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DISEASES OF HOPE AND THE WORK OF DESPAIR

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Hope is not always an asset for the client or the psychotherapist: many difficult conditions can be described as diseases of hope. Hope becomes diseased partially as a function of its unlikelihood, but also when it leads to disparagement of the present, to mindless sacrifices, and to rigid attitudes or behaviors. We suggest that at such times therapists may need to assist clients to let go of their hope. Far from discouraging the client, this "work of despair" can prove energizing and liberating.

Hope is and has been one of the most purely positive ideas cherished by the Western mind. Its opposite, despair, has been viewed from time immemorial as the counsel and work of the devil. Hope leads to vigor and life: despair, to helplessness, self-destruction, and death. In the present century, hope has risen even higher: hopeful images are now often believed to cure not just apathy and depression, but also poverty and cancer.

There is a downside to hope, though. There are endless victims of "singing tomorrows" that tell us many a horrid tale. Consider the following cases.

Case Example 1

A concert pianist asked for help with shoulder and wrist pains which he thought might be psychosomatic. In the last few years he had started on an extremely demanding and rigid schedule of practice. Although he had made little progress, he kept hoping for a breakthrough. In the meantime, he developed an inflammation of the joints.

About five years ago, he had traveled abroad to study with a reputed teacher, known for his strictness. After six months of what he then viewed as senseless mechanical drudgery, he left the teacher and came back home. Once in a while, however, he would go back to the spartan practice he had learned with the teacher abroad. In one of these periods of intensive practice a miracle occurred: for two marvelous weeks he played as in a dream. People who listened to him at the time could not believe their ears. But then, just as it had come, his newfound agility left him. In the beginning he was sure that, with patience, he would get it back. Little by little, however, he came to believe that this would only happen if he took it upon himself to follow the teacher's method to the letter. He traveled back to the teacher and stayed with him for another six months. He set himself ever harsher demands and would not ease off despite the ensuing pain and the lack of any positive effect on his playing. He had become a virtual prisoner of his hope for a return to the days of his paradisical playing.

Case Example 2

A man came to therapy because his wife was physically abusive. This had been going on for many years. His wife periodically would go into a rage and attack him, not just with her fists and nails, but also with whatever object came to hand. The client had suffered many bruises and had often asked for therapeutic help to improve the marital relationship. His last therapist had warned him that the violence might escalate, but the client hoped that his love and understanding would reform his wife. After a prolonged absence he came back to therapy and told that he had been in the hospital. His wife had taken a large kitchen knife and plunged it up to the hilt between his ribs. He had been recovering from the attack ever since. Once again, he raised, in the usual tones, the issue of how the relationship might be improved. His therapist was dumbfounded, and said: "I don't understand. How can you stay with this woman, after she's stuck a knife in you?" The client answered: "Well, she didn't hit anything vital."

Case Example 3

A forty-year-old woman with terminal cancer went to a therapist for hypnosis to help her overcome negative thoughts. She had recently decided to give up conventional medical treatment and to rely instead on a healer who had convinced her that she could stop poisoning herself with medications and cure herself with the power of the mind. Initially, the new hopes and the healer's support improved immensely her quality of life. She ate and slept better and was no longer dazed by narcotics. The home atmosphere radiated optimism. Little by little, however, the wheel began to turn. Pain came

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back, worse than ever before, but it was clear to everyone in the house that painkillers were out, to say nothing of narcotics. If the sick woman chanced to waver, her husband would keep her from temptation. The healer, however, became disappointed with her lack of fighting spirit. The husband, too, blamed her for giving in to negative thoughts if her hope wavered or she expressed her suffering. The woman became isolated and depressed.

Case Example 4

A highly successful businessman in his early 30s found himself in a dilemma about his marriage. He and his wife were excellent friends and a good parental team. However, he was dissatisfied for he no longer felt any romantic attachment or sexual interest in his wife. He was tormented by the thought that at such an early age he should be saying goodbye to love. He had a vivid image of how love could energize his life and endow it with a sense of fullness and purpose. He knew it would probably take him years to find his dream of love, for he was not an emotionally expansive person. The very vision of such a possibility, however, had the effect of draining his life with his spouse of all value. He ended by leaving her: the image of love in the horizon of his hope proved stronger than the reality of his bond.

These people were all arguably suffering from a disease of hope. How can we characterize this disease? Is it that the hopes were illusory or misplaced, that the objects of hope in these cases were hollow or false? Not necessarily. It is not impossible that the pianist might recover his skill, the abusive wife overcome her aggressiveness, the cancer patient get cured, or the businessman find romantic love. The panegyrics on hope are full of such tales. The merits of hope are often viewed as highest precisely when its objects seem farthest. Hope would not be so seductive if it could only be placed on easy objects.

The disease of hope is thus not solely, or even mainly, a function of the likelihood of its realization. Hope can be diseased not just in its object but in itself, in its very process and mechanism, when it: (a) it leads to a disparaging attitude toward the present, (b) it is mindless of sacrifices, and (c) it hampers flexibility. On these counts we could say that all four characters above suffered from diseases of hope: the pianist inflicted on his body an inflexible and pitiless regime of practice that exacted a heavy price; the battered husband made little of his wife's almost fatal attack and continued expressing, in almost exactly the same words as before, his wishful dream that the relationship might improve; the cancer patient and her family lived under an atmosphere of terror in which the very thought of pain was rigorously outlawed, and the businessman was cut off from a present that had become desiccated by his dreams. Needless to say, the diseases of hope may manifest not only toward the self but also toward others. Hope then becomes not only inwardly but also outwardly inflexible, blind, and cruel.

This idea is, of course, not new. Alongside the dominant outlook on the blessings of hope, a dissenting tradition bespoke its dangers throughout the ages. In classical times, the Stoics and the Epicureans were most eloquent in linking hope to human misery. In the beginning of the modern era, Montaigne, Pascal, and Spinoza have reiterated and strengthened their admonitions. Needless to say, in the East there has long been a philosophical and ethical tradition viewing hope as a major source of unhappiness. In our generation, a French philosopher, Andre Comte-Sponville (1984), took it upon himself not only to harmonize these many voices but also to present the arguments against hope in a highly pertinent and actual fashion.

The philosophers in the antihope front have argued that: (a) hope goes hand in hand with fear and disappointment; (b) hope creates unwholesome dependent attachments to phantoms of desire; and (c) hope stands between us and life. Let us review these contentions briefly.

On the relationship between hope and fear, Comte-Sponville (1984) quotes Spinoza: "There is no hope without fear nor fear without hope" (Spinoza, *Ethics*, part III, explication of definition 13). The same could be said about hope and disappointment: each entails the actual or virtual presence of the other. Disappointment, moreover, is not merely the underside of unfulfilled hopes but an inner strain in the very heart of seemingly fulfilled ones: "There are two catastrophes in life: the first is when our wishes are not satisfied; the second, when they are."[1] Thus, if our wish seems to be satisfied it is only to make us aware that it is not really *the* wish. In other words, we are either frustrated or find to our chagrin that satisfaction fails to bring contentment.

The second argument is that hope leads us to grasp at phantoms. When, as invariably happens, their attainment fails to satisfy us, hope persuades us that the disappointment is merely temporary, being due to our incomplete possession of these objects, persons, or situations we define as necessary for our bliss. We are thus made to go on yearning for fuller possession, ever tantalized by

[1] This epigram is attributed to Bernard Shaw.

the image of a satisfaction that lies just around the corner. Like insatiable lovers, who feel that they just cannot hug, penetrate, or possess their love object enough, so we keep pushing on and on for a satisfaction that ever eludes us.

The third argument is that by focusing on our hopes we keep missing what is there. Comte-Sponville (1984) quotes Pascal: "We never live but expect to live. We are never happy, because we are always readying ourselves for our future happiness" (Pascal, *Thoughts*, 47).[2] Hope is thus the shadow of the postponed reality that falls between us and our life. Hope is thus, in the view of these philosophers, inherently illusory.

The critic, however, might object that without hope only apathy is left and that our ability to act is predicated on some image of the future. Comte-Sponville (1984) counters by a distinction between hope and desire: hope is our image of a future state which we can only expect; desire, in contrast, is the immediate mover of our actions: I get up from my armchair because I desire the food on that table. No one would say that I *hope* for the food. Hoping to stand up has never moved anybody's legs. While agreeing with Comte-Sponville's idea, we might substitute the word "will" or "intention" for desire,[3] and view hope and desire as lying along a continuum: where we feel our power and ability most, we speak of will or desire; where, instead, we feel our incapacity and powerlessness most, we speak of hope. Hope makes us close our eyes, as in prayer; will and desire make us act.

Comte-Sponville (1984) comments incisively on the deep symmetry that often obtains between future and past in the dialectics of hope. We hope for an ideal future because we cling to an idealized image of the past. The hope for the millennium thus turns out to be almost invariably rooted in the belief in an aboriginal golden age. Thus, in most religions the joys of kingdom come are a replay of those of the lost paradise. Likewise, many political utopias hark back to a lost primitive harmony. In psychotherapy, we see our clients reaching for a future which embodies the past as it "should" have been, the fantasy of a family where love reigns without conflict, hurt, or disappointment.

In contrast to the golden past and the promised future, the present reality is devalued as being in a state of decay. The dialectics of hope and of nostalgia thus lead to a proportional devaluation of the present: the greater the past and the future marvels, the shabbier the actual reality. In the individual this interplay between what was, is, and should be manifests itself with a vengeance: nothing in the present can compete with the shining glories lost or to come; to accept, affirm, or become even minimally involved with the present is nothing less than a betrayal of the light.

People who cannot outgrow the loss of a condition or a promise that, to their minds, had embodied all their most pregnant expectations may have their life blighted by the carcass of a dead hope. The prototype of this disease is Miss Havisham, the self-immured lady in Charles Dickens' *Great Expectations*. Miss Havisham lives in a house in which all clocks always display the same hour in a day long past. Sunlight is kept out of the rooms. She wears a bridal dress which has long grown faded and yellow. Her withered bridal veil is crowned by the specter of waned flowers. Everything has been left as it was in that awful moment when she was forsaken at what should have been her marriage altar. Miss Havisham does more than arrest time and block out the world. She hates life. Her blasted hopes have been transformed into endless brooding on revenge. Fittingly, she ends by being burnt alive in a fire that is ignited by her own bridal dress.

But can we view Miss Havisham as suffering from a disease of hope? Is she not the obvious victim of the loss of hope for whom the instillment of new hope would be the only possible medicine? She is. However, it is one of the characteristics of a diseased hope that it will not leave room for new ones. Miss Havisham cannot renounce that ardent moment in which her life should have been exalted into absolute bliss. The hope was killed, but the acute intensity of the bridal moment fills her and warps her thoroughly. The world that denied her ardent wish is ardently cursed. In effect, the old hope has not vanished but has been subverted into the black hope of revenge which is infinitely more blinding, rigid, and mindless of sacrifices than almost any other hope in existence.

[2] Comte-Sponville's abundant use of quotations is germane to this outlook: he speaks in the name of a tradition, claiming no originality. This attitude reflects Comte-Sponville's reaction to the cult of originality and of the self which, to his mind, is one of hope's most dangerous traps.

[3] Although somewhat out of favor now, the notion of will has a long history in psychotherapy, particularly in the work of Adler and Rank.

Dead hopes, however, poison lives also in less picturesque forms: many people who have been greatly disappointed go on nourishing an intense hatred of the world that refused them the bliss they had been led to expect. Similarly, clients suffering from posttraumatic stress disorder are often caught by their inability to let go of their hope that a perfect world could exist; a world shining with the brightness of their own idealized, pretraumatic past, completely free from loss, disability, anger, and despair.

Unburied dead hopes may thus have effects that are similar to those of our diseased hopes for the future. Could we learn to give up these total visions and achieve thereby a positive reevaluation of the present, a mindfulness to sacrifices, and a greater flexibility? Comte-Sponville's (1984) answer is a decided yes. For him, the renunciation of hope or, as he terms it, *the work of despair*, is the very condition of happiness.[4] But how? Despair is almost invariably viewed as a deeply negative condition. Indeed, other thinkers in the antihope camp have usually opted for more positive terms to indicate the release from hope's bondage, such as *ataraxia* (the haven of the Epicureans) or *nirvana*. Some thinkers have even tried to coin a new word, *inesperance* (in French, *inespoir* instead of *desespoir*). So why *despair*? Comte-Sponville explains: before reaching the beatitude of freedom from hope we must first let go, and all letting go entails some feeling of loss. To fully accept that our hopes are will-of-the-wisps and that our life is no more than what it actually is can be a painful process, similar to Freud's work on mourning. To speak of a leap into happiness without a preceding work of letting-go is an illusion.

Relinquishing hope hurts, but it can also be a turning point. In this article, we present the work of despair as a viable option in psychotherapy. We hold that, when the client displays signs of suffering from a disease of hope, the therapist may suggest that "a course of constructive despair" might serve as an antidote. This seeming oxymoron turns out to be surprisingly acceptable to clients. There are, of course, deep differences between the psychotherapist and the philosopher in their attitude toward despair. The philosopher may view hope as invariably diseased and real happiness as only attainable beyond the reach of hope. Not so the psychotherapist, who knows that hope may also be the very condition of survival. In contrast with the philosopher, the psychotherapist must perforce assess which clients are losing most from their rigid hopes and are not endangered by the option of despair.

This is no mere practical difference, but a fundamental one: therapists cannot but view hope as basically adaptive. Such a universal mechanism could not have evolved unless it were good for living. Even Comte-Sponville (1984) admits that we invariably begin by hoping: for example, children believe in Santa Claus. We, therapists, would add that there must be a sound reason for their doing so. Hope is, for us, often an adaptive expedient or coping mechanism. Like other coping mechanisms, however, hope may at times turn into a destructive overgrowth.[5] The same is true of despair: it can be a poison or a boon.

A final clarification before we turn to the clinical material: what we have termed *diseased hopes* is hardly ever presented by clients as the problem. If anything, clients are more apt to ask for help in realizing than in eradicating their hopes, however rigid or irrational. Therefore, if the therapist views the client's hopes as inherently problematic, a change in the therapeutic contract may be required. More often, however, the problematic hopes are not presented at all as part of the complaint, either in a negative or a positive sense. In the course of therapeutic work, however, the therapist may detect the attitudes of disparagement, rigidity, and mindlessness of sacrifices that characterize diseased hopes. Sometimes, these attitudes paralyze the therapy altogether. The therapist may then reassess the problem, point out the putative diseased hopes, and offer the client an alternative to grasping at straws.

Case Example 1: Fear and Hope

Dov worked as a gynecologist in one of the most reputable hospitals in the country but suffered from acute anxiety in the presence of the head of his ward. Dov's superior was known for his cold and critical attitude toward physicians, nurses,

[4] The title of his major work is *Treatise of Despair and Beatitude*.

[5] There is an abundant literature on the relation between coping and defense mechanisms, the latter being shown to be simply an overgrowth or perversion of the former. In the life-sciences, also, there is barely an adaptive mechanism that cannot, in certain circumstances, become destructive. The double-edged immune system is, in recent years, one of the most pertinent examples of such a possible reversal.

and patients alike. He never greeted anybody on his own initiative, limiting himself to a mechanical, reactive nod. He never praised, but rebuked abundantly. He was especially lavish in biting remarks. He would pour his derision, preferably before an audience, on his underlings' slightest peculiarities of behavior or dress. As might be expected, he was uniformly feared and hated.

In spite of these characteristics, Dov had not suffered from any special discomfort in his supervisor's presence during his first year in the ward. Gradually, however, Dov became aware of a growing uneasiness. He had tried to soften the chief's unpleasant reactions by behaving civilly toward him, but when these attempts failed, the anxiety grew. A significant change for the worse had occurred in his third year in the ward. Dov's wife had fallen ill with lupus erythematosus. He had told the chief about it, so as to explain beforehand any possible need he might have to absent himself from work. The chief had seemed understanding. A few weeks later, however, the chief expostulated with Dov when he asked to be relieved from his post for a few hours. The chief also remarked, before the staff, that Dov was lately behaving like a sleepwalker.

Dov started to stammer and sweat in the chief's presence. He found it harder to get up in the morning to come to work. He tried to avoid any chance encounter with the chief and, if such an encounter figured in the ward's agenda, Dov would work hard at devising a way of bringing the chief round to a positive appreciation of his work. Nothing helped, however. The chief remained gruff and unapproachable, and Dov's anxiety grew apace. Gradually, everything connected with the ward became aversive. He stopped participating in the staff's meetings and discussions, where the chief's mere presence made the situation all but unbearable for him. Dov began considering transferring to another hospital, although this would be detrimental to his career. At this point, he came to therapy to one of the authors (H. Omer).

Dov's complaint had all of the characteristics of a phobia: systematic avoidance, high physiological arousal, a sense of imminent catastrophe when the chief was nearby, a feeling that the fear was irrational and irresistible, and a constant preoccupation with the phobic object. These characteristics led the therapist to consider a treatment by desensitization *in vivo*. However, when the therapist explained what the treatment would involve, Dov objected that all his previous contacts with the chief had only increased his fears. When told that the exposure would be graduated and that he would learn ways to cope with the anxiety, Dov raised other difficulties: he could not accept the fact that his boss refused to recognize the value of his contribution to the ward. Actually, he was sure that deep inside him, the chief could not but admit that he was a most promising physician. There should be a way to make him say so openly! This hope, it seemed, lay at the root of Dov's fear. Some additional data from Dov's past shed further light on this link between his hope and his fear.

Dov had grown up with a very demanding father, who seemed, on the surface, very much like his chief: he was highly critical of his children's achievements, would often poke fun at their performance, and always asked for more. In spite of this apparent strictness, however, Dov loved his father and felt very secure in his presence. Dov had also never feared to confront his father. On the contrary, he had always felt very sure of his footing for, underneath the father's rugged exterior, Dov knew that the father loved, respected, and admired him. Growing up with such a demanding but appreciative father had been, to Dov's mind, one of the formative influences in his life.

The comparison between the father and the chief allowed for the formulation of a hypothesis about Dov's anxiety. In the first year of his stay in the ward, Dov had viewed the chief's gruff manner as a mask, very much like his father's. With time, he hoped, the human face behind the mask would surely manifest itself. Since he was one of the best workers in the ward, Dov was sure that it was only a matter of time until the chief changed his attitude toward him. Dov thus became the victim of his hopes. As time went by, Dov started to hang on the chief's every word and gesture: the human face behind the mask just had to betray itself! Dov's anxiety thus grew in proportion to his expectancy. This analysis suggested that Dov's anxiety, which had seemed refractory to ordinary exposure, might respond to the work of despair. Dov's fear, as in Spinoza's dictum, seemed to go hand in hand with his hope. Learning to despair of the hope might perhaps eliminate the fear as well.

Dov reacted positively to the suggestion that he should learn to despair of his chief. Each time he felt his anxious expectancies on the rise, Dov should engage in a meditation about the void behind the chief's mask. The fact that the chief never greeted anyone on his own initiative but only nodded back mechanically was turned into a cue and a prop for this meditation: it showed that the chief was effectively absent as a human being. The chief's biting remarks were also turned into grist for the mill of despair: they were nothing but the vocal and facial spasms of the mask, behind which there were only more vocal and facial spasms. The hoped-for human face was thus an ever-receding mirage. The mask was rather like a pseudo-Janus face built out of two identical halves that added nothing to each other. Dov was encouraged to search for intimations of the chief's humanity in his interactions with him in the past and in the present (for instance, in the apparent understanding displayed by the chief when Dov had told him about his wife's illness) and to reconstruct these events as the traps of hope. On meeting with these traps, Dov was to disarm them by giving the crank of despair another turn. Additionally, Dov was enjoined to try as best he could to resurrect his hopes, so as to despair of them more effectively. We tape recorded these ideas and Dov listened to them repeatedly.

The work of despair quickly changed Dov's attitude toward his chief. Instead of hurting him, the chief's biting remarks now confirmed him in his meditations. He began to see the chief as a creature who lived by preying on the hurts of others. It was as if the mask would freeze completely unless it found a new victim to feed its scornful motion. These images were followed by the emergence of memories about Dov's father that showed him to be more and more dissimilar to the chief. Dov's anxiety diminished in proportion as the gap between the two figures widened. Gradually, a new hue came to tinge the chief's figure in Dov's mind: the chief seemed to be the victim of a curse. As often happens, once hope was given up and mourned, the reality of suffering—his own and his chief's—gave rise to compassion. A tinge of pity crept in where hate and fear had ruled unopposed. Two months after he had started on the work of despair, Dov noticed that he was aware of a clear change in his feelings since he no longer felt an aversion to the ward and did not constantly monitor the chief's movements. Instead, he wanted very much to put his new attitude to the test in a really big forum where the chief could have ample opportunity to express his sarcasm. At this stage, we agreed to finish the therapy. Dov's forward-looking attitude toward a possible attack from the chief in

precisely those circumstances which had previously been most acutely feared and avoided bore witness to the change in Dov's condition.

Case Example 2: Hope and Hell

Iris and Adam came to therapy because of endless fights, characterized by vicious mutual accusations. For almost a year, there had been no physical intimacy between them. Adam complained, additionally, that Iris never helped him in the management of the house and never showed him any civility, to say nothing of respect or affection. Iris, on her part, felt persecuted by Adam's attempts to dictate to her how she should behave. He never stopped ordering her about and criticizing her behavior. His criticisms had, in the course of the marriage, turned gradually into extremely offensive remarks. He taunted her with being slovenly, spiteful, hateful, destructive, and mentally ill. She felt that any compliance or sign of weakness on her side would only aggravate Adam's domineering and disqualifying stance. They started to sleep head to foot. They even humiliated each other before friends. When Adam returned home after a hospital stay of three weeks following an accident, Iris said that it was a pity he was back.

Adam believed that, deep inside her, Iris still loved him. In the past, she had told him that she loved him more than herself and that if something ever happened to him she would die. He was sure these feelings were still alive. The change for the worse had been, in his view, the consequence of a difficult pregnancy and the need to adapt to the baby's needs. With the birth of their daughter, Iris had channeled to the baby her attention and positive feelings. Adam hoped, however, that Iris would slowly find a new balance. Iris, in contrast, could not stand Adam's unshakable certainty that he was always in the right and that she alone was to blame. She believed that he felt himself unconditionally entitled to her body, service, and love. His certainty of her underlying love seemed to her the most offensive proof of his sense of entitlement. For her, the marital union he dreamed of would be the most abject servitude.

Besides a weekly meeting with the couple, the therapist also saw each spouse individually. Iris told her that she had been a battered child. She bore on her body the scars of her father's and elder brother's abuse. Adam knew nothing about this. Iris was sure that, were he to be informed of the abuse, he would only make use of the knowledge as further proof of her inadequacy. All Iris wanted from the marriage was that they continue to bring up their child (parenting was the only area where Adam and Iris expressed some approval of each other) and that he leave her alone. She should not be obliged or expected to talk to him when he came home. Every now and then Iris would raise the possibility of a divorce, but would invariably stop short of any actual steps. On the aftermath of a particularly acute crisis, the therapist encouraged her to meet with a lawyer. She did so and decided she was not ready for divorce. Adam's declared goals were the opposite of Iris's: he would never divorce her and a cease-fire would not satisfy him. He wanted to improve the marriage in a positive way: he wanted friendship, respect, and physical intimacy.

Although the individual sessions were helping each spouse achieve his or her personal goals apart from the marital area, the therapist felt that the couple sessions were only a turf for marital jousting. Her therapeutic suggestions were being turned upside down, furnishing fuel to the couple's rows. The two seemed to be veering dangerously close to physical violence. A knife and a pair of scissors were brandished in one of their fights. The therapist feared that she might be contributing to this negative spiral. She therefore decided to bring the case for a group consultation conducted by one of the authors.[6]

A major issue that concerned the group was whether the marital (as opposed to individual) therapy should be continued. Six months of biweekly meetings had only served to make the spouses ever more vocal and intransigent. Therapy, by its very nature, fosters hope of change: maybe that very hope was fueling the couple's anger and disappointment. After a lengthy discussion, the following message was formulated by the therapist:

> I want to share with you my thoughts about you as a couple, openly. I was not sure, until now, whether I should speak my mind in full, so I asked for a professional consultation. I became convinced that I would be harming you if I tried to sweeten the pill.
>
> I think that you live in a mutual hell. You cause each other endless suffering and damage. Your wishes for each other are deeply destructive. You, Iris, wish from Adam that he not *be*. You want him not to speak, not to ask, and not to desire. No act of his is acceptable to you. His mere presence insults you. When you told him, on his return from the hospital, that you were sorry that he was back, you were not talking from impulse, but expressing your real, persistent wish regarding him. You, Adam, would like Iris to be someone else: she should be a friendly, cooperative, warm, helpful, and loving woman. These are not negative wishes, but they are not Iris. Finding that Iris will not be the person you wish her to be, you fall back on an attempt to prove to her that she is not only wrong but also evil, perverted, and sick. You want her to acknowledge herself as such. You both stay together because you fear the hell of divorce which, to your minds, might make the present hell small in comparison. I cannot tell you whether this fear is unfounded. For the moment, I can only acknowledge the fear and the fact that it is the fear that keeps you together.
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> Your life in hell is made worse by hope: the belief you have that the other might change, realizing his or her mistakes and becoming a better spouse, makes you both more cruel in your demands and more vulnerable to disappointment. Because of these hopes you both continue to inflict your wishes on each other.
>
> I have decided to stop our joint sessions. I believe that they do damage because they feed your hope. Our joint meetings have only made you to push ever harder in the direction of your hopes. I believe that what you need is the very opposite: you need to despair. Despair, however, is not a passive process. You need to engage in the work of despair. You, Iris, must despair of bringing Adam to inexistence. You will never reduce him to silence, to apathy, or to absence. If you had your way, he would be turned into a vegetable. You, Adam, must despair of molding Iris according to your ideas. She will never be the person you wish her to be. You must also despair of your wish to break her, to make her acknowledge her faults, and confess how right you were all along. If you had your way, she

[6] This variety of consultation oriented to the resolution of therapeutic impasses was described in Omer (1994).

would hate herself to destruction. The work of despair consists in telling this to yourselves, again and again; in learning to bury the very prospect of improvement in the other and in mourning your desires for a good marriage. It consists in letting your hands fall down with the sheer weight of your helplessness, whenever you think of influencing each other. When you fall prey to your hopeful images, kill them, bury them, mourn them, and let the word "never" resound irretrievably over their remains.

I believe this will help you, not by making your marriage more fulfilling, but by making the fire of hell burn lower. You may become softened in your destructive anger and torture yourselves less acutely. You will also damage your daughter less. She may then grow up in a sad family, but not in a seething cauldron. Despair may lead you to recover your humanity at home. I know you apart as well as together and I find it a great pity how the two of you, whom I have learned to respect and admire as individuals, become so awfully transformed into each other's mutual hell.

The couple remained silent for a long while. They asked whether the therapist would be willing to renew the marital therapy in the future, and the therapist answered in the negative. There were two more sessions with Adam. Iris stayed in therapy for a year. The bitter fighting stopped. Sometimes they had sex together. They even bought a new house. They stopped talking about divorce and went about the daily business of managing the home in a smoother manner. This much the despair allowed them. They did not, however, become close or even pleasantly companionable. Iris made up her mind that they would not have any more children together. Maybe it would have been better if they had found the courage to divorce. They did not choose this option, however, and the therapist did not find herself entitled or capable to push them.

Far be it from us, however, to imply that all the silly hopes come from the client and all the wise despair comes from the therapist. It often works the other way round. Clients may feel justifiably persecuted by therapists who would accept no less than "total cure" or "full maturity" as the goal. Many a lesser achievement, which would perhaps satisfy the client well enough, has been dubbed by the deeper therapist as manifestations of "flight into health." Sometimes the therapist's lofty hopes for the client creep in almost invisibly. Fortunately, in the following story, the client did not swallow the bait.

Case Example 3: Lofty Goals

A therapist (R. Rosenbaum) was seeing a client who was dying of cancer. She had worked hard on coming to peace with her condition and enjoying each moment of life that remained to her. The client had mentioned that she had conflicts with her grown daughter. She had adopted her daughter when she was around eight, and the relationship had always been a stormy one. The daughter had drug and alcohol problems. She was demanding and entitled. She rarely showed consideration for her mother, and was generally a drain. After many years of struggling with this, the client had achieved an uneasy truce with her daughter by setting rather rigid boundaries. They saw each other seldom and kept a distant politeness.

During one session, the client told the therapist that she was nearing the end: it would be but a few months now, but she felt she was achieving serenity as death approached. As an aside, she mentioned that she had decided she would not speak to her daughter again, even if the daughter called. When the therapist tried to inquire about this, suggesting that it might be a pity to end a lifelong, difficult relationship unharmoniously, the client became angry. She told the therapist that he had no right to question her about this. The therapist replied that he was simply trying to find out if there was some more work the client would want to do on that issue. The client felt that the therapist's questions implied she was not good enough or reconciled enough.

The therapist realized he had been harboring high hopes for the client: he had an ideal image that she should attain enough serenity to end her life on a loving note with her daughter. He had to accept this was not possible and embrace the different, meaningful course the client chose: honestly mourning her unrealized hopes for a harmonious relationship with her daughter. In doing so, she found great peace before her death.

Discussion

This article has described the present approach to hope and despair as stemming from philosophical sources. On closer look, however, one may discern a similarity to ideas that have appeared elsewhere in the psychotherapeutic literature. Thus, the diseases of hope are akin to Kaffman's (1981) monoideism and to Ellis' (1962) tyranny of shoulds and oughts; the work of despair, as mentioned above, is similar to Freud's (1917) work of mourning. We gladly acknowledge this noble parentage. If anything is peculiar to our view it is the attempt to promote a particularly militant attitude regarding diseased hopes. Let us clarify.

Hope attaches roots to our innermost being and we grab at it with all our might. A hope which failed to grasp us body and soul would never make us diseased. Once hope has entrenched itself within us, though, it will not give way to polite requests; we will need all our strength to free ourselves from our attachment to hope, to "de-hope" or (from the French *desespoir*) to despair. Indeed, the word despair evokes the implacable, unyielding effort that is often required to pry hope loose from our soul. For this reason, asking clients to bravely embrace despair often helps mobilize their courage. Rather than asking them to meekly resign themselves to giving up their aspirations and bow their heads in submission to their fate, we ask clients to fight back against an enchanter that tries, with daydreams, to deceive them with pleasant fantasies while depriving them of the vitality and actual immediacy of their lives.

Most of the clients consulting us are in pain and turmoil about their lives; it might seem cruel and counterproductive to ask them to give up their hopes. Perhaps for this reason, many have suggested it is better to speak of "coming to terms" with or to "become resigned" to their troubles. Giving up hope, though, is not the same as becoming resigned. In resignation, we passively bow our heads to a verdict we deplore. In actively giving up hope, we strive to kill and bury the enemy of our peace.

To some therapists, this attitude may seem bleak and cold. How can we steal from suffering people the only consolation that may be left to them, the glimmer of hope that still gives them a semblance of light and warmth? The work of despair, however, seems to us at once energizing and matter-of-fact. Once we become ready to let go of our dreams of what life "should" be, we can get down to the business of meeting each moment as it comes. Then the gateway to joy opens up. Hope always places paradise in some postponed future; if we want to live our lives fully, we must learn to break free of hope, to "de-spair," and to find ourselves where we are.

There is a potential trap here. Telling ourselves not to hope may not lead to freedom. In fact, this is a common game many of us play: we tell ourselves not to hope for a desired outcome, even while harboring a secret, magical thought that by these very means we offer an opportunity for the wish to come true. Similarly, we may imply to our clients that if they are "good despairers" they will get a prize in the end. To ask clients to despair in the service of hope sounds nicely paradoxical, but the fact is that new hopes, even if they do help us to live, help us to live badly (Comte-Sponville, 1994). Dangling a new hope might dampen the immediate pain, but this can be close to a deceitful palliative, like offering a child ice cream after he has had his tonsils removed. The child often finds, after the operation, that the throat is too sore to enjoy the ice cream. The prior hopeful promise then becomes a betrayal.

Therapists need to avoid this. The work of despair is based on respect for the client. If therapists try to use hope and despair as the proverbial carrot and stick, these will not work well together. The client will merely get pulled back and forth between promises of pleasure and threats of suffering. If there is any ultimate "goal" in giving up hope, it should be an increase in freedom rather than a new bondage.

So in pointing out a path based on the clarity of hopelessness and the courage of despair, the therapist would do better to refrain altogether from rosy visions. Ultimately, neither positive thinking nor negative thinking leads to peace. Life is life and it is indifferent to our optimism or pessimism. Hope draws a curtain between ourselves and our lives, and this is the reason it can become diseased, a form of alienation rather than a fulfillment. One never knows what the future will bring; to hold out for a happy future (the carrot) or shrink back from a feared one (the stick) still places us in a position of not living our lives. Therapists have long worked to free clients from bondage to their past: Comte-Sponville (1994) reminds us we must also work to free them from bondage to their future. This does not mean that we live timelessly with no memory and no dreams; it does mean that we can avoid being subjugated by "before" and "after." Then we can drink deeply of our present lives whether they be joyful or sorrowful. We can appreciate each moment as it unfolds and say, as did Nikos Kazantzakis' dancing Zorba:

> I fear nothing.
> I hope for nothing.
> I am free.

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