Towards a Concept of Hope: A Functional Reconceptualization

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Abstract

The concept of hope, though greatly debated over the years, still eludes a formal definition. As this paper seeks to move the discussion on the concept of hope forward, it will not recapitulate theoretical orientations. Instead it will offer thoughts on the concept of hope that are grounded in empirical research; a view of hope is obtained by examining its functional characteristics. Specifically, the paper reviews empirical studies on hope's inspiration and maintenance within the field of nursing. From the perspective of inspiration, two seemingly competitive conceptions are found. The research embodying the first conception shows that hope is inspired relationally, through emotionally significant relationships. Competing research asserts that hope is more of an idiosyncratic attribute whose inspiration is tied more closely to the individual's agency and sense of power. The cognitive dissonance between the two views is considered and reconciled. In light of this reconciliation, a preliminary reconceptualization of hope is proposed: hope is a relational product of hoping. Hoping is relating to the future as a subject whose subjectivity is created by projecting feelings generated from relationships onto the future.

Keywords: hope, hoping, relationality, future, relationship, nursing

1. Introduction

Hope has long been viewed as the blessed child of the church. Indeed, it ranks as one of St Paul's three great virtues along with faith and love. Over the last one hundred years, with the ascension of psychology, hope has been recast as a function of desire or positive expectation. Torn from its metaphysical moorings, hope now abides discretely within the mind of the individual. Hope has undergone a translation from theological virtue to an idiosyncratic attribute. This translation constitutes a comparatively hurried process if one considers that the theological version of hope has been thousands of years in the making. Regardless of one's theoretical orientation towards hope, one is compelled to wonder if some vital aspect of the former incarnation has been excluded.

The purpose of this paper is to offer stimulation to the discussion on hope, in order that we might guard against the reduction of the concept of hope in its current instantiation. In particular, one of the views not

currently in discussion is the functional aspect of hope—what gives hope life? What maintains hope? No one has performed a literature review or generated a concept of hope from the point of view of what has been empirically shown to inspire or maintain hope. Part of the reason for this oversight is that there has not been a substantive body of literature regarding the functional aspects of hope. Now, however, such a possibility exists within the literature of the field of nursing. In reviewing the nursing literature, though, it becomes apparent that there is a difference of opinion on what inspires and maintains hope. Two competing conceptions of hope emerge: alongside the concept of hope based on an individual's desire or expectations, a relationally-grounded concept of hope emerges.

Due to the varied nature of the research presented, it is important that we begin with a roadmap for this review of the literature. We begin this review where many others in the field of nursing have, with the oft-cited empirical study of Dufault and Martocchio.[1] The pair establish one of the earliest empirical concepts of hope from their qualitative research. From within this framework, we will review studies that give us an empirically-grounded sense of what inspires hope; the studies conducted by Cutcliffe and Grant[2], Cutcliffe[3], and Gibson[4] help to elucidate the relationality between emotionally significant relationships and hope inspiration. Following these studies, we will consider the more idiosyncratic elements of hope inspiration; studies by Bunston, Mings, Mackie and Jones[5], Salerno[6], McCann[7] and Wall[8] discuss the relationship between an individual's sense of power, locus of control and hope. From these studies we will attempt to discern how a sense of power and control affect one's ability to hope. These considerations will lead to a deeper analysis of efficacious elements in hope inspiration which will engender my conclusion, the conceptual revamping of hope in relational terms.

2. Method

The research for this enterprise was culled from the field of nursing. This may come as a surprise to many, as nursing has not often been seen as the "go-to" discipline for psychological discourse. Still, nursing has the proud distinction of being the pre-eminent research field on hope-inspiration for the past twenty years. To search as comprehensively as possible, a keyword search of the term 'hope' was performed on CINAHL (Cumulative Index to Nursing & Allied Health Literature) and produced nearly one thousand articles. I narrowed the search to only those articles that were empirical investigations, qualitative and quantitative, concerning the inspiration of hope. This method returned

a much more manageable nineteen articles whose salient findings I have assembled here.

3. What Hope is Made of: A Review of Relevant Literature

In their 1985 study Dufault and Martocchio developed a theory on the structure of hope. Their study was conducted on two populations each of which was surveyed over a two year period with the purpose of describing hope and its "spheres and dimensions." Initially, Dufault and Martocchio surveyed a population of 35 elderly patients (those 65 and older). They then collected data from 47 terminally-ill patients (fourteen years and older) and found similar results on how hope was maintained through a "reanalysis of longitudinal data." All data were collected through the observation of the participants in a number of settings.

The following structure of hope assembled by Dufault and Martocchio is complex and multilayered. One facet of their proposed structure addresses the 'spheres of hope.' Dufault and Martocchio describe two spheres of hope, generalized and particular. Generalized hope is characterized by "a sense of some future beneficial but indeterminate development."[9] Generalized hope manifests itself as a general outlook. Dufault and Martocchio found that this hope gives "overall motivation to carry on with life's responsibilities" as well as a "flexibility and openness to changing events."[10] Generalized hope is without an object, unlike its complementary sphere, particularized hope.

Particularized hope is "concerned with a particularly valued outcome, good, or state of being, in other words, a hope object."[11] The particularized hope sphere is characterized by both desire and an expectation for particular circumstances to materialize. An individual exercising particularized hope might look forward to an upcoming event or to the completion of a project. Dufault and Martocchio understood that particularized hope "clarifies, prioritizes, and affirms what a hoping person perceives important in life."[12] Particular hopes represent an investment in life and reveal a commitment and attachment to something specific extending temporally into the future. Particular hopes can be identified and are open to revision both in terms of the hoped for object or outcome and the means by which the hoped for object or outcome is obtained. The manipulation of particularized hope is the intervention accessed by cognitive therapies. The fluidity of particularized hope is the characteristic that allows it to thrive even when frustrated.

Dufault and Martocchio found that the hope of the individuals in the study fluctuated. They noted that as one sphere of hope was compromised, the other sphere displayed a more prominent role in maintaining hope. As particularized hopes were threatened or abandoned, individuals often were found reminiscing about the good things in their life or "how things have worked out before."[13] Doing so helped them

maintain an overall positive outlook. By contrast, when generalized hope was threatened by such possibilities as limited life expectancy, individuals were seen to invest more in particularized hopes. The spheres functioned complementarily to help the individuals give meaning to their lives and stay involved with the process of living, even if outcomes seemed bleak.

Along with this complementarity between spheres, there exist many commonalities. Dufault and Martocchio identified six such commonalities, which they termed 'dimensions.' These dimensions operate in both spheres of hope, allowing added flexibility to coping by giving the individual alternate possibilities for hope when other dimensions of hope are frustrated. The one dimension that is exceptional to us, as it is to Dufault and Martocchio is the 'affective' dimension. As Dufault and Martocchio remark, "the affective dimension permeates the whole of the hoping process."[14] Though their model suggests that hope exists in two spheres through six dimensions operating equivalently in each sphere, they give pride of place to affect, the emotional connection one human being has with another or desired outcomes in one's life. To hope is to feel, but more so, to feel *for something* or *someone*. At the heart of Dufault and Martocchio's conception of hope, even in the face of death, is relationship. Dufault and Martocchio are not alone in their results, that hope is inspired and maintained by emotionally significant relationships.

Cutcliffe and Grant also found that the elderly were inspired by caring relationships, though the sample was significantly different. In this grounded theory study researchers interviewed five nurses (two men and three women) who were giving care to thirty elderly clients diagnosed with Alzheimer's type dementia at "various levels of cognitive impairment." The interviews were semistructured and lasted one to two hours. In their responses to questions about how they inspired hope in their clients, each of the nurses revealed similar patterns in which they emphasised interpersonal interactions and a caring relationship. The nurses also said that they attempted to promote activities that would keep their clients from feeling isolated and from being ignored. They said that hope was strengthened in clients who stayed connected to the community and who felt that they were important to others and that others cared about their well-being.[15]

This same point concerning the maintenance of hope through relationality reverberated through a study of terminally-ill HIV patients published by Cutcliffe in 1995. He argued that how the clients felt about themselves was greatly influenced by how others treated them. Cutcliffe conducted a grounded theory study in which data was collected through semi-structured interviews. The interviews were conducted with one-third of the nursing staff at a teaching hospital in the Yorkshire region of

England, though Cutcliffe did not report the actual number of nurses. All nurses were registered mental health nurses having at least two years of first-hand experience of caring for terminally-ill HIV clients. In addition, Cutcliffe found that two other variables figured prominently in the inspiration of hope: self-awareness of the nurse and the creation of a partnership with the client. Self-awareness is essential, Cutcliffe argues, because without it, the nurse cannot properly empathize with the client to form the partnership. Moreover, Cutcliffe argues that having a sense of self-worth is the greatest factor in facilitating hope in the clients.[16] Cutcliffe sees the inspiration of self-worth as the central construct in his theory because of its ability to help remedy the effects of isolation and rejection, which are felt particularly strongly by this population. Again, though, the point remains the same: feeling self-worth from being cared for is a constitutive element in the inspiration of hope.

Surveying a group of people with multiple chemical sensitivity (MCS), Gibson makes a similar point about hope. Little is known about MCS and even less can be forecasted in terms of the course of the disease, making these patients excellent subjects to determine the predictors of hope in the case of complete uncertainty.[17] The study was conducted among 305 self-identified persons with MCS contacted through support groups, newsletters and a national publication. Of the 305 questionnaires mailed out, 288 people responded. A follow-up questionnaire was mailed six months after the initial questionnaire and 268 people out of the 288 respondents answered. The Herth Hope Scale (HHS)[18] was used to measure hope for the two samples. In addition, social support and attitude towards healthcare were measured by part 2 of the Personal Resource Questionnaire 85 (PRQ85)[19] and Healthcare Orientation subscale of the Psychosocial Adjustment to Illness Scale Self Report (PAIS-SR).[20] The correlation between perceived social support and hope was extremely significant ($r = .71$, $P = .001$) and contributed to most of the variance in hope scores.[21]

Gibson's study adds a rather crucial element to the discussion of the inspiration of hope. In the above studies, the populations are either dying or otherwise faced with their mortality. Gibson's population is different; while the other population knows (to some extent) what awaits them, Gibson's population faces only uncertainty. The medical establishment to whom all trust has been given can tell these patients precious little about their outlook. In fact, medicine is even confounded by their present state of being, unable to provide details about aetiology or course of the illness. Gibson's population truly faces the unknown. In some sense, their problem provides more emotional turmoil than recognizing their mortality; these people do not have to worry about dying and being released from their problems. They have to worry about living and being continually at their illness' mercy. And they do not even know

what trials they will have to endure. Still, in the face of such adversity, hope is inspired by relationship.

Thus far, we have had mostly consensus among the studies on hope inspiration; emotionally significant relationships do a great deal of work in inspiring and maintaining hope. While this fact will remain undisputed, what will come into question is whether emotionally significant relationships do the *greatest* amount of work regarding the inspiration of hope. The above theorists and researchers would all subscribe to a common assessment of hope: it is relationally generated and maintained. Hope exists and thrives within relationships. The theorists and researchers below, with the exception of McCann and Salerno, provide something of a challenge to this assessment in that they believe that hope rises and falls with how much control an individual has or their perceived power. While McCann and Salerno support a "relational hope" theory, their arguments bear directly upon the arguments of those researchers who have found hope more determined by an individual's sense of power/control than by relationships. Considering McCann and Salerno's arguments in juxtaposition with the latter will make more sense as we move into a deeper discussion of the research.

McCann interviewed schizophrenic clients (n=9), partners (n=1), parents (n=7) and mental health nurses caring for the clients (n=24). McCann accompanied the nurses on home health visits and observed all the interactions between the above-mentioned parties for approximately 55 hours. McCann conducted in-depth interviews, with each lasting between 60 and 90 minutes in a private atmosphere.[22]

The general findings of this study were three-fold: 1) hope cannot be imposed, it must be uncovered, 2) uncovering hope involves enhancing motivation and developing goals towards wellness and, 3) only when a nurse has developed a mutually trusting relationship with clients suffering from schizophrenia can hope be uncovered (McCann). Regarding the first finding, it became evident to the researcher that when the nurse attempted to impose personal hopes or aspirations on a client concerning a specific goal, the client was likely not to achieve the goal. That is, when the client was not personally invested in the goal, because the goal was set by the nurse without consulting the client, the client had a high failure rate. The interventions that tended to be successful occurred within a context of a trusting relationship between the nurse or family member and the client where there was a mutually agreed upon goal. The role of the nurse or family member in these instances was only to "help clients draw hope from within their own resources."[23]

Concerning the enhancement of motivation, clients found that their relationships with nurses provided them with motivation to begin

achieving their goals, such as telling their friends that they suffered from a mental illness. The client benefited from achieving such a goal because it was the first step towards coping with their illness and involving other people as opposed to attempting to cope with their illness in isolation. This study shows that a mutually trusting relationship is helpful for providing strength and motivation to the client. The relationship with the nurse assisted the clients in achieving their own goals, such as increasing their interactions with others, and increasing their sense of hope.[24] In other words, clients realized hopefulness as their relationship with the therapist empowered them to motivate and set their own goals.

It would seem then that relationality is responsible even for creating and maintaining the sense of power and control these individuals have over their goals. This, however, is where the discord in the research begins. Bunston, Mings, Mackie and Jones have an understanding that one's sense of control, which the researchers reference as 'locus of control,' actually drives one's hopefulness *and* emotional well-being.[25] This is a mighty claim because, if substantiated, it constitutes the rationale for maintaining the status quo with regards to hope: hope might really come from within the individual, only being buffeted by external sources and have little relational aetiology.

Bunston et al. chose a population of outpatient cancer patients. The individuals (n=194) were interviewed twice, with meetings one week apart. Each interview included administration of Herth Hope Index[26] and the Locus of Control Scale developed by Pearlin and Schooler[27]. Locus of control is defined specifically here as

> the extent to which individuals believe that the outcomes of their actions are either the results of their own personal efforts (internal control) or of environmental constraints beyond their control (external control).[28]

In addition, other aspects of life that are known to influence hope such as occupational status, affect and quality of life were measured with Duncan's socioeconomic index,[29] the Affect Balance Scale,[30] measuring psychological well-being, and the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire.[31,32] Pearson correlational values were determined for a wide range of factors contributing to and detracting from hope and from these correlations, and finally, a path analysis was performed.

The most significant Pearson correlation values were found between hope and the quality of life indicators. The strongest relationship present was between hope and positive affect ($r = .52$, $p < .001$) with the Affect Balance Scale showing the second strongest correlation ($r = .48$, $p < .001$). Global quality of life was the third strongest correlation ($r = .47$, p

< .001). Finally, the highly touted locus of control was fourth strongest (r = .41, p < .001). That is, those that reported more control reported more hopefulness. Correlations were also performed to see the relations between social domains and hope; remarkably, the social network need and the emotional need of the patients produced correlations of small magnitude (r = .26, p < .001 and r = .16, p < .001, respectively). From these as well as many other correlations, the authors performed a path analysis that yielded the single greatest determinant of hope, locus of control, with a Beta weight of .42.[33]

The study found that hope was most influenced by locus of control both directly and indirectly; those who felt more control were seen to be more hopeful. Indirectly, as locus of control influenced a person's coping skills and emotional functioning, it effected hope through these attributes.[34] As compared with the above studies, however, emotional functioning showed little direct impact on individual's hope in Bunston et al.'s model. This is a counterintuitive finding as the positive affect, psychological well-being and quality of life correlations were so high. In fact, these correlations were each higher than the locus of control correlation and they each have social/relational components. Alas, Bunston et al. did not explain these rather anomalous statistical findings. Instead, they conclude their research with a recommendation for planning interventions that helped increase locus of control so as to enhance hope in individuals.

It would seem that despite some unexplained path analysis anomalies, one's sense of control greatly affects one's sense of hope. Still, two other studies on hope and power give us pause. Salerno's findings are incongruent with those of Bunston et al. Salerno and Wall understand the relationality between hope and power to be more dubious than do Bunston et al.

Salerno focused on the role of power and its relation to hope. The researchers attempt to understand whether hope or power has a greater impact on a person's perception of themselves, that is, their potential for recovery and living a fulfilling life.[35] Salerno administered three inventories to a group of 107 volunteer participants diagnosed with schizophrenia. The first of these was the Human Field Image Metaphor Scale (HFIMS),[36, 37] which measures self-perception regarding one's sense of integration in one's environment (higher scores indicating more integration, lower indication more isolation). The second inventory administered, the Power as Knowing Participation in Change Tool, Version II (PKPCT, VII),[38] measured the client's perceived sense of power, the control one has over the course of one's life (higher scores indicating more perceived power). Finally, the third inventory

administered was the Miller Hope Scale (MHS)[39] which attempts to ascertain the level of hope held by the participant.

Salerno found that "hope and power together did not statistically significantly contribute to more of the variance of perception of self than hope alone."[40] Hope was a greater predictor of what a person thought of their own potential than was their sense of power. Though a very strong correlation between hope and power was found ($r = .74$, $p = .000$ – did you drop a number from this p value?), a theoretical analysis indicated that these two words did represent different concepts.[41] In addition, 20% of the variance in perception of self among participants was uniquely accounted for by hope after controlling for power. The researchers linked this variance to the relational and anticipatory dimensions of hope.[42] Though perhaps a little surprising, this study reveals an interesting characteristic of hope: hope helps people connect with their potential to change and adapt more than their sense of power does.

This finding, of course, directly contradicts the work of Bunston et al. Salerno's point is not simply that hope and power are not connected. She states that hope actually predicts one's sense of power better than one's perceived sense of power. Just as Bunston et al. show that locus of control determines hopefulness, Salerno shows that level of hope determines locus of control. Though more will be made of this in the discussion, we must now add Wall's study on power and hope to the chorus, so that all relevant literature can be considered in the discussion.

Wall examined the relationship between power and hope more concretely, among participants who had lung cancer. The purpose of the study was to assess the change in client's hope and power over time relating to participation in an exercise program. The sample ($n=104$) was randomly split into two groups, an exercising and a non-exercising group. Hope and power were measured three times. The first time (T_1) was seven to ten days prior to surgery; the second (T_2), the day before the surgery and the third (T_3), four to six days after surgery but prior to the client receiving information pertaining to their final surgical pathology (so as not to influence their change in hope based on prognostic information). The Hope Herth Index[43] was used to measure the change in hope. The Power as Knowing Participation in Change Test, Version II[44] was used to measure the change in perceived power.

The changes in power were evident: those clients participating in exercise had a greater sense of power and manifested that sense by increasing the difficulty of their workouts without prompting from T_1 to T_2 to T_3. Those who did not exercise had a decrease in sense of power from T_1 to T_2 and maintained that low sense of power but lost no more from T_2 to T_3. There were, however, no changes associated with hope for either group. Each group maintained the same high level of hope throughout the study that was manifested during T_1. Despite the findings, the researchers suggest that there was some moderate, positive correlation between hope

and power, although no interpretation is possible from the results of this study.[45]

4. Discussion and Conclusions

The articles presented in review here filter rather nicely into two categories, those finding a relational aetiology to hope and those who find hope created and sustained by individual effort, here portrayed as 'locus of control' and 'power.' By way of understatement, there is some asymmetry between the two groups: the group of articles presenting hope in relational terms seems to be a unified front while the group of articles that attempt to think about hope as an idiosyncratic attribute show a great deal of incongruence. While the researchers may agree that hope has a basis in the individual's sense of power, there is certainly no consensus as to how hope relates to locus of control/power in these articles. Our first task in making sense of the articles as a whole will be to make sense of the varying views of hope and power/locus of control. Once some common ground has been established between these discordant views, we can then attempt to reconcile the research that portrays hope as an idiosyncratic attribute with the research that suggests hope is relational in nature.

To begin, we must address the cognitive dissonance between Bunston et al.'s study and the works of Salerno and Wall. Each studied the individual's ability to hope and found three different correlations regarding power. Bunston et al. show that power, or locus of control, determines the level of hope. Salerno shows that, while power and hope are different concepts, hope better approximates one's sense of power than does one's perceived sense of power. Finally, Wall suggests that hope and power are correlated in the context of a study that shows them not to be correlated at all. How do we begin accounting for such disparate claims?

Assuming Bunston et al.'s path analysis to be correct, we must account for the fact that one's sense of control helps determine hope. Yet at the same time, there seems to be evidence that hope and power are not related[46,47] and even that hope connects us with and/or determines power.[48] We have reviewed another study that may help us make sense of the relationality between power and hope, though it is not directly referenced – McCann's work with schizophrenic patients.

McCann shows that relationality can be the foundation for engendering control initially. Emotionally significant relationships foster emotional well-being and entreats patients to have and achieve particularized hopes, increasing the individual's sense of control. Control, can ultimately, then, be seen as more a function of relationality; specifically, the relationship between a therapist and a patient. I believe

what ultimately bridges the interpretive gap is a look at the populations relative to each study. Bunston et al. are working with outpatient cancer patients. McCann is working with floridly psychotic schizophrenic patients. While it is difficult to generalize about each population, general rules of physics still apply. That is, objects in motion tend to stay in motion; objects at rest tend to stay at rest. Outpatient cancer patients, while often depleted by their treatments still retain some control over their lives, choices they make and general autonomy. No one confines you to a state hospital if you have cancer. Schizophrenic patients by contrast are forced by their illness to give up their autonomy as their minds have turned against them. The point is this: schizophrenic patients have *a priori* less control than cancer patients due to the condition of their minds. In viewing schizophrenic patients, we view patients whose control is often less than that of cancer patients. As such, schizophrenic patients are at a point prior to cancer patients in the process of hope inspiration and they need relational stimulation of goal-setting and motivation to move them to hope. Secondly, the support cancer patients get, even if only from the medical establishment is enough relational interaction to begin the process of goal-setting and motivating necessary to increase hope. The fact that they were in treatment presupposes something of the relationship described in McCann's study and suggests the cancer patients probably derived hope relationally in a similar manner. Once control is established, it is easy to see how Bunston et al. arrived at their conclusion that control engenders hope. The larger point here is that there is consistency between the two studies, if we understand that McCann's study represents a more primitive state of hope-inspiration and that relationship, as she shows, is the foundation for engendering control initially. Salerno's findings are consistent with this interpretation as she found that hope actually predicts power and one's sense of control.

Thus we find that solipsistic control of one's environment is not tantamount to hope. Rather, we have seen relationality inspire control even as it inspires hope. Furthermore, we see that even the aspect of hope that seems entirely idiosyncratic, one's sense of power/locus of control, is relationally determined. Currently free of viewing hope as an idiosyncratic attribute, we can consider hope more deeply as a relational process through the preponderance of the evidence put forward in the studies reviewed.

First and foremost it is clear that all the studies agree with varying vehemence that hope has an affective component pervading the entire act of hoping.[49-52] That is, the act of hoping is sustained by the act of relating affectively to individuals and events both generalized and particular.[53] Negative emotion impacts hope just as positive emotion does; hope is diminished through isolation and rejection and increases with the number of caring relationships.[54,55] We see therefore a dynamic of interdependence between emotionally significant relationships and hoping.

This dynamic is delineated more carefully by Cutcliffe: he notes that the way individuals are treated has a great deal of influence on how they feel about themselves. Similarly, if an individual is feeling positive self-worth, that they matter to others, their hope increases.[56,57] We have also noticed, through Salerno's work, that hope influences self-perception, at least in regards to power. The research, then, seems to indicate reciprocity between hope and the perception of self, particularly the perception of self by others, such that a boon to one will be a boon to the other and a detraction from one will be a detraction from the other.[58,59] There appears to be a reciprocal process between perception of self and hope and a new concept of hope can be couched within this relationship.

5. Reflections on the Concept of Hoping – a Preliminary Sketch

I suggest first that we define hoping in terms of emotionally significant relating on the basis of empirical evidence. Hope seems to thrive with the existence of interaction in emotionally significant relationships, and withers when such interaction is absent. Relationships are a necessary condition to the process of hoping. This necessity is evinced by the fact that when relationships are strong, hoping is possible and hope is therefore stronger. When relationships are poor, hoping becomes more difficult and hope thereby declines. I propose that the reason why hoping experiences this tight correlation with relationships is that hoping *is* those same relationships projected on the future.

To consider hoping as a relationship, or a relating to be more precise, we still must consider that to which hoping is relating. After all, there is not simply a relating; there is always a relating to, or a relating with. For us, hoping is the activity of relating to the future. Hoping, though, is never without its affective component, as Dufault and Martocchio have attested. The character of this relating takes on the emotional quality of the relationships that give it life; it is the character of the reciprocal relationship discussed above; we relate to the future as we are related to in the present and have been related to in the past. Past and present relationships act on the individual to make them feel a certain way and this feeling is projected onto the future in the act of relating to the future. It is this affective relating to the future that I call hoping. 'Future,' then, seems to be a product generated by the projected relational residue of relations occurring in the present moment and in the past. We relate to the future as if it were a subject, a composite subject, the sum total of our relational experience. What we hope for and how much we hope is then shaped by the amalgam of positive and negative relational experiences we have had. More, though, our hope is determined by our relationship with

our projected future. As we have affectively projected our future, it then embodies a certain emotional reality distinct from us with which we can interact.

Hope, then, is that state which is generated from our relationship with an emotionally charged, "subjectified" future. Thus, hope can be understood as a strictly relational concept, itself a product of relationality. It is possible from this perspective to see, however, how one might think of hope as the idiosyncratic attribute of the individual; the state of hope manifests idiosyncratically. That is, I am the only one who can embody/represent my hopefulness. The hope that I am so idiosyncratically manifesting, however, was generated and is being maintained through relationships – those I have had in the past, those I have in the present with individuals, objects and events and, finally, with the future itself.

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