# Understanding Hope and Debunking Its Myths Forge a Valuable Tool for Clinicians

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## CASE PRESENTATION

A 64-year-old engineer was diagnosed with a cT2cN0M0, Gleason score 8, adenocarcinoma of the prostate. His prostate-specific antigen level was 15 ng/mL. The case was discussed at the hospital tumor board. On the basis of the results of genomic testing that revealed high-risk disease, a consensus emerged to intensify treatment. He embarked on a course of neoadjuvant hormonal therapy (antiandrogen + luteinizing hormone-releasing hormone antagonist), followed by concomitant treatment with external beam irradiation (encompassing the prostate and pelvic nodes), with hormonal therapy continuing for a total of 18 months.

A first-year oncology fellow assigned to care for this patient, noted that he was cooperative and even proactive in his behavior, yet he seemed pessimistic. In their conversation, he expressed considerable worry that the therapy "would not work" and that he would still pay the dear price of lost libido, hot flashes, and—"with my luck"—neurocognitive decline. Before the fellow could respond, family members coaxed the patient to cheer up. "Stay positive," they insisted. "That attitude is gonna kill you!"

The fellow left the room to confer with her attending physician. She felt that, although it was not anyone's right to invalidate the feelings of patients, perhaps the care team should be doing something to alter this patient's outlook. She wondered whether effective management and even hope could coexist with the worries he was expressing.

## INTRODUCTION

In an oft-quoted but ill-titled piece that appeared in the *New England Journal of Medicine* in 1978,[1] Groves argued that physicians often dread caring for individuals he designated "hateful patients". In our opinion, no patient should ever be labeled hateful. Nonetheless, Groves was observing something important: All physicians encounter patients who can kindle aversion, fear, and despair. Everyone has unique personal reactions to patients given their particular life histories and challenges. However, in our experience, patients who express significant pessimism often trigger such feelings as physicians struggle to balance a realistic presentation of the clinical facts with a desire to encourage hope.

On the one hand, oncologists are rightly concerned about taking away hope, fearing the consequences of a blunt or unfiltered delivery of clinical information. On the other hand, sugarcoating somber news to protect patients might have the unintended effect of compromising effective medical decision making. In this pragmatic article—written with the travails of our colleagues in mind—we discuss how a new understanding of hope and cultivating skills that allow a clinician to foster hope may help restore equanimity, thereby allowing physicians to remain present in this most challenging space.

## HOPE—DEFINITIONS AND MISCONCEPTIONS

Human beings require and even crave hope.[2] Yet, a bibliometric analysis of nearly two decades of articles published in two high-impact oncology journals found that physicians appear to be reluctant to use the term "hope" in their writings, except in the context of less scientifically

oriented reports such as narrative essays.[3] This leads us to consider whether a similar tendency to shy away from such terms may affect clinician's interactions with patients and families.

We surmise that some physicians may recoil from the language of hope and its associated terminology because such concepts seem to lack empirical grounding and, therefore, feel amorphous. In reality, however, considerable empirical effort has been expended to understand the notion of hope, in view of its foundational importance. In the field of psychology (and increasingly in medicine), Hope Theory has emerged as the dominant paradigm for defining hope.[4] This model was developed by Snyder, one of the founders of the field known as positive psychology. His efforts began in the late 1980s, when he sought to develop a formal, operational definition of hope.[5] During a sabbatical year from the University of Kansas, he interviewed a large number of individuals whom others had identified as being hopeful, asking them to describe how they thought about their lives. He discovered that they shared three tendencies in common: goals, pathways, and agency. In Snyder's formal theory, he referred to these as the three components of hope although they can more intuitively be considered the three conditions for hope to thrive.

The first condition is to have something to hope for: a goal or goals. Hopeful individuals tend to set intrinsically meaningful goals in multiple areas of their lives. Second, hopeful individuals engage in pathway thinking. That is, they tend to produce a kind of mental map to their goals, plotting out possible routes to their objectives. Indeed, they often make contingency plans, realizing that not all pathways may initially succeed. Finally, hopeful people find sources of personal agency, the motivation, or energy to pursue those pathways. Sources of agency can include our beliefs regarding our own personal abilities or can derive from the support and encouragement of other people in our lives.[6]

Snyder and other framers of Hope Theory proceeded to develop and subsequently validate a variety of self-report scales,[7,8] allowing for hope to be monitored over time.[9] Using these measures, physically healthy individuals with higher levels of hope have been shown to experience lower levels of depression and anxiety than their lower-hope peers, tend to be more resilient in the face of traumatic experiences, are more likely to report that their lives are meaningful, and are more likely to engage in health-promoting behaviors (eg, diet, exercise).[10-12] Moreover, patients with cancer who manifest higher levels of hope appear to experience better outcomes—including lower pain levels and possibly even better prognosis—when compared with those with lower levels of hope.[13,14] Whether such outcomes are truly spawned by hope and whether hope must be linked with positive clinical outcomes to be considered worthwhile (as opposed to the pursuit of hope for the sake of hope) have also been addressed in previous publications.[9]

In crystallizing Hope Theory, it became evident that misconceptions would also flourish. We have summarized the most common fallacies pertaining to hope in Table 1 and will briefly elaborate on the issues cited there. First, a fundamental premise of Hope Theory is that cure need not be the only goal of patients diagnosed with cancer. McClement and Chochinov[15] have cautioned that, in the field of oncology, physicians and patients are at risk for conflating hope and cure. By contrast, even patients who almost certainly will succumb to their malignancies can be guided to identify other goals that are meaningful and achievable. In other words, patients can die *with* hope.

Another proposition that collapses in the face of this model is the equation of hope with optimism. Optimists, according to Scheier and Carver, harbor an expectation that the future will be good. This belief is considered highly generalized, meaning that optimists generally believe that things will turn out well regardless of their personal actions.[16] Optimism is, in some sense, what many people mean by the term "positive thinking." It involves seeing the glass half full even when, perhaps, it is not.

Hope, on the other hand, is a belief in one's personal ability to move in a positive direction given the realities of a situation. It can therefore exist even in circumstances that are objectively dire because it does not require a general positive outlook, but rather a belief in one's ability to set goals, plot pathways, and conjure agency. In this regard, validated and widely used measures of hope and optimism/pessimism generally only moderately correlate with one another and have been shown be empirically distinct in terms of their predictors and outcomes.[17,18] Thus, as ironic as it may initially seem, someone can be a hopeful pessimist. Even someone who tends to think pessimistically can be taught to acquire the skills to set these conditions for hope to thrive in their lives. It is possible for pessimists to become hopeful[19] without necessarily becoming optimists.

While there is certainly a risk of creating false hope—which we view as an unhelpful and possibly unethical development[20]—this is unlikely to arise as long as the goals selected are characterized by plausibility. Even the arduous task of delivering bad news need not extinguish hope, provided that the process is done with authenticity, without threat of abandonment, and with a commitment to join patients in selecting meaningful goals given the realities they are facing.[21] What is

**TABLE 1.** Misconceptions Pertaining to Hope

| Common Misconceptions |
|---|
| Hope is equivalent to cure |
| Hope is synonymous with optimism |
| Hope is incompatible with pessimism |
| Hope might be regarded as hazardous in clinical interaction because it engenders false expectations |
| Breaking bad news to patients necessarily extinguishes hope |

more, physicians can draw reassurance from qualitative studies of patients in the final months of life, which have found that the personal meaning of hope for these individuals appears to be more related to the perceived importance of the objective that they have attached it to, rather than to the likelihood of actually achieving that objective.[22] Even more intriguing, an exploratory longitudinal study of patients with cancer found that, over time, levels of overall hope tended to remain constant or increase, even among patients who reduced their particular hopes for cure.[23]

## TECHNIQUES TO AUGMENT HOPEFULNESS

Mack et al[24] have shown that physicians bear responsibility for cultivating realistic clinical expectations. While data have previously been presented to refute the mistaken notions of the six bulleted items highlighted in Table 1,[25] perhaps the most helpful way to dispel these myths is to offer practical tools to derive clinical upside from hope.

### Hope Interventions and Workshops

Hope appears to be modifiable through a variety of psychosocial interventions. When such interventions were initially proposed, they were administered over a 5- to 12-week period,[26,27] which can be impractical for many people who might not have the necessary time owing to competing demands. Thus, Feldman and Dreher[28] designed a 90-minute single-session intervention for university students, which has come to be called the Hope Workshop, documenting its ability to enhance hopefulness. Such low-burden workshops generally contain three components: a didactic overview stressing the clinically relevant aspects of Hope Theory, a hope mapping exercise in which goals with accompanying pathways are chosen while participants assist each other in devising creative ways to overcome obstacles that may block progress, and, a guided imagery activity designed to increase agency and internalize the previous principles.

Since the initial description of such workshops for college students, efforts have been made to apply the underlying principles in the setting of illness, particularly among patients with cancer and those who care for them. In this regard, Shah et al[29] used a single-session, in-person workshop—modeled after the guidelines of Feldman and Dreher—with women with metastatic breast cancer, documenting a significant augmentation of hope. Similarly, McLouth et al[30] used a combination of individual counseling sessions and telephone-based contacts to increase hope in patients with advanced lung cancer. However, there remains a need for long-term follow-up of such interventions and more studies with randomized designs.

During the COVID-19 pandemic, versions of initially in-person interventions were delivered through a videoconferencing platform augmented by a smartphone application.[31] Moreover, given the large number of populations that could potentially benefit from hope enhancement techniques (ie, patients, caregivers, etc), attempts are now being made to pursue scalability through completely self-guided learning modules.[32] Whether self-directed learning, which de-emphasizes the social support[33] present in the in-person or videoconferencing venues, is effective will be the subject of future studies.

### Developing Comfort With Uncertainty

Talking about hope with patients requires physicians to become comfortable with uncertainty. Many physicians prefer structured conversations adhering to codified guidelines,[34] and veering from traditional topics and methods can create anxiety. Conversations about hope often go beyond traditional medical goals and require that the clinician tolerate a considerable amount of ambiguity, something we recognize is neither easy nor intuitive. Although there is no single method to develop or perfect the necessary communication skills, some medical schools have incorporated techniques from improvisational theater into their communication skills training that we feel can be particularly helpful. The evolving field of medical improvisation, rooted in the teachings of experiential learning[35] and social learning theory,[36] has spawned workshops designed to impart competencies in dealing with uncertainty.[37,38] Improvisational approaches enable physicians, through the use of games and playful engagement, to feel more at ease in going off-script. Regardless of the method by which it is learned, hope-related conversations will likely require cultivating comfort in veering from the traditional cancer care conversation.

### Exploring a Breadth of Hopes

Oncologists are thrust into an arena wherein they invariably encounter and interact with the hopes of their patients. Feudtner[39] wrote that it may be desirable to foster a wide range of hopes—from the mundane to the miraculous. However, he noted that when hopes appear to be meaningful but grand (and, therefore, likely out of reach), it may be worthwhile to reduce the magnitude of the goal, thereby rendering it attainable. Importantly, this does not necessarily mean abandoning the initial goal, but guiding patients to reconfiguring it as a collection of smaller hopes (ie, baby steps instead of giant leaps or moonshots). Indeed, strategies involving adjusting the framing and difficulty of goals have been used in hope enhancement interventions.[40]

A related tip, particularly when patients realize that a previously sought goal is no longer possible, is to gently inquire "Do you mind telling me what else you might be hoping for?" We also often ask patients what was important to them about the unreachable goal, engaging a discussion about how other goals might satisfy a similar underlying desire. In doing so, clinicians can determine which goals are malleable and, in turn, nurture an array of hopes. Thus, there is a higher probability that alignment can be established along both an internal axis (ie, coincidence of patient goals with patient

values) and an external axis (eg, patient and physician as stakeholders both hoping for the same thing).

### Borrowing and Lending Hope

In the first act of Hamlet,[41] Shakespeare—speaking through Polonius—famously cautions "neither a borrower nor a lender be." While this iconic statement might constitute sound financial advice, if extended more broadly, it may hinder the ability of hope to thrive. Indeed, Lopez has proposed[42] that some individuals are endowed with a surplus of hope. In effect, they can lend hope by serving as exemplars who might be emulated. In addition, friends or family members may lend various forms of support that may help facilitate goal pursuit by others. In this regard, physicians do not function in a vacuum and are often supported by a team of allied professionals. Li et al[43] characterized an array of problems (eg, depression and other forms of psychological distress) that potentially compromise the ability to hope. They suggest that psychiatrists and other professionals with skills in addressing these issues can be consulted to assist with case management. Members of the cancer care team, such as chaplains, are often particularly adept at reminding physicians that professionals can "hold hope" on behalf of patients.[44]

### Case: Epilogue

After conferring with the senior physician, the oncology fellow returned to the room to re-engage with the patient. While swinging the swivel chair around from behind the desk to eliminate any physical barriers, she offered to quantify the risks of the side effects he feared. On hearing the data, the patient remarked that the dangers of treatment seemed less perilous.

> "Would it be ok to tiptoe into territory that isn't, um, oncological?" she hesitatingly asked. The patient put down his cell phone and looked up with a nod.
>
> "When I introduced myself to you, I made sure to emphasize that I'd only recently started my training as a cancer doctor." It was clear that she was cushioning her message, yet the genuineness was palpable and elicited a noticeable sense of trust. "Even though I'm relatively new at this, in my experience, I've found that moments like these lend themselves to inviting hope into the room." She did her best to explain some of Snyder's theory in a way that was not so much disruptive as it was disarming. Then, she asked what his goals were—not only his goals for care, but also other goals in his life.

Before long, the patient acknowledged that what he was characterizing as his bad luck was actually a sense of guilt that he had prioritized his work over almost everything else in his life. He mentioned that, lately, he had been entertaining the possibility of attending church services—something he had abandoned long ago—and volunteering at a local food bank, which was managed by an organization he admired. In addition, the hospital chaplain was enlisted to help the patient both act on his social conscience and adhere to hormonal therapy. None of this magically turned the patient's emotions around, of course, and he continued to express doubts and worries. Yet, the conversation began a process of strengthening his hope that—even in the midst of apprehension—he could take practical and even powerful steps not only to beat the tumor but also to reach other meaningful goals.

In conclusion, there is an emerging evidence base substantiating the value of hope. With methodical rigor, hope has been operationalized and shown not only to be measurable with validated tools but also augmentable with targeted brief interventions and techniques. An understanding of hope's subtleties can provide a much-needed tool for oncologists to counsel patients without necessarily attempting to deflate pessimism or inflate optimism. Clinicians who are dedicated to acceptance can provide temperance when hope is brought into realistic focus as the patient-clinician dyad concertedly identifies priorities in care and in life. Ultimately, the collaborative pursuit of meaningful goals is likely to be rewarded by valuable outgrowths as decision making is facilitated, empathy is replenished, personhood[45] is affirmed, and the social contract between the patient and the oncologist is strengthened.



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