Hope Can Play a Transformative Role in Cancer

**NEW ORLEANS —** Hope plays an important role in the experience of cancer patients, especially those with poor prognoses, and it often follows an unexpected trajectory.

These were the findings of several studies presented at the annual conference of the American Psychosocial Oncology Society.

“While patients have a hard time defining hope, they almost always know exactly what it means to them, and they usually define its opposite as ‘giving up,’” said Amy Pearson of the Lung Cancer Alliance in Washington. Her study was conducted with the National Brain Tumor Society and the Pancreatic Cancer Action Network.

Meredith Cammarata and colleagues from Mount Sinai Hospital in New York added that hope has been described as the ability to acquire belief in one’s ability to control one’s circumstances, a positive expectation for goal attainment, belief in probabilities for the future, and belief that one’s present situation can be modified—that there is a way out of difficulties.

Others have suggested that hope is an experiential process; a relational process; a rational process; or a spiritual and transcendent process that might be determined by one’s faith and belief or one’s life experiences, her poster noted.

Studies further indicate that hope exists along a continuum, with goals ranging from cure to comfortable death; that hope is fluid and changes throughout the course of the illness; and that hope is dynamic, beginning with one’s reaction to a diagnosis, according to Ms. Pearson’s study, which examined this “hope trajectory” in 15 long-term survivors of lung, brain, and pancreatic cancers.

Although the 5-year survival rates for these cancers are approximately 30%, 15%, and 5%, respectively, the subjects in the study had survival that was double the 15%, and 5%, respectively, the subjects in these cancers are approximately 30%, with survival that was double the 15%, and 5%, respectively, the subjects in these cancers are approximately 30%.

The study validated that patients want a rational process; or a spiritual and transcendent process that might be determined by one’s faith and belief or one’s life experiences, her poster noted.

Strong religious affiliation, a supportive family, cancer prognosis, and treatment plan are “not always associated with hope in the manner in which we would expect them to be,” said Ms. Cammarata. “It is not immediately obvious to some that they can be associated with hope,” she added.

As the treatment plan and bone marrow transplant team became positive about her diagnosis, she remained hopeful. Even in remission, she refused to leave the house and obsessed over relapse. Despite having a loving support system, she was unable to accept and benefit from their support.” The hope trajectory, which plotted the patient’s expression of hope against the treatment course, showed that her hope plummeted continuously from baseline, with the curve continuing to fall even when the transplant appeared to be working.

Patient No. 2 had acute myeloid leukemia and expressed minimal hope from the time of diagnosis. “Instead of focusing on getting better, she ruminated on her symptoms and the possibility of relapse,” the researchers noted.

Patient No. 3 expressed “endless hope,” in spite of a poor prognosis, the death of a friend who also had leukemia, and ultimately his debilitating graft-vs.-host disease. “He had a tremendous amount of support and was determined to live,” according to Dr. Carl G. Kardinal of the University of Missouri in Columbia.

Go Carefully With Informed Consent

Dr. Carl G. Kardinal of the University of Missouri in Columbia suggested that Phase II trials offer patients with advanced disease hope that might not otherwise be available. He and his colleagues evaluated the hope trajectory of 50 consecutive patients who consented to participate in Phase II cooperative trials. Patients were interviewed by a psychosocial worker who was not directly involved in their care.

All 50 patients stated that hope of therapeutic benefit, however small, was their primary motivation to join the trial. Other motivating factors were altruism (29%), avoidance of regret that later they should have participated (19), lack of other treatment alternatives (14), and trust that their oncologist thinks this trial might help (10), Dr. Kardinal reported.

He pointed out that this is a vulnerable patient population for whom “truly informed consent” might not be possible. He further maintained that the current informed-consent process is too cumbersome and should be simplified.

“Hope of a treatment response is the overwhelming emotion of cancer patients to participate in phase II trials. This places an even greater responsibility on the physician-investigator to protect these human subjects,” he said.

Source: Ms. Pearson

Physicians Can Create a Space for Hope

Health care providers can foster hope in the following ways:

- **Even in cancers of poor prognosis, patients can survive.** When physicians deliver the diagnosis, they can create a space for hope.
  - **“What can I control?” is an important question for patients.** Assess what level of information the patient wants, and communicate accordingly. For patients who believe that a healthy lifestyle might make a difference, help foster this belief.
  - **Psychosocial and support resources might have a positive impact.** Inform patients about support resources and peer support programs. Connecting with other patients might help survivors find meaning.
  - **Cancer is an existential crisis.** Some patients search for the meaning of their illness; and their beliefs, spirituality, and personal beliefs might be challenged. If the patient uses faith or spirituality to gain hope, find ways to support this tool. If the patient’s questioning of his or her faith results in a loss of hope, consider helping the patient connect with a spiritual community or advisor.

Source: Ms. Pearson

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