Hope constitutes an essential experience of human condition. It functions as a way of feeling, a way of thinking, a way of behaving, and a way of relating to oneself and one’s world. Hope has the ability to be fluid in its expectation, and in the event that the desired object or outcome does not occur, hope can still be present. As a way of feeling, hope opens to the painful feelings of the experience, goes beyond emotions and functions as an energizing force. As a way of thinking, hope is associated with a sense of fortitude, described as the dealing of facts beyond the visible. As a way of behaving, hope expresses itself as an active process to seek the possible and appropriate alternatives.

Wishing can be defined as desiring or longing for something, or having a strong inclination for it (Webster II 1984). The goals of wishing are more specific, and the possibility of the desired for outcome actually happening is more limited whereas the goals of hope may be specific or non-specific. Affectively, persons who wish think of the possible in positive terms only and are more closed to the painful feelings of an experience. Cognitively, persons who wish are constricted in their thinking. They can think of the most positive outcome only. As a way of behaving, wishing is more passive in nature; the persons often engage in few behaviors that work toward obtaining the wish for outcome. The outcome is more inflexible in wish than that of hope, in that it anticipates only something positive. In reality, wishing and hoping often function simultaneously. Wishing may pay important functions as persons work through difficult experiences toward a more hopeful stance.

Hopelessness leads to spiritual distress. Fostering hope is a component of spiritual care. Hope is expressed and articulated in the lived experience, in the context of life itself. But, what is the meaning and nature of hope in the context of palliative care?

Hope is the major factor in a patient’s ability to rise above the adversity of progressive, life threatening illness. Hope plays an important role in effective coping, enhances the quality of life while hopelessness is commonly associated with depression, suicidal intent, negative changes in physical health. But the use of hope in clinical practice is still under utilised, especially in palliative care.

Hope is a multidimensional dynamic life force characterised by a confident and yet uncertain expectation of achieving a future good, which to the hoping person, is realistically possible and personally significant. There are 6 dimensions of hope—each dimension is depicted by a set of components that structure the experience of hope: (1) Affective dimension focuses on sensations and emotions which are part of the hoping process. (2) Cognitive dimension focuses on the processes by which individuals think, imagine, perceive, remember, learn, generalize, interpret and judge in relation to hope. (3) Behaviour dimension focuses on the action orientation of the hoping person. (4) Affiliative dimension focuses on the hoping persons’ sense of relatedness or involvement beyond self. (5) Temporal dimension focuses on the hoping
person’s experience of time (past, present and future) in relations to hope and hoping.

(6) Contextual dimension points out that hope is brought to the forefront of awareness and experience within the context of life as interpreted by the hoping person. It focuses on those life situations that surround, influence, and are a part of persons’ hope. The context serves as the circumstances that occasion hope. A frequent context within which hope is experienced is the situation of actual or potential loss.

**Myths and Hope**

People who are terminally ill often become marginalized from the mainstream of the society. Debilitating symptoms displace them from prominent social roles and functions. There are 3 popular myths within our current healthcare culture which further marginalize these terminally ill patients. Myth means widely held false belief. The 3 myths are: (1) myth of immortality, (2) myth of the magic bullet, (3) myth of truth telling.

**The Myth of Immortality** is a societal attitude of denying our physical mortality and a strong collective death denial. Immortality is a way of coping with the fear of death- the denial of physical death that all human beings must endure. The society has a predominant focus on physical health and fitness. It is the fear of death, not death itself, that keeps men incomplete, thus driving them to seek immortality. In the disease illness paradigm, there is a strong tendency to link hope with cure. If there is no cure, there is no hope, so the terminally ill patients are often written off as hopeless. Within this myth of immortality, people live their lives in their future, where time is seemingly endless. The experience of hope of many is linked to this timeless future and people focus mainly on goal setting for their hope. Terminal diagnosis confronts people with their mortality, stripping their view of an infinite, futuristic hope. For the terminally ill, time slows and stops entirely, (the experience of hope is related to time), while it continues to move forward for the rest of the world. Terminal patients have little or no future because they have no time and therefore they have little hope. There is a Strategy to extend hope through time. It is a process of extending the self in time beyond the present moment in time into the not yet lived future and also into the already lived past. The patients either identify hopeful moments or models from the past that may be helpful to them now to go through the difficult times or we explore the patients’ belief about immortality and try to expand their view of immortality. A broadened view of immortality creates possibilities for integrating the patient’s past, present and future as a part of life review and gives a sense of purpose and meaning in lives. Lifton reframes immortality symbolically in 5 ways: (1) biological - living on through one’s descendents, (2) theological - belief in life after death, (3) creative - works of art and science, (4) nature - the timelessness of the natural environment, (5) experience - transcendence the realm of mystic. Not everyone may be opened to Lifton’s approach and it is important to acknowledge the uniqueness of each person’s perception of immortality.

**The Myth of the Magic Bullet** means that every illness is curable with a magic bullet, which leads to a desperate search for cure. This view obscures other possibilities, however. Illness may be chronic, progressive or potentially incurable. A chronic framework of understanding the life-threatening disease is more suitable in the palliative care setting, not a cure or dead attitude. Perakyla identifies 3 types of hope works. Hope work
refers to the recurrent interactional patterns among the caregivers, patients and family members that either enhance or diminish hope in the clinical setting. (1) Curative hope work is a biomedical model, the ultimate goal of which is cure and physical improvement, which are the markers of hope. (2) Palliative hope work aims to make patient feel more comfortable or better with no focus on cure. (3) Work to dismantle hope is to undo previous hope work e.g. caregivers dismantle curative hope work when a terminal illness is diagnosed or dismantle palliative hope work when death is imminent. Kubler-Ross disagrees with the concept of dismantling hope at any time. She suggests that hope for a cure is both normal and functional even in the end stages of life. But how can caregivers extend a patient’s hope beyond the hope for a cure? There are 2 spheres (types) of hope which may coexist in the final stage of life: (1) Particularized hope is associated with specific goals or objects while (2) Generalized hope refers to an intangible inner experience of hope that is not connected to any specific goal or object. It refers to a ‘hoping self’ - the part of self which gives rise to hope. This corresponds to 2 critical components of hope experience: (1) Doing - a more tangible and visible hope for cure e.g. hope for relief of pain, to accomplish a specific task, peaceful death. (2) Being - a personal inner experience that may be difficult to express outwardly and may be more accessible by the use of symbols, metaphors, stories and images. It is this part of the hope experience that is important to nurture and enhance within patients, as their ability to engage in the action oriented part of hope wanes with advancing disease.

The Myth of Truth Telling is a belief that patients need and want to be told the truth. This may be more a cultural phenomenon in some societies and not so in others, e.g. the Japanese and Italians are less open in sharing medical information with patients. A USA survey on physicians showed that in 1961, 90% physicians did not disclose cancer diagnosis to patients while in 1979, 97% physicians prefer to inform patients about their cancer diagnosis. The recent emphasis on patient autonomy, informed consent and patient’s right to self determination influence our information disclosure pattern. These principles imply and assume that patients all want to be told the truth and to be involved in decision making. But any moral obligation of truth telling should balance with the moral obligation of respect for the value of hope of patients. Truth should be provided in a way that respects patient’s experience of hope. The amount of information and the manner it is offered are important. Full information disclosure may not necessarily be desirable and helpful for every patient. The information needs of the patients should always be established first. False despair, the provision of truth without hope, is equally destructive as false hope, the provision of unrealistic hope without truth. But how can one tell patients the truth without destroying all their hope? How can one enhance patient’s experience of hope without denying the reality of the disease? These are the questions we have to ponder on.

The three myths provide a background for understanding the experience of hope in palliative care. The initial diagnosis of a life threatening illness challenges our personal belief in the first myth, the myth of immortality. In response to this threat to immortality, patients, family and professionals may grasp the second myth, the myth of the magic bullet, in their desperate search of cure. When a diagnosis of incurable disease is made, the
professionals may embrace the third myth, the myth of truth telling, which may not be equally endorsed by the patients. The multidimensional framework of hope, (vs the unidimensional framework of hope that primarily focuses on futuristic goal setting and problem solving) which includes the more intangible inner experience of hope, should be emphasised and recognised more in the terminally ill. The patient’s intangible dimension of hope is a more inner process oriented experience of hope which includes, according to Nekolaichuk’s hope model: (1) personal spirit (personal dimension) which revolves around a core theme of meaning (2) risk (situational dimension) which refers to a balance between predictability and uncertainty (3) authentic caring which refers to a blending of the components of credibility and comfort.

Illnesses teach us how to confront and deal with the inevitable fact that we will all die, each of us. The choice is not whether or not we go, but how we go. We cannot expect our patient to relinquish the myths if we cannot do it ourselves.

In conclusion, by dispelling these myths, we hope to open ourselves to new possibilities that more closely capture the nature of hope in palliative care patients and thus meet their hope needs more accurately and effectively.

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With compassion, hope blooms.