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Hope as a motivational agent

La esperanza como agente motivador

Sandra Buechler

William Alanson White Institute

Abstract

This paper explores hope as an agent of change in psychotherapeutic treatment. Throughout my clinical career, the work of H.S. Sullivan, Frieda Fromm-Reichmann, and Erich Fromm inspired hopefulness in me. I greatly benefitted from their perspectives about sources of their patients' motivation to grow. Their unyielding hope, dedication to their work, courage, integrity, belief in human potential, and other qualities made them inspiring role models. Each of these three psychoanalysts contributed to my hopefulness a unique way. Studying the theoretical contributions of H.S. Sullivan, and being supervised by his followers, gave me a basic framework for treatment, which increased my confidence as a clinician. Frieda Fromm-Reichmann served as a model of therapeutic dedication and absolute conviction in the value of therapy. The writing of Erich Fromm provided guidance about treatment's (and life's) ultimate goals, maintaining faith in the process, (even in the absence of signs of progress), living a passionate, socially responsible, ethically committed life, and working toward the fullest use of my own potential.

Keywords: hope, psychotherapy, motivation

Resumen

Este artículo explora la esperanza como un agente de cambio en el tratamiento psicoterapéutico. A través de mi carrera clínica, los trabajos de H. S. Sullivan, Frieda Fromm-Reichmann y Erich Fromm inspiraron la esperanza en mí. Me beneficié ampliamente de sus perspectivas sobre las fuentes de motivación de sus pacientes para crecer. Su esperanza inflexible, su dedicación al su trabajo, coraje, integridad, creencia en el potencial humano, y otras cualidades hicieron de ellos modelos inspiradores. Cada uno de estos tres psicoanalistas contribuyó a mi esperanza de una forma única. Estudiar las aportaciones teóricas de H. S. Sullivan y ser supervisada por sus seguidores me proporcionó un marco básico para el tratamiento, lo que aumentó mi confianza como clínica. Frieda Fromm-Reichmann me sirvió de modelo de dedicación terapéutica y convicción absoluta en el valor de la terapia. Los escritos de Erich Fromm me orientaron sobre los objetivos últimos del tratamiento (y de la vida), sobre cómo mantener la fe en el proceso (incluso en ausencia de signos de progreso), sobre cómo vivir una vida apasionada, socialmente responsable y éticamente comprometida, y sobre cómo trabajar para aprovechar al máximo mi propio potencial.

Palabras clave: esperanza, psicoterapia, motivación

La correspondencia sobre este trabajo debe enviarse a sbuechler2@msn.com

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One of the most powerful sources of the motivation to grow is a combination of hope and love. Out of love for her husband and hope for their future, a long-term patient gambled that they could raise a child together, despite her history of crippling depression. Out of hope and love another mother faced her alcoholism, and the inner emptiness that fueled it. Another patient, a middle-aged man, hoped treatment would enable him to form a lasting relationship, despite decades of fruitless efforts in a previous classical analysis. A severely depressed, wheelchair bound abuse victim dared to hope for a career and intimate relationship and faced seemingly impossible obstacles. A woman, hounded by terrible nightmares and suicidal fantasies, came to treatment hoping for the health that could enable her to become a freer person and wife. A middle-aged woman, who had lived most of her life in institutions, dared to hope for a life in the outside world. A young man, newly released from a mental hospital, plagued by compulsions, still inwardly bound to his abusive parents, somehow preserved hope for a normal life. An elderly woman with a progressive hearing loss still hoped to preserve, and improve, her communication with her sister. Another patient, who had suffered from cancer and was likely to die from a recurrence, hoped to make the most of the disease-free time she had left. A man, hospitalized after losing all four of his arms and legs in battle, hoped to learn to paint with his teeth. Another man, recently blinded in a car accident, struggled to discover new interests that didn't require sight. The combination of hope and love can be a powerful motivator of the determination to benefit from treatment. The love can be love for oneself, a partner, a child, or even life itself. For the clinician, the challenge is to nurture that hope, in the patient and in ourselves.

After more than 50 years of clinical work, I still find hope mysterious. Where does it come from? What can we do when it is absent? Why can some people hold onto hope, through life shattering traumas? Did someone believe in them at some crucial point? Did they know someone who was a model of hope? Even when, somehow, glimmers of hope still exist, in spite of horrendous circumstances, what can keep it alive long enough to enlist it to motivate change?

In this paper, I explore how the writing of three Interpersonal psychoanalysis has helped me maintain hope as a clinician. H.S, Sullivan, Frieda Fromm Reichmann, and Erich Fromm were like my psychoanalytic grandparents, in that they were the teachers of all my teachers at the William Alanson White Institute, where I trained from 1979-1983. While I never met them personally, I felt their presence in the people who molded me as an analyst, including my training analyst, supervisors, and teachers. I will try to identify some of the ways their thinking promoted hope in me as a clinician and, more generally, as a human being. First, a quotation from Stephen Mitchell, from his book (1993) on hope and dread in psychoanalysis:

> The more we have explored the complexities of countertransference, the more we have come to realize how personal a stake the analyst inevitably has in the proceedings. It is important to be able to help; it makes us anxious when we are prevented from helping or do not know how to help. Our hopes for the patient are inextricably bound up with our hopes for ourselves. (Mitchell, 1993, p. 208)

My training as a basis for hope

During my training and my clinical career, I frequently looked to H.S, Sullivan, Frieda Fromm Reichmann, and Erich Fromm for inspiration. I found it in their passionate

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dedication to treatment. While they used different words, I think there was some significant overlap in their visions of the need to define health and work toward it.

Sullivan's Inspiring Dedication

Sullivan was my hero during my graduate school days, and beyond. Looking back, I think his work provided a singular voice of hope. Sullivan inspired through his profound dedication to his patients' welfare. I was struggling to find some way of bearing the bleak conditions and searing tragedies in the State and Veterans hospitals where I worked as a young psychologist. The walls were dingy, the professional staff mainly burnt out, the patients in varying states of mind. Some, recently released from military service in Vietnam, were not psychotic, but were intensely angry. Many had lost their spirits, in addition to limbs or other body parts. In one hospital, the average stay was twenty years. Many patients had not taken their medication in years. They found creative ways to dispose of it, some feeding it to the cats that roved the hospital grounds.

I was unprepared for these jobs, in many senses. Sullivan was a beacon in this bleak picture. Here was someone who believed even patients in the chronic wards were "more simply human than otherwise"! Here was someone who thought he could actually help them! As I look back, about half a century later, I think Sullivan's fundamental optimism, his mid-century "can do" spirit, greatly encouraged me. His famous "one genus" concept (1953, p.32) was that "...everyone is much more simply human than otherwise..." I think he is saying two important things in this postulate.

1. He has a humanistic intention. The regressed schizophrenic is a human being who can, potentially, be understood by other human beings, and deserves the respect we expect to be accorded to ourselves.

2. The unique individuality of the patient is not the psychiatrist's primary focus (but that does not mean it doesn't exist). We get further in treatment if we assume that human living occurs in characteristic patterns that we can know, and use, in understanding a particular person.

I think this postulate was enough to inspire me, in itself. It spoke to me of hope. The ranting patient who frightened me was a human being, more like than unlike other people I knew. He had been an infant and had a history. He was born needing contact with other people, however he acted toward them now. Perhaps if I treated him with these beliefs in mind, I could reach him.

Many experiences reinforced this idea. For example, one patient wouldn't speak to me, but played the song "For Once in My Life" every time I walked on the ward. However strange and limited it was, we had a relationship.

I think Sullivan's "one-genus postulate" inspired me because, first of all, it communicated respect, for my patients and for the work I was trying to do. I was very young and idealistic. I needed a sense that what I was doing was worthwhile. Beyond that, I think it told me that I could use what I did know (about myself and others) to begin to understand my "simply human" patients. They were not a foreign species. It began to feel both possible, and worthwhile, to stretch to try to reach them emotionally.

Studying Sullivan helped my sense of competence and confidence

Based on Sullivan's (1953, 1954, 1956) writings, I was taught a basic framework for treatment. It included frame setting as a first phase of the work. I include in frame setting trying to be as clear as possible about both participants' expectations. The next phase consists of taking a rather extensive history. It lays the groundwork for later understandings. While each treatment, and each history, is different, we usually try to find out about the patient's life experiences at home, at school and later work, and with friends and later partners. I usually start a history by asking about "the situation you were born into." This is just as much a statement as a question. We were all born into an environment, an interpersonal, social, geographic, temporal context, which will affect our experience growing up. The bulk of the treatment is called the detailed inquiry. In it, Sullivan emphasizes staying in touch with even minute shifts in the patient's level of anxiety. I would broaden that to include staying in touch with shifts in my own anxiety, and shifts in intensity of all the fundamental emotions, in each participant. Fundamental emotions include curiosity, joy, sadness, disgust, anger, fear, shame, guilt, and contempt. During the detailed inquiry interpersonal patterns get clarified. My way of talking about this is to try to understand what recurs in the patient's interpersonal life. I hope to inspire the patient's curiosity about him or herself. I believe that a great deal of treatment really occurs outside the session, as the patient notices reactions, interactions, feelings that might have gone unnoticed previously. As I have written many times, I believe that it is principally life experience that cures people, but treatment can make more life experience possible. My hope is that the way we live the session together, and the enhanced self-awareness and appreciation of emotional nuance, will facilitate more life outside the session. This way of working can make the treatment a true collaboration. Each participant has a crucial role. Neither can function without the other. But, perhaps just as important, each can conceivably fulfill their function, with effort.

Tracking fluctuations in the patient's anxiety, my own, and shifts in other feelings, gives me a pretty clear task. History taking and observing emotional shifts is work that requires alertness, concentration, effort, and the ability to organize. But they can be done. With experience, they begin to feel more familiar.

Emotionally, having a relatively clear task helps me feel more competent and, in a certain sense, more hopeful. There is a certain "can-do" quality in this way of working. It can make you feel that it is possible, in Sullivan's language, to profit from one's experience. Embedded in this ideology is a faith that people have, in his words, a drive toward health. Furthermore, when we look at what has interpersonally recurred in the patient's life, we are likely to see similar patterns in the treatment relationship, and, perhaps, in our own life, or the lives of others we have known. This demonstrates that we are all more human than otherwise. It can promote a kind of carryover from what we have learned from literature, art, our personal relationships, our personal treatment, and many other sources. We can bring our whole selves to our work.

The analyst's role can be described as a complicated process of self and other observation. The importance to Sullivan (1954) of being a good observer cannot be overstated. Without good observation we can't know what makes the patient anxious, we can't monitor the effect we are having on the patient, we can't modulate the inquiry to keep anxiety at tolerable levels, and we can't recognize the defenses the patient uses when he is made anxious. Through observation and inquiry, the clinician pictures the situation the patient describes, getting a feel for what the patient might be defensively leaving out of the story. Observation is, of course, central to Sullivan's conception of the analyst as a participant observer. I think of our movement in treatment as a kind of rocking motion

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between participation and observation. As participation gathers momentum we begin to shift toward an observing stance, and vs. versa. But I would extend this to say that participant observation is as important for the patient as the analyst. Nurturing this capacity is a significant part of the work.

Several of my supervisors taught me that, very frequently, change precedes insight. That is, for example, one patient avoided most social contact. As this changed, and she exposed herself to peers, she began to feel the anxiety social contact stimulates in her. This helped her understand why she had avoided socializing in the past. In other words, changing her behavior brought her insight about her old patterns. Once again, I think this approach can evoke hope in both participants.

Conviction as a source of strength in the work of Fromm-Reichmann

Frieda Fromm-Reichmann verbalized her strong beliefs about what constituted emotional health and enacted them in her work with patients. I believe the strength of these convictions greatly contributed to her therapeutic effectiveness. A German Jew, Frieda (biographical data taken from Hornstein, 2000) was born to Adolf and Klara Reichmann on October 23, 1889, about ten months after her parents' marriage. From early in her life, she used her talent for understanding emotional nuances to help soothe hurt feelings in those around her. Frieda began her medical training in 1908, the first year women were admitted to Konigsberg's university, the Albertina. Some of the professors were openly antagonistic to teaching women, putting Frieda, among others, through humiliating trials. Frieda responded with a determination to excel in all her courses and succeeded.

Frieda's approach embodied her irrepressible hope, determination, hard work, and strong belief in the patient's inherent self-curing powers. She integrated these attitudes with the values she learned from her Judaic background. In danger from the Nazis, Frieda fled, first to Palestine, and then to the United States in 1935, where she got a job at Chestnut Lodge in Rockville, Maryland, and started a new life. Chestnut Lodge was a mental hospital that specialized in the psychoanalysis of psychotic patients. In this phase of her life, Frieda was totally dedicated to her career. She had a cottage on the grounds of the hospital and made little separation between her personal and professional activities. More than one hundred of Frieda's relatives were killed by the Nazis. During these years Frieda worked tirelessly, perhaps partially out of survivor's guilt, certainly out of a need for money, and clearly, out of a passionate desire to be of help to her patients.

Once at the Lodge, Frieda was able to enlist others, including Harry Stack Sullivan, in her efforts to save colleagues, friends, and their families from the Nazis. Sullivan became one of her closest friends and taught a four year seminar at Chestnut Lodge. Both clinicians were extraordinarily able to reach even the most disturbed patients. Focusing on the interpersonal nature of treatment they became intensely interested in each other's ideas.

In 1950, Frieda published her major work, Principles of Intensive Psychotherapy. Colleagues agree that she saw treatment as a mutual adventure, urged her patients to guide the process, and had an unshakable belief in psychotherapy. Time after time she refused to give up on her patients, going to extraordinary lengths to reach them. As may be expected, she couldn't reach them all. But, like Ferenczi, she worked tirelessly and suffered greatly on their behalf. In addition to the patients she reached, she also had a

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significant impact on a whole generation of young clinicians. What is the legacy that Frieda left for future generations of clinicians? Surely, part of it is her embodiment of certain attitudes toward life in general, and treatment in particular. For example, even her detractors saw her clinical work and writing as expressing an abiding sense of purpose. As I (2004) understand it, having a strong sense of purpose requires that the analyst embrace several seemingly contradictory truths. Clinical work occurs in a particular time and place but also, in a sense, outside time. It is based on a profound acceptance of patients as they are now, and a powerful need for change to occur. It attempts to know the ultimately unknowable unconscious. It is an interpersonal process where two equal human beings play very different roles that can, at times, feel hierarchical. The analyst is paid as an "expert" in a process that, by definition, is largely ineffable.

Training is the process whereby clinicians learn to hold these seemingly contradictory truths simultaneously. Hopefully, at the same time, they are learning to embody a sense of purpose, and inspire it in their patients.

The need to experience our work as having purpose is embedded in a set of fundamental clinical values that clinicians absorb from our professional culture. This sense of purpose includes an expectation that the work will be meaningful. The clinician's sense of purpose is most often expressed in what we privilege. That is, our attitude of purposefulness shows itself in a focus that looks for meaning and both embraces and eradicates time.

Frieda's approach has been immortalized in a book written (Green, 1964) by her former patient, entitled I Never Promised You a Rose Garden. In it, "Dr. Fried" (who represents Frieda) clearly asserts that she can bear whatever Deborah, her patient, thinks and feels. As I read it, this frees Deborah to speak without worrying about her impact. For example, at one point (p.53) Dr. Fried tells Deborah to declare to her inner demons that this therapist won't be cowed by them. Their work will continue, no matter what. Since Deborah thinks of herself as poison, Dr. Fried must convince Deborah that she has the capacity to withstand her patient's rages, terror, binges of self-destruction, and scathing contempt.

At the same time, Dr. Fried allows her empathic permeability to show. I think the combination of durable strength and empathic sensitivity is crucial to her inspiration of hope in her patient. One without the other would not have been enough. Throughout the book Dr. Fried clearly expresses her anger at Deborah's tormentors, from the anti-Semitic children and adults who shunned her, to the unfeeling doctors who lied to her about the unbearable pain their medical procedures would cause. Dr. Fried shows she is a sensitive yet sturdy human being. Elsewhere (2008) I discuss the need for the clinician to be "semi-permeable." It must be possible to get through to us, yet not possible to destroy us. We must show we are porous, that our emotional skin can be penetrated. But we don't lose our own shape. Dr. Fried is penetrable and steady as a rock. This allows Deborah to unleash her rage, voice her despair, whisper her terror.

How Frieda Inspired Hope

It would be hard to imagine a more despairing human being than Deborah at the beginning of this treatment. Her experience is of a drab, colorless world. This is true for her on a literal as well as a figurative level. She feels permanently relegated to a position outside the human race. She will always be "other." So when (p.143) Dr. Fried declares

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that she will not betray Deborah, the patient challenges her to prove it. Deborah has heard too many promises that turn out to be meaningless. Dr. Fried is undaunted, answering that time will show Deborah that she is trustworthy. I believe that the hope that is kindled in the patient begins as a belief in Dr. Fried's absolute integrity. Whatever this clinician promises will be delivered. She doesn't promise "rose gardens." But she does promise effort. And she means it.

In a number of books and chapters, I have thought about what inspires hope in clinicians and our patients. Elsewhere (2004) I suggest that in treatment the most crucial hope is not a mere cognitive expectation but, rather, an active, propelling emotion. Hope can be a gift one person gives another as, I believe, is true in this case. Many gifts change hands in the story of Deborah and her therapist, and hope is essential to them all.

Initially it is the clinician's task to maintain hope about the work, since it is often impossible for the patient to hope. But in order to be strong, and contagious, hope has to be realistic, grounded in self-knowledge. Dr. Fried can hope because she knows she will do whatever this treatment takes.

In this treatment the patient's hopefulness is a hard won, but awe-inspiring achievement. Dr. Fried is encouraging, declaring her own hopefulness without exaggerating. For example (p.198) she tells Deborah that the process won't be easy but with patience and hard work they will make it. Her integrity shines so bright that it is impossible to disbelieve her. Against her great resistance, Deborah's hope (which never completely died) is kindled and grows.

Dr. Fried doesn't lie and expects the same from her patient. At one point (p.199) she registers her belief that they have that in common. With a wry wit Dr. Fried declares that, since Deborah is allergic to lies, her therapist must try not to tell them. I believe that telling inconvenient truths is vital to the work. It is crucial for both participants to become able and willing to voice their subjective truths, even when they know they are saying something the other may not want to hear, or something they, themselves, are loath to admit.

I believe it is Dr. Fried's unflagging perseverance that calls out something similar in her patient. By the end, Deborah feels proud of her own strength, as she battles to achieve a high school diploma. She now has the experience of being someone with some sterling qualities. Her positive self-reflections are not empty praise, but accurate, hard-won achievements, modeled by her devotedly, dependably persistent clinician.

Frieda's belief in the patient's life force

At first, and at many times throughout this treatment it was certainly hard to discern the life force in Deborah. After every insight or bit of progress her self destructive tendencies held sway, and she would cut or burn herself, and end up in ice packs. And yet, there was something alive and kicking, and Dr. Fried never forgets it, and takes every opportunity to point it out. For example, (p.192) after one of Deborah's extremely bloody self-destructive rage attacks, Dr. Fried points out that Deborah made sure to time it for when she would be most likely to be rescued by her favorite nurse. While recognizing the tremendous suicidal force in Deborah, Dr. Fried never loses sight of the self-protective side. She communicates her belief that, at some point, Deborah's will to live will be the

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stronger motive. I see this unshakeable belief in Deborah's healthier side as part of Dr. Fried's ability to inspire her patient's hope.

Frieda's humility and willingness to learn

Dr. Fried is always open to learning from her patient. For example, when Deborah challenges her (p.143) by saying that, since the doctor has never been a mental patient, she doesn't understand her experience, Dr. Fried reacts with humility rather than defensiveness. She admits that she can only guess at what it is like and asks Deborah to be patient with her and explain everything fully. Without being self-effacing, Dr. Fried shows her willingness to be taught, and her recognition that empathy only goes so far. I think she is showing respect for her patient, as well as modeling prioritizing truth over pride. Clearly the treatment (and Deborah) mean more to Dr. Fried than looking like she is always the expert.

There is one scene (pp. 198-199) that demonstrates Dr. Fried's brand of hope and empathy more clearly than any other, in my opinion. Deborah has declared that she doesn't want to think any more. Why should she keep working so hard when it doesn't seem to be getting her anywhere? What is the treatment's purpose? As I read Dr. Fried's reply, I hear frustration and exasperation, as well as profound empathy and dedication. Dr. Fried raises her voice and says that the treatment is for getting Deborah out of the hospital. Deborah balks, and declares that she won't tell Dr. Fried anything more. The doctor grows quieter but not any less determined. They engage in a real battle. Dr. Fried mobilizes her own aggression in order to actively counter Deborah's stubborn self-destructiveness. Essentially, in a provocative way, she gives her patient a stark choice. Deborah has to decide whether or not she wants to stay in mental hospitals for the rest of her life. Dr. Fried's tone is not soft. It is challenging, and, at moments, sarcastic. She implies that Deborah can feel sorry for herself and try to evoke the world's pity or help Dr. Fried fight to save her patient's life. The doctor does not promise her exhausted, demoralized patient any comfortable rose gardens. She doesn't let up on the pressure. She meets aggression with a kind of steely aggression of her own.

Elsewhere (1999, 2008) I have explored the notion of empathy in treatment. I would say that in this encounter, Dr. Fried exemplifies empathy, as I understand it. Briefly, I think that empathy often requires us to feel what the other is feeling, but that is just the first step in an empathic interaction. For example, when a child is having a tantrum, it is not empathic for a parent to simply join in and tantrum too. A moment of resonating with the tantrum may be a necessary first step, so as to truly understand the child's experience, but empathy doesn't stop there. It goes on to supply something the child needs. The parent uses his or her ego strengths to modify the anger enough to transform it, and then (re)presents it to the child, in a form that helps the child find constructive outlets.

In the pivotal exchange just described, I see Dr. Fried as at first reverberating with Deborah's rage. But then the doctor's rage becomes her own version of rage, which includes a strong, assertive push. Dr. Fried has felt Deborah's anger (in what can be called projective identification) but then the anger is transformed inside Dr. Fried. It is no longer merely a copy of Deborah's anger. We each bring to the clinical situation our own history with each of the basic emotions. No one can put "their" anger into me, without it being shaped by my life experience. I have a history of Sandra feeling anger, Sandra feeling

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fear, Sandra feeling joy, and so on. Similarly, Dr. Fried had a history of using anger to forge strength, before she met Deborah, and she brought that to her work with this patient.

Erich Fromm's Passionate and Hopeful Legacy

Every time I re-read Fromm his passion stuns me. Can anyone read his insistent prose without feeling profoundly affected? Here is just a brief sample of Fromm's statements about emotional health, as it affects the analytic task.

1. Fromm was absolutely clear about the goals of treatment (quoted in Funk, 2009, p.20). "The aim of the analytic process is to help a patient grasp his hidden total experience." In this, I believe he didn't fundamentally differ from other analysts, but his vision of what is "hidden," or dissociated, was somewhat broader. It includes becoming aware of the "filter" that comes with membership in a particular culture.

2. Health also includes an awareness that (Funk, 2009, p.22) "...everything is inside us- there is no experience of another human being, which is not also an experience we are capable of having." I see this as similar to Sullivan's one genus postulate.

3. Essentially, as I understand it, we help people by relating to them in a very direct way, so that they feel less isolated, and by avoiding intellectualization. (Quoted in Funk, 2009, p.34). "...the task of analysis is that the patient experiences something and not that he thinks more" (italics in original). We should not withhold what we see, out of concern that the patient isn't ready to hear it, because that would not fully reach him. In Fromm's words, when you think you see something, you have to "stick your neck out" (Quoted in Funk, 2009, p.36) and say it. My way to describe this (2004, 2008) has been that the analyst has to have the courage to voice inconvenient truths. Training (including one's personal analysis and supervision) should enable us to become radical truth tellers. Ideally the patient leaves the session with an exhilarated feeling of increased vitality.

Fromm called his way of working "central relatedness." As he (Funk, 2009, p. 18) described it "Then I do not think about myself, then my Ego does not stand in my way. But something entirely different happens. There is what I call central relatedness between me and him. He is not a thing over there which I look at, but he confronts me fully and I confront him fully…"

Fromm's hope: Embracing contradictions

Here is one of Fromm's most evocative and inspiring statements:

> To have faith means to dare, to think the unthinkable, yet to act within the limits of the realistically possible; it is the paradox of hope to expect the Messiah every day, yet not to lose heart when he has not come at the appointed hour. (Fromm, 1973, p.485)

For me this suggests that contradictions do not, necessarily, mean that we should choose one side to be true and the other false. The Messiah has not come at the appointed hour, but that doesn't mean we should alter our expectations.

Fromm has a permanent place in my own "internal chorus." That is, he is a kind of professional ego ideal. Particularly when my stamina wavers, thinking of him lifts me. What my internalized Fromm can do, more than any other theoretician, is inspire me to

engage in treatment passionately. The clinician needs adequate inspiration to be motivated to take "long shots." In clinical work, we are often operating against the odds. Why should my patient and I believe that what we do today will help, when it hasn't helped before? And yet we must be inspired to try. We each search, our whole lives, for what really helps anyone have a richer life.

Conclusion

Aside from being among the first interpersonal psychoanalysts and founders of the W.A. White Institute in New York, what do Fromm-Reichmann, Fromm, and Sullivan have in common? Like many others, they had the power of believing fervently in what they were doing, which facilitated their students' and patients' hopes. Trained by their students and colleagues, I was profoundly affected by their passion. More than I realized at the time, I was primed to be inspired by the legacy of these three great clinicians.

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