided her to a chair and sat her down. She walked fast, but seemingly without direction. So, I walked with her. I held her hand. I sang to her. Sometimes I got in front of her to create an obstacle. I picked up leaves if we were outside, or toys if we were in her room, and placed them in her hands, and she held on to them until I took them away. The longer I worked with Lizzy, the more desperate I became for some sort of connection. After a few weeks I could tell she knew who I was, and there were small signs that she trusted me. But I was looking for noticeable improvement. I eventually learned that my supervisor and Lizzy's parents had long ago given up on Lizzy improving. I realized that floor time was not for Lizzy at all; it was for her regular caretaker to get a much needed break.

I also realized that this present was exactly Lizzy's future: she would have to be looked after for the rest of her life. According to the floor time model, I was supposed to be able to take Lizzy back to the very first developmental milestone she had missed and progress anew, "one rung at a time" (Greenspan & Wieder, 1998, p. 121). But Lizzy had nothing to recover from, and at 16 she was settled into an isolated inner world that others could never really penetrate. I began to lose hope, not just in the specific floor time techniques or my ability to help Lizzy improve, but in her life having any meaning. Lizzy, as far as I could tell, did not hope for anything. She merely existed, out of touch with herself, others, and the world.

Reasoned Hopelessness

Is there room for the therapist to lose hope, given the negative impact it may have on client outcome? We may first assess what exactly is involved when therapists are hopeful for a client in the first place. Mitchell writes,

we all know that it is...personal...that the analyst's hopes for her patients are embedded in and deeply entangled with her own sense of herself...what she has found deeply meaningful in her own life. The more we have explored the complexities of countertransference, the more we have come to realize how personal a state the analyst inevitably has in the proceedings....Our hopes for the patient are inextricably bound up with our hopes for ourselves (1993, p. 208).

I would maintain that the therapist's hope for his/her clients goes further than simply an egocentric need to feel competent in one's profession. I think that successes or failures with clients actually affect a therapist's worldview in the broadest sense. Existential questions such as what it means to be human and what the purpose of life is are bound together with the trajectory of the individual storylines that we hear about and try to reshape.

When the trajectory of an individual's story is flat or negatively sloped, how does the therapist protect him/herself from losing hope not only in that particular client but in larger constructs as well? The question is pressing, since therapists are often dealing with clients or

families who have lost hope. Indeed, the therapist's struggle with hopelessness can mirror a client or family's struggle (Flaskas, 2007, p. 196). The question is also important because therapists are not immune to depression. The uneasy proof of this is that psychiatrists have a higher suicide rate relative to other specialists, a fact which Yalom attributes to (secular) psychotherapists not having their own "ultimate rescuer" (2005, p. 313). The fact that therapists are "an occupational group committed to hope for change" means that we are also "quite vulnerable to embracing hopelessness" (Flaskas, 2007, p. 195).

Hope Revisited

I do not propose to have a solution for every unique case of hopelessness a therapist may encounter. Anyone who has experienced despair knows that there are no quick and easy answers. I do think, however, that the psychological literature which defines hope is lacking in several ways, and that identifying these limits can increase our understanding of hope. Obviously one deficit is that hope is almost always conceptualized within the context of higher functioning individuals who can improve psychologically. This is not to say that these clients, their problems, or their healing process is easy by any means, only to say that they have the potential for growth. There is no physical limit to what they can achieve in therapy. Myers claims that "[a]ll therapies offer hope to demoralized people—the hope that accompanies a plausible explanation of one's problems and a ritual for surmounting them" (1980, p. 133). However, many therapists work with individuals with organic brain disorders which have no clear etiology, let alone a cure. The client's problem goes beyond demoralization.

Weingarten points out that Western psychology has individualized hope (2000, p. 401). She proposes that the African philosophy of *ubuntu* (community) is a better fit for hope, which is something people *do*. Hope is communal. And hope is a responsibility. Her response to clients

who feel hopeless is to say, “Of course you feel hopeless. It is not your job right now to feel hope. Rather, it is the responsibility of those who love you to *do hope* with you” (Weingarten, 2000, p. 402). A third deficit in psychology’s consideration of hope is that it consistently limits its scope. The psychological objectives that therapists hope for are all temporal. But Christianity bespeaks of a hope that is eternal and living. The hope of the church is for a new heaven and earth (Tillich, 1990, p. 1064). Paul writes “we hope for what we do not see” (Romans 8:25). How does this fit into self-improvement or symptom reduction? Hope in the Bible is not goal-centered, nor is it self-centered.

The conclusion I finally came to during my time with Lizzy was that our way out of her “hopeless” situation was to hope for something different. The solution may sound trite, but it is more than a psychological reframe. Sometimes hope in an eternal reunion with God is one’s only hope. Moreover, Christian therapists believe that this, rather than increased functioning, is the ultimate hope. Indeed, whenever we set our hope solely in particular things or timeframes we risk hopelessness: “[d]esperair results from the lack of trust that demands God’s promises to be fulfilled *now*, on our terms” (Myers, 1980, p. 145). Instead, we maintain hope for healing—the healing that is offered by God—through faith in what Paul proclaimed to the church in Rome: “that there is nothing in death or life, in the realm of spirits or superhuman power, in the world as it is or the world as it shall be, in the forces of the universe, in heights or depths—nothing in all creation that can separate us from the love of God in Christ Jesus our Lord” (Romans 8:38-39). Let us rest assured in the hope that Lizzy, and all those who suffer, are not separated from the love of God.

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