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THE TREATMENT OF RESIGNATION AND HOPELESSNESS

HOPELESSNESS AND ITS TREATMENT

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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 inabilities 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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