

Faith and hope

David Clarke

Objective: The words 'faith' and 'hope' are generally associated with religious discourse, yet they are fundamental human concepts. In the present paper the phenomena of faith and hope and their place in the discourse of psychiatry are explored.

Conclusions: The concepts of faith and hope are not explicit in the language of psychiatry. It is suggested that this is a result of the cultural gap that exists between psychiatrists and the Australian community, assisted by a clinical approach that seeks to avoid exploration of the difficult experiences of helplessness and hopelessness. Hope and faith are multilayered phenomena involving a belief about things of which we are uncertain accompanied by an expectancy and/or conviction. Many things in life are uncertain. However, the 'reasonableness' of a belief is an important judgement that psychiatrists make. Hopefulness (genuine hope as compared to false hope) and optimism are associated with positive health outcomes. Hopelessness is associated with poor outcomes. Psychiatrists need to be able to explore issues of hope and faith with patients at times of life crises in order to facilitate adjustment. This can be an important part of the treatment of a depressed or demoralized person.

Key words: faith, hope, psychiatry.

The words 'faith' and 'hope' are not often used in psychiatry, being more commonly associated with religious discourse. Yet the concepts are critical to the human experience and on that basis might reasonably be expected to be a part of our conversation with patients. In the present paper I explore their place in the discourse of psychiatry.

HOPE

The *Macquarie Dictionary* defines hope as 'an expectation of something desired; desire accompanied by expectation'.¹ In psychiatry we speak little of hope but we do talk of its opposite, hopelessness – although with little meaning beyond it being a symptom of a disease state, depression. It is uncommon to hear, for instance, in a case presentation, a consideration of the loss of hope that has occurred in a depressed person, or the nature of the hope that was lost, or how hope may be restored.

Yet Viktor Frankl and Elisabeth Kubler-Ross have both eloquently described for us how where there is no hope, death follows.^{2,3} It is a most basic and fundamental part of life. We know hope when we see it, and feel it intensely when it is gone. But it is hard to describe. It has an intangible quality, deeply personal, rooted within our unique experiences. But it is also, to some extent, shared, dwelling in our communal experience and shared beliefs. It is expectant, and forward looking. Its very nature is to inspire, to draw forward, to bring vitality. Where there is loss of hope, there is loss of anticipation, desire, and conviction about the future; loss of vitality and loss of meaning and purpose in life.

Hope is not just a phenomenon of cognition or thought. It is affective and volitional. It affects emotion and will. It is not just desire – some unrealistic fantasy or wish – but desire accompanied by (reasonable) expectation. It is therefore grounded in reality and expectant. Hoping is

David Clarke
Consultation-Liaison Psychiatry Research Unit, Monash
University Department of Psychological Medicine, Melbourne,
Vic., Australia.

Correspondence: Assoc. Professor David Clarke, Department
of Psychological Medicine, Monash Medical Centre, 246 Clayton
Road, Clayton, Vic. 3168, Australia.
Email: david.clarke@med.monash.edu.au

longing and believing for something that is not certain, but at least possible.

FAITH

The writer of the letter to the Hebrews in the Bible says, 'Faith is being sure of what we hope for, and certain of what we do not see'.⁴ But can we be certain of things we do not see? We might be boarding a plane this evening having 'faith' that it will not crash. But, of course, we cannot be absolutely certain about such things. For practical purposes, we might say that it is unlikely that the plane will crash, and that we are 'reasonably certain' that it will arrive safely. The decision to travel on the plane is a 'reasonable' one. Yet, we cannot be certain. Our safety is not a fact.

This is where some of our problems with the language begin. Although often we may say that we believe something is true (i.e. factual), what we really mean is that we consider it a reasonable proposition on which to plan life. This is a statement of thought or cognition, of which we are making a judgement of reasonableness. This is a necessary but not sufficient basis for faith. To be 'sure of what we hope for and certain of what we do not see' involves more than a statement of 'reasonable' belief. It requires conviction, which includes our emotion and will – a leap of faith, as it is often called. Korten has recently described how much of our life is built on things that we cannot know as fact (i.e. objectively), but rather know as 'lived reality' (subjectively).⁵ Rather than fact, this is represented by the values we hold, the beliefs we intuitively affirm, the assumptions about the world that we make. Frank and Frank have called this the 'assumptive world',⁶ being similar also to the concepts of 'global meaning'² and 'generalized hope'.⁷ These are the ideas, beliefs and values that we hold and with which we make sense of the world and upon which we base our daily decisions. Traditional religious beliefs may or may not be a part of our assumptive world.

IS IT REASONABLE TO HAVE FAITH AND HOPE?

Living in a post-enlightenment, post-Christian world, many of us are materialists – affirming belief only in the physical realm – and many of us are rationalists – believing only what we think is rational. (In this environment, the unconscious, which is neither rational nor physical, is ignored by many and reduced to a mental structure to be observed and made rational by others.)

But whose measure of rationality do we use? While most Australians acknowledge a belief in a higher being, even if not an active 'faith', most psychiatrists do not⁸ and many so-called 'intellectuals' cringe at the words 'faith' and 'hope', being associated for

them with the immaterial and the irrational. We are all too ready to reject ideas not based on our premises and our style of logic. The philosophical ethicist Alasdair McIntyre has made the point very clearly that there is no single rationality (just as there is no single justice).⁹ This is something developed and understood within a culture and community. Psychiatrists live in a particular culture – a particular stratum of society – and may well be out of touch with the values and beliefs of the general community in which they reside and work. Psychiatrists often express, I would assert, an instinctive rejection of the notions of faith and hope.

Faith and hope are both beyond the realm of proven fact, and yet we function every day on the basis of these two things. No matter how often we have done a particular action, each time we cannot be certain of the outcome, but our belief system or assumptive world gives us the confidence to proceed. An important issue is whether the belief (faith or hope) is reasonable. Hope of course can be based on assumptions that are patently false or at least extremely unlikely – what has been called a 'false hope' or a 'foolish hope'.¹⁰ Some people equate hope with denial of reality, which at times it may be. But hope does not necessarily preclude reality. Indeed, human experience shows that genuine hope can lead a person to confront and overcome obstacles with vigour and confidence, and to achieve things many people might have thought impossible.

In any situation there is a range of realistic possibilities. Take a patient with cancer, for instance. There is always a degree of uncertainty in the prognosis. Realistic hopefulness (desire accompanied by expectation) looks for a favourable outcome within the reality of possibilities. In contrast, depression, pessimism and hopelessness are very often associated with negative distortions of reality – hence the therapeutic role of cognitive therapy.¹¹ We know that an optimistic disposition is good for health and wellbeing.¹² We also know that hopelessness and helplessness are associated with poor outcome, in both morbidity and mortality, in a range of illnesses.¹³

There are therefore two types of hope (Fig. 1). One is a realistic and genuine hope that is associated with health. The other is a false hope built on a denial of reality. The latter is associated with poor health and poor adaptation to life – except perhaps in the very early stages of illness when a certain amount of denial can be protective.¹⁴ Hope is therefore an important consideration in a person's ability to adjust to any serious or threatening event. Particular hopes (e.g. for a long life) might of course be quashed. But a generalized hope and an optimistic disposition will sustain a person through the necessary psychological adjustment. This phenomenon has been observed in a number of illness experiences, such as in cancer,

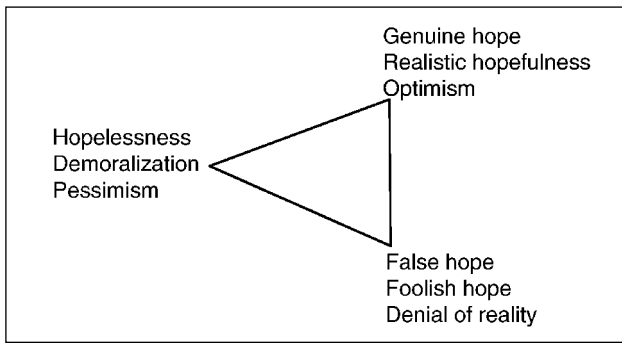


Figure 1: Spectrums of hopelessness, genuine hope and false hope.

AIDS and end-stage renal disease.¹⁵⁻¹⁷ Conversely, loss of hope leads to suffering and poor physical outcome.

FAITH AND HOPE IN THE DISCOURSE OF PSYCHIATRY

Although discussion of faith and hope is not often explicit in psychiatry, its remnants are certainly there. Take, for instance, the concept of hopelessness. It is used as a symptom of depression – a pathway to making a diagnosis. A diagnosis of depression gives us something to treat. But it also often has the unfortunate outcome of stopping any further consideration of the issue of loss of hope or the awful helplessness that often precedes it. It is possible to be depressed without being hopeless, and to be hopeless without being depressed.¹⁸ Furthermore, although depression and hopelessness both contribute to a desire to die, their contribution is independent and the contribution of hopelessness is greater than that of depression.¹⁵ This has been known since the studies of Aaron Beck 25 years ago.¹⁹ It is important therefore to consider hopelessness in its own right.

Faith also appears in psychiatry, in our theories of personality. Consider, for instance, the application of cognitive therapy. At a superficial level the therapist will identify and challenge negative automatic thoughts. Questions that might be asked to assist this are: how much do you believe this thought? What is the evidence that supports this idea? What is the evidence against this idea? Is there an alternative explanation? All very 'rational' questions. We are testing the 'reasonableness' of the thoughts, not the factual basis. But sometimes the therapist will go beyond the automatic thoughts to the core beliefs and assumptions of a person, and there are various techniques for doing this. Core beliefs commonly come down to issues of control versus helplessness, lovability versus fear of rejection, and achievement versus fear of failure²⁰ – the most fundamental issues associated with human existence.²¹ In engaging with

a patient in therapeutic conversation we encounter deep human issues. In refusing to participate in a discourse that we see as being peculiarly religious – that is, being unwilling to talk about faith and hope, belief and uncertainty – we prevent a conversation that might go to the core of a persons' sense of helplessness, unlovability and failure.

DEMORALIZATION AND THE RESTORATION OF MORALE

Demoralization is the name given by Frank and Frank to a syndrome characterized by loss of hope and loss of faith (or a breakdown in the 'assumptive world').⁶ It is observed constantly in people struggling with serious physical and mental illness. In a difficult situation, it is the experience of being overwhelmed and 'unable to cope' (Fig. 2). Not knowing what to do, a person feels helpless and eventually hopeless. Because the myth of mastery over life is challenged, shame develops, leading to a view of oneself as incompetent and different (inferior) to others. In this state the sense of self-worth and meaning to life is eroded. We have shown that demoralization is distinguished from clinical depression, the latter characterized by pervasive anhedonia.²² The most frequent symptoms of patients – anxiety and depression – are direct expressions of demoralization. In the medically ill this is often recognized as an existential despair.²³

Subjective incompetence, helplessness and hopelessness are the hallmarks of demoralization. Some element of hope (a particular hope) might be lost with the diagnosis of an incurable cancer, but will be protected by a generalized hope, perhaps of a beneficial although indeterminate future (Fig. 2). Generalized hope preserves the meaning of life when specific hopes are absent or quashed, and can enable a person to find value in the most negative situation. In contrast, severe stresses also challenge our belief system. A deep shock such as the death of an infant through cot death, or the loss of a child into psychosis, challenges the faith we have in the world – challenges our beliefs that somehow life is controllable, or fair, or comprehensible, or even meaningful. At such times we may see people railing about the unfairness of God. Others find solace in religion, which gives them a reassurance that there is meaning to life. Severe stresses such as a serious illness cause a disjunction between one's core beliefs (assumptive world) and 'lived reality'. Psychological help in this situation assists the adjustment required to bring the two together.

A number of workers, particularly in the cancer field, have begun to examine the possibility of restoring hope in situations where hope has been lost – where people have become demoralized. This, of course, was exactly what Frank and Frank described when they considered the role of the talking therapies

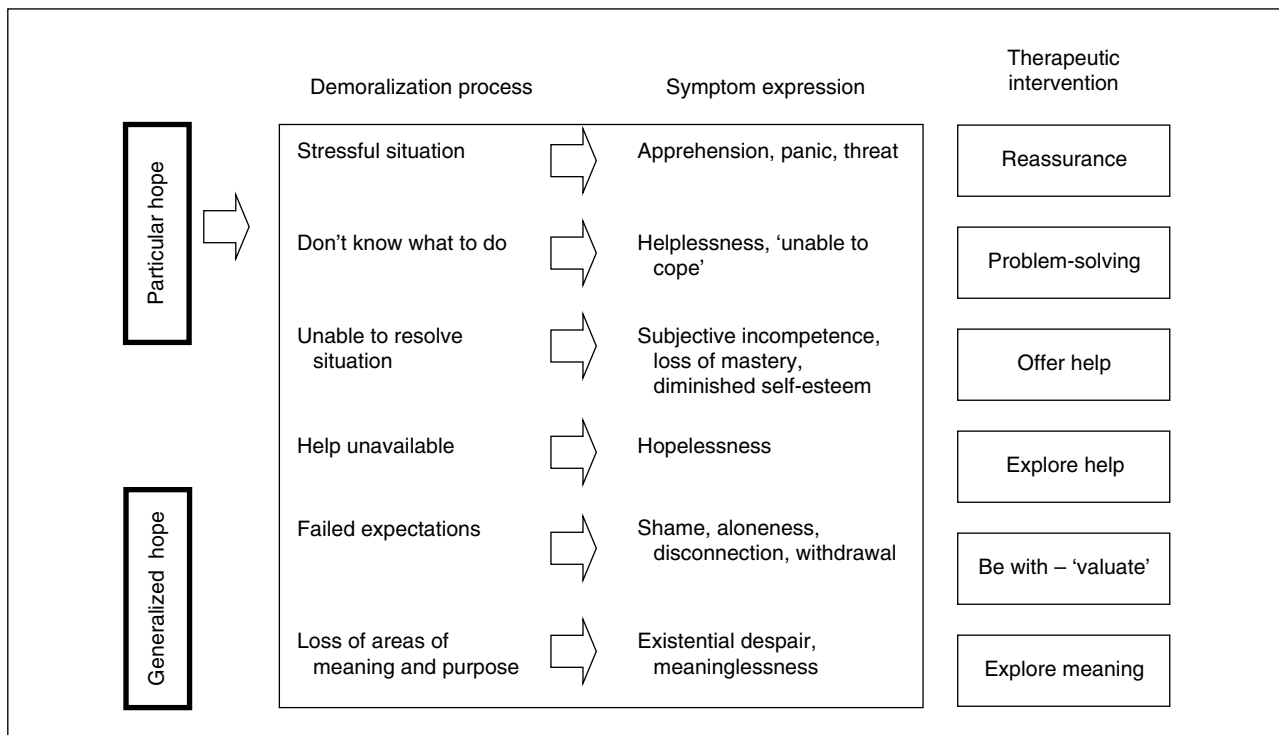


Figure 2: Demoralization process, hope and appropriate therapeutic interventions.

across different cultures.⁶ Folkman and Greer have expanded the model of stress and coping to include not only emotion-focused coping and problem-focused coping, but meaning-based coping.²⁴ This idea was derived from their experience with AIDS patients and their carers, in whom they observed for many a remarkable rediscovery of meaning and purpose that sustained them. Greenstein and Breitbart, also, have reported on a group-based psychotherapy for cancer sufferers that they describe as 'meaning-centred'.²⁵ One of the features of these approaches is a realistic examination, within whatever constraints life brings, of what inspires and gives meaning. Many goals and ambitions may have to be given up with a diagnosis of terminal cancer. But there are still things to do, and new goals (albeit restricted ones) to be discovered, planned for, and worked towards.

There is treatment for demoralization, and it involves the restoration of hope. An outline of an intervention is illustrated in Fig. 2. The simplest way to abort a descent into demoralization is to offer help or to assist in problem-solving in such a way that the problem is removed – for instance, successfully treating the pain or the psychosis. If these cannot be done, a form of psychotherapy that examines the gap between the assumptive world and the reality is needed. This includes an exploration of hopes, ambitions and expectations; an examination of basic assumptions (faith) about the world and how they

have been challenged, and; a review of goals and encouragement in planning to achieve goals in a way that restores a sense of competence and control. Being with a person and listening empathically can restore to them a sense of value – that they are valued. All these things can contribute to a person regaining their self-respect and re-engaging with friends and life. It is sometimes difficult in a pluralistic society, without a strong sense of shared values or beliefs, for us to discern a genuine, healthy, reasonable, and life-giving hope, from an artificial or false hope. However, this we must do. We may challenge false hope, but should nurture genuine hope and optimism. For loss of hope leads only to hopelessness and despair.

CONCLUSIONS

I have tried to show that the concepts of faith and hope are fundamental to life and unavoidable in any meaningful dialogue with troubled people. Psychiatrists tend to be less associated with formal religions than the Australian population and eschew religious concepts such as faith and hope, almost believing them to be superstitious. On the contrary, however, faith and belief are embedded in reality. Faith and hope acknowledge that there are things in this life that we do not see, do not know, and do not understand, things of which we cannot be certain. This is an important existential reality. Psychiatrists need to be able to discuss concerns of faith and hope,

and wade into areas of uncertainty. This may include specifically religious concepts and language, but need not necessarily.

Now we see in a mirror dimly, but then we will see face to face. Now I know only in part; then I will know fully... and now faith, hope and love abide.²⁶

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