

## THE MEDICAL USES OF HOPE

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"Hope is the thing with Feathers  
That perches in the soul and sings the tune without the words  
And never stops at all."  
(Emily Dickinson)

Too frequently patients will complain, "The doctor gave me no HOPE," as if it were a sample or prescription that should have been offered along with the rest of the treatment. If HOPE were a medicine and listed like other drugs in the PDR, the entree might look like this.

### Clinical Pharmacology:

HOPE is a naturally occurring substance created by an individual's ability to project himself into the future and imagine something better than what exists in the present. It serves as a co-factor for most purposeful behavior and is necessary for coping with fluctuating feelings of despair, depression, fear, anxiety and uncertainty.

HOPE has three components: The individual hoping; the projection into the future (expectation); and the object, event, or state desired.

Individuals experiencing HOPE vary with respect to the density and binding constants of HOPE Receptors. There is both up- and down- regulation of receptors depending on the danger of the circumstances, the individuals' sense of vulnerability, and the support system available. Certain individuals have a pathological need for HOPE and are susceptible to False HOPE.

Expectation, comprised of the subunits Credibility and Attainability, is conveniently measured as a vector having units of distance and difficulty (X,Y). Even if there is a strong belief that a goal is possible (Credibility), if the individual perceives it to be too difficult to attain, or that it is impossible to project himself into the future, Expectation will be low. Both intellectual and emotional Expectancies must be above threshold levels for HOPE to be effective.

The Object Desired is the most visible aspect of HOPE and may be expressed concretely or implied, (e.g. "I hope the surgery will cure the cancer." "I hope everything turns out all right.") The strength of HOPE often depends on the meaning or importance (Preciousness) of the Object.

### Pharmacokinetics:

After administration either verbally or visually HOPE enters cortical and thalamic pathways where it is processed for Credibility and Attainability. If receptors are blocked by depression, anxiety, or distraction there is no binding and HOPE dissipates immediately. Depending on the number and avidity of open receptors, there is an immediate effect that has a half life of minutes to hours. Longer effects require repeated administration. Both sensitivity and tachyphalaxis can develop depending on how often the Desired Event occurs or does not occur.

### Indications:

HOPE is indicated in the treatment of **HOPE Deficiency, Depression, Anxiety** and to increase **Motivation** and **Compliance** with treatment. It is useful in relieving fear, pessimism, and a sense of vulnerability. It increases energy and courage in all individuals, resulting in greater likelihood of difficult goals being accomplished.

HOPE should be given at the initial diagnosis of a potentially fatal disease, at any recurrence and when the disease is terminal. It should also be used when dealing with chronic “benign” diseases such as arthritis, diabetes and hypertension. It should be given whenever despair is anticipated.

HOPE Deficiency (Hopelessness) is a state of despair characterized by the inability to anticipate any positive outcome. Patients are generally unable to act decisively, make decisions, have meaningful relationships or experience joy or meaning. They are described as having “given up.” The Will to Live is diminished in proportion to the degree of hopelessness.

**Contraindications:**

There are no known contraindications for giving HOPE.

**Mechanism of Action:**

Depression is characterized by the inability to imagine anything different from the present. HOPE, because of the component of Expectation, relieves the inability to project into the future. HOPE allows such individuals to create a possible future, thereby relieving the onus of living in the present. The anticipation of pleasure relieves pessimism.

Anxiety, characterized by a sense of loss of control, is alleviated by predicting a desirable future event, thereby providing an anchor for the individual in the midst of free-floating anxiety. The sense of aloneness is relieved by anticipating allies or help. Fear, which consists of projecting into the future an undesirable event (helplessness, pain, etc.) is redirected by the expectancy of a positive rather than negative outcome. Motivation to accomplish goals and compliance with medical treatment are increased by a sense that the goal is attainable.

**Warnings:**

False HOPE is the intentional or inadvertent creation of the expectancy that a low probability outcome is likely. It is a violation of medical ethics to intentionally deceive a patient for the purposes of manipulating their behavior. Physicians and nurses generally try to avoid any appearance of False HOPE and may generate False Despair instead. Certain individuals, because of a high need for HOPE based on the seriousness of their condition or their premorbid personality characteristics, are prone to misinterpret information given and develop False HOPE or False Despair even when none is intended. Patients generally use False HOPE to diminish the full emotional impact of an intolerable situation.

False Despair is the intentional or inadvertent discrediting of any probability that a desired outcome is possible. In order to avoid any suggestion of False HOPE some medical professionals will purposely lower patient expectations to avoid any chance of disappointment. Patients likewise may avoid the disappointment of unrealized hopes by purposefully keeping their expectations low, feeling it is safer to expect the worst. It is a violation of compassion and the Hippocratic oath to purposely withhold HOPE of a low but finite probability outcome from those patients who desire it. It may be pointed out that even under the bleakest of circumstances there are some survivors.

**Usage in Pregnancy and Children:** HOPE is safe during Pregnancy. It passes into the breast milk and is known to be safe for infants. HOPE may be used in pediatric patients, adjusting language but not dosage according to age.

**Adverse Reactions:**

Adverse reactions occur when physicians or nurses, out of a desire to please the patient, try to appear more powerful than they are and manipulate patient behavior by substituting False HOPE for True or Realistic HOPE. Patients likewise may distort ethically administered True HOPE out of an inability to cope with reality. False HOPE leads to persistent denial of reality and poor judgment. It causes 1) persistent goal oriented behavior toward an unobtainable goal; 2) distraction from necessary activities; and 3) delay in resolving emotional issues. **There are no adverse effects of True HOPE.**

**Overdosage:**

Individual's capacities for HOPE vary considerably. Excess True HOPE is very rare. More common is the medical personnel's assessment that the patient's estimate of outcomes is "unrealistic." Conflict arises when the patient's need for HOPE differs from the nurse's or physician's. If overdosage is suspected, however, the patient must be assessed carefully and the consequences of acute HOPE Deficiency considered. Acute HOPE Deficiency may precipitate sudden depression and increased anxiety. Withdrawal of HOPE must be done slowly and gently.

**Withdrawal:**

If it is determined that the patient is using False HOPE and suffering one or more of the above mentioned adverse reactions and the danger of the continued False HOPE state is greater than precipitating Acute HOPE Deficiency, the patient may be withdrawn carefully. Efforts should be made to substitute another goal for the previous unobtainable one, preserving the positive expectancy while the goal is shifted. This may be done more easily if it is recognized that the patient is actually in a HOPE Deficiency state of fear and depression.

**Dosage and Administration:**

Dosage and duration of treatment must be individualized. The only limit on maximum dosage is the patient's ability to receive and the professional's ability to administer HOPE at an appropriate rate.

HOPE must be administered in a form compatible with the patient's receptor system. Patients with a predominance of Factual HOPE Receptors are best given HOPE in the form of facts and statistics, phrasing them according to "the glass is half full" philosophy. For patients with a predominance of Emotional HOPE Receptors manifesting symptoms of anxiety and depression, HOPE should be administered in a form that can be digested emotionally. "Living proof" stories about other patients who have done well in similar circumstances are more easily accepted and can be applied directly to emotional wounds.

**At the time of diagnosis.** Because excessive information may block receptor sites for HOPE, patient's needs should be determined before either Information or HOPE is given. Open ended questions such as "What have you been told?" or "What do you think is the matter?" will elicit responses that indicate primary needs for Information (intellectual) or encouragement (emotional). Information should be given in amounts that will not overwhelm the patient's ability

to incorporate it. Such overload increases the distortion of the Information and produces either anxiety or numbness. Unless specific actions based on this Information must be taken immediately, attending to emotional needs by giving HOPE first before Information will create a more credible physician-patient or nurse-patient relationship.

**During therapy.** HOPE is easily administered with technical interventions. Patient HOPE may exceed

the professional's HOPE. If HOPE is necessary for the patient to cope and there is no contraindication (see False HOPE above), then HOPE should be maintained as long as possible.

**When “nothing else can be done.”** This is the most critical situation in which HOPE must be administered. Both medical personnel and patients must shift the object of HOPE to something that is more credibly obtainable, maintaining a positive expectancy while changing goals. Generally it is possible to offer HOPE for comfort. It is always possible to offer the commitment to be there for patients as they die. Often that is enough.

**How Supplied:**

There is no standard dose. Individual patient needs and individual personnel styles determine how HOPE should be given. Listening carefully to both verbal and non-verbal communication will often suggest the best preparation of HOPE to use. Sometimes it is pointing out that even though the chances are slender, there is at least a chance. Sometimes it is just being there, with a gentle smile and a promise not to abandon the patient. Sometimes the greatest challenge is keeping a sufficient supply on hand for the personnel dispensing it.