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In This Issue:

THE TREATMENT OF
RESIGNATION AND HOPELESSNESS

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A STATEMENT OF PURPOSE

This journal is part of The Bar-Levav Educational Association's (BLEA) general program to advance the science of psychotherapy and the understanding of the hidden forces that shape individuals and societies. Such an understanding is derived from our clinical work and is useful in the on-going treatment of patients. Additionally it has been found to have wider implications in practically all areas of human endeavor.

Learning to think critically requires first that we make room for it by diminishing the domain of feelings. These have the power to bend thinking and to distort one's view of reality.

The ability to think critically develops only in the absence of fear and with freedom from the dictatorship of other feelings. The *Journal* is dedicated to examining psychotherapy and human behavior and motivation with the yardstick of critical thought.

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All articles reflect the point of view of the respective writers. They are not necessarily those of the Bar-Levav Educational Association. We invite readers with diverse points of view to participate in the discussion of topics presented in the *Journal*. Subject to the availability of space, we will publish all thoughtful comments.

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INTRODUCTION TO THIS ISSUE

Resignation and Hopelessness Treating Depression's Prominent Symptoms

I kept finding other things to do as I began to put this edition together. Not usually a procrastinator, I began to think that my reluctance was related to the topic itself, perhaps unconsciously knowing that delving into resignation and hopelessness would lead me to visit territory that I apparently wanted to avoid.

As I considered the subject, I was reminded of a physician friend who developed multiple sclerosis thirteen years ago. Previously athletic, he has been reduced to stumbling with a walker. Beyond the tragic toll the disease has taken on him physically, it has also brought to the fore his underlying depression. So hopeless and resigned is he that any attempts to involve him in life's activities are met with cynicism, bitterness, and despairing complaints about the pointlessness of life. I rarely see him anymore. As a friend, I find it hard to be with him. As a psychotherapist, I have encouraged, urged and pushed him to get help, all to no avail. I have often thought that were I in his situation, I would either be dead, having succumbed to the disability and depression, or would have pushed through and be living by now, with it, in spite of it, in sober acceptance. I wonder.

Resignation and despair are the prototypical presentations of depression which is the "bread and butter" of most psychotherapy practices. The Editorial Board has selected this topic because the problem is so widespread. As psychotherapists we are routinely exposed to patients' oppressive cloaks of despondency which make us vulnerable to our own sense of powerlessness and hopelessness. To help our patients we must be open to these aspects in ourselves without allowing them to overcome us. It can be a draining and difficult course to maneuver at times, requiring us to have sound but flexible ego boundaries and a good grasp of reality and life's "big picture." It is no wonder that antidepressant medications hold such allure, with their promise of quick relief from the affective symptoms of depression. But the antidepressants "du jour" do not alter the roots of resignation. They merely bypass the folded-in character structure which formed when infantile needs were unmet and angry protestations unrecognized.

The venue of resignation goes beyond the clinical realm of depression. It is a societal problem, recognizable in the alienation, disaffection and indifference that are so typical today as to represent the norm. It is played out in drug abuse, lowest-common-denominator education systems, political apathy and basic ignorance of much of what goes on in the world. Millions of people now live with a pervading sense that nothing can be changed, so why bother, why argue, why try, why even know?

This issue of the Journal aims to sharpen our understanding of this important subject. We thank our contributors for their frank personal and clinical comments and invite you to join in the discussion.

Ilana Bar-Levav, M.D.

HOPELESSNESS AND ITS TREATMENT

Reuven Bar-Levav, M.D.

Hopelessness is at the heart of depression. And although the sub-clinical form of depressive illness is endemic practically everywhere, hopelessness is not as common. It represents the deepest layers of despair, a fatigue of the soul that weighs heavily on every part of the body and slows it down, with the physiologic "aim" of stopping it altogether. Spitz's babies (1945) actually died because hopelessness drained all their energy and their will to live, until none was left to sustain the organism.

Hopelessness causes a withdrawal from all involvements with people, with things and even with one's own needs. It is a decathexis from life itself, a blackness that allows no penetration of any light. Only the idea of suicide provides a glimmer of almost-hope, since it holds the promise that the suffering can have an end. But in the midst of hopelessness, people do not generally even find the energy to suicide. The deep freeze is so paralyzing that hopeless people do not usually experience themselves as strong enough even to kill themselves. Suicide becomes a real threat to survival only later on, as such people emerge from the depths of their despair, and once they have improved a little.

Hopelessness even prevents most people from seeking help for their debilitating condition. How can anyone reach for a helping hand in the midst of certainty that none exists? This is why such people do not usually activate themselves to look for physicians or for psychotherapists who might lessen their pain. Relatives and others who worry about the survival of those who demonstrate no wish to care for themselves sometimes push them to seek help. Although no one may consciously know that the hopeless person wishes to die, it is easy to figure it out from behavior which looks as if it was designed to promote the likelihood of a premature death. Anorectic patients, for instance, usually resist all attempts to feed them, even forcibly. Dying is often experienced by hopeless people as a welcome relief, not as something to be dreaded.

The unwillingness, and sometimes the actual inability, to care for themselves is the reason that severely depressed and hopeless people used to require hospitalization, a very costly choice. It also is an undesirable option since the hospital setting provides total care and allows for

behavioral regression. But even so, hospitalization was, and sometimes still is, needed for the patient's protection.

But not always does it protect. I remember as if it was yesterday how, over 35 years ago, an elderly woman actually succeeded in killing herself within the walls of the closed and well-supervised psychiatric unit where I served as a resident physician, with nurses all around and strict suicidal precautions in place. Somehow she managed to hang herself in the middle of a dark night. Even extreme interventions do not always suffice to save the lives of those who have so totally given up on life and on their own living.

Our new anti-depressants have sharply decreased the need for hospitalization and electroconvulsive therapy. The best of our medications are now often successful in lifting people out of the deep pit of hopelessness, but they do not cure the depression. It continues to feed the hopelessness and to fuel it. The dangerous signs and symptoms may dramatically disappear with the aid of such chemical crutches, but the underlying pathology remains the same and unchanged. The resignation, withdrawal, passivity and lack of energy eventually return, often coalescing into true hopelessness again when patients fail to take their drugs regularly or when they eventually tire of the demanding and expensive regimen. The rate of recidivism is high. Besides, the enormous weight of hopelessness is such that in many cases the medications provide only partial relief. Hardly ever are they a good enough solution that makes a long life possible. To achieve better results, accepted practice follows the conventional wisdom that psychoactive drugs must be combined with psychotherapy.

And psychotherapy too has improved. We now have more effective and much more powerful interventions, non-cognitive forms of intensive psychotherapy that aim at altering the physiologic underpinnings of the character structure. These can often bring about a complete reversal of the lethal condition.

But in the past, outpatient psychoanalysis and psychotherapy almost always failed in their attempts to treat stubborn hopelessness. Not only are such patients generally too sick to mobilize themselves to come to appointments regularly and on time, but the basic assumptions of the Freudian model have also proven themselves to be incorrect and

irrelevant. Both insight and understanding that uncover the hidden roots of the malaise are powerless when pitted against this life-threatening illness. It is interesting to make the unconscious conscious but doing so has absolutely no effect on the illness. Besides, anyone lacking in hope is not in the slightest way interested in such matters.

Even if all the psychoanalytic interpretations were correct they still would have no power to overcome the deeply rooted physical stillness of the body. This condition is not governed by the cortex (to whom all explanations, reconstructions and interpretations are addressed) but by subcortical brain centers. The basic pathological condition is not the absence of understanding but the absence of warmth.

Hopeless people are emotionally frozen in the present because they lacked sufficient "warming" in the distant past, very early in life (Bar-Levav, 1988, pp. 326-327). Typically they also complain of being physically cold, even in warm weather. Their condition results from a severe deficiency in consistent, sensible and empathetic mothering during the first few months after birth (Bar-Levav, 1988, pp. 44-45) when the roots of the capacity for intimacy and trust were laid down in the character structure. Such serious early developmental defects often cause otherwise well-functioning grown-ups to experience themselves at times as emotionally incompetent and vulnerable, as if their status were still that of newly-born infants.

Hopelessness can, and sometimes does, occur even when the real mother is adequate, well-meaning and sufficiently involved. The reports of a relative absence of good mothering may only reflect a subjective experience of early infancy, the result perhaps of an inborn defect in the baby's capacity to absorb what a good mother may have eagerly tried to provide. As adults, such people also experience themselves emotionally as fragile and empty, as if they had actually been motherless orphans. The net effect is one and the same, whether the defect is in the baby or in its mother.

Above all, to get well hopeless people need long-term close involvements with committed, consistent, competent, sensitive and loving caretakers, those who do not have a compulsive need to "care" or to do good. Such therapists are able to wait and to tolerate the slow pace often dictated by the patients' incapacity for closeness and for trust, even as such therapists

also push and consistently pressure the patient to progress. Over time they provide the adult equivalents of good mothering, the active ingredient that hopeless people are starved for the most. Treatment is so difficult and so long because even though the patients crave such mothering, they never reach for it and often reject it when available. They cannot really believe that such a quality actually exists or that it can be genuine.

Terms such as "warming the soul" are generally taboo in scientific writings and their use suggests an amateurish, non-serious and non-scientific approach. The same with literary metaphors. Even so, there is really no more accurate description of hopeless human beings than that which depicts them as suffering from chronic and life-endangering emotional hypothermia. It is as if their soul had never been sufficiently warmed in the arms of a steady, sensitive and sensible caretaker. As a result, the young organism lacks a basic sense of physiologic safety, something needed to serve as a rudder of stability in life's turmoil and storms (Bar-Levav, 1988, pp. 322-323). Those who for whatever reason have not experienced the needed minimum of such good mothering end up with varying degrees of hopelessness.

Medications and/or hospitalization are often successful in mobilizing at least a tiny island of mental health within the hopeless patient, large enough to serve as a beachhead for anchoring the tedious but life-saving work of psychotherapy. When successful, the extinguished light in a hopeless person's eyes is eventually rekindled. But success is never certain. Since the basic assumptions, the clinical approach and the specific interventions of traditional analysis and psychotherapy have generally been wrong, successes were rare and merely coincidental.

These many failures have convinced most patients, third-party payers and even many psychiatrists that psychotherapy for hopelessness was itself faulty. This and the cost factor explain the current almost-exclusive interest in medications, perhaps combined with some form of short-term, supportive psychotherapy.

By way of summary and to further clarify the issues, here are nine questions and answers to help focus the consideration of this difficult clinical entity and its treatment:

1. Differentiate between depression, resignation and hopelessness.

Sub-clinical depression is practically universal. It results from the impossibility of getting perfect mothering very early in life, and thus it is everyone's experience. Resignation comes from persistent inadequate early mothering and is a prominent feature of *clinical* depression. Hopelessness is the most malignant form of the illness, generally incurable. It is a basic physiologic infolding and giving-up.

2. How are the dynamic roots of these three different from each other?

- a. Mothering is never perfect from the newborn's point of view. This, and the preverbal realization of one's powerlessness, result in depression. But with relatively decent mothering, and with a little bit of luck later on, no symptoms appear. A sense of basic safety develops anyway.
- b. Resignation results from more serious and chronic deficiencies in early mothering.
- c. Hopelessness is the outcome of grossly inadequate, inconsistent and/or poisonous early mothering. It generally is a life-long condition and can precipitate or mimic any physical illness. It severely limits human achievements and relationships, and shortens life spans.

3. Specifically describe two major difficulties in the psychotherapeutic treatment of hopelessness.

- a. Hopeless patients have no hope of getting well. Therefore they do not usually seek therapy except for relief from acute pain, often not even then.
- b. With no "knowledge" of a reliable relationship of trust, hopeless people do not generally remain in therapy long enough to discover that human relationships can be

basically different from their physiologic experience. To succeed, therapists must first pass a seemingly endless series of tests to prove their reliability, a task requiring more time than such deeply troubled people usually devote to therapy.

4. Describe at least three major physical features that are diagnostic of hopelessness.

- a. An immobile face with eyes lacking a spark
- b. A monotonous voice and manner of speaking
- c. A still and essentially frozen body

5. Is suicide a pathognomonic sign of hopelessness?

Suicide is *not* pathognomonic of hopelessness. At the depth of hopelessness, people usually do not even find the energy to activate themselves to suicide. The risks increase as the heavy weight of hopelessness begins to become lighter.

6. List and explain briefly both the benefits and the shortcomings of the pharmacologic treatment of this condition.

The benefits of pharmacology:

- a. Symptom removal is frequently possible, sometimes even resembling a magic cure. This can be life-saving in the short-run, but is dependent on the patient following an uninterrupted course of therapy.
- b. As the subjective experience of hopelessness is lessened, patients can become available for involvement in serious psychotherapy.

The shortcomings of pharmacology:

- a. Since the inability to trust and to be involved in intimate relationships are not treated, the basic skills required for a minimally satisfying emotional life are not developed. Patients thus acquire nothing to sustain themselves and they never find reasons for wanting to live. With time, this only

deepens the hopelessness. Medications tend to become increasingly less effective, and often are discontinued.

- b. The implied message of life-long dependence on major antidepressants is that the patient is incurable. This confirms and validates the sense of hopelessness, often eventually tipping the balance in favor of despair and totally giving up.

7. List at least two serious dynamic obstacles that frequently interfere with the successful treatment of hopelessness.

- a. Hopeless people welcome death more than being alive. They are sure that the latter is not possible. This attitude is tenacious and its power is immense. Patients are usually dedicated to proving that their view of life and human relationships is correct. Stubbornly they frustrate the best efforts of therapists, often with passive hostility and for years.
- b. Hopeless patients have an underdeveloped capacity for experiencing love or caring from others, often distorting such "warming" involvements automatically into experiences of fear or hurt. The island of health within such patients is so small and well-hidden that they often leave therapy before it is discovered.

8. List at least two practical/financial obstacles that frequently interfere with the successful treatment of hopelessness.

- a. Hopeless people have underdeveloped capacities for earning a living. They usually cannot afford to pay for long-term therapy, even if it could literally save their life.
- b. Successful psychotherapy for hopelessness is lengthy and is therefore expensive. Insurance companies normally provide limited coverage only. This can doom the chances for a cure.

9. List three common personality shortcomings of psychotherapists that frequently interfere with the successful treatment of hopelessness.

- a. The work requires *active* psychotherapists with enough supplies from within to stay with the patient for years, in spite of seemingly endless complaints of frustration and disappointment. The effort itself often appears hopeless. Staying requires relatively intact ego boundaries and understanding that open expressions of resignation and hopelessness indicate progress.
- b. Deeply withdrawn patients are even more taxing than those who chronically "suck" because of preverbal hunger. Many therapists need to see progress or else they lose interest. They often also lack the wisdom provided by a correct theoretical model.
- c. Most psychotherapists have not resolved their own preverbal hunger and rage enough, and working with distrustful, silently withholding and sullen, stubborn patients often activates their own anger and a sense of powerlessness. These are usually present in hiding, even if consciously denied. To protect the repression and their own equilibrium, therapists sometimes terminate the work of such patients, claiming that they are "hopeless cases," thus validating the hopelessness that the patients experience.

Although such acts of dismissal are free of malice, they have the effect of a death sentence, and they are therefore ethically and humanly irresponsible and impermissible.

The exciting new understanding about early human development and human motivation that we now possess promises real breakthroughs in the treatment of hopelessness. Non-cognitive psychotherapeutic approaches that repeatedly mobilize frozen early affects within a nurturant, non-acting-out setting appear to be capable of changing basic physiologic reaction patterns of the body. Mounting evidence suggests that old subcortical brain pathways associated with hopelessness and depression can actually be altered. We now have a large series of clinical cases in which a complete reversal of this malignant condition appears to

have been the result. Real cures may now be achievable, though the process is costly and long.

In an age of managed care it is also prudent to note that a full course of such psychotherapy for depression and hopelessness is by far less expensive than repeated episodes of hospitalization. But the extreme shortage of qualified therapists able to provide such a service still limits the number of patients who can benefit from such treatment.

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Reuven Bar-Levav, M.D. is a psychiatrist, author, an editor of *Voices* and the *Detroit Medical News*, and founder of the Michigan Group Psychotherapy Society and the Bar-Levav Educational Association. The developer of Crisis Mobilization Therapy, his publications include *Thinking in the Shadow of Feelings*, *Every Family Needs a C.E.O.* and numerous articles in professional journals.

WHAT IS THE BLEA TUESDAY SEMINAR?

A BLEA postgraduate clinical psychotherapy seminar has been held in Detroit every week for over fifteen years, from 12:00 noon to 2:00 p.m. Practical issues of patient management have been supplemented by theoretical examinations of the nature of psychotherapy and human behavior in general. The Socratic method of teaching has typically been used. Seminar participants have been challenged to think critically and to examine afresh their own, and everyone else's, opinions and statements. We have grown together in our competence and in our ability to articulate the rationale, techniques, and methods of our clinical work. Our patients have also been the beneficiaries of this ongoing effort.

The BLEA Tuesday Seminar has thus been and is a laboratory in which new ideas are spawned and tested. Carefully prepared but brief assignments, no longer than 250 words, are prepared by seminar participants from questions distributed the week before. The answers are read aloud, discussed, critiqued, and sometimes debated.

There is now a chance for you, the reader, to also benefit from this stimulating experience. Each issue of the Journal, devoted to one Tuesday Seminar topic, will bring to you the questions asked and some of the responses. In this issue we examine the issue of hopelessness and resignation in psychotherapy. What follows are the assignments and some of the answers which were presented over a three-week period. Your thoughtful responses are welcome and, if suitable, will be published in a future issue. The deadline for responses (in 250 words or less) to this issue is November 30, 1996.

BLEA TUESDAY SEMINAR

Hopelessness: Re-examining Depression's Prominent Symptom

Assignment for April 20, 1993

Even though we routinely examine ourselves, meet for ongoing supervision and invite peer consultation, working with patients who experience hopelessness can lead to fleeting or more lasting ego boundary confusion. This confusion on the part of the therapist leaves patients without a dependable reality anchor when they most need one.

In an effort to continue working with ourselves on the issue, review a period in your life when you experienced a sense of despair or hopelessness. To help your thinking, consider the following:

1. What important life events were you going through during the time?
2. What impact did this period have on your self-image?
3. How was this period typically in or out of character for you?
4. What helped you resolve or move beyond this emotional period?

Having considered the above, explain dynamically what you believe happened to you in that experience and how it impacted your work with patients.

TUESDAY SEMINAR RESPONSES

I have lived close to hopelessness most of my life. I allowed myself hope only when I was sure that I could prevail. Until victory was palpable, I accepted as emotional "fact" that my wishes were futile. I often tried anyway because there was nothing better to do, but I minimized my emotional investment.

I came closest to utter hopelessness several years ago. Never before had I been as committed to an intimate relationship as I was then. I tried to hold on to a woman who had touched my deepest yearnings. She left me. This occurred on the heels of a visceral awareness of how I maintain distance from my patients, leaving them in their isolation or foiling their healthy efforts to emotionally attach to me. I acutely recognized the need to push myself beyond my protective barrier to be effective, yet was unsure that I was capable of doing so. I nursed the fantasy of quitting everything: my job, my profession, even my life. And yet, I had already committed so much of my life to this field.

It is a paradox that I was stronger than ever, otherwise I would not have risked so much, and yet I was so vulnerable.

Yesterday I told a patient that I know what deep hopelessness is like. I told him that it can be overcome. Though I am still not out of my own resignation consistently enough for the good of my patients, I know I spoke honestly. The impact on my work is basic and profound.

Joseph Gluski, M.D.

Direct contact with a sustained internal sense of hopelessness and/or despair has been, thankfully, rare for me. I have been blessed with resilient defenses in this regard and, therefore, have not had to endure this bleakness.

I know *what* it is though. Every once in a while my psyche lets me pay a brief visit. I don't often talk to another person about it. I don't expect anyone to know what, or why, it is. I believe at such times I distrust the "holding" power of others. I don't expect them to have the non-busyness or the freedom to lift their own defenses in order to help me carry this feeling and maybe work it through.

That's the quality of it. Fortunately it doesn't plague me over time as it does many. I'd be in trouble if it did. I'd be reluctant to reach for help and might withdraw with sudden disappointment or fear if what I was presenting was met with any insensitivity. Touchy stuff.

Drawing on this personal note and my clinical experience I can say with assurance that this territory takes a special person, in both the patient and the therapist, to navigate it properly. It has to be navigated openly, which takes courage on the patient's part and a freedom to tolerate the feeling on the therapist's part. It has to be navigated within workable boundaries. In sum, it has to be felt openly without letting the feeling itself take over all else. And, the imposition of workable limits cannot serve to ward off the patient's openness with this terrible feeling sense. All this equals a secure alliance, with extraordinary sensitivity and undefendedness on the therapist's part, inside of a therapeutic framework that consciously "zones" feelings in respectable but separate territory from action and the cognitive processes.

In my view, this terrible sense is a remnant of infancy, a voiceless cry to be held and thereby reassured against the sense of boundless emptiness that accompanies being left alone before one is ready. The appropriate framework and the real sensitivity of the therapist provide a new holding environment within which healing and healthy boundary formation ideally take place.

Ronald J. Hook, M.S.W.

As a first term freshman at Michigan State University, I was overwhelmed. I did not know how to study and was failing miserably in academics. Seriously troubled, I had been left by my first "true love," was desperately homesick, and had no social life to speak of. While not truly suicidal, life seemed so meaningless to me and suicide seemed to make sense. My parents and siblings, meaning well, were not helpful since they tended to infantilize me. My friend Carl, however, was seeing someone at the counseling center and suggested it might help me. The approach used there was "Rogerian" following the thinking of Carl Rogers, which was to approach the "client" with an attitude of "unconditional positive regard." I had only ten sessions, once a week throughout winter term of my freshmen year. My therapist said very little except to repeat my words and ideas back to me. It was very settling to me that he was not just sitting

there while I talked, but demonstrated that he actually heard me and picked out the most salient words to repeat. I knew that he was responding sensitively to what I said, and that I wasn't alone. Life seemed less empty, my grades improved dramatically, and I began to get my bearings.

My clinical experience has shown that accurate and genuine empathy is the single most important factor in treating hopelessness and despair. Primitive yearnings to find safety with a good mother are mobilized, providing the emotional spark upon which to build a corrective real relationship.

Paul P. Shultz, M.S.W.

My role model, my confidante, my anchor was leaving home. My brother was going away to college, and I was panicked. I began eating more, sneaking drinks, and smoking marijuana and tobacco. At these times I felt like a flailing infant screaming for someone to grab and hold onto me. At other times I withdrew deep into myself. I was unreachable, not speaking or responding to anyone. I soothed myself through sleep, self pity and fantasies of self-mutilation. All these were my defenses against a sense of hopelessness which would come and go over many years. Only after years of therapy do I experience enough safety to feel my despair and resignation without these harmful defenses.

For me there is a fine line between empathy and over-identification with a despairing patient. I know that I am more solid with someone who openly speaks of hopelessness or whose body obviously demonstrates despair. With such a person I am empathetic. I can see the pathology clearly and have a healthy understanding that there is a way out of the depths of despair. I can effectively hold people to reality and help them pull out of their resignation.

I tend to have difficulty with the patient who denies the resignation within while acting it out. Since this is closer to how I am, I am more likely to over-identify. As I sit with such a patient I tend to deny having felt so desperate in the past. But patients tell me at such times that my face takes on a pained, suffering look; then there are two despairing people in the room. At that point I am aware of my need for a supervisory hand so that I can regain my perspective.

Helene Lockman, M.S.W.

THE CASE OF ANGELA

History and Course of Treatment

Angela is a 41-year-old, overweight, single physician who sought serious psychotherapy nine years ago, sometime after she had "hit rock bottom." At that time, her isolation had been so great and her depression so deep that she had found herself unable to reach out for help. After "floundering" for nearly a year, barely able to work, a friend referred her to the practice in which I and several colleagues work together in co-therapy teams.

Angela is the third of four children, having two older brothers and a younger sister. Mother was rigid, controlling and emotionally cool. Her serious difficulties with her own female identification made it particularly difficult for her to like her daughters. Father was weak: "a marshmallow with no backbone. He always tried to be Mr. Nice Guy and almost never said no." He made attempts to spend time with Angela when she was small and these contacts are among her fondest memories. But she always believed her brothers were favored. She felt unwanted both as a person and as a girl. From early on she consciously wished she had been a boy.

She was a bright, withdrawn child who felt safer with books than with people. When, as a teenager, she experienced her terrible sense of inadequacy more profoundly, she developed a "tough guy" front which was prominently displayed in her therapy as soon as her depression began to lift. Her demeanor and mannerisms were not so much masculine as they were anti-feminine. Her voice was often sharp or rough, her gestures broad and awkward, her wit tinged with sarcasm, her laugh too loud. Not only had her attempts at softness and sensitivity been ridiculed by her mother but they had also been crudely put down by her brothers. Father, the only person who had seemed to have some understanding of his daughter's difficulty, had been too frightened and unsteady himself to take her side in the conflicts with other family members. She was hurt, angry and trusted no one. Her "toughness" kept everyone at a "safe" distance.

With fierce determination Angela pushed herself through college, medical school, and residency, fighting her difficulties with concentration and a

nagging sense of hopelessness. She took a low-paying public health job, having no strength to set her sights higher or work longer hours.

In her work Angela was competent and professional, often even innovative. But her personal life was lonely, her relationships with both men and women only marginal and usually disappointing. She lived alone, literally and figuratively. In her twenties she had found sexual activity with women more satisfying than with men but had given up on that, too. No relationship was ever lasting or really satisfying and meaningful to her. She became more and more isolated and despairing and now says she would have killed herself had she not come to therapy.

Since Angela's father had been experienced as the best "mother" she had known, we concluded that it would be easier for her to become involved with a male therapist. She looked forward to her sessions and very slowly began to take more chances with him. After many months her therapist insisted she be in an ongoing group in addition to her individual sessions since repair of such early psychic damage and treatment of such deep resignation require the involvement of a co-therapist and contact with other patients. Although very frightened, Angela agreed. This was the beginning of our relationship since I was a co-therapist in that group. For months Angela spoke little but followed everything that went on in the group sessions. Gradually she began to take more chances, allowing her sensitivity, her wit and her bitter sarcasm to show. To her surprise, she began to feel that she had a place in this "family" different from in her original family. She lost a little weight and began to dress in a slightly more feminine manner, at first claiming that it was just to get her therapists "off her back." But slowly she began to derive some pleasure from being a woman. Her yearnings for closeness began to surface along with deep hurt at not having been properly cared for as a child.

After about three years, we believed she was ready to face yet another layer of her deep fears and test the waters of a trusting and more intense involvement with someone more closely evoking her painful experiences with her mother. She began to see me for her individual sessions, continuing her contact with her original male therapist in her twice-weekly group. Those times with me were often stormy because her previously hidden and suppressed rage now came out into the open. She hated the woman who had mothered her so poorly and, consequently, she hated all other women, including her therapist and herself. For weeks at

a time I could do nothing right. If I spoke little in her sessions, I was tight and ungiving like her mother. If I intervened more frequently, I talked too much and wanted the session to go my way. Just like her mother, I was not making enough room for her, she would bitterly complain.

Clinical Vignette

This phase of therapy was understandably very difficult and painful for Angela. She had taken many courageous steps out of her deep withdrawal and isolation. Sometimes she had found pleasure in being involved with others but with such exposure she also ran the risk of getting hurt. I had become very important to her, both transferentially and as a real person. When she felt hurt by me, it seemed almost more than she could bear.

In order to keep her group members and the male therapist she had first seen from becoming too important to her, she frequently found fault with them, too. Her complaints about me and about the rest of these people found their way into most individual sessions. While her ability to complain represented a step out of her withdrawal, she was generally unwilling to examine her exaggerated reactions. What was the point of being in therapy? We weren't helping her anyway. Her life was no better and why should she pay money to be with people like us who disappointed her again and again and didn't really see her? She alternated between angry diatribes and silent pouting. I tried to help her express her feelings without getting lost in them, knowing that she needed to be openly angry to counteract the years of withdrawn hopelessness, but that it would not lead to basic change unless she also exercised her observing ego.

She often hinted at leaving therapy in individual and in group sessions, always watching for reactions to such remarks and always stopping short of a threat or an actual announcement. Comments about her manner from therapists and patients and invitations to wonder what was happening inside her were met with dismissal. Sometimes she had to be pressed to even acknowledge that others had spoken to her.

After months of such interchanges and no apparent movement I began to see her resignation less as an expression of depression and more as a character resistance which stubbornly refused to yield. Earlier in her

therapy Angela had needed support and encouragement and her condition had required that she be figuratively taken by the hand and "pulled" along to rekindle hope. But now she required more of a "push" to help her give up a character trait she no longer needed and probably had the strength to go beyond. About halfway through an individual session in which Angela again sighed and pouted about the uselessness of therapy, I said:

"If you're not just talking about your feelings, Angela, if therapy *really* isn't helping you, then maybe you should leave."

"Oh! You're fed up with me. You want me to leave!"

"No, I don't, but if I can't help you I don't want to go on taking your money for nothing."

"Well, it's obvious you're not helping me. Look at my life! I still don't have friends, I don't date, I still can't concentrate on my work. What good is it? I don't think I should keep coming. You might as well cancel my sessions. There's no point in them."

"Do you mean that? Because if you *really* tell me to cancel your sessions, I will."

"You might as well."

I picked up my appointment book and slowly and deliberately opened it to the following week. With my bottle of White-Out open, I looked at her and asked, "Are you sure this is what you want?" Slightly taken aback, she nodded. I carefully whited-out her regular Thursday sessions for the next month which was as far ahead as I had written them in. Slowly and deliberately I closed my book, put it down and sat quietly. After a long silence she said, without lifting her eyes from the floor:

"I didn't think you would really do that."

"Your words have meaning, Angela. Even though you often experience me as deaf and insensitive, I do listen to you and take you seriously."

For the next few months, Angela had no individual sessions with me. With help, she brought this incident into her group and talked about her shock and hurt about what I had done. At first she accused me of acting on my feelings, saying that she knew she was a difficult patient and that I had gotten discouraged and wanted to get rid of her. But when it became apparent that I was not angry, she began to look more at herself. She had a few sessions with my colleague, the co-therapist in her group, to help her further process this crisis. She talked and even cried about not wanting to lose me and accepted help in exploring her own behavior. She finally asked me to reinstate her sessions and I was glad to be able to do so. She is still in therapy and while much remains to be done, the little girl who fought and pouted to such extremes is rarely seen anymore.

Discussion

One of the reasons resignation is so difficult to treat is that it so profoundly permeates the perceptions of reality. The whole body "knows" there is no possibility of change. The eyes "see" others as uncaring and ungiving. The ears "hear" harshness. The body walks on its daily path with no sense that any roads might exist aside from this familiar rut. The heart "knows" there are really no friends in the world, no help available. The thick walls of protection against fear and hurt keep everyone out and loneliness prevails without hope of change. Since even the fantasy life of the deeply resigned is limited, there is no relief in dreaming of what might be.

Those who come to us as patients have at least a glimmer of hope which we must build on. Reality testing must be encouraged and sometimes forced again and again as we did with Angela in both individual and group sessions, pushing her to take chances with people and relationships and find out if they were really dangerous, as she expected, or whether her perceptions and assumptions were faulty.

But this was not enough and a stronger confrontation was called for. Angela had emerged from her deep withdrawal and could push out against people with anger. But she was still resigned in her assumptions about the world and the accompanying bitterness would defeat her few feeble attempts to get involved with people. She felt like a hurt, abused child and she lived as if that were actually true, making little effort to reality-test or otherwise make use of her ego strengths.

But she had taken a step forward in allowing herself to like and to trust me. Painful as it was to her, I had to use myself and our relationship as a wedge to try to push her beyond her characterologic resignation and hopelessness to face the reality of herself as an adult. Holding her to her words sent the message that she was not a child and I was not the all-accepting, loving mother she had been longing for, but I was a therapist who treated her respectfully as an adult and who would work *with* her to help her repair her life.

Fortunately for Angela, the message got through. Her emotional health was jump-started by the shock of my words and my actions. My statement that I would not remain with her indefinitely and unconditionally and her realization that she might really lose a relationship which was one of the most important she had ever had forced her to engage her observing ego, an anti-resignation phenomenon.

Pamela Torracco, M.S.W.

Pamela Torracco, M.S.W., a member of the Editorial Board of the *International Journal of Psychotherapy and Critical Thought* and a past president of the Michigan Group Psychotherapy Society, practices in Southfield, Michigan. She has written previously for this journal and has published articles in other professional journals as well.

THE CASE OF ANGELA: RESPONSE

I was quite touched by the case of Angela and the very sensitive and genuine concern for her that Ms. Torracco demonstrates. Reflecting on this I am aware of how difficult it is to accept hopelessness and the resignation it can engender. Two things come to mind. The first is an anecdote from my training when a supervisor was relating to me how he had used his usual upbeat optimism to try to reassure a client who felt increasingly hopeless. As the client detailed further and deeper what made her life and prospects look hopeless the therapist began to descend into the darkness with her. Finally, feeling drained, he told the client that he, too, believed it was hopeless. She immediately began to see things differently and her entire attitude eventually changed in a most positive manner. The other thought that comes to mind is the sense of endless hopelessness I encountered on a recent trip to India. The problems, as a Westerner would portray them, were of a seemingly measureless depth. I found this depressing at first but quickly realized that the populace did not share my depression, and so I could re-evaluate that hopelessness and discover a resignation to or perhaps understanding of what the world was and accept it without feeling any drive to change it in a substantive way. Something in me was freed up.

I believe that Americans have a constitutional (pun intended) predisposition to despair about hopelessness. It overwhelms and defeats us. And yet it is often the human condition. The clinical vignette about Angela demonstrates the therapist's difficulty (which most of us share) with anger and hopelessness. Even her writing style changes when she describes her confrontation of Angela, and she seems uncomfortable in the interaction as she disappoints Angela, who has certainly received more than her share of disappointment, but who's measuring? The therapist's willingness to stand her ground so that Angela becomes aware that she has control over whether her hopelessness will hurt her or not is very significant. Hopelessness is the obverse of autonomy and as terrifying as the prospect of being autonomous is, that is exactly the terror which the client must confront in order to have hope.

The bracketing of hopelessness and resignation is an important aid in grasping the issues here and is thus a helpful construction. If the therapist accepts the power of the client's hopelessness and resignation and if the

therapist acts on that acceptance (however that is appropriate) then the client may effectively grasp the terror which is under the absence of hope. My experience is that as painful as touching our terror is, it is always helpful in energizing us to get on with life. We all have to find or construct meaning in our lives and can do so, although sometimes we have to be shocked into it.

Murray Scher, Ph.D.

Murray Scher, Ph.D., has been in the independent practice of psychology in rural northeast Tennessee for twenty years. His major area of professional inquiry has been the intersection of gender roles and psychotherapy. He has published and presented extensively and is currently working on a graduate level textbook entitled *Gender and Counseling*.

COMMENTS FROM OUR READERS

Resignation: A Teacher's Perspective

Is the light on or off? As a teacher I watch for brightness in students' eyes as they file into the classroom during the first days of the new school year, and hope it will still be there when the last bell rings in June. With some, the door is open. These are the students who eagerly take what is given and ask for more. Others are more fearful and need more encouragement. Then there is a group who seem to have lost hope. Though some assume that these kids are destined to fail, this is not necessarily the case.

Even students who had given up during the previous school year may be available at the very beginning of the next. In those early days many of them seem involved, watching, answering questions. The experienced teacher should identify those who are at greatest risk and who would benefit most from early intervention. Unfortunately there is not enough time to make solid contact with every student. I can choose only a few to actively pursue.

The younger the child, the greater the potential for success. As students progress to middle school and high school, resignation often has taken a firmer hold. Additionally, the likelihood of older students getting personal attention is diminished; typical secondary school teachers deal with over 100 students a day so, inevitably, more of those youngsters slip through the cracks.

Almost all students initially carry some hope into the classroom. Their gazes are full of questions: What do you expect of me? Can I make it? Will you help me? Will you like me? While such "checking out" occurs preconsciously, the fact that they examine and test me at all is a step away from resignation. As a teacher I am often touched by these innocent, hopeful looks and notice how my open response to these students helps motivate them to continue. This is the best of possibilities. At other times the connection is poor, distorted, or severed by typical classroom interruptions, competition for attention, or insufficient time. And some students have such a strong tendency to withdraw that they have no choice but to anxiously avoid a relationship that might have been.

As time passes, students demonstrate their habitual patterns more openly. Feelings of helplessness arise. If they have not found a lifeline in me or in someone else, there is no force opposing their resignation. Academic failure and negative social behavior reinforce hopelessness. Those who have been victims of resignation in the past may find themselves dangerously close to the familiar spot again. Blank stares become increasingly common. Some sleep in class. I notice that even their shoulders seem to slump more, advertising their sense of powerlessness. Excuses increase in frequency. Acceptance of responsibility fades.

From this point a variety of self-defeating behaviors appear that perpetuate a vicious circle. In an effort to connect with withdrawing students, I push myself to make class more interesting, trying out new methods. I make calls to parents to enlist them as partners. While most parents are supportive, many are so frustrated that they no longer believe their children *can* be successful or that anything they suggest will have impact. These desperate parents believe they've tried everything and are often resigned themselves.

But the most powerful tool is personal contact with the student. A short conference, a brief note, a call to his or her home, even regular eye contact in the classroom can be potent. It is important to meet the student where he is and go from there, encouraging small steps. Despite the uphill battle with some whose resignation is deeply entrenched in their personality, I continue to try. One of the ways I have sometimes been able to alter their course is by keeping myself in front of them as if to say: "I am here! Join me!"

It is a daily challenge what we teachers face to make a connection with these hard-to-reach students. It helps me to remember that although it is often hidden, there is usually at least a dim ray of light.

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Hopelessness, Resignation and Depression in the Elderly

Statistics on depression in the geriatric community vary from a decreased incidence of new onset depression in the healthy elderly to an increased incidence of depression in the sick and institutionalized elderly. The criteria used to diagnose depression in DSM-IV are primarily vegetative symptoms, including sleep, appetite, energy and concentration disturbances, and psychomotor agitation or retardation. Guilt, apathy, hopelessness, resignation and suicidal ideation are more subjective symptoms. Since they are more difficult to assess and easier to hide, they carry less weight in the diagnosis of depression. But in the geriatric patient these symptoms are most important as they are more likely to reveal true depression than vegetative symptoms which may be caused by other processes, including physical illness, medication reactions, dementia, or even at times a normal change in physiology.

Geriatric patients, when viewed like other adult patients struggling to survive, go through the same process of adapting to their environment as best they can while trying to avoid fear and hurt. For some, hopelessness and resignation have been a lifelong tendency. As characterized by Bar-Levav (1988, p. 91), "The depressive position represents the social outlook determined by the subclinical depressive core. It is characterized by an attitude of futility...It is the pessimistic view par excellence...Many people know of the depressive position and sometimes they live there, even if they never develop the full blown clinical syndrome of depression. This happens less often, and only when important enough losses later in life tip the scales." The struggles facing the elderly are sometimes enough to tip those scales. An assessment of how the individual coped with previous developmental tasks is an important factor in determining how each will adjust to old age.

According to Erickson, the task of a person entering a later stage of life is to maintain integrity and avoid despair. Physical decline threatens integrity, since we experience things first through our bodies. Emotional integrity, according to Erickson (1986), is maintained through *vital involvement*. Retirement, loss of loved ones, family shifts, displacement and so on threaten this involvement. These losses can bring a subclinical depressive core to the surface.

It is also important to distinguish a pathologic depressive state from the normal process of mourning and acceptance of a changing internal and external environment. Both may appear as resignation. Kubler-Ross (1969) designated the final two stages of coping with dying as depression and acceptance. There is some flow from one into the other. At some point, the same fight that made sense at an earlier stage no longer fits. A quiet acceptance might be confused with hopelessness or resignation.

In assessing the geriatric patient, the bio-psycho-social model is essential. Medical illness must be ruled out or treated. Previous history of depression and coping mechanisms need to be assessed. Hopelessness and resignation are seldom novel reactions for the elderly and usually represent a characteristic depressive position. Social stressors are easy to identify but often difficult to remedy.

The use of antidepressants in the depressed geriatric patient is a reasonable treatment, as they are often effective in treating the vegetative symptoms and achieve a rapid response. They are not a panacea, however. While some behavioral or mood shifts may occur because the patient is feeling better, deep and lasting changes rarely occur. An example is Mr. A, an 84-year-old man with a severely depressed character. In his earlier years he survived with the help of a supportive family, a steady job, friends, and good health. After he retired and his wife died, he drifted further into resignation. When physical illness struck him, he truly gave up, stopped eating, made little eye contact and rarely spoke. He was treated with an antidepressant and the results were readily apparent. He slept and woke with greater ease. He began to eat, but without pleasure. His eyes were more open, but his eye contact remained poor. The medication which improved his body could not reach his soul. Mr. A died shortly after saying goodbye to his family. Medication can help a troubled person to eat, sleep and breathe, but only vital involvement keeps him or her alive.

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A Clinical Comment on Hopelessness and Resignation

Robert, a 34-year-old father of two, was the second child in a sibship of five. His mother was overly sensitive and weak, his father extremely critical, cold and distant. He grew up afraid to "burden" his mother with his concerns lest she have a "nervous breakdown" like *her* mother. He hated his father who repeatedly criticized him. He grew up certain he could never live up to his father's standards nor depend on his mother's support. He entered therapy resigned to the "fact" that no one could love him or help him. During individual and group sessions he often sat with a glassy, distant look in his eyes, drawn facial features and a slumped posture, enveloped in resignation and afraid to risk involvement with others.

The roots of resignation are in the earliest experiences of life. When the mothering parent does not satisfy the infant's needs, it responds in the only way it can, protesting until it is exhausted. When it stops, with needs unmet, resignation begins to set in. Such experiences of need frustration, repeated again and again, deepen to despair until that becomes a central feature of the personality. In the realm of physiologic research, this can be compared to Selye's General Adaptation Syndrome which describes a similar "resignation" process in an animal's management of stress.

Establishing a real relationship with Robert and persistently welcoming the vocal expression of his feelings were the initial goals in therapy. He needed a safe, steady holding environment to express his pain. In group and individual therapy he was also confronted repeatedly about giving in to resignation and firmly encouraged to seek more for himself. As he began to come alive, the anger beneath his hopelessness was intense and often tainted with bitterness and bile that came from years of suppressing it.

Working with patients with such deep feelings of hopelessness is draining because it evokes similar feelings in me. I count on the help of my co-therapist, consultation with peers, and ongoing supervision to maintain a firm boundary between my patient and myself.

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