Faith and Despair in Psychoanalysis

THE TERM FAITH is not commonly used in psychoanalytic discourse. An important exception can be found in Bion's (1970) writing, where he refers to the state of mind that emerges when the analyst approaches his work without memory, desire, or understanding as one of faith: "faith that there is an ultimate reality and truth—the unknown, unknowable, 'formless infinite'" (p. 31). He emphasizes the way in which the analyst's desire for mastery and understanding can block the openness of mind necessary for perceiving the emotional truth that emerges in the session. In an evocative paper, Coltart (1992) builds upon Bion to argue for the fundamental ineffability of the analytic process, and the role that the analyst's faith must play in the face of this ineffability.

However much we gain confidence, refine our technique, decide more creatively when and how and what to interpret, each hour with each patient is also in its way an act of faith, faith in ourselves, in the process, and faith in the secret, unknown, unthinkable things in our patients which, in the space which is the analysis, are slouching towards the time when their hour comes round at last. [p. 3]

The emphasis for Bion and Coltart, in this context, is on the analyst's faith. In this article I focus on the patient's faith and the processes that can give rise to it when it is lacking. As I argue, there is an important parallel between the type of attitude that develops for patients when faith emerges and Bion's understanding of the nature of faith.

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The problem of faith lies at the heart of the analytic process. Despite Freud’s best efforts to distance psychoanalysis from its roots in hypnosis and suggestibility, faith inevitably plays a central role. Whether one seeks relief from physical or emotional pain in the form of medication, spirituality, or psychoanalysis, at some fundamental level there has to be the possibility of believing that things can be different. One has to have some hope that one has the ability to change and that the healer has the ability to help. All people in analysis struggle with varying degrees of demoralization. In many cases the balance between hope and despair is such that the patient can readily come to believe in the analyst’s good will and potency and in the value of the analytic process. In some cases, however, the process of coming to have faith is a struggle of Herculean proportions.

When life experiences have been such that one has little faith in the possibility of influencing one’s own destiny or that others will be willing or able to act on one’s behalf, the process of cultivating such hope becomes the problem of analysis. In such cases, the severity of the patient’s bitterness, cynicism, and despair makes it virtually impossible for him or her to find any kind of solace from other human beings, and leaves others thwarted in their efforts to make contact or be helpful. Patients experiencing this type of cynicism and despair are likely to engender intense countertransference feelings in their analysts.

Often people hide the full intensity of their despair from others because of a belief that others will be alienated by it. They also hide the full intensity of their despair from themselves because it feels too painful to fully acknowledge. For such patients the first step in the process of cultivating faith often involves fully acknowledging and owning their despair and sharing it with another human being. It is thus critical for the analyst to be vigilant for any indication of cynicism or despair in patients when they first begin treatment. The task is to encourage them to bring whatever cynicism, anger, or despair they are feeling into the here and now of the therapeutic relationship. In this way, a vague, generalized feeling of hopelessness and despair the patient experiences in isolation can be transformed into a concrete feeling of hopelessness in a specific relational context. Through articulating his or her feelings of hopelessness to the analyst, the patient acknowledges these feelings more fully to himself. This process helps the patient to contact the pain underlying the feeling of having given up and rekindles the unfulfilled yearning of which he or she may not be fully aware (Safran & Muran, in press). This yearning provides an opening for human contact. The patient thus be-
gins the journey back from exile to being a member of the human community. If the analyst is able to respond to the patient's despair without shrinking or withdrawing, the patient begins to see that he does not have to be alone in his despair. By responding to the patient's despair in a compassionate and understanding fashion, the analyst provides him with the experience of being cared for and connected to another in his pain.

What I am saying here is captured in certain respects by Bion's (1963) conceptualization of the role that the analyst's containment of difficult and painful feelings plays in the analytic process. Both Aron (1996) and Mitchell (1997) have recently provided evenhanded and nuanced critiques of the concepts of containment and projective identification, and I have no intention of rehashing these critiques here. I believe, however, that notwithstanding the fact that a growing number of theorists now emphasize that the analyst is never an "empty container" for the patient's projections (e.g., Gabbard, 1996; Ogden, 1982; Joseph, 1989), the use of concepts such as containment and projective identification can still, in subtle ways, help analysts to shield themselves from the full impact of confronting and dealing with their own feelings of despair, thereby removing them from the immediacy of the therapeutic relationship. In other words, such concepts can provide a type of a priori understanding of painful feelings emerging in the session that is antithetical to the type of "unknowing" faith advocated by Bion. In the moment that I think of myself as "containing my patient's projective identification," I distance myself from my lived experience. This can detract from the mutuality of the encounter—an element which, as I argue later, is essential to the change process.

In order to be able to tolerate the depths of the patient's despair, analysts must be able to tolerate whatever personal feelings of despair are evoked. One can understand the analyst's despair in this context at two levels. The first consists of despair experienced in empathic resonance to the patient's self-experience of despair. The second consists of despair related to the analyst's feelings of impotence vis-à-vis the patient.

In terms of the first level, it is critical for analysts to be familiar with the experience of working with feelings of hopelessness in their own lives and to have developed some degree of compassion for themselves in their own despair. Otherwise there will be a tendency to avoid real contact with patients who are in despair and to retreat to the safety of formulations or engage in futile attempts to take patients' despair away through interpretation, consolation, hollow empathy, or reassurance.

In terms of the second level, it is critical for analysts to develop toler-
ance for their own impotence as helpers and their inability to solve patients' problems for them or take their pain away. Often patients, in the urgency of their need, make demands that are experienced as overwhelming by their analysts. No matter how mature the patient is, it is only human to want the other person to take one's pain away and to magically transform one's life. As Lacan (1966) suggested, human beings exist in a fundamental state of alienation, which gives rise to desire that by its very nature can never be fulfilled. Theorists such as Winnicott (1965) and Balint (1968) have made important contributions by exploring the way in which facilitating and working with regression to dependence can be a critical component of the analytic process. A problem with the concept of regression to dependence, however, is that it implies that the longing to have someone else assume responsibility for one's life is relegated to a certain developmental stage and is not part of the mature individual's experience. This way of viewing things can reflect a disowning of our own longings for a sense of completion and magical transformation, and this in turn can make it more difficult to tolerate our patients' yearnings for magical transformation and our own inabilitys to fulfill them.

When we have difficulty accepting our own limitations as helpers, there is a tendency to respond defensively in the face of patients' impossible demands and to shrink from their pain and despair. When we have a need to experience ourselves as helpful to our patients, they may unconsciously sense this and feel coerced into looking after our needs rather than their own. It is thus critical for us to come to terms with the fact that in the end there is a limited amount that one human being can do for another. No matter how deeply empathic toward our patients we can be, when the session is over, the patient goes home and we go on with our lives. This realization, however, must not be transformed into cavalier indifference, but rather into the compassion of one human being who experiences the pain of life for a fellow human being.

Benjamin was a thirty-six-year-old man who was extremely socially isolated and had never had a long-term relationship with a woman. Although he acknowledged being distressed by his circumstances, I was surprised by the relative degree of equanimity with which he appeared to be dealing with the situation. He had initially been referred to me by a relative, approximately a year prior to beginning treatment, but maintained that he had not contacted me at that time because he didn't feel that his problems were severe enough to warrant treatment. He had no previous treatment experience and knew nothing about therapy. On the
face of things he was optimistic about the possibility of being helped and open to giving things a try. From the outset, however, I had an intuitive sense of a subtle element of cynicism in his attitudes about treatment and about life in general, that was implicit as much in the way he spoke as in the specifics of what he said. I was also aware of a growing feeling on my part of inadequacy—a sense that somehow nothing I could do would be helpful to him. As time passed I found myself feeling progressively more deadened and irritated with him, and I began to dread our sessions. Although it was difficult to articulate to myself what aspects of his presentation, if any, evoked these feelings in me, I consistently felt at a loss to say anything that I imagined might be meaningful to him. My understanding, in retrospect, is that his difficulty in acknowledging his feelings of despair had left him affectively frozen and unavailable, and that the subtle hint of cynicism I had been picking up was the only thread linking to his underlying longing and vitality.

During the first phase of the treatment, much of the work in our relationship involved giving him feedback regarding my intuitions about his cynicism and my feelings of impotence vis-à-vis him, and helping him to acknowledge and articulate this cynicism. For example, in one session in which I was feeling particularly stymied I said to him, “I’ve been feeling something for some time, and I’m not sure if this reflects anything that’s going on between you and me, or if it’s just me. But I feel at a loss to say anything that might be helpful to you. Somehow, I imagine nothing I might say will seem meaningful to you.” In response, he was able to acknowledge that it was also difficult for him to imagine me saying anything helpful or meaningful. I responded, “It sounds to me like you're feeling kind of cynical and not too hopeful about things between us.” In turn, he was able to begin acknowledging these feelings, and with my encouragement he was able to begin elaborating.

Over time, his initial tentative acknowledgment of an edge of cynicism deepened into an exploration of deep and corrosive feelings of bitterness and hopelessness. Gradually he was able to become more frank with me about his skepticism concerning my ability to help him and his suspiciousness of my motives for seeing him. He confessed to suspecting that I myself had no faith in the possibility of helping him and that I was just seeing him for the money. Over time, my ability to listen to his skepticism about my competence and motivation in a nondefensive fashion helped him to become a little less mistrustful, and to deepen his exploration of his feelings of hopelessness and despair about treatment, and about life in general. As he was able to contact and articulate these
feelings I began to feel less paralyzed and to develop more of a sense of affective engagement with him. In turn, he began to experience his own pain more deeply, and my feelings of empathic connection to him deepened.

Much of my internal work during this phase involved observing my instinctive tendency to distance myself from Benjamin with feelings of anger, condescension, or dismissiveness, and then tracking the flow of inner experience back to my underlying feelings of impotence, futility, and despair. Over time, the process of fully acknowledging these feelings to myself, and dwelling on them and associated memories, began to reopen analytic space that had been collapsed by my need to defend against them. I believe that in this type of reverie it is important to open oneself up to pockets of despair in one's own life, both past and present.

When I was growing up, my sister was chronically depressed and my role was to try to make her happy. The periodic moments of success I experienced were always rewarding, but I also came to resent the responsibility I felt for her and her failure to help herself. During one session with Benjamin, I recalled a memory of a telephone conversation with my sister that took place when I was in my early thirties. During this conversation I was feeling exasperated with her apparent helplessness and inability to do anything to change her life situation. She sensed my exasperation, and I remember her saying, "You don't understand. I don't have any will." Perhaps I was able to hear her in a new way because of changes that we're already taking place in me. Perhaps it was her intuiting of these changes that led her to say what she said, or perhaps she didn't really say what I recall her as saying. In retrospect, however, this event, in my mind, marks the beginning of a turning point in my relationship to her despair and to my own as well.

In the years following this incident with my sister, a number of events in my own life had led me to confront my own feelings of despair more deeply, and I simultaneously came to experience less of a need to "help" her, and less of a tendency to judge her harshly for her inability to change. As I worked with Benjamin, I recalled some of these difficult episodes in my own life, when it had felt impossible to communicate the depths of my despair to anyone else, when I could not imagine the painful feelings ending, and the prospect of someone else being there for me in a meaningful way had seemed inconceivable. I also dwelled on areas in my current life where I felt stuck and at times hopeless: ways in which the same conflicts I remember struggling with in early adult-
hood continue to play themselves out with dreary monotony. This process helped to rekindle a feeling of compassion for myself in my own struggles and my impotence with Benjamin. This in turn helped me to feel more accepting of him.

Gradually we moved into a phase of treatment in which isolated moments of hopefulness began to emerge for Benjamin. These would typically take place following an extended interaction between us, during which I had helped him to articulate whatever cynical feelings he had about me and the analysis, without responding defensively. What was striking, however, was that these moments of hopefulness would immediately be followed by a return to his more customary state of cynicism and hopelessness. This shift would take place so quickly that I would be unaware of it until I would find myself locked into a futile attempt to reassure Benjamin or to convince him that things would get better. When I was able to track these rapid shifts in Benjamin’s state as they took place and explore his experience in the moment, he was able to articulate a fear of being “conned” or “taken in” by me. This, it emerged, would lead him to retreat to his familiar self-protective cynical stance. Over time, this fear of being conned became further fleshed out into a concern that any feelings of hope would inevitably lead to disappointment and more pain. Gradually, the process of articulating his fear of hoping, both to himself and to me, helped Benjamin to sustain longer and longer periods of trust, both in our relationship and in the process, and we began to move into a new phase of the treatment in which the moments of hope became less isolated and Benjamin’s predominant experience of despair began to give way to an underlying longing for nurturance and support.

Will versus Counterwill

People in despair have no sense of personal agency. They experience an inability to will and have no faith that their efforts can make a difference in their lives. While they may at one level blame themselves for their lot, they paradoxically do not experience an ability to choose differently and to act in a way that will change their lives. They may be ruthless in their self-recriminations, yet at the same time experience themselves as victims rather than as agents who are shaping their own destiny.

With some notable exceptions (e.g., Farber, 1966; Rank, 1945; Schafer,
1976, Shapiro, 1981), the field of psychoanalysis has neglected the topic of the will. Freud's perspective on psychic determinism challenged the Victorian notion of man as master of his own house and its emphasis on the primacy of willpower, and portrayed human beings as motivated by instinctual forces that are outside of their awareness. Freud's challenge to the Victorian emphasis on the primacy of rationality and self-control ushered in an important revolution in our conceptualization of human experience. It also, however, set a precedent for ignoring an important domain of human functioning—the will, or human choice and agency.

Mitchell (1988) does an excellent job of reviewing the most notable psychoanalytic contributions to the topic of the will and ultimately concludes that the will plays an important role in the development and maintenance of patients' problems, insofar as people make "conscious, willful commitments and choices [that] support and embellish unconscious commitments and choices" (p. 270). Furthermore, he concludes that the will plays a crucial role in analytic inquiry at critical points when the patient has to choose to look at that which has been repressed and disavowed. While Mitchell's discussion of the topic is valuable, his emphasis is on the role of will in analytic inquiry in general. My concern here is with the question of how the analyst can help patients to recover the experience of being able to will when they are in the depths of despair and experience their will as atrophied or non-existent.

It is here that Otto Rank's prescient and relatively neglected thinking about the will can be particularly helpful. According to Rank (1945), the ability to intentionally assert one's self within the world and to individuate from others involves the development of a healthy will. Developmentally, the expression of will is first manifested in the form of what he referred to as counter-will, that is, the assertion of will in opposition to the will of the parental figures. He believed that the exertion of will is inherently guilt-producing because it involves individuation and separation from the parental figures. It is thus particularly likely to be suppressed or prevented from healthy development if one's parents have difficulty accepting one's initial acts of self-assertion and individuation.

For Rank, the development of the will played a central role in analysis. In his thinking, the expression of the will is inextricably bound to the creative act, which for him is the sine qua non of healthy human existence and self-expression. Conversely, neurosis is associated with a paralysis of the will, resulting from the failure to succeed at the important developmental task of developing a sense of agency. A central aspect of
his therapeutic approach thus involved helping the individual to develop his or her stunted sense of will. According to him, therapy in some ways involves a recapitulation of the normal developmental process, and it is inevitable that patients will respond to analysts with counterwill in the same way they would with their parents. Counterwill in therapy is expressed in the form of resistance.

As Aron (1996) suggests, Rank's perspective on the role of will and counterwill in the analytic process provides an important tool for rethinking the concept of resistance from a relational perspective. From a Rankian perspective, resistance is not something to be worked through or analyzed. It is a process that should be nurtured, for it bears within it the seeds of healthy will, which if cultivated, will lead to the process of individuation and creative expression of the self. Over time, momentary experiences of agency can be transformed into the ability to engage in sustained pursuit of a chosen goal.

Often I find that with patients who feel completely hopeless and who have no experience of the capacity to choose and to act in accordance with their choices, the ability to will in opposition to me can be a critical turning point in therapy. I am thus particularly interested in subtle indications of nonresponsiveness, withdrawal, irritability, or criticism in my patients because, if properly explored, they can provide an opportunity for them to begin to express their counterwill in a more direct fashion (Safran & Muran, in press). This focus is similar in some respects to the type of intensive focus on the way in which patients respond to the analyst's interpretations, which is characteristic of the work of contemporary Kleinians such as Joseph (1989). While I admire Joseph's detailed attention to the more microscopic aspects of the patient-analyst interaction, I am less sympathetic to her readiness to interpret patient nonresponsiveness or criticism in terms of preexisting formulations regarding envy or aggression.

In general, my preference is to explore patients' experience of interventions that they have not experienced as facilitative, from their own internal point of reference, and to keep in mind that the process of directly criticizing or expressing opposition to the analyst can be instrumental in helping to remobilize their experience of agency and to shift out of a stance of helpless victimization. As Winnicott (1965) put it, "In the end the patient uses the analyst's failures, often quite small ones, perhaps maneuvered by the patient... and we have to put up with being in a limited context misunderstood. The operative factor is that the
patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control and is now staged in the transference" (p. 258).

In Benjamin's case, some of the most powerful sessions were those in which he was able to explicitly criticize me for not being more helpful to him. Early in treatment there would be sessions in which it felt like anything that I said evoked a type of cold, sullen withdrawal on his part, and what felt like a pained tolerance of my presence. On such occasions I might say something such as "It feels to me like the things I'm saying are really rubbing you the wrong way." In response, he would begin to acknowledge his anger at me for not being of greater help to him. This was a difficult thing for him to express, for he felt that "blaming me" was a reflection of his own immaturity. Over time I explored his feelings of shame about his anger at me as well as his fear that I would respond to his anger by abandoning him. I showed a genuine interest in hearing about his anger at me, and as he gradually came to express it more directly, he began to feel more empowered in his life in general.

The Problem of Responsibility

It is inevitable that we will feel frustrated when our patients are not changing, and the line between understanding that our patients are ultimately responsible for their lives and defensively blaming them can sometimes be a fine one. As Kaiser (1955) argued, however, the patient's task is not to take responsibility for changing, but to experience responsibility for his or her actions. The first step in taking responsibility for one's actions involves standing behind one's current actions, that is, experiencing one's current actions as chosen or willed.

In order for this shift to take place, patients must feel sufficiently self-accepting in the moment. The fact that they are currently feeling self-critical prevents them from fully seeing the way in which they are currently choosing to live their lives in a self-defeating way. To experience oneself as choosing one's unfortunate life can be a painful thing. People in pain and distress are already full of self-loathing. They feel blamed for something they have no control over. It thus becomes extremely hard for them to acknowledge the way in which they may be contributing to their own problems. People in despair have a constant experience of trying and failing, and then feeling condemned by self and others for their failure. They experience the will as atrophied and have no experience of
choosing their actions. An important element in the process of developing a sense of agency thus involves beginning to experience a sense of compassion for oneself. For this reason, the analyst who unconsciously feels condemning toward those who are not experiencing a sense of agency can make it even more difficult for them to begin to have such an experience. It is thus vital for us to be able to appreciate the phenomenological reality of being unable to will.

It is also helpful to remember that choices are not made at a global level, but rather on a moment-by-moment basis. Thus, in order for patients to begin to recover a sense of agency, it is helpful for them to discover the choices they are making in the moment in the therapeutic relationship. For example, the act of unconsciously resisting the exploration of a particular feeling or fantasy can be transformed into the act of intentionally deciding not to do so in the present moment.

In the early phases of treatment with Benjamin, it was customary for him to talk about his daily experience in a very general and superficial fashion that omitted details of interactions as well as any reference to underlying feelings or conflicts. Sessions often had a monotonous and redundant quality to them, with little if any sense of movement. When I would give him feedback about his style and ask him if he had any awareness of it, he would respond that there was nothing important to talk about. In this context I might respond with a simple question, such as, “Do you have any awareness of choosing not to talk about something right now?” or “Are you aware of avoiding anything in this moment?” Although at first he did not indicate any such awareness, over time he was able to begin acknowledging some awareness of not wanting to touch on painful feelings of shame and humiliation. He would then condemn himself for his cowardice and question the value of our work together, given the fact that he felt unable to go into things more deeply. At this point I would emphasize that it was important for us both to respect his need for privacy and for him not to push himself to talk about things before he was ready. This helped him to experience his resistance as legitimate and enabled him to stand behind it, rather than experience it as something outside of his control. Working in this way is reminiscent of Gray’s (1994) close process analysis. The emphasis, however, is on helping patients to experience the capacity to choose through identifying with a dissociated aspect of the self that is experienced to be in opposition to the analyst (Bromberg, 1995).
Optimal Disillusionment

Learning to will is only half the battle. The other half involves coming to terms with the limits of one's ability to obtain one's ends (Safran & Muran, in press). A recurring theme in the psychoanalytic literature is that the process of optimal disillusionment constitutes an essential ingredient of both normal, healthy development and a successful analytic process. While Freud emphasized the process of instinctual renunciation as the pathway toward maturity, contemporary relational analysts, influenced by theorists such as Ferenczi and Winnicott, are increasingly coming to emphasize the centrality of the negotiation between the needs of self versus the needs of the other. Mitchell (1993), for example, states that "What may be most crucial is neither gratification nor frustration, but the process of negotiation itself, in which the analyst finds his own particular way to confirm and participate in the patient's subjective experience yet slowly, over time, establishes his own presence and perspective in a way that the patient can find enriching rather than demolishing" (p. 196). Pizer (1992), as well, places the negotiation between the needs of the patient and analyst at the heart of the change process. According to him, "the transference-countertransference tapestry is woven between analysand and analyst through a process of intersubjective negotiation. Much of what is essentially mutative in the analytic relationship is rendered through mutual adjustments that occur largely out of awareness in both parties" (p. 217).

Historically, Ferenczi (1931, 1933) was the first to emphasize the hazards resulting from the infant becoming overly adapted to the needs of the parents, thereby losing his or her own vital, affective core. He believed that the therapeutic relationship can be used to allow the patient to abandon himself or herself to the phase of "passive object-love," that phase in which, like the infant, his or her needs are responded to perfectly by the other. According to him, when the patient experiences the inevitable limits of the analyst's responsiveness, a trauma ensues that constitutes a reenactment of the trauma the patient originally experienced. As Balint (1968) subsequently described, by working through this trauma in a constructive fashion, the analyst can provide the patient with a "new beginning" through which the patient finds a way to learn to relate to others without splitting off a part of the self.

Winnicott (1965) added further texture to this line of thought by sketching out a developmental process in which the mother gradually
moves from a state of primary maternal preoccupation and attunement to the infant's needs at the expense of her own, to one in which she becomes more attuned to her own needs. According to him, if this process takes place prematurely, the infant experiences an impingement on his own development or spontaneous experience and becomes overly adapted to the needs of the mother. If, however, this process takes place in a gradual enough fashion, the infant comes to accept the mother's separate existence without stifling his or her own bodily felt needs.

In Kohut's (1984) thinking, the notion of working through empathic failures in the analytic relationship is seen as the central mechanism of change. He elaborates on and extends a number of threads present in the writing of previous theorists. Whereas Ferenczi, Winnicott, and Balint all emphasized the importance of both reenacting a developmental trauma in the analytic relationship and reactivating an arrested developmental process, Kohut made it clear that it is the repeated process of working through failures that brings about change. He also emphasized that patients need an optimal balance between support and frustration in order to grow, and that support in the absence of frustration will block growth.

Why is this frustration essential to the growth process? Kohut framed his thinking on this point in terms of his notion of transmuting internalization. He believed that a tolerable degree of frustration enabled the patient to internalize certain selfobject functions of the analyst (e.g., soothing, validation of subjective experience, recognition and confirmation of uniqueness), thereby becoming more self-supporting, and not having to make pathological use of relationships to compensate for missing internal resources.

Although this conceptualization has a certain intuitive resonance, it is still sufficiently elusive to warrant further unpacking. One line of thought worth pursuing further concerns the relationship between the experience of loss and the development of guiding ideals and values. Thinking on this issue can be traced back to Freud's (1917) classic paper, "Mourning and Melancholia," in which he first observed that people establish an identification with abandoned objects as a way of dealing with loss. The notion that people develop ideals and values through identification with the lost object, however, fails to account (at least by itself) for the importance of repeatedly working through experiences of disappointment in the analytic relationship.

A second line of thought on this issue concerns the role that repeated
cycles of disappointment and repair play in modifying the patient's internal object relations, such that the self is experienced as capable of reestablishing relatedness once it has been ruptured and the other is represented as willing and available to work through and repair such ruptures (e.g., Beebe, Lachman & Jaffe, 1997; Safran, 1993). Through this process the patient can begin to develop faith in the possibility of relationships working out.

The disappointment that patients experience when the analyst fails them plays a critical role in helping them come to terms with the reality of the analyst's limitations. In the absence of working through this disappointment in an empathic fashion, however, the risk is that patients will retreat into a type of pseudomaturity that recognizes the analyst's limitations, but masks an underlying despair about the possibility of things ever being different. This results in a shutting down of one's spontaneous vitality, yearning, and hope.

When the analyst is able to empathize with this disappointment, however, patients are able to experience their disappointment as meaningful and the underlying yearning and desire as valid. This is critical because it promotes a growing acceptance of their own feelings and needs. At the same time, they are able to experience the analyst as being there for them in a certain way, despite the fact that he or she is not able to fulfill their fantasies of the ideal analyst. This is, of course, Winnicott's good-enough analyst, but it is worth meditating a little further on what exactly this means.

In relating to the analyst through their fantasies of the ideal helper, patients are essentially relating to her as a character in their own dramas, rather than in her own terms—as an object rather than as a subject. In a healthy developmental process, the individual, to some extent, comes to accept the independent existence of the other. One comes to accept the other's status as a subject rather than an object of one's desire, without having to stifle one's own creativity and bodily felt needs in order to maintain contact with the other. Although in some cases this disillusionment process—coming to terms with the separate existence of the other—is less traumatic than in others, it never takes place completely smoothly. To varying degrees we all spend our lives struggling with the challenge of maintaining a sense of self as a vital, alive, and real subject, at the same time maintaining a sense of others as real, independent subjects; but we continue to relate to others as objects, as characters in our own dramas, rather than as independent subjects.

Much has been written about intersubjectivity in recent years, and a
consensus is emerging that the process of coming to experience the other as a subject is an important part of normal development as well as of the successful analytic process (Aron, 1996; Benjamin, 1988). There is an aspect of intersubjectivity, however, that I would like to dwell on further. This involves relating to the other as a subject, in Buber’s (1958) sense of relating to the other as a “Thou” rather than as an “It.”

The I-It relationship, in which the other is related to as an object, is nonmutual. It is characterized by a lack of presentness, in that the other is related to in terms of preexisting categories rather than in his or her own terms. He or she is related to in terms of memories of the past or expectations of the future. The I-It relationship is planned, willed, or purposeful. A person’s actions in this mode of relating are means to an end rather than an end in itself. In contrast, the I-Thou relationship is characterized by mutuality, directness, presentness, and an absence of contrivance. It cannot be forced, but rather emerges in moments when one is able to let go of striving. It is thus associated with an experience of surrender or grace.

The journey from despair to hope involves a subtle dialectic between learning to will and to act on one’s own behalf and learning that others can and will help. When patients experience no capacity to will and to act on their own behalf, they experience themselves as victims. On the other hand, when they try to help themselves without any faith that the analyst will meet their efforts with his or her own, there is no opening for the analyst to be there for them. It can be useful in this context to distinguish between two different types of will—\textit{willfulness} versus \textit{will}—in a manner reminiscent of Ghent’s (1992) distinction between neediness and need.

\textit{Willfulness} has a desperate and contrived quality. It stems from a fundamental sense of despair about the possibility of things working out, a belief that the experience of relatedness to others is difficult to attain and that nurturance is not forthcoming. It thus has a frantic and effortful quality to it that blinds the individual to the subtleties and unique particulars of the present situation.

The foundation of \textit{will} is the basic trust that things will work out and that the world is fundamentally a hospitable place. The ability to will in this fashion evolves in the context of a basically dependable relationship with significant others that is not jeopardized by the expression of the individuals’s self-agency. Willing of this type has a spontaneous and relaxed quality to it. Because it takes place in the context of a fundamental
sense of trust, the experience of disappointment is not catastrophic. One does not need to be overly attached to the outcome of one's efforts. If one has faith in the future, one can invest more fully in the present moment, knowing that the future will take care of itself. One is thus better able to relate to the present moment as it is, rather than trying to force it to be something that it is not. In this same sense, one is better able to relate to the other as a subject, or in Buber's terms, as a Thou, rather than as an object of one's own needs. This paradoxically transforms the situation so that one is better able to be nourished through one's relationships with others. Willing in this fashion requires the type of faith that Bion (1970) speaks about.

The ongoing process of intersubjective negotiation in analysis can help patients to develop this type of faith in the following fashion. As they come to accept the analyst's limitations and to appreciate what he or she has to offer, without stifling their own vitality and bodily felt need, they are able to let go of their attempts to manipulate both self and other in pursuit of perfection. As their acceptance of their own pain and irrevocable aloneness increases, as well their faith that moments of comfort and real contact are possible, they become less desperate in pursuit of nurturance and less relentless in pursuit of some idealized state. This permits them to be receptive to those things that the analyst can provide (Safran & Muran, in press). This process is captured in certain respects by Winnicott's (1969) thinking about object usage, in the sense that the analyst's survival of the patient's destructiveness allows the analyst to be experienced as having an autonomous existence (thereby existing as more Thou than It). Winnicott, however, does not emphasize the interdependent nature of coming to accept both the analyst's limitations and one's own. Coming to accept the analyst as an autonomous being inevitably involves coming to accept his flaws. And this in turn allows him to serve as a model for the patient as a flawed human being who is nevertheless worthy of acceptance. At the same time, as patients become more accepting of their own desires and imperfections, they have less of a defensive need to reject or condemn the analyst's imperfections.

At first, Benjamin compared me unfavorably to a therapist he had consulted with briefly and who had seemed to him to be more “potent” than I was. Benjamin had experienced this therapist as more confrontative than I and imagined that the other had the capacity to help him achieve the type of dramatic breakthrough that did not seem forthcoming in our work together. At the same time he admitted to terminating treatment
with the other therapist because he felt frightened by him. Still, his disappointment in my failure to deliver something more substantial remained an ongoing theme. As our relationship evolved, however, and he was able to confront me with my limitations without destroying me, he gradually came to feel more tolerant and accepting of them. As his stance toward me softened, his stance toward himself softened as well, and he was gradually able to acknowledge his pain and longing for nurturance and support more directly. He spoke of feeling like a pariah because of his failure to establish a long-term romantic relationship, and I was able to feel genuinely caring for and connected to him in his despair. After one session, in which I had been particularly moved by his sadness, he remarked, “You know, you haven’t delivered the magic I’ve been looking for, but somehow that feels okay, right now. I don’t feel so alone anymore.”

I don’t want to end on an unrealistically positive note. I am still seeing Benjamin in treatment, and we still go through periods during which he despairs about the possibility of being helped by me. He acknowledges feeling somewhat stronger and more resilient as a result of our work together. He has not, however, gotten into a satisfactory intimate relationship with a woman, and at some fundamental level still feels dissatisfied with his life. Ironically, in some respects it is even more difficult for him to tell me when he feels despairing these days, because he does feel grateful and does not want to hurt me. By the same token, sometimes it is even more difficult for me to tolerate his despair than it was at the beginning; during such periods it can feel like all we have been through together is for naught. Periodically he contemplates leaving treatment. So far we have managed to work through these more difficult periods, and it feels to me that we have both been changed by this process. I am all too aware, however, that he may ultimately leave treatment during one of these periods; should this take place, an important task for me will be to struggle to have faith that the positive things I believe have come out of our work together are real.

**Conclusion**

A colleague who read an earlier version of this article asked me why I chose to use the term *faith* in the introduction rather than *hope*. Faith, it seems, has a more spiritual connotation than hope, although Bion (1970) was quick to insist that “faith is a scientific state of mind” (p. 32). The
virtue of the word faith, however, is that it implies something more than an expectation that a positive outcome will take place. Faith has a paradoxical quality to it, implying both a fundamental trust that things will be all right and a tolerance for not knowing what the final outcome will be or how it will emerge. For example, one can have both faith in the existence of a divine principle and the acceptance that “God moves in mysterious ways.” Thus faith implies something beyond simple hope. This is captured beautifully in Eliot’s (1963) “East Coker.”

I said to my soul, be still, and wait without hope
For hope would be hope for the wrong thing: wait without love
For love would be love of the wrong thing, there is yet faith
But the faith and the love and the hope are all in the waiting. [p. 186]

When patients are in despair, the analyst’s task is to help them wait. This can only be done when he or she is willing to struggle to wait along with them—without hope, desire, or understanding, with nothing but faith. As Bion (1970) suggested, it is this faith that makes it possible for the analyst and patient to tolerate the painful emotional experiences that are inevitably part of the analytic process for both of them.

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