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le projet Pallium



Working Together to Improve the Quality of
Living and Dying in Canada

Travailler ensemble pour améliorer la qualité
de la vie et de la fin de vie au Canada

MAGNIFYING HOPE - SHRINKING HOPELESSNESS

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Edmonton, Canada**

Original event air date – 26 May 2005

Post-production running time - 45 minutes, 43 seconds

Companion written transcript for a post-event MP3 Podcast (Individual Web License)

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Effective 04 July 2006

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¹ A companion kit entitled *Conversations on Caring – Volume 1* is available through the CHPCA Marketplace (www.chpca.net) for use in Canada in staff development, continuing professional development (CPD) and health sciences education.

INTRODUCTION AND SUGGESTED LEARNING OBJECTIVES

INTRODUCTION

This transcript is a web-based version for use with a companion MP3 professional development podcast. This MP3 session is also part of a larger set of digital audio recordings forming a resource entitled *Conversations on Caring, Volume 1* (CoC). CoC is a learning resource which has been prepared from previous Pallium Project professional development events. These events are the *Monthly Continuing Professional Development (CPD) Audio-conference Program* series. The *Monthly CPD Audio-conference Program* series was supported in 2005 and 2006 through a contribution from Health Canada's, Primary Health Care Transition Fund (PHCTF) as part of Primary Health Care Renewal in Canada. The views expressed in these sessions do not necessarily reflect the official policies of Health Canada or the employing organizations of members of the Pallium Project's, Community of Practice. These materials have been prepared as "reminder resources" for participants of the original CPD sessions and as learning resources to help support improved access and enhanced quality for provision of Hospice Palliative Care in Canada.

The MP3 audio files and this PDF of the written transcript have been post-produced from the original event in order to provide essential information and enable use, generally within 1 hour time blocks. Each of the sessions has been based on topics which practicing Registered Nurses have identified as important to improving practice and service locally as part of a 2005-2006 audio-conference series entitled *Improving Care in Our Communities*. While program-developed and organized principally from a nursing process and case-management perspective, sessions reflect the inter-professional and trans-disciplinary perspectives of both the Guest Resources/Invited Panelists and the local participants, many whom reflect a diversity of perspectives of social workers, spiritual care providers, primary-care physicians, hospice/palliative program volunteers and others.

SUGGESTED LEARNING OBJECTIVES FOR THIS SESSION

By the end of the podcast a listener should be able to discuss all or part of the following:

- Contemporary concepts and a functional definition of hope.
- Common influences of hope for individuals.
- The importance of personal leadership in supporting, facilitating and re-framing hope as part of professional practice.
- Strategies for engaging false/unrealistic hope.
- Cues for engaging with patients and families about end-of-life issues and re-framing of hope.
- Common things that can threaten hope.
- Everyday practices that can increase hope.

Editorial note: The user of this object may also wish to investigate the 17 minute video entitled *Living With Hope*, an award winning video explaining recent research findings about Hope in the context of life-limiting illness. *Living With Hope* can be viewed in streaming video at <http://www.usask.ca/nursing/research/livingwithhope/video.htm>. More information about ordering a copy of the video as well as the broader research project can found by clicking the Overview menu at the site.

MAGNIFYING HOPE – SHRINKING HOPELESSNESS
Guest Resource
Wendy Edey, C. Psych., M.Ed.
Director of Counselling, Hope Foundation of Alberta
<http://www.ualberta.ca/HOPE/>

Moderator
Jacque Peden, RN, MN

Original Air Date – May 26, 2005

JACQUIE PEDEN

We are really pleased that you are here to speak with us Wendy. Can you tell us a little bit about the Hope Foundation?

WENDY EDEY

The Hope Foundation of Alberta is a centre for hope studies centered in the University of Alberta Faculty of Education Department of Educational Psychology. We are a center for the study of hope in practice – how to use hope, how to work with hope, how to talk to people about hope. We have an on-site library. We have a website with an international database on hope research literature. We do workshops and support groups and keynote speakers and at the University of Alberta there is even a credit course to be taken at the graduate and undergraduate levels in hope. More important than that, we talk to and with a lot of people on hope in our counseling program and group sessions that we offer so when we say hope in practice, we really do mean a practice about talking about hope or putting activities in place that are thought through the research to enhance hope and draw attention to hope.

JACQUIE PEDEN

Can you tell us what hope is?

WENDY EDEY

Well, what hope is varies according to the purpose for which you wanted to study hope. We tend to think of hope in terms of disease and treatment paradigms where we think of hope as something objective, you know, an assessment – what is the likelihood of cure for example. That is kind of a traditional way of thinking about hope – how much hope do I have? Do I have 85% or do I have 75%? We can think of hope much more broadly than that. If we think of a conversational paradigm for thinking about hope, then hope is really a shorthand that we use in conversation to refer to a whole bunch of constructs. It is a noun – so we talk about having hope or being hopeful as an adjective. We can also use hope as a verb in terms of, “I hope that I will feel better” or “I hope that I will have an opportunity to have some of my needs met”.

Hope is actually a broad term. It has kind of a planning and goals aspect to it. It also has sort of a sustaining that sort of resourcefulness from inside us characteristic too. So if we are talking about hope in terms of support, often we are looking at goals by hope of success. If we are talking about hope in terms of palliative care, often we are thinking about

that resource inside people that allows them to still think a bit about what the future might hold, but be healthy – be ok and feeling alright.

JACQUIE PEDEN

What influences hope?

WENDY EDEY

Well, there are lots of studies about what influences hope. I would think that the primary thing that comes out, study after study, as we study hope in the doctor-patient relationship, hope in nursing studies, hope even in studies of teaching students. The thing that patients or clients identify most often as being part of what made them hopeful was a sense of connectiveness.

In Gena Wong-Wiley’s study of hope in the doctor-patient relationship for people who have HIV for example. Those patients said it wasn’t really so much the smart physicians that gave them hope, but the ones who were willing to be connected with them in a genuine, personal way to answer their questions, to accept articles from magazines they might bring in to be collaborative and to keep them involved in whatever might be happening with their treatment. It seems that hope has a huge relational element. Another thing that influences hope appears to be the amount of control that people have. I don’t mean control over making ultimate decisions and big things, but it seems to be the little things that matter in terms of having control - just being able to decide certain things for myself, to have some say in the way that I might be treated.

Hope is also influenced by the idea of having possibilities or having options. We tend to think in terms of having only 1 or 2 options – will she live or will she die? Will she succeed or will she fail? Really, in most cases, we have many different options. How will I live? In what way would I be treated? Where will I be for example? Seeing a world in which there are many possibilities other than just two narrow choices seems to be an important element in influencing hope. The option that there might be humor. The option that there might be more than one way to see a situation.

Another thing that influences hope is sensory cues. When we ask in research to people, what is it that reminds you of hope, they point to pictures on the wall, they talk to us about particular fragrances in the woods at a certain time, they talk about eating chocolate. Sensory cues are an important influence on hope. Much research shows that we can actually

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produce a sensory cue that people have associated with hope. For example, if you had a conversation about hope in terms of being in the woods – the old pine woods where I used to live. I think about the smell of the woods, the sound of the birds singing in the woods. If you have that conversation again at a later point it seems to be a very easy shortcut back to hope. Pictures on the wall and things that people can carry with them. Right now, there is a lot of research being done in the area of treasured objects and what it means to people to have a treasured object that they keep with them that they can pull out and look at in times when they need hope.

Probably the last thing that is important in terms of influencing hope is leadership from others. Just this morning I was talking in my counseling practice to a young man who was telling me that he needs an apartment – a place to live that is very clean because of a lung condition he has and when he was looking at a place with his parents, they were saying to him that you have to know exactly how much the utilities are going to cost and you have to know exactly how much the damage deposit is going to cost and you have to have all the details in place for a contract. This particular leadership is wise leadership in looking for a place to live but it wasn't very wise leadership in the area of hope for him. Partly because he is moving into a situation where he cannot afford to live by himself anymore and he has a very low income so he has to live with others. The leadership and hope that he would really need them to have is to say this is a very clean place and the people do seem to be very friendly here and it does appear to be a place that will work out. All of those things are true.

We can, in very subtle ways, offer leadership to others in hope rather than in hopelessness or in caution or in despair. It is a leadership strategy that we can take with others towards hope; that perhaps it is the thing in which we have the most influence.

JACQUIE PEDEN

When you talked about the pictures, it reminded me of when I was visiting the Edmonton General Hospital. There was a group of pictures on the wall that was relating to hope. There were pictures that people had of their grandchildren and pets. I thought that, yes, I could find hope in a picture in my new puppy. That is the future. Grandchildren too. It looks more like the future when you look at a picture like that.

WENDY EDEY

Pictures chosen will be quite different for different people. The Caritas Health Group has made a very dedicated effort to have hope displays and very special hope projects in their health care centers so people have an opportunity to express what would be their own hope (both patients and staff). Just last week when my mother was admitted to the Grey Nuns Hospital here in Edmonton and my father brought her in from out of town one of the things he wanted to tell me

when we first spoke afterwards was, “I saw your hope tree and I looked for you on that hope tree.” He didn't even know a hope tree would be there but as soon as he saw it he was attracted to go towards it and to looking for things that would be familiar and meaningful to him on that.

JACQUIE PEDEN

Which probably gave him comfort of being in that hospital and being in that setting with your mom being ill. Can you tell me how you would deal with unrealistic hope?

WENDY EDEY

The question of unrealistic hope is a question that is of most concern in the area of medicine. There has been a lot written in the area of false hope and unrealistic hope. One person has written that false despair is more dangerous than false hope.

False hope is really just hope that one person has that another person doesn't share. For example, Jacquie, if you are just hoping that you will feel better tomorrow and I am thinking she won't feel better tomorrow, I would say that your hope is false hope. Really, it is still your hope. I am just calling it false because it is not congruent with my hope. One of the problems we have with the idea of unrealistic hope is who gets to decide what is realistic and what isn't? When we think of the amazing things that have happened in the history of the universe, each and every one of those things happened once for the first time. Before that it was absolutely impossible. In 1954, for example, Roger Bannister ran a mile in less than 4 minutes and before that it had been proven to be physiologically impossible for a human being to do that. I don't know if Roger Bannister just didn't listen to all the statistics or didn't read up on it or why he thought it would be a good idea to run a mile in less than 4 minutes. Interestingly enough, as soon as he had done so, a second person had done it also within 3 weeks.

If we always judge the realism of hope based on what has happened before we aren't really taking into account, even if it is 100% unrealistic, we are not taking into account that the notion that everything that ever happened new had to happen once first. Even as I say that I can feel the blood pressure raising across the 4 western provinces and New Brunswick because we can understand that people can get so unrealistic that we tell them, “You know, it is time to go into palliative care” and they are going, “No, no, no, I am waiting for treatment still.” I think that if we look at the history of the people who we have known, one of the things that we know is that sometimes a thing can be impossible and I mean impossible now, but possible later. Impossible now. So it may be impossible for a person to accept palliative care today, but even by tomorrow enough things might have changed so that it would be possible.

I knew a man named Darryl Skidnick who was the editor of a newspaper in Fort McMurray. He wrote about his illness in the Fort McMurray newspaper, so we have a record of things

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that he wrote. After a discussion about hope, he went home and he wrote in the newspaper, “My cancer has spread and the doctors aren’t hopeful that I will be able to make a full recovery.” Notice he wrote that the “doctors” weren’t hopeful. He didn’t write there is no hope. Later on he wrote about some of the treatments that were being put in place now, but he wrote, “At least for now, my hopes for a medical cure are being replaced with my hopes for a cure through prayer or positive thinking or healthy living. We can see in the development of this writing how he had begun to think about hope. Not is there hope or is there not hope, but well, if I can’t hope for one thing, then what can I actually hope for? Who isn’t hopeful? Is it the doctor that isn’t hopeful? I can still be hopeful. We may have deemed any of these hopes to be realistic or unrealistic, but to Darryl these were hopes and he was thinking about how can I face this situation in which people are predicting my certain death and still be hopeful at the same time? He thought that through very carefully before he wrote to the citizens of Fort McMurray.

Cheryl Nekolaichuk, who has been a great hope researcher in the area of palliative care, writes about some myths that we seem to hold on to in terms of hope. One, being the myth of truth telling. That is the idea that everyone wants and needs the truth – the real facts and the truth right now, but really some people, in order to have hope, they don’t really want to hear the truth because they don’t know if they can hear what they want as the truth and have hope at the same time. It may be impossible for them to do that now, but it may be possible later. It may be done all in one day. It might not even be important. Another one of the myths she writes about is the myth of the “magic bullet”. This is where we tend to think that there is a cure for everything – that there is a solution for everything and that we just have to find it. If there is no magic bullet, then there is no hope. People have to think their way through this too. They have to ask themselves how they can be hopeful if we cannot find the magic bullet. They have to ask themselves at what point do they stop looking for the magic bullet. Sometimes we don’t all stop at the same time. Sometimes, the person stops looking, but the relatives are still looking. Sometimes the medical people are still looking while the person has stopped looking. Sometimes the patient is looking for the magic bullet long after the other people have stopped. Eventually we have to think that there will be some coming together of this search.

Finally, the other myth that she writes about is the myth of immortality. This is the idea that in some way any of us would be able to live forever. When we think about that, to have a death predicted is to have no hope at all and this, of course, is ridiculous because we know even from the time of our birth that there will be a death and that doesn’t remove all hope from the world.

There is still hope in the world everyday even though we know that each and every one of us is going to die. Why should we assume that when death is imminent that hope

suddenly vanishes? There is still hope out there – still hope around – if we were to go out on any given day, we could find 100 evidences that there is hope in the world. It doesn’t vanish on the day that we begin to speak of death. It is still there.

JACQUIE PEDEN

I think that one of the biggest challenges I had when working in palliative care was talking to my clients and their families about end of life issues with that worry that I was going to threaten their hope. When you talk about knowing the truth now, it reminded me of this challenge. How do you know when to talk to somebody about end of life issues and how do you do that? I mean as part of our goal as a nurse in the community.

WENDY EDEY

I think that it is important to issue invitations to people to talk about issues and to respect them and what they do with that invitation. Just as we would issue an invitation to a gathering and we would let people decide whether they would want to attend. Just this week I said to someone you know pretty soon people are going to begin asking us about do not resuscitate orders. They are going to ask us what we want to do if a crisis comes up? Do we want to bring this person back? The person to whom I was speaking said, “Oh yeah, I guess so” and went on to another topic. That is a pretty good clue to me that this isn’t something that we are ready to discuss yet, however, having raised the topic, I know that it will come back later and be ready for discussion.

I did a whole bunch of conversational work with kidney patients who were on dialysis. They said that really there were times which they wanted information and it was hopeful for them to have information. There were other times when they got the information that just had to put it aside and think I am going to do this today and that tomorrow and the next time I think something is wrong, then somebody will tell me about that so that they kind of have the big picture at first but then it was better for them just to wander off and ignore the picture and for us to understand that to give people a binder full of information and blame them for not having read it later or to think that I gave it to them, therefore, they read it and so they know it is perhaps, not realistic on our part.

What is more realistic is from time to time to offer invitations to speak about things that may be relevant – maybe family visits or things that need to be taken care of, details, paperwork, the idea of what things may still be left to be done, treatments that could be chosen. People will find a readiness to talk about these things if we are willing. I think that in my own past, a lot of times it has been me that is chicken to raise topics. Now, I am not very chicken about raising topics and I don’t worry if people don’t pick it up. I think, well, I raised it and often they will come back and raise it again or I can raise it again later.

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JACQUIE PEDEN

So, it sounds like we shouldn't have our own agenda about what it is we want to talk about? We need to allow the patient or individual to guide us in what information they need at that time.

WENDY EDEY

I think that if we do have our own agenda we will soon feel that rising sense of frustration that comes up inside us when you are trying to talk to someone about things and it is not going well. I often feel that feeling inside of me. I feel it as a stress. If I am conducting a conversation and suddenly I feel stressed inside of me and if I start to pay attention to that stress, often it is telling me that I am working way too hard at that conversation and the other person is not really participating in it but they are looking for a way out and that is why it is seeming like so much work for me because they are just not there with me yet. I say the word "yet" because "yet" is a hope word. That person is not ready for this conversation "yet" and "when" she is then we will be able to have it.

The language of "yet" and the language of "when" are important languages when we think about hope. They give us some reassurance that "when" you are able to eat solid food again. Talking about the language of "yet" and the language of "when" is different than making promises. If you promise someone you will be able to eat solid food tomorrow, well maybe they will and maybe they won't and then you have broken your promise. We can always talk to people about "when" you are able to eat solid food, "when" you are not in so much pain, "when" some of these details are taken care of. Some of these important languages are very subtle.

JACQUIE PEDEN

So what does threaten hope?

WENDY EDEY

What threatens hope? Loss of control threatens hope terribly, isolation (feeling like you're the only person that understands you), just feeling like nothing that you say can matter, that your own condition is totally misunderstood by everyone else (a very threatening thing to hope). Another thing that threatens hope a lot is a phenomenon that we call "bruising" which is when a lot of bad things happen in succession and we don't really get over one thing before the next thing happens.

Say your sister died last year and your brother died last month and now you have been diagnosed with a serious illness as well. You don't just feel the impact of your diagnosis. It is as if you have a big bruise and you bumped it again and you feel multiple pain – much larger than even the impact of your own diagnosis. In the case of the bruising effect, we have to think that people are feeling a level of pain that is coming from many things and in general, bruises are healed by time and rest and we cannot do a lot actively around it. What we can do is protect a person from being bruised more. We can be gentle around them. Bruising is an

important thing. The other thing is to have things keep turning out badly. You know, you are right back in the same place you were in before and nothing ever seems to change.

It is interesting that when we ask people about caregivers or health care people who have given them hope, often the things that they say are the little things that made a huge difference and these are sometimes things that wouldn't be thought of as a person's job, but also, just the smallest of gestures. This last week I was in a hospital visiting someone and we needed Q-tips to put Vaseline on her lips. We asked for Q-tips and they said at the station, "Here is one, but we don't have that many here at all." So, I had thought well, I will bring Q-tips tomorrow. By tomorrow, I had forgotten to bring Q-tips. I said it out loud that, "Oh no, I forgot Q-tips!" Someone passing by heard, came into the room and said, "I will just get them from the desk." We said, "That is good, but there may not be any there." She said, "Just give me a minute then." Off she went and she came back and said, "Sorry, it took so long, I just went to the next unit and got Q-tips." You know that is such a silly little thing, but if I was to think of the most rewarding experience I had in a hospital last week, it was really that. Some of the simplest things in patient research have been reported as hope again and again.

JACQUIE PEDEN

That gives me hope, actually to think that what you have spoken about so far is the need to connect with people and to listen and to change your perception on what we need to think the patient/client needs – to listen more to what they are telling us. That is quite helpful. Can you talk about what is the smallest thing I can do to increase someone's hope?

WENDY EDEY

Well, that depends on what it is that threatens that person's hope. People can tell you if you ask as often as I always do in counseling because I work at a center for hope studies. I always ask people that when you think of things the way they are now, what is the thing that most threatens your hope? They will tell you all kinds of things. The thing that most threatens their hope is not always what we think it might be.

Recently a man told me that the thing that was most threatening his hope was that he was never going to be able to have a conversation on the street anymore without somebody asking him how are you now or how is it going now. What was threatening his hope was the loss of happy, joyful, ordinary conversations with people and having every conversation being about the illness. Other people will say, what threatens my hope is that my family might not get here in time or that I might not see them again.

The things that threaten people's hope really vary from person to person and they are not always what we would think they would be. One of the ways to know what would be the smallest thing that I could do to increase anyone's hope would be to find out what is this thing that is threatening their hope right now. What is it that makes them not hopeful?

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I can remember being at someone's house near the time of a funeral and I said, "What can I do?" She said, "The thing that you could do is to look after my Aunt Pat. Aunt Pat drives me crazy and I am at the bursting point. If you can do something about Aunt Pat then I think I can get through the rest of it." You know, doing something about Aunt Pat was a very simple thing. It was getting Aunt Pat to come on an errand to go to the drugstore and get things we need to get. You know, come to the grocery store. It was a very small thing to do, but it was not what I would have thought of to do.

JACQUIE PEDEN

I don't have any more questions for you. There was a question sent in on a registration form – I think that you may have already answered it. The question was how to address refusal of palliative status? It is the person clinging to the hope of cure. I am wondering how to manage that situation?

WENDY EDEY

Well, because I don't work directly in a hospital setting I don't have a good sense of the physical things that might be involved in making a change over from active status to palliative status. You know, when we watch things from the outside, they look pretty simple and to me we provide care to people. We try to relieve their pain. We provide other kinds of medications for them that we might provide whether they had palliative status or whether they had active treatment status, we talk about providing the best care possible.

The difference between palliative status and active treatment status is that we have stopped looking for a cure or treatment, however, this doesn't say that at the very last moment some treatment wouldn't come along that would be relevant. I think we can move towards palliative status without saying, now we are going to give up all treatment – now we are going to give up all hope. We can talk in terms of, "We are going to move to this kind of care now because that seems the most relevant and it seems to be the thing we need most right now is to take care of the pain. We don't have to talk in such an upfront way that it seems like there is just this one choice – palliative or not palliative. We can talk in terms of the best possible care and if people still want to seek information about treatment, they are following a hope and it is a hope that they have and whatever we can do to respect that without having to do things that we don't believe in. Whatever we can do to show respect for that is really showing respect for the person.

JACQUIE PEDEN

Jennifer, we are ready for questions from the audience.

LANA TACEY - CALGARY, ALBERTA

Hi, I was wondering with my readings on hope, I was wondering what your beliefs are? Do you believe that there is such a thing as hopelessness or do you believe that hope is innate and sometimes people just have to redefine their hope?

WENDY EDEY

I do believe that there is such a thing as hopelessness. I don't necessarily believe that it is a permanent condition, but certainly there are times when people cannot see hope, just as in when people are depressed. Good things may be happening to them but they may not be able to see those good things because of their depression so hopelessness can exist.

In fact, we did a random survey of 1203 Albertans (a telephone survey) about hope and health and fully 25% of those people reported that they had experienced hopelessness at some time during the last two weeks. I think it would be disrespectful to say to those 25%, it wasn't really hopelessness, it was something else. They felt it as hopelessness and were willing to report it, so, yes I think we would be remiss if we said there wasn't such a thing as hopelessness.

The question is how can we accept hopelessness and still be hopeful ourselves. One way I can do that is I can think, perhaps this isn't permanent – perhaps that person as not seen all the options – perhaps it is impossible for that person to see hope now, but it would be possible for them to see it later.

DARBY JOHANSON - THE PAS, MANITOBA

When you were talking about what threatens hope in a particular patient and you used the example of a man who felt that he was never going to have a conversation on the street that wasn't going to be about illness again. Once you find out what threatens hope in a particular patient, how do you deal with that?

WENDY EDEY

Well, this is your opportunity to show how creative you might be. The person I was talking about in this particular instance is the same person whose information I read a little earlier in the session. We had a long talk about what he could do to facilitate having conversations in the future – the kind that he wanted. Now he, it turns out, was not powerless at all. He was an editor of a newspaper and he said that he cannot always be writing about my illness in the newspaper. However, we had a chat about what he was able to do and how often he would be able to do it. One thing he wrote was cancer patients still like to talk about hockey pools, golf, music and politics. It is talking over and over about treatment and prognosis that some of us find hard. So when you see me on the street, just say hi and start talking about something. I didn't suggest that he write a column. We were thinking through alternatives that he has of speaking to other people, so it really is about connectedness and figuring out not what can I do to solve this problem but how can we talk about it so there will be more options.

What ways might there be of making one small difference – something that I could do to help think it through and to make it happen. There is no substitute for really listening to

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people and trying to think things through yourself. There can never be any magic formula that could take the place of a good honest conversation with people and a willingness to hear what they have to say and to try to think that through with them rather than for them.

TRACY HOUTSTRA - EDMONTON, ALBERTA

Hi Wendy. I was wondering if you might comment on your own experience and maybe the literature too about sort of an innate sense of hopefulness and optimism.

WENDY EDEY

Well, there is a lot of controversy about whether any personality factors the degree to which they are inborn and the degree to which they are environmental. Hope is right up there with other positive psychology traits which are personality factors, so I don't think there is a final diagnosis as it were about to what degree these things are innate. Certainly though, it would appear that some people are more, by nature, optimistic than other people.

Ric Snyder who has done a great deal of work in the area in the measurement of hope. He has tried to develop two scales. The trait hope scale, which would talk about hope as a trait where the personality trait would be quite stable. The state hope scale, which would measure how hopeful am I today, for example, about this particular thing. Hope in terms of being a trait, then we have to accept that some people will find it easier to be hopeful than others, but we don't have to accept at all that we don't have to make a difference for all people.

The literature would seem to indicate that say your normal level of hopefulness was between 7 and 10, that on some really bad days you might feel like you were down at 7 and we might be able to do certain things - to have certain conversations - that would move you up to an 8. If my normal level of hope was down between 1 and 3, it is highly unlikely that the same intervention would bring me up to 8, but it might bring me from 1 to 2 or 2 to 3, so we have to think that when we are doing interventions that might enhance hope or that might shrink hopelessness that we're making a difference somewhere within a normal range that any given person might have. Is that helpful?

TRACY HOUTSTRA - EDMONTON, ALBERTA

It would be sort of saying that it is necessary to separate the state of hopefulness from the trait of hopefulness?

WENDY EDEY

Well, the state of hopefulness is very fluctuating for any of us depending on what's happening and the trait of hopefulness is maybe more stable, so if we think about it that way, we see that we don't change the trait that much but even still we might fluctuate quite a bit in a range that is kind of natural for us. There are people who tend to see the world in quite an optimistic manner no matter what is happening. Some days they might lose sight of that, but they might easily regain that.

Other people who are more pessimistic by nature, they will see the world normally in quite a pessimistic way, but it doesn't mean that they cannot be influenced in the other direction just as when we go shopping some of us might be more apt to choose red than blue, but we will still buy a blue thing. Some of us might be apt to choose more blue than red but we still buy a red thing if someone points it out to us.

TAMMY M^cCLUSKEY - TRAIL, BRITISH COLUMBIA

Wendy, I was wondering if you could recommend any resources for our lending library, either which is used for hospice volunteers or professionals and in which as well you can give to patients and clients on hope?

WENDY EDEY

Well, two things that I would recommend and I haven't asked here if you have received any paper in conjunction with this conference, so I am going to ask. Jacquie, have they been sent a handout?

JACQUIE PEDEN

We did send out a handout that listed references for this presentation. I am not sure if you have received them Tammy?

TAMMY M^cCLUSKEY - TRAIL, BRITISH COLUMBIA

Yes, we do. I would like you to talk a little bit about those.

WENDY EDEY

I will. The book that is on that list by Jevne and Miller called "Finding Hope: Ways to See Hope in a Brighter Light" is a very simple book of pictures and essays that people find to be extremely accessible and anybody can pick up that book and start a conversation about hope from one page or another. They don't have to read it from start to finish. It is not really a how-to book, but it is a book with ways of thinking about hope. There is another book that isn't on this particular list. It is called "It All Begins With Hope" and it is also by Rona Jevne. It is a book of stories from the perspective of cancer patients, caregivers and health care providers. It is very specific to the experience of hope and cancer, but it does address many issues that are relevant in palliative care. It is also quite an accessible book as well. It is not a how-to book about hope, it is just a book of stories embedded about it.

JACQUIE PEDEN

I would like to thank Wendy for joining us today and helping us to understand issues relating to hope at the end of life.