

“Paradoxically, hope is on intimate terms with despair. It asks for more than life promises. It is poised for despair.” — Cheryl Mattingly

Hope is a multifaceted thing that can be “characterized in multiple ways: as an existential state; as a posture towards the world; as a practice involving significant work; and importantly, as inherently paradoxical.”¹ In society’s morals, hope is viewed as a “sign of health, a fighting spirit, and faith something good will triumph.”² Thus the chronically ill often walk a tightrope of *being* hopeful—a balancing act with despair for coping with daily living and pursuit of treatment that may not be successful—and *appearing* hopeful—conforming to the societal and cultural expectations and ideals of others about improving their health.¹ In a similar manner, those living in oppressed conditions—whether in a broader sociopolitical context or more personally in their private relationships—are often in a position of “hoping against hope” or “hoping without hope,” an attempt to combat the hopelessness of believing that it is not possible for their situation to improve: that their oppressor is too powerful, their situation too dire, they themselves not strong enough or resourced enough to escape.³

Hope has a profound effect on a person’s identity and moral agency, as the belief in a positive future is foundational for self-worth, motivational for meaning and resilience, and is often a heavily-weighted component for ethical decision-making during adversity.³ Hope orients around: 1) the possibility of a desired outcome 2) that is believed to be achievable 3) but with uncertainty as to its occurrence, often due to some personal agency limitation or a reliance on factors outside of one’s control; this definition highlights the uncertainty inherent in hope, both in outcome occurrence and in self-efficacy to make it happen.² Hope involves looking towards the future “with no guarantees against disappointment.”¹

The far poles of hopefulness—sanguinity-bliss and utter despair—are extremely deep emotions, so much so that they are experienced by the whole of the being; a person “can only ‘be’ blissful or in despair. We cannot in the strict sense of the word, ‘feel’ bliss or despair. . . nor can we even feel ‘ourselves’ to be blissful or in despair. . . [T]hese feelings are not expressed at all, or they take possession of the whole self.”² “Because sanguinity-bliss and despair are reflections of moral values, they become metaphysical self-feelings.”²

If hope is so related to moral agency and personal identity, and yet is so multifaceted and culturally-implicated, how is a person to understand it, particularly if they are chronically ill, have difficulty registering or processing their internal emotional state, and/or are in an oppressive environment? Let’s discuss the different types of hope I researched this month, the concept of hope, the opposites of hope in hopelessness and despair, how chronically ill people with different balancing patterns best respond to four different aspects of the diagnostic journey, and close with a short interlude on Erikson’s Adult Stages of Psychosocial Development, particularly ego integrity versus despair.

Hope as Two: Hoping and Hopefulness

The first request I ask, reader, is that, for the sake of this article, you take a thought

experiment with me and split the concept of hope into two distinct components, as premised by Kwong.³ When we're done here, if you don't like this approach, you can merge them back together, but in my readings this month, this concept was what struck me the most deeply and I am going to utilize it heavily.

The author of *Despair and Hopelessness* argues that *hoping* and *being hopeful* are two distinct mental phenomena, and that *hopelessness* and *despair* are their respective counterparts. Hoping is a mental assessment that an outcome is desirable and to believe the outcome is obtainable, often with the belief that the attainment is not entirely within one's control;^{3, 2} hoping, in this split construct, does not involve a person's emotional appraisal of the possibility of obtaining the desired outcome, only that it is *possible*. [I use 'desired' throughout this article for clarity, but an outcome could also be specifically *not* desired, such as "I hope I am not beaten" or "I hope I do not puke."]

To be hopeful (or unhopeful) is the appraisal of the likelihood of obtaining the desired outcome one is hoping for and its emotional valence or pleasantness, whether that is positive, neutral, or negative. Despair would be the term for having negative emotional beliefs about the likelihood of obtaining a desired possible outcome, and is the emotional polar opposite is sanguinity, which is having positive emotional beliefs about the likelihood of obtaining a desired possible outcome.² However, both unhopefulness/despair and hopefulness/sanguinity (negative or positive feelings about a possible desired outcome) necessitate hoping (the belief that a desired outcome is possible) before they can occur.³ If a person believes a desired outcome is impossible (whether or not it actually is impossible, the crucial aspect here is the individual's belief), they are *hopeless*.³ Those who stop hoping, may begin to *wish* for their desired outcomes instead, applying a mental attitude directed towards things believed to be impossible.³

For example, Katie, Claire, Elle, and Joan all want to get promoted. Katie, Claire, and Elle think it is possible they could be chosen for the position; they are all hoping. Joan does not believe it is possible and does not apply; she is hopeless and wishes circumstances were different. Katie thinks it'll be tough competition but she's upbeat and believes she stands a good chance; she's hopeful. Claire is extremely apprehensive to put her name in the ring, she believes she is likely to get passed over and puts her success at under 10%, but you lose all the chances you don't take; she is not hopeful, even though she is hoping. Elle is new to the department with a bubbly personality who sees the best in everything, she knows it is likely too soon for her to get promoted, but she'll take this as a great learning opportunity for how to interview for a higher position and whatever the outcome, it'll be a win in her book; she is hopeful, even though she does not believe she will succeed in obtaining the possible desired outcome of being promoted.

While hoping addresses the desired outcome, hopefulness addresses the thoughts and feelings aimed at the likelihood of that outcome occurring.³ It is not necessary that a person's emotional orientation and their assessment of the outcome occurring align.³ A person can be hopeful (have an overall positive orientation) and believe that the desired outcome will occur

["I hope I pass this midterm I studied very hard for."], and a person can feel unhopeful (an overall negative orientation) and believe the desired outcome will not occur ["I hope I can put this complex machine back together."]; however, a person can also be hopeful (have more positive thoughts and feelings than negative ones) and not believe the desired outcome will occur though it remains possible ["I hope we go out to eat tonight."], or be unhopeful/despairing (have more negative thoughts and feelings than positive ones) and still believe an outcome will occur ["I hope my friend doesn't die from their severe car crash injuries." ie despairing about a friend's death but believing it will happen anyway].

Separating hoping from hopefulness in this way creates psychological space for those in difficult situations, particularly those of oppression and abuse, to maintain hope that it is possible for their situation to improve, without requiring the hopefulness of overall positive orientation in thoughts and feelings being present, mitigating the harm to individual's moral agency and personal identity and preventing the onset of hopelessness that leads to the belief one's health or circumstances cannot improve or accepting oppression under the premise that it is impossible to oppose or withstand.³

Types of Hoping*

The researchers quoted and compressed in this section explored different kinds of hoping: the possibility of a desired outcome.¹ They did so in the context of living with chronic pain and pursuing treatments that may or may not work. These styles of hoping were considered an active moral practice, an existential paradox necessary to live day to day, and framed as a place in between what hope is not: neither demoralization that surrenders to one's limitations and losses nor delusion that denies them.¹

Realistic, practical hope: any hope for a reasonable or probable outcome in terms of normal or expected outcomes in the broader medical community, which most participants were not hesitant to disclose to their provider and which allows individuals to live up to cultural ideals of realism and adherence to evidence while maintaining openness toward the possibility of positive change.¹

Utopian hope: a collectively-oriented, outward-focused hope that group action can lead to a better future, which does not require individuals to factor in prognosis or practical considerations.¹

Wishful hope: very high hope that is not necessarily 'realistic', and which participants rarely expressed without simultaneous descriptions of realistic hopes or explaining hope is necessary to continue to seek treatment or cope with daily pain to avoid appearing unrealistic.¹

Transcendent, existential hope: An open-ended hope that everything will work out in the end, that doesn't make conditions of the future, and is directed toward an objective which defies any attempt to map it; a generalized, universal hope that isn't directed towards a specific

outcome or goal, but rather the possibility of a good life in general, and provides a general defense against despair or giving up (hopelessness).¹

Religious-based faith: a way of taking care of oneself, a way of being uplifted, and a way to feel as though one is part of something larger and 'not alone'.¹

Faith in science and medicine: more common than religious-based faith and not necessarily based on current knowledge or technology; for those with illnesses for which there is little possibility of cure, faith in technological or scientific breakthroughs in the future.¹

Faith in hope itself: faith in the body's ability to heal can counterbalance despair that one's body has somehow let them down and feed hope that a treatment may be out there that can trigger the body's natural healing capacity.¹

“‘[S]mall moments of suffering’ in daily life with chronic illness can lead to either hope or despair. Individuals living with chronic pain work to maintain a “safe” space between the vulnerability of overly-inflated hopes and the vulnerability of losing hope. [A participant] feels safe from the vulnerability of having high hopes by remaining somewhat pessimistic. In this sense, pessimism is a protective strategy, avoiding the much more daunting possibility of despair. . . In life with chronic pain or illness, finding hope is part of appropriately working toward mastery over one's condition.”¹

Spectrum of (Un)Hopefulness: Sanguinity-Bliss to Utter Despair

The spectrum of hopefulness—in the sense of the appraisal of the likelihood of a desired outcome, including the overall emotional orientation—runs from sanguinity to optimism to pessimism to despair.² The author of the paper primarily referenced for this section is of the position that despair is “the collapse of one's social resources and social involvements, the demise of one's social world, and a disintegration of self-representation.”² Again, there is a focus on personal agency and confronting the limitations of that agency, as “a distinguishing feature of hope is precisely one's reliance on factors and conditions that might be beyond one's control.”²

The human brain is an “anticipatory device” whose “main purpose . . . is to produce a future.”² In response to these anticipated, projected, possible futures, the author describes emotional combinations involved in three kinds of positive emotional assessments and three kinds of negative emotional assessments. Since hope is an assessment of possibility, anticipation is involved in all of these emotional combinations from sanguine-bliss to despair.

“Sanguinity is ‘a disposition towards hopefulness or confidence of success’ or being undeterred by risk and uncertainty about the actual value of what is sought.”² Sanguine people have a cheerful, confident disposition about their future with a high risk tolerance. Sanguinity has been split into three primary types by the referenced author by merging a

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primary and a secondary emotion of hope to create the 'eager hopefulness' and 'confidently optimistic' tertiary emotion of sanguinity.² Those primary emotions are: anticipation, acceptance, and joy-happiness. The secondary emotions are: optimism, fatalism, and love.

Optimism = Anticipation + Joy-Happiness

Sanguinity₁ = Optimism + Acceptance

While optimistic, sanguinity₁ is underpinned by acceptance, knowing that goals cannot always be achieved and failures cannot always be avoided. Not easily discouraged, the sanguine₁ person continues to value and pursue their desired outcome and find alternate paths forward if needed, rather than giving up on their goals.²

Fatalism = Anticipation + Acceptance

Sanguinity₂ = Fatalism + Happiness

Fatalism is a sense of powerlessness, a view that an individual ultimately has little control over the desired outcome, that some external force—whether a powerful other, luck, fate, or a god—holds the control. The author suggests that sanguinity₂ is resourceful when hopes, goals, or resources desired are to be gained through some external source and not personal effort. These are individuals who may feel fortunate, lucky, or blessed—happy that they are “successfully negotiating life’s perils.”²

Love = Joy-Happiness + Acceptance

Sanguinity₃ = Anticipation + Love

Sanguinity₃ is a self-confidence oriented around finding and securing the object of their love and the joy of being fully alive. In medieval humors-temperment beliefs, a sanguine-dominant person was optimistic, confident, cheerful, passionate, hopeful, with a courageous disposition, and a propensity to fall in love, as well as a willingness to fight and bleed for their desires.²

As we move from the positive end to the negative end of the hopefulness pole, we leave sanguine, cross over optimism, hit pessimism, before settling in despair. Optimism and pessimism are half-opposites with both of them orienting around anticipating the probability of an outcome and whether that probability sparks happiness or sadness. While happiness is the emotional response to gain, sadness is the emotional response to loss—whether of one’s authentic self, their social standing or inclusion, their future, or feeling “abandoned to the present” while “neither the past nor the future offers anything.”² As pessimism and despair begin to dominate, exploration becomes boundary defense, around one’s territory, around one’s self.²

Pessimism = Anticipation + Sadness

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The creation of the three types of despair follows a similar approach to sanguinity with one primary and one secondary emotion being merged to create the tertiary emotion of despair. The primary emotions are: surprise, sadness, and disgust. The secondary emotions are: disappointment, loneliness, and shock.

A despairing person is sad, melancholic, miserable, despondent, gloomy, grieving, and may be clinically depressed.² Despair's root is self-estrangement from the social world, a loss of the self's place in social involvements and relationships, a draining of vitality, and the "narrow[ing of life so] that it is nearly empty."² When despairing, the boundary-defense affects cognition, creating a sort of tunnel thinking often oriented around disgust—particularly a moralizing self-disgust of feeling unloveable and unworthy, more commonly known as self-loathing, which contracts or collapses a person's social identity.²

Disappointment = Surprise + Sadness

Despair₁ = Disgust + Disappointment

Despair₁ is the result of experiencing disgust around missed chances or failures or disappointments in life. When something doesn't go as hoped for or as anticipated or when the desired outcome doesn't come to pass, disappointment can be immense; when paired with not seeing an alternative path, this can lead to despair. "Disappointment is milder than despair, for in despair the world becomes menacing, frightening, and unbearable, so that disappointment comes to augmented by a rejection of, and disgust for, a world that has become unlivable."²

Loneliness = Sadness + Disgust

Despair₂ = Surprise + Loneliness

Despair₂ is the result of the collapse of social territory, of the sense of not belonging, of the absence of attachment figures, of the lack or breaking of close relationships. This is "the despair of being alone," of feeling separated from the social world, and is an intermediary step between social isolation and suicide. For the individual experiencing despair₂, their world has become "filled with stale, tedious, lifeless routines from which he or she yearns to escape."²

Shock = Surprise + Disgust

Despair₃ = Sadness + Shock

Despair₃ results from a shocking loss, whether social or physical, such as a sudden injury, an unexpected death, an emergency surgery, a traumatic pregnancy loss, or realization of a deep interpersonal betrayal.² These experiences are often unexpected, revolting, degrading, or shocking, and bring the autonomy, control, and capability of the individual into a challenged state.

Hoping Against Hope: Despair, Hopelessness, and Integrity

Hope is desiring a particular outcome and believing or trusting that outcome is possible in the future. When a person has a “basic mistrust” of the future their brain anticipates, so that nothing good can be seen, despair sets in.² Despair can be maladaptive in that it can make unreasonable or uncertain things appear reasonable or certain, further isolate individuals, strip access to the authentic self, and block the ability to envision a future.² In despair, one experiences loss, one’s social resources collapse, and one is left without recourse.²

Despair and hopelessness can both be excruciating experiences, yet (at least under this split construct model) they are distinct. Hopelessness may prompt feelings of resentment, anger, frustration, sorrow, and other unfulfilled or catastrophic outcomes, particularly if tied to a person’s sense of self, life goals, intimate relationships, or fundamental beliefs; however, in a hopeless situation, the individual can also find relief in impossibility, abandon their plans or desired outcomes, and perhaps create new hopes or goals.³

In despair, the individual still believes their desired outcome to be possible—by however slim a margin—and may become desperate (act in despair) in the hopes—without hopefulness—that their desperate act may bring about their desired outcome, as they do not yet believe it to be impossible and are not hopeless; “desperation is not a negation of hope but a mode of it.”³ Despair may be especially tormenting and without relief, as the individual still believes there is at least a miniscule chance for their desired outcome to occur and so they do not give up hope, yet they are overwhelmed with negative thoughts and feelings about the possibility, kept in a state of emotional affliction and cognitive limbo.³

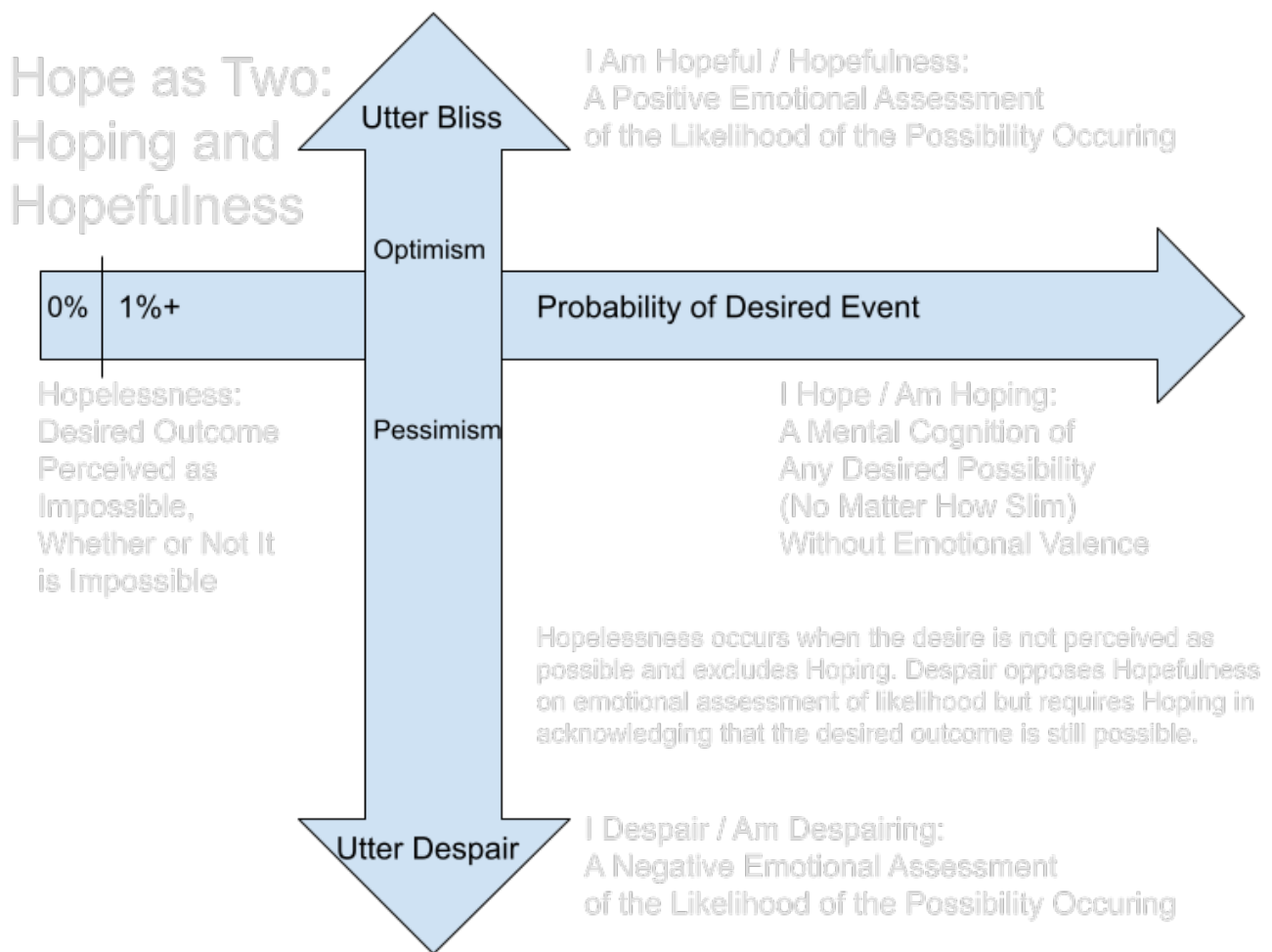


Image Credit: CRPScontender, demonstrating principles from Despair and Hopelessness by Kwong³

Four Patterns, Four Domains*

The paper referenced and compressed in this section studied patients with chronic illness seeking diagnosis and how they balanced hope, despair, and hopelessness during the diagnostic phase. “[P]articipants had emotional boundaries concerning how deep into despair they could go before losing control, or how focused on hope they could be without losing track of reality. If they let despair and their worst fear become too strong, controlling and hiding how painful their situation was and how weak they actually felt became difficult. This moving between hope and despair influenced for example how they processed information. The more hopeful they were, the more realistically they could appraise and process their situation but when they moved towards despair, they withdrew and were less able to process their situation.”⁴

The ambiguity and uncertainty of the diagnostic phase is experienced as the most stressful part of illness trajectory for patients. Having accurate information gave patients some control and possibilities when judging their own situation, and the longer a patient had been waiting

for a diagnosis, the more important the accuracy of the information was to them. Information was best accepted when provided in accordance with their balancing pattern.⁴

The researchers studied four categories and four patterns for balancing between hope, despair, and hopelessness. While individuals could move between balancing patterns and use more than one, people often had a dominant balancing pattern of either: controlling pain, rational awaiting, denial, or accepting.⁴

The study observed how patients responded to: seeking and giving information (how to physically and mentally prepare for investigations and results, how to structure time at medical facilities, how information was given by staff in such a way that it was not misinterpreted); interpreting clues (remembering what happened before they became ill, considering changes in their body, paying attention to medical staff behavior and diagnostic interventions and priority); handling existential threats (considering possible outcomes of their illness, apprehensions of the future and what it might hold and what might change, reflecting on the meaning of life); and seeking respite (psychological breaks from the tension of uncertainty, seeking alternative mental states where thoughts were concerned with things other than waiting, mental escape for rest and renewed strength).⁴

The study also offered some recommendations to healthcare providers for each balancing pattern to help them have a smoother, less stressful time during the diagnostic phase and to improve patient-provider relations and help patients better make sense of what is happening to them. One overarching recommendation across all processing groups was to assign a knowledgeable and experienced nurse as a designated contact person to each patient entering for diagnostic workups to coordinate care and provide accurate information to reduce patient uncertainty and improve patients' sense of control.⁴

Those in the Controlling Pain balancing pattern wondered what the truth about their situation might be and felt large amounts of painful uncertainty about the future, which they managed by controlling thoughts related to the future. When seeking information, they did not want too much information nor did they desire to be involved in discussions about all possible outcomes and preferred to wait until doctors had specific information to share. When interpreting clues, they were very sensitive to all clues due to the distressing uncertainty creating vulnerable feelings; to protect against that distress, they did not allow themselves to consider the full range of outcomes. When handling existential threat, they did not dwell too much on what they feared could be a serious outcome. When seeking respite, it was to find a break from the pain caused by uncertainty and to be able to endure new investigations and more waiting. In the medical context, these patients distance themselves from thinking about the worst case scenario and experience a great deal of emotional pain; building trusting and caring relationships and having continuous contact with a few key people could offer healthcare resources to strengthen their hope and support them emotionally, and assisting with respite may help offer a break from their anxiety.⁴

Those in the Rational Awaiting balancing pattern were focused on facts rather than

hypotheticals and did not allow troublesome thoughts and feelings to emerge as long as the individual lacked accurate knowledge on their status. When seeking information, they wanted information to base judgement on facts and emotions were kept on hold until they knew for sure what the outcome would be. When interpreting clues, emotions were put aside until a diagnosis and prognosis were known, and they interpreted as many comprehensible clues as possible to make sense of their situation. When handling existential threat, uncertainty about the future and various consequences of different outcomes were not considered before they had been given a diagnosis. When seeking respite, it helped move time forward towards a conclusion. In the medical context, these patients have limited conscious contact with their emotions and postpone emotional processing until they know the outcome; accurate information is highly valued by these patients.⁴

Those in the Denial balancing pattern focused on recovering from acute symptoms rather than dwelling on possible underlying problems. When seeking information, they overlooked negative possibilities and signs of danger and some saw serious questions from medical staff as impolite. When interpreting clues, they focused on positive signs and compared their situation to others who managed to live well despite diseases. When handling existential threat, they tended not to examine threatening prognoses, which limited exploring what it could mean for the future. When seeking respite, they actively sought it out as a welcome break, often utilized humor, and kept busy by following up on fellow patients. In the medical context, these patients tend to distort their situation to protect themselves from emotional threat; by earning trust and strengthening hope, the need for this distortion may reduce, and by demonstrating competence, continuity, and care healthcare providers can help patients in a more realistic appraisal to prepare for when they receive their diagnosis and life afterwards.⁴

Those in the Accepting balancing pattern were fearful about the future yet at peace from the belief they would be able to cope. When seeking information, they confidently sought out information about their situation and were able to process it and the related emotions. When interpreting clues, they compared them with knowledge and former experiences. When handling existential threat, they discussed the distress of uncertain futures and trust in their ability to handle their situation based on former experiences of their own resources and the available support of others. When seeking respite, it was appreciated as it provided a welcome break from dealing with uncertainty. In the medical context, these patients are able to appraise their situation realistically and trust they will have the resources to cope with the outcome; a contact person, a well-coordinated program, and continuity of providers would increase predictability and ease pain.⁴

Erikson's Psychosocial Development

One of the most influential frameworks for aging and development throughout a lifespan is Erikson's Psychosocial Development.⁵ This theory has four stages that occur in childhood and four that occur in adolescence and adulthood; each stage has a particular trait it is developing and there is an adaptive and a maladaptive response.^{6,7} It is a biopsychosocial,

epigenetic framework, where later stages build upon or readdress earlier stages with more complexity, depth, and maturity.⁷ While specific ages have now been added to this framework, there were originally only general life stages (eg infancy, play age, young adulthood) associated with each developmental milestone.⁷ These stages are associated with both who one is as a person and as a member of society; “the sense of integration is both intra- and interpersonal.”⁵ As many with CRPS develop their condition in adolescence or adulthood, we will primarily address the last four, with a focus on the final one, which is when individuals address their mortality and whether they feel they have lived a meaningful life, whether they feel they have ego integrity or fall into despair.

The fifth stage, which is undertaken during adolescence, orients around developing an individual identity, discovering ‘who am I?’, and moving from the instilled morality of a child to the developed ethics of an adult; a maladaptive response can lead to a weak sense of identity, insecurity, confusion, or rebellion.⁶

The sixth stage, which is undertaken during young adulthood, orients around forming intimate relationships, developing mutual trust and respect, and being willing and able to commit to, be open with, and sacrifice for close others; a maladaptive response can lead to isolation, alienation, and challenges maintaining relationships.⁶

The seventh stage, which is undertaken during middle adulthood, orients around making valuable contributions to society, showing concern and nurture for the next generation, and feeling as if a person is making a positive difference in a way that will outlast them; a maladaptive response can lead to self-absorption, a lack of personal growth, a sense of stagnation, or a midlife crisis.⁶

The eighth stage, which is undertaken in older adulthood (or earlier for some individuals), orients around addressing one’s mortality and the fear or acceptance of death and reflecting on whether one felt content with one’s life or if instead there were more regrets, bitterness, and dissatisfaction; a maladaptive response can lead to despair, depression, hopelessness, fear, and dread about a person’s mortality.⁶

Which factors in particular play a role in ego integrity and despair? Research shows that three primary needs—and whether those needs are satisfied or frustrated—play a large role in accepting death to reduce anxiety and depression, increasing life satisfaction, increasing a sense of meaning in life, and improving adaptive functioning in areas like self-esteem, self-concept clarity, internal locus of control, self-realization, and existential well-being.⁸

The three basic psychological needs are: autonomy (a sense of volition and psychological freedom); competence (a sense of mastery and effectiveness); and relatedness (the experience of caring for and being cared for by important others). These needs can be frustrated by, respectively: feelings of pressure or coercion; feelings of failure; and experiencing exclusion or loneliness.

People with perceptions that their lives were filled with autonomy, mastery, and interpersonal care signal higher ego integrity, characterized by “unity, harmony, and completeness in one’s identity and life as a whole.”⁸ Conversely, those who had more experiences of need frustration, such as pressure, failure, and social isolation, have more difficulty integrating and finding meaning in their life, which can create a sense of despair, characterized by “feelings of regret, bitterness, and disappointment over a life misspent.”⁸

Other research demonstrated that those who struggled with the young and middle adulthood stages of forming intimate relationships and nurturing something or someone (whether a career or a creative outlet or the next generation) were more prone to lower global cognitive function and executive functioning and higher levels of depression three to four decades later.⁹ The researchers thought those with difficulty meeting the milestones were more vulnerable to depression, despair, and stagnation as they aged.⁹

Closing

As we face our mortality, we reflect on whether we lived a life filled with autonomy, competence, and connection or coercion, failure, and social isolation. Whether these core human needs were satisfied or frustrated plays roles in not only whether individuals subjectively found life meaningful, but also their psychological function and whether their final years are filled with peace and acceptance or bitterness and despair.

Humans exist not only as individuals developing their own identities, but also as interwoven threads of a larger social tapestry. Balancing hope, despair, and hopelessness when one deals with chronic pain or illness is a critical component of daily life, and it can be made all the more challenging if interpersonal or sociopolitical dynamics include oppressive and abusive behavior. Keeping up the “fighting spirit” when it feels hope has abandoned an individual or a community or a society can be exhausting, heavy work. It is this reason why I found the distinct mental split between *hoping* as desired outcome being possible and *(un)hopefulness* as the emotional orientation towards that possibility so powerful.

When we lose hope—when we become hopeless—and cede the ground that our desires are possible, we give up, we lose the fight, and the spirit is extinguished. Sometimes realizing something is impossible is important and it lets us reorient and move forward another way or towards a different goal. However, sometimes hopelessness means surrendering something crucial, something essential to who we are, and we become a hollowed-out shell of who we used to be, of who we want to be.

Despair is a collapse of social resources and an emotional orientation of loss—including a breakdown of our sense of self. Social resources can be rebuilt, reinforced, or created anew, even if it takes significant effort; we can work to recover what is lost and process our sadness over what cannot be reclaimed, even if it takes significant time. Despair and desperation are not inherently bad states, though they may be uncomfortable and unpleasant to endure and may attempt to blind us to the potential of a positive future. They reveal we still believe our

desires for a future are possible, that we can still fight to make them a reality, even if we're tired, even if it hurts.

To all the hopeful, hopeless, and despairing out there reading this today, I hope you found something in this article as relevant and useful as I did.

In solidarity, contender

* These sections are mainly direct pulls from the referenced papers that have been heavily compressed and rearranged for ease of reading. All credit to the original authors, as these sections cannot be claimed to be my original writings based on synthesized notes, but rather primarily quoting directly from the journal articles so heavily from so many disparate sections that the quotation marks would truly get out of hand. Please see the linked papers if you would like to read the original work.

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