

Reasonable Hope: Construct, Clinical Applications, and Supports

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Hope may be the most laden shorthand term of all time. Everyone wants it; few know how to articulate what it is. Although family therapists frequently work to restore hope with hopeless families, they have contributed little to the abundant literature on hope. I present a new conceptualization of hope—reasonable hope—that reflects how family therapists think and practice. By subscribing to reasonable hope, clinicians enhance their ability to offer accompaniment and bear witness to clients. I describe clinical practices that, informed by reasonable hope, also facilitate its cocreation. Finally, I suggest supports for clinicians who practice reasonable hope.

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How we think about hope has all to do with whether we can cocreate hopefulness with our clients and whether we can maintain our own. While family therapists work to restore hope in hopeless families, their ideas about hope and about how to promote it are often implicit not explicit in their practice.

Family therapists are not alone in this. Hope may be the most laden shorthand term of all time. From the Greek and Roman period to the present, hope has been a fundamental construct, with its meanings to individuals dependent on dominant cultural discourses and unique personal experience. Within theology, philosophy, medicine, psychiatry, psychology, nursing, sociology, and anthropology definitions of hope abound. Yet, few theoreticians have been able to move from the abstract to the pragmatic. Few clinicians have taken up the challenge to articulate specific connections between hope as a theoretical construct and hope as a practice.

Unlike Nietzsche (1878/2006), who wrote: “Hope is the worst of evils because it prolongs the torments of men,” I come down firmly on the side of hope's significance. Hope confers many advantages, for individuals (Cheavens, Michael, & Snyder, 2005) and societies (Bar-Tal, 2001). Individuals who are hopeful do better at problem-solving, at managing challenging situations, and even in coping with illness and disability (Snyder, Cheavens, & Cheavens, 1999). However, while hope may be desired, it is also

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difficult to sustain (Lynch, 1987). The conditions for hope are rarely felicitous. I offer the construct reasonable hope, a variant of hope, which I believe fits with how family therapists think and act and fits with conditions of contemporary life. I believe that it is wise for family therapists to make the practice of reasonable hope central to their clinical work and to find ways actively to support themselves as they endeavor to do reasonable hope.

PART ONE: LITERATURE REVIEW

Family therapists “know” that hope is beneficial but few have written about exactly what hope is and why it is advantageous. In her comprehensive review of the hope literature, Elliott (2005) makes reference to a single article on hope published in a family therapy journal.¹ Flaskas’ review (2007a) turns up comparably low numbers—two books (Flaskas, McCarthy, & Sheehan, 2007; Monk, Winslade, Crockett, & Epston, 1997), two articles (Perlesz, 1999; Weingarten, 2000), and one chapter (Hines, 1998).

It is more difficult to review the absence of a literature and speculate why than to categorize a robust literature. Yet that is the task in regard to hope in the family therapy literature. Before the second half of the 20th century, clinicians more often than not viewed hope as the special province of theology and philosophy, more a moral than a psychological construct. Starting in the 1950s, there began a trickle of interest in hope within the medical and psychological community. In 1959, Karl Menninger gave an address to the American Psychiatric Association, later published simply as “Hope,” in which he clearly held doctors responsible for enhancing a patient’s hope. This address coincided with the establishment of the field of family therapy whose most prominent leaders were psychiatrists. The language of Menninger’s address, the individualistic and paternalistic orientation of it, may have been objectionable to the zeitgeist of the family therapy pioneers, leading to an avoidance of the topic.

Other health service professions did not avoid the subject. In fact, one might say that hope has since become a growth industry, with medicine and nursing ultimately surpassing all other disciplines in their investigations of hope. In addition to the kick off provided by Menninger, specific claims for hope created interest in it. One such claim is that hope enhances the function of the immune system, a premise memorably articulated by Victor Frankl (1942/1963) when, recounting his experiences in Auschwitz, he wrote that there was an explicit link between “the state of mind of a man—his courage and hope, or lack of them—and the state of immunity of his body.”

Frankl, and others who followed him, drew upon a biological discourse within which to set their ideas about hope. It is not surprising, then, that beginning in the 1960s medicine dominated the direction of hope studies for the health sciences. Two additional areas of study also placed hope within the province of medicine by describing it as a biological not a social variable. One linked hope to the placebo effect (Frank, 1968). Another, following the work of Elizabeth Kübler-Ross (1969), made a patient’s hope a significant factor in health outcomes, including death. Given that at this time family therapists were eschewing the biological for more social and political discourses, hope was not an attractive area of inquiry.

¹The paper that she references happens to be mine, Weingarten (2000).

Other movements occurred in the 1970s in regard to hope. Sister Madeline Vaillot, a nurse, wrote persuasively about the nurse's role to "inspire hope" in patients (1970). Research on hope became a priority of the nursing profession (Farran, Herth, & Popovich, 1995; Herth, 2005). Gottschalk (1974), a psychiatrist, developed the first hope scale, inaugurating another phase in hope studies. Hope was no longer an abstract concept to be theorized but rather a within-person variable to be measured and manipulated. The 1980s saw a proliferation of hope scales; in each scale "hope was converted to a number" (Elliott, 2005, p. 22). At a time when family therapists were interviewing whole families and focusing on patterns of interactions, the turn toward the psychometric properties of hope had little appeal and seemingly little to offer. From the 1990s forward, the positive psychology movement dominated the work on hope in psychology (Seligman & Gillham, 2000; Snyder, Cheavens, & Michael, 2005).

Only a few articles on hope were published in family therapy journals in this intellectual environment. In 1981, Beavers & Kaslow published a paper calling on the family therapist to be an "ambassador of hope." Hof (1993), whose work falls within the tradition of positive psychology and who uses the language of instilling and fostering hope, provides a practical toolbox for therapists to enhance client hope. Perlesz (1999) cautions that therapists must understand that hope and despair frequently coexist; the task is not to fix the despair but to embrace both as so.

Clearly the literature on hope in family therapy does not do justice to the ways in which hope animates the perspective of so many clinicians who work with families. I join the small ranks of those who have tried to articulate both theory and practice in regard to hope (Flaskas et al., 2007).

PART TWO: CHARACTERISTICS OF REASONABLE HOPE

I distinguish reasonable hope as a variant of hope. Classic images of hope—a butterfly, a rainbow, an undemanding bird that perches in one's soul—set up expectations and standards that are without limit. Reasonable hope, consistent with the meaning of the modifier, suggests something both sensible and moderate, directing our attention to what is within reach more than what may be desired but unattainable. Many people, considering their experience in relation to "hope," are daunted by its accumulated lofty meanings in current cultural discourse and (wrongly) classify themselves as hopeless. Reasonable hope softens the polarity between hope and despair, hope and hopelessness (Flaskas, 2007b) and allows (more) people to place themselves in the category of the hopeful.

Reasonable hope refers to actions that one takes not, as hope does, feelings one may or may not be able to summon. A person who takes actions expressive of reasonable hope may act with others. Whereas hope is most often considered the attribute of an individual, reasonable hope can be the actions of one or many people.

Time is a critical dimension of our understanding of hope. Hope's objective is most often placed in an eagerly awaited future, with the arc of time between the present and the future filled with anticipation. Reasonable hope's objective is the process of making sense of what exists now in the belief that this prepares us to meet what lies ahead. With reasonable hope, the present is filled with working not waiting; we scaffold ourselves to prepare for the future.

The colloquial understanding of hope's trajectory is that of the progressive narrative (Gergen, 1988). Hope traces an upward flight, a line from current to better

circumstances. The line drawn to depict a reasonable hope narrative does not necessarily go straight from bottom left to top right. A variety of lines may represent a reasonable hope narrative because it is the activity of making sense of what is happening to us, not a positive outcome, that is the heart of reasonable hope.

Reasonable hope gives family therapists purchase; it provides a way of thinking about hope for therapist and client alike that makes it more accessible even in the grimmest circumstances. There are five characteristics of reasonable hope, which, taken singly or together, illustrate the construct. These characteristics are drawn from a number of domains, including writing on hope. They are that reasonable hope: is relational; consists of a practice; maintains that the future is open, uncertain, and influenceable; seeks goals and pathways to them; and accommodates doubt, contradictions, and despair.

Reasonable Hope is Relational

Hope is considered an attribute of an individual. In the last 35 years, there have been over 14 scales developed to measure hope in individuals (Elliott & Olver, 2002). Reasonable hope, on the other hand, flourishes in relationship. I liken it to the concept of *ubuntu*, an African concept probably most familiarly articulated by Archbishop Desmond Tutu. In describing *ubuntu* he has said, “A person is human precisely in being enveloped in the community of other human beings, in being caught up in the bundle of life” (Battle, 1997, p. 1). Or, put more simply, I am because we are.

I see reasonable hope in this way as well. I hope because we hope. Gabriel Marcel (1951/62) also writes about hope as relational. He calls it “choral” and he likens it to Buber’s I-Thou relationship. Yet, one cannot romanticize relationships; not all relationships will give rise to or support reasonable hope.

Reasonable Hope is a Practice

Reasonable hope is a practice; it is something we do with others. A practice is a program of action undertaken, not just or even for pragmatic purposes, but as an expression of who one wants to be and how one wants to act in the world (Griffith & Dsouza, 2010). Reasonable hope is about being not having (Marcel, 1951/62), doing not wishing. Reasonable hope as a practice is not about accomplishing a goal but about aiming toward it. It is—to quote the well-worn phrase—the journey not the arrival that matters. This emphasis on process is constitutive of reasonable hope.

Thinking of hope as a verb not a noun helps make the shift from considering hope as a feeling to considering reasonable hope as a practice. Hope as a verb automatically conjures a subject, a person who hopes. Hope as a noun is a quantifiable thing that resides within a person. An amount of hope is deemed appropriate for the circumstance and interventions are designed to enhance hope in those who are deemed deficient. Hope as a verb, as a practice, leads to different activities than hope as a noun. Reasonable hope as a practice, doing reasonable hope, is oriented to the here and now, toward actions that will bring people together to work toward a preferred future.

Reasonable Hope Maintains that the Future is Open, Uncertain, and Influenceable

Reasonable hope does not struggle against an uncertain, unknowable future, but rather embraces it as its best bet. In dire circumstances, for example, amidst violence, poverty, or fatal illness, it is precisely because we cannot know what the future may

bring that using reasonable hope, with its limited horizon of expectations, helps us work toward something better than what we are living now. The practice of reasonable hope feels justifiable because the future is not determined but is influenceable.

Marcel (1951/62) describes this “fundamental openness” as an expectant act of the whole person in which “the soul turns toward a light which it does not yet perceive, a light yet to be born” (p. 31). If we could count only on those future handholds that we could see, I suspect that for most of us the future would look scary indeed. It is because we can join with others, because creative communal synergies can happen, because spontaneous actions do arise from collective commitments that an open future is full of possibilities. Put differently, reasonable hope thrives in advance of a coherent image of the future (Ludema, Wilmot, & Srivastva, 1997). To return to Marcel’s image, it is precisely because the light is “yet to be born” that we can anticipate that we will be the ones who, together, create the light we seek.

Reasonable Hope Seeks Goals and Pathways to Them

We tend to feel hopeful when the goal is clear, the pathway known, and hopeless when the way is blocked, the goal obscure. Hopelessness arises from the conviction that nothing that one wants is within reach, whether love or security or health. As clinicians who subscribe to reasonable hope, we can cultivate a practice of identifying realistic goals and pathways toward them for ourselves and for others.

Clarifying realistic goals and pathways is not necessarily simple, even given the more modest expectations that occur with reasonable hope than with hope in general. First, there is often a lot of trial and error. Goals and pathways to them may have to replace each other at a rate one would never have expected or wanted. Second, life deals us circumstances in which we have to select goals and pathways we never thought we could accept (Weingarten, 2004a, 2004b). Yet, the practice of reforming goals and cultivating pathways to them stretches us, helping us sustain reasonable hope.

Elizabeth Buckley, LICSW, and her supervisee, Suzanne Hecker, who have applied this idea in an intensive, home-based therapy program for multistressed families, provide a wonderful example of this. A client of Hecker’s, with whom she had been working for several weeks toward reunification with her children, made an error, was now in jail overnight, and the Department of Social Services was working to remove her children permanently. The client had no legal recourse left. Both Buckley and Hecker felt hopeless as the goal they had worked toward evaporated.

Buckley writes:

I asked Suzanne what she was hoping for in this situation. I wrote it down. It was something like: “Bail Chloe out of jail, and make sure that the kids are returned to her.” We reflected together that she could work to make this happen, but that it was unlikely. What might her next hope be—just a bit smaller and more attainable than that one?

Suzanne thought that maybe Chloe could get bailed out of jail, and find out where her children had been placed. Again, we wondered together if this might be attainable, specifically since DSS would not grant permission for Suzanne to disclose the location of the children. Still, Suzanne thought—maybe it would be enough for Chloe to know they were safe? She could say that. Okay, I said, but what about the next smallest thing you can hope for? What if Chloe can’t get out of jail? Suzanne thought for a moment, and generated the idea that she and her co-clinician could make sure that they called Chloe, and maybe they could go

visit her in jail—to let her know that they still cared for her, and believed in her. And what would be the hope smaller than that? That they could write to her, to convey their hope for her in words, to reach out. This was, Suzanne thought, a hope that no one could interfere with. Suzanne began to wonder with me if it might be helpful to ask Chloe the same questions that I had asked her. (Hecker & Buckley, 2007, p. 3)

Reasonable hope is a humble hope. It allows reasonable goals to trump ideal ones. It is satisfied to do less than everything that needs to be done in order to ensure that something be done.

Reasonable Hope Accommodates Doubt, Contradictions, and Despair

Hope is a black and white category; it admits no doubt, no contradictions, no despair. Reasonable hope functions in a gray zone, where doubt, contradictions, and despair quite definitely coexist. Doubt and despair are not antithetical to reasonable hope but rather can run parallel (Perlesz, 1999) or be in dialectic relation to it (Byrne & McCarthy, 2007). One can feel despair and reasonable hope simultaneously, an experience that many people have. However, those who do often assume it means that their hope is insufficient to keep despair at bay.

Hope has a connotation of purity, whereas reasonable hope accepts that life can be messy. It embraces contradiction. Public life is rife with contradictions as is family life. Reasonable hope is easier to sustain since it does not get dashed, as innocent hope may, if contradictions emerge.

Serena is 8, angry, and confused. Her hopes for a “happy, normal family” have been crushed recently because she is having difficulty accepting contradictions. The youngest child in a family I see periodically, she was 3 when her parents separated for the final time. Her mother is dating for the first time in Serena’s memory and she hates it. “When Paul is there, she is not my mother anymore,” Serena says emphatically. “She looks different. Her laugh is so fake. She’s like a teen-ager. Disgusting!”

With no memories of her parents kissing or hugging, with no memories of her mother as a wife, she must integrate that her mother is her mother when she is also Paul’s girlfriend. She likes Paul and hopes her mother will marry him. Wanting something that also upsets her disorients her. “How can I hope for something I also hate?” she asks. Reasonable hope, with its acceptance of contradictions, offers her a platform on which to stand, even when she cannot stand what she must stand.

PART THREE: CLINICAL APPLICATIONS

A clinical practice based on the concept of reasonable hope is compatible with the systems thinking of family therapy. The construct of reasonable hope can be integrated into any model of family therapy since it infuses an attitude, informs a stance, and opens areas of inquiry that might otherwise be dormant. It does not specify or require any particular type of clinical work.

The five characteristics of reasonable hope make it a more robust concept than hope in general. Because our expectations of it are more realistic, we are less often disappointed by reasonable hope than hope. Clinicians cannot be effective with clients if their ways of thinking about hope make them vulnerable to feeling hopeless themselves.

It is important to work with hope. Research confirms that hope confers survival advantages (Groopman, 2004) and that hopelessness confers risk. Hopelessness correlates more strongly with suicide and predicts it better than depression (Grewal & Porter, 2007). Assisting clients with forming positive visions of a preferred future can be life-saving. Working with the idea of reasonable hope gives clinicians more latitude in imagining preferred, reachable futures.

One of the major tasks clinicians have is to accompany their clients through their suffering and hopelessness (Weingarten, 2004c). Clinicians can develop apathy as a numbing strategy when confronted with the hopelessness of their clients and the seemingly impossible task of instilling hope in them. By subscribing to reasonable hope, we enhance our ability to offer accompaniment and to bear witness (Felman & Laub, 1992; Weingarten, 2003a). The metaphor of accompaniment (Weingarten, 2004c) and the language of cocreation (Weingarten, 1991, 1992) rest on a different set of premises from the language of instilling or inspiring hope, which is the dominant language in hope studies. When the task is to instill hope, the therapist must provide the grounds for hope or hopeful thinking.

The language of cocreation of hope and of hope as something we do together derives from a different way of thinking. That is, no one gives or provides hope to another, but rather one creates the conversational space for hope to arise from the forms of conversation one shares. The clinician's responsibility is to create the conversational spaces in which reasonable hope rather than hopelessness is more likely to arise (Anderson, 1997; Larsen, Edey, & Lemay, 2007). When the task is to cocreate reasonable hope rather than instill hope, the bar changes from the unattainable to the attainable.

The application ideas that follow are an illustrative not exhaustive list of ways of cocreating reasonable hope with clients. Without the first two, it is difficult to succeed at the practice of reasonable hope.

Understand Your Witness Position

Providing witnessing is a key component in cocreating reasonable hope with clients. Thus, a crucial task for clinicians is to understand fully their witness position and attempt always to be aware and empowered witnesses. Anything less will likely not position therapists to have the perspective necessary to launch the kinds of conversations that cocreate reasonable hope.

To witness well, we must resist indifference (Weingarten, 2007, 2009). Indifference ropes us in by our feeling inadequate and then, overwhelmed. Recognizing these seductions is the first step of resisting indifference. The second step is recognizing our witness position (Weingarten, 2000, 2003a).

There are four witness positions that arise from the intersection of two dimensions: awareness and empowerment (Figure 1). Position One occurs when one is an aware and empowered witness to violence or violation. Taking action, and clarity about what actions to take, goes along with the experience of this witness position. A person is likely to feel competent and effective in Position One. Position Two may be the position that is most dangerous to others. People who witness violence and violation, who are oblivious about what they are witnessing, but nonetheless respond as if they know what they are doing, will be misguided. Their actions will be ineffective at best and harmful at worst. The negative impact of witnessing from this position may be

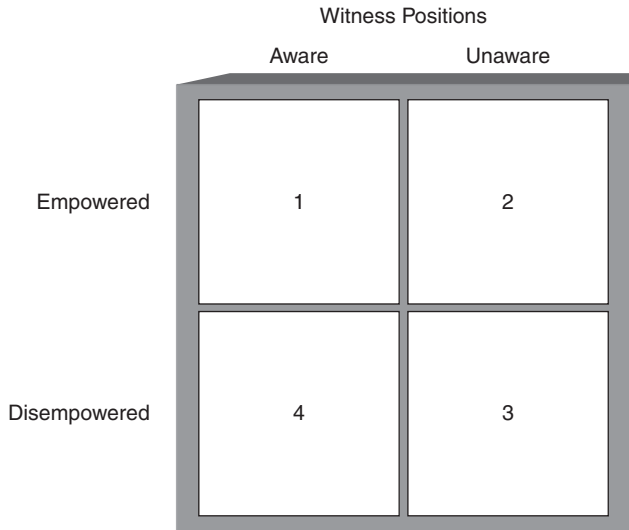


FIGURE 1. Reprinted from Weingarten (2000).

far-reaching, particularly if the person witnessing occupies a position of power or is perceived as having power. Position Three warrants a certain amount of pathos, except that the effects on others, not just the self, are so disastrous. If one is unaware and disempowered, the potential for being nonprotective when one should be protective and passive when one should be active is so great as to make it a near certainty. A professional who is unaware of and thus passive in relation to the urgent need of a client has abandoned that client and the effects may be as harmful as actions taken from Position Two. Position Four may be the most common for health care professionals. In this position, a person is aware but uncertain what to do or lacking the internal or external resources to act exactly as he or she knows to do. This position saps clinicians' energy, enthusiasm, and resolve.

Aware of our witness position, clinicians have a chance to change positions. An overwhelmed clinician may erroneously believe that relief can come by moving into unawareness, a cognitive numbing strategy. However, the only relief to the clinician and benefit to the client comes from moving into the aware and empowered position, i.e., moving up not over (Figure 2). Learning how to do that for ourselves helps clinicians assist clients to do it. When people work toward an aware and empowered position in relation to what they must witness, they manifest doing reasonable hope.

Assess for and Work with Trauma

There is a relationship between trauma and hope. Those with unrecognized trauma and those with unrelenting trauma are both often unable to feel hopeful. Trauma clamps down on hopefulness; fear trumps hope. Clinicians must recognize the ways trauma operates in clients' lives and work effectively with it. Fortunately, in the last

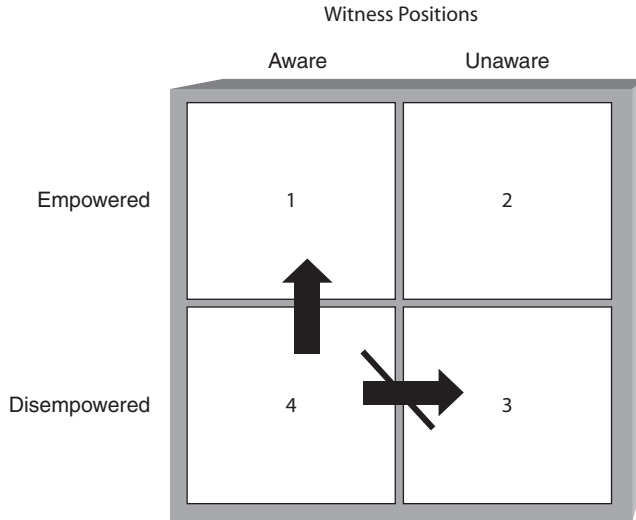


FIGURE 2. Moving into the Aware and Empowered Position: Moving Up Not Over.

30 years good treatment options have come to exist (Foa, Keane, & Friedman, 2000; Herman, 1992).

Hope requires ready access to the resources of the prefrontal cortex, which trauma diminishes. The amygdala, a key part of the limbic system, plays a decisive role in the experience of fear (LeDoux, 1998). Chronic exposure to stress can induce rapid and sustained excitation of the limbic system, creating the sensation of hyperarousal and fear. Work that quiets the limbic system is imperative to access hope. Richard Davidson and his colleagues at the University of Wisconsin have found that positive emotions that originate in the prefrontal cortex set off chemical cascades that flow to and infuse the limbic system (Davidson, 2003). (Chemicals flow the other way also.) The amygdala is quieted by the chemicals released by the prefrontal cortex.

Importantly for understanding reasonable hope, Davidson believes that setting goals and pursuing pathways toward them activates the reward circuitry of the prefrontal cortex, setting in motion the complex chemical interplay between the prefrontal cortex and the amygdala (Davidson, 2003). In a very tangible way then, assisting people with the formulation of goals and pathways toward them—doing reasonable hope—activates a neurochemical cascade that dampens fear and makes people feel more hopeful.

Family clinicians must have a superior grasp of how to work with trauma that includes understanding the neurobiology of trauma as well as its psychodynamics, family and societal dynamics. Family clinicians must be as comfortable helping traumatized clients develop good sleep hygiene, for instance, as they are comfortable helping clients talk about histories of neglect.

Unrecognized and/or unresolved trauma frequently underlies the seemingly frozen capacity of individuals, couples, and families to communicate well with each other and to resolve longstanding grievances. When unrecognized and unresolved trauma is at play or when the trauma is recognized but remains unmetabolized, there will be restrictions on hopefulness.

Alice and Douglas had been married for 12 years at the time of their consultation with me. While obviously connected and concerned about each other, they had little to say to each other and their conversation with me was flat and lacking in detail. They reported themselves as hopeless about the future.

After taking a careful history, it was clear that Alice had experienced significant physical and emotional abuse in her family of origin. She had emancipated herself at age 17 and had little contact with her family. Douglas alluded to Alice's "fits of rage," that terrified and infuriated him. Using the metaphor of unopened suitcases that the couple was carrying around, we decided to unpack them one at a time. The first "suitcase" they chose to unpack was an argument Alice and Douglas had while vacationing with a mutual friend during which Alice had exploded at Douglas and their friend such that the friendship had ended.

I gave this couple a primer on how unresolved trauma works, how triggers can stimulate "low road processing," and how one can "come back" from traumatically triggered emotional dysregulation (Siegel, 1999). In reviewing the circumstances surrounding Alice's explosion, the couple was able to see that specific factors were present that could account for Alice's loss of control. Alice's shame diminished and Douglas' fear of a "repeat performance" decreased, leaving the couple with more emotional vitality.

Provision of information about trauma and the tools to work with its manifestations within a family gives people grounds for reasonable hope. It provides a goal and a pathway to manage trauma reactivity. The couple accepted that Alice might have an altered neurobiology. They grasped that they could anticipate episodes of traumatic rage from signs of dysregulation, take steps to moderate outbursts and recover more quickly from them. Less saddled with a view of hope as a perfect state, they accepted that their imperfect relationship could be one in which they practiced reasonable hope with each other.

Cocreate Conversational Hope Spaces

Hopelessness thrives when the future is perceived as known, certain and bleak. Good therapy creates conversational spaces where the partners to that conversation have never spoken with each other before (Anderson, 1997). It is in these virgin clearings that new interactions can occur, new thoughts and feelings can be expressed, and known futures become uncertain again. Reasonable hope flourishes when the future is seen as uncertain and undetermined.

Rachel, 44 years old, and Tory, 19 years old, her ward for the past three years, consulted me about Rachel's being on the brink of asking Tory, whose mother died after a long illness, to leave home. Rachel and her partner, Sharon, had opened their home and their hearts to Tory, who blocked their earnest efforts to care for her like their own child. Infuriatingly to Rachel, Tory presented herself as the "victim," while Rachel saw Tory as continually abusing her trust and dedication. After about an hour, I introduced the notion that Tory still needed scaffolding to accomplish the tasks that other 19-year-olds were able to do on their own. Tory began to cry. She said, "I lost three years crying about my mother. Other people can do things I can't do." She then began to describe her relationship to her single mother whose boundaries were more like a friendship than the clear parent-child household in which she was now living.

Tory: I miss my mother and miss that way.

Interviewer: How were you with your mother?

Tory: I was loving.

Interviewer: Did you get separated from that way of being when she died?

Tory: Yes.

Interviewer: What else did you get separated from?

Tory: Trust.

Interviewer: What do mean?

Tory: I'm not trustworthy.

Interviewer: Are those things that you want to get back into your life? Do you prefer to be loving and trustworthy?

Tory: I do.

The conversational space shifted dramatically. Rachel had a moment of caring about Tory and Tory expressed interest in Rachel caring about her. They entered a conversational hope space, where the future is open. The space may close down but, for the moment, each person is motivated to try to live together in a more trusting and loving fashion. They are willing to try again because once more the future has become uncertain. Tory may change her defiant behavior; Rachel may feel a renewal of empathy for Tory. There are grounds for reasonable hope.

Interview for Resilience

Considerable research has shown the relationship between hope and resilience, in the direction of hopeful individuals manifesting greater resilience than individuals low in hope (Mednick et al., 2007; Seligman & Gillham, 2000). Helping clients perceive themselves as resilient increases their hopefulness. However, if the standard of hopefulness that must be attained admits of no complexities—no doubt or despair—many people will not stay in dialogue about resilience or hope. They will have predetermined that they cannot feel hope and are not resilient. Presenting ideas about doing reasonable hope with others increases the likelihood that clients will stay in conversations that negotiate their identities as resilient people (Ungar et al., 2007).

Ted first consulted me after his wife of 20 years asked for a divorce. Blindsided, Ted was simultaneously enraged, devastated, hopeless, and paralyzed. He felt betrayed by her actions and wanted to cut off contact with her. "If she wants a divorce, fine, I'll take care of myself," he said. In subsequent sessions, Ted returned to an anecdote that he had brought up in our first meeting: "All you need to know about me," he had said, "is that at our dinner table there were six boys. After prayers, I learned to leap across the table and grab the drumstick. That was how I survived."

Ted clearly saw his ability to put himself first as his hallmark survival skill. In his version of the scene, he elbowed his brothers out of the way, an aggressive ball of energy who got the goods. I asked Ted to tell me more about the dinner table.

Interviewer: Did you have fixed seats?

Ted: Yeah.

Interviewer: Who sat next to you?

Ted: My younger brother, John.

Interviewer: How did John do at dinner?

Ted: Fine. We always worked the table. John got the vegetable. We were going to have to eat them anyway and no one ever went after them. We always shared.

Learning about John and Ted's alliance shed new light on Ted's attributes and became the basis for expanding the story of Ted's survival path and ultimately his understanding of what qualities had contributed to his resilience (Walsh, 1998). He learned to appreciate his early aptitude for common purpose and cooperation. As his sense of himself as a collaborator and not just a fighter grew, he softened in his stance toward his wife. He became reasonably hopeful that regardless of whether he reunited with her, he was not destined for a solitary life and that he could cooperate with her around common goals.

Use Questions that Activate Reasonable Hope

Clinicians who work with the idea of doing reasonable hope convey three main ideas to their clients: 1. The practice of reasonable hope is more a course of action that allows one to follow a path toward a goal than it is a feeling. 2. Hoping does not preclude doubt and despair. 3. Others can help one do reasonable hope, both in imagining the goal and pathways toward it and in taking actions towards the realization of the goal.

Clinicians who wish to help clients practice reasonable hope build a repertoire of questions that activate awareness of all three of these component ideas.

Anna was a 37-year-old client of mine who returned to consult me after a three-year interval. She had just begun treatment for a curable cancer and was enraged at her misfortune. She said, "Cancer has cut hope off at the knees. It's mangled my hope that my life will ever be different." Eventually in the session I asked her, "*What is the work you need hope to do for you? What do you want hope for?*"

These questions took her off guard and were immediately generative for Anna. Without hesitation she answered, "When I have hope, I have the ability to imagine something good and then I can take steps to do it."

Interviewer: So what does hope actually do?

Anna: It illuminates the corridors. It helps me see the way out?

Interviewer: What about now? Is there a beam of light shining anywhere in the corridor? Can you see anything at all?

Anna: Truthfully, right now, there is a tiny beam and I can see a few steps ahead of me.

Interviewer: Who's holding the light?

Anna: I am.

Interviewer: Is that OK with you?

Anna: Damnit, you know it's not.

We were off and running. The questions had elicited an image that invigorated Anna and gave her many angles to explore. It triggered her imagination, unblocked her thinking, and unstuck the painful emotional rut she was in. It freed her to work on the very real dilemmas in her life. For instance, she wanted to know: Who could hold the flashlight when she got tired and why were there so few candidates for that position? How was she deciding which part of the corridor to illuminate and how did she know it was the best place? If she took the cancer as a wake-up call, where might she shine the light?

These conversations produced a corollary to the first two questions about hope. *What is your hopelessness insisting that you understand about your life?*

The conversations addressing each question took us into the domain of reasonable hope. None of the questions was a literal transform of the three main points articulated above, none uses the term reasonable hope and none uses an awkward syntax to ensure a verb not a noun form. That is not the point. The point is to ask questions that facilitate talking with clients in ways that are consonant with the idea of reasonable hope.

Identify Barriers and Supports for Reasonable Hope

Clinicians have always worked with clients to connect them to positive resources. When people are lacking in hope or are feeling hopeless, this work is exponentially more difficult since hopeless people generally withdraw from social contact, assuming that others share their grim view and share their negative view of them. The task for people who lack hope is to resist isolation (Weingarten, 2007, 2009).

The construct of reasonable hope is predicated on its being relational, something one does with others. It stands in contradistinction to the dominant discourse of hope as a feeling achieved by an individual. Conversations that identify barriers to association and gain support for affiliation cocreate reasonable hope with clients.

In the clinical illustration above, questioning about hope surfaced the relatively sparse social network with which Anna was engaged. A single woman, focused on her career for a sense of meaning, purpose, and economic survival, Anna had spent little time cultivating friendships. Only one friend and no colleagues knew about her cancer diagnosis and treatment. Part of our work together was to help Anna build a supportive network so that doing hope with others might be feasible.

We identified two longstanding friends whom she felt she could trust to tell about her current situation. Both were women who lived out of town. This initially felt safer to Anna and more likely to protect her privacy. After their very warm reception, Anna decided to confide in another friend who lived in her community. This conversation also went well. All three friends volunteered to spend leisure time with Anna to lighten up the coming months. Anna's sense of the future brightened as she imagined doing fun activities with her friends.

Assess for and Remove Obstructions to Love

Linares (2006) has written that Humberto Maturana said that obstructed love makes us ill. This simple pronouncement is a profound statement of the importance of relationships. It is also a succinct rationale for the work that family therapists do. We help people remove obstructions to love.

Hope is negatively affected when love is obstructed—in all the endlessly Byzantine and straightforward ways that can happen. Hope can be compromised between good friends, lovers, husband and wife, parent and child, or siblings. When obstructions to love are removed, people feel a resurgence of hope.

Given the characteristics of reasonable hope, it should be clear that obstructions to love can be removed in many ways. The bar is not set unrealistically high. The removal of an “obstruction” is not synonymous with the resurgence of passionate love between partners or harmony between generations.

An older couple consulted me about their strained relationship with the family of their married son. Over a period of time, they came to accept that the longed-for intimate relationship with his family was not possible. This led to a decrease in tension and restoration of some warmth that had been foreclosed by the implicit critical judgments that had accompanied the parents’ previous disappointment.

By accepting some losses, other gains open up. Reasonable hope provides a foundation for presenting this possibility to people who might otherwise believe that hope is lost if the preferred relationship cannot be achieved.

Clinicians are also in relationships of love with their clients. If clinicians do not come to love their clients they are not creating the conversational spaces for their clients to emerge as understandable, lovable people. Of course the love to which I refer is not romantic but the kind of love one has for one’s friend or child or neighbor. Nor is it unconditional love. Still, for many clients, the love of a therapist may be the first experience they have had of unselfish love. It is just as important in the therapeutic relationship to remove obstructions to love as it is important to help clients do so in their lives outside of the office.

I have proposed that therapy takes place in the conversational space between therapists and clients—in the ways they share meaning and share the meaning of the meanings that they share (Weingarten, 1992). Although intimate interaction, as I have defined it as the sharing and cocreation of meaning (Weingarten, 1991), is difficult to sustain moment by moment, this must be every therapist’s ultimate goal. The inevitable lapses that arise can become opportunities for reestablishing intimate interaction—removing obstructions to love—if the therapist is able to acknowledge his or her inability to understand or empathize with the clients when these episodes occur and if clients are helped to notice when they have contributed to lapses in rapport. This kind of acknowledgment and discussion, in and of itself, is therapeutic, for while the failure of intimacy is bound to be painful for both clients and therapists, it is not nearly as devastating as the failure to acknowledge and rectify these occurrences. It is by doing so that therapists work toward the removal of obstructions to love in all arenas of clients’ lives.

PART FOUR: SUPPORTS FOR CLINICIANS DOING REASONABLE HOPE WITH CLIENTS

The clinical practices presented in Part Three are best applied when clinicians have integrated an understanding of reasonable hope into their worldview, are comfortable with it and cognizant of the implications for caring for clients. While the construct of reasonable hope has value in circumstances that deplete hope, nonetheless, it is important for clinicians to identify activities that support them while doing reasonable hope with their clients. A list of activities that bolster morale can support a therapist

doing reasonable hope. Such a list would be long, for instance, finding inspiration in the arts, using global resources, being on the look out for courage, deeply engaging one's imagination, and investigating taken-for-granted categories. The activities described below specifically relate to sustaining reasonable hope. It is not surprising that many if not all of the activities that sustain reasonable hope for clinicians also sustain reasonable hope for clients.

Many clinicians find that a daily practice of awe—be it prayer, meditation, yoga, communing with nature, or reflecting in community—sustains reasonable hope. For some, a daily practice of awe makes possible all other activities, both personal and professional. A daily practice of awe contributes to a clinician's ability to offer radical listening, the kind of listening that neither judges nor prejudices, that hears what is absent as much as what is present, that pauses when words fail, and that is, above all, welcoming (Weingarten, 1995). Any of the activities suggested below are compatible with a daily practice of awe.

Believe that the Small is Not Trivial

All too often clinicians sit with clients and become mesmerized, as the clients may have, by the enormity of the problems the clients face. Whether it is a multigenerational history of abuse, extreme poverty, or intractable fighting, the problem may overwhelm the clinician. When we work with clients within a framework of reasonable hope, we are not casting about for the perfect solution but are considering what may be good enough. From this perspective, we realize that small actions need not be trivial. They may also have ripple effects.

Nancy, 54 years old, had struggled mightily with her acting out daughter, Martine, 20 years old. After a rocky high school career and a “wasted” year off, Martine moved to Philadelphia, where she began college. It was her habit to call Nancy whenever she happened to be walking on the street, whether going to classes or returning from a late-night party. Nancy was so relieved that Martine was in contact with her that she gave no indication that she often called at inappropriate times.

During these brief phone calls Martine never inquired about her mother but rather treated her like a toxic waste dump, depositing her angst and distress. After many months, Nancy felt depleted, depressed and helpless. She knew she had to set a limit with Martine but she was terrified that if she did so, Martine would recoil and cut her off. Nancy consulted a therapist and together they looked at how to address Martine's issues: her compulsive spending, her poor self-esteem, her difficulty maintaining friendships, and her marijuana habit. Looking at the “big picture” of Martine's difficulties and the complexities of the relationship, neither Nancy nor her therapist could imagine intervening effectively. After advice from her peer supervision colleagues, the therapist shared a new insight with Nancy. While Nancy might not be able to solve the dysfunctional pattern, she could take self-protective steps. Coached by the therapist and supported by her husband, one morning Nancy calmly told Martine, “I love you and I can't really listen to this anymore. I'll call you in a couple of days.”

Nancy felt better and there were no negative repercussions with Martine. Nancy learned to assess when she had had enough and to calmly tell Martine this. She realized that sometimes trying to fix everything prevents us from solving what we can. Her behavior kindled reasonable hope.

Accept Proxy Measures of Success

Clay Ward is an artist affiliated with MIT in Cambridge. In March 2007, learning that a homeless man was set alight while sleeping in a park, he and a group of colleagues staged an art installation on the very spot where the man was assaulted. Believing that all homeless people are entitled to permanent housing, that no homeless person should ever be assaulted, the group scaled their goal to one they could fight for in the present and developed two pathways toward reaching it. Their poster, a succinct educational tool, stating that a “Safe Bed Is A Human Right” has been widely disseminated and their art installation jump started a community response to issues of protection and shelter for the homeless.

Clearly, they could not immediately wave a wand and achieve their goal of safe shelter beds for all. But by accepting proxy measures to their goal, in this case publicity and community pressure, they believed they could come closer. Working with the idea of reasonable hope opens us to options that may previously have been viewed as too distant from exactly what we have wanted. Doing reasonable hope with others means we cannot know in advance what will unfold, since collective effort produces synergies that solo action does not. It is this uncertainty, also, that makes accepting proxy measures to our goals sustainable.

Register Reasonable Hope

We are used to the progressive narrative of hope, which we learn when we are young. We learn its visual tropes—rainbows, butterflies, looking up—and its auditory ones—laughter, song, the vocal lilt. But the images and sounds of reasonable hope may well be different. As therapists, the task is to train ourselves to see and hear signs of reasonable hope. A colleague of mine at the Family Institute of Cambridge, Elizabeth Buckley, showed a portion of an interview she had done with a 32-year-old former heroin addict, the mother of two school-aged children who had relinquished her children to her own mother. The children had recently reunited with their mother.

Ms. Buckley: Why didn't you want your kids to see you using? Why didn't you want them around the life you were living?

Mother: I thought it would be safer for them.

Ms. Buckley: You made this decision, not DSS. What does this say about your hopes for the children?

Ms. Buckley skillfully heard an aspiration of reasonable hope amidst the mother's tale of turmoil during her days of addiction. By amplifying that aspect of the mother's account, she also made it more likely that her client would carry that image of herself forward.

Welcome Joy

It may be hard to imagine that one can notice reasonable hope in situations that are dire. It may seem odd to feel joy or to allow oneself to feel joy amidst the worst conditions on the planet. Yet joy can support reasonable hope and in some circumstances contributes to it.

My daughter, Miranda Worthen, has been working for the last 5 years in 22 communities in Sierra Leone, Liberia, and Northern Uganda with former girl soldiers who became mothers in the bush (<http://www.PARGirlMothers.com>; McKay, Burman, Gonsalves, & Worthen, 2004). In these communities, families and villagers often reject girls who return home after the war with the babies they conceived while with the rebels. According to Miranda, most of the girls and their children experience physical and psychological health problems. When asked about her experience of letting herself feel joy as a deliberate strategy to manage the grim conditions she witnesses, she said:

When we go to the field sites, we see the girls themselves feel joy. Not always, of course, but they can. They may burst into song spontaneously or planfully and if they do, the energy just changes. It lifts up. And this isn't merely escapism, but something they understand they have as a resource. . . . Watching them, as an outsider, I let myself feel that joy. I think you'd have to deny their experience to not feel that joy. . . . Back home, I do feel joy. One of the things I am working for in the world is for everyone to feel joy, security and happiness. I shouldn't deny myself those experiences even if some people don't have them yet. . . . Being engaged in the process of change . . . gives me a lot of joy and enthusiasm and excitement. I can go to a field site and see something really awful and know that something is going to change, has changed.

Of interest, one of the few psychologists to explore the concept of joy, Verena Kast (2004), notes that joy is a foundation for alliance and solidarity, precisely the conditions this project strives to create.

Enjoy Vicarious Hope

Hope confers many advantages. However, we cannot always maintain our hope, especially when we work under challenging conditions, are relentlessly exposed to violence and its aftermath or have pileups of personal misfortune. Under these conditions, another channel may open for us: vicarious hope. Vicarious hope, like vicarious resilience, a concept introduced by Hernandez, Gangsei, and Engstrom (2007), arises when we allow ourselves to be influenced by the hope that others express and to join in on the actions that they take. This is a bit like drafting during a bicycle race. We accept that we do not have the resources even to do reasonable hope and allow ourselves to be buoyed by others who do.

A therapist was in a supervision group with a woman in her seventies whose second marriage ended precipitously in divorce. The therapist watched her colleague move through grief to acceptance to contentment over a period of years. When her own husband was diagnosed with a terminal illness she was shattered and felt despair. However, she drew comfort from the example of her colleague and believed that she could survive and thrive because her colleague had. She experienced reasonable hope vicariously until she could summon her own.

Embrace Resistance

The practice of reasonable hope is compatible with incorporating social justice concerns into clinical work. Three ideas that are conceptually linked to reasonable hope make the connection straightforward: holding modest expectations, accepting proxy measures of the goal, and believing that uncertainty is an ally. A fourth idea

provides the tightest link between social justice and reasonable hope, namely that we must resist what is unjust to realize what is just. Recognizing and resisting unfair conditions sustains a practice of reasonable hope. It feels good to notice what is unjust and to work for what is just.

Roger Gottlieb (2003), who has written about the spirituality of resistance, writes: “We can open our hearts to full acceptance of the world, but not by telling others or ourselves that there is some cosmic meaning for all of this pain. Instead, we find that the only way to fully take in what surrounds us, to be fully at peace, is to resist” (p. 159).

Mark and Sharon consulted me with their 12-year-old daughter Molly who had written them a note expressing rage and informing them not to have any guns or poison around the house. During the interview my questions surfaced a primary cause of Molly’s anger: unfairness at school, particularly by the principal who seemed biased to Molly against the “kids who are too poor to pay for their lunches. That’s about half the kids who come from downtown.” During the interview, we learned how ineffective Molly felt “fighting for justice” and we identified ways her parents could help her be more effective. We supported her healthy ways of resisting what was unjust and identified means to diminish unhealthy ways.²

Grounded in principles, anchored in commitments, resisting can feel like our roots are deep in the ground and our hearts are soaring. This form of resistance is not about rejection but about connection. It seeks what people deserve, namely a just society. Resisting what is not just and pursuing what is just activates and promotes reasonable hope.

CONCLUSION

Hope confers many advantages to individuals (Cheavans et al., 2005; Groopman, 2004) and it is imperative that family therapists—who work with hopeless families and family members all the time—work productively with it. By conceptualizing reasonable hope as something we do together, I have brought hope in line with the traditions of family therapy, making it a more viable and reliable resource for clinicians. When we practice reasonable hope with our clients, we become part of the process by which possible futures emerge. In this way, doing reasonable hope together becomes a profoundly creative process, requiring radical listening (Weingarten, 1995) and a radically open heart.

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² For a more complete version of this case see Weingarten (2003b).

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