Hope as a Practice

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This series of *Psychiatric Annals* articles, guest edited by Lorenzo Norris, MD, of George Washington University, has much to teach a clinician. Dr. Norris has written an editorial reviewing the series of articles in this issue under the title of “Resilience and Hope in Cancer Survivorship.” His editorial begins with two short sentences that convey the theme of this series: “Hope is more than a word. Resilience is not just a state of mind.”

Cancer survivorship is probably the greatest test for a person, but the concept running through this series is important for anyone who is trying to reduce the pain in this world coming as it is from so many sources.

Because Dr. Norris ably leads us through the contents and unifying themes, I will focus on the articles entitled “Hope in Cancer Treatment” by James L. Griffith, MD, and “Survivor Surveillance: A Resident’s Perspective” by Sanaa Bhatti, MD, and Allen R. Dyer, MD, PhD.

By presenting two contrasting cases of patients with advanced leukemia for which chemotherapy was failing, Griffith points out that hope is a practice, at its core “something you do” rather than “something you feel,” further defining a practice as “a program of action undertaken, not for utilitarian reasons, but to shape one’s being as a person and how one chooses to live in relation to others.” Griffith then teaches us that pathways for mobilizing hope usually can be grouped into one of three categories: individual problem-solving strategies, relational coping, and mobilizing a core identity. Hope practices must be more than the expectation of success or optimism but connected to social, religious, or ideological traditions whose values extend beyond the life of the individual person. Then comes a wonderful section on how a clinician can help mobilize hope. It is suggested in a specific case that a clinician help the patient make two lists (possibly engaging the patient’s cortical functions in-
stead of the patient’s current focus on amygdala responses).

The first list was made by order of issues by degree of importance to address, the second by order of issues listed by degree of what is hardest to address. Then, an issue of some importance—but not the hardest to address—was chosen to focus on in an action plan. In this case, it was determined that the patient tended to cope relationally. Then, the patient’s relational world was queried for helpful relationships, and a psychotherapist was suggested.

There are other excellent examples of hope-building in this article. It is pointed out that sustaining hope is vital in cancer patients. However, for me this goes much further—it is crucially important to sustain hope in each of us, whether we are receiving treatment or providing it.

Drs. Bhatty and Dyer’s “Survivor Surveillance: A Resident’s Perspective” is a beautiful example of this. This resident is presented with a woman experiencing low mood and panic attacks as she struggles with the diagnosis of stage III ovarian cancer, multiple surgical procedures, and a high risk of recurrence. The patient had been unable to tolerate a course of sertraline given to reduce her symptoms.

Dr. Bhatty was faced with the question, “What am I supposed to do”? The realization came that, based on training, an attempt was being made to “pathologize” the patient’s situation when this approach “missed the big picture.” Dr. Bhatty took an inventory of skills that might be relevant to the patient’s situation, a knowledge of psychopharmacology allowing the patient to successfully benefit from sertraline by starting with much lower dosages and with support tolerating nausea that was time-limited long enough to feel a benefit. Dr. Bhatty realized an ability to relate to the patient as a “present” therapist. As hope increased, the patient began to improve, and Dr. Bhatty realized how helpful she could be: “It was reassuring to her that I viewed her as a person and not as a particular disease or a sick individual. Even though this principle was something I had been taught before, I never truly understood it until working with S.”

We are faced with degrees of hopelessness all the time. Yes, this is particularly important in cancer patients, but because it is a product of demoralization, which is widespread, hopelessness is omnipresent in the human consciousness. Thank you, Dr. Norris, and all of your authors, for one of the most important lessons that a clinician can learn.

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