

Institute for Clinical Social Work

VICISSITUDES OF HOPE IN THE PSYCHOANALYTIC CLINICIAN:
AN EXPLORATORY STUDY

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ABSTRACT

The objective of this psychoanalytic case study was to examine what comprises the vicissitudes of hope in five seasoned clinicians over the course of their professional lives. The data was obtained through several interviews with each participant. The data was first analyzed by looking at each individual narrative for the resonant themes that emerged for each participant. The findings then were compared across individual narratives to construct a more detailed psychoanalytic understanding of the meaning of the vicissitudes of hope for these participants.

The overarching finding is that the sense of hope of the participants stemmed from a larger and more expansive experience of the self. This state of the self develops over time through the integration of experiences, of which professional experience is one facet. The participants also described a developmental trajectory in terms of the establishment of professional self-esteem and the expansion of professional hope that occurred over time. The vicissitudes of hope in the countertransference was found to be an inevitable and valuable part of the treatment process for the participants. These countertransference expressions of hope were forms of communication from the patient, the psychoanalytic clinicians studied, or how they and their patients come together that could be used to facilitate the treatment or deepen self-understanding of the participants. The participants actively regulated their hope over time to maintain hopefulness through an ongoing process of self-expansion and self-protection.

For Talia and Ani

May you always strive for a resilient sense of hope

We must accept finite disappointment, but never lose infinite hope.

~Martin Luther King, Junior

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CHAPTER I

INTRODUCTION

Formulation of the Problem

I have been practicing psychotherapy for 17 years. The foundation of my belief system rests on the notion that, under the right circumstances, therapy can be deeply profound and transformative. As I have evolved in my professional life, however, the pureness within which I held fast to this belief has shifted.

In the first several years of my practice, my hope and optimism about the transformative power of therapy transcended all therapeutic encounters and outcomes regardless of whether clients had life changing experiences or whether their treatment got derailed, stopped abruptly, or we did not make the progress we had hoped.

This therapeutic idealism most significantly grew out of my own personal therapeutic journey. Feeling stuck in my life in my mid-20s, I began what has been an adult long process of understanding and growth in both psychotherapy and psychoanalysis. This process has been life altering. It helped me reach many of my life goals: to find a profession that is meaningful to me, as well as give me a wider skill set to perform my job; to meet a life partner who is a good fit; and to become a good-enough mother.

My optimism was further solidified in graduate school. I felt stimulated by what I was learning. I held fast to such clinical principals as “start where the client is;” let the

client lead you at her own pace. Manned by intellectual understanding and clinical tools, I felt hopeful that I would help people in their lives.

Over time, however, the therapeutic idealism that was once the bedrock of my professional belief system has narrowed. Questions, disappointment, and sadness have emerged at times as I struggle with complex bio-psycho-social problems of clients that make change quite difficult and complex therapeutic issues that often do not have clear answers.

How do you think about a client who has been extremely engaged in intensive psychotherapy for many years not being able to meet the one goal, of getting married and having a child that she has longed for her whole life? What do you do when the therapist, not the patient, feels stuck in the treatment in spite of receiving on-going consultation from seasoned professionals? How do you reconcile being in transformative depth psychotherapy and still struggling with distressing core relational difficulties?

I feel as a though I have begun a process of mourning. Mourning the loss of idealism related to therapeutic promise for all who desire it and work at it. While my hope is still present it is no longer all encompassing.

I can see a more balanced or “realistic” perspective emerging. My hope is more client or situation specific. I look more often at the full range of possibility regarding the therapeutic encounter: what and who can psychotherapy help and not help; what is possible and impossible; what are the promises and the limitations. It is a perspective that also recognizes the ambiguity, middle ground, or ever-changing nature of these dichotomies within each therapeutic encounter.

It was the outgrowth of my own experience that prompted me to explore in greater depth the vicissitudes of hope in the psychotherapist and how it evolves over time.

Study Objectives

The objective of this study was to examine the vicissitudes of hope in the lives of psychoanalytic clinicians over time especially as they experience complex, emotionally stirring, and in depth clinical relationships and therapeutic situations. This study also captured how personal history and life experiences outside the professional realm framed this narrative in their work.

Through the use of in-depth detailed interviews, I explored how these clinicians experienced the vicissitudes of hope, ranging from an idealized sense of hope to a complete loss of hope, in order to capture this inner dialogue. The clinicians in this study were seasoned to lend the perspective of time to their stories. They also practiced from a psychoanalytic perspective as this perspective values introspection, countertransference and transference and recognizes conscious and unconscious phenomena, which are among the components that provide these stories with both depth and texture.

When I analyzed the data that emerged from the interview process, I first looked at each individual narrative for the resonant themes that emerged for each of the five psychoanalytic clinicians that were interviewed. I then compared these themes across individual narratives to construct a more detailed psychoanalytic understanding of the meaning of the vicissitudes of hope for these participants.

Operational Definitions of Major Concepts

According to the 3rd edition of *American Heritage Dictionary*, hope and vicissitudes defined as follows:

- Hope: To look forward to with confidence or expectation.
- Vicissitudes: 1. A change or variation. b. the quality of being changeable: mutability 2. The shifts often encountered in one's life, activities, or surroundings.

The vicissitudes of hope in this study encapsulate everything from an idealized sense of hope at one extreme to a complete loss of hope at the other. It includes the derivatives of vicissitudes of hope that have been used in the psychoanalytic literature such as faith, hopefulness, confidence and good feeling, loss of hope, hopelessness, disappointment, dread, despair, and loss of faith.

Statement of Assumptions

- Hope is an essential aspect of the clinician's experience in their work.
- "Hope can be observed in behavior, nurtured, and brought to life in the clinical situation as can lack of hope" (Schechter, 1999, p. 372).
- Hope is not static; it shifts and changes over time.
- A clinician's personal history and life experience affects their clinical work.

Conceptual and Theoretical Framework

The theoretical and conceptual framework used for this study was a pluralistic psychoanalytic orientation. While contemporary psychoanalysis is comprised of complex and varied theories and areas of knowledge, there are beliefs and principles that all psychoanalytic theorists and clinicians subscribe. These psychoanalytic principles are part of the conceptual and theoretical orientation of this study and thus will be described throughout this dissertation. Due to their significance in this study, however, these psychoanalytic tenants will be explicitly described in this section. These principles are: a recognition of the complexity of the mind- filled with complexity, ambiguity, and conflict, a questioning of absolutes, the importance of unconscious mental process, and the value of a sustained inquiry into subjective experience (Black and Mitchell, 1995) (Schafer, 1970).

This study was based on the belief that human nature and human experience are multi-faceted and mostly not simplistic (Hoffman, 1998). Hope, which is one small aspect of the human experience of a clinician, was examined in an in-depth manner that considers its many ever changing and evolving layers.

My aim was to understand both the superficial and the underlying structures that can be used to understand the many processes related to hope in the clinician. I used free association (Cartwright, 2004, p. 9) to try to ascertain how elements of each clinician's narrative were consciously and unconsciously associated. Empathy was also utilized as a research tool as I tried to put myself in the shoes of the participants to understand their experience (Black and Mitchell, 1995). Additionally, I attempted to understand how context-internal, external, or interactional was organized for the participants (Cartwright,

2004, p. 10). Through the use of sustained inquiry using multiple interviews, I developed a narrative that described both the subjective experience of hope in each participant as well as the collective themes among all participants.

Just as psychoanalysis has shifted from a one-person to a two-person psychology that recognizes the participation of both the patient and the clinician in the analytic process, this study recognized the inevitability of a mutual and reciprocal two-way influence between each participant and the researcher (Aron, 1996). While a certain mutuality existed between researcher and participant, the relationship “will simultaneously and inevitably remain asymmetrical” (p. xi). In other words, while influence and regulation moved in both directions from each participant to myself like a self-perpetuating conversation, the roles and responsibilities of the participant and myself were quite distinct. I collected and interpreted data from the participant’s subjective experience of hope and the participant provided that data.

While I did my best to open my mind so I was able to observe associations, verbal, and nonverbal reactions in myself and the participant, the meanings generated in this study were not considered objective. I entered this study with the knowledge that my perception and behavior in the interview situation and theoretical reflections are always consciously and unconsciously interwoven in constantly ongoing cyclic processes between the researcher and the participants (Leuzinger-Bohleber and Fischmann, 2006). As a result, meaning was seen as being interpretative and co-constructed by the participant and the researcher (Cartwright, 2004).

CHAPTER II

LITERATURE REVIEW

Introduction

“Hope and losing hope are experiences that are intertwined and linked in every individual in a continuous natural fluctuation throughout life” (Mehler and Argentieri, 1989, p. 295). The ongoing fluctuation of hope is an aspect of the personal narrative of the individual. It is also a narrative thread that runs through much of Western history, Judeo-Christian religion and the formation and evolution of psychoanalytic thought. Each particular narrative of hope reflects a confluence of factors that reflect both the specific context in which hope is situated, as well as how hope is experienced by the interpreter.

The narrative of “hope is among the most important—‘obvious but unseen’ (Bion, 1967)—elements” (Cooper, 2000) in the field of psychoanalysis. On a macro level, this narrative thread is implicitly present in the metatheoretical and historical evolutions that have occurred in the field of psychoanalysis. Furthermore, while hope is rarely explicitly referenced in most psychoanalytic approaches, the very fact that each has a theory of cure implicitly suggests that each contains a sense of hope.

The psychoanalytic endeavor also fundamentally implies hope, expressed at times as confidence or optimism that something positive can occur. The patient who seeks treatment, to some degree, believes or hopes it will help, which is why they make the commitment of time and money to engage in the process. The clinician who offers

treatment also believes that the process can be useful, and they feel some degree of hope in their efforts to help the patient.

The hope, optimism and confidence that seemed so basic and pure in the beginning of treatment, however, becomes ever more complicated over the course of a therapeutic relationship, as “the fostering and losing of hope develops and becomes necessarily more articulated within the frame of the analytical relationship, involving as it does subtle transference and countertransference, conscious and unconscious issues” (Mehler and Argentieri, 1989, p. 295).

While the vicissitudes of hope are so much a part of the ebb and flow of life, and thus part of the psychoanalytic process, this narrative has rarely been explicitly explored in the psychoanalytic literature. Boris (1976) contends that the focus of psychoanalysis has been on the theory of desire and its vicissitudes rather than hope. Searles (1977) argues that the reason hope has not been explored in greater detail is because we like to hold onto the cherished illusion that hope is good and pure. He states hope “is a realm into which we are most reluctant to allow, so to speak, our conscious ambivalence to enter” (1977, p. 9).

In this study, I attempted to capture the many dimensions that comprise the vicissitudes of hope in the clinician. The clinician’s narrative of hope is situated in the clinician’s constitutional and developmental history that comprise who the clinician is and how hope is perceived and filtered into their work and life. The vicissitudes of hope fluctuate in the clinician within specific therapeutic situations and relationships, within the transference and countertransference, conscious and unconscious processes that exist between the clinician and patient(s). Hope also fluctuates in the clinician in relation to the

clinician's professional sense of self: how competent, supported, admired and useful the clinician feels about the work she or he is engaging in, and how the clinician and her or his work is perceived within the psychoanalytic community. The clinician's narrative of hope is not static, but continuously evolving and changing the longer the clinician practices and moves through life.

The evolution in psychoanalytic theory in the last several decades, which has placed greater emphasis on the dyadic relationship, given voice to the clinician's subjectivity, and elaborated on the phenomenon of countertransference, has led a few psychoanalytic writers to address the clinician's experience and/or the dyadic experience of hope and its complexities. Mitchell (1993) and Cooper (2000) write about the clinician's vicissitudes of hope from a relational lens, whereas Searles (1977), Menninger (1987), and Schechter (1999) come from other psychoanalytic traditions.

The literature review will begin by describing most broadly how the vicissitudes of hope have been described throughout our history and in the metatheory of psychoanalysis. Next, the literature review will be structured thematically to encapsulate the ways these, as well as additional contributing psychoanalytic writers, have addressed the clinician's fluctuating hope. These contributions fall into three categories. The first section, the clinical engagement between clinician and patient, explores how the vicissitudes of hope in the clinician are understood in the psychotherapy process. Hope is described primarily in terms of countertransference, but is also briefly described in terms of transference. The second section, which combines the second and third categories, describes the developmental path of hope in the clinician from beginner to seasoned professional and illuminates the ways the clinician regulates hope throughout their career.

The Historical and Metatheoretical Evolution of Hope

The vicissitudes of hope is a narrative thread throughout history as well in metatheory of psychoanalysis. Yet, each time hope emerges as a narrative thread, whether in history or psychoanalysis, it is not the same. Rather, it reflects the particular period in time and the cultural and intellectual climate in which it is situated.

This section will attempt to articulate, in the broadest sense, the ebb and flow of hope throughout history and in psychoanalysis, with the aim of orienting the reader to the pervasiveness of this implicit narrative throughout time. Specific focus is given to how the field of psychiatry transformed from disparaging to hopeful with Freud's discoveries and how hope is conceptualized in psychoanalysis today.

History of Hope and Despair in Western Civilization

The idea of hope has been a major thread running through Western History beginning with the ancient Greeks (Averill, Catlin, and Chon, 1990). Due to their cyclical worldview, the Greeks felt ambivalent about hope. Hope and despair were seen as almost synonymous. Fate was unchangeable (ibid.); so hope was considered an illusion: "man's curse" (Menninger, 1987, p. 450).

In the myth of Pandora, when her curiosity led her to open the box from which all the evils of the world flew, remaining behind in the box was man's consolation: hope (Averill, Catlin, and Chon 1990). It is unclear whether hope was good or evil, hopeful or disparaging. "Was hope another ill like the others that had escaped or was it a benefactor left behind to aid humankind" (ibid., p. 3)?

In Judaism and Christianity, hope was transformed from an ambivalent condition to a highly valued one. In Christianity, hope became one of three theological virtues along with charity and love (ibid.). The Jewish people also hold fast to hope. “In spite of the many struggles that have challenged the Jewish people, they have held onto the hope “that a Messiah will come” (Menninger, 1987, p. 450) and bring a better life.

Since religion was the dominant source of orientation and meaning, a hopeful message took hold throughout the West as Christianity spread. The hopeful message in Christianity and Judaism was a message that addressed the interplay between traditional faith and transforming hope (Eliade, 1987). Hope and despair were seen as opposing forces that were inextricably intertwined. Through religious observance and repentance, people always have the hope of transforming their lives and transcending despair.

To be religious must be characterized by the hope that present vicissitudes will be overcome, that faith will be vindicated, and that the group, if not the individual will realize a joy or bliss of which we now experience only passing intimations (ibid., p. 460).

“Those who sow in tears shall reap with shouts of joy” (Psalm 126:5).

During the medieval period the definition of hope expanded from being only a virtue to being regarded as a fundamental emotion. In the 13th century, theologian Thomas Aquinas designated hope as one of eleven basic emotions, and of these 11, four (joy, sadness, hope, and fear) were considered primary (Averill, Catlin, and Chon, 1990). In the 1700s British empiricist David Hume popularized the belief that hope was an emotion. Hume stated, “If our hope is fulfilled, the result is joy” (ibid., p. 4).

In the nineteenth century, science, rationality, and objectivity took the place of religion as the most reliable explanation of human experience (Menninger, 1987). Hope became secularized (Averill, Catlin, and Chon 1990).

Science, and the explosion of technology fostered the belief that the sure knowledge provided by science, and the control it granted us over the world around us and in us, would lead to deeper understanding, wisdom, and a better life (Mitchell, 1993, p. 15).

Some philosophers and poets, however, expressed a sense of fatalism or despair similar to the Ancient Greeks because “science rang hollow in the sweatshops spawned by the industrial revolution (Averill, Catlin, and Chon 1990). Nietzsche wrote, “Hope is the worst of evils, for it prolongs the torment of man” (Nietzsche, 1878). In 1819, Shelly, in *The Cenci*, wrote: “Worse than despair? Worse than the bitterness of death, is hope” (in Menninger, 1987, p. 451).

From Despair to Hope: The Transformation in the Field of Psychiatry

Menninger (1987) argued that one of the outcomes of this scientific revolution of intellectual and cultural thought was that the field of psychiatry transformed from a profession characterized by despair to one characterized by hope. Prior to World War I, psychiatrists did not understand the phenomena of “madness” (p. 451). There was a belief that patients with mental illness were mental degenerates. Therefore, “psychiatric efforts were focused on identifying, naming, describing, and graphing disease entities.”

Menninger states, “This was the traditional concept of diagnosis and it offered little to justify hope” (p. 456). A common objection to entering psychiatry was an impression that patients “never get well” (p. 460).

Following World War I, large numbers of returning veterans required psychiatric treatment. As a result, psychiatrists began to see the symptoms of “stress and overstress develop and recede” as patients talked about what happened to them” (ibid.). In addition, Sigmund Freud developed the psychoanalytic method of treatment. This method “allows us to see beneath the appearance of things and the surface of mind: by uncovering unconscious thoughts, through the generation of insight, psychoanalysis can transform the mind’s unconscious underlying structures” (Mitchell, 1993, p. 15).

The hope that Freud’s discoveries gave the psychoanalytic field was the belief that psychological symptoms can be understood and have meaning. He believed in psychic determinism; transforming the previously held belief that symptoms are the result of constitutional deficits that cannot be helped. The incurable became curable.

Freud also presented us with “the realization that we must encourage each individual to see himself not as a mere spectator of cosmic events but as a prime mover; to regard himself not as a passive incident in the infinite universe but as one important unit possessing the power to influence great decisions by making small ones” (Menninger, 1987, p. 60). It enabled the psychiatric community “to replace therapeutic nihilism with constructive effort, to replace unsound expectations—first with hope, and then with sound expectations” (p. 461).

Freud’s Hope and Despair

Freud’s discoveries began the trend away from names, states and entities and toward dynamics, relativity and process. In his early works, Freud made an absolute distinction between normality and pathology: repressions could be lifted, fixations

removed, transference neuroses resolved, libido was enabled to find new channels for discharge and pathological neurotic transferences differentiated from the useful benign ones (Abend, 1986).

Freud conceptualized the human experience of hope and despair as unconscious regressive “infantile processes” in the human psyche. Mitchell (1993) summarized Freud’s conceptualization of hope in the following way: “Hopes derive from infantile impulses for oral, anal, and oedipal gratifications and triumphs. Dreads derive from fantasied punishment (particularly castration) for forbidden wishes” (p. 15). “Through the analytic process hopes and dreads are transformed into rational understanding. The ego, which operates in terms of rationality (secondary process), is now free to employ that energy in more pragmatic, realistic endeavors” (ibid.).

Freud thought that the hope that brings a person to psychoanalysis is derived from the longing for gratification of infantile sexual and/or aggressive impulses. These hopes are embedded in primary process thinking and wish fulfillment and are removed from reality (ibid.).

In Freud’s theory, the analyst has privileged access into the patient’s experience; the analyst knows what is real and what is not. As a result of the analyst’s insight, the patient is freed from the clutches of unconscious regressive infantile processes. Freud introduced the concept of countertransference, which will be described in greater detail in the next section, “believing that the reactions in the analyst should be recognized and overcome” (Racker, 1968, p. 26).

Psychoanalytic Theory and the Regulation of Hope

Freud's psychoanalytic theory transformed the field of mental health, yet the more it was experienced, utilized and pondered by psychoanalytic clinicians, the more major pillars of his theory began to be challenged even by Freud himself. New psychoanalytic theories were also introduced including ego psychology, object relations theory, self psychology, interpersonal psychology and most recently, relational theory. These theories also broadened or re-conceptualized psychoanalytic thinking.

The commonalities of all psychoanalytic theories are that they offer a certain narrative vision of reality that emphasizes a "recognition of the depths of the inner world, complexity, ambiguity, conflict, the ubiquity of the demonic and of suffering, the frequent interpenetration of victory and defeat, unremitting questioning of absolutes, and the like" (Schafer, 1970, p. 274). At the same time, each new theoretical school within psychoanalysis has attempted to address some themes over others, or what Schafer (1970) describes as "the comic, romantic, tragic, and ironic visions of reality" with varying levels of emphasis (ibid.).

The fluctuations of hope can be implicitly seen in the narrative thread that runs through the development of theory. Experience and observation leads clinicians to develop new theory because something has not been emphasized enough or in the right way. With the introduction of each new theory, there is the implicit hope that this new theory will articulate something that will resonate with clinicians and patients more profoundly. "Our constant hunger and receptivity to new theory of any kind is because of the failure of each theory to make clinical work unconfusing" (Spezzano, 1993 p. 25).

The specific way that hope was understood within these new psychoanalytic theories also shifted. While Freud saw hope as a regressive phenomenon interfering with mature and rewarding experience, other psychoanalytic traditions introduced a more “progressive view of hope. Hope came to be viewed as constructive and growth enhancing, evolving in a developmental context” (Mitchell, 1993, p. 221).

Erikson believed that hope emerged in infancy in the basic sense of trust and mistrust “which remain the autogenic source of both primal hope and of doom throughout life” (Erikson, 1950, p. 80). Erikson adds, “hope is the first and most basic of the vital virtues to connote certain qualities which begin to animate man pervasively during successive stages of his life” (in Mitchell, 1993, p. 221).

Winnicott’s (1956) also located the beginning of hope in early childhood and believed it evolved over time. He believed that,

Hope is achieved through a developmental process, whereby infants become effected by the nurturing experience with the mother and significant others. Parents influence the young child to invest and hope for good things in life, and the older child has learned how to hope through the early example modeled by the parents (in Cunningham, 2004, p. 226).

Winnicott saw delinquency and antisocial behavior as signs of hope in that they are the adolescent’s best efforts to get better. He stated in relation to the treatment of antisocial adolescents it “is not psychoanalysis but management, a going to meet and match the moment of hope” (Winnicott, 1956b, p. 309).

Kohut, like Winnicott, believed the patient’s ill-fated attempts to be in the world as hopeful because they enabled patients to grow in spite of adversity (Kohut, 1984).

Just as a tree will, within certain limits, be able to grow around an obstacle so that it can ultimately expose its leaves to the life-sustaining rays of the sun, so will the

self in its developmental search abandon the effort to continue in one particular direction and try to move forward in another (Kohut, 1984, 204).

Hope in Psychoanalysis Today

Psychoanalysis today is part of another, larger revolution in scientific thought (Kuhn, 1962) called the Post-Scientific or Postmodern era. Science is no longer seen as the only framework to understand and give meaning to human experience. There is recognition of how embedded people are in their world and how impossible it is to stand objectively outside nature in order to study it.

In Postmodernism “all knowledge, including scientific knowledge, is regarded as perspectival, not incremental; constructed, not discovered; inevitably rooted in a particular historical and cultural setting, not singular and additive, thoroughly contextual, not universal and absolute” (Mitchell, 1993, p. 20).

Psychoanalytic theorizing has been redefined from a representation and reflection of the underlying structure of the patient’s mind to a construction, an interpretation of the patient’s experience (Mitchell, 1993, p. 67). “The patient may benefit from clarification and insight from the analyst, but equally, if not more importantly, the patient will benefit from the sustained experience of being seen, personally engaged, and basically valued and cared about” (ibid., p. 25).

The therapeutic aspirations of hope in psychoanalysis today are not about the renunciation of the illusion in the hope of joining a common, progressively realistic knowledge and control, but rather the hope of fashioning a personal reality that feels authentic and enriching (ibid.).

Hope is often expressed as being able to bear affect, ponder experience, integrate complexities in the form of conflicts, or mourn and grieve for lost opportunities in relationships and work (Cooper, 2000).

While there is no uniformity among psychoanalysts practicing today, there are common threads in the visions of psychoanalytic theorists. Mitchell (1993) contends that psychoanalysis today emphasizes the importance of relationships with others and the embeddedness of the individual in a social context (*ibid.*, p. 21). While the present is given more weight than the past, the past is explored in terms of how it lives on in the present.

Mitchell (1993) explains, “The analyst is seen not as a semi-detached observer of the patient’s operations rather a full participant in interpersonal relationship they create and maintain together” (p. 79). “Every psychoanalysis inevitably consists of an interaction between the patient, with all his or her values, assumptions, and psychological idiosyncrasies, and the analyst with all his or hers” (Renik, 1993).

The certainty and hopefulness that pervaded psychoanalytic theory has become a thing of the past (Mitchell, 1993). No longer do analysts consider themselves all knowing and all powerful. Rather analysts strike a more modest tone of being more of an equal participant in the analytic process (Kepinksi, 1981). “There have been some voices in different psychoanalytic traditions that emphasize how little the analyst knows and how anxiety provoking that really is. The capacity to contain the dread of not knowing is a measure of analytic virtue; the fewer convictions, the better (Mitchell, 1993, p. 43).

Since psychoanalytic theory has evolved to a perspective that values understanding the clinician’s experience, it seems relevant, by natural extension, to study

the vicissitudes of hope in clinician's work. Mitchell (1993) believes psychoanalytic theorists do not write about the analysts' hopes because "that sounds too personal somehow" (p. 207). Menninger (1987) writes, "Hope seems almost to be a tabooed topic, a personal matter, scarcely appropriate for public discussion" (p. 448).

Yet, hope is a necessary quality that the treating clinician must have in order to take a patient on the psychoanalytic journey. "Hope is another way of saying the analyst is trying to learn as much as possible about what the patient wants, what the patient is afraid of, how the patient protects himself, and the like (Cooper, 2000, p. 32).

Loss of hope, disappointment and despair emerge in contrast to hope as darker moments emerge in a treatment and/or potentially in the wider professional life of the treating clinician. "Hope and despair are deeply embedded in the analyst's sense of self-worth, what she can offer, and what she has found to be meaningful in her own life" (Mitchell, 1993, p. 208). "Furthermore, hope and despair motivate an analyst's technical decisions, adoption of particular theories, and view of therapeutic action in analytic work" (Cooper, 2000, p. xiii). This natural ebb and flow between and around hope and despair seems part of the inner dialogue of every person and, for purposes of this dissertation, an essential part of the fabric of the treating clinician.

Countertransference

While the clinical relationship has many facets, countertransference is the place where facets of hope are experienced by the clinician, and therefore it is essential to explore in greater depth. The psychoanalytic literature describes countertransference predominately in four ways: as feelings or reactions that emerge within the clinician that

interfere with the clinician's functioning, as feelings and reactions within the clinician that emanate from the patient that if used properly can help facilitate the treatment, as some combination of both, or as a co-construction between patient and clinician.

The clinician understands countertransference reactions as related to the clinician's issues that she or he brings into the therapeutic relationship, as related to reactions the clinician has that are specifically related to the patient's transference, or as all reactions, unresolved, real or transference, the clinician has within the therapeutic relationship.

The literature on hope in the countertransference, while primarily understood from the lens of contemporary theorists as being part of an interpersonal interaction, does describe instances when hope in the countertransference can be experienced as related to the clinician's experience of the therapeutic situation, and less so but also, when hope is related to a patient communication.

Countertransference as an Interference

Freud was the first to identify the phenomenon of countertransference. Though he did not discuss it extensively, he believed that the analyst's own neurotic conflicts could interfere with the analytic process. Freud (1910) stated,

We have noticed that no psychoanalyst goes farther than his own complexes and resistances permit, and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients (pp. 141-42).

Freud believed that countertransference was the result of unconscious pathological forces arising in the analyst that impede his ability to receive and correctly

understand communications from the patient (Jacobs, 1999). As a result, Freud saw countertransference solely as an obstacle in analysis and a problem for the analyst to overcome outside the analytic encounter (Racker, 1968; Tyson, 1986).

As was discussed in greater detail in the previous section, Freud's views reflected the underlying assumptions of the nineteenth century scientific world, where:

The analyst was seen as an objective observer, who was able to remain outside the field of observation and who could maintain a position of neutrality. According to this view, countertransference served as a disequilibrating disturbance to the objectivity and separateness of the analyst/observer. Hence countertransference was to be reduced or eliminated as quickly and expeditiously as possible (Levine, 1997, p. 50).

Since Freud introduced this viewpoint, countertransference reactions that were considered an interference have expanded. Reich (1951) and Frieda Fromm-Reichmann (1950) considered an interference to include anything within the analytic encounter that interfered with the analyst's functioning. This included the analyst's unmastered personal conflicts, transference to the patient (e.g., McLaughlin, 1981), or as a response to the patient, the patient's transference, the act of doing analysis, or some other element of the analytic situation (Levine, 1997, p. 49).

Baum (1977) added that the clinician's life stress can make the clinician more vulnerable to countertransference pitfalls. He states, "there are many transient life stresses-perhaps with spouses or children or job-that affect his analytic stance and interfere with his empathic ability" (p. 547). The analyst may become more preoccupied with their own problem solving, or may have an unconscious wish for help. Thus the stage is set for a countertransference response.

Many dimensions of countertransference have broadened, expanded, and even reconceptualized its definition (which will be described in greater detail below). While this position still is posited within the psychoanalytic literature (Gabbard, 1995), it is usually understood as part of the countertransference response as opposed to all of it.

Eagle (2000) argues that the pendulum has swung so far away from this position in favor of looking at countertransference as patient communication that a new kind of blank screen or tabula rasa in the clinician has emerged where the clinician's mind is exclusively populated with the patient's mental contents and devoid of any of his or her own contents. He concludes,

Do not assume that all feelings and thoughts that emerge in your experience necessarily, and in any simple, uncomplicated way, reflect what is going on in the patient's inner world. A little dose of the classical view of countertransference, define as a possible barrier to understanding is, I believe, in order (p. 36).

Countertransference as Facilitating

In the late 1940s and 1950s the Kleinian and Object Relations schools broadened the definition of countertransference, equating countertransference with "the analyst's total responses, responses which, in large measure, reflected the projected and displaced inner object world of the patient" (Jacobs, 1999, p. 582). As a result, the analyst's countertransference responses or reactions to a particular patient were seen as useful in gaining more understanding of the patient while at the same time leaving open the possibility that they could also be an interference.

Heimann (1949) and Winnicott (1949) stressed this more complex yet optimistic understanding of countertransference. Heimann (1949) was the first contributor to the literature that viewed the analyst's countertransference as constructive rather than entirely

pathological (Mills, 2004). She contended that “while some countertransference is troublesome and in need of self-analysis and rectification, it also can be used to help understand the experience of the patient” (ibid., p. 470). Winnicott, on the one hand, reiterated Freud’s position that the analyst clarifies the countertransference in order to maintain objectivity. At the same time, Winnicott (1949) suggested that some very disturbed patients evoke intense hatred so that the analyst should be able to “hate the patient objectively” which, in turn would provide beneficial, realistic communication to the patient concerning the patient’s provocation (ibid., p. 472).

The broader conceptualization of countertransference was significant for several reasons. The first is countertransference for the first time became something that could facilitate the therapeutic process as opposed to just being understood as an interference. The second is that this broader definition enabled countertransference to be viewed as more of an inevitable component of the analytic process. Whether it is facilitating or obstructive depends on how it is put to use by the clinician or the patient (Levine, 1997). The third is that countertransference became understood as part of a dyadic interaction between patient and clinician.

As this broader definition has been developed, however, two different conceptualizations of countertransference seems to have emerged. One view emphasizes countertransference totalistically (Kernberg, 1965) as all the reactions, real or imagined, facilitating or inhibiting, the clinician has to the patient. Another view emphasized countertransference as a specific set of responses by the clinician to the patient’s transference relationship to her or him (Mills, 2004).

The concepts of projective identification and countertransference enactment describe how object relations theorists and ego psychologists initially emphasized the dyadic view that the patient usually unconsciously sets in motion a communication that then the clinician consciously or unconsciously reacts to either internally or behaviorally.

Countertransference from this lens is thus considered a type of patient communication. As these concepts have evolved, however the quality of the relationship between clinician and patient has shifted to a more complex and mutual understanding of the relationship between patient and clinician.

Projective Identification

Klein initially conceptualized projective identification as an intrapsychic fantasy within the patient. In the 1950s, however, projective identification became linked with countertransference and understood as part of an interpersonal interaction.

Projective identification was initially considered a pathological, primitive defense that was utilized by patients who functioned in paranoid-schizoid position (Spillius, 1993). As the concept of projective identification has been refined, however, that notion has been modified and expanded to include both normal and pathological aspects of a patient's communication (Spillius, 1994) as well as more subtle and complex notions about the way in which the patient and analyst experience each other (Jacobs, 1999. p. 583).

Bion (1970) and later Ogden (1979, 1982) conceptualized projective identification in a manner that is still used in contemporary psychoanalysis. Both writers emphasized the potential therapeutic role of projective identification: Bion focused on the maternal-

child relationship and Odgen applied Bion's ideas to the analyst-patient relationship.

Bion linked projective identification with his container-contained model. He believed,

The infant projectively disavows affect and internal states that are intolerable and thus facilitates their containment by the mother. These feelings are detoxified and metabolized by the mother and reinternalized by the infant, who is able to experience them more fully through means of identification with the mother (Gabbard, 1995, p. 477).

Ogden (1979, 1982) contended that an aspect of the patient's self is projectively disavowed and unconsciously placed in the analyst.

The patient exerts interpersonal pressure that coerces the analyst to experience or unconsciously identify with that which has been projected. The analyst contains the projected contents which then leads to reintroduction by the patient in modified form (Gabbard, 1995, p. 477).

Joseph (1989) expanded projective identification even further. Joseph contended that while the patient "nudges" the analyst to act in the manner the patient unconsciously is seeking to replicate, for that projection to stick in the analyst, there needs to be a corresponding "hook" in the recipient. "The pre-existing nature of intrapsychic defences and conflict, as well as self-object-affect constellation in the internal world of the recipient, will determine whether or not the projection is a good fit with the recipient" (ibid., p. 478).

Joseph's notion of projective identification was very similar to Sandler's notion of role responsiveness in that both describe a role that the analyst was playing that was derived from the patient's intrapsychic world. Sandler, however, clarified that the intense emotional reactions that the analyst experiences can only be considered part of a projective identification if it can be ascribed to the specific role that the patient was unconsciously trying to evoke in the analyst (Gabbard, 1995).

Another dimension of projection identification that has been explored is the idea that the analyst must allow herself or himself to respond to such pressures in an attenuated way so that they become consciously aware of the projected contents and can bring it to bear constructively through interpretation (ibid., p. 477).

Kernberg (1987), Sandler (1987), Spillius (1992), and Eagle (2000) have been critical of a broadened definition of projective identification. They are concerned that including the analyst's responses to the patient's provocative behavior in the definition of projective identification will result in analysts blaming their patients for all their own countertransference difficulties.

Countertransference Enactment

Ego psychologists added "Countertransference enactment to the dialogue on countertransference, although there is a wide variation in how the term is used and a specific definition has not been reached" (Gabbard, 1995 p. 5). Essentially, however, enactments focus on how clinician's feelings in the past are revived in interaction with a patient and how that experience gets actualized with the patient (Roughton, 1993). In other words, there is a behavioral component to a countertransference enactment.

Boesky (1990) has shown that enactments are inevitable in analytic work. The pressure to feel, fantasize, behave in a particular way often lead to at least minimal actions in the clinician. It is through the processing of an enactment that the patient can understand his or her impact on the analyst and how this links back to aspects of the patient's history. Chused (1991) also sees enactments as inevitable, yet she insists that it is important for the analyst to catch themselves in the process of carrying out an

enactment. Through self-analysis, the analyst may be able to gain insight into those communications that the patient evoked in him and try to curtail the behavior before it is damaging to the patient. McLaughlin (1975, 1981, 1988) illustrates the way in which the lives of patient and analyst intertwine and how subtle enactments of aspects of both of their histories influence the analytic process (Jacobs, 1999, p. 31).

Countertransference as a Co-Construction

The contemporary ideas about projective identification and countertransference enactment in conjunction with emergence of intersubjective, relational, constructivist, and postmodern theory have influenced ideas about the analytic process and the analytic situation.

Contemporary views on countertransference challenge the notion that the psychoanalytic method is purely archeological and reconstructive. “The patient’s dynamics and life history do not have an independent reality that can be uncovered or grasped by the outside” (Mitchell, 1993, p. 58). Eagle (2000) contends that the therapist can no longer be a blank screen.

The clinical process is seen as a two-person psychology (Aron, 1990, Spezzano, 1996). It is the product of interaction of two participants inexorably engaged in a relationship.

Gabbard (1995) contends,

While a continuum exists among differing psychoanalytic perspectives that give more weight to the analyst’s contribution on one end and more emphasis to the patient’s contribution on the other, there is agreement within the psychoanalytic field that countertransference is a creation forged out of the interplay of patient and analyst (p. 485).

Bernstein (1999) contends that the acceptance of the clinician's subjectivity has enabled the clinician to be viewed as a human being with feelings fantasies, and thoughts which no longer make it possible to conceive of her or him as the neutral, objective observer.

Levine (1999) argues the patient and clinician are always emitting cues to which each reacts. Each participant will subjectively experience what is mutually encountered with a special slant, one that will be determined in large measure by the internal world that each brings to the encounter.

Countertransference, on the one hand, is considered an "indispensable instrument (Eagle, 2000, p. 26);" a crucial source of information about the patient. It is the clinician's moods, feelings, fantasies, and stray thoughts that provide a route to the patient's issues (Mitchell 1993, p. 61).

Mitchell (1993), Eagle (2000), Bernstein (1999) among others also view countertransference as the personal reactions of the clinician. "There are certain kinds of patients and life stress, and the vicissitudes in the clinician's personal and professional life that increase the probabilities of countertransference response" (Baum, 1977, p. 551).

Mills (2004) adds that countertransference must include the patient's intrapsychic and relational stance toward the inner life of the therapist (and vice versa). These ideas have been raised by Gill (1983) when he considered the patient's view of the analyst's attitude toward the patient; by Hoffman (1983) when he wrote about the patient's interpretation of the analyst's experience; and by Aron (1991) who wrote about the patient's experience of the analyst's subjectivity.

Mills concludes that countertransference cannot be dissected or removed from the intersubjective environment of therapy and exclusively attributed to the clinician because he or she is always embedded in a relational experience (Mills, 2004).

The two subjectivities of patient and clinician will also come together and form their own unique dyadic system. This new field in the treatment process, is what “Beebe, Jaffe, and Lachman (1992) call a “dyadic system of reciprocal mutual influence, what Storolow and Atwood (1992) call the “intersubjective field,” or what Odgen (1994) refers to as “the analytic third” (Mills, 2004, p. 471).

Mills summarizes the intersubjective aspects of countertransference. He states,

Countertransference is an ongoing trajectory of relational exchange that can be seized up and continually altered, revamped, and reincorporated. Countertransference is the coming to presence of a co-constructed reality where no single agency manufactures it alone: it materializes out of the moment-to-moment tensions of broaching psychic union with the other’s subjectivity (p. 477).

While the interaction between clinician and patient is “conceptually parallel,” Levine (1997) contends that their participation is not equal. It is the responsibility of the clinician,

by virtue of training, experience, personal and self-analysis, and so forth to place him or herself as much as possible at the service of the analytic process rather than of personal motivations, such as drive discharge, narcissistic gratification, financial remuneration, professional advancement, and so forth. In this model, the patient remains freer to pursue his or her own (p. 51).

Owen Renik’s (1993) view on countertransference is more radical and controversial. He contends that the analyst’s clinical activity is so bound up in his or her personal psychology that it is an irreducible part of the analytic process (p. 553). As a result, Renik maintains that countertransference is a redundant idea in the sense that the

analyst cannot identify or control his or her subjectivity from impacting the clinical encounter in both subtle and obvious ways (Jacobs 1999).

Hope in the Countertransference

The contemporary literature on hope in the countertransference mirrors the wider discussion on countertransference in the psychoanalytic field. There is the recognition and appreciation that each therapeutic relationship is based on the “unique stamp” of the therapist and patient and how each come together in their own unique way (Tolleson, 2003). Hope in the countertransference has also been explored as the result of contributions from the clinician and to a lesser degree as, usually unconscious, communication from the patient.

Hope as a Countertransference Expression of the Clinician

The vicissitudes of hope in the clinician that get stimulated in the therapeutic relationship are at times the expression of a countertransference reaction that expresses something in the clinician that interferes with the clinician’s functioning. While contemporary psychoanalytic writers frame countertransference, to varying degrees more broadly than Freud did, a few writers have described both those instances when the clinician’s hope is an expression of the clinician’s conflicts as well as what happens when the clinician’s countertransference expressions of hope get played out in the therapeutic relationship.

Boris (1976) frames hope in the countertransference from a classical lens. He recognizes how problematic it is for the therapeutic process when the clinician’s

countertransference expressions of hope can become entangled in the patient's hopes. "The therapist's vicarious hopes for his patients or his need for daily rejuvenation of hopes of his own soon find him doing something other than psychotherapy" (p. 89). He contends that through supervision and analysis the clinician can learn,

to become free of making his patients the object of his desire, his voyeurism, rescue impulses and the like, so in the psychotherapy of hope the therapist must recognize the force and play of what he hopes for, for and from his patients (p. 88).

While Stark's (1999) and Tolleson (2003) conceptualize countertransference totalistically, they also describe different ways that hope as a countertransference reaction in the clinician can be utilized as a defense to manage or ward off feelings that are too intense for him or her. Stark's concept of "relentless hope" describes a defense that can get activated in the clinician (or patient) wherein she or he is unwilling or unable to bear the pain of disappointment (p. 311). There is a refusal to accept that disappointment and limitation exist and thus a refusal to grieve.

When this unresolved issue is present in the clinician and gets activated in the therapeutic relationship, the clinician attempts to become the "perfect therapist" so she or he works hard to compensate for all the ways the patient was failed by the parent in childhood (p. 314). The clinician's infantile hopes related to achieving professional perfection can at times be sustained by the patient; and the patient's infantile hopes related to the belief that all of her or his longings can be satiated by the clinician become sustained by the clinician.

The difficulty with this form of hope, for both clinician and patient, is that it cannot ultimately be maintained. Stark (1999) states,

Much as the therapist might wish to be able to make up the difference to the patient, the therapist will never really be able to compensate the patient entirely for the damage sustained early on—and both patient and therapist will eventually have to grieve this reality. For the therapist to believe that she can, and should, be the good mother the patient never had is to rob the patient the opportunity to confront the grief she harbors deep inside about her actual mother (p. 314).

Tolleson (2003) describes instances when facets of hope in the therapist are the expression of particular countertransference positions to manage or avoid the clinician's personal anxiety. In what Tolleson terms "the benevolent countertransference position" the clinician attempts to manage her anxiety over the emergence of her own or the patient's aggression by taking a passive and, at times, masochistically submissive role and pursuing corrective emotional provisions that allow the clinician to remain good and hopeful.

Defensive benevolence is essentially an effort to avert the arrival of psychic pain in the patient fearing that it will be too difficult for the patient or clinician to manage. Tolleson argues that it is essential to approach the patient with deep respect but not be fearful of his or her anxieties and feelings. "After all, the patient's problems in living often reflect his efforts to avoid-to disavow or obliterate-thoughts, feelings, and memories that are disturbing him" (p. 4).

Tolleson describes another facet of hope in what she terms "the manic countertransference position." In this position, the clinician attempts to manage the anxiety related to a sense of self-doubt and lack of faith in the her or his abilities or in the therapeutic process by adopting the belief that pain is something to "fix" as opposed to something to understand over time (p. 6). Therefore, the clinician becomes active on the patient's behalf,

giving advice, assigning homework, making phone calls, going to court, writings letters, coming up with concrete solutions to the patient's problems, educating the client about his or her problems, having all the answers, all without thinking about what she is doing and why (ibid.).

“Mania in the therapist is common in our profession especially in the early stages of practice before one has acquired faith in the process and faith in oneself as a therapist” (p. 7).

In addition to hope being an expression of the clinician's conflicts or issues, the clinician's countertransference expression of hope can also be “the result of emotional reactions to supervisors, teachers, colleagues, or the community at large that exert influence on the clinician's way of perceiving and working with a patient” (Jacobs, 1999, p. 28). Racker (1968) defined this idea as indirect countertransference.

While the clinician's sense of hope in working with a patient can be internalized from many professional influences, Cooper (2000) addresses one particular example. He contends that the way the psychoanalytic community valorizes psychoanalytic thinking and overestimates the importance of psychoanalysis on human life is an “institutionalized form of pathological hope” that is internalized by many practicing clinicians (p. 221). The goal of psychotherapy and psychoanalysis has shifted from the “removal of conflict to a broadened capacity to observe and work with conflict in an ongoing way” (ibid.).

The outcome of this shift, Cooper argues, is the belief in the psychoanalytic community that more treatment can achieve better and more lasting result. This belief however is not always the case. He argues when the clinicians overidealized views of the possibilities of psychoanalysis enter into the therapeutic relationship, without also

recognizing the limitations, the outcome is often problematic for both the clinician and the patient.

The Clinician's Hope as a Patient Communication

The vicissitudes of hope in the clinician that get stimulated in the therapeutic relationship can also be the expression of a countertransference reaction that expresses usually an unconscious communication from the patient. Historically speaking, understanding countertransference as communication from the patient is an idea that initially emerged within the Kleinian and Object Relations schools. As a result, the analyst's countertransference responses or reactions to a particular patient were seen as useful in gaining more understanding of the patient while at the same time leaving open the possibility that they could also be an interference.

Hope, in particular, as exclusively a countertransference communication from the patient is not a concept that has been discussed in the psychoanalytic literature. Searles (1977), however, does highlight one particular way that hope in the clinician is an expression of a transference communication from the patient.

Searles describes a particular dynamic where the repeated experience of hope followed by disappointment in the clinician, upon exploration, was an indication of a transference communication from the patient. He contends,

The chronically schizophrenic patient derives enormous gratification, sadistic in nature, from watching the recurrently hopeful therapist make eager and vigorous, but increasingly anguished, attempts to rescue the seemingly so-tormented patient from the latter's schizophrenia. By now I have learned that, whenever I am finding the course of work with any patient (whether psychotic or non-psychotic) to prove recurrently and painfully disappointing to me, I am alerted to the

presence of more sadism in the treatment relationship than I had suspected previously (p. 14).

This clinical example highlights the usefulness of looking at hope in the countertransference as a patient communication. Searles was able to learn something about the unconscious of the patient that would be used to inform his work with this patient.

The Clinician's Hope as a Joint Reaction between Clinician and Patient

The contemporary psychoanalytic writers, Mitchell (1993) Cooper (2000) and to a lesser extent Shabad (2001), have explicitly explored how the vicissitudes of hope in the therapeutic dyad are the result of an interplay of a countertransference-transference dance between clinician and patient.

Cooper contends that the clinician and patient serve as objects of hope for the other. The patient endows the clinician with hope and the clinician has hope toward the patient. He states,

Objects of hope are in a powerful position to exert change for better and worse. Because of this potential for aroused wish and need, objects of hope are also often objects of disappointment, destruction, danger, competition, and envy. Our patients, like our children, become the repository for our hopes, and this process is a part of what fuels development, just as this imparting of our hopes and even induction can be highly problematic (p. xiii).

According to Cooper, when treatment begins, the clinician becomes a kind of symbol or icon of psychic possibility or hope for the patient. The patient's hope is that their clinician will help them be able to "bear experience, learn from experience, and to learn how to have new experience" (p. 21). While the patient also has reluctance or disappointment, those feelings are held at bay in the initial phase of treatment, and hope

takes center stage. During the stretches of time where there is a hopeful feeling between clinician and patient, the patient uses interpretations to grow and expand in useful ways.

Mitchell highlights a paradox at the heart of the therapeutic process between the hopes of the patient and the clinician especially at the beginning to treatment. Both the patient and clinician want the patient to have a richer, fuller life; yet the patient and clinician understandings about how this goal is achieved are quite different.

“A patient’s hopes comprise wishes that span development prior to and including the clinical experience” (Cooper, 2000, p. 29). Mitchell contends that these hopes are often based on infantile longings (Friedman, 1988) and/or are “generated from old traumas arrived at to deal with dread, disappointment, despair” (p. 221). Hopes that are comprised of a complex blend of “wishes and needs; hopes fashioned from pain, frustration, longing, laced with restoration, magical transformation, and retribution” (p. 228). The patient’s vision of hope related to feeling better grows out of this place. For example, “the obsessional patient is looking for more effective techniques of control; or the narcissistic patient who is looking to repair a diminishing sense of perfection” (p. 209).

Mitchell also believes that the clinician’s vision of hope for the patient is based on a vision that essentially seeks to dismantle these infantile hopes of the patient. Ideally, the clinician looks to find opportunities for new growth embedded in old hopes, to see the patient’s hope as a dialectical relationship between static and familiar. Yet, the clinician’s hope for the patient is related to expanding the patient’s underlying structure and subjectivity to help the patient to generate a more sustained sense of personal meaning (p.

221). Over time, the clinician holds hope that her or his hopes and the patient's hopes will converge.

Mitchell contends that while the clinician's "hope is embedded in the service he or she offers—a form of treatment, a way of practicing, a set of techniques (p. 207)"—it is also more expansive and personal than that. "Our hopes for our patients are inextricably bound up in our hopes for ourselves" (p. 208).

Mitchell further elaborates, "The more we have explored the complexities of countertransference, the more we have come to realize how personal a stake the analyst inevitably has in the proceedings." The clinician's hopes are "embedded in and entangled with her own sense of herself, her worth, what she can offer, what she has found deeply meaningful in her own life" (ibid.).

As a result, when periods of stalemate or difficulty occur in the therapeutic relationship, the clinician's equilibrium can get distributed. Mitchell contends that "it is a mistake for the clinician to understand these times as only reflecting the experiences of objects within the patient's world or to the patient himself" (p. 213). It is likely that "periods of impasse in analyses are likely to disrupt the analyst's own personal equilibrium, awakening the analyst's own dreads, and challenging the analyst's hopes not only for the patient but for himself as well" (p. 214).

To complicate matters further, the emergence of dread and despair in the patient can result in the patient attacking the clinician's capacity to understand. Mitchell argues that this attack deprives the clinician of the comfort and faith that enables her or him to work. "Understanding does not provide solace for among other things, real loss, grief over lost opportunities, irreconcilable conflicts, and, ultimately, death. To be confronted

with the limitations of that understanding, our helplessness in the face of some of the deepest sources of human suffering is a cause for dread indeed” (p. 214).

Shabbad (2001) believes that the clinician must struggle with his or her countertransference reactions to understand his or her own despair, dread, disillusionment as well as the specific defenses that have been resurrected to defend against a repeat of more pain. Many of the clinician’s disappointments and disillusionments can be traced back to despair and helplessness that emerged in his or her childhood.

Shabbad contends while work can be done to understand and resolve these countertransference reactions, “the core of helplessness that lies at the basis of the clinician’s understanding of personal interaction, professional ideology, conceptualization of human nature will probably never be resolved entirely” (p. 247). At the same time, how the clinician has “come to terms with her or his personal disillusionments has major implications for her of his theory of cure and the methods used to affect that cure” (p. 263).

Mitchell argues that it the clinician’s therapeutic task is to survive the patient’s dread and despair without withdrawing while at the same time working through this internal crisis of dread and despair. If this occurs, the tensions and reconciliations of hope and dread become the mediums from which essential change takes place (p. 46).

“Sometimes hope for the right thing can be reached only through immersion in prolonged and harrowing dread” (p. 59). By finding again and redefining his or her own realistic sense of hope, the clinician “is more able to find a voice in which to speak to the patient that is different from the voices of the patient’s past, offering their perpetually enticing and perpetually disappointing false promises” (p. 214).

The Clinician's Development

Several psychoanalytic writers have described how hope traverses a certain developmental trajectory as the clinician moves from being a beginning clinician to becoming more seasoned. It is a process that ultimately leads to the transformation of hope and ideally to the greater acceptance of the possibilities and limitations that exist in the psychotherapeutic process.

The following section will address the developmental trajectory of hope in the clinician. It describes the history of Freud's expectations of psychoanalysis, from initial optimism to a later more limited view of what it can achieve. It illustrates how more contemporary theorists conceptualize this developmental trajectory. Lastly, it also outlines the tools that the clinician uses to regulate hope and the skills the mature clinician can acquire throughout development.

Freud's Developmental Trajectory of Hope

Freud's theoretical writing that spanned much of his adult life details how his thinking and expectations evolved and changed over the course of his professional experience and his life experience.

When Freud first began writing about psychoanalysis, he summed up his attitude about the possibilities of psychoanalytic work. He stated that "much will be gained" by

the process of psychoanalysis “if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health, you will be better armed against that unhappiness” (Freud, 1895, p. 305).

In Freud’s early works, such as *The Interpretation of Dreams* (1899) and *Studies in Hysteria* (1893), there is a sense of excitement about what Freud is discovering. Freud has an implicit sense of hope about the possibility of psychoanalysis.

This feeling is encapsulated in *Katharina, Case Histories from Studies on Hysteria* (1893). Upon taking a vacation in the mountains Freud meets a young girl, Katharina, who shares with him what ails her. Freud essentially uses his analytic understanding to interpret her symptoms and cures her. In discussing his understanding of what happened he states, “The anxiety from which Katharina suffered in her attacks was a hysterical one; that is it was a reproduction of the anxiety which had appeared in connection with each of the sexual traumas. I shall not here comment on the fact which I have found regularly present in a very large number of cases-namely that mere suspicion of sexual relations calls up the affect of anxiety in virginal individuals” (p. 134).

As Freud’s career progresses, his sense of possibility about all the psychoanalysis can do is tempered. In his paper, *On Narcissism*, Freud begins to recognize the limits of psychoanalysis and the complications of psychological development and unconscious wishes and fantasies. Freud contends that some patients, whom he diagnoses as having dementia praecox or schizophrenia, are not treatable. “Patients of this kind, whom I proposed to term paraphrenics, display two fundamental characteristics: megalomania and diversion of their interest from the external world-from people and things. In

consequence of the latter change, they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts” (p. 74).

At the end of his life, Freud struggled both the limitations of psychoanalysis and the impact of psychoanalysis on the well-being of the analyst in his paper *Analysis Terminable and Interminable* (1937). Freud’s views were also affected by his life circumstances. Vienna was threatened by Nazis, World War II loomed, the psychoanalytic community was somewhat fractured, and his relationship with Ferenczi was very strained because of psychoanalytic politics and, as well as Ferenczi’s illness and imminent death.

In his paper, Freud outlined the many ways that psychoanalysis is either not helpful or its cure is not permanent. At one point, in reference to describing the alteration of the ego through psychoanalysis, he states, “we have an impression, not of having worked in clay, but having written on water. In the words of the proverb: “Soon got, soon gone” (p. 241).

Freud’s describes the ways that analysis can be detrimental to the analyst’s well-being over time. He contends that the “constant preoccupation with all the repressed material which struggles for freedom in the human mind were to stir up in the analyst as well all the instinctual demands which he is otherwise able to keep under suppression threatens the competency and well-being of the analyst especially if he practices psychoanalysis over many years” (p. 249). It is for this reason that Freud believed analysis to be “the third of those ‘impossible’ professions in which one can be sure beforehand of achieving unsatisfying results” (p. 248).

The Developmental Trajectory of the Beginning Clinician

Menninger (1987), Kepinski (1981), and Searles (1977) have explicitly described a developmental learning curve in the beginning clinician from a more contemporary perspective. The beginning clinician brings a certain attitude and sense of expectation that is not yet tempered by experience. This “therapeutic zeal” propels the young clinician to apply all that she or he learned in training to his or her patients.

The young clinician practices what Menninger (1987) calls “furor therapeutics” (p. 448). In an effort to be effective, in a new kind of relationship with patients, the young clinician “often goes too far and presumes, expects, or promises too much” (ibid.). The clinician believes she or he can help anyone and everyone and she or he is incredibly invested and devoted to all patients. Each patient’s struggles and issues are scrupulously felt, analyzed and pondered.

At the same time, the beginning clinician is prone to experience a wide spectrum of voices from “fearful insecurity to bold over-self-confidence” (Menninger, 1987, p. 448). These voices can fluctuate quickly and extremely, especially since the new clinician does not have a reservoir of experience to ground their professional sense of self.

“The enthusiasm of inexperience only awaits the disillusionment of time” (Menninger, 1987, p. 448). Kepinski (1981) describes the cycle of hope followed by disappointment in the beginning clinician.

At the beginning one literally pounces upon the first patients and filled with ambition and the wisdom of the book-learning expects to penetrate their innermost affects, to fathom the furthest reaches of their souls, to even cure and redirect their distorted life-lines. Soon deep disappointment enters. Somehow everything is other than according to the texts. There everything was simple and clear; here on the other hand everything is changing, in flux, and foggy. The key that appeared during the lecture like a passer partout will not fit. One tries other

keys, looks for other personality theories and concepts of psychopathology. The new keys are just as worthless. One loses faith both in any proffered key to the human psyche and in one's own therapeutic ability. Listlessness overtakes us. The only comfort and stimulus to further investigation is the circumstance that at times the patient's condition improves—and we are not even clear as to why (p. 392).

The supports that were in place during training that provided clear recognizable goals and guidance many no longer be in place for the beginning clinician, which can also potentially exacerbate feelings of disappointment and/or despair. The clinician is now expected to know what they need to learn and how to obtain whatever input is necessary (Buechler, 1995).

The young clinician is also trying to figure out their professional standing within the psychoanalytic community. When difficult clinical situations arise, the young clinician may be tempted to “cover up” vulnerabilities within the community in which they are trying to gain acceptance to avoid shame from self-exposure (ibid., p. 71).

Capacities to Regulate Hope

Several psychoanalytic writers describe a number of different capacities that can be helpful for the clinician to help regulate hope throughout the process of development. These capacities include finding a psychoanalytic theory that is meaningful, engaging in psychotherapy or psychoanalysis, identifying with a supervisor, and expanding the capacity to hear painful material.

Psychoanalytic theory is one of the ways that clinicians regulate hope. Cooper (2000) contends that clinicians gravitate toward theories that are helpful and meaningful” (p. 36). Theory helps to structure the clinician's observations of clients and to understand

the transference potential (Schechter, 1999). Theory can also provide a “holding environment for clinicians to contain hopelessness and uncertainty and the inherent vagaries and ambiguity of clinical work” (Adler, 1989, p. 81).

Personal therapy is another capacity that can help the clinician regulate hope. “Personal reflection helps the clinician set transference reactions aside and respond to the needs of clients” (Schechter, 1999, p. 382). Psychotherapy and psychoanalysis can also help the clinician find meaning in work and life. Freud (1937) recognized the necessity of the analyst being in analysis to help maintain their well-being. Symington (1996) adds, “the development of the clinician’s emotional capacities is clearly central to being a psychotherapist, and without it all intellectual striving to master concepts becomes a hollow endeavor” (ibid., p. 11).

Another capacity to help regulate the clinician’s hope is identification with a supervisor or consultant. Schechter (1999) argues that identification with a supervisor can result in a certain “adaptive grandiosity,” which enables the clinician to have a strong positive view of her own potential to be effective (p. 381). This identification can become a symbol of hope for the clinician and help fight feelings of hopelessness that could emerge in the treatment setting.

The tolerance for psychic pain and despair of others is another capacity that will help the clinician regulate hope. Schechter (1999) states, “The tolerance for psychic pain is an important aspect of the empathic-self that can expand in the course of training and experience. With that expansion comes greater therapeutic fortitude and a capacity to work with intense personal conflict, or tragedy, from a position of hope” (p. 373).

Mature Hope

Over time, the clinician will ideally go through a maturational process which involves the transformation of unrealistic, infantile hope into a more realistic, mature hope (Searles, 1977). This process entails “confronting certain intolerable painful realities head on and discovering that one survives the experience” (Stark, 2002, p. 286).

Searles (1977) argues, “Developing a mature sense of hope, whether you are a patient or a clinician, is one of the ‘harshes’ maturational tasks of becoming an adult. It entails realizing and accepting that hope is ‘impure’ in two vast ways: first, it is not unitary in nature but multifarious and permeated with ambivalence, with conflict (such that no one hope or set of hopes is completely fulfillable, for it is opposed by powerful contrasting hopes), and secondly, many of these hopes are devoted not to living, but rather to destructive ends” (p. 9). Exploring our sense of hope essentially means questioning “one of our most tenaciously clung-to refuges for our repressed fantasies of omnipotence” (ibid.).

The clinician can experience progressively intense feelings of disappointment, “discouragement, despair, grief, and infantile-omnipotence-based frustration-rage as they face the mutually irreconcilable experience of hope and begins to relinquish their unconscious fantasies of omnipotence” (p. 27).

The ideal outcome of this grief process can be the emergence of a more modest or realistic sense of hope. Stark (2002) describes this process in the patient. Stark contends by facing disappointment, discouragement and despair and surviving it, the patient is able to find her or his way to a healthy capacity for hopes based on realistic aspirations, not inappropriate, unattainable and unrealistic hopes.

“The mature hope that results from the experience of mastering disillusionment has to do with attaining something that is realizable” (p. 286). Stark adds, “As the patient discovers he or she survives confrontations with reality, the defenses to which she or he has clung since earliest childhood in order not to feel the pain of her or his knowing those truths become ever less necessary” (ibid.).

The maturing clinician has the potential to develop skills that will help them regulate hope. The attainment of these skills will, ideally, reflect a more realistic view of the possibilities and limits of the therapeutic process, so the clinician is better able to deal with the fluctuations of hope within themselves when they inevitably occur.

The clinician, who has a mature sense of hope, stops striving to “cure” his or her patient (Kepinski, 1981, p. 392). Instead, the clinician practices with a therapeutic modesty hoping at least to ameliorate his or her patient’s suffering a little and to be satisfied with a fragmentary understanding of personality structure. The clinician uses theories to give a frame of reference in the process of exploration rather than as universal truths in understanding of psychic illness (ibid.). The clinician practices with a certain amount of clinical flexibility, ready to revise and change the treatment strategy if the one in place is not working (Schechter, 1999). The clinician appreciates every patient as unique with surprises, which will unfold with time. “The clinician will reject the role of the ‘all powerful therapist’ and fight for a more democratic relationship, which the patient will fight against especially in the beginning” (Kepinski, 1981, p. 392).

The clinician who holds onto a mature sense of hope will strive to recognize her or his professional limitations. They will understand that no clinician can successfully work with every patient equally well; nor can a clinician be equally effective with all

types of empathy and situations (Schafer, 1979). The mature clinician will have experienced some professional success to be able to understand it is not about skill but rather about “goodness of fit.”

The clinician with a more mature sense of hope can provide clearer boundaries of the therapeutic relationship. The clinician understands that the patient is ultimately in charge of making changes to their life and change cannot be “coerced out of the patient in conformity to some omnipotence-based ego-ideal based on the analyst’s narcissism” (Searles, 1977, p. 17).

The clinician with a mature sense of hope recognizes the necessity of receiving professional support, either from a supervisor or consultant and/or being part of a professional community, to counteract feelings of disappointment and despair when they emerge.

Hope comes into being when one discovers that such feelings as disappointment and despair can be shared with a fellow human being—when one discovers, that is, that the sharing of such feelings can foster one’s feeling of relatedness with one’s fellow human beings, rather than stigmatizing one as something less than human, something alien and unqualified to be included among human beings (Searles, 1977, p. 13).

Attaining mature hope is an ongoing maturational process, which is never finally completed (ibid.). “It is a route traversed by every therapist, not only in the beginning of her or his professional career, but in terms of “the evolution of his or her own personal feelings in relation to each of the patients with whom the clinician becomes deeply and sustainedly involved” (ibid.).

Conclusion

Psychotherapy is an,

endless exercise in paradox. To realize that we have at least been a factor in bettering lives and perhaps releasing creativity and joy where none existed before can provide great satisfaction, privilege and hope for the clinician. At the same time, the clinical endeavor is emotionally intense, demanding high degrees of affective awareness and control, empathy and tolerance for the uncertainty (A.M. Cooper, 1986, p. 576).

The clinician must strive to maintain a balance of the right amount of hope in the therapeutic endeavor, yet begin to understand that achieving that goal is often fleeting. “It is wise to be aware of how easily we can become de-skilled and of how difficult it is for us to maintain an optimal balance of hope as clinicians” (ibid.).

While the concept of hope in the clinician is central to the therapeutic process, this literature review has shown how rarely this idea has been written about in the psychoanalytic literature. The emphasis in contemporary psychoanalytic theory on the therapeutic dyad, and specifically the clinician’s experience, paved the way for Mitchell (1993), Cooper (2000), Searles (1977), Menninger (1987), Schechter (1999) and a few others to begin to describe this experience in the clinician. The central ideas described in this literature review are as follows:

- The narrative of hope is a theme throughout history.
- The vicissitudes of hope is a narrative thread that is part of life as well as the therapeutic relationship.

- Fluctuations of hope in the clinician are a normal part of the therapeutic relationship.
- Hope is in the fabric of the therapeutic quest of the therapeutic dyad. It is a narrative thread that combines the patient's experience of hope in the past, present and future with clinician's experience of hope in the past, present and future.
- Hope can be part of a countertransference reaction in the clinician. It can be understood as stemming from the clinician's history, a transference communication from the patient, or as an interaction between clinician and patient.
- Hope evolves and changes as the clinician matures and comes to accept the possibilities and limitations of psychotherapy through certain experiences and forms of learning.
- There are tools that the clinician can use to help to regulate hope throughout the developmental process. These include: using theory, attending therapy, and identifying with a supervisor.
- The transformation of hope that occurs through the process of maturation results in acquisition skills that better arm the clinician to deal with the fluctuations of hope.

These ideas presented in the literature review are embedded in a psychoanalytic tradition that has a theory and methodology to deal with emotional states, hope included, and this implicit hope pervades the theorizing and practice.

CHAPTER III

METHODOLOGY

Type of Study and Design

This qualitative study examined the vicissitudes of hope in the lives of psychoanalytic clinicians over the course of their careers. As was previously mentioned, I expanded the definition of hope to represent derivatives of this state that have been used in the psychoanalytic literature. The derivatives of hope refer to faith, hopefulness, confidence, and/or good feeling, loss of hope, hopelessness, disappointment, dread, despair, and/or loss of faith.

The focus of this study was to capture the dimensions and complexities that comprised the vicissitudes of hope in the clinician and how they change over time. The case study methodology was utilized as research tool as it provides an in-depth exploration of a limited number of issues pertaining to the person and his or her circumstances (Runyan, 1982).

The case study inquiry is driven by prior development of theoretical proposition and is especially appropriate when there are many variables of interest (Yin, 2009, p. 18). As a result of a thorough review of the psychoanalytic literature on hope in conjunction with my own self-exploration, specific units of analysis such as personal history, personal life, years in practice, countertransference, professional identity and theoretical lens emerged as relevant variables.

The data collected was subjective, based on the narrative account of each participant in conjunction with my interpretations of these experiences, which included looking at manifest and latent content. The data was analyzed using the within-case and across case analysis (Yin, 2009) as well as psychoanalytic interpretative analysis (Tolleson, 1996). These methods of analyses are described in greater detail in the data analysis section.

While the case study inquiry was the methodology used for the study, the philosophical underpinnings of the study were guided by hermeneutic principles which appreciate the uniqueness of lived experiences, look for the meanings embedded in situations, and recognize that all data is interpretative and meaningfully experienced (Van Manen, 1990). The participants' reflections of their experiences in combination with my interpretations of these experiences added to a rich tapestry of ideas that were meaningfully captured.

This study resulted in an in-depth description of the clinician's evolving narrative that illuminates the vicissitudes of hope for the participants interviewed. It also helped to build a more comprehensive theory as a result of looking at the themes and patterns that emerged across cases. The reader should interpret the material as it resonates with him or her to increase self-understanding. The study will also help expand scholarly knowledge of the clinician's evolving narrative of hope.

Scope of Study

The case study methodology favors depth over breadth (Tolleson, 1996). Therefore, I interviewed five subjects 3-4 times. Each interview lasted between 60-90

minutes. Given that the intention of the study was to capture complex phenomena, the rationale for such intensive interviewing was as follows: it was expected that the more time the subjects spent with me would enhance familiarity and comfort with me and allow for more in depth interviews; I hoped to glean a view of my,

subjects which would neither be reductionistic nor simply bound by verbal discourse, but which would incorporate the complexity of their psychological experience as manifested in an array of communicative modalities, e.g. language, nonverbal behavior, and interactions with the examiner; and lastly, it was believed that multiple interviews would enhance the strength and validity of the researcher's resulting interpretations (Tolleson, 1996, p. 91).

The screening process entailed sending out letters, emails, and/or having phone contact, with psychodynamic clinicians that I knew to describe the study. I specified that I was looking for seasoned psychoanalytic clinicians, who were unknown to me, to volunteer to be interviewed for my study. I asked colleagues to distribute flyers (See Appendix A) to clinical social workers, psychologists, and/or psychiatrists who were seasoned psychoanalytic clinicians.

The potential participants who were interested in volunteering in the study indicated their interest either by leaving me a voicemail or an email. I contacted those interested and conducted a screening interview over the phone to make sure that the participants fit the criteria for the study and understood the requirements of participation.

All participants were considered for inclusion in the study if they met the following criteria:

- Currently practicing psychodynamic psychotherapy
- Practiced psychodynamic psychotherapy for approximately 20 years
- Currently in a psychodynamic psychotherapy or psychoanalysis and/or have completed an in-depth psychodynamic psychotherapy or psychoanalysis

- Currently receiving or has received Post-Master's clinical training via a program and/or ongoing consultation
- Clinicians were clinical social workers, psychologists, or psychiatrists
- Clinicians resided within the Chicago area

Since the capacity for self-reflection in the participant's work is central in the collection of data for this study, participants were also asked about their self-awareness, and I used my own subjective reactions, to gauge the participants "goodness of fit" for the study. Candidates were not discriminated against based on racial, ethnic, or socioeconomic group.

I also informed the participants' that privacy will be protected by use of methods that will ensure their confidentiality. Only first names will be used in the interview. The names of participant and all others mentioned in the interview will be changed to provide additional privacy. All information will be disguised. During the compilation, analysis and presentation of findings, each participant's name will be camouflaged using a fake name to help with privacy.

While I used the aforementioned strategies to disguise any identifying information, I also informed the potential participants that there may be a chance that given the small size of the psychoanalytic community in Chicago, participants may be recognized when the dissertation becomes available to the professional community. Potential participants will have to make an informed decision as to whether engaging in this research is a risk worth taking in the service of providing a professional contribution to the field.

Data Collection Methods and Instruments

Once participants were selected for the study, they were interviewed in a confidential location of their choice. All of the participants were interviewed in their office, and one of the interviews for one participant was conducted in my office. All clinicians were interviewed face-to face as nonverbal communication adds to the depth of the interview.

I used a combination of three to four semi-structured and open-ended interviews lasting approximately 60 to 90 minutes to collect data from the participants. Each interview was audio taped and professionally transcribed.

The initial interview began me giving a brief introduction to the study. I asked the participants to sign a consent form (Appendix B). I then asked some preliminary questions about the participant's professional work which included the participant's education, training, the type of work they do, and their caseload, which includes population, longevity of cases, and the per week frequency range.

The remaining interviews were all open-ended and flowed more like conversations. The participants followed their own narrative threads regarding the topic area describing those areas that were most salient to the participants. During the data collection phase, I aimed to be as flexible as possible to collect the most relevant data. (Yin, 2009, p. 90). I often responded with clarifying questions to elicit more detail or asked related questions that arose in my mind from what they were saying to keep the process flowing so it is organic and self-perpetuating (Tolleson, personal conversation).

There were some broad topic areas that were in my mind during the interview process that were related to three topic areas: 1) those factors which may affect the

vicissitudes of hope in the clinician such as personal history, personal life, countertransference, professional identity, theoretical lens; 2) how hopes have evolved and changed over the clinician's career; and, 3) those times when a particular experience of hope can be contained in one or a few areas of professional life and those times when it becomes the over-riding experience. I did my best, however, to remain open to the participants own process rather than being guided by these topic areas.

I took field notes after the end of each interview and reviewed my notes prior to the start of the subsequent interview. Reviewing the notes helped me prepare for subsequent interviews in three ways:

1. It helped me to see themes and patterns in the emerging data that might need to be addressed in greater detail;
2. it assisted me in identifying issues that needed clarification; and
3. it helped to amplify research transferences and conceptual biases in order to identify their influence as much as possible. (Servatius, 2010, p. 75).

I also began each subsequent interview by inquiring about the participant's thoughts and feelings regarding previous interviews. "Often interviewees, having had time to reflect on the interview, recall particular details, or begin to experience differently what they had spoken about in the previous interview" (Cartwright, 2004, p. 222).

Throughout the interview process, I took note of the nonverbal material that was expressed by the participant as well as impressions, observations, and reactions made by me both during the interview process and following each interview (Yin, 2009). I was attuned to both manifest and latent content, which added depth to the verbal material

obtained. This method of clinical interviewing is similar to the psychoanalytic method of inquiry of which I am very familiar.

Data Analysis

The purpose of the data analysis is explanation building, making theoretical statements about behavior and process (Yin, 2009). The researcher applied the psychoanalytic interpretive analysis (Tolleson, 1996) and a hermeneutic perspective to within-case and cross-case case study analysis.

Psychoanalytic Interpretative Analysis

The researcher analyzed the interviews and field notes utilizing psychoanalytic interpretive analysis, a technique developed by Tolleson (1996). This technique looks at the manifest and latent content of the data of each participant, and observations and reflections by the researcher, using a combination of free association and the interpretation of motivation and content.

Within-Case and Cross Case Analysis

The within-case and cross-case analyses, which are the most widely used forms of analysis in the case study inquiry, were also used in this study. Utilizing both forms of analysis enabled me both to appreciate the uniqueness of the vicissitudes of hope in each participant as well as develop a more comprehensive theoretical understanding of /the experience of hope in the clinicians studied.

The within-case analysis occurred at the level of each individual case since the depth of the psychological world in relation to the clinician's hope has been so rarely studied. Using the psychoanalytic interpretative analysis, each case was examined in its entirety to assess the unique, distinctive, and compelling elements that are specific to each participant.

I analyzed the data for “various categories of meaning based on the words and behaviors of subjects as well as the researchers own inferences and observations derived from her experience of the subject and her own clinical and theoretical knowledge” (Tolleson, 1996, p. 93). The transcribed interviews will be coded according to these initial categories.

Each case study report delineates the psychological processes related to the vicissitudes of hope in each participant and how these processes change over time as well as which categories are most salient to each participant.

After examining the data of each individual case, I looked at the themes that emerged in the entire sample of participants interviewed using a cross-case analysis. The researcher categorized the themes and offered some comparative analysis for these connections looking at the significant data themes.

This data was then examined in relation to the psychoanalytic literature that describes the vicissitudes of hope in the clinician. Rival explanations or alternative explanations will also be considered as the researcher is analyzing the data (Runyan, 1982).

Hermeneutic Perspective

I also examined the data using a hermeneutic lens, which emphasizes the understanding of subjective meanings (Craighead and Nemeroff, 2001). I interpreted the data from a hermeneutic perspective, which regards “reality as knowable through different possible understandings that are partially constructed by the knower” (Black and Mitchell, 1995, p. 227). While the “knower” in this study is the participant, I also provided my own interpretations of the data, which emerged as a result of being attuned to manifest and latent content of both the participant and myself. To ensure interpretations are coherent, comprehensive, and capture the complexities and experience of the participant, I had each participant review the findings of their material. I also discussed my interpretations and potential biases with the researcher’s dissertation chairperson and/or committee members. The researcher strove to achieve a hermeneutic vision by presenting the data in a rich, complex, and aesthetically appealing manner that ultimately gives the reader a more valued understanding of this particular human experience (Craighead and Nemeroff, 2001).

The information gathered from this data analysis was synthesized together and is presented in the findings section of the research study. This summary of findings provide the reader with a detailed view into the unique and special nature of the vicissitudes of hope of each clinician. In the discussion section, I will contribute to building a more richly detailed and comprehensive theory related to the collective themes that are experienced by all of the clinicians in the study (Yin, 2009). The reader will then be able to both use the findings that most resonate with their experiences as well as build a more

comprehensive scholarly understanding of the evolving and complex nature that encapsulates the vicissitudes of hope in the clinician.

Statement on Protecting the Rights of Human Subjects

In order to ensure that participants' rights are protected, I worked in close contact with my Dissertation Advisor to ensure that I adhere to the IRB protocol. Before agreeing to participate in the study, all participants signed a consent form indicating both her or his willingness to participate in the study and understanding of the project. The informed consent outlined the following information (Appendix B):

1. The purpose of the study
2. The researcher's name and her credentials
3. The names of the researcher's dissertation committee
4. Participant's agreement to complete three to four 60-90 minute in-person interviews
5. The benefits of participation in the study: increased self-understanding and scholarly contribution to the knowledge concerning clinician's hope and disappointment
6. No costs will be incurred by the participants.
7. Risks of participation: limited. The clinician's studied will be experienced clinicians who have strong professional identities and have much experience, via their own treatment or clinical training, reflecting on and talking about their subjective experiences. If risks do emerge, they will occur in the psychological realm. Talking about disappointment,

hopelessness, and dread, in particular, may trigger underlying Post Traumatic Stress and/or depression in the clinician. Additionally, the participants may feel more exposed professionally, especially as participants imagine that their interviews will be published in a document, which could be seen by colleagues. Should a participant feel vulnerable during or following the interview process, the researcher will refer the participant to another colleague for de-briefing.

8. The participant will have the right to withdraw from the study at any time.
9. Confidentiality will be upheld in the following ways:
 - The interviews will be held in a private location;
 - confidentiality will be provided during the interviews;
 - names and other identifying information will be disguised;
 - each transcriber will have to sign a confidentiality agreement (Appendix C);
 - all transcribed tapes and data will be identified fictitious name and will be kept in a locked cabinet where only me and my advisor have access to them for 5 years.

CHAPTER IV

FINDINGS

Sample Profile

In order to maintain the confidentiality of the participants, I changed their names as well as other identifying information and characteristics. The participants interviewed met the criteria for participation. All participants were self-identified psychoanalytic clinicians who had been practicing psychodynamic psychotherapy or psychoanalysis for a minimum of almost 20 years. At the time of the interviews, three participants were in full time private practice, one participant split his time between working as a clinician at an agency and his private practice, and one participant was ending an administrative position and part time agency clinical practice to join that agency as a full time clinician. Two of the subjects identified as clinical social workers, two identified as psychologists and one was at the end stage of analytic training and did not identify as either. Three of the participants were women and two were men. Four of the participants had concluded an in depth long term psychotherapy and one participant completed an analysis. All of the participants had received on-going clinical training via consultation groups and individual consultation or supervision for much if not all of their professional lives. All participants lived in the Chicago area.

Responses to the Researcher

All the participants expressed interest in the topic. They were interested in providing me with material that would be useful as I tried to understand to a greater degree the vicissitudes of hope in the clinician. During the interview phase of this process, each participant varied in the comfort with revealing personal information outside the clinical realm, which I will describe in greater detail in each case study. The way I handled any reluctance was by respecting the boundaries of each participant so not pushing beyond their own comfort level.

When I sent the case write-ups to each participant for review, each felt comfortable with my presentation of the themes that emerged over the course of our interviews. In fact, all were complimentary as to how I really seemed to capture the essence of what they were saying in a sensitive way. One participant, however, also expressed a feeling vulnerable about being more open with me than she had intended, but said that I should not change her write-up.

I felt very sensitive about the fact that each participant was going to read their case studies when I was writing them up. While I feel that I addressed both the themes and my reactions to the themes of the participants in a manner that was reflective of my experience, I would also say I struggled with feeling more inhibited than I otherwise might have had they not been reading their case studies.

Within-Case Analysis

The findings of all five psychoanalytic case studies will be presented in this section. The data for each subject is organized in the following ways: Clinical Training

and Professional Development, Organizing Principles, Interview Reactions, and Significant Childhood (and, when relevant, Life Experience). The last section for all participants is the Categories of Meaning Section. This section will be comprised of several sub-categories, which will vary depending on what themes were most relevant to each. While there may be some similarities between sub-categories across subjects, I employed labels for each sub-category that were generated, when possible, by the subjects themselves in an attempt to capture the idiosyncratic nature of each subject's experience of hope.

Natalie: Clinician 1

Clinical Training and Professional Development

Natalie is a psychodynamic psychologist in her 50s who has been in private practice for over 20 years. She works exclusively with adults in long term in-depth psychotherapy, seeing patients from once a week to multiple times a week for several years.

Since beginning in private practice, Natalie's involvement within her professional community has been a priority. Natalie began her private practice when her children were young, however, so her involvement in a professional community was more limited. She joined a peer supervision group and also met with colleagues and friends a few times a month to discuss their work.

As her children got older, Natalie's involvement in her community has increased. She has continued her involvement in peer supervision group and meeting with colleagues, but also joined a consultation group that reads articles together and presents cases, and she has a leadership role in a professional organization. She has also been in psychotherapy on and off over the course of being in private practice, and receives one-on-one consultation.

Natalie believes that her ability to sustain a baseline of hope in her work over many years in practice is the result of maintaining professional and personal relationships outside her private practice. She observed,

The relationships outside—I mean my husband, my friends, and a group of colleagues that know me and know how I work—we use each other a lot to get through rough spots and keep our heads in the game. I think it would be impossible to do this work without outside relationships.

These relationships provide Natalie with a safe place to look at the full spectrum of what is happening with patients. Natalie also feels that these colleagues, friends and husband have faith in her ability, which is sustaining especially in those moments when she doubts herself. “Knowing that somebody believes in you, whether you succeed or fail or whatever. To know that they have hope in me is hugely sustaining.”

The reciprocity involved in sharing with colleagues also helps sustain Natalie's sense of hope in her work. It is a good feeling to be able to help a colleague who is having difficulty. It is also normalizing to realize that everyone gets into difficult spots. These experiences help Natalie remember that she is not alone but all psychotherapists have these experiences.

Natalie also sought out more formal professional learning opportunities to keep psychoanalytic theory “alive” for her especially when she began experiencing fluctuations in hope in her work.

When I would feel isolated or unsure of what I was doing, I always sought out other people who were doing what I was doing or doing it better than I was doing or more than I was doing, just to be in the room and hear what they were saying. I would try to go to conferences and seminars.

Natalie became involved in a professional organization to be part of a professional community and to help buffer her against the negative psychoanalytic messages that are prevalent in today’s culture. As Natalie’s involvement within this organization became more pronounced, and she has taken more of a leadership role, Natalie’s sense of hope is expanded by helping to “feed the community.” “By helping the generation grow, we are sustaining ourselves which gives me hope for the future of our profession and the way we practice it.”

Organizing Principles

“It’s all about the relationship.” Natalie believes in the power of the therapeutic relationship. It is within the safety of this relationship that patients can experience the profoundness of human connection. The therapeutic relationship allows patients to have the experience of attending to what is happening inside them while in the presence of an interested, curious, and attuned other. This process allows patients to experience the transformative nature of deep relationships in creating meaning, healing, and purpose in their lives.

Natalie believes that patients are always better off facing what is inside them rather than denying or avoiding what they are experiencing. “I always encourage my patients to face whatever is inside them, because I know that’s going to be better than if they don’t.”

As difficult as it can be to face what is inside, it allows for healing and the development of unanticipated possibility. When patients are able to face what is inside in the context of a therapeutic relationship, it can help them not feel so alone while they also come to understand themselves.

When Natalie first began in private practice, she was much more focused on the therapeutic outcomes of her patients. As Natalie has gained more experience, however, this belief has shifted. Natalie focuses on the small internal shifts in patients. She recognizes that these small changes are cumulative; they often grow into big changes.

Interview Reactions

I quickly developed a positive transference to Natalie. Her informal and casual use of language put me at ease when I initially spoke to her on the phone to do a pre-screening interview. She used phrases like “That’s great” and “That’s cool,” when we were figuring out the logistics of meeting face-to-face.

Upon meeting for the first time, the ease that I felt on the phone deepened. Natalie was open and engaging. Our interviews were easy and free flowing conversations that were free associative in nature. My anxiety as a new researcher was nonexistent.

Natalie described her patients with a depth, emotional investment, and sensitivity that made me feel that she was both a competent and accessible therapist. Her emotional accessibility also enabled me to connect on an emotional level to the material.

My most profound experience of Natalie was that she truly did possess a grounded sense of hope. It was mature and authentic, grounded in the experiences she had in her personal and professional life over time, and not compromised of many facets to defend against the emergence of intolerable affective states. While Natalie did experience fluctuations in her sense of hope, she always found her way back to a hopeful baseline.

Natalie's sense of hope was contagious. I found that my sense of hope over the course of these interviews was grounded. I felt hopeful in Natalie's capacity to be a therapist, hopeful about the connection that Natalie and I were able to establish over the course of the interviews, and hopeful that the maturational process in therapists could produce a grounded sense of hope. I also carried in me the hope that as I continued to mature as a clinician that I might be able to sustain a mature sense of hope as Natalie has.

When the interviews with Natalie came to an end, I felt a bit sad. The sadness for me is part and parcel of what I often experience when patients end their therapy especially after a mutually meaningful experience. I felt privileged that Natalie felt comfortable enough with me to be so open and accessible. I also really enjoyed the depth of connection that I established with Natalie especially in such a short time, and I will miss that continued opportunity.

Significant Childhood Experiences

Natalie's sense of hope in her work is effected by being in therapeutic relationships that are both growth producing and emotionally rich. Natalie's described two pivotal relational experiences in childhood that facilitated the connection between the quality and depth of her relationships to her sense of hope.

This first relational experience began to take shape when Natalie was 7 and her youngest sister was born with significant neurological, emotional, and physical impairment. While Natalie's parents tried to prepare her and her three siblings for the birth of her sister, she recalls, "At 7 I am not sure I understood those words, but we all knew something was wrong."

Natalie wrestled with hoping and wishing her sister could reach the normal milestones of childhood. Natalie recalled, "From the moment she was born, I was hoping to teach her everything which for her meant to teach her how to talk, to teach her how to walk. I was always hoping to make her into somebody normal."

Yet, Natalie was repeatedly faced with the painful reality that her sister was not like other children. She could not read. She also "didn't know how to play, which I look back now and think well that was really the biggest deficit. She didn't know how to relate. She didn't understand how to have a conversation."

Natalie "always wanted more, but nothing ever changed." She recalls, "I shared a room with her, so I was always trying to comfort her, but it never worked, it worked for a little while but nothing ever really changed, which was exhausting."

Natalie began experiencing facets of hopelessness around being repeatedly unable to relate, nurture, and help her sister to grow and change as a result of her sister's severe limitations. Natalie internalized this relational experience.

As a teenager and a young adult, Natalie was drawn to working with handicapped children and developmentally disabled adults perhaps in an attempt to achieve a sense of mastery that may have come with being able to help people with significant impairments grow and change. These experiences, however, only reinforced the familiar feelings of hopelessness that emerge in Natalie when she attempts to help people who have significant limitations in their capacity for growth.

These experiences were eventually growth producing for Natalie in that they eventually helped her find profession as a psychotherapist where she began working with people who may have deficits but also have some capacity for growth. "I just feel so blessed when I see growth because it sort of counters the hopelessness I used to feel."

Since the need to have growth producing relational experience is being met in her professional life, Natalie is able to find a new way of experiencing and being hopeful with her sister. She recalled,

[Now] there is a lot more peace and acceptance which I think I can do because I do have that hope of my own fulfilled somewhere else. In a sense there is a little hope for something different that comes with acceptance.

Natalie's sense of hope in her work is also linked to being in relationships that are emotionally rich. This connection was made for Natalie in her childhood in response to an internal longing for a type emotional connection that was not met in her family of origin. She describes her family as being "emotionally limited." "My father had a kind

of army mentality, so he really valued being a good soldier, being self-sufficient, non-emotional, very rational and loyal.”

While Natalie prided herself on being a “good soldier,” she “secretly” desired more emotionally connected and full relational experiences. Natalie nurtured this longing by seeking out real and imagined relationships outside her family that enabled her to experience the “fullness” of relationships. “I fell in love with my first grade teacher who also fell in love with me. She was really loving and really disciplined. It was really sustaining and hopeful for me.” She also recalls being drawn to television shows, such as the Walton’s, that gave validation to a wider range of emotional affect that can be experienced in relationships. Natalie idealized Olivia Walton and applied Olivia’s sensibilities to situations in her own life.

Natalie also felt that growing up in the 1960s help nurture a sense of hopefulness related to being emotionally connected. “There was all this talk of love and peace and understanding, that actually permeated me cause I was 8, 9, 10 and I thought well that’s the world, like that’s what the world is.”

In both childhood experiences, Natalie’s sense of hope became linked to her experience in relationship with an “other.” Natalie was skillful enough in her childhood to actively pursue getting these particular relational needs met outside the family, yet they have persisted as organizing principles for her in her work. When Natalie is part of a meaningful therapeutic relationship, where she is also an agent of growth in her work life, her sense of hope is maintained. Vicissitudes of hope emerge in Natalie, however, when this relational dynamic is not maintained in her work perhaps because it comes to approximate these more painful relational experiences of Natalie’s childhood.

Categories of Meaning

The Therapeutic Relationship

As is the case for most psychodynamic therapists, the most sacred part of the therapeutic endeavor for Natalie is the relationship between patient and therapist. The therapeutic relationship holds additional significance for Natalie, however, because how Natalie experiences the quality and depth of the therapeutic relationship is the most significant factor that affects her sense of hope in her work.

In the interviews, Natalie described that both the patient's emotional accessibility—what the patient brings to the therapeutic relationship and her emotional availability—what she brings to the therapeutic relationship affect her sense of hope in her work. As a result, two categories of meaning will be devoted to both of these parts of the therapeutic relationship.

The patient's relational accessibility.

Natalie described the patient's relational accessibility in following descriptive ways:

If I can find something in them that really touches me, I feel very hopeful about being able to connect to them deeply, which is hope for the treatment in general and hope for them. If there's something that feels alive, I feel really hopeful.

The type of relational accessibility that Natalie tries to find in her patient's is not directly connected to having access to a full range of affect or even being expressive. It is something less tangible that she intuitively experiences. It is "some kind of energy" to

which Natalie can connect. “Even if they are dead sometimes there is just something alive about that.”

Natalie recalled a specific example of a working with a woman who was very silent:

She would sit kind of in the corner of her chair with her head down. She never made eye contact and was silent for most of a session, but there was so much energy around her. It looked like there was nothing going on, but I could just sense her and it was a powerful experience for both of us.

While interviewing her, I experienced an emotional openness or freedom within myself to the emotional ebbs and flows of our dialogue, which I believe Natalie seeks from her patients. It was an experience within myself that was unique to my relationship to Natalie and not something that existed in the same way in interviews with the other participants. It was my sense that it was related the unconscious and conscious ways that Natalie engages people to establish a connection that unlocked that within myself (what Natalie brings to this experience will be described in greater detail in the next section).

When Natalie’s connection to the patient is lost, her sense of hope fluctuates. She recalls, “I might wonder if they are gonna make it or get through something.” Natalie uses these fluctuations in her sense of hope as an opportunity for her to reflect on what is happening with a particular patient.” I will try to “re-find something to connect to somewhere where I know we are joined together.” Natalie will also internally reflect on the transference and countertransference and, when appropriate, address relevant transference themes with the patient. “I bring them in closer; make it more real right in the moment.”

The following clinical example illustrates this vicissitude of hope in Natalie that gets stimulated in relation to the patient's relational accessibility. Natalie recalls,

I did not know what to hope for this patient. He was anxious and depressed, and he couldn't really tolerate hearing me tell him, you know, what I thought was going on. He just kept saying fix me; well just fix me, why aren't you fixing me?

Here's a person begging me to help him. I can't find the way; you know I can't find the way to open the door to that, or to engage him with me. I just couldn't figure it out and, yeah, I started losing hope, you know not completely in myself but in myself to be with him and in his ability to be with me. I said I can't fix you by myself, you have to be in this with me.

He realized he didn't really want to be in it with me and he left treatment. A few months later, he returned to treatment. He said he realized that I was telling him the truth and he wanted to shoot the messenger. He thought he could trust me to tell him the truth and so then all of a sudden I was like wow, now I was really hopeful that we might be able to get something going.

The capacity in people to develop deep and meaningful connection is such an organizing principle for Natalie that it extends beyond her work into her life and the larger culture. "The values our culture is organized around makes me lose hope. Everything gets so superficial so fast." Natalie feels a sense of desperation about the fact that human interaction and the depth of relationships and inner life are not valued in our society. She wonders how her kids and kids in the future are going to learn about face to face interaction, when they're all looking down at their phone, texting, and they're not talking to each other and not sharing the experience of being together.

Natalie counteracts this sense of hopelessness by being more determined both to help her patients find meaningful relationships in their lives and to disseminate these values to people in her world. "It inspires me to work harder at what I do to hold onto that in whatever way I can. I do bring that with me not just to work, but to everything. It is my greatest fear, my life and death."

The therapist's emotional availability.

In the previous section, Natalie described how hope is connected to the patient's emotional accessibility. Yet hope for Natalie is even more profoundly connected to the other side of this relational experience, what I have called the therapist's emotional availability. When Natalie experiences herself as being emotionally available with a patient, Natalie's experiences greatest sense of hope in her work.

This category is comprised of several ways that Natalie uses herself in her work that I have grouped together as: emotional investment, openness, vulnerability, and inspiration. While Natalie never articulated a specific theoretical lens to which she ascribes, it seems that many of the ways that she uses herself and her emphasis on the relationship echo aspects of relational theory.

Natalie's sense of emotional availability starts with investing in her patients on a human level. She states, "I always let myself care—to be touched by their stories or what they are feeling. I care about patients as people that are actually in my life at the moment."

The word that Natalie repeatedly uses to encapsulate her sense of emotional investment is to be "real" with patients. She recalled, "I understand how much being real and being available are parts of the process."

At another point in the interviews, Natalie stated, "A relationship that really is attuned and where there's really real meaning being created is a powerful vehicle and medium for growth."

In the third interview, Natalie recalled,

I think what worked with this patient was just the realness of allowing him to be present and responding to his presence, and him eventually allowing me to be present, and we could have a back and forth. It felt very real.

Natalie brings an emotional presence or openness to the work that both enables her to be attuned and empathetic to her patients. Natalie describes how she uses empathy in her work.

I have one patient who never understood empathy at all. He was telling me about something really sad and I started, you know, tearing up. He sort of looked at me and was like, what are you crying about? It didn't happen you. I said no, it didn't happen to me but I can feel it for you. It happened to you. He was like, what? You're, you're crying for me? I said well, yeah. He was like in shock. He did not know what to do with that, and he kind of wanted to make fun of me initially but it became a very important thing to him that he had that impact.

This emotional openness also enables her to experience in herself the flow of her and the patient's emotional reactions that occur in the transference and countertransference. Natalie describes her use of countertransference,

I have often had the experience that something the patient has experienced has touched on something similar in myself and I don't say that but I let it open up there and I let that impact happen and then I figure out what to do with it from there.

The use of these therapeutic tools, empathy as well as a sense of attunement to transference and countertransference phenomena, are among the foundation of basic tenants for practicing psychoanalytic clinicians, yet for Natalie they hold significance in that her capacity to use these tools buoys her sense hope in her work.

Yet the therapeutic process for Natalie is more than either investing or using these therapeutic tools: it is about being emotionally vulnerable or "risking something."

If the patient's really going to feel you with them, you have to actually be, your defenses have to be down too. You have to let them in, you have to let yourself out, and sometimes you don't know what's going to happen and you risk it

anyway. It's not the same as the patient's vulnerability. It's a choice to be vulnerable.

Emotional vulnerability for Natalie is not about sharing inappropriately with patients. It is about the therapist being open and available to experiencing the therapeutic relationship as fully as possible. Natalie states, vulnerability "has to be there. Even though you don't say it to the patient, there is something that gets understood, like they know they've touched you or they know there is something there."

As Natalie has gotten more experienced, this sense of being emotionally vulnerable has become more important. "When I was younger I wanted to be smart and knowledgeable and insightful, but I didn't value as much the vulnerable side. I probably dreaded it. Now I understand how much it plays a part in being effective."

In my interviews with Natalie, I experience the depth of her emotional presence. While she was very engaging, her authenticity was profound. She swayed in and out of appropriate affective states as she compellingly described her experiences with patients in a manner that unlocked a range of emotional affect within me.

It became clear in the second interview why emotional availability has become so central to Natalie's sense of hope. Natalie had a profound experience simultaneously with a patient and in her own therapy that crystallized the importance of this category to her.

Natalie began working with a patient that she described as the most intense treatment experience of her life. While he was high functioning in his professional life, he dissociated everything, and he was split off from parts of his body. Language and

emotion were disconnected from each other. He was always addicted to something to help him get through life.

While this patient was not psychotic, there was a kind of “psychotic enmeshment” that occurred in the relationship. “It got very mergy.” Since he was very nonverbal, communication became very intuitive. I often felt I was kind of crazy, or I couldn’t really tell what was happening.”

Natalie realized that she needed “someone to hold on to me, who knew me” so she returned to her old therapist who she had seen in intensive psychotherapy for 9 years.

Natalie contended,

While my therapist was a good anchor for me, I could not get her to understand what was happening to me; it was so inarticulate I couldn’t find the way to really communicate what I needed. I needed something more than words.

Natalie described a parallel process occurring where the patient could not make himself understood to Natalie through verbal communication, and Natalie did not feel understood by her therapist. Yet, Natalie felt as though she allowed herself to “get dragged into” her patient’s process. Natalie started using music, art, and metaphorical objects as mediums to begin to relate to this patient.

[I] allowed him to be a real person to me and he allowed me to be a person to him. We related in a real way. Gradually, he stopped using; he started to create art, which he had not done for years, and he was able to have some relationships.

Natalie, however, felt as though her therapist defended against getting “dragged” into Natalie’s process. “She always stayed right where she was supposed to be, and I really needed to move her off her mark, and that’s what she would not do.” Natalie and her therapist tried to address Natalie’s disappointment, but Natalie ended up leaving treatment. When Natalie ended her therapy, however, her therapist surprised her and

gave Natalie a kiss goodbye. The kiss for Natalie was meaningful because it represented “the most real thing I’d ever felt from her. It meant everything to me. I could finally feel that she was really there with me.” Yet, Natalie “lost hope in me for getting help in therapy.” It is a feeling that has persisted over time.

The treatment with the patient also ended prematurely. Natalie had to go on medical leave for a few weeks, and the separation and meaning of it to her patient, facilitated him leaving treatment. With the support of colleagues and much personal reflection of what occurred with this patient Natalie recalls, “I kept reflecting on the realness of what happened between us. It was something too meaningful to be emptied of hope.”

Natalie describes these experiences with this patient and her therapist as “a source of hope for all my work.” It strengthened her belief in the importance of the emotional commitment from the therapist as a necessary agent of change in patients. “It is a grounded hope for what’s possible if you are willing to belabor with patients...and it makes the laboring of the work worth it to me.”

Natalie’s emotional availability with patients also includes being inspired by her patients. Her sense of inspiration comes from more than feeling gratified by the seeing growth in her patients. It is also learning from patients how they have the courage to face and overcome difficulty. In describing how she was inspired by the growth of a patient, Natalie states,

I actually admired her cause I thought, wow, if she can do that, you know maybe there’s hope for me and my mother too. I don’t know how she did that. She could do something I couldn’t do, or hadn’t found my way to do yet, but she really got there and it was very hopeful on many levels for me, of what’s possible.

Natalie also believes that it is useful for patients to realize that they have the ability to inspire her. Depending on the situation, Natalie will either choose to share more generally that she is inspired or it will get communicated nonverbally. Regardless of how it occurs, Natalie feels that the experience of inspiring another is profound and reinforces greater inspiration in patients.

The Regulation of Hope through a Sense of Agency

Hope for Natalie in her work is also linked to trusting her own authority to make sound decisions; what I am calling a sense of agency. Natalie describes it as a sense of “confidence in my own intuition or my own authority over my own work.”

Natalie’s sense of agency is affected by both professional and personal experiences. When she is new to a role, in either her professional or personal life, she experiences more fluctuations in her sense of hope in her work.

Natalie remembered experiencing these fluctuations when was a new psychotherapist, which also coincided with her becoming a mother for the first time. She recalled,

I was learning both roles at the same time; it was very stressful and interesting. When I felt hopeful about one [role], it helped me feel hopeful about the other and when I would lose hope in one area, it would be hard to not let that create doubt in the other area too.

As Natalie has matured in her life and as a clinician, personal and professional experiences have helped to gradually solidify her sense of agency and thus reinforce feelings of hope in her work. Natalie described an example of how being a mother has helped to expand her sense of agency. When her daughter was having serious difficulties

in elementary school several years ago, Natalie made the decision to get her daughter evaluated. While Natalie found this to be a negative experience in some ways, she also described it as “transformative” for her. Natalie contended,

I realized that this isn't up to anybody else. I am the authority figure, I am the mom, I gotta take care of this and it was really empowering. It empowered me there and it empowered me in my work. I mean it just sort of felt like where I was losing hope I really found it and it was very powerful in terms of just taking life on and not being so tentative.

This realization propelled Natalie to make the decision to have her daughter change schools and allowed her to advocate for her daughter with the principal at the new school. Natalie felt as though she ended up making the “right changes” for her daughter, which in turn made her feel more competent in her capacity to use good judgment in her professional life.

Another area of her personal life where Natalie felt an increase in her sense of agency was in her own therapy. After several years in her first intensive treatment experience, Natalie recalled getting to a place where she began feeling like she had grown up. Natalie described this experience as coming out of the “transference spell.” She came to recognize that her therapist was not the one who knew and could tell her what was right and wrong, as she wished for. Rather she was a human being who was supporting Natalie's efforts to establish her own ability to discover her own voice, supporting her own ability to discover what was right and wrong for herself. Her therapist was not an authority but rather just a human being, an equal, which enhanced Natalie's confidence. After processing this internal shift with her therapist, Natalie recalled, “ending treatment to see how I could fly.”

In Natalie's professional life, an increase in her sense of agency is related to having witnessed and internalized therapeutic success with patients. She recalled,

I learned that I have something that's real to offer. When you're young and first starting, you're a young therapist, you know you don't really know what you have to offer, you don't know if it's real, you don't know if it's strong enough, you don't know if it has enough complexity to it to really meet people where they are. I mean you hope you do, that's part of the hope, at the beginning, and then you feel, then after you kind of see a couple things come to fruition. You think well it's not exactly like I hoped but maybe it's something even better. Something more real and you think well maybe I can be what I hoped I could be.

Natalie's sense of agency in her work has also been solidified by witnessing, time and again, the power of the psychotherapeutic enterprise in facilitating change. She recalled,

I learned to trust the process. Being part of watching other people grow from it. I know there's something real. I can have doubts and I can have questions, but I've just seen too many things that have really been moving in other people and I feel pretty grounded in those experiences.

The more confident that Natalie has gotten in her work, the more able she is to use consultation more flexibly. When she was less experienced, she saw her consultant as the authority in relation to her work with patients. As Natalie has become more seasoned, she considered her own authority to be as equally valid as her consultant's. She became more discriminating in relation to how she uses her consultant's insight. Natalie stated,

The more confident I have gotten in my own authority over my own work the more I didn't have to rely so much on getting someone else's opinion. I still find that [consultation] really valuable but I also realized I didn't have to agree all the time. I was the one responsible for treatment, not somebody else, so it still would have to come down to me. And I feel more able to accept that responsibility and that feels really hopeful.

It is clear from the aforementioned experiences that Natalie's sense of hope is linked to the sense of agency that has grown over time as a result of the many experiences she has had in her personal and professional life.

There is also facet of Natalie's sense of agency, which is informed and reinforced by two experiences that I described in greater detail in the previous category, that I believe reveal a more defended component to her sense of agency. Natalie described in detail a parallel treatment experience where she re-entered therapy to help her address what was being stimulated in her as a result of working with a difficult patient. The outcome of those experiences was that Natalie felt that her therapist failed her, while at the same time feeling that she succeeded in providing a meaningful treatment experience for her difficult patient.

These experiences engendered in Natalie what she describes as being "defiantly hopeful" in her work. The word "defiant" is an interesting descriptor because it expresses a refusal, or what Natalie describes as a sense of stubbornness, in relation to allowing this situation to be experienced in her work as anything but hopeful. In contrast, these experiences have engendered a complete loss of hope in relation to her capacity to be a patient.

Helping Patients Relinquish a Fantasized Sense of Hope

Natalie has found that one way her patients' growth gets thwarted is by holding on to a fantasized sense of hope. When hope becomes a fantasy, no choices are made so there are endless possibilities of what could or may happen. Patients also believe that nothing bad or worse can happen because nothing is pursued.

Natalie described, “It is like being confined to a “box where nothing can happen so that at least nothing worse happens. But nothing better happens either. They can always imagine that better something out there as long as they don’t try and fail.” Natalie equated this fantasized sense of hope to unrequited love “you always can hold onto it as long as you never go for it.”

Patients often are fearful of exploring this fantasized sense of hope. The fear takes on life and death proportion. It’s as though the preservation of the self depends on holding onto this fantasized sense of hope.

Natalie’s works with her patients to help them find the courage to explore this fantasized sense of hope. “It takes so much courage to cross that line and take that risk. The real hope is in trying, and however that comes out, something will be gained by going there, which is something you or they can’t imagine.” Patients are opened up by this process of discovery. A new sense of hope emerges that is about something real that patients can feel and experience rather than defend against.

Natalie gave an example of a 50-year-old woman patient who held on to a fantasized sense of hope that her mother could love her, in spite of the fact that she and her mother had a very conflictual relationship throughout her life. The patient’s relationship with her mother was further complicated by the fact that she was finding it difficult to have compassion for mother and take care of her, as she was getting older.

The treatment focused on exploring with the patient her fantasies and fears related to how her mother felt about her. Over time the patient came to accept that her mother’s love for her was complicated by who her mother was, with her own struggles, her own story and her own shortcomings and it was never going to get better. The patient came to

realize that the hope she held onto that her mother would change and be able to love her in the perfect way she had always wished for was not going to occur.

The patient's capacity to explore and grieve her hopeful fantasy ultimately helped her to begin to accept her mother for who she was and she came to love her in a different way than she thought she could. She came to a point where there was some forgiveness, and it opened up a different kind of relationship she could have at the end of her mother's life.

Steven: Clinician 2

Clinical Training and Professional Development

Steven is a 50-year-old psychodynamic psychologist who has been in full time private practice for approximately 20 years. He sees individuals, couples, and runs psychotherapy groups, in most cases, once a week over many years.

Steven's practice consists primarily of men, gay and heterosexual, although he does see a few women. Since Steven is openly gay, a portion of his caseload is comprised of gay men who want to work with a gay male therapist. He does couple's work and runs two psychotherapy groups.

Steven's clinical training began in a community mental health setting. During his internship he worked with children, adolescents, adults, and families who were mostly from underserved communities. He stayed at the community mental health center for six years after his internship ended.

During his time at the community mental health center, Steven saw many clients who were experiencing a litany of pain, deprivation, and trauma. While he felt

overwhelmed at times, he most often felt supported and optimistic because he was part of a team. He recalls,

I felt so much part of a part of a team when I worked in community mental health. If I ever felt overwhelmed by something I always had the opportunity to go 60 seconds after a session ended, and poke my head into someone's office, and say what do I do, or, oh my god.

The last few years Steven was at the at the community mental health center, he began a small private practice which turned into a full time practice a few years later. Steven's experience as a psychotherapist in private practice felt very different from his work at the community mental health center. The built in support did not exist, so Steven implemented several strategies to help him sustain a sense of optimism in his private practice. These strategies include actively setting parameters around his patient load, relying largely on his own internal resources and developing external supports.

Steven had a sense when he began his private practice that he needed to actively set limits regarding the type patients he decided to work with to avoid feeling overwhelmed. "I was fairly cautious and learned early on with the help of a supervisor or two that it's ok to say to somebody in private practice this isn't a good fit."

Informed by his training as a self-psychologist, Steven feels as though his sense of optimism is strengthened by those people who he had idealized over the years that he has internalized such as his mother, his therapist, mentors and supervisors. These "idealizable others," as Steven called them, all have an internal strength and an unflappable sense of hope that Steven draws on in his work. He recalled, "They all had a degree of hope and optimism and were not daunted or intimidated by tough times or pain. They live inside me; they are woven into my fabric that I have made into my own."

Steven also draws on his own experience in therapy in his work. Steven saw his therapist off and on for 13 years. While that relationship ended 18 years ago, the power of that experience still lives on in him.

I think that I am still channeling him, not quite on a conscious level but on some level reminded of my experience of him because I am doing it too. I wonder if I were an accountant if it would be so fresh in my memory.

Steven's hope is also sustained by turning to outside supports he has established over the years including supervisors, colleagues, and his partner. Steven trusts and admires them and they help him with the kinds of things that can lead him "toward a feeling of hopelessness" such as fear that a person is not getting better or that he is not helping.

Supervision helps Steven gain a sense of perspective with his patients. It gives him insight into the defensive function of the patient's behavior as well as feedback about what is going well in the therapy.

Steven described a particular patient where supervision helped him persevere with a challenging patient. His patient was so narcissistically vulnerable that almost every encounter he had with another human being resulted in him feeling hurt or slighted. He would react to these experiences with a tremendous amount of contempt and hate that Steven likened him to a porcupine. Steven at times wondered if this patient could really get better or if he could really help him. The supervision that Steven sought out to discuss this patient helped to restore his sense of hope. He recalled,

It [supervision] helped me interpret the impasses and the resistance as being about vulnerability rather than insurmountable, unresolvable problem. I would get re-energized, I'd come back to the treatment thinking okay, we can do this.

While supervision is mostly helpful in “re-instilling a sense of hope” in Steven, there have also been instances when this restoration of hope may not have been in the best interest of the patient or the therapeutic relationship. Steven described working with a patient who explicitly and persistently asserted that Steven was not doing the type of therapy that this patient wanted. Steven discussed this patient in supervision, and would return to the treatment feeling reinvigorated. Over time, the therapeutic relationship ended up not working for this patient, and it was a painful ending for both Steven and his patient. In hindsight, Steven felt as though supervision replicated the treatment. He recalled,

It was very supportive and interpretative. I was offered new perspectives and ideas about how to think about working with this patient, it also prolonged the agony. I needed for someone [a supervisor] to be able to see this what for it was and to say to me it is okay not to continue.

Steven finds the empathy that he receives from colleagues sustains a feeling of optimism in his work. He is part of a study group that meets regularly where case material is discussed more formally; and he informally discusses his experiences at work with colleagues. Steven enjoys the mutuality of sharing his experiences with colleagues and them sharing with him. He is reassured others do and have had similar professional experiences as him. The “built-in empathy” that Steven gets from his partner, who is also a therapist, is also invaluable. He contended,

There is a certain empathy that I know I can get when I go home at the end of the day, which you can get from any partner of course but somebody who is in the field gets it in a slightly different way how overwhelming the work can be and how scary certain situations with clients can be.

The reading of theoretical and case material is another way that has helped him maintain a sense of optimism in his work especially as he has matured as a therapist.

Steven has found it useful to both read both about the wonderful treatments by highly skilled therapists as well as those difficult cases where the patients were in the abyss of despair and ultimately something happened that helped them turn it around.

Steven has always been actively involved in several professional organizations. He also is a regular participant and discussant in conferences. He enjoys this involvement.

In most instances they [conferences] are celebrations of the field. People are talking about the newest developments in theory or practice. There's a lot of energy and enthusiasm that I feel like I can really feed off of and I feel energized when I come back.

There are changes in the field, however, that challenge Steven's sense of hope about the longevity of field of psychoanalysis and psychotherapy. The indoctrination of manualized treatments, cognitive behavioral therapy, and the emphasis on diagnosis that is prevalent in training institutions makes him question the sustainability of psychoanalysis. This concern causes fluctuations in his sense of hope. There are times when Steven contextualizes these worries by remembering that psychoanalysis has been challenged for decades, and other times when he sees these new developments as a real threat to the sustainability of the field.

Organizing Principles

As will become clear in this write-up, Steven's life experiences serve as a frame of reference in Steven's work. Steven truly has had varied experiences (which will be described throughout this case study), and many of these experiences have been difficult. He draws on his own history of being able to adapt to difficulties as a source of hope that

others, including his patients, can also recover from their struggles and find meaning and satisfaction in their lives.

Steven is a practicing self psychologist. This lens frames the clinical the diagnostic picture he develops of his patients as well as his clinical approach. Yet, Steven's self psychological lens remained more implicit than explicit in the interviews. The one time when he explicitly mentioned self psychology in the interviews was when he described how he has internalized idealizable others, and their sense of optimism, and he carries them with him in his life and work.

Interview Reactions

I had many different reactions to Steven over the course of our interviews. While he was interested in participating in my study, he also expressed some apprehension. His initial concern was related to the loose parameters of the time commitment specified in my flyer. He was concerned that there was a possibility that he would have to devote more time than he was comfortable with if he agreed to be a participant. When I became aware that this potential time commitment would be difficult for many participants, I adjusted the time expectation. Steven then agreed to have a phone-screening interview.

The next concern that Steven brought up was related to how his confidentiality would be maintained. When I mentioned that I would change his name and that he would be able to review his case study write-up, he expressed some relief and agreed to our first meeting. In these initial exchanges, I experienced Steven as being engaging yet cautious. He was interested in protecting himself, and he shared his concerns in a warm and engaging way. I respected how seriously he took participation.

When we met face to face for the first time, I liked him immediately. He was warm and welcoming and able to dive into this material quickly. It was clear that he had pondered the question of hope prior to our first meeting so he seemed eager to share his thoughts with me.

His protectiveness again emerged when he started talking about clinical material and his concern about maintaining the confidentiality of his patients. I reassured him that the focus of this study is related more to him than his patient but that I would maintain their confidentiality as well.

As the first interview unfolded, I was moved by the intersection of personal and professional life experienced that resulted Steven's strong sense of confidence. He had a thriving practice, and while he struggled with certain issues, his sense of confidence was solid.

I also was aware that I felt intermittent anxiety throughout the interviews, as was the case with many of the participants I interviewed. A piece of my anxiety had to do with being new to research interviewing and my lack of comfort being in that role. My anxiety, however, felt manageable in the first interview.

In the second interview, my anxiety was more pronounced and at times left me with the experience of being slightly tongue tied when it came to asking questions. When I became anxious, I also got in touch with my own feelings of hopelessness not feeling as competent in the role of researcher as I desired to be. As I look at the transcribed interviews, it is interesting that that my internal experience did not seem reflect the reality. The questions I asked both made sense and Steven repeatedly praised me for asking deep and thought provoking questions throughout the interviews.

I believe my reaction reflected a dilemma that seemed more profound during the second than the first because we were getting a little deeper in the interview process. I felt torn about wanting to both to encourage Steven to reveal the many layers of complexity related to his sense of hope, while also respecting his own limits related to what he felt comfortable sharing in the interviews.

Additionally, I respected Steven very early on in the interviews, the stakes felt high in me wanting him to respect me as a researcher and clinician. When I did not feel like I was asking questions that were probing enough, I felt more in touch with feelings of incompetence. I also believe there was a parallel process in the interviews with my own feelings of incompetence or hopelessness mirroring Steven's elaboration of those times he has struggled with feeling effective in his work.

Lastly, I also personally struggled with Steven's sense of hope, certainty, and "happy outcomes" that were part of his narrative most significantly in the second interview. I felt longingly as though I wanted to obtain that sense of pervasive unambiguous certainty that seems part of his narrative rather than the more ambivalent, complex sense of hope that is part of my personal narrative.

The countertransference complexities that I felt most profoundly in the second interview seem to dissipate when we met for the third interview. I returned to marveling at the generosity with which Steven opened his life to me and really feeling connected to him. I also felt sad to say goodbye to him, and wished there was some way we the relationship could be maintained in the future.

Steven experiences his optimism as an inherent part of himself. It has always been part of him as far back as he remembers. “I have always been inherently fairly optimistic.” He believes that this unflappable sense of optimism has allowed him to persevere in the field over time. He says, “I have a lot of hope. I don’t know that one can really stay in the field if they don’t have it.”

Steven’s experience of his parents has also contributed to his sense of optimism. His mother was optimistic. The phrase “You can’t go through life being afraid” captures her perspective of life. She felt that people have to live their life and things will work out. Steven’s father, however, was a more fearful and anxious person. He approached life much more cautiously. He frequently worried about bad things happening. Steven recalls, “He was fearful. You know, what if we run out of money, what if somebody breaks into our house, what if—.”

Steven’s mother’s optimism, in Steven’s eyes, served as a counterpoint to his father’s sense of fearfulness. Steven idealized his mother, and thus has internalized her sense of optimism. “She was very optimistic and I really adopted that so I think that I was not somebody who felt all that easily intimidated. And if I wanted to do something I usually at least tried.”

When Steven described the internalization of these ideals of his parents, he also made the connection between that occurrence with the emergence of a sense of “grandiosity or naïveté” that he has observed in himself. He described his sense of grandiosity specifically in relation to a sense of reluctance to give up in certain situations

when it was time to give up. (This process is described in greater detail in subsequent sections).

Steven has also internalized his parent's relationship. It seems he always has felt that they had a good relationship, but as he has gotten older and experienced his own relationships, their relationship has served as a model. Their relationship gives Steven a lot of hope about the sustainability of relationships over time. Steven recalled,

I have an image in my mind of my parents who had a really wonderful marriage. I remember when they were retired in their 60s or early 70s and seeing them when they were visiting sitting on the couch at our house watching television and holding hands and just looking at them. You can just be in love forever and feel close and intimate forever. It doesn't have to stop or be fleeting. If they have it, they have on a daily basis and that has instilled such a sense of hope in me that it can happen and does happen.

Categories of Meaning

There were four themes that seemed to emerge repeatedly in my interviews with Steven that are encapsulated in the following categories: *Resilience*, *Efficacy*, *Adaptation*, and *Hope Defined*. Each of the specific details of each category will be described below, however, it seems necessary to note that there were certain experiences that Steven describes which have multiple layers meaning. Therefore, while the experience will be replicated in potentially more than one category of meaning, how these experiences are understood and considered will differ. This repetition highlights the complexity of experience and how it is often full of many meanings.

The Use of Resilience in the Regulation of Hope

Hope for Steven is intimately connected to feeling resilient. Steven's resilience is comprised of a sense of optimism and confidence that emerged as a result of going through many challenging life experiences, and in almost all instances, feeling as though he has grown and thrived as a result. It is through the acquisition of his own resilience that that Steven holds the view that all human beings have the potential to be resilient.

Life is really, really hard sometimes and as I matured as a therapist that became less abstract and it was easier for me to understand that life is a process. As I dealt with really difficult challenges I discovered my own resilience. As I realized myself as resilient, it helped me understand that people are resilient.

While each challenge that Steven experienced occurred in a particular area of his life—personal, professional, and his own therapy—Steven feels that all the challenges he faced “mutually influence” each other and cannot be separated. While Steven did not describe that his resilience grew as a result of living through a societal crisis, I would also add this dimension as a factor in building his resilience.

Steven both lived through, and was immersed, in the breakout of the AIDS epidemic in the early 1990s. The gay community was in crisis: friends were becoming sick, incapacitated, and dying. Steven also started a small private practice at that time and specialized in working with men with HIV and AIDS. His patient load was also becoming sick, incapacitated, and dying. Steven recalled, “All hell was breaking loose in the gay community, and in my network of friends, and in my patient population. I was losing patients and losing friends. At certain points, I experienced multiple losses.”

Death and dying became a significant part of his work with his AIDS patients. Some of his patients died when they were actively involved in treatment. Steven recalled two patients who he saw for a session one week and by the time of the next appointment,

both had died. More often, however, patients tapered off from therapy as they were getting sicker and getting ready to die.

Steven described feeling deep sadness, but his sadness did not also elicit feelings of hopelessness because he felt effective; he was doing something to help his community (Steven's sense of effectiveness in relation to this crisis will be elaborated on in the next section). Steven recalled,

I felt a lot of sadness but not hopelessness at that time because I felt like I was doing something. I think that other people I know, peers who were also experiencing multiple losses, or maybe they were ill themselves, felt utterly helpless and the sense of helplessness fueled their hopelessness.

By the mid-1990s enough medical breakthroughs had occurred that dramatically changed HIV and AIDS treatment. Fewer people were dying, and those that were infected were not becoming as sick.

There was an awakening of hope in the community, which reinforced Steven's sense of hope. He recalled, "It was such a relief. While we knew that some people were not going to respond to treatment and still may die, it was a very different experience." His work with patients became less sad and more about looking at what their life would look like now that they were living with AIDS. This experience broadened Steven's resilience. He not only survived this crisis, but he was actively involved in helping his community deal with it. He recalled, "I was in the trenches doing something. I rolled up my sleeves and was really inviting these people into my office and into my heart and I think that is what mitigated feelings of hopelessness."

While not ideal, there also was some resolution to this crisis. Medical breakthroughs transformed this disease from one that was life ending to one that was

more often life prolonging. This reinforced a narrative thread that contributes the optimism that part of Steven's resilience: there can be some resolution after hardship.

Steven's experience in intimate relationships has also help to expand his resilience. In the early part of his adult life, Steven entered a very challenging significant long-term intimate relationship with a partner who he described as being deeply unhappy and narcissistically vulnerable. After many years and many difficult experiences, Steven learned that he could not fix his partner and that he needed to end the relationship. (The specifics of this relationship as it relates to Steven's sense of hope will be described in the next section).

As he grieved the loss of the relationship, he also maintained a sense of optimism about relationships by reflecting on his parent's relationship. They had been married many years and still were very much in love with each other. He decided that he would rather stay single or find the kind of love that existed between his parents. Eventually, he entered an extremely gratifying partnership, which has lasted for over a decade.

The sense of optimism that is implicit in Steven's resilience expanded as a result of his experiences in intimate relationships. He learned first-hand about relationships that are not a good fit. He survived a painful breakup. He also learned from that experience that he was able to be in a relationship that is healthy and a good fit. Steven came to believe if learning and introspection occurs, people can grow from hardship and there can be some resolution.

Steven's experience in his own therapy, which was chronologically occurring at the same time the AIDS epidemic broke out and he was in this difficult relationship,

significantly frames his narrative of resilience. While it ended almost 18 years ago, Steven feels that it is very much alive in him.

He described the “resilience” of a good therapy relationship, which he experienced in both individual and couple’s therapy. When he began individual therapy, his feelings of despair and hopelessness were profound. Over the course of therapy, however, Steven acquired a sense of hope and optimism that has sustained him throughout his adult life. While that is wonderful in and of itself, personally experiencing the transformation from despair to hope instilled in Steven a broader sense of optimism about the therapeutic enterprise and the capacity to overcome hardship.

As an outcome of his individual therapy, Steven gained a sense of maturity that allowed him to accept his therapist’s humanness. He recalled, “I did not need my therapist to be perfect, but I needed him to be good for me.”

Steven felt that his therapist got him. He was an ally, incredibly affirming and supportive. Steven recalled, “I had those moments where something was such a home run that it changed, it felt like it changed everything.” At the same time, Steven also experienced moments of disappointment in his therapist; when his therapist had his off days, ham-handed interpretations, and even at moments struggled to stay awake.

While Steven primarily focused on his experience in individual therapy in the interviews, Steven also had a wonderful experience in couple’s therapy that occurred when he was in his difficult relationship. Steven described his couple’s therapist as being so skilled that he described carrying his therapist on his shoulder when he is seeing couples. At the same time, Steven acknowledged a real “affection for the foibles and missteps” of his couple’s therapist.

Steven's internalization of Winnicott's idea of being "good enough" in relation to his own experience in therapy has given him a sense of perspective in his professional life. Steven feels that he does not have to be perfect; he can be "good enough." It also gives some leeway in his work, which enables him to weather many experiences and feeling states-expanding a sense of resilience and hope. Steven recalled,

My own experience in therapy helps me retain hope that even if I'm struggling with a patient, not really getting them, not hitting the mark, my comments are falling flat, that doesn't mean that we won't eventually get to a point where something totally clicks and, there can be a game-changer. Just knowing that happened to me as a patient and it helps me feel like with most of my patients if it's not happening now, we'll get there. Maybe not as dramatic as some I experienced, but we are going to figure this out and something's going to happen here.

There is also a sense of confidence that Steven brings to his work that has come with experiencing success with patients. This success has helped to lesson his anxiety and reinforced a sense of hope in his abilities as a therapist. He stated,

I have enough experience under my belt that I don't worry so much session to session. I feel much more like, this process works it changes lives, and I am good enough at it that I can help people change their lives and that is the equivalent of feeling less anxious and more hopeful.

The many experiences Steven has had in his life frame the optimism that is part of Steven's resilience. There have been moments of significant pain and hardship but also growth and resolution. Steven actively draws on these experiences in his work with patients, which enables him to have a sense of perspective and maturity to preserve with patients. He contended,

When someone is going through a horrible divorce, or something terrible rather than just theoretically understanding that chances are they will recover, there was a certain point where it was no longer theoretical. It was like, oh I've been through it. This is wrenching, this is life, this is shattering. And then it gets better. I think that really made a big difference, charting the course of my work.

While Steven feels that drawing on his life experience is most often a useful work strategy, he is insightful enough to recognize there can be a sense of grandiosity related to relying too much on his own experience in his work with patients. Steven has noticed this occurring when he is working with patients on their intimate relationships. He contended,

Sometimes I am tempted to hold my experience as the standard by which relationships should be measured and that's not realistic and it's not helpful. It's not what I am here for as a therapist is to sort of get people to have their relationship look like mine. That's super-arrogant, it's not helpful, it's sort of ridiculous but it is something I think that I wrestle with some times.

Steven also noticed that when he works with patients on their relationships he often has a "life is short" bias. If something is too much work for a couple, and too painful, maybe the relationship should end. This view also emerged from his life experience, but Steven feels as though this view is changing.

When his patients are in intimate relationships, Steven has come to look more for strengths and resources are being met in the relationship such as affirmation, sex, a sense of belonging in the community, attention, stimulation, etc. While he may be candid with a patient regarding his assessment of their relationship, Steven looks to meet his patients where they are, and when necessary Steven works to manage his disappointment and his sense of optimism.

Steven has a strong sense of resilience that he brings to his work. This resilience is comprised of a sense of optimism related to potential of the psychotherapeutic enterprise to benefit patients; the deeply held belief in capacity of people to grow and change from going through difficult experiences; and his ability to help his patients.

Steven acquired his optimism as a result of going through challenging life experiences and building his own resilience.

When Steven experiences fluctuations in his resilience, it is related to an excess of optimism or grandiosity especially related to the realm of relationships. It took Steven a long time to accept that he could not transform this broken relationship before he ended it (discussed in greater detail in the next section). In addition, he hopes the most for the intimate relationships of his patients, which tempts him to want patients to end relationships that are not gratifying. Yet in both cases, Steven's self-awareness seems to provide containment of his grandiosity or excess of optimism.

It is interesting to note that the emergence of hopelessness is almost nonexistent in Steven's acquisition of resilience in spite of the fact that he has gone through several very challenging life experiences. The only time when Steven described feeling a sense of hopelessness was when he described the transformation from despair to hope that occurred in his own therapy. I wonder if Steven's sense of optimism is inherently part of him and thus frames his experiences. It is also my sense that there is strength in Steven's defensive structure that works hard to help mitigate feeling a sense of hopelessness, which will be described, in greater depth in subsequent sections.

The Regulation of Hope through a Sense of Efficacy

Steven's sense of hope is linked to feeling efficacious. When Steven is making genuine connections with people and helping them grow and change, he feels effective and is hopeful. Over the years as he has matured, his sense of efficacy has transformed from more idealized to more realistic, which has enabled him to sustain a fairly consistent

sense of hope over the years. At those moments when he does not feel he is having an impact or being effective, however, he is prone to have fluctuations in his sense of hope.

In clinical situations when I have felt like I was making a difference, I feel energized, inspired, and hopeful. When I felt like I couldn't get in, I couldn't connect, I couldn't help, people got worse instead of better and I was ineffectual, that is when I have really wrestled with feelings of hopelessness.

As long as Steven is feeling efficacious, he is able to sustain a sense of hope while working with patients who are struggling with a wide range of trauma, difficulty and tragedy. The most profound example of this capacity is seen in his work with HIV and AIDS patients. While he experienced a lot of deep sadness working with HIV and AIDS patients who were getting very sick and dying, especially before any effective medical interventions existed, he was able to sustain hope through this time of crisis because he felt effective and he received a lot of supportive feedback from his patients and the community.

Steven approached his work with his HIV and AIDS patients by letting them know that they could bring all that they were thinking and feeling to him and he could handle it. He observed repeatedly that his approach was a tremendous relief for these patients. They could come in and talk about how miserable they felt, how terrified they felt, and how ugly they felt. They did not have to pretend for the sake of buoying their loved ones or helping everyone else in their lives feel hopeful.

Another strategy Steven adopted which helped him sustain hope was he kept his focus on what was happening in the moment rather than what was being lost. He recalled,

I was able to maintain some sense of hope that something important can still happen even as you're getting sicker and facing death, so I don't think that I got caught up in the hopelessness around the issue of death and dying and AIDS.

Steven got a lot of explicit feedback from his HIV and AIDS patients who told him what a relief it was not to have to put on a happy face or be strong. Additionally, the gay community gave Steven a lot of social support for taking care of people with HIV and AIDS. Steven recalled,

I got a lot of social support from peers. They would say oh yeah, you're the guy who's doing such great work, whether it was true or not. They had no way of knowing that and I wasn't always doing great work.

Steven understood that to some extent he became an idealizable figure in the gay community. Gay men needed people to look to and Steven took on that role in the community. It is my sense that as a leader, Steven became more focused on what was needed by the community than getting flooded by his own individual feelings, which helped him stay motivated and sustain a sense of hope during this tragic time.

Gay men in that era needed idealizable figures in order to feel somebody was having an impact. Everybody was really scared and feeling traumatized and I think that there were a lot of people who needed to have somebody to look up to as knowledgeable, sort of calm in the midst of the storm, somebody who was not getting overwhelmed by it all and was able to hang in there and do the work.

Steven's sense of hope most frequently fluctuates when he feels he is not helping or having an impact. This internal experience most often occurs in relation to how the therapy is going rather than his patient's circumstances. He stated, "When I get to the point where I am wondering can I help? Am I helping? I don't think I can, that is when I start to feel hopeless."

While Steven feels that a fluctuation of hope can be related to what the patient brings to the therapeutic relationship, he described in greater depth his sense that his

feelings of hopelessness are the result of what he brings to the therapeutic relationship. When he is not able to help or connect with a patient, he can experience a narcissistic injury, which affects him on a deeply personal level and elicits “something like hopelessness.” Steven elaborated,

I feel like my efforts are being rejected. The thing that I am best at as a therapist, which is helping people feel close, connected, and cared for is failing or is being rejected. It's not just troubling on a professional level like I'm not connecting, I'm not helping, I want to help. It feels personal. I 'm not getting narcissistic gratification because what I normally do that really proves effective isn't and my ego gets compromised.

It seems to me that Steven is elaborating on an experience that is quite common in therapists. Since there is a personal component related to what each therapist brings to the therapeutic endeavor based their own idiosyncrasies, it is my sense that it is quite common for therapists to be effected in deeply personal ways when their professional efforts are rebuffed or ineffective. At the same time, how it is experienced by Steven is related to all of the personal aspects of himself that he brings into each therapeutic relationship, which were outside the scope of what was obtained in my interviews with Steven.

Steven described times when fluctuations in his hope can also emerge when he works with patients who have intractable depressions that are characterized by their own sense of hopelessness. When he was newer to private practice, he began working with a woman who was an incest survivor where her father was the perpetrator. The impact of this experience on her anxiety, self-loathing, depression, and hopelessness was profound. Steven recalled, “I felt like she was in the deepest pit imaginable and that I was tasked

with the job of helping her climb out and there were many times when it felt like there was no way out.”

This woman was feeling such despair and hopelessness and Steven started experiencing those feelings with her. He began to understand why she might act on her suicidal feelings, which is a feeling that went against all his beliefs including that therapists should ideally be the holders of hope for their patients.

Steven understood the emergence of his sense of hopelessness as being related to two factors. The first was related to her condition. Steven would often have the experience that there is no way that she could improve because her trauma is too pervasive and her internal resources for dealing with the trauma are not sufficient. It sounds as though Steven’s sense of hopelessness was related to the fact that he had real questions about her treatability.

The second factor was related to what Steven described earlier: his ability to be effective, his professional self-esteem. This countertransference reaction is related to what Steven brings to the therapeutic relationship. Steven was trying his best with this patient and not feeling like he was having an impact. He wondered, “Do I have what it takes? Do I know what I am doing? Can I help her? Which is a different question than can she be helped?”

It is my sense there is a third factor that needs to be considered. I think that Steven was also having a countertransference reaction to the patient where he was experiencing the patient’s intrapsychic experience related to how painful and hopeless she felt in the world. This reaction was quite painful for Steven to experience.

Eventually Steven stopped working with this patient when she was unable to follow through with treatment recommendations that Steven implemented to keep her safe such as following through with psychiatric appointments and going to a hospital that had provided support for people who were experiencing suicidal crisis. After processing this turn of events with her, Steven facilitated a referral to another therapist and the treatment ended.

Steven experienced a wide range of feelings related to the end of the treatment. He grappled with feelings of failure and came to accept the limitations of his ability to effectively help this patient. Steven also felt a great sense of relief that he was not working with her and felt hopeful that maybe someone else could help her more effectively.

It was only after Steven experienced his own sense of hopelessness that he was able to provide the most effective intervention: a referral to another therapist who may have been a better fit. He recalled, "I really did think that ultimately she was somebody who could get better, with somebody else. And maybe I got to that point by confronting my own hopelessness."

There is a component of his sense of effectiveness that he describes as having "too much hope" or "grandiosity." It is an inflated sense of confidence related to his capacity to be effective. This part of his effectiveness existed to a greater degree in his personal and professional life when he was a younger and less experienced therapist. Steven stated,

There is a thing called too much hope that spilled into grandiosity. I am thinking in terms of my relationship and probably other things as well where I would think, I can fix it whatever it is. Whatever your problem is, I can help you with it. And

even more embarrassing to acknowledge than that is that sometimes it would be; only I can help.

Steven also describes how his grandiosity resulted in him staying with a partner who was not good for him.

I used to think that I am the one who can stay with this partner who is a train wreck because I am so supremely patient and so supremely empathetic and so supremely good and I understand this person in a way that no one else possibly can and I am the angel who is going to stand by his side even though he is a train wreck.

Several factors occurred in Steven's professional and personal life simultaneously that challenged his grandiosity and made him feel overwhelmed, ineffective, and hopeless. Steven's intimate relationship was falling apart in a difficult and painful way at the same time he also faced challenges in his professional life, working both with AIDS patients as well as very challenging patients like the woman patient mentioned above. He recalled,

The interface between what was going on at home and what I was facing at the office did some times leave me feeling something akin to hopeless about can I help, what am I doing here, am I bringing anything to the table today or these days when I am so drained by what is going on in my life outside of work. Those were times when I was more uncertain about whether what I was doing was going to be helpful.

The experience of having to face his limitations especially related to not being able to cure his depressed, angry partner and being able to salvage his relationship, again helped him develop a more realistic sense of being effective. He states, "One of those ways that my personal life really affected by professional life is that sometimes it is necessary to say I can't do this. It is a failure in a sense, but it's okay."

There is an aspect of Steven's grandiosity which is characterological, based on who is his. There is another aspect of the maturational process of his sense of

effectiveness, however, which mirrors the maturational process of hope described in literature by Menniger (1987) and Searles (1977). The less experienced therapist begins work with excess of zeal and hope, and over time, and through the experience of disappointments, this idealism is transformed to a more mature realistic sense of hope.

While Steven has adopted a more mature sense of effectiveness in relation to his professional life, there may be a few glimmers of his inflated sense of effectiveness that he described not in those terms but may still occasionally emerge. He told of a recent experience with a patient who from the start was looking for a different kind of treatment approach than what Steven offered. Both Steven and this patient tried very hard to make it work, and ultimately it was not a good fit.

Both of us really wanted to make it work because we cared about each other, so I tried much longer than I should have in retrospect, to try to find a way to give him what he was looking for. I feared that if it didn't work, it could sort of fuel his hopelessness and I did not want him to feel hopeless and I did not want either of us to feel like a failure.

It seems hard to distinguish whether Steven's perseverance in spite of it not being a good fit is the result of an aspect of grandiosity or just related to the great investment he has in his patients. Even if it is related to a glimmer of grandiosity, it is clear that in spite of it, there has been significant maturation of Steven's sense of effectiveness.

Steven feels that he is able to effectively manage his private practice seeing patients who are a good fit and regulate his practice and his availability in a way that has enabled him to sustain his sense of efficacy and hope over time. I think this example highlights the complexity and nonlinear nature of development. It is possible to both acquire new capacities while continuing to work on the more deeply entrenched parts of ourselves.

This section also highlights the usefulness of experiencing our limitations in our role as therapists and as people. If we have the capacity to reflect on and learn from these often painful experiences, as Steven has, growth can occur. The two times in this section that he described facing his limitations, he was able to make choices that ultimately better for his patient—referring her to another therapist, and himself—ending a professional and personal relationship that was not a good fit.

Adaptation as a Defense against Hopelessness

Steven adaptively tries to ward off hopelessness and burnout and maintain a sense of optimism in his work. When he experiences feelings of hopelessness or burnout, he becomes active in trying to restore a sense of hope. While this sense of adaption is in some ways a defensive process, it also adaptive. When his sense of hope fluctuates, he has been able to repeatedly make changes to find his way back to feeling optimistic over many years of practice.

In an effort not to give up, as I start to see hopelessness on the horizon, then I rallied and said I am not going to give up and I've gotta do this or I've gotta introduce this intervention to ward off impending hopelessness.

This sense of adaptation is so much a part of Steven that there are times when it is part of his consciousness and other times when it is out of his consciousness. He contends, “Even if it is not something I have been conscious of, I’ve known it is a survival thing, to in a sense, not succumb to hopelessness.”

Steven has adaptively evolved and changed his practice to sustain his sense of optimism and interest at work. He began his private practice specializing in working with survivors of trauma and people with AIDS. After several years, he started to feel the

effects of burnout so he broadened his practice and began working primarily with gay men. Again after several years, Steven began feeling like his practice was too homogenous, so he decided to broaden his referral base. Currently, he works with a more varied population of men and some women.

Steven was propelled to take action to stave off hopelessness in a more profound way at a particular point in his life. He was feeling hopelessness in his personal life as his relationship was nearing its end while he was also experiencing feelings of burnout at work. The accumulation of feeling hopeless and burned out pushed Steven to take action in his professional life. For a few days, he explored ending his career as a therapist and pursuing a career as a lawyer. He went to the library and researched law schools. He recalled,

Some people when they get really frustrated go to the gym and punch a punching bag; I went to the library and read about law schools. I just needed to somehow do something; I needed to do an action of some sort or another to help me feel like there was an alternative. There is something else I could do if this doesn't get better.

Steven's ability to take action by going to the library had a stabilizing and calming effect on him. He recalled, "It helped me go back and sort of regain a sense of perspective, like I'm not trapped in this career. I want to do this, I don't want to change careers this is what I do." It also allowed him to recognize that given the debt he was saddled with because of breaking up with his partner, he needed to continue working for financial reasons.

Steven then re-committed to being a therapist. He expanded his practice from full time to part-time. He added hours to his schedule, and he started getting more varied kinds of referrals. It became a very different kind of practice.

While it was not discussed at the time of the interviews, I also wonder if his ability to recommit to work was related to the fact that he took action to end of his relationship. He may have had more space to experience and work through his feelings of burnout at work after his relationship ended.

Steven also adaptively attempts to ward off feelings of hopelessness in clinical situations. He had been working with a patient for several years in a very deep and meaningful way when he started experiencing feelings of despair regarding this patient. These feelings propelled him to actively understand and deal with this situation with his patient.

Steven described this patient as challenging. He had experienced a great deal of traumatic loss in his life and was prone to debilitating depressions. He felt hopeful about the treatment, yet there were periods when he worried about him and wondered if he could help him.

This patient experienced another loss while in treatment. His partner died. This patient felt very lost. He tried to cope with the situation by hanging out with some new friends that introduced highly addictive drugs to him and he began using with increasing frequency.

Steven's sense of hope with this patient became threatened in spite of the meaningful connection between them. Steven stated, "He was descending into more and more drug use and I felt him slipping away."

After much contemplation, Steven took a stand in the treatment to prevent his patient from self-destructing. He recalled, "I said if you don't some way or another find a

way to stop using this drug, I've done all that I can. I can't be of help to you and it doesn't make sense for us to continue."

This intervention felt risky to Steven given that this patient was so vulnerable and so dependent on him. It also felt like the most empathetic and loving intervention at the time. Steven felt that the relationship was the only leverage he had to stop him, and it got his patient's attention. His patient experienced Steven's concern deeply, and he stopped using. Steven intervened to adaptively stave of his despair. He recalled,

I was so close to giving up and was feeling sort of despair. I didn't know what else to do. I was afraid for his safety, certainly for his psychological well-being. It was the last step I could take prior to simply giving up and succumbing to the hopelessness. Now it feels like a brave thing to do, but at the time it felt risky.

This intervention was a pivotal moment in therapy. Steven believes that it was helpful because it was experienced by this patient as an expression of Steven's concern. It really was the beginning of a very productive long therapeutic experience. This action by Steven also helped him feel confident and hopeful about his therapeutic abilities. He recalled,

It felt super-risky because I hadn't been in practice all that long and that it was effective bolstered my sense that I can help him. I can and should trust my instincts. I don't have to do it by the book. I can use my judgment and have it work out well.

As Steven has matured as a therapist, he has come to realize the importance of self-care in sustaining his optimism. Typically he takes about 5 weeks of vacation, which consists of a combination of international and national travel.

I am really generous with myself with time off from my practice. It took me a while to get there because of the financial implications of cancelling appointments. One year when I did not take sufficient time off, I felt less patient and less resilient.

Steven, however, feels that his capacity to manage his stress is still evolving. He went through a period where he got better and better about “leaving it at the office” but in the last 5 years or so that has changed. Steven understands that change as being related in part to an increase in patient volume. While he struggles with his stress level, it does not seem that it impacts his sense of hope.

When I feel burned at work I remind myself how fortunate I am to work for myself, how privileged I am that people can invite me into their lives and allow me to help them. The risks that people take, I feel very inspired by the work and by how brave people are coming into therapy. So I feel like it is easy for me to regain perspective when it starts to feel hard.

Steven adaptively tries to maintain a sense of optimism in his work. If he experiences feelings of hopelessness or excessive burnout it serves as an internal signal where some action needs to occur to try to restore a sense of hope. This sense of adaptation has enabled him to shift his practice, set limits with his patients enough, and care for himself enough that he seems to return again and again to a state of optimism over many years of practice.

Hope Defined

Steven grappled with the definitions of hope and hopeless at different points throughout our interviews. When I asked him to define hope and hopeless, this is how he articulated it: “Hope is the sense that things can and will get better, however better is defined. Hopelessness is the sense that you are out of options or you don’t know what else to do.

Steven first wrestled with the definition of hope, when he was trying to capture whether a sense of hopelessness propelled him to briefly consider changing careers.

When he thinks about that experience now, he considers that he must have felt a sense of hopelessness. Yet when he reflects on his conscious processing at that time, he does not remember that he felt something akin to hopelessness.

I must have really at that point felt like practicing as a psychologist is not going to get any better. I have to get out. I have to change careers because I can't do this anymore. That sounds pretty hopeless.

Reflecting on that time in his life later in the interview, Steven recalled, "I devoted my twenties to a tremendous amount of blood, sweat, and tears to get that doctorate and get licensed and there I was researching law schools, how could that represent anything but a crisis of hope."

In the second interview, Steven again ponders whether hopelessness contributed to thinking about changing careers. This time he considers the differences between sadness, fatigue, and burnout versus hopelessness. "I am trying to sort out the distinction between feeling really sad or feeling drained versus feeling hopeless. Hopelessness is not the same as sadness and it's not the same as fatigue; it's closer to burnout."

Steven concludes that perhaps it is difficult to recall affectively exactly how he felt at the time he pondered changing careers since those feelings occurred such a long time ago.

Steven raises an interesting point in the second interview that encapsulates at least a part of the reason he is grappling with the definitions of hope. He is aware that he feels a pull to frame his experiences from the lens of hope and hopelessness to be a "good research subject," even when he may not use those words or that language to frame experiences in life and work.

I responded to Steven by trying to clarify what vicissitudes of hope encapsulates. “What I am trying to capture are fluctuations in the experience from hope to hopelessness. Clinicians feeling good about the process and variations of that, whether that is defined as hope, optimism, dread, faith, loss of faith, hopelessness.”

Steven answered,

I am not sure it makes it clearer but it actually helps a great deal because it kind of allows for, gives license to it not to be clear. For it to kind of be ambiguous and subjective. That helps.

Steven is thoughtful and invested in accurately capturing his experience in the interviews and framing his experience with the words that most accurately reflect his subjective experience. While I responded to his inquiry by giving him permission to use whatever language reflects his experience, the fact that he brought this point up in the first place reflects a certain discomfort or ambivalence about framing his experience in the language of hope. I was aware throughout the interviews that he seemed much more comfortable with the term optimism than hope.

It is also interesting that Steven struggles with the definitions of hope when he is considering his sense of hopelessness. I believe that there is also some reluctance on Steven's part to be hopeless, which is reinforced by the efforts he goes to in order to ward those feelings off and return to a baseline of optimism.

Steven is clearly a predominantly hopeful and optimistic person, which is probably one of the reasons he was open to being interviewed. The concluding remarks in his final interview reflect the depth of his optimism as it relates to his beliefs that he is both an inherently hopeful person and the importance for the therapist to be hopeful.

I have a lot of hope. I don't know if one can really stay in the field if they don't have that, you know I really have gotten in touch with my optimism and my hopefulness about people's capacity to change.

I started in this field seeing people who were sexual and physically abused and abandoned by their parents. I started out as a child psychologist in a community mental health setting and had plenty of reason I think to feel, to get, to give up, to feel hopeless, to feel despair, and you know as we have talked about it sometimes I've certainly flirted with those feelings, but they did not overwhelm me and I think that they do overwhelm some people and they can't do this work.

I feel just feel like it's probably if not a prerequisite; it's certainly an asset to be a fundamentally hopeful person. If you're really going to thrive doing this work and I've feel like for the most part I have thrived.

Cara: Clinician 3

Clinical Training and Professional Development

Cara is a clinical social worker in her 50s. Cara has held a few different positions since she began practicing almost twenty years ago. The first position that Cara held for almost ten years was as a medical social worker in a hospital. Cara did discharge planning, crisis intervention, grief counseling, and shorter-term psychotherapy with women who were experiencing health crises such as high-risk OB patients, gynecologic cancer, and infant loss. Typically, Cara would see her OB patients over the course of their pregnancy, 9 months, and could see cancer patients for a year or more.

This experience was meaningful for Cara. She was gratified helping these patients in crisis. Her own sense of hope was reinforced seeing the strength of these patients. After a few years, however, Cara found that she wanted to work with patients in a more in-depth capacity. She recalled, "I really wanted to know what happened to a mother 6 months after her baby died or what happens to the sister of a woman who died of endometrial cancer. I wanted longer-term engagement."

Cara entered a 2-year Post-Master's program where she received advanced clinical training. She began seeing patients in longer-term psychotherapy. Since completing the program 12 years ago, Cara has been working part-time at the agency that is affiliated with this training program.

Cara characterized her experience working at her agency as "precious." She is able to do long-term, in-depth work with patients usually once a week in an environment where she feels stimulated, held, and hopeful. The patients that Cara works primarily with either are dealing with health concerns or are women in their 30s who have long histories of depression with occasional suicidal ideation, anxiety, and life transitional issues such as divorce or death of a family member. She also sees a few male patients.

The agency provides on-going in-service training as well as case consultation. During staff meetings, the executive director often reminds the staff of therapy's creative process by referencing poetry and literature, which Cara finds meaningful in her work with patients.

Cara feels incredibly supported by her supervisor. When her own sense of hope fluctuates in relation to struggling with patients, Cara's hope is restored by both the insights and support she feels in that relationship. The clinical consultation with other therapists in her agency also helps to sustain Cara's sense of hope in her work. Many of the other therapists are very experienced and have been working at the agency for many years. Cara enjoys the reciprocity of these relationships, the mutual exchange and sharing that occurs.

Cara's work at the agency is only one facet of her professional life. At the time she was interviewed, Cara was in the process of leaving a full time administrative

position as the Master's level field placement coordinator for a university. Cara held that position for 7 years and was leaving it to join her agency on a full time basis.

While Cara has enjoyed working with young people at this important life juncture, cultivating relationships with students and helping them find internships that are a good fit; the job has become more difficult in recent years causing her hope to fluctuate. She recalled, "I love them [students], I see them, they tell me their dreams and stuff. I try to get them field placements. It's been cool for 7 years, but then the system started to really break me."

This position was always demanding but Cara enjoyed the challenge. Cara placed a few hundred students a year in various field placements. Cara's hope started to fluctuate, however, when she did not feel supported by the administration. Her supervisor who she had a close relationship with left the university. The field placement system was not automated, which made the placement process very time consuming. Cara also began feel overloaded by additional administrative reports and not appropriately supported. Cara also had some very challenging experiences with students. These factors resulted in the emergence of feelings of hopelessness. She recalled,

So there were these factors that were like wow there is probably another place for me. But as soon as I started to feel hopeless, I tried to take that energy and focus on the things that I can do that can make a difference.

Cara is nervous transitioning to a full time position at her agency, but feels hopeful that she made the right change for herself.

Cara has also been in weekly therapy intermittently for the past 30 years. This experience has helped her sustain and restore hope over time. The significance of these experiences will be described in greater depth in a subsequent category of meaning.

Organizing Principles

While Cara believes that connections in any part of a person's life are healing, she focused primarily on the primacy of the therapeutic relationship in facilitating that process. Cara tries to create a space that feels safe for her patients by being "soft yet sturdy" so her patients can share all parts of themselves. Cara used the analogy that she tries to become "a tether that gets stretched and pulled but doesn't get broken."

She reiterated the importance of "hearing all the details" and "deepening the storytelling." She described a session with a female patient where deepening the work helped her patient feel heard and supported.

I would say things like tell me about your fantasies about him? She would say to me thank God I can talk about this; nobody else will listen to me. I would say, what about this? Where do you see your relationship going with him? It's really speaking about unspeakable things and not being afraid to say how ugly something might feel or how inappropriate this expression must be, not shying away.

It is crucial to allow your patients to have their hopelessness and desperation and staying in those moments with them even when it is difficult. Cara explained, "When a clinician doesn't look like they are being broken by what you are saying and they're hanging in there with you. They are fazed by what you are saying in an appropriate way but they are not despairing."

Cara realizes the importance of listening. The therapist is not the solver. It is about sitting back and letting things flow. "It is about holding the flashlight and letting the clients do the work." It is helping the clients learn to trust themselves and helping them understand that they are more capable than they realize.

Cara believes that therapists cannot do this work if they do not have a fund of hope. It is about helping patients find their sense of hope and helping them access it. It is also about sharing your own hope when it is necessary and appropriate. She often reminds people that they are capable of much more than they realize.

Significant Childhood Experiences

Cara's sense of hope is framed by her family's narrative that exemplifies the ideals of the American dream. Both sets of her grandparents were from Italy and they came to America with no education and very little money. Cara remembers her father telling her about his childhood. She recalled that he had a job at a pharmacy delivering medications to doctors. After a while, her father decided that he is not going to deliver these medications anymore, he was going to become a doctor. He worked hard, got into an Ivy League school and became a surgeon. As a teenager, Cara would go in and watch her father perform surgery. She recalled,

I would go in and watch surgery, I was like, wow, here's Papa. You know this wild guy who cuts the shrubbery and makes spaghetti sauce and here he is doing a mastectomy on somebody and I was like wow, Papa, you know you're amazing, so you know what we can make of ourselves.

Cara is understandably awed by her father's accomplishments. She contended, "How do you come from you know your roots in an olive grove and make things better for the next generation?"

Cara's mother also exemplified internal strength that has filled Cara with a lot of hope. As a girl, she experienced multiple sexual molestations living in different tenement apartments. She never told anyone until the past 10 years or so. She was a wonderful

mother who also helped her father manage his medical practice. These childhood memories and experiences helped Cara enter adulthood with a lot of hope for what is possible.

After revealing these significant and positive childhood memories, she shared a traumatic experience in her young adult life that was life altering. When Cara was in her twenties and living alone, a man broke into her apartment while she was in the shower. He raped and almost killed her. She recounted this experience in detail that I decided not to include in this case study out of respect for her. The experience was horrific and it took a while for Cara's sense of hope to be restored. Its significance in terms of hope was described at different points throughout the interviews and thus will be described in subsequent categories of meaning.

Interview Reactions

I had many reactions to Cara throughout the interview process as well as while writing up her case study. Cara was the first person that I interviewed, so going into the interviews I was the most anxious. I had no sense of how exactly the flow of interviews would be structured, and if I would get the type of material that I wanted to get from the interviews.

Cara put me at ease quickly. I found her likeable and buoyant. She had a real upbeat and positive energy that really put me at ease. She had a genuine optimism that I observed instantly that made me want to be around her. She was incredibly open from the start of the interview process, sharing both personal and professional information. I

would come to realize later that she was the most open and least protective participant. There was a free exchange which made the interview process flow.

Cara spent much of the interview process talking about her personal life. It is clear that her personal life significantly informs her sense of hope in her work. The interviews with her also took place at a very interesting point in her life. She was just leaving her job of 7 years and moving into another position. It is my sense that the interviews were an opportunity for her to reflect on her job as field placement coordinator as well as her life.

There was something about the flow of our interviews, or the fact she was the first person I interviewed, where at times I felt as though I temporarily lost sight that I was a researcher and moved very comfortably into the role of therapist. This dynamic occurred for me with greater frequency as we developed greater intimacy. I found Cara affectively incredibly and unambivalently hopeful during the interview process. My affective experience resulted in feeling as though many of the questions I asked were focused on trying to elicit a more complex experience of hope from her. I remember feeling a bit disappointed that her sense of hope was not more complex.

I had a completely different experience of Cara when I was writing up her case study. I was struck by the fact that there was much that she discussed that contained a more complex experience of hope, especially in the clinical examples she used.

As I read through the transcripts I found that my own sense of hope began to fluctuate. I think it touched me more when I was writing up the case study partially because I was more able to let the material wash over me. I felt sadness that she was raped and almost killed. I felt sadness that Cara feels that her life has not gone as she

would have wanted it. I felt sadness that she was not able to have children as she had dreamed.

The sadness, and subsequent fluctuation of hope, that I felt were in part related to our empathic connection. Cara evoked in me a sense of protectiveness and wanting to care for her, which I think is related to what she stirred in me. I also experienced a countertransference reaction related to my own history of profoundly feeling the unacknowledged sadness and disappointment of an intimate other. My reactions made the write-up somewhat challenging to do until I had some time to understand the complexity of my experience. Even then, however it was particularly challenging for me to critically challenge the material that she presented.

It is my sense, however, that there is another layer related to the discrepancy between Cara's affect and her content that was related to her. I recalled something that Cara described in the second interview. There have been instances when others, such as her therapist and a supervisor in graduate school, have observed that she has been "too hopeful" than is appropriate in a given situation. Cara understands this occurrence as "disavowal" of disappointment that emerged after her sexual assault.

I wonder if at least some of what accounted for my difference talking to her face to face versus reading the transcripts was related to this disavowal that Cara described. The interesting twist in this understanding, however, is usually face to face contact is often more revealing in terms of affective complexity than reading transcripts.

My overall experience of the interviews with Cara was very positive. She was so generous with her time and so open about very personal experiences that I felt a real closeness to her. As the interviews came to the end, I felt the urge to hug her.

Categories of Meaning

Working Through as a Capacity in Achieving Resilience

Cara's sense of hope is organized around a sense of faith she has in the resilience of people. Her capacity to move forward and integrate difficult experiences reinforces an optimism that all people have the courage to move beyond difficult experiences. "People have a lot of courage. They are more capable of managing and integrating things because I've seen it and I've done it. There is a cellular thing that comes. It's how we're all made."

Throughout the interviews, Cara used an Italian expression used in her family, *sempre avanti*, which means always forward. Cara holds a deeply held sense of optimism that there is an internal force that exists within most people that moves them forward in their lives, allowing the human spirit to regenerate in difficult times and be resilient. "I am just going to throw it out there to some power that's gonna help me have strength, and just trust that there is a flow, like *sempre avanti*, that something is going to move forward."

Sempre avanti was not only a phrase used often in her family, but she witnessed her parent's ability to overcome hardship. Cara's mother and father had difficult and traumatic experiences as children of immigrants as described in the section on significant childhood experiences, but persevered and made a "good life" for their family.

Cara has repeatedly shown resilience in her own life that exemplifies the ideals of *sempre avanti*. Cara displayed a sense of resilience that helped her find a way to heal after she was raped and almost killed. In addition to reaching out to family and friends,

she found the courage to get the therapeutic help she needed to feel supported and to help her process this trauma. Cara's therapist at the time reinforced and expanded the ideals of *sempre avanti*. Cara recalled an exchange between her and her therapist. "When I would say to her, how am I even going to be the same? She would say you are not going to be exactly the same but you're going to get through this."

Cara eventually found greater meaning in her professional life. She ended her career in public relations and went to graduate school in clinical social work. This career change has been a good fit for Cara. Her first job after getting her master's degree was working in a hospital setting. Cara found it was reparative to be able to give to others as Cara had been given to in the aftermath of her trauma. She recalled, "I just really wanted to be with people because somebody was there for me at the worst moment in my life. I did not want people to feel alone."

The ability to make peace with disappointments is a component of what enables Cara to live out the ideals of *sempre avanti* and to reconstitute her life. This ability is exemplified in how Cara has had to reconcile that she will not have children, which is something she always wanted. Cara said,

My life hasn't gone the way I've wanted it to, my marriage ended because I wanted to have children and my husband did not want to. I've had to reconcile that sort of ragged ending that, you know, I'm not going to have kids. You know you can't always fix stuff the way you see it, so you have to make peace.

Cara found compensatory ways to nurture young people in her professional and personal life; restoring a sense of hope in her life. She stopped working at her job in the hospital as it was too stirring to work with women around pregnancy and loss, and began working with graduate students who were trying to figure out the directions of their

careers. She also expanded her social network, which included cultivating relationships with her friends' children and becoming a mentor to a young girl.

I made the decision to make a family and community in a different way. It wasn't going to be my own nuclear family, but it was going to be the students and developing friendships with young people outside of work. Part of being in these friendships really helped me heal and not think there's only one way to have a life as a mother and a wife, there's not.

Another aspect of her regeneration process entails experiencing periods of hopelessness. Cara described a fluctuation in hope this past fall that occurred as a result of a confluence of events. She felt unsupported and overburdened by the supervisors in her job as field placement coordinator, her 11-year-old dog almost died, and her relationship with a boyfriend of 2 ½ years ended. Cara also turned 50 and was grappling with the transition to mid-life.

Cara became depressed. She put on weight, became reclusive and feelings of hopelessness emerged. Alongside these moments of hopelessness, however, Cara has a sense of optimism that these feelings will be temporary. She recalled,

I am not going to sit in this hopelessness too long, but I am gonna acknowledge it. You know like I would see myself at home like wow, Cara, you're really hurting. But I knew these feelings of hopelessness would pass, but I also knew I would have to make some gestures. You just go forward, *sempre avanti*; you just go forward. It's not always going to be this way.

Cara's own capacity to move forward and integrate difficult experiences gives her faith in her patient's ability to integrate difficult experiences. Cara described seeing hundreds of patients over the last 20 years that have been able to integrate tragedy and loss in their lives. Cara recalled, "I have seen hundreds of patients just seeing the grace

with which people turn their losses around or the way people behave in the room of their dead loved ones or how mothers hold their dead babies.”

These experiences inspired her and reinforced her belief in *sempre avanti*, the optimistic internal force that gives them the ability to move forward. Cara recalled seeing this capacity especially when she worked in the hospital.

There was an element at my job of people coming back after multiple losses. How do you even embark on another pregnancy and people hold onto hope again? The hope that they could get pregnant again, the hope that they could carry a baby to term, the hope that they could cope with this devastating loss and that the marriage could sustain itself. People are capable of much more than they realize.

There is a sense of courage that Cara has observed in her patients’ capacity to regenerate. It is related to their ability to face pain and tragedy. She recalled an unforgettable experience of courage displayed by a mother who had a stillborn. This mother did not want to see her baby. Cara always tried to help mothers hold their babies because of the belief that you have to say hello before you can say goodbye to someone who has died. The mother refused. Two weeks later, the mother called Cara and the chaplain and asked if they could bring her baby out for her to hold. Cara made sure the baby was wearing a hat and blankets. Cara recalled,

We went into the morgue together and it was cold and the baby smelled like formaldehyde. The mother held the baby as if she was just about to feed it and change it. She kept kissing her and saying, “You are my girl.”

Cara has also seen this resilience in work with her longer term patients in disparaging situations. She feels that “something always comes around.” Cara described her work with adult man patient that she has been working with for who experienced

extreme neglect and misattunement as child. His mother had undiagnosed schizophrenia and his father used to lock him in a trunk and drive around. Cara described,

He often cries and says when is my life going to start. How am I supposed to understand how to have a relationship? How am I supposed to know what it's like to receive love when my mom was seeing mushrooms grow out of a wall?

Cara has seen him make strides since he has been in therapy. He is not actively suicidal; he is in recovery from alcohol; he has some friends; he has plans for the holidays; he shows up at a job he hates; he takes care of his cat; he cooks for himself for Christmas; he goes on job interviews; he is able to engage in a relationship with Cara; and he pays his bills. He makes a life for himself.

While his life does entail struggle, he seems also at times able to display a sense of optimism around his own capacity to regenerate. It feels reminiscent of how Cara describes this capacity in herself; perhaps an indication that he has internalized some part of her. Cara recounted,

This patient does what is necessary to right himself and it happens that he is overeating. He is not drinking again, he is not trying to hurt himself, but he made himself lasagna and he says that's really the worst thing I am doing. I'm kind of depressed, I don't like my job. I am isolating and I'm eating a lot. He is a personal trainer. He's eaten before. He has eaten Twinkies and he says to himself. I'm just gonna eat until it's not interesting anymore. Then I'll start to exercise again. He is the person whose life you know he has worked very hard to reconstitute but there is real despair there.

It is clear to me that Cara fundamentally believes in people's capacity to move through hardship and to regenerate. The examples above suggest that this belief is one she carries with her in her work with patients. It is worth noting, however, that most of the clinical examples she described to me in the interviews were those patients who were in the midst of experiencing some sense of hopeless and desperation and how Cara stayed

in those moments with patients (described in more detail in the subsequent section) rather than how patients have reconstituted their lives. I do not believe that this discrepancy in any way diminishes the force with which resilience is a fundamental belief of Cara's. Rather it is instead a reflection that Cara described this sense of resilience more expansively in how it relates to herself than her patients.

As Cara reflects on her experiences as a field placement coordinator, she also noted that she often witnessed the acquisition of resilience in her students during their time in the Master's program. She recalled seeing how "wide-eyed" they were when they first came into the program. Over the course of the program, she observed how they would get "a few scrapes but then they matured, developing a greater sense of resilience by graduation."

Cara has been in her own personal therapy much of her adult life. She spends time alone which also helps regenerate. Cara also controls to some degree the flow of information in her world. She chooses to avoid the news on television where bad things are often accentuated. She additionally seeks out biographies about women like Gloria Steinem that reinforce this ideal of *sempre avanti*. She said, "Most biographies have to do with a force that people have, this isn't always enacted but people push forward. It's natural." These women have given Cara permission to have a unique life.

She described another strategy that allows her to remain hopeful and thus resilient. She at times defends against becoming disappointed. I described this defense that Cara labeled as "disavowal," in the section that described my internal reactions. This defense was first pointed out to Cara when she was a student. Her supervisor at the time observed that she only looked at the strengths and not the limitations of patients. Her

therapist more recently brought it to her attention in relation to the difficulty Cara was having for a long time being anything but hopeful regarding her field placement position when it seemed more appropriate to have other affective reactions.

It sounds to me what Cara described as disavowal is similar but a less extreme version of Stark (1999) describes as “relentless hope.” This is a defense that can get activated when in the clinician (or patient) is she is unwilling or unable to bear the pain of disappointment (p. 311). The fact that Cara has some awareness of her propensity to use this defense combined with the fact that she was able share a wide range of fluctuations in hope during the interviews makes me feel that, while it is a defense that may be operating, it does not seem to be adversely impacting her or her patients.

The Power of Connection in the Attainment of Hope

Hope exists for Cara in the heightened emotional experience of a meaningful and authentic connection. She described experiencing this sense of connection in a variety of contexts with patients, her therapist, and her supervisor and colleagues. While her role within each of these relationships differs, when Cara has a positive affective feeling related to making an authentic connection she experiences a sense of hope. When Cara is not able to experience a meaningful relational connection, in her sense of hope fluctuates.

Throughout the interviews Cara described the heightened emotional experience of authentically connecting with her patients in terms of a sense of energy that she experiences which feels hopeful to her. She contended,

It’s an unspoken energy that exists between two people, two strangers and that to me is the privilege of being the person in the office that is sitting with a stranger

who is sharing all this stuff. I am all ears and I am open to hearing their story and just trying to accept it and to me hope exists in energy.

Cara further elaborated on what she meant by the energy of a positive affective experience with her patients:

It is energy around a connection that exists between two people where you're really staying with them in a really sort of awkward moment or hard to verbalize moment, and having sort of the patience and energy to hang in there. It's faith based a little. Not God based necessarily but it's human connection based.

Cara is describing her own affective experience of feeling a real connection to a patient. It seems to me that she is describing from the therapist's perspective the affective experience of a therapeutic relationship working at its best. Therapist and patient are truly connecting and invested in the process. The therapist is creating a sense of safety by being attuned, invested, and empathizing with the patient, which allows patient to share deeply with the therapist and feel heard and understood.

Cara described a clinical example of experiencing this energy with a male patient she has seen for 7 years. She experiences a depth of relationship with him that they have effectively built over time. It is a relationship where he has shared many parts of himself and Cara has come to know him and support him. He can be low and Cara will be low with him, but there is a history there between them that Cara experiences as "very powerful."

When Cara is working with patients where she experiences fluctuations in her sense of hope, she seems able to ground herself in those hopeful moments when feels as though she is attempting to make an authentic connection. This experience occurred for Cara when she was seeing a transgendered young woman patient who is in the process of becoming a man. She has one of the most horrific histories Cara has ever known. Her

mother was physical abusive to her and ultimately committed suicide in front of this patient when she was a young child. The father was not part of her life. While this patient was able to go to college and did establish a relationship with a professor and a psychiatrist, her capacity to be in a relationship was very limited.

Cara experienced fluctuations in her sense of hope throughout this treatment. This patient had tremendous need that far exceeded Cara's role as her therapist. Cara felt a sense of hopelessness in those moments when she got in touch with how difficult this patient's life was and how difficult this patient's life will likely be with the choices she was making. Yet, she was also able to hold onto a sense of hope in those moments when she was helping her patient experience, even to a small degree, that human connection can be reparative.

I have more hope now because even the most tenuous connection can still matter to a person. So even if I am reaching out to her cause she has not shown up and I am texting her and saying just checking in and wondering how you are doing I think that's some times more than a lot of people get from others.

Cara experiences feelings of hopelessness when she does not experience even tenuous glimmers present in the patient's capacity to establish a deep relational connection. She had this experience with a woman patient who Cara described as having borderline characteristics. Cara repeatedly felt present and tried to help this patient feel comfortable telling her story. At one point many years into the treatment her patient became so injured when Cara forgot her birthday that she began raging at Cara. At another point in the treatment when Cara was visiting this patient in the hospital this patient could only attend to the fact that Cara had forgotten her anniversary of sobriety. The lack of positive affective connection made Cara feel hopeless. It is my sense that the

sense of hopelessness that Cara is experiencing is diagnostically related to extreme relational deficits within the patient.

Cara's sense of hope has also been profoundly affected by the heightened positive affective experience of authentically connecting with the different therapists she has had in her adult life. Cara describes her internal affective reaction of feeling okay or made whole by being in the presence of many of these therapists. She said,

I felt hopeful and whole just by being in their presence. I don't remember all the sentences or times; I just remember that they stayed the course with me. It was not about solving the problem. It is the sharing of something.

At another point in the interviews, Cara again recalled how the presence of her therapists listening without becoming overwhelmed was grounding and restorative. Cara is experiencing, from the lens of a patient, the ideal components of a therapeutic experience. She added,

When I think about all the stories I shared with my therapists over time. All the affect that has been in the room and just all the normalizing that they do by just being there and not being like, falling back in their chair. I think about the words steadying, normalizing, grounding. They never really said you're going to be okay, but they help you know that you are going to be okay by their presence.

Over the course of her own treatment, Cara experienced one therapeutic relationship that lasted a few years where she did not feel that positive affective connection. This therapist was not really attuned to Cara but more interested in rigidly following her own therapeutic approach which was trying to induce regression and dependency on Cara in weekly psychotherapy. While the details of this treatment will be elaborated on in a subsequent section, the lack of positive relational experience caused Cara to feel a sense of hopelessness.

Cara described the heightened positive affective experience of authentically connecting with her supervisor and colleagues as occurring when she is able to share her clinical struggles with them. It is through this process of sharing and the subsequent growth that Cara has observed in herself that reinforces feelings of hope. Cara explained,

If you don't share your authentic struggle with your supervisor, you're not going to grow. Over time being supervised there and going to in-services and sharing, you know, I've been morphed in a way based on my community and based on thinking of things in a new way. We're never in isolation that's why I would never want to have a practice alone. I really appreciate being connected to other.

Cara's sense of hope is sustained by being continually reminded in these clinical meetings that she and her colleagues are trying their best, but no one has the right answers. Cara recalled,

I'm part of this larger community of therapists who are muddling through this and there's not gonna be clarity and every in-service we go to—no one has, no one raises their hand and says this is how you manage this person. It's every step and what's it like to be in the room and so there's not a clear-cut strategy, there's some postures that we have. I guess in some better directions maybe to go or considerations to have but it is hopeful to accept that there are no real answers.

While Cara felt a positive affective connection with the team of people she worked with as coordinator of field placements, she described the experience of not having that type of connection with a particular superior in another department. This lack of positive affective experience caused her to experience a fluctuation in hope related to her work at the university.

Cara elaborated that the time-intense nature of her job placing students prevented her from starting an accreditation report for the university. When she finally looked at the report and reached out to this administrator to do the report together, the administrator was not responsive. She did not return her calls or emails. She described,

It was so shaming. I'm the kind of person that would be like come on let's do the report. Let's get pizza; who cares if we have to work late? Let's work together. We're both representing our university; let's do our best. But I was being punished for not opening the email.

While Cara completed the report on her own, it was not done to the liking of the wider accreditation body so she was reprimanded. While Cara's sense of hope fluctuated as a result of not feeling supported, she was able to keep in perspective the systematic reasons for what happened and so she did "take the blame" for it not being completed as the governing body had intended it to be.

The Regulation of Hope through the Use of Affective Attunement

There is a particular affective experience with patients that is linked to hope for Cara. It is her capacity to stay with patients in their most painful moments of despair, hopelessness, and depression. When Cara is able to stay affectively attuned to patients in these moments, while difficult, she is able to experience a sense of hope.

As is the case with all psychotherapists, there are times when Cara's empathetic attunement to her patients can trigger reactions, often countertransference in nature based on her own intrapsychic history, her patient's intrapsychic history or some combination of both. Cara then experiences many reactions including fluctuations in hope. When this occurs, she is successful at actively trying to restore her sense of hope either by reminding herself of the value she places on affective attunement in healing or by processing these fluctuations with her supervisor. Cara described her internal experience of affectively staying with her patients when they are experiencing moments of despair and hopelessness. Cara described,

It's a physical feeling, it's just like being laid bare in the room with this person and it's depletion, you know we are both sort of depleted in the moment. It's silent. My tone is more quiet. I certainly at the end don't try to lift them up and say, see you next week because you just stay in this sort of subterranean place of being both drained.

Cara recalled several experiences when she worked in the hospital of being present and empathetically attuned to patients who were in the midst of terrible tragedy. One such experience she described was going into the emergency room with a patient to identify the dead body of her husband. Cara and the patient held arms and stood by the body in silence. Eventually, Cara encouraged this patient to share some reflections about her husband.

Cara's capacity to sustain hope, however, is about more than staying in the affective moment with patients. It is about striking a balance between being affectively attuned while being differentiated enough to help patients. Cara described it as "feeling that desperate feeling and being scared for the person but still believing in the services I am providing." Cara will at times give her patients encouragement in moments of hopelessness that they do have the capacity to heal. Cara related,

You know being in the room, being there consistently not judging what's coming out of their mouth, is very powerful and healing. It is not for me to remove that hopelessness. It is to remind them that they are worth telling their story, that they do have some strength to manage this, and I think you know by just witnessing you're reminding people of their worth and letting them know that they can sustain themselves through this.

The balance of being affectively attuned yet remaining differentiated is a skill that Cara has used in her job as field placement coordinator. She reflected on several times when students would be share their struggles by confronting Cara about certain decisions she made. Cara was able to make room for their anger while holding her ground. It was

often the case that after the fact the students would apologize for their behavior, which sustained a sense of hope in Cara that she had appropriately managed the situation.

Cara described instances when it was more challenging to hold onto this balance in clinical situations and her sense of hope fluctuated. She has observed this occurring occasionally with her longer term patients who are in the midst of a major depressive episode. Cara recalled an intense and difficult session with a woman patient that unlocked a sense of hopelessness in Cara.

Cara has seen this patient for 12 years. She has a history of major depression and has had two suicide attempts. She is currently on medication regime, which has been helpful. She is married to a man who is a hoarder, and who she wants to leave. Her client's anxiety and depression escalated in reaction to two experiences. The first is that her patient found out that the couple's therapist she had been seeing unexpectedly disappeared as a result of committing some unethical and illegal acts, which may result in him serving a jail sentence. The second is that this patient received criticism in her art therapy consultation group that her work, which she thought was going well, was perceived otherwise by people in the group. Her patient said,

I am not suicidal but there is nothing in my life. I can't even do social work. My couple's therapist is nowhere to be seen. I am 30 pounds overweight. I don't have a plan, but this one thing I thought I could do well [in art therapy]. I've been blasted by my peers. I can't even hold the interest of a couple's person. I don't know if my marriage is going to last. I don't know if I want to be a social worker anymore.

Cara described experiencing feelings of hopelessness when her patient was expressing her despair. Cara was able to contain those feelings fairly quickly by

remembering both that this sharing is part of the therapeutic process and that she is this patient's only support.

So it's this whole conflagration of bad things in her life, and I've been through things with her before. At least if there was something good going on in her life, but she had nothing. When she leaves my office, I am like God help me. I just have to go to a place in my gut that just says hang in. Hang in there until next week at the same time and the week will have molded her in a new way. I am going to be there. I say to myself, you're going to do this, hang in with this person because nobody else believes in her. She does not believe in herself.

While the emergence of feelings of hopelessness can be challenging for any therapist to experience, it can often help deepen the treatment. Cara recalled an example with a woman patient who she had been seeing for a long time that was experiencing tremendous desperation. She was crying and crying, and for a long time, Cara was listening and acknowledging her pain. Yet this woman was not able to get up in the morning, get out of her house, she wasn't really functioning. A sense of hopelessness emerged in Cara. She became fearful and tried to intervene to help contain those feelings. Cara recalled,

I tried to solve it. I lost hope in the process of just listening. It just took on this fevered pitch, she was wailing and wailing, people were near the door and wondering if I was okay. It felt like I was stabbing her. I was scared. I felt like I had to contain it, so I suggested that medication might help her, but people her whole life were trying to contain her. So she pushed back and said how dare you try to contain me after you have been encouraging me to express my feelings.

Cara felt that her reaction to her hopelessness with this patient was reflective of her lack of experience. She feels as though she has learned to stay with more challenging affective content as she has become more experienced. I would argue, however, that the hopelessness that Cara experienced was helpful for a different reason. Cara was in the midst experiencing an important relational exchange or projection that was ultimately

gave Cara greater insight into the patient's relational world. Cara affectively experienced how scared and out of control the patient feels, and the fear that this patient elicits in others that make them want to contain her. The fact that Cara and this patient were able to reflect on this relational exchange helped deepen the work with her patient and made it more real.

Cara restores her sense of hope after painful and hopeless moments through meditation and self-reflection. She will occasionally turn off the lights and pray after an especially painful or difficult session. She also seeks solitude and being in nature. After a full day of seeing patients, she often is not interested in having another conversation with a human being. She will get on her bike, walk her dog, or even knit.

It is also restorative to process her feelings of hopelessness with patients with her supervisor. Her supervisor helps her think through what she is experiencing with patients. She also validates that fluctuations in therapist's sense of hope is part of the therapeutic process. Cara recalled a conversation with her supervisor:

I said you know I'm really struggling with this person and it's, you know it feels really hopeless and I'm not sure what to do here. My supervisor said you know it's really not about the doing. Do you know what are you so worried about here?

So my hope gets restored by knowing that this is part of it and if you're not having feelings in the work, eliciting that, eliciting them or feeling them yourself then you're not really doing work.

Reflections of Personal Experiences in Therapy

Cara has been in her own personal psychotherapy for nearly the past 30 years, almost her whole adult life. She was incredibly open about sharing her experiences in therapy with me during the interviews. This category of meaning comprises a compilation of personal feelings and reflections of Cara's own treatment

experiences. As is the case for many psychotherapists, Cara's personal treatment serves as a backdrop of healing, support and learning that has been incredibly grounding and restorative.

Cara's therapists provide a holding function that have enabled Cara to have hope, faith, and optimism in her personal life and professional life. When more specific fluctuations in her sense of hope occur either in either realm, the constancy of her own therapeutic relationship helps to restore her sense of hope quickly. The one time that she was in a therapeutic relationship that was not a good fit, she experienced a fluctuation in hope which compounded other feelings of hopelessness that she was experiencing in other areas of her life. Her experiences in therapy also helped her feel an ongoing sense of professional hope in that they have helped her learn about how to be a therapist. She recalled, "One of the cool things about treatment is that you know obviously a little bit that you learn in school from your instructors but it's really how you've been, what my ex-boyfriend used to say, therapized."

Cara reflected on her therapeutic experiences as having shared a passage together. She recalled, "I have internalized them, my treatment experiences. They sit in you and you can see their faces and recount experiences."

Cara has worked with five therapists in her adult life. The length of each once a week therapeutic relationship ranges in from 6 months to several years. The impetus for changing therapists has usually been the result of external factors such as the therapy was time limited or she or the therapist moved to another geographic location. There was only one relationship that ended because Cara felt it was not a good fit.

Cara described the profound effect of her first experience in therapy throughout our interviews. It was a brief treatment that occurred in a hospital for 6 weeks after her sexual assault. While Cara did not recall many of the specifics of that experience, she affectively recalled her therapist's presence. She contended, "It was a soft and soothing. It was the experience of not being overtaken."

This experience lives on in her memory. She recalls this feeling of sitting with her therapist when she is trying to assess the capacities of students prior to put them in field placements. It is my sense that while this experience in therapy did not completely restore Cara's sense of hope after her sexual assault, it is unrealistic to assume that it could. This experience seemed rather to provide a hopeful counterpoint to the more profound sense of despair that was Cara's experience at the time.

Cara described her second therapist as also being a "gentle and soothing presence and a lovely person to sit with." The experience of "feeling known," however, stands out in how Cara described what was especially restorative about this therapy relationship. Cara described that she was there to help me with the "confusion around all of the feelings" Cara experienced after the sexual assault.

Cara saw this therapist during the time that the man who raped her was being prosecuted. She helped Cara understand the posttraumatic stress reactions she was experiencing. She helped Cara create a life that felt safer and helped her find meaning in her life, which eventually included being able to make a commitment to a man. Cara recalled a particular significant moment that encapsulated her sense of feeling known by this therapist.

My therapist was with her sister looking at the space for another occasion at the place I was getting married. I saw her when I was in my bridal gown. Her eyes welled up a little bit and so did mine. I was like, you know, I really thank you for everything. You know this was a great destination to get to, being able to make a commitment to this person. I thanked her and she sent me a beautiful note after. It was just one of those really touching moments.

The next experience in therapy was Cara's only experience that she described as "not about instilling hope but trying to unleashing primitive stuff." Cara went in great detail about this negative experience. It seems as though this therapist was not attuned to Cara, but rather followed her own agenda. The lack of attunement to Cara and what she needed at the time exacerbated feelings of hopelessness that emerged in Cara's life.

This therapist repeatedly seemed to thwart Cara's expressions of adaptation and resilience instead wanting to induce a dependency. She became enraged that Cara did not "respect the primacy of the therapeutic relationship" at one point when Cara did not "adequately" process changing jobs prior to accepting a new position. Cara accepted a new job because it allowed her to nurture graduate students rather than being in an environment where she was continuously dealing with obstetrical issues and infant loss at the time when she was realizing she was not going to have a child.

When Cara brought in a self-help book she found helpful on another occasion, the therapist also felt Cara was diluting the transference and responded that the book would not "cure" all her problems. Cara also described her therapist's reaction when Cara brought her Christmas cookies. Her therapist seemed to provocatively respond by asking Cara how she would feel if she ate one in front of her. When Cara responded by saying she was uncomfortable, the therapist interpreted that she was ingesting Cara.

Cara describes this practice as analytic psychotherapy. It is my sense however this therapist practiced “wild analysis” provocatively trying to unleash in Cara regressive, primitive material as well as trying to induce a dependence in a once a week therapy that served the therapist’s interests more than Cara’s. In another sign of her resilience, Cara decided to end this therapy relationship. This experience compounded a sense of hopelessness at the time in relation to grieving the end of her marriage and not being able to have children. Cara has been able to learn from this experience. She uses it as a frame of reference in what to avoid in her own personal therapy, in her own work with patients, as a learning tool with her students.

The next experience in therapy Cara described as strength-based. This therapist helped Cara process the previous experience in therapy. Cara’s sense of hope was restored by identifying with the approach of this therapist and, in doing so, more clearly found her own therapeutic voice.

This therapist was strength-based, but that whole concept, you know I am a social worker. I don’t really talk about the primacy; I would never say that to a client. I would want them to bring in a book.

The nonjudgmental presence and continuity of her current therapist has been among the qualities that helped Cara feel as sense of hope both in her own life and about people. Cara reflected,

I would share these ridiculous stories about whatever I was doing at the time, and you know she really honored it. She never judged me. It’s precious what people do for each other. Just by being there, she helped me know I was going to be okay.

Clinical Training and Professional Development

David is a clinical social worker in his forties. For the past 11 years, David has worked full time at one of the few social service agencies that does long term therapy with children, adolescents, families and adults from diverse ethnic, socioeconomic, and religious backgrounds for a sliding fee. David sees people along the developmental spectrum from latency aged up through adulthood utilizing individual, family, and couple treatment. These patients tend to range from being higher to lower functioning. David sees patients weekly for as long as is needed; some patients he has seen for 10 years. In addition to seeing patients, David supervises students and staff.

David also maintains a private practice, which he began 7 years ago. When he began his private practice he joined a clinician who was expanding his child therapy practice. David primarily saw children and received supervision from this therapist. After about 4 years, David started his own practice where he sees adolescents and adults.

David began his professional career working with HIV and AIDS patients at an agency doing case management, referral and advocacy. After a brief period, David got a job as a medical social worker at a Children's Hospital. He worked in their pediatric and adolescent HIV clinic both in the inpatient and outpatient departments for several years. He did individual and family therapy as well as case management. When he started, there was a real emphasis on the "person in the situation" as many of his supervisors had been in the field since the 1960s-1970s. Gradually however the hospital had a more "managed care" focus so social workers were expected to do discharge planning.

As David became more experienced his interests evolved. He became less interested in larger cultural, political, and advocacy issues and more interested in

intrapsychic psychological and emotional issues, which is why he made the transition to working at his agency and engaged in more in-depth therapy.

The psychodynamic lens frames David's life giving him meaning and a sense of faith. He feels that life is about trying to express emotion, find deeper meaning, persevering through challenges and getting stronger. It is a shared language with his partner, friends, and mentors.

David sustains his sense of hope by finding a balance between engaging in psychoanalytic learning more directly and disengaging to pursue other artistic interests such as reading, listening to music, and going to the movies. He often attends workshops and reads about psychoanalytic theory on his own. He also meets with a consultant outside of the agency monthly. Professional development is also provided at his agency, which he finds growth-producing. He has seen the same supervisor weekly for the last decade to discuss his clients; he is part of a peer consultation group, and he participates in-service training several times a year.

David's own experiences in weekly psychotherapy have been formative in helping him find and sustain hope in his life (described in greater detail in a subsequent section). It inspired him to want his patients to have a psychotherapeutic experience. David's first psychotherapy experience began when he was an adolescent when he was going through a depression. David not only connected with his therapist's but felt the power of thinking about himself for the first time. This experience was so positive it made him consider joining the field. His most recent experience in therapy was formative in a slightly different way. While David felt that his weekly 12 year self psychological therapy was helpful in that he felt very supported, he got to a place where

he wished he worked with a therapist who challenged him.

Interview Reactions

When David and I met, I felt an instantaneous comfort with him. He was easy to talk to and warm. I was struck by the fact that he was the youngest person I interviewed, approximately 10 years younger than the rest of the participants and younger than me as well. I wondered how his age might play into his perspective on hope. David was also one of the last participants that I interviewed. When we began the interviews I had a greater sense of perspective regarding the flow of the interview process and greater comfort in my ability to conduct research interviews.

When the first interviews began I was aware that David seemed a bit uncomfortable sharing personal information about himself as well as his personal reflections. He was at times vague about more intimate details about himself. Additionally, there was a sense of hesitation and tentativeness around reflecting on his sense of hope, which at times made it hard for me to get a sense of what he was saying.

In an attempt to help David feel comfortable, while also getting the material that I needed, I felt like I became more active in trying to clarify what he was trying to say and deepen his thoughts and reflections. My tone, at times, felt supervisory. When I looked at the transcribed interviews, I noticed that there were occasions when the point that he was trying to make did not always correspond with how I was trying to clarify what he was saying, even if he often agreed with how I was framing what he said. This observation makes me wonder if we were getting into a kind of transference dance that was not related to the content of hope.

As the interviews progressed, David became more comfortable. He gradually became more and more open with what and how he shared. There still was a sense of protectiveness about personal material, which I came to understand was related to shame about completely disclosing his disparaging feels and struggles around competence in his personal life.

It became very evident to me, especially as I reflected on the written transcripts, that David is an intelligent and thoughtful therapist. There was a depth and complexity to how he thinks about hope, which was very refreshing. He articulated in a more in-depth way, more than any of the other participants, fluctuations in hope especially as it relates to his personal life. I particularly appreciated hearing about that aspect of hope. He really captured how there is a continuous feedback loop between success at work, bolstering his sense of sense self, which in turn makes him feel hopeful. It is my sense that these factors are interrelated for many people.

David also helped to further my thinking on my dissertation. When I started the project I thought more about the vicissitudes of hope in the therapist. What I have gotten to with the help of David is that hope is just one aspect of the therapist's experience I am interested in. I am most interested in the therapist's experience of painful affective states, despair, loss of hope, etc., being just one particular affective continuum.

Organizing Principles

The principle that really seems to underlie David's professional and personal beliefs is related to the importance of acquiring self-understanding to facilitate change and a more integrated self. The importance of self-awareness for David is similar to

Freud's belief that it is about making what was unconscious conscious, so it can be understood and worked through. David explained, "it's about trying to liberate ourselves from our issues in our past and things we are not real conscious of."

In the second interview, David described how his patients' increased self-awareness becomes the gateway to change and growth. He stated, "To really help people deepen their understanding of what was happening for them and, you know, hopefully figure that out better, make changes, feel differently, act differently, and grow."

The process of self-awareness for David also involves learning to feel painful affective states, mourn painful experiences, and learn to tolerate feelings. It is about learning to see and accept split off parts of the self.

David's organizing principle encapsulates the general principles of a psychoanalytic approach. What makes this lens an organizing principle is that it is a particular belief system that encompasses the many dimensions of David's life. It is a process in which he engages in his personal life both within the context of his own therapeutic relationship as well as in other relationships, and in his metabolization of professional readings. It is a process in which he engages in his professional life. It is through his own application of these principles in his use of self as well as by creating a safe environment that enables his patients to learn these abilities. (This concept will be addressed in greater detail in a subsequent section.)

Significant Childhood Experiences

David's sense of hope as a child was connected to "trying to make sense of things." This curiosity was a value that David learned within his family. His mother is a

social worker and a lot of people in his extended family are therapists so there was a certain emphasis placed on looking at deeper and more complex meaning. While this psychotherapeutic value existed in the family, there were times when it was not utilized. David experienced a lot of anxiety and other affects that were not openly discussed in his family. He wondered if it was related to his brother who struggled as a child with learning disabilities, ADHD, and difficulties with emotional regulation. David recalled, “Growing up my family had a lot of anxiety and I think I was always trying to make sense out of things. I was trying to understand what things meant and what all the affect was about.”

When David had his first experience in therapy as an adolescent, his sense of hope related to figuring things out became directed towards himself and his internal experience. This experience was powerful. It instilled in him a sense that self-awareness can make things feel better. It helped to lift David’s depression. This experience was so powerful that it made David consider entering the field. David recalled,

I was always wearing all black and smoking cigarettes and sitting in therapy at like 15 or 16 with this guy and really for the first time really feeling like I was allowing myself to think about myself. I had a really good experience. It made me think about going into doing some kind of therapy or becoming a helping professional.

Categories of Meaning

Personal Mastery as a Factor in the Acquisition of Hope

I was always not really consciously certainly but trying to deal with this concept of hope. I have never thought of myself as really optimistic or hopeful because it wasn’t what I was attracted to or it wasn’t what I felt like I was demonstratively. There was an incongruence I think in some ways of how and what I was all about so now I feel a lot more whole and certainly a lot more integrated. So I wonder if I really had a lot of hope and optimism and sort of exuberance and stuff like that,

but it wasn't something that I felt real connected to that part of myself, and now I feel a lot probably a lot more.

David has struggled to sustain hope in his personal life. His lack of hope seems most pervasive in his adolescence and earlier adulthood as David was consolidating his sense of self and striving to figure out who he was in the world. It seems connected to his struggle to establish a secure sense of self, which is linked for David to feeling competent. David recalled his feelings of despair as they are related to his sense of self:

Grappling with my own despair around feeling uncomfortable and trying to figure out what that was about. I am always trying to become more comfortable with myself and trying to be more comfortable with people. I was trying to find faith in myself, faith in my own power and my own voice, which has certainly been a struggle.

David specifically described his feelings of despair that emerged in graduate school. He struggled with the academics, which brought up feelings of shame and caused him to distance himself from others. He stated, "I struggled with my competencies, being able to do things. I feel like I hid a lot of struggles with school and with academics and really dealt with the anxiety, you know, pretty much alone."

David was conflicted about making a commitment to being a social worker because he lacked faith in being able to use himself in this role as helper and professional. The first time he joined his supervisor as the co-facilitator of a HIV and AIDS support group as a first year intern, he recalled that the group members began talking quite emotionally about their feelings about death and dying. David left the group really feeling overwhelmed and questioning if he would have anything to offer these patients.

While David's feelings of despair were more accessible to him in graduate school, he described glimmers of hope that were present even if they were split off from him. Hope was present in the fact that he did not quit the field in spite of feeling ambivalent about his performance as an academic and professional. His optimism about the sense of possibility that exists in the psychotherapy process, which primarily emerged from his own experience in therapy, also helped him find the strength to persevere in the field in spite of self-doubt.

When David began doing clinical work, he observed that he had the ability to really connect and listen to people in a way that was helpful to them. Perhaps his own experience of "feeling marginalized or confused" enabled him be attuned to the struggles of his patients. The experience of helping his patients gave him a greater sense of mastery, which made him more hopeful. David recalled,

When I think about my personal journey, I think some of it for me was showing myself I can handle this. I can do this, I can, you know I think I am relatively good at it and that's some of the feedback I am getting.

The experience of being with patients in their most vulnerable times also strengthened David. He gained a sense of perspective as he learned more intimately about intrapsychic life, people, and the wider world. He stated,

I've definitely gained so much understanding of the world and people through the work and so it's sort of just I mean it's been such a privilege for the most part to be able to do this even though it can be hard.

David took work very seriously. He felt a real pull to become a good and authentic therapist, to help his patient's grow in therapy with him as he was growing in his own therapy.

I felt a real pull on myself to really want to be providing really good therapy. My own growth, you know and my own development as a person and doing the same kind of work, you know basically myself that I was I think wanting clients to do and wanting to do with them.

The experience of allowing himself to feel painful feelings in the safe space of therapy as well as in his close relationships was growth producing. David recalled,

I pushed through a lot of things some of which were very painful. I let myself really go there and feel the shame, feel the guilt of choices I had made and to try to understand why I made the choices I did. I worked through a lot in therapy but also in relationships and in my life.

The more David opened up in his therapy and in his close relationships, the more competent he felt being able to work things out with others. This internal strength was first noted by his therapist. David said, “One of the things my therapist said to me was you always sort of work things out. You’re not the client who was always talking about struggles and interpersonal relationships. I was always sort of working those things out.”

David’s personal struggle to consolidate his sense of self, which has enabled him to feel more competent and become more hopeful, informs his professional narrative. It makes him hopeful about the potential for change in his patients. He recalled, “It helped in terms of hopefulness. You know, having to sort of walk the walk. I think you are gonna be a better therapist; it’s all going to feel more whole and more genuine.”

The personal growth that David has experienced over time has given him the hope that continued security and integration will occur with time, effort, and experience. He stated,

I have always imagined what happens with age that you hopefully continue in some ways to just keep feeling comfortable and more secure in a lot of ways while dealing obviously with a lot of change and everything. But that’s my hope too as I continue to do the work and go through my own life that’s gonna just keep being like what happens.

While David has become more competent and hopeful, he has a sense that this process is ongoing. I experienced an initial level of uncertainty and tentativeness in him that was present during our interviews that I think reflects a certain remaining vulnerability in his sense of competence. While he had sensitive and in-depth insights about himself and his patients, there were times especially when we first began meeting, they were presented as questions or with hesitation and repetition.

David also noted that he observes remaining fluctuations in his competence and/or hope, yet he seems to have developed the internal resources to find his way back to the optimistic aspects of himself. When he went into private practice several years ago, some of his old anxieties related to his sense of competence re-emerged. He wondered if he was worth what he was charging and he felt a certain discomfort with the clientele being wealthier. At the same time, however, this fluctuation in his sense of competence did not lead to the re-emergence of despair. He felt able to understand and work through these feelings on his own and in clinical consultation and regained his feelings of competence quickly.

It seems clear that for David as is the case with many therapists there is a connection between their personal and professional sense of hope and mastery. When David experiences professional success with patients, there sense of hope both in the therapeutic process and in his own ability that is strengthened. Furthermore, when he is able to consolidate his sense of self in his own therapy and within his relationships, he is also able to use that feeling to sustain his sense of hope in his work.

The Clinician's Affective Use of Self

David's sense of hope is linked to his capacity to tolerate, understand, and use affective experiences within the therapeutic dyad. As is the case for psychotherapists, this process for David involves remaining attuned to the patient, who is moving in and out of different affective states, while also trying to notice and understand his own affective reactions in the process. It also includes helping his patients develop the capacity to learn to tolerate and integrate their affective experiences. He described,

I think it fluctuates all the time, throughout the day and through all of the interactions emotion is getting revealed, expressed and understood. You're going in and out of all these different kinds of states and trying to understand all different kinds of levels of expression and make sense out of it.

When David is able to remain attuned to a patient who is vulnerable and in pain, he experiences a sense of hope. The acquisition of this capacity is one that has come rather naturally for him. He noted,

I feel hope in terms that I think I was always very able, I was able to really tolerate a lot of really painful, really depressing, really marginal things that were going on with clients' lives and just for probably you know a variety of reasons, really able to sort of deal with it.

David also experiences a broader sense of faith in humanity that he is contributing to making the world a better place.

Being with people and kind of going through the experience and tolerating the anxiety and tolerating the despair and everything I think, in part sort of thinking about the humanity of it and the human part of the experience is hopeful.

David understands painful affect as being part of a therapeutic process that is working. He feels a sense of hope when trying to tolerate and understand the painful feelings in himself and his patients that include hopelessness, despair, and loss of faith. He sees the expression of feeling as an opportunity to deepen the clinical picture as well

as self-understanding because it can reveal transference, countertransference and/or diagnostic themes.

David recalled a clinical example when the emergence of feelings of hopelessness in him was related to him diagnostically recognizing a more entrenched sense of narcissism in his patient. He had been seeing a couple for three years and their relationship had really improved. The couple's therapy seemed to be becoming more like an individual therapy for the woman in the couple.

The woman was struggling with her tendency to disregard her own strength and insight. David tried to help her understand and work on this issue, as did her husband, but there were no changes in behavior. David then recommended that the wife continue in individual therapy, but the wife with the support of her husband preferred to continue the couple's treatment.

David noticed that he was getting irritated with this woman patient and feelings of hopelessness emerged in him. As he explored his feelings, he gradually began to understand these feelings as symptomatic of a deeper kind of narcissistic personality issue in this woman. Her desire to stay in couple's therapy to deal with an issue that would be better suited in individual therapy was another manifestation of her narcissism.

In addition to David's hopelessness being diagnostic, it is my sense that it was also the result of his own narcissism being challenged because this woman making him feel conflicted about whether to continue to engage in a modality of treatment that was not the appropriate fit at this point.

The capacity to feel hopeful about experiencing fluctuations in his sense of hope is a connection that David made over time as he became more seasoned. He stated,

You know with experience it has become a lot more tolerable and understandable when there is despair or lack of hope...it is not such a big deal, but there is usually a feeling of this is temporary and this is gonna pass and this is just part of the process.

So much of therapy is, is sort of surviving so many processes and injuries you know and it, it makes you more understanding of what human nature is really like. I ultimately feel that all of these relationships just informed my sensibility so much it's just I mean it kind of blows me away when I really take it all in.

David's experiences supervising a Master's level graduate student have reminded him how overwhelming it can be to experience fluctuations in hope when you are new to the field. David is helping this student process the emergence of feelings of despair that resulted from several of her clients that she was assigned not working out. He contended, "She really needs to figure out who she is as a therapist and a social worker, it is what everyone has to do and it takes time. "

David recalled his own process of maturation. When you're young and inexperienced, there is so much you just really can't know; you just don't have that many experiences. He recalled,

Maybe it's helpful to have a different kind of energy when you're at that, at that time of life, and that can be really helpful, but I think you don't necessarily have the depth of, of everything, it just often really comes with age and experience.

David's ability to help his patients develop the capacity to tolerate and integrate painful affective states also sustains his hope. He tries to help his patients learn to tolerate their feelings and to be less split off from parts of themselves. He also strives to help them see more of the big picture of what is happening to them rather than focusing on a particular symptom or crisis.

David recalled working with a patient who developed the capacity to sit with pain and become better integrated. He began working with this patient who was a member of

the orthodox clergy. His whole world—his family, career, and his marriage—was shattered as a result of a sex addiction. David recalled,

He was so very depressed, you know very much in a state of loss, but he had a good ability to sort of sit with some of the guilt and a lot of the shame and the ability to really tolerate a lot of those feelings, which I always actually find is a hopeful sign in somebody. Someone who is capable of really sitting with a lot of depression, because I tend to think that that's probably gonna be somebody who is going to really be able to work something through and grieve and integrate, and probably move forward.

After 2 years of treatment, this patient is now going to law school and is joining the bigger culture where he is beginning to relate to women in a more integrated way. It has really been a profoundly hopeful experience for David to watch this patient become so much healthier and happier and to begin to internalize the work they have done together.

David seems impervious to more pervasive and longer lasting fluctuations in hope in his work. It seems what helps him sustain this hopefulness is an internalized realism about his patients. He seems able to accept that a patient will get better over time or will have to accept the more chronic nature of the patient's limitations. He stated,

You know with really difficult kinds of cases I just have this sort of inherent sort of kind of hopefulness about things either you know getting better or working themselves out or accepting things that are more chronic and in some ways not as horrible as they might at first seem. The reality is that people live all kinds of lives and not everybody is gonna be great.

When we discussed the strength of his hope in a more in-depth manner, David wondered if there is a defensive component to his hopefulness. He observed that when his colleagues meet for group supervision and everyone in the room becomes hopeless about a particular patient he always seems to remain optimistic. He recalled,

It struck me how you know other people were feeling hopeless and it made me think why, why, I don't tend to go there. I never really have and that's always been the feedback I've gotten from colleagues. For whatever reason, which I do not understand it's just not been a place I've felt about the work.

From this example, it seems hard to know if there is a defensive component to David's sense of hope or just that he is able to hold on to his different affective experience from the group.

David's sense of hope is linked to his capacity to tolerate, understand, and use affective experiences within the therapeutic dyad. This capacity is a therapeutic value for him. Therefore, when he is engaging in this process with a patient, he feels he is doing his job well and thus he feels hopeful about himself and the therapeutic process.

Authenticity and the Regulation of Hope

David has worked with latency age boys and their parents as part of his psychotherapy practice for several years. He has had success working with this population. He has also gotten feedback from many of the parents and children that he has worked with, that as a result of their work together, these children's self-esteem has increased, and they have had an increased capacity to regulate their affect. In spite of his professional success, he has consistently experienced fluctuations in his sense of hope working with this population. He described the fluctuations as ranging from intermittent hopelessness to sometimes feeling a more consistent sense of despair.

David initially described the reason for this fluctuation in hope as being connected to a shift in his thinking about working with children. His interests have evolved, and he is more gratified doing talk therapy over play therapy. He has also become increasingly ambivalent about individual child therapy. He feels children are often best served when parents receive support and help in understanding themselves and

their reactions to their children rather than the interventions happening independently with children.

It became clear as we talked in greater depth about David's feelings of hopelessness, however, that they seem to emerge most significantly as a result of another reason. His work with these latency age boys stimulates an internal conflict between his personal and professional worlds. He has made the decision not to disclose to patients in the initial phase of treatment that he is gay. This stance is one that he utilizes with all of his patients regardless of developmental stage. He is comfortable sharing his sexual orientation when it feels it is appropriate for patients and not burdensome to him. He explained,

When people make that assumption, I don't really deny it. I don't necessarily come out at that time and I certainly come out to clients when it's becomes more of a need for them to want to know more than about me.

The conflict arises in David when these latency aged boys and their parents make the assumption that he is a straight. "I think people [his patients] presumed I was straight and married and I wear a ring, I've been with my partner for 25 years so I mean in a sense we are married."

David is then faced with managing his own internal tension around this misperception. While he did not articulate it this way, it almost feels like he becomes the keeper of a "secret" that he has to manage in these treatment relationships. He stated, "I've been experiencing this sort of tension and discomfort on a certain level, you know despite other parts that have been really good."

The burden managing this internal tension in conjunction with the lack of authenticity of not being himself in all respects with these patients results in the emergence of feelings of hopelessness. David described,

I have been grappling with my own despair around feeling uncomfortable, in certain ways, trying to figure out what that was about. . . I mean cause I think I'm always trying to become more comfortable with myself and trying to be more comfortable with people.

David recognizes that he does not know whether his sexual orientation would be an issue for parents or these kids, yet he feels instinctively that it would be with this population. He contended,

It may be my own perception, I don't know if it would be or not, but you know how you know what the issues would be with people? If I were to be out with these families, I would feel more self-conscious with them than with other people.

When David elaborated on what his concerns were regarding sharing his sexual orientation with these families, he was most concerned about homophobic reactions. It seems he was most concerned with the reactions of the parents more than the children, yet he did not elaborate further on what these concerns would be. I wonder if the homophobia he was worried about was related to these parents' more rigid conceptions that having a different sexual orientation would make David less able to connect to their and their children's experience.

It is clear that this conflict is specifically related to David's work with latency age boys and their parents. He is not conflicted in how he has chosen to disclose his sexual orientation with his other patients. Additionally, he has been out at all of the institutions he has held jobs. He has actively worked to include sexual orientation in part of his anti-discrimination policy wherever he has worked.

While David has not spent much time processing these feelings of hopelessness that get triggered, he is self-aware enough to recognize that perhaps there is something related to this population that countertransferentially touches something deeper in him. He elaborated, "I think it's really myself not wanting to, I guess, connect to that part of myself, you know that age developmentally."

As part of David's growth and maturity, he has worked hard to accept himself and the inevitability that certain people and situations will result in fluctuations in his internal states. He has restored his sense of hope by making the decision not to work with this population. "Instead of feeling hopeless, you know, change it, just don't work as much with kids, accept it."

The Effects of Agency Discourse on the Therapist's Sense of Hope

David primarily practices psychotherapy at an agency. There are aspects of his sense of hope in his professional life that are influenced by the cultural experiences of working at an agency. While these experiences occur outside the realm doing clinical work they do impact his professional sense of self and thus are relevant. He specifically reflected on how the shifts in use of theory at his agency have affected his sense of hope related to how he practices and his concerns about the direction of the field.

In the past several years David's agency, which traditionally practiced longer term psychodynamic psychotherapy, has shifted to accommodate the current trends in the field of social work and psychology. While psychoanalytic psychotherapy is still practiced, the administration is increasingly in favor of evidence-based practice. The models used include cognitive behavior therapy, child-parent psychotherapy, emotional focused

couple's therapy. The administration expects the clinicians to utilize these new treatment models in their clinical practice. He contended, "There is an authoritarian sort of tone about what works and what doesn't work."

While David sees the strengths in utilizing these models, he considers himself a psychoanalytic clinician. He has a clear sense of optimism about the usefulness of psychoanalytic treatment. This position is in conflict with the expectation of the agency administrators. David either overtly or covertly has to struggle to defend his treatment beliefs at his agency, which at times erodes his sense of optimism. He recalled,

It has an effect on sort of a sense of security and feeling like knowing what you're doing. I think it has an effect on the debate and how things are even talked about and the process that has become a lot more charged in a way and sort of split. There is a feeling of having to defend certain positions, which I can do and I do, but it is a struggle to keep thinking about it.

In an attempt to maintain a sense of optimism about his work, David described disengaging from this conflict within the agency. He feels like the process of doing psychotherapy is in itself emotionally challenging. He is holding so many people's psyches and giving so much of himself. Dealing with these conflicting positions within the agency while doing the work seems like "too much," so he distances himself as much as he can from these agency-wide conflicts. He recalled, "not really numbing myself to it but probably trying to find the balance you know, how to sort of have some space from it to keep myself fresh."

David feels like he has successfully been able to separate these struggles within the agency from his work with patients. "I am really focused about what I can offer, so I am not definitely not struggling clinically in the room with somebody with competing things."

Since David practices in a small satellite office that stands apart from the main agency, he is somewhat protected from some of these political undercurrents. He has observed fluctuations in his supervisor's sense of hope as she negotiates her own practice views versus the larger agency's expectations of her. When these new models were first introduced to the agency, she adopted them wholeheartedly and expected her supervisees to do the same. Over time, however, she has not followed through on this "crusade" as others in her position have. She has integrated the models in ways that she finds useful, but has returned to practicing in a more psychoanalytic way. David's optimism is sustained by observing this shift in his supervisor especially since it coincides with his orientation.

David has observed that the sense of certainty that is embedded in manualized treatment models often have resulted in the fluctuation the sense of hope in the graduate students' he has supervised. These theories tend to focus on what is going to work and what you do. The complex and ambiguous facets of treatment and the importance of building a relationship are not emphasized. These students at times become despairing when their structured interventions do not lead to clear and positive outcomes.

When David began supervising his student this year, she felt like she needed to be really defined in her methodology and in her technique more than David felt she really could without having experience. Her sense of hope in her own ability fluctuated when her clients did not progress as she had hoped. David's capacity to teach her about building relationships and to process the intricacies of what occurred in these treatments resulted in a great sense of relief and the restoration of hope. David recalled, "She realized that there isn't really only one way to practice and one way to think about

things.” David’s sense of optimism regarding practicing psychoanalytically is reinforced by repeatedly witnessing how helpful psychoanalytic principles are to students who are struggling to understand their own and their clients’ experiences.

The fact that David has been in the field significant amount of time gives him a sense of perspective in relation to these new treatment trends, which also allows him to remain optimistic about the field.

It always amazes me how easily people in the field get caught up with new things and idealizations of things and just sort of I mean I’ve seen it again and again, and then you know it sort of dissipates with time.

David feels that he is able to remain optimistic about the work because he is not looking for “truth” in psychotherapy. Rather he relies on the tried methods of what he has repeatedly experienced in his own therapy and seen with patients that seem to be helpful. He stated, “I am trying to explore and trying to understand things and trying to you know be genuine and honest and things like that but, but not so much a truth or a cure, or a fantasy of a cure, or perfection.”

David seems able to maintain a sense of hope regarding his psychoanalytic treatment approach when his choice of approach conflicts with the treatment approach of his agency. Yet in order to maintain that hope, he internally has to distance himself from the agency to protect himself against this incongruence. In the long term, this disparity may erode his sense of hope about being able to work at a organization with differing views from himself.

Allison: Clinician 5

Clinical Training and Professional Development

Allison is a psychoanalytic clinician in her mid-60s who has worked in the field for more than 30 years. Most of her work has been in agency and hospital settings in a variety of different capacities: as a psychoanalytic clinician, clinical supervisor and program director. The primary focus of her psychotherapeutic work in these settings has been with children and their families, but she also has worked with older children, adolescents, adults, and couples. She has hired and supervised many clinicians. She has started and run many different programs that have benefitted children and families.

Allison is very close to completing her analytic training. She finished her coursework several years ago and is at the very end of completing the prescribed number of cases and terminated cases, which are required for her to become an analyst. Her own analysis began several years before she started analytic training. It lasted over 10 years, varying in its intensity from twice a week to five times a week depending on what was happening in the treatment. Allison's analysis not only underlies most of how she thinks about and uses hope in her work, but it is where she believes she has learned most about the psychoanalytic process. Its significance will be described in detail in the category of meaning section of this case study.

Approximately 12 years ago, Allison began a part-time private practice. Her practice is comprised primarily of adults, although she sees adolescents and families occasionally. Last year, Allison retired from agency work and is now in full time private practice. There is a range of how in-depth Allison works with her patients in private practice. At one end of the spectrum, she sees patients weekly for psychotherapy and at the other end of the spectrum she works with patients psychoanalytically seeing patients

up to five times a week. Over the years she has worked with patients less frequently especially if they are commuting from out of town and has also used Skype occasionally when appropriate and necessary.

Allison characterizes her work with patients as intensive and characterological.

I work at the level that I found was so transforming for me. Maybe people leave if they don't want to do it (in-depth work), but I just find that if you approach it in a non-threatening, non-jargonistic patient way, that almost everybody who walks in the door can benefit and does want to work that way.

Since Allison's experience in the field has been varied, she has had the opportunity to work with a broad range of patients from different races and socioeconomic classes in many different settings, which she has found to be gratifying.

I wouldn't say that I get more gratification working with a particular population. I think it's easier not to have to deal with poverty. I mean there is no question about that. It's so stirring and the tragedies are so hard to take.

The institutional challenges that come from working within a bureaucracy have at times caused fluctuations in her sense of hope. Allison contends, "It's never the people or the population I am working with that's the problem, but more really the bureaucracy and some of the impediments in the very difficult setting."

Allison's hope is restored by focusing on the resilience of her patients especially when they are faced with tragedies and poverty. She states, "I couldn't have lived through this I think. How are they living through it? How do they still have hope?" Her sense of hope is also sustained because she has witness repeatedly growth in her patients. "It is just very pleasurable, very gratifying to see people blooming and their lives transformed, their relationships, their work, their sense of themselves just so drastically changed, so I really love my work."

Organizing Principles

Allison believes that the three things that flavor her approach are her politics, being a mother, and her analysis. The focus of the interviews stayed more on her politics and her work rather than being a mother. The issues of race, gender, and class inform her work whether it is with somebody who can pay full fee or someone with no money. She holds hope for a better way for all people, individually and as a community of human beings.

Allison contends that human nature is constructed and embedded in a social matrix. She also believes in the perfectibility of human beings. While she knows human beings are capable of evil, she believes there is an enormous potential for pro-social, altruistic kinds of behavior and she chooses to focus on that. She believes, “working psychoanalytically does promote openness, greater tolerance, greater flexibility, less scapegoating, and stereotyping.”

Political and personal freedom are the driving forces in Allison’s life. Allison believes that psychoanalysis is the best tool for self-understanding, which can promote personal freedom. Allison stated,

My political kind of activism on the one hand and psychoanalysis as the methodology. I’m talking about sort of the methodology of how do you understand human society. What are the impediments to a free or more just kind of life. The reason I got so interested in psychoanalysis is because I am interested in personal freedom at the core.

The developmental lens frames Allison’s understanding of people. When she thinks in developmental terms she feels hopeful.

If you keep out of its way, it just happens. If there's there is a nice, benign supportive environment and you don't muck around too much things grow. It's the natural order. Something about it just feels expansive. It makes you feel open.

In her work with patients, Allison tries to understand where people are developmentally to put their behavior in context. She also helps her patients understand themselves from a developmental frame. She stated,

I talk a lot in terms of how they imagine their earliest experience, even before patients can remember, so there's a lot of trying to put things in context. First of all it decreases shame enormously. You know when somebody does something they're terribly ashamed of it but then you can link it to when you were two years old and this is what you were doing if you had this experience as an infant. You can see how this sort of unfinished business reduces shame and the feeling of being judged. It helps people to be more hopeful about themselves.

Interview Reactions

I had a very intense idealizing transference upon meeting Allison that felt quite personal. As she articulated her experiences both in her analysis and with patients, it was clear she held something that I have had difficulty achieving both personally and professionally in a deep and sustained way. As I reflect on it now, I believe it is a grounded, mature sense of confidence and hope that seems almost impervious to fluctuations that emerge from fluctuations in self-esteem. There was a sense of hope that got ignited in me that I could achieve what she has if I worked with her in a more in-depth capacity either in a psychoanalytic or consultative capacity.

The way that Allison articulated her experience of hope did not feel at all defensive, but deeply real and hard fought. Her faith in herself and the psychoanalytic process was profound. My reaction to Allison also made me realize to a greater degree

that part of my interest in this topic is related to my own desire to work on my own issues of hope and hopelessness by learning about other clinician's experiences.

I do recognize on some level that the intensity of my reaction to Allison may have colored my ability to question and critically look at the material she presented. I have noticed that the times I critically questioned something she said have been almost non-existent. While I do think that there was thoughtfulness in how she presented her ideas, I am sure my internal experience made it difficult to have the same distance that was present in some of my other write-ups.

Significant Childhood and Life Experiences

Allison described herself as being inherently hopeful. This sense of hopefulness has always been part of her even during difficult times.

I have certainly experienced plenty of depression and many times when I have been quite miserable, but I never have I thought of myself as a person who wasn't hopeful. I always had a sort of glass half full kind of frame of reference.

Allison understands her hopefulness as correlating to her character that developed within her family of origin. She has a balanced view of what went wrong and what she got within her family that was good. Allison described, "I was basically stable. I didn't have any alcoholism in the family; my parents had a stable marriage. You know they had basically decent, good values, so I got a lot of good things."

Allison knew that her parents essentially loved her. Her father is a very hopeful person and he influenced Allison a great deal in terms of who she wanted to be like. While her father was not home so much because he was working, Allison recalled, "I was

the apple of his eye which was a saving grace for me. It made me an optimistic person.”

Allison’s mother was more difficult. Allison described her as,

Infantile, more narcissistic, very anxious and attention seeking I mean that’s not good. Those are not good characteristics for a maternal presence, but I know she loved me. I mean she was critical, she was mean, she was all kinds of things, but I didn’t doubt that she loved me.

Allison believes that her analysis gave substance to her optimism. What brought Allison to analysis was that so much in her life was not turning out. She had gone down various paths and found herself in her 30s with none of the paths working out. At the same time, Allison held the conviction that she would get past her difficulties and her life would work out. Allison recalled,

I knew I wasn’t on the right road. It hadn’t turned out. I knew I was developmentally behind. I mean I don’t know if I would have said then, but I just felt like I’ve got to do something, I’ve got to get to the bottom of this.

There is, however, the recognition that if Allison’s depression and misery remained untreated by her analysis, those feelings could have transformed into more substantial feelings of hopelessness.

Allison hopefulness is a mainstay in her work that seems impervious to the stresses and strains of her personal life. When she started working as a therapist her “life had come together and had gelled more so than it had previously.” She described an incredibly difficult period in her personal life that spanned about 10 years, when her child was battling a life-threatening health issue. While this experience was far and away the most difficult experience she ever had in her life, it did not affect her hope in her work. Perhaps this is because she always believed that her child would survive which is what occurred. She recalled,

Those experiences I don't think influenced my hope in relation to my work. I was terrified for him and for us that we might lose him, that we would not live, that his life would be so traumatized. I don't think that it affected my work that much. I don't think that even though I was, well I was I guess optimistic that he would live.

Categories of Meaning

The Analytic Relationship: The Deepening of Hope in the Clinician

I do really experience it [her analysis] as lifesaving, in the psychic sense. I mean I wouldn't have this life, which is a very good life and a very satisfying one, where I could really love my work, couldn't imagine being luckier in that sense and I have really great kids and been married now for 30 years and in a relationship that grew a lot and struggled and grew. I mean I just feel like I wouldn't have this life.

I would be here on Earth, flopping and flipping around doing various things but not, not solid, not solid not who I should be. I wouldn't have become who I should have been, that's how I'll put it. I won't even say I wouldn't have had any satisfaction or any of that. I don't think that's quite true, but I think I would have been a very, much more unfulfilled and working across purposes with myself and much more turmoil and more difficult, much more difficult life. I could have had and it wouldn't have been from my point of view, it wouldn't have been a life. It would have been sort of a more fragmented, would have lacked the meaning and the coherence and it would be so much more suffering.

There is profound hopefulness in the growth that Allison experienced in her analysis. It was life changing and transformative in a lasting way. It clearly has helped her live a more grounded and fulfilled life. The growth that she experienced from her analysis fuels the deep faith she has in the psychoanalytic process. Psychoanalysis did not embed her with hope, yet it "strengthened and gave more substance to my hopefulness."

The certainty with which Allison described how her analysis deepened her sense of hope, while not surprising, spurred my curiosity to learn what elements she found deepened her hope. I understood the most significant feature for Allison was the

experience that both she and her analyst “survived,” both intrapsychically and relationally, the many challenging episodes of her analysis. It was the repeated experience of investment and determination that Allison observed within herself and experienced from her analyst that was growth producing and thus expanded her sense of hope. Allison recalled,

I had some very challenging episodes in my own work, which were extremely trying for me and for my analyst. I think probably he and I were similar in our determination or stubbornness, however you want to put it, to hang in under any circumstance and so it bore fruit even more fruit than I expected.

Allison and her analyst struggled to understand and work through transferences as well as what Allison described as “transference-informed” real issues that emerged within their relationship. Allison remembered,

Some very, very difficult times, I would say in the interaction. Some of it was, you could just call it transference but I think there were things that I wouldn't even necessarily say were only transference. I think it had to do with how he's built, how I'm built, the interaction, so I guess everything was transference informed, but there were aspects of our personalities or even maybe similarities in our experience that contributed to some very difficult times but I think it was so beneficial to work through those things and to be able to put them into perspective and, very difficult times, that I'm not talking about a session here or there.

I asked Allison if she could recall a specific example of a difficult period in her analysis that helped deepen her sense of hope. Allison had difficulty recalling one. In part because Allison finished her analysis several years ago, and she said she “metabolized” a lot of the specifics. Another concern was that Allison felt the examples she recalled were more revealing than she wanted to be in the interviews.

Allison did recall an example of the many layers of feeling that she and her analyst experienced, as transference and real, in relation to him raising his fee and her experience of his need to feel good or moral about what he was doing. She described the

back and forth between them that at times became bitter, which lasted for several months. Allison ultimately came away from this experience with a clearer understanding of what she “got out of it,” which in many ways was not substantially different from where she started. It was the relational engagement between her and her analyst that took place around the fee increase that created healing and also deepened Allison’s hope. She recalled,

It was very powerful because I felt kind of like both of our untrammelled feelings came to bear in the circumstance. We didn’t really resolve it, but it was okay. It was okay. I came to grips with the fact that we did not have to resolve it or have a common agreement about it. It was okay with me to have a different point of view and to accept the fact that he wasn’t perfect and that just was that.

There was an emotional exchange between Allison and her analyst, which allowed Allison to experience it, as she needed to for as long as was needed. She and her analyst were invested and committed in this relational exchange between them. It also became personal for her analyst so Allison was able to see her analyst as a real person, which was normalizing. There was strength to Allison’s confidence that also is present in this example. Allison had the capacity to understand her experience and hold on to her experience of the situation, which differed from her analyst’s. Lastly, and of great significance, was that her analyst had the internal strength to allow Allison to have a different experience than he did without withdrawing or retaliating in a conscious or unconscious way.

This example also highlights another significant factor in her analysis that expanded her sense of hope. Allison characterizes it as “deep and encouraging.” There was a strength that she experienced in the relationship, and in her analyst, of being gently

held and safe to reveal all parts of herself to him. It was within this safety that Allison's flourished. Allison recalled,

I think in some unconscious way, I felt very safe. I didn't always feel safe on a more conscious level, but I think I mean I never went to get a consultation to find out if this treatment is working...so I take all that to be very indicative of the level of trust that had to be there fundamentally, even when I was very unhappy with myself or very unhappy with him or whatever. On the most basic level, I did trust that this was what the process was and I was going to stick with it.

Allison's analysis also helped her address what she recognizes as an impediment to her sense of hope: fear. The fear that Allison is referring to is related to a struggle that she had, especially when she was younger, of not feeling confident or solid and properly assessing her abilities. Her analytic experience helped her to have a more realistic assessment of who she is and what she could and could not do, which in turn strengthened her confidence. The more confident she has become in herself and her abilities the more hopeful she also became. Allison related,

I could see more realistically the things I didn't like, which causes us to revise our image of ourselves as well as have a better appreciation of the things that I could do well. And I think that by reducing very substantially insecurities and fears that are not based on anything reasonable, I think it did strengthen my hopefulness. It kind of got more robust.

The more Allison's confidence solidified in her analysis, the more she began to differentiate herself from her analyst. While she continued (and continues) to deeply value his integrity, intelligence, dedication and the deep connection they had, she also came to increasingly value the aspects of how she works which are different than him. She values her intelligence and the fact that she is more flexible in her work than he is. While she understands these differences as related to the fact that her analyst was schooled at a different time as well as much of Allison's experience developed from her

work with families, they are differences nonetheless. Many of these differences were openly discussed within the analysis. Again, the lack of defensiveness present in her analyst, I believe reinforced a sense of differentiated confidence, which further strengthened her feelings of hope.

The Use of Clinician's Treatment Experience on the Clinician's Sense of Hope

I really think that my own analysis is the most, has been the most informative to me. I've had a lot of training and a lot of supervision over the years with the very best. All kinds of wonderful mentors who I have learned so much from but nothing has been, nothing has really informed my work in the way my own analysis has.

Allison's experience in her own analysis not only deepened her sense of hope in her life; it also fortified her sense of hope in her work with patients. Its impact in terms of her how she utilizes hope in her work is profound. As a result, I have devoted three categories of meaning to different dimensions of how her analytic experience affects her sense of hope in her work. The first category of meaning is *Competence as an Aspect of Hope*—Allison's analytic experience has given her the capacities to be a more skilled clinician so she feels hopeful about her ability to help her patients. It has also given her a deep faith through personal experience of potential for transformation possible through the psychoanalytic process. Allison brings this faith in to her work with patients. The second category is *Holding Hope in the Clinical Relationship*—Allison's analysis helped her hope become more actionable allowing her to hold onto to hope even when patients and supervisees cannot do so themselves. The third category is *Sustaining Hope through the Treatment Process*—Allison's sustained sense of hope also allows her to “hang in” with her patients through the dark and light moments of the psychoanalytic process.

Competence as an Aspect of Hope

I feel like the quality of one's analysis, one's own work, really is almost like a mainstay of everything and it's really, it gives us tools to understand our self and to understand others and it also gives us the kind of depth.

Throughout the interviews Allison described capacities within her, or as she calls them tools, that were enhanced from her own analytic experience that she uses in her work with patients. The acquisition of tools can in some ways insulate the clinician, as it does for Allison, from fluctuations in hope within the self of the clinician that can emerge as a result of not feeling competent to adequately help patients.

Allison's deepened capacity for self-reflection that emerged as a result of her analysis allows her to use herself to aid in the treatment process. She has the ability to attend to the patient's experience while also differentiating her patient's experience from her own experience. She also uses her own reactions diagnostically to understand a patient's unconscious nonverbal communication. Allison stated,

We have to know where we begin and end, so to speak, and we have to be relentlessly aware of what's going on inside ourselves not for any pathological reason but because we're the instrument so to speak, so our feelings and thoughts and reactions and fantasies and I mean bodily sensations, in my opinion, can have and often do have a bearing on what's going on in the room. So much is diagnostic that one might not recognize as such without doing that kind of in-depth work and having familiarity with the subterranean landscape.

Allison's empathy for a patient is also enhanced by accessing and using the insights gained from her analysis. Allison uses her own history and experiences to connect to the patient's experience. She particularly feels that her own experience being in those "dark routes" in her life and in her analysis helps her to connect and not become frightened by those experiences in patients.

It [accessing one's own experience] gives one a much sharper, keener appreciation for what's going on, not because it's identical, but because we are all human and whether by inference, by analogy, by ballpark comparison, whatever. There are ways of approximating successfully somebody's experience. I don't think you can ever really know what another person is experiencing, but you can get closer and closer using your own self, it's ourselves as the instrument.

While her analysis was central in the acquisition of these skills, Allison also has the perspective that her sense of confidence and hope in her work has increased with experience and maturation. She reflected,

Everyone in the beginning is frightened that they are going to do the wrong thing, say the wrong thing, miss the boat, how can I really help this person. I think that I questioned myself as much as anybody else. I don't think that I was secure at all, but I would say it didn't take me more than a couple of years before I started to calm down and feel more relaxed and begin to trust that I was doing okay. It did not take me a long time but I certainly did not feel the way I do today. This is the product of year and years of, well learning and knowing things and getting a sense of what your vulnerabilities and strengths are, how you fit with other people and who you work well with and who you don't work well with at all.

Embedded in Allison's confidence is a deep felt hope that the psychoanalytic process works. It worked for her. She carries that faith into her work with patients.

There was a time when I could say absolutely and for sure that I was in love with psychoanalysis. I just think it's the best tool that we have for self-understanding. It feels like I got this gift. I was so lucky and now I can pass it along. I can help other people have what I had or their version of it.

Her faith in the psychoanalytic process and in her own ability to help patients is further deepened when she helps her patients' progress in their lives. It inspires her and gives her life meaning. Allison stated,

It's kind of a quiet elation, when you see the people before you, or in yourself, fulfilling a potential. There is something joyful about mastery. Feeling it and seeing people master things that they wish to master, things in their way. Getting more pleasure, more meaning, having an enriched life rather than an impoverished one. I don't mean money. It gives me a feeling of exuberance.

Holding Hope in the Clinical Relationship

As an outcome of her analysis, Allison described her hopefulness as “more actionable. I can use it much better.” She is referring to having a greater capacity to hold onto hope in her work especially when supervisees or patients have difficulty accessing hope within themselves. Allison is describing the internal affective experience of feeling hopeful, which may not necessarily get explicitly expressed within the supervisory or clinical relationship but nonetheless is present within the relationship.

Although Allison is no longer a clinical supervisor, the first example that she gave in describing how her hope has become more actionable was within the context of supervision. Over the last 30 years Allison hired and supervised many clinicians. Under her supervision many of these clinicians thrived, becoming “phenomenally talented.”

Allison understands that this occurrence, in large part, is due to the fact that she is able to assess and hire candidates with the potential to become competent clinicians. She hired clinicians who were open and self-reflective rather than solely on the basis of strong credentials. When they begin working together, Allison is invested in their success and holds a tremendous amount of hope for them. She clarified, “I don’t feel hopeful for everybody. I certainly would not consider myself to be Pollyanna or unrealistic. I think I hired good people.”

While Allison was a demanding and tough supervisor, her sense of hope for her supervisees is communicated in the professional holding she provides. She believes it is this holding that repeatedly helped her supervisees grow and develop.

I think it [their growth] has a lot to do with their feeling professionally held, personally and professionally, not that it was therapy but in a supervisory process.

I think that I have a wide conception of clinical supervision. Never to take the place of or be the same as therapy, but you know where there is a broad and deep vehicle for people.

Allison shared how her supervisees have been helped enormously by her hopefulness for them even when they did not have faith in themselves. One woman Allison supervised, whom she described as smart, sharp, and talented, lacked confidence. She had such a distorted view of herself. Allison recalled,

I sort of helped her along and so she's been in therapy most of the time and has just become the extraordinary person who she should have always been and would never have been, I think, had she not had some felicitous meeting with somebody who could offer the things we can offer with our training.

This woman is now a competent supervisor, running many programs at an agency, and went back to school and got her MSW. Several other supervisees have become supervisors themselves or have pursued post-graduate training.

The fact that Allison has seen her supervisees thrive time and again has also reinforced a sense of self-confidence and hope in her ability to be an effective supervisor.

Dozens of people I have worked with I think have just blown me away with their achievement and personal growth. I won't say it is entirely due to the supervision especially because it is up to the person who has the guts and ability to do it, but I do think that I played a very important role and in some instances it would have not happened. That is one way that my hopefulness carries into the world.

Allison also holds hope for her patients. How she uses that hope in the treatment varies depending on what is helpful to the patient. She described her relationship with S., a young woman patient where Allison was "silently the keeper of hope" in the relationship. S. presented with significant medical, psychological and characterological issues. She has Crohn's disease as well as bulimia, which caused her to lose the function of some of her internal organs. There were several times when she ended up in a coma in

her apartment in which she lived alone. S. also struggled with a chronic severe depression. While S. managed to complete college and was very smart and artistic, was unable successfully pursue a career.

In the first 2 years of treatment, Allison was terrified for S.'s life. She had never met anyone who was so anxious. She was taking a few classes at a university that made her so anxious she was vomiting more than 14 times a day, which was especially dangerous given her health condition. Allison contended, "I was terrified that she was going to be dead in any time, any minute, but I also could feel such a spark and that gave me the courage, you know to persist with her." Allison's capacity to hold on to this hopeful part of S. helped Allison sustain her hope for S. in spite of the scary self destructive aspects of this patient.

S. railed against Allison and "pretty much cut me to pieces" regularly. She continually felt that Allison did not understand her. She repeatedly expressed her misery and told Allison that she hadn't done anything to help her. Allison did not try to talk S. out of her experience. S. terminated constantly and would come back. As challenging as this treatment was, there were other times when she and Allison had a very good rapport. Allison recalled, "I liked her so well and she certainly had to feel that."

The biggest treatment issue was this issue of hope. S. was of Asian heritage so she did not take the western point of view that life should be rich and meaningful. Rather she took more of the eastern point of view that life is misery. S. felt at home, feeling herself to be so defective and damaged. Allison interpreted to her over time,

I thought that what she really wanted for me to silently keep the hope to myself, but to keep it. I was going to hold the hope and, you know, we could joke about it

and she would yell at me if I said something that was too optimistic or hopeful. I did not do it too much because it was counterproductive.

As the treatment progressed, Allison mostly had the ability to not become overwhelmed by S.'s pain. She was able to hold onto her hope for S. By looking at the external signs how S. was doing in her life. While S. was constantly telling Allison that nothing was changing, S. started managing health issues in a healthier way. She started a graduate program and found a profession that was meaningful. She also met someone and was able to sustain an intimate relationship with a man that she eventually married.

There were those times in the treatment, however, when doubt and helplessness arose in Allison. Allison was in part experiencing the depth of S.'s helplessness, which at times was extremely painful. It caused Allison to question her "hubris;" yet her hope did not fluctuate. Allison recalled,

There were moments when S.'s suffering was so great and her battering of me was so relentless. It was really hard to tolerate her pain, and I wasn't her. There were those moments I would say when I would really feel "helpless, really helpless and down and kind of like who do I think I am anyway?"

In those moments of doubt and helplessness with S., as with other patients, Allison obtained consultation.

I think consultation is very important. I have always used it, since I started in this field 30 years ago. It does not matter how experienced you are, how smart you are, how good you think things are going or bad. You can't help but get caught up, so I think consultation is what I use.

Allison worked with a particular consultant over the years she worked with S. What was useful about it was her consultant helped to "remind me of what I thought and felt myself." It helped her to sustain her equanimity throughout the treatment process.

Sustaining Hope through the Treatment Process

The theme of “hanging in under any circumstances” is quite significant for Allison in how she talks about hope throughout the interviews. In a previous section that described Allison’s analytic experience, it was discussed in relation to how her own experience in her analysis of her and her analyst “not giving up” deepened her sense of hope in her life. Allison enters into her work with patients with a similar level of commitment and tenacity. She has hope for patients and faith in the psychoanalytic process that is not easily prone to fluctuations as exemplified in the previous section in her work with S. She elaborated,

I am not easily frightened by much. I can withstand a lot of ambiguity and a lot of potentially very disturbing kinds of transferences or even at periods of great extraordinary pain with a patient. I can relate to it from the inside and I have a lot of faith in the process. I don’t mean to say I never feel anxiety or anything of the sort, but that relatively speaking it helps me sit with some equanimity.

As this excerpt suggests, Allison attributes the depth of her capacity to sustain hope with patients as strengthened from her own analytic experience. She knows what difficult periods feel like. She contends, “I have some idea of how gloppy it can get.” Additionally, she knows that difficult periods are part of the psychoanalytic process that is working. She also has the capacity to understand herself and to differentiate her own reactions from her patients. It is also my sense that fact that Allison’s confidence deepened as an outcome of her analysis insulates her from fluctuations in her sense of self that could impact her sense of hope about her work.

Allison’s ability to sustain hope for patients is also the result of a sense of realism and maturity present in how she understands hope in her work.

Being hopeful is not about feeling good. Particularly because God knows much of what we do is, you know, maybe all of it in the end is about mourning, grief, and mourning and loss and what separation is all about and growing up is all about. So it's not because it feels jolly, although sometimes it is fun and jolly, but there is so much deep disappointment, profound disappointment and sadness and pain and hurt and feelings of betrayal but that does not bother me. I mean I don't have a problem with that. I mean I feel bad, but that does not make me less hopeful.

People who have worked with Allison over the years have remarked that her ability to “hang in” with patients stands out. Allison stated,

My colleagues and mentors indicate that I seem to be able to hang in better and longer with people who others might have given up hope for or just it was too trying or too scary. There are lots of people who either don't choose to or don't have to or don't want to-not in private practice. It's different in an agency where you have the whole agency behind you.

My own experience of Allison during our interviews reinforced an authenticity present in the depth of her capacity to sustain hope with patients through the difficult moments of treatment. It did not feel defensive. While she mainly described the achievement of a realistic sense of hope as emerging from her own analysis, it is my sense that it emerges from many places: her analysis, clinical and supervisory experience, and her life. Additionally, since Allison does not define hope in terms of feeling good she is more insulated against fluctuations.

Allison recalled her work with a patient D., a 40-year-old woman that exemplifies her capacity to hang in with patients. D. has a very entrenched set of difficulties and a character structure that is resistant to change even after 12 years of psychotherapy. D. described her as masochistic in a non-traditional presentation. She bends herself into a pretzel, yet underneath is punishing herself for not being the “saint that her mother is.”

D.'s mother is a very dissociated woman, very limited emotionally and extremely religious. Her father was a hardworking man but "completely bankrupt interpersonally."

D. has tremendous difficulty making decisions especially in her personal life, which has been a profound struggle throughout her life and in treatment. D. is an accomplished businessperson but is in a loveless marriage. When treatment began, she was a binge drinker and would engage in high risk behavior such as having sexual encounters with men she met in airports.

While D.'s self destructive behaviors ceased early in treatment, the profound stuckness that is part of D. has persisted. D. began a romantic relationship with a man, which is emotionally fulfilling. Pursuing that relationship exclusively, however, would mean that she would have to end her marriage and move to be with him since he lives out of state, is divorced and has children. This decision would also mean she would have to give up her job, which has been a place where she has felt good. Since turning 40, D. has come to realize that she wants to have a child, but she has not decided what relationship she wants to be in.

Allison describes the treatment with D. is arduous. She states, "From time to time I really feel down about the pace of how much she is able to take in." D. continues to be so depressed and unable to make a decision about who to love and who to have a child with. Her self-esteem is so fragile despite the fact that she is extremely attractive and smart. There is such a distortion between how she sees herself and how others see her. She tries to turn herself into a pretzel trying to be all things to all people, usually minimizing her own pleasure in the process.

During those times Allison can feel despair. Allison mostly understands her despair as part of the transference: a communication of D.'s experience. Allison recalled, "I feel so much pain on her behalf because she's suffering a lot. I have felt less hopeful and even at times despair, but I think it has to do with how she feels a great deal."

There is also a real sadness that Allison feels because she cares about D. She wonders if D. will be able to live a more fulfilled life. The depth of this patient's stuckness has also caused Allison to periodically doubt herself and whether this patient is treatable.

Am I helping her or what would help her? Am I not doing something? Would someone else help her better? I never really thought somebody else would help her although that's always a possibility in one's mind.

Allison is also aware of D.'s gains, which can often help her restore her sense of hope at times when it fluctuates. D. is extremely successful at work. She is a good team builder and people look up to her. She is able to intellectually and emotionally realize that maybe she really suffered and didn't get her needs met as a child. She is so much more able to express herself and to assess other people.

Over the course of treatment with D., Allison has received ongoing consultation. There is a strength of hope that seems to get remobilized in Allison when her consultants share fluctuations in hope about D.. Early on in treatment when Allison presented her work with D. to a famous well-respected visiting analyst at a seminar, he raised questions about her treatability. What he saw was what Allison was experiencing with this patient: a very prolonged and entrenched masochistic depression. This analyst was quite pessimistic about her treatability.

In spite of this feedback, and after Allison “picked herself up off the floor and recuperated,” she continued to work with D. Four years later, she re-presented her treatment with D. to this analyst to show this analyst that this patient was in fact treatable. Her symptoms were less florid and less dangerous and she was no longer in danger. At that time, this patient started a new romantic relationship with someone with whom she could connect. Allison recalled,

He was right in the sense that she is very, very difficult to work with on the one hand. On the other hand, he was I think, quite wrong that she was untreatable because even if she walked out the door tomorrow, she is so much better off in so many ways.

Allison received consultation from another analyst more recently at a point when D. was coming less frequently given work schedule changes as well as living out of town. The feedback Allison got from consultation suggested that she end treatment if D. could not come to therapy more regularly. Allison eventually convinced her consultant that his perspective “it was not right.” I wonder if this consultation experience reminded Allison that D. was getting something out of treatment thereby remobilizing her hope to persevere with this patient. She continued, “I just could not do it. She would have felt so rejected. I am the only person who really knows what is going on with her.”

At one point in the interviews, Allison wondered if her capacity to hang in better and longer with patients has to do with “personal character formation.” It is my sense that what Allison is referring to is the culmination of her inherent character that developed as a result of what she is born with in conjunction with the social environment (described in the Significant Childhood Section).

The implicit hope that keeps Allison going with this patient is a deep faith in the process of psychoanalytic process and the faith in the patient to make use of the process in the ways that they are able. Allison reflects,

I always come back to the same place that she is in her process and it takes what it takes. I think if she weren't getting something important out of it she would just... I mean she is very clear about what she can't fit in and what she does not want.

Allison described a talk that she heard several years ago that I think serves as a metaphor for the strength of Allison's hope with patients. It was a program given both by Joanne Greenberg, the woman who as a girl wrote *I Never Promised You a Rose Garden* and a professor from Smith who was writing a book about Frieda Fromm-Reichmann, who was Greenberg's analyst. Someone in the audience asked what Joanne Greenberg thought was most helpful to her in her treatment with Frieda Fromm-Reichman. Greenberg did not flinch. She said she would not take no for an answer. She just wouldn't give up.

I then asked Allison how this example applies to her work with patients. Allison replied,

I am really determined and very hardworking and I think that I have that. I don't give up. I mean I will take no for an answer because I am respectful, but not until it's really clear to me that everything has been exhausted.

CHAPTER V

DISCUSSION

The focus of this study was to examine the vicissitudes of hope in the lives of five seasoned psychoanalytic clinicians. The following section illuminates the commonalities in the vicissitudes of hope that emerged between participants across cases. The limitations of this research study will also be discussed as will the clinical and research implications.

The most resonant experience of the participants was one of hopefulness, which is quite noteworthy considering the participants were not selected based on this criteria. When fluctuations in hope did occur, they were temporary and situational for the participants. The participants were extremely motivated in both conscious and unconscious ways to try to restore their sense of hope.

The reason for the collective experience of hopefulness among the participants can only be conjecture. It most likely was related to the self-selecting sample of those psychoanalytic clinicians that agreed to be research subjects. It might be, however, that this sample is reflective the larger population of seasoned psychoanalytic clinicians who have achieved a certain amount of hopefulness by the time that have been in the field for 20 years.

Summary of Cross Case Analysis

The themes that emerged in the vicissitudes of hope between participants across cases expand the current psychoanalytic theory that describes the vicissitudes of hope in the clinician in three significant ways. The first elaborates on the connection initially made by Mitchell (1993) between the self of clinician and their sense of hope. While the experience of hope felt like an embedded part of these participants, it also was experienced as changeable. The participants also described a developmental progression between the acquisition of professional self-esteem and the stabilization of hope that occurred with experience. The second theme elaborates on how the participants vicissitudes of hope become a countertransference experience within the treatment relationship. These countertransference manifestations ranged from being hopeful to disparaging and could be either useful or potentially hindering to the treatment relationship. The third theme described the ways these participants actively regulate hope in their lives so they retain the experience of hopefulness in their work over time.

The Experience of Hope and the State of the Self

Through the analysis of the data as well as my own subjective reactions, it became clear that the experience of hope reflected the state of the self of the participants. I am using the state of the self to describe the unique sense of groundedness, stability, and confidence that appeared both in the cohesiveness of the verbal and nonverbal narratives of each participant as well as what was exuded by each participant during the interview process.

When the state of self was more grounded, robust, and stable the participants hoped to be more resilient. A resilient sense of hope is equated with an optimum ability to understand and tolerate the fluctuations in hope. While fluctuations in hope may occur in the participant with resilient hope, these fluctuations became irrelevant in that they did not alter or disrupt the state of the self of the participant. When the state of the self was less resilient or more vulnerable, the participants' hope tended to be more prone to states of fluctuation or fluctuations were avoided altogether. These fluctuating states of hope became more disruptive to the participants' overall well-being or state of the self. It also took more effort to restore a sense of hope especially without drawing on internal psychic supports (such as defense mechanisms) or external environmental supports (such as support from colleagues or supervisors) used to shore up the self that is more vulnerable.

The professional life of the participants and their professional sense of hope are windows into the state of self and the more encompassing hope of the participants. The accumulation of all of the participants' experiences contributed to the acquisition of their professional self just as the acquisition of professional self-esteem that occurred with experience helped the self become more robust. While the professional self took time to develop (described in greater depth in a subsequent section), the ease with which the participants were able to navigate through the establishment of a professional self, the acquisition of professional self-esteem, and the development of a mature sense of hope depended on the state of the self.

When the participants had a more solid sense of professional self-esteem, their professional sense of hope was more resilient. They had a grounded confidence in their ability to help their patients utilizing the psychoanalytic process and a deep faith in the

psychoanalytic process to help their patients. While fluctuations in hope are inevitable for the treating clinician given the complexities of transference and countertransference phenomena (described in greater detail in a subsequent section) the more solid the professional self-esteem of the participant, the less likely that fluctuations in hope arose from self-doubt in their work. The participants also had the self-awareness to reflect on what was happening with a patient, were more able to distinguish their own dynamics from their patients, so they were less likely to act out when fluctuations in hope arose. These factors made the participants more apt to weather the ebbs and flows of treatment with a sustained sense of hope.

Allison exemplified this connection between a robust sense of self and a resilient sense of hope. She had a grounded a mature confidence that she carried into the world. She felt experiences deeply but was rarely overwhelmed by them. She had deeply held beliefs and a strong moral compass that informed her life, the psychoanalytic process, and her patients. She exuded a strength to withstand difficulty that was hard fought and well-earned that grew out of surviving her own difficulties as well as a long and productive analytic experience.

The strength of Allison's hope emerged from within herself. Her hope reminded me of a very old mature tree that had very deep and pervasive roots that had survived and could survive all kinds of weather. The resilience of hope was so pervasive that she did not experience fluctuations of hope that often emerge from self-doubt that is an inevitable part of being a new clinician.

Allison's professional hope was comprised of a sense of a deep faith in the psychoanalytic process that she knew works from her own personal experience. It also

encompassed a faith in her capacity to help her patients through the use of the psychoanalytic process that was authentic not grandiose. The maturity of Allison's hope allowed her to attain what is reasonable for herself and her patients (Stark, 2002). She stood faithful to her experience of a patient, herself, and the relational relationship even when colleagues and consultants raised questions about the treatability of her patients. Her professional hope was so solid that it was even sustained in her work in spite of the emergence of disappointment, anxiety and fear outside her professional world that occurred during a time when her son was profoundly ill.

The other four participants possessed many of the qualities that exemplify a solid sense of self and a resilient hope. They possessed, to varying degrees, maturity, self-awareness, and confidence. They also had a professional sense of hope in their ability to help their patients and hopeful in the process to effect change that was the result of experience and competence that was acquired over many years.

The frequency and quality of their fluctuations in hope, however, were more prevalent. These fluctuations would often emerge when the self of these participants became vulnerable. These four participants often had less available internal resources to sustain the self from fluctuation so they relied more heavily on external factors in an ongoing way such as positive feedback from patients, the community, self-care, collegial, therapeutic and supervisory support. While utilizing these regulatory strategies to maintain hope is optimal, the intensity of how these supports are utilized can be reflective of a less resilient sense of hope.

The fluctuations in hope that occurred in these participants were more often related countertransference expressions such as the emergence of self-doubt in their

capacity to help their patients, doubt in the psychoanalytic process, anxiety related to becoming overwhelmed by the patient's affect or difficulty, disabling transference, or the participant's own issues related to their own history.

The types of fluctuations in hope described by these participants ranged from being more defensive such as being "too" hopeful, "defiantly" hopeful, defending against hopelessness to experiencing their own feelings of hopefulness, disappointment, loss of faith, and despair. While these fluctuations occurred with greater frequency in these four participants, they all took steps to regulate their hope (described in greater detail in a subsequent section). Thus all the participants were able to sustain a sense of hope over time.

The exact reasons for Allison's resilience are beyond the scope of this study. It is important and relevant, however, to theorize about resilience by looking at the identifying data of all the participants. There are some notable differences in identifying data that distinguished Allison from the other participants that I believe have contributed to the depth of her resilience.

Allison was the oldest participant; she was about ten years older than the other four participants. She also has been in clinical practice about ten years longer than the others and has the most extensive experience supervising others. Allison's age and experience contributed to the maturity of Allison's hope. There was a certain wisdom and intactness that made me think about the middle to late adulthood phases of Erikson's psychosocial stages of development: generativity versus stagnation and integrity versus despair (Erikson, 1950). In the stage of generativity versus stagnation the adult is faced with the task of being productive and working to shape the next generation.

Allison was at the mature end of having achieved generativity in her professional and personal life. She has many years of experience working with patients and supervising others, which have repeatedly resulted in helping people grow and live more fulfilled lives. While Allison did not elaborate on her experience of being a mother, she does feel that this experience also significantly contributed to the establishment of maturity and confidence.

There was a certain integrity that was also part of Allison that made me think that she was part of Erikson's final stage of integrity versus despair even though she chronologically did not fit in this psychosocial stage. Allison looks back on her life with satisfaction not regret. There was a wisdom and strength that she exudes in her work that was steady and solid.

Allison was the only participant who has been in analysis. Her analysis lasted longer than the other participant's psychotherapy experiences. While all the participants valued their treatments to varying degrees (which will be described in another section of the findings), Allison saw her analysis as life changing both professionally and personally. It also was a catalyst in expanding her sense of hopefulness.

Several psychoanalytic writers including Fromm-Reichmann (1950) to McWilliams (2003) have described the benefits of analysis over psychotherapy for psychoanalytic clinicians. Fromm Reichmann (1950) contends:

Effective treatment results in increased self-esteem that is not as prone to fluctuations from conscious and unconscious patient provocation. Personal treatment increases the probability that the therapist will have an adequately secure and satisfying professional life reducing the likelihood of using patients to gratify unmet needs. Thirdly, increased self-knowledge from an analysis can reduce the likelihood of acting out rather than reflecting on countertransference.

Lastly, Familiarity with one's own dynamics makes it possible to recognize those dynamics in patients (in McWilliams, 2003, p. 42).

Silber (1996) contended that for the analyst to work effectively, to enjoy and believe in his work, his own analytic experience has to have been fulfilling and convincing in both a personal and professional sense. Allison saw her analysis as the main factor in saving her psyche and deepening and giving substance to her hope. She also described it as the single most significant source of learning about the psychoanalytic process, which enabled her to have a depth and confidence in her work that was the result of knowing herself and knowing others.

Allison recounted an analytic experience that was on the optimum end of the spectrum, which is also not the case for all analyses (Tussman, 2003). She and her analyst were a good fit. Also, we do not know what Allison's psychological makeup was prior to her analysis, which may have also contributed to her ability to make optimal use of her analysis.

Since Allison was the only participant that had an analysis, it seems important, however, to interpret this data point with caution. Tussman (2003) points out that there are those resilient analysts who emerge from disappointing and damaging relationships to their analysts that become excellent analysts themselves. She uses the analogy that resilient children can emerge from families that are quite toxic.

Another factor, which may have affected Allison's resilience of hope, is that she was the only participant who is in analytic training. While Allison did not discuss her formal training experiences as being a factor in their sense of hope, it seems intuitive that experience and training are contributing factors in expanding the professional self-esteem

of the clinician. It is my sense that one of the reasons that Eitingon's (1923) tripartite model of psychoanalytic education, which emphasized training, supervision, and theoretical and clinical seminars, is still being used in psychoanalytic institutes today is because there is a belief that these three avenues become integrated in promote a sense of strength in the analyst and in the psychoanalytic process. The clinician that is psychoanalytically skilled and self-aware both reduces the probability that fluctuations in hope are related to professional self-esteem vulnerabilities and increases the chances that they will be able to navigate these fluctuations more effectively when they occur.

The Embedded Experience of Hope

All of the participants except Natalie experience their sense of hope as an embedded part of them that has been with them since childhood. While they described a natural propensity towards hopefulness or despair, they also experienced that their sense of hope was changeable with experience. The participants' perception about the developmental nature of hope supported a more progressive view of hope that has been posited in the psychoanalytic literature. These theories starting from Erikson, Winnicott, and Kohut view hope as constructive, growth enhancing, and evolving in a developmental context (Mitchell, 1993). While these theorists contend that the seeds of hope begin in infancy, there is much room for growth and change throughout life.

The participants believed that their sense of hope developed early in life. Allison, Steven, and Cara described a more embedded sense of hopefulness whereas David pointed to a more embedded sense of despair. Allison stated that she always tended to see things from a "half glass full" perspective. She said,

I have certainly experienced plenty of depression and many times when I have been quite miserable, but never have I thought of myself as a person who wasn't hopeful. I always had a sort of glass half full kind of frame of reference. Steven, too, said "I have always been inherently fairly optimistic."

Steven believed that it was his inherent optimism that has allowed him to persevere in the field over time. In contrast to Allison and Steven's hopefulness, David revealed what seemed to be a more embedded sense of despair or lack of optimism. He added, "I never thought of myself as a really optimistic or hopeful because it wasn't what I was attracted to or it wasn't what I felt like I was demonstratively."

The participants who had a more embedded sense of hopefulness believed that it emerged within their family of origin. Hopefulness was believed to have emerged from being loved by their parents. Additionally these participants described a process of identification that reinforced a sense of hopefulness. Allison and Steven described an awareness of identifying with a particular parent who held the optimism within the family. Cara described that she identified with the family narrative. She witnessed many examples of both parents overcoming hardship to create a good life for her family.

While the participants believed that the establishment of their sense of hopefulness started early, they also believed that hope was changeable with experience. All the participants hope expanded over time. Personal treatment was the primary factor in expanding the hope of the participants, but many of the participants also attributed an increased sense of hopefulness as being related to professional success.

The Developmental Trajectory of the Hope in the Clinician

Psychoanalytic writers such as Menninger (1987) Kepinski (1981) and Searles (1977) and more recently McWilliams (2004) describe the maturational process of the clinician. According to them, inexperienced psychoanalytic clinicians enter the field with an excess of therapeutic zeal that they can make sweeping changes and help anyone with anything. These clinicians often experience wide fluctuations of feeling from excess of confidence to a complete loss of faith. As they mature and become more experienced, a realism emerges that grounds the professional hope of these clinicians.

All of the participants in this study, except for Cara, described a maturational process that exists in relation to their professional self-esteem and their sense of hope. As beginning clinicians, most of participants described either an excess of confidence, which made them idealistically hopeful, or a lack of confidence, which made them more prone to fluctuations in hope. As each gained experience, their professional sense of self became more solid and their sense of hope stabilized so fluctuations in their sense of hope occurred with less frequency.

The remaining fluctuations in hope or the defensive avoidance of fluctuations in hope that persisted in all the participants except for Allison seemed related more often to vulnerabilities that remained in the overall self of the participants even after the participants attained a sense of professional maturity (elaborated on in the previous section on *The Experience of Hope and the State of the Self*).

Steven entered the field with an excess of zeal related to a sense of grandiosity in his ability to help anyone. As Steven gained experience in his personal and professional life, his inflated sense of hope was challenged. Steven experienced disappointment in his

personal life related to the realization that he could not make his partner into someone who was a good fit for him. Steven also faced limitations in his professional life as he came to accept the limitations of his ability to help certain patients. These realizations helped temper his grandiosity and made his hope more grounded and realistic.

David and Natalie described a developmental trajectory that was the opposite of Steven's. As David and Natalie attained different experiences in their clinical practice, their own treatment, and their life, their self-confidence increased and their hope expanded. David described the most dramatic internal transformation. As a young adult he was filled with despair that was related to having low self-esteem. When he started to experience success at work and in his own therapy, his sense of self expanded. David began to feel more globally hopeful, and hopeful about his ability help his patients in his work.

When Natalie was a new psychoanalytic clinician, she also became a mother for the first time. She felt tenuous and lacked confidence in both roles and thus her hope fluctuated with greater frequency in both her professional and personal life. Natalie recalled,

I was new to my role as a psychotherapist and the same time I became a new mother. When I felt hopeful about one, it helped me feel hopeful about the other and when I would lose hope in one area, it would be hard not to let that create doubt in the other area too.

As Natalie gradually gained more experience as a mother and psychoanalytic clinician, she began feeling more confident in being able to use good judgment to make sound decisions. Her sense of self expanded as she came to trust her own authority,

which helped her sense of hope stabilize in her professional and personal life so fluctuations in hope occurred with less frequency.

Allison's developmental trajectory differed from the others. As a younger adult, Allison's self-confidence and her sense of hope were somewhat connected. Allison described herself as to not feeling confident and properly assessing her abilities. Allison's analysis solidified her sense of self and expanded her sense of hope by "reducing her fears and insecurities that were not based on anything reasonable." Thus when she became a clinician, her feelings of competence at work were not connected to her sense of hope. While Allison experienced self-doubt that is part of the experience of being a new clinician, she did not experience fluctuations in her sense of hope because her more global sense of self remained intact.

Maturity in the Clinician

The participants described a professional maturational process that was painful and difficult but also affirming and growth producing. Steven and Allison had to relinquish those self aspirations that were unrealistic; David faced his feelings of despair; and Natalie experienced feelings of uncertainty and doubt in her roles as new mother and psychotherapist. Ultimately facing their limitations and pain helped their sense of self expand and their sense of hope to stabilize.

Searles (1977) argues that developing a mature sense of hope, whether you are a patient or a clinician is one of the harshest maturational tasks of becoming an adult. Stark (2002) adds by facing disappointment, discouragement and despair and surviving it, the

person is able to find their way to a healthy capacity for hopes, based on realistic aspirations, not inappropriate, unattainable, and unrealistic hopes.

The participants professional maturity also enabled them to realize more clearly the boundaries of the therapeutic relationship. While all the participants' have hope for their patients, their maturity of hope allowed them, to varying degrees, to accept that it is ultimately the patient's job to make the changes in their life and change cannot be "coerced out of the patient in conformity to some omnipotence-based ego ideal based on the analyst's narcissism (Searles, 1977, p. 17).

This aspect of professional maturity was addressed by all the participants. Allison extensively described her ultimate powerlessness in her ability to change the masochistic aspects of a patient. Steven realized that he could not help all patients. Cara struggled with her limitations with a patient who had extraordinary difficulties with basic functioning. Natalie had to accept that even though she and a patient were doing extraordinary work, he was unable to continue because of his own intrapsychic limitations.

Allison's maturity of hope also included seeing hope in the psychoanalytic process as something that is often not connected to feeling good. Allison recognized that so much of psychoanalytic work is about experiencing the feelings related to mourning, loss, separation, profound disappointment, and sadness, This knowledge helped to sustain her hope through powerful affective experiences and disabling transferences that occur within the treatment relationship.

The affirming and confidence building part of the maturational process occurred for the participants as they witnessed the growth of patients. It helped the participants learn that they do have the ability to help patients psychoanalytically. Natalie recalled,

I learned that I have something that's real to offer. When you're young and first starting, you're a young therapist, you know you don't really know what you have to offer, you don't know if it's real, you don't know if it is strong enough, you don't know if it has enough complexity to it to really meet people where they are. I mean you hope you do, that's part of the hope, at the beginning, and then you feel, then after you kind of see a couple things come to fruition, you think well it's not exactly like I hope but maybe it's something even better. Something more real, and you think well maybe I can be what I hoped I could be.

The participants described therapeutic success as observing the external changes in their patients such as: seeing patients become more engaged in their lives and seeing them make healthier choices in relation to love relationships, friendship, professional life, and with their children. The participants also observed the intrapsychic successes of their patients such as observing patients grieve, becoming less self-critical, allowing themselves to feel a broader range of affect or to regulate their affect in healthier ways.

Witnessing the success of patients gave the participants more stamina to persevere through the most challenging aspects of the therapeutic process. It helped them become more focused on the fact that the process works over time, which helped them feel less worried session to session. It also helped the participants realize that they had acquired the psychoanalytic capacities, that they identified as self-awareness, tolerating intense affective, empathy, awareness of transference and countertransference themes, to help their patients make changes.

The growth of patients deepened the participants faith in the psychoanalytic process. When the clinician observes that the patient growing it "not only inspires hope

in the analyst but often represents a revived capacity for hope with the relationship” (Cooper, 2000, p. 24).

The success of patients provided more, for many of the participants, than just stabilizing their hope and enhancing their professional self-esteem. Natalie described a certain reciprocity that she experienced in her work with patients. She often felt inspired by their growth. The ability of her patients to overcome difficulty gave Natalie hope that perhaps she too could find the courage to work on difficult problems in her life.

The participants either explicitly or implicitly described a sense of meaning in their lives that was gained by being able to make a difference in the lives of their patients. It gave many of the participants a broader sense of purpose. It helped them feel as though they were contributing to the betterment of humanity. There was a sense of privilege that the participants experienced both that their patients allowed them in to their inner world and that the participants felt able to help their patients better their lives.

The Vicissitudes of Hope in the Countertransference

In contemporary psychoanalytic theory, the clinical process is seen as a two-person psychology (Aron, 1990, Spezzano, 1996). The acceptance of the clinician’s subjectivity has enabled the clinician to be viewed as a human being with feelings, fantasies, and thoughts which no longer make it possible to conceive of the clinician as a neutral objective observer (Bernstein, 1999). The therapeutic relationship is the product of the interaction of two participants inexorably engaged in a relationship.

The recognition of the clinician’s subjectivity supports a more totalistic view of countertransference as all the reactions, real or imagined, facilitating or inhibiting, the

clinician has to the patient (Kernberg, 1965). While countertransference is considered an “indispensable instrument (Eagle, 2000, p. 26)” as it serves as a crucial source of information about the patient, it is also a crucial source of information about the clinician (Eagle, 2000; Mitchell, 1993; Baum, 1977), and how patient and clinician come together and form their own dyadic system (Ogden, 1994; Mills, 2004).

The findings in this study, while not generalizable, illuminate the complexities of the vicissitudes of hope in the countertransference as experienced by the participants. The findings support a more totalistic view of countertransference as, at times, relating to the clinician’s issues, a patient communication or a co construction between patient and clinician. The participants countertransference expressions of hope were revealed in two ways. The first, which emerged through the analysis of the data, was related to a mostly unacknowledged sense of hope in the clinician that they brought into the clinical relationship. The second was related to the emergence of feelings of despair and hopelessness that the participants described got stimulated in the therapeutic relationship.

The Clinician’s Experience of Hope: A Countertransference Expression

In the section on the Experience of Hope and the State of the Self, I described how the clinician’s experience of hope is a reflection of the state of the self. These hopes span the development of the clinician as the self is developing. The clinical implication of the relationship between the state of the self and resilience of hope is that the clinician brings these parts of the self into the therapeutic relationship. These hopes are an often unacknowledged and usually unconscious facet of the clinician. These hopes in the clinician get activated within the treatment relationship in the unique conscious and

unconscious ways that the patient and clinician come together just as Cooper (2000) highlights is the case with the patient.

Mitchell (1993) and Cooper (2000) support the notion that the clinician's hope in the countertransference is an essential part of the treatment process. Mitchell contends that countertransference expressions reveal the clinician's "personal stake" in the psychoanalytic process. He adds, "The clinician's hopes that get activated in the treatment are embedded in and entangled with her own sense of self, her worth, what she can offer, and what she has found deeply meaningful in her own life" (p. 208). Hopes are embedded in the service the clinician offers: "a form of treatment, a way of practicing and a set of techniques" (p. 207).

These hopes in the countertransference are often unconscious to the clinician and patient, yet their influence on the treatment process can range from being facilitating to hindering. Cooper (2000) adds, "Our patients, like our children, become the repository of our hopes, and this is what fuels development, just as this imparting of our hopes and even induction can be highly problematic" (p. xiii).

The participants with resilient hope were more apt to utilize their countertransferential hopes to facilitate the treatment process. The participants described those times when their hopes in the countertransference served as a fund of hope that was utilized in the treatment process. This reservoir of hope differed for each participant and it expanded for most of the participants with experience. Steven referred to his capacity to hold hope for his patients who were in the process of dying from AIDS in ways that helped them find meaning at the end of their lives. Natalie held hope in a patient's ability to develop a more authentic emotional life in spite of how underdeveloped he was

emotionally. David had the capacity to hold hope for his supervisee because he held onto the developmental view that fluctuations in hope occur more often in beginning clinicians and stabilize with time. Cara was able to hold hope for a mother, who was experiencing emotional devastation in response to experiencing the loss of her baby, because she felt it would ultimately be better to express her feelings rather than avoid them.

Allison's resilience of hope enabled her to use her hope as a central capacity both in the treatment process and in her supervisory relationships. Her patients and supervisees experience Allison's unbending hope, which helped them develop the capacity to hope for themselves. There were times when Allison explicitly shared her hopes with patients and supervisees. There were other times, when she was the silent keeper of hope when patients could not tolerate more explicit expressions. Allison's hopes persisted through the most difficult phases of a treatment because she knew that treatment can be complex, painful, and difficult often before any gains are seen or experienced. She also sustained her hope by holding onto those hopeful parts of the patient or supervisees in the more difficult moments of treatment.

The participants countertransference hopes got intuited by the patient. They were the music behind the words. The psychoanalytic writers Gill (1983) Hoffman (1983) and Aron (1991) emphasize that countertransference must include the patient's intrapsychic and relational stance toward the inner life of the therapist. Allison illustrated the power of these facilitating countertransference hopes that were described by a patient in a lecture she attended several years ago.

I attended talk that was given both by Joanne Greenberg, the woman who as a girl wrote *I Never Promised You a Rose Garden* and a professional from Smith who was writing a book about Frieda Fromm-Reichmann, who was Greenberg's

analyst. Someone in the audience asked what did Joanne Greenberg think was most helpful to her in her treatment with Frieda Fromm-Richman? Greenberg did not flinch. She said she would not take no for an answer. She just would not give up.

When a clinician is in possession of the stamina required to “never give up” on a patient, it means that the clinician’s hope in her ability to help a patient and a hope in the psychoanalytic process is so resilient that she has the capacity to hang in with patient through the ebbs and flows of a treatment process. While it is not curative in and of itself, its power to help facilitate the psychoanalytic process is profound, which is why it lives in the memory of Joanne Greenberg decades after her treatment ended.

The participants’ hopes in the countertransference can potentially hinder the treatment process when there is a lack of resilience to their sense of hope. Since the self of the participants was more vulnerable, doubts emerge in their ability to help the patient and the participants lose hope in their ability to be helpful. Even when these hopes in the countertransference may have been hindering, they were the participants best efforts at maintaining hope within the treatment relationship.

There are times when the emergence of self-doubt is a useful indicator to the participants of their limits with their patients. The participants at times recognized their professional limits and took steps to help their patients find other ways to get their therapeutic needs met. This ability helped to sustain hope in the participants over time. This occurred with Steven when he recognized his inability to help a patient who had such an intense depression that was so triggering to him that he referred her to another therapist.

When the emergence of self-doubt and hopelessness occurred in the participant, and they continued to work with a patient, this type dynamic can complicate and potentially hinder the treatment process. The patient may unconsciously experience the participant's feelings of hopelessness, understanding these feelings in ways that are specific to the patient, but may include reinforcing their own feelings of hopelessness. When the participant relied on outside regulatory measures such as supervision, self-care, and collegial support to try to restore their hope in the countertransference (described in greater detail in a subsequent section), the outcome was usually more optimistic because the participants were able to re-find the hope necessary to persist with a patient.

The participants described two ways that this more vulnerable sense of hope in the countertransference had the potential to hinder the treatment. The first way was when the participants became overly reliant on their patients to sustain a sense of hopefulness in the treatment relationship rather than that experience of hope residing in the participants or equally within the participants and the patients. The participants' depletion of hope had to be restored by the patients usually by the patients making progress in treatment or praising the participants. David described that his reliance of his patient's successes made him feel hopeful and expand his sense of self. Steven also felt effective when his patients were succeeding and giving him positive feedback about their progress.

McWilliams (2004) contends that "there are some mature and reasonable narcissistic needs met by clinical practice, in the form of appreciative patients and satisfactions of a job well done." When the clinician relies too heavy on the patient to sustain a state of hopefulness, it can be problematic for the clinician and the patient. Boris

(1976) contends, “the therapist’s vicarious hopes for his patients or his need for daily rejuvenation of hope of his own soon find him doing something other than therapy” (p. 89).

The potential burden on the patient to be hopeful for the participant or the therapeutic couple can complicate the treatment. It can replicate the care taking dynamics in the patient’s early life. It can also prevent patients from accessing the more despairing and hopeless parts of themselves for fear the participants won’t be able to tolerate those feelings or hold hope for them. While David and Steven’s hopes in the countertransference, to varying degrees revealed inclinations of this tendency, the overriding experience that their patients made gains in spite of this dynamic means that it did not seem to hinder the success of patients.

The second way that the participants described how hope in the countertransference can potentially hinder the treatment is when the participants defended against the experience of hopelessness and despair by developing an overinflated sense of hopefulness. The concern with this form of countertransference expression of hopefulness is, in order for hopefulness to be maintained, the participants needed to disconnect from their self. This disconnection means that they are less able to use their self an instrument to aid in the treatment process. Additionally the patient is less apt to experience a certain authenticity within the participants, which was a key factor in facilitating healing in the treatment process.

The defensive sense of hopefulness, at times, became a way for the participants to manage or avoid the personal anxiety of the clinician. Tolleson (2003) described the manic countertransference position as arising in the clinician in reaction to self-doubt.

The clinician responds by becoming active to try to come up with concrete solutions to restore their hope rather than understanding that the feelings of hopelessness are important to understand over time. Several of the participants recalled examples where they suggested medication, housing solutions, and different kinds of treatment options in moments as a measures to maintain their sense of hope in the treatment when they lost hope in the value of understanding the internal experience of their patients.

Another defensive manifestation of hopefulness in the participants occurred when the participants' drive to maintain hopeful became bound in their perception of a being a "good therapist." Cara described her tendency to see only the strengths in her patients or in her work situations, which at times prevented her from looking at the more complex levels of her or her patient's experience. Stark's (1999) concept of "relentless hope" describes a defense that can get activated in the clinician (or patient) wherein they are unwilling or unable to bear the pain of disappointment (p. 311). Stark also adds that having relentless hope can set up an unrealistic belief in the therapist that they always have to be the "good therapist" to make up for all the ways the patient has been harmed. It prevents the therapist from realizing that she will never be able to compensate the patient entirely for the damage sustained early on; and prevents both patient and therapist from grieving this reality as a necessary part of the therapeutic process (p. 314).

Tolleson (2003) describes this defensive facet of hopefulness as defensive benevolence, which is essentially an effort in the clinician to avert the arrival of psychic pain the patient. The therapist fears that it will be too difficult for the patient or clinician to manage.

The participants brought their experience of hope and state of their self into the treatment relationship. These often unconscious hopes affect the treatment in ways that range from being facilitating to hindering. When the participants self is resilient, they are in possession of hope that can aid the treatment process. When the participants self is more vulnerable, the participants relied more on the patient to restore their sense of hope or they avoided the experience of any fluctuations in hope, which have the potential to hinder the treatment. Even when hopes in the countertransference are hindering, they are the participants' best efforts to maintain a sense of hope in the treatment relationship.

Hopelessness as a Countertransference Expression

The emergence of feelings of hopelessness, despair, loss of faith, and disappointment was by far the most common countertransference expression described by the participants. When these feelings arose, it caused the participants discomfort that was often hard to tolerate. The meaning of these countertransference expressions varied depending on the participant and situation. The participants experienced hopelessness as a countertransference expression in a variety of ways: as an expression of their own conflicts, as a communication from the patient, and as co-construction between participant and patient. The participants dealt with the emergence of these feelings of hopelessness in ways that were always attempts to restore or maintain a sense of hope in the clinician.

The participants revealed instances when countertransference expressions of hopelessness were related exclusively to the unresolved issues of the participants that got activated in the therapeutic relationship. The participants, however, were usually not very

forthcoming about elaborating on their particular intrapsychic issues within themselves that triggered these feelings of hopelessness. They instead preferred to describe the interpersonal experience of how these feelings manifested themselves in the treatment relationship. David described that he consistently experienced a feeling of hopelessness in relation to working with latency age boys and their parents. He understood the reason for his countertransference reaction of hopelessness was that it touched something in him that is connected to being latency aged. He did not elaborate further on its meaning.

The participants, to a lesser degree, also described instances when the emergence of hopelessness in them was related exclusively to a usually unconscious communication from the patient related to the profound despair in the self of the patient. Allison described intense feelings of hopelessness she felt in relation to a patient she has been seeing for 12 years. Allison recalled, "I feel so much pain on her behalf because she is suffering a lot. I have felt less hopeful and even at times despair, but I think it has to do with how she feels a great deal."

The most common manifestation of these countertransference expressions of hopelessness in the participants was related to a relational exchange that expressed an unconscious communication from the patient and how that was experienced in the clinician was related to the clinician's own issues and conflicts. Steven described the emergence of feelings of hopelessness when he worked with a female patient who had a profound sense of hopelessness, anxiety, self-loathing and depression. Her despair was so intense that Steven began to understand why she wanted to kill herself. Steven understood this unconscious communication from his patient as a diagnostic indicator of the lack of treatability of this patient. Her past traumas were too pervasive and her

internal resources not sufficient. He also understood his participation in this countertransference reaction. He was not feeling effective with this patient and his professional self-esteem was decreasing, which contributed to his sense of hopelessness.

The participants varied in how they handled the inevitability of the countertransference expressions of hopelessness. Although the participants' understanding of the hopelessness was often incomplete, the participants reported that their patients often still made progress. When circumstances were optimal, the participants generally tried to understand, in the moment, from where their hopelessness stemmed: was it related to something within them, their patient, or the treatment. When the hopelessness was related to them, as was the case with David, he made the decision not to work with the population. When the hopelessness was a communication from the patient, the participants often silently used it to deepen their understanding of the patient without doing anything. There were other times when the participant's would use these feelings to engage with the patient about the feelings of hopelessness as an attempt to deepen the clinical picture.

If the participants' hopelessness persisted, they would continue to reflect on what happened alone or would reach out to colleagues, supervisors, partners, consultants, to process these feelings with "trusted" others. The processing of their hopelessness with another person was the most successful strategy in re-instilling hope for these participants. It gave them greater understanding as to what was occurring. The input given by the participants' supports was at times strategic, to give the participants some way to think about the treatment. They made suggestions such as encouraging the participants to sit with the feelings of hopelessness rather than "do something about it."

Other times they recommended more interpretative and concrete solutions. The participants felt heard and validated by people they trusted and admired. The support and validation either restored a sense of hope in the participants or gave them stamina to continue treatment in spite of the more persistent feelings of hopelessness.

While the participants were mostly helped by discussing their feelings of hopelessness, there were times when discussing these feelings more formally either in consultation or their own therapy complicated the countertransference-transference expression of hope. The exchange that a Steven had with a consultant, which restored his sense of hope with a patient, made harder for him to use his hopelessness to help him accept the reality that his patient wanted to end his treatment.

When Natalie understood that feeling of hopelessness as eliciting something related to her own issues, she returned to therapy as an attempt to restore hope. Shabbad (2001) contends that the clinician must struggle with her own countertransference reactions to understand her own despair, dread, and disillusionment as well as the specific defenses that have been resurrected to defend against a repeat of more pain. While this decision is usually restorative for the clinician, Natalie found her own personal experience in therapy disappointing. It did not facilitate greater awareness into the complexities of her countertransference response as she had hoped. Following its conclusion, she retained a sense of hopelessness regarding her own capacity to be helped by the therapeutic process.

In spite of her disappointment in her own therapy, Natalie found a way to be with this patient that helped him to make progress. It was through her work with him that her sense of hope in her work was restored. I wonder if in some way, Natalie's own

disappointment increased her investment in finding a way not to be disappointing to her patient. It certainly reinforced in Natalie the connection between self-reliance and hope that was established in her case study. Mitchell (1993) stated, “Sometimes hope for the right thing can be reached only through immersion in prolonged and harrowing dread” (p. 59).

While these participants tried their best to understand the emergence of hopelessness, there were occasions when their experience of hopelessness would elicit an immediate response without forethought. It might have touched something so deep, primitive, and intolerable that the participants just needed to get rid of it. When this experience occurred, the patient would often react in some way i.e. getting angry or crying that would inspire self-reflection in the participant to facilitate some dialogue between participant and patient. The process of engagement around what occurred between the patient and participant often had the effect of restoring some amount of hope in the participant as it illuminated the dynamics of the relationship by discussing those dynamics in the here and now. The participants were usually less forthcoming with their patients when the hopelessness in them was related to something that got triggered in their own history.

Cara described an exchange with a patient that exemplifies this dynamic. Her patient was crying so intensely at such a fevered pitch, that feelings of hopelessness were elicited in Cara. She responded by suggesting a medication evaluation. The patient became enraged, contending that Cara had wanted her for years to express her emotions, and now that she was, Cara could not handle it. The way that Cara and her patient

processed this exchange, which I believe was a projective identification, ultimately really benefited the patient and deepened the treatment.

The experience of hopelessness is common among participants. It reflected their own issues, their patients' issues, or a joint reaction between patient and patient. The participants were very driven to restore hope in whatever way they could. When the participants were conscious of the emergence of hopelessness, they tried their best to understand these feelings, use them to deepen the treatment or self-understanding and restore hope. When these countertransference reactions occurred out of their awareness, the participants were unable to use these expressions in ways that were optimal. When the patients became aware of a behavioral manifestation of hopelessness, they helped to bring into awareness these more unconscious reactions in ways that restored hope in the participants. Although the participants at times lacked the awareness of the emergence of hopelessness or only had partial understanding of the complexity of meaning, their patients seemed to benefit from treatment because there were other strategies that the participants used to facilitate treatment that were helpful. The greater the participants self-knowledge, professional self-esteem, and ability to use support to deepen understanding, the more effectively these participants could use their countertransference expressions of hopelessness to help themselves and their patients.

The Regulation of Hope in the Clinician

The participants elaborated extensively on the factors that helped to regulate their hope throughout their development. The existing psychoanalytic literature on the regulation of hope in the in the clinician is somewhat minimal. While it is addressed by

Cooper (2000), Schechter (1999), and Symington (1996) among a few others, the finding of this study will expand on the existing psychoanalytic knowledge.

The participants described several factors that helped to regulate their hope throughout the process of development. These include: personal treatment experience, consultation and supervision, the use of psychoanalytic capacities, self-care, personal resilience, and mutuality. The factors provided two different regulating functions. The first was to expand the professional self-esteem of the participant: making the participant feel more competent and thus hopeful about being able to help the patient and more hopeful about the psychoanalytic process. The second regulating function is protective. It helped to insulate the clinician from fluctuations in hope and helped to restore a sense of hope if fluctuations occurred.

Personal Treatment Experience

The participants to varying degrees believed that their own treatment strengthened their sense of self and deepened their hope. Treatment expanded the self of the participants making them feel more confident personally and more skilled professionally. Although only one of the participants was in the midst of a weekly psychotherapy at the time of interviewing, all participants felt the expansion of hope both when they were in treatment and long after treatment ended.

The participants studied entered treatment initially for personal reasons rather than for professional growth. The reasons given ranged from feeling a sense of despair, depression, low self-esteem, the after-effects of trauma, and feeling stuck in life. While Steven was the only participant who was in the field when he entered therapy, he entered

for personal reasons. As is the case for most patients entering treatment, there was sense of hope in each participant that the psychoanalytic enterprise could help them feel better, get unstuck, and/ or deepen their self-understanding (Cooper, 2000).

The anticipatory hope that was expressed by each participant was fulfilled to varying degrees once they began treatment. As mentioned in another section, Allison's experienced her analysis as profoundly transformative. It "deepened and gave substance" to her hope. It saved her psychically. Steven described that his personal experience transformed feelings of despair to hope and that the "resilience" of his therapy relationship lives on within him. David's sense of self-esteem expanded in therapy and he began to realize the power of his own voice. Cara's experience in her treatment provided holding, which has helped her feel supported over time.

Natalie was the only participant to have a more ambivalent experience in her own treatment. The first time she was in therapy she described that it instilled her with hope because it helped her find her own voice and deepen her confidence. When she returned to therapy a second time, however, she experienced profound disappointment related to feeling as though her therapist could not meet her where Natalie needed her to be, which has made her lose hope in her capacity to benefit from psychotherapy.

As personal treatment came to be meaningful and useful in the personal lives of the participants, they became able to harness that hope in their professional lives. McWilliams (2004) states, "Analysts have faith in the therapeutic project because they have experienced it themselves" (p. 42). The participants experienced the power, to varying degrees, of the psychoanalytic relationship as healing. They carried this personal knowledge of the hope and promise of psychotherapy into their work with patients. There

was heartfelt desire in all the participants, but Natalie, to give their patients what they had gotten.

These participants also believed that their own therapy as the most significant source of learning about how to do therapy. McWilliams (2004) contends that “candidates from psychoanalytic institutes uniformly comment that their own personal analysis gave them the richest source of knowledge about how to do sensitive therapy, which no textbook could substitute” (p. 65). The participants learned what it was like to be a patient. They implemented techniques and skills used by their therapists that they found useful as patients in their own clinical work. They also tried to actively avoid those aspects of therapy, which were not helpful in their own work with patients.

Another source of learning that came from personal therapy for all the participants was the internalization of a sense of faith in the process that is derived from personal experience. McWilliams describes,

The faith of the therapist is not attached to the particular expected outcome but to the conviction that if two people conscientiously put a certain effort in motion, a natural process of growth that has been arrested by the accidents of the patient’s life thus far will be released to follow its own self-healing logic. This kind of faith assumes that the effort to pursue the truth of one’s experience has intrinsic healing value (p. 43).

In his book entitled *The Making of a Psychotherapist*, Symington (2002) highlights that “the most essential use of personal treatment for psychotherapists is helping them develop the emotional capacities and knowledge of their true self, which is essential and without it all intellectual strivings to master concepts becomes a hollow endeavor” (p. 11). Schechter (1999) adds, “Personal reflection helps the clinician set transference reactions aside and respond to the needs of clients” (p. 382). While Allison was the only

participant to elaborate extensively on how the knowledge of herself gained from her analysis has helped her maintain a sense of hope in her work with patients, I do believe that this is the case to varying degrees for all the participants. Allison elaborated,

We have to know where we begin and end, so to speak, and we have to be relentlessly aware of what's going on inside ourselves not for any pathological reason but because we are the instrument so to speak, so our feelings and thoughts and reactions and fantasies and I mean bodily sensations, in my opinion can have and often do have a bearing on what's going on in the room. So much is diagnostic that one might not recognize as such without doing that kind of in depth work and have familiarity with the subterranean landscape.

In spite of the expansion of hope attained in treatment, the participants all described at the end of treatment beginning to see the fallibility or humanness of their therapists or analyst. Tussman (2003) describes that a process of individuation needs to occur as the clinician integrates the experience in therapy into his or her own work with patients. The way in which that individuation occurs is different for those who felt that their treatment experiences were more deeply satisfying than for those who were less satisfying or even damaging.

Allison and Steven who had the most satisfying treatment relationships, described an enhanced sense of hope that occurred as they recognized the fallibility of their analyst and therapist. Allison sense of hope in her ability expanded as she came to value her flexibility over her analyst's, which she understood as emerging from her work with families and from being educated at a different time. Steven internalization of his therapist's fallibility helped him sustain hope in his work by helping him realize that he does not need to be perfect.

David and Cara who were mostly satisfied with their therapeutic relationships, disidentified with those aspects of their therapists that were not satisfying in their work

with patients. David expressed disappointment at not being challenged more by his therapist, and shared how he finds it useful to challenge his patients at times. Cara integrated the experience of a therapeutic relationship that was not a good fit, which ultimately helped her to know more the type of therapeutic relationship she needed. Cara also utilized this “bad experience” to teach her graduate students what not to do in the therapeutic relationship.

Natalie shared the most complex reactions in her therapeutic relationship. Natalie’s first experience in therapy she found to be satisfying . As was mentioned previously, the second time she returned to therapy, however, Natalie was disappointed in her therapist for not being able to meet Natalie where she needed her therapist to be. Natalie described being able to use that disappointment instructively in her professional life, as to how not to be in her work with patients, which helped her sustain hope in work over time. Tussman (2003) contends that “analysts tended not to pass on this wounding legacy, but instead, through intuiting the specifics of how they had been failed, in disidentification with the analyst, forged an impressive commitment to fostering the analytic process” (p. 211).

The personal treatment experiences of the participants was probably the most crucial tool in the expansion and regulation of hope in the participants. To varying degrees, it helped the participants understand and work through their own issues that contribute to a vulnerable self. The more growth the participants experienced in their own treatment, the more able they were to use their self-awareness to aid them in their work with patients. Personal treatment was also the best tool available to help the participants learn about the psychoanalytic process.

Consultation and Supervision

All of the participants received consultation or supervision regularly since they started in the field. The three participants, who were in private practice, chose their consultants. The other two participants, who worked at agencies, were assigned a supervisor. David began working with a consultant outside his agency once a month for the past few years in addition to receiving weekly supervision. Even when choice was involved, most of the participants have seen a particular consultant for several years as it takes time to develop a sense of trust to share the vulnerabilities of the participants and clinical dilemmas that arise in psychoanalytic practice.

All the participants considered having obtained consultation and supervision an essential component in their maintenance of hope over time. The support, insight, and guidance they obtained was invaluable. McWilliams (2004) contends that, “supervision becomes a nourishing balance of support, stimulation, and challenge” (p. 54).

Schechter (1999) adds that identification with a supervisor can result in a certain “adaptive grandiosity, which enables the clinician to have a strong positive view of her own potential to be effective (p. 381). Many of the participants described the importance of their supervisor or consultant validating their work and what is going well in therapy. This experience reinforced feelings of competence in these participants.

Consultation and supervision also helped the participants restore a sense of hope when fluctuations occurred especially in the countertransference and transference relationship between participant and patient. Allison summarized the importance of consultation that was echoed by all the participants. She contended,

I think consultation is very important. I have always used it, since I started in this field 30 years ago. It does not matter how experienced you are, how smart you are, how good you think things are going or bad. You can't help but get caught up, so I think consultation is what I use.

This belief is echoed by McWilliams's (2004) in the literature. "No matter how 'well analyzed' any of us is, we cannot expect to find ourselves unaffected by the powerful psychological forces that assail us in a therapy session" (p. 62).

Consultation and supervision adds another perspective to the participant's experience of what is occurring within the therapeutic dyad. The insight and guidance helped to frame what was happening both within the self of the participant and within the therapeutic process. It better equipped the participants to both understand and use their reactions within the therapeutic relationship or work to resolve their reactions outside of the therapeutic relationship. Consultation and supervision also helped to validate for the participants that fluctuations in hope are a normal part of the process, which helped normalize the intensity of the participants feeling state.

Allison and Natalie described that the way they used consultation shifted as they became more experienced and their faith in their capacity expanded. Natalie described that when she was younger she considered her idealization of her consultants as all encompassing. As she and Allison have matured and become more self-confident, they both described becoming more discriminating in how they use their consultant's insights, which fueled a greater a sense of hope in Natalie and Allison as it was indicative of a more expansive sense of self.

Consultation and supervision was essential to the regulation of hope in these participants. It helped to share the complexities of the treatment process with someone

who is admired. It also helped to get guidance as to what may be helpful to try when the participants are feeling stuck or hopeless with a patient.

Psychoanalytic Capacities

The use of psychoanalytic capacities for these participants was a way that they applied psychoanalytic theory to their work. Psychoanalytic theory served as a frame of reference in the process of exploration (Kepinski, 1981). The participants highlighted those psychoanalytic capacities they felt were most essential in treatment: self-awareness, emotional openness, tolerating, understanding and using affective experiences within the therapeutic dyad, empathy and attunement to transference and countertransference.

When the participants utilized, what each considered the most essential psychoanalytic capacities to them, even in those affectively challenging moments, they experienced a sense of hope. They experienced hope in themselves because they are fulfilling a professional ideal. They also experienced a sense of hope that in utilizing these skills they were utilizing psychoanalytic theory to engage in a psychoanalytic process.

Allison was the only participant who explicitly described the importance of self-awareness in the treatment process (see Personal Treatment Experience, above). Her highly developed sense of self-awareness guided her through the treatment process in a way that helped her to sustain hope. She used herself as a finely tuned instrument to understand as much as possible the experience of her patients and to help her differentiate her experiences from her patient's. Her self-awareness also helped her navigate through

the countertransference and transference manifestations within the treatment process, which was able to do quite effectively.

While the other participants described components of self-awareness that are described below, none mentioned this overarching capacity in the interviews. I do believe that all the participants utilized self-awareness in their work and value it as a psychoanalytic capacity. At the same time, their explicit omission of its importance in some ways underscores the qualitative difference in the level of self-awareness between Allison and the other participants, which I believe is in large part the result of Allison's more in depth psychoanalytic treatment experience.

The participants all described feeling hopeful about their work when they were emotionally open, and able to tolerate the intense affective experiences of their patients. Schechter (1999) describes this capacity in clinicians as a tolerance for the tragic, which is tolerance for the psychic pain and despair of others. She argues that this capacity is an essential aspect of the empathetic-self of the clinician (p. 373).

The participants' capacity to be emotionally available included being affectively flexible, having the capacity to move in and out of affective states without becoming overwhelmed. This ability helped their patients feel known, understood, not judged and the treatment often deepened. While these strong affective expressions at times triggered intense reactions in the participants, they were often able to maintain a sense of hope. It was as though a sense of broader hope—that fluctuations are part of the psychoanalytic process—would co-exist with their other feelings, which helped make them more manageable.

The acquisition of the perspective that fluctuations in hope are part of the process is something that many of the participants acquired with experience. David recalled,

You know with experience it has become a lot more tolerable and understandable when there is despair or lack of hope. It is not such a big deal, but there is usually a feeling of this is temporary and this is gonna pass and this is just part of the process.

The participants also felt hopeful when they were empathic with their patients. Many of the participants used their own history and experiences to connect to their patients' experience. Allison said, "I don't think you can ever really know what another person is experiencing but you can get closer and closer using your own self. It's ourselves as the instrument."

The use of empathy helped give the participants a sense of perspective to persevere with their patients through difficulty. Allison's capacity to tap into her own experience of being in those "dark routes" in her life, and in her analysis, helped her to connect and not become frightened by those experiences in her patients. Steven and Cara's own capacity to overcome hardship in their work with patients helped them feel empathic yet hopeful about their patients capacity to do the same. Natalie's use of her own emotional reactions with patients helped them get in touch with those parts of themselves, through her, that seem the most painful and difficult to stay with in the treatment process.

All of the participants experienced hope when they utilized the psychoanalytic capacities that are part of psychoanalytic theory. The use of these capacities help to expand the sense of self of the participants because they felt competent and able to help

their patient by utilizing those techniques that are essential to the success of psychoanalytic process.

Self Care

Since the founding of psychoanalysis, even Freud recognized that psychoanalysis could be detrimental to the analysts' well-being over time. More contemporary psychoanalytic writers Symington (2002) Coltart (1993) and McWilliams (2004) attest to the absorbing and demanding nature of being a psychoanalytic clinician. Each writer suggests that it is imperative from the earliest of days in the profession to actively pursue stimulation, change, refreshment, and expansion of body, spirit, and intellect to counteract the challenges that can be experienced in the self of the clinician over time.

All of the participants highlighted an active involvement in taking care of their own needs, which is what has helped them to sustain a sense of hope over time. While there were some commonalities in the strategies implemented by the participants to sustain hope, there were also differences. This variation underscores the uniqueness of the psychological make-up of each participant.

McWilliams (2004) provides a useful framework for understanding the needs of the psychotherapist. She divides a psychotherapist's needs in three categories: care of the id, care of the ego, and care of the superego. Care of Id includes taking care of one's body, emotional capacity, and basic human needs. Care of the ego includes caring for one's sanity, competence, and professional growth. Care of the superego as preserving the sense of integrity, pride in work, and protection from situations where the clinician

can feel morally compromised. The participants in the study only emphasized the importance of care of the id and care of the ego in helping them sustain hope over time.

The participants sustained a sense of hope by caring for their id in two ways: by developing and maintaining personal and professional relationships and protecting their emotional availability with patients. Cara, Natalie, and Steven contended that the support from personal and professional relationships is invaluable. It is the reciprocity of sharing with intimate others that they found nurturing and helped them sustain their hope. They feel known, heard, and supported in these relationships, and it also made them feel good to provide that support to those closest to them.

The participants also described a variety of ways that helped them maintain a sense of emotional availability with their patients. Cara seeks solitude and being in nature especially after a full day of seeing patients. Exercise also helped to nurture Cara's body and spirit. She often goes bike riding or walks her dog. Steven focused more on controlling his practice. He set limits on the type of patients he decides to work with; he limits his patient volume; he takes about 5 weeks of vacation every year. David regulated his emotional availability by finding a balance between engagement in the field through psychoanalytic learning and disengagement in the field to pursue other artistic interests such as reading, listening to music, and going to the movies.

Allison and Cara both described controlling, to some degree, the flow of information in their lives as a strategy to maintain optimism. Cara limited what she watches on television; and she reads biographies that she finds inspiring. Allison focused on the enormous potential in humans for pro-social, altruistic behavior rather focusing on evil in the world.

The participants sustained a sense of hope by taking care of their ego by participating in professional learning opportunities. As was mentioned earlier, personal therapy and supervision were some of the ways the participants achieved professional growth that also enhanced their feelings of competence. The participants also described how stimulating it is for them to read case material and professional articles as well as to attend conferences and workshops. Steven characterized attending conferences as energizing “celebrations of the field.” Natalie contended that seeking out professional learning opportunities, especially when she was new to the field, which helped her with feelings of isolation and uncertainty.

All the participants were also part of peer or consultation groups. These groups reminded the participants everyone is trying their best but no one has the right answers. The participants also described the importance reciprocity in the groups. It felt good to give and receive insight and guidance to respected colleagues.

The use of self-care was essential in the maintenance of hope over time. The participants varied in the ways they took care of themselves, although there were some communalities. The participants seemed to need some variation of solitude and connection with colleagues, engagement in professional learning and disengagement to pursue other interests, and limiting the amount of affectively charged material outside the professional realm.

Personal Resilience

There is an explicitly stated optimism that two of the participants (Steven and Cara) bring into their work with patients, which is related to drawing on their own

personal experience of having overcome hardship. These participants believe that if they can get to the other side of a difficult experience so too can their patients, and more globally so too can all individuals.

Cara's sense of hope in the resilience of people was learned in childhood and is truly part of the fabric of her self-narrative. When she experienced difficulty in her young adult life she drew on the strength she witnessed in her parents. Steven's belief in the resilience of people emerged through finding his own internal resilience by overcoming difficulties as an adult. He personally transformed feelings of despair to hope in his own therapy; he ended a difficult significant relationship and found a more satisfying relationship years later; and he lived through the AIDS crisis.

The belief in the resilience of people is also reinforced in Steven and Cara's work with patients. Time and again they have seen their patients overcome traumas, loss, and difficulty, which makes them feel optimistic about the strength in people to survive especially when a therapeutic intervention is part of the healing process.

Cara frames the experience of overcoming hardship as following a particular narrative sequence. First you have to allow yourself to experience the pain that can include sadness, despair, hopelessness, and depression. At a certain point, you have to find the strength to move past these painful feelings and make peace with the pain and disappointment so a regeneration process can begin.

While Cara and Steven explicitly described how they utilize their own personal resilience in their work, personal resilience has meaning for all the participants. Allison hopes for a better way for all people. David's enhanced self-esteem instills him with a faith that growth can occur for all people throughout the life cycle. Natalie has a deeply

held a belief in the power of the relationship to overcome hardship to facilitate meaningful connection and healing.

Buechler (1995) Fromm (1968) among others contend that this optimism related to personal resilience is communicated to our patients often not overtly but in subtle ways. It is the clinician's psychic commitment to a "life and growth" (Fromm, 1968, p. 13). Buechler (1995) adds,

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 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 the words (p. 69).

The belief in the personal resilience of people was explicitly stated but implicitly felt by all of the participants. This belief is a fundamental reason that the participants are psychoanalytic clinicians. They all believe that people can overcome hardship especially with the help of a therapeutic relationship.

Mutuality

This study found that for two of the participants (Natalie and Cara) their sense of self expanded when they experienced the relational experience of mutuality between them and their patients. Mutuality is a concept that has been explored in relational theory. It is related to the dyadic experience between therapist and patient and their mutual influence on each other (Aron, 1996). When these participants feel mutuality, it ignites in them a certain hope for what is possible in the therapeutic relationship.

When Cara and Natalie observe their own authenticity or realness when they are with a patient, they experience a sense of hope. This sense of hope seems connected to feeling of confidence that they are doing a good job. It gives them the greatest access to their “best” therapeutic selves and their sense of self expands. They feel most able to use the psychoanalytic techniques such as empathy, attunement, and self-awareness in relation to transference and countertransference themes.

The patient’s contribution to these participants sense of mutuality varied slightly for Natalie and Cara. Natalie felt the patient’s participation when she could experience an “aliveness” within the patient. Cara framed the patient’s participation more as the patient staying in awkward and hard to verbalize moments within the therapeutic relationship. When these participants feel that connection and engagement by the patient, their sense of hope is also heightened.

There is a part of what Natalie and Cara described about their experience of mutuality that reminded me of the idea of mutual empathy proposed by a group of theorists at the Stone Center at Wellesley College (McWilliams, 2004). Their research on women’s psychological development has furthered the idea that empathy needs to be seen as mutual, active, and interactive (Surry, Kaplan, and Jordan, 1990). There is a developmental need not only to be understood, a need for empathy, but also a need to be empathetic with others (Aron, 1996). “In the therapeutic process, empathy may be thought of as a quality of relationality, a movement or dynamic of relationship (Surrey, Kaplan, and Jordan, 1990, p .2). “ While not articulated by Natalie and Cara, I believe an aspect of the hopefulness of these participants was related to them experiencing that their

patients had the capacity for mutual empathy, which is good prognostic indicator of their ability to make use of the therapeutic process.

When mutuality in the therapeutic dyad was lost or not experienced by Natalie and Cara their sense of hope tended to fluctuate. When this occurred, they both worked hard to reflect on what was happening in the relationship. Natalie looked at the transference and countertransference relationship to gain additional understanding. Cara worked hard to reflect on restoring hope between by recalling the hopeful parts of the patient or the hopeful moments in therapy.

Limitations of the Study

There are limitations in this research study that need to be addressed. While this study is useful in illuminating the experience of the vicissitudes of hope in the clinician, the findings cannot be generalized beyond the five participants studied.

Another limitation is related to the potential for researcher bias given the qualitative methodology utilized. My own biases may have influenced my interactions between me and the participants. My biases may also have effected how I analyzed the data. I tried to anticipate these sources of error by utilizing field notes and by engaging consultation with secondary reviewers.

A third possible limitation existed in terms of the emergence of inconsistencies in data. I tried to avoid any inconsistencies by engaging in multiple interviews with each participants, looking at the data from a variety of different perspectives, and also discussing my findings with my committee members. I also had each participant review their individual case study report upon completion to make sure my analysis accurately captured their experience.

Clinical Implications

While the findings of this study cannot be generalized, the type of qualitative study that I used made it possible to explore the vicissitudes of hope within these five psychoanalytic clinicians in an in-depth manner. It afforded me the opportunity to really examine these processes with a richness of detail and nuance. My hope is that clinicians and clinical educators will use the findings that most resonate with their experience and pass this knowledge on to their students. Additionally, I hope that the findings will be

used to build a more comprehensive and scholarly understanding of the evolving and complex nature that encapsulates the vicissitudes of hope in the psychoanalytic clinician. There were four broad findings that were illuminated in this study. The first established a connection between the state of the self and hope. The more robust the state of the self of the participants the more resilient their sense of hope. The second described the developmental process that exists between the acquisition of professional self-esteem and hope. As the participants became more experienced their sense of hope stabilized. The third highlighted the complex nature of the vicissitudes of hope in the countertransference as it relates to what the participants bring into the relationship, what the patients bring into the relationship, or what emerges in the dyadic relationship between the participants and their patients. The fourth described ways the participants actively regulated their hope over time to maintain hopefulness through an ongoing process of self expansion and self protection.

The implications of these findings are that psychoanalytic clinicians should work toward the attainment of a robust self and solid professional self-esteem to ensure a more resilient sense of hope in their lives and in their work. It will improve the quality of the lives of psychoanalytic clinicians. It will also help them weather the complexities of the treatment process so they are more apt feel gratified and hopeful about their work over time.

The knowledge gained from this study should also help psychoanalytic clinicians understand that the attainment of professional self-esteem for the participants was something that was only acquired over time, with the experience of doing the

psychoanalytic work while also receiving ongoing training and personal treatment to hone psychoanalytic capacities.

These findings also illuminate for psychoanalytic clinicians the essential nature of vicissitudes of hope in the countertransference. It expands the current theory by elaborating on how these vicissitudes of hope in the countertransference were experienced by the participants studied. The specific recommendations for psychoanalytic clinicians are that they work toward increased self-awareness and a resilient sense of hope. The more self-aware the participants were the better able to utilize these vicissitudes of hope in the countertransference to deepen the treatment process or expand their self-understanding outside the treatment process. These fluctuations then became something that were useful and rather than overwhelming and potentially hindering to the patient and/or the psychoanalytic clinician. The more resilient the hope of the participants, the less prone to they were to experience vicissitudes of hope in the countertransference that were the result of vulnerabilities in the self, which also helped to preserve hope over time.

This study offers practical recommendations for psychoanalytic clinicians regarding how to expand the self and regulate their hope. While there were some variation among participants, they all considered four capacities the most essential and effective. These strategies include: personal treatment, professional training, the application of psychoanalytic theory in work, and self-care.

The participants all believed that the most successful way to strengthen the self and expand hope was to engage in an in depth psychoanalytic treatment. The findings suggest that the more in depth the psychoanalytic treatment experience, if it is a “good

fit,” the greater the chances of increasing the depth of resilience of self and of hope. Psychoanalytic treatment helped the participants work on their own unresolved issues that may affect their self and hope. It also helped the participants develop greater knowledge of their true self (Symington, 2002) to better pursue those avenues in work and life where they can find and sustain meaning and let go of unrealistic aspirations.

Psychoanalytic treatment more specifically helped to expand the participants professional self-esteem, which helped to minimize fluctuations in hope that can emerge from self-esteem vulnerabilities. It increased the participants self-awareness, which is probably the most essential quality of the psychoanalytic clinician. It enhanced their capacity to reflect on what is happening with a patient, and increased their ability to differentiate their own dynamics from their patients. The development of this capacity helped to protect the participants from acting out when fluctuations in hope occurred.

The psychoanalytic process also gave the participants the greatest insight into how the psychoanalytic process works. It helped them acquire an “in your bones” belief that the psychoanalytic process is a useful tool in effecting change. This hope in the process gave them stamina to hang in with patients during those painful and difficult moments in therapy because they have experienced firsthand what those moments feel like before change occurs.

The use of theory helped the participants because it provided them with a road map about how to engage in the therapeutic process. It also helped them feel a sense of hope that in utilizing these capacities they were facilitating a psychoanalytic process.

This study also highlights the importance of professional training both in expanding the self of the participants and helping them sustain hope over time. The

participants primarily highlighted individual consultation and supervision, but I would also add that more formalized training especially workshops, coursework, or Post Master's clinical training programs. Professional training accomplished two things for the participants. It helped the participants hone their psychoanalytic capacities so they were more skilled clinicians, which made them feel more competent and hopeful in themselves. They were also better able to navigate fluctuations in hope when that emerged in treatment. Additionally, professional training provided the participants with emotional support and holding so that the participants felt supported in an endeavor that can feel isolating and where the participants are prone to "blind spots." Consultation groups also offered an additional opportunity for the participants to provide holding and guidance to their colleagues, which also reinforced feelings of competence in the participants.

The fourth capacity that the participants used to regulate their hope was self-care. The power of this capacity should not be underestimated, even though in many ways it is the least "sexy" capacity described by the participants. The practice of psychotherapy is one that requires a deeply personal investment in the self of the psychotherapist. The participants all used their self as their instrument to understand and help their patients heal and grow, so it is essential the every psychoanalytic clinician understands what they need to feel nourished both inside and outside of work to preserve their hope over time.

This study underscores how in depth psychoanalytic treatment can help anyone who is interested in developing a more resilient self or more resilient hope. It was particularly useful to the psychoanalytic clinicians studied, whose use of self and hope were both capacities that facilitate the psychotherapeutic process.

This study highlights the fact that psychoanalytic clinicians should get a lot of support throughout their professional lives but especially when they are younger and less experienced. They should seek out those environments where this support exists via individual supervision, supervision groups, and more formalized educational opportunities, so they feel more held as they are both learning how to be psychoanalytic clinicians or continuing to develop as more seasoned clinicians.

These findings contradict the mental health trends that are valued both in popular culture, mental health institutions, insurance companies as well as educational programs in social work, psychology, and psychiatry, which diminish the value of psychoanalytic treatment and instead favor more short term, targeted treatment. Another difficulty is that many mental health settings that supported psychoanalytic training do not exist anymore. The few remaining institutions that do value this type of work often have limited available resources to provide as comprehensive support to young and seasoned psychoanalytic clinicians as they might have in the past. They also lack appropriate pay given to psychoanalytic clinicians in these institutions, which is yet another measure of how the psychoanalytic endeavor is devalued.

Psychoanalytic clinicians often need to look outside the workplace or their private practice to psychoanalytically oriented training institutions or associations to obtain adequate professional training support . It is essential for the psychoanalytic profession to provide these supports to psychoanalytic clinicians, and for psychoanalytic clinicians to seek out these opportunities, throughout their development so the psychoanalytic profession will continue to have psychoanalytically skilled clinicians who feel hopeful about the work they do.

Research Implications

The findings of this study offer implications for further research. The connection established in this study between the sense of self and sense of hope of the participants should be explored in greater depth through clinical research. This finding has implications for how we think about clinical hope in our work and how to create resilience of hope.

Another critical factor to consider in future research is broadening the sample of psychoanalytic clinicians studied. Since this was a voluntary study, the clinicians that were selected all felt very hopeful about the work they do. While these findings have important implications as it relates to the experience of hope for clinicians and how these clinicians have regulated their hope over time, I think it would also be important to study psychoanalytic clinicians who are not so hopeful or who have left the field due loss of hope. These clinicians will add greater complexity to the experience of hope in psychoanalytic clinicians. This knowledge may help the field understand the experience of despair and hopelessness as a more encompassing feeling state rather than as something that is more contained and temporary.

A second way to consider broadening the clinical sample is to study analysts as opposed to psychotherapists. While I know that Allison has a unique narrative based on her who she is, I wondered if there might be commonalities in her experience that were true for other analysts. I was curious to understand how a more in depth analytic treatment experience and training experience might add another layer of complexity to these findings. I also wondered if the countertransference and transference manifestations

of the vicissitudes of hope would also have been more expansive with a sample of analysts given the fact that they engage in more in depth work with their patients.

Conclusion

This psychoanalytic case study examined what comprises the vicissitudes of hope in five seasoned clinicians over the course of their professional lives—as they experienced many complex, emotionally stirring, and in-depth clinical relationships and therapeutic situations. The vicissitudes of hope in these participants was a central facet of the treatment process in part because it was a reflection of the state of the self of the participants. The more resilient the hope of the participants, the more apt they were to use their hope in ways that facilitated the treatment process; the better able the participants were at weathering the complexities of the treatment process; and thus the more able they were at sustaining a sense of hope over time. When fluctuations of hope occurred more often, or were avoided altogether, this revealed a greater sense of vulnerability in the self of the participants. The participants then had less available resources to meet the needs of the patients and to navigate the complex nature of the treatment process effectively. While the sense of hope is embedded part of the participants that they brought into their professional lives, and got activated in each clinical relationship, it was also changeable. It expanded for the participants when they were engaged in an active process of self-expansion and self-protection.

APPENDIX A
RECRUITMENT FLYER

Hope and Loss of Hope are so much a part of our clinical work but it is not really talked about or written about.

Come and be part of a research study that will look at the fluctuations of hope in seasoned clinicians.

What does it entail?

- 3-4 interviews.
- The researcher will come to your office or home.

Who does the researcher want to interview?

- Clinical social workers, psychologists, or psychiatrists who have practiced psychodynamic psychotherapy for approximately 20 years.

Learn more by calling

Andrea Harris Alpert, MS, LCSW at (312) 409-7272

APPENDIX B
CONSENT FORM

Individual Consent for Participation in Research

Institute for Clinical Social Work

I, _____, acting for myself, agree to take part in the research entitled: How Hope and Disappointment Evolve in Clinicians’ over the Course of Their Careers?

This work will be carried out by Andrea Harris Alpert, MS, LCSW under the supervision of Jennifer Tolleson Ph. D.

This work is conducted under the auspices of the Institute for Clinical Social Work at the Robert Morris Center, 400 South State Street, Suite 822, Chicago, Illinois 60605, and (312) 726-8480.

The purpose of this study is to explore the vicissitudes of hope in clinicians’ over the course of their careers especially as clinicians experience more complex, emotionally stirring, and in depth clinical relationships and therapeutic situations. This research is designed to help provide a more in-depth and thorough understanding of this complex yet not widely studied process to help clinicians’ learn more about themselves so they can be more effective and energized clinicians throughout their careers.

Benefits

The benefits of participation in the study will you learn more about the many factors that contribute to your hopes and disappointments as a clinician. This study will also help contribute to the body of work on hope and disappointment in the field.

Costs

There will be not monetary costs to participants.

Possible Risks

I understand that talking about such issues may trigger some uncomfortable feelings and/or memories. If the participant feels vulnerable during or after the interview process,

the researcher will either provide one or more de-briefing sessions with the participant (s) or, if preferred, refer the participant to another colleague for de-briefing.

Privacy/Confidentiality

I understand that my privacy/confidentiality will be insured in the following ways:

- Andrea Harris Alpert will be the only person who will know my identity.
- No identifying information regarding my participation in this study will at anytime be available to anyone except the researcher, Andrea Harris Alpert.
- Only first names will be used in the interview.
- The participant and all others mentioned in the interview will be changed to provide additional privacy.
- Each interview will be coded using a changed name with the first letter of the name staying the same and the last four digits of their social security number.
- All identifiable information will be kept separate of the rest of the research in a locked cabinet.
- The data will be stored in a secure locket cabinet for 5 years after finishing the study at which point, the data will be disposed of by paper shredder and the audio taped will be erased and destroyed.

Use of the Data

The written compendium of data analysis and discussion will appear in my completed dissertation, which will be printed and placed in the library of the Institute for Clinical Social Work, Chicago, Illinois. An abstract of the complete dissertation will be placed in Dissertation Abstracts; and a copy of the complete dissertation or abstract will be available to anyone requesting it.

It is the researcher's hope to share some of the findings in workshops, seminars, and/or journal articles related to the topic studied. At some point, the material may also provide the basis for more extensive research and/or may lead to a book. Should this occur, the participants' confidentiality and privacy will continue to be maintained in the ways stated in the previous section.

Subject Assurances

By signing this consent form, I agree to take part in this study and to be audio taped. I have not given up any of rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact, Andrea Harris Alpert at (312) 409-7272 or Jennifer Tolleson at (312) 409-2851.

If I have any questions about my rights as a research subject, I may call Daniel Rosenfeld, M.A., Chair of Institutional Review Board, ICSW at the Robert Morris Center, 400 South State Street, Suite 822, Chicago, Illinois 60605, and (312) 726-8480.

Signatures

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

Signature of Participant

Date

I certify that I have explained the research to _____

and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

Signature of Andrea Harris Alpert, LCSW, Researcher

Date

APPENDIX C

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

Transcriber's Confidentiality Agreement

I _____ agree to protect
and

(Name of transcriber)

maintain confidentiality of all the interview material that is transcribed.

In signing this form I understand the following provisions:

- A) All information will be handled confidentially and will not be re-disclosed.
- B) I have the right to revoke this consent at any time except to the extent that action has already been taken.
- C) Failure to consent to release the information specified will mean that the researcher will not use me for transcription.

(Transcriber's signature) (date)

(Researcher's signature) (date)

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