

Illness-Related Hopelessness in Advanced Cancer: Influence of Anxiety, Depression, and Preparatory Grief

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The growing interest in the psychological distress in patients with cancer has been the major reason for the conduction of this study. The aims were to assess the relationship of hopelessness, anxiety, distress, and preparatory grief, as well as their predictive power to hopelessness. Ninety-four patients with advanced cancer completed the study at a palliative care unit in Athens, Greece. Beck Hopelessness Scale, the Greek version of the Hospital Anxiety and Depression (HAD) scale, and the Preparatory Grief in Advanced Cancer Patients scale were administered. Information concerning patients' treatment was acquired from the medical records, whereas physicians recorded their clinical condition. Hopelessness correlated significantly with preparatory grief ($r = .630, P < .0005$), anxiety ($r = .539, P < .0005$), depression ($r = .642, P < .0005$), HAD-Total ($r = .686, P < .0005$), and age ($r = .212, P = .040$). Multiple regression analyses showed that preparatory grief ($P < .0005$), depression ($P < .0005$), and age ($P = .003$) were predictors of hopelessness, explaining 58.8% of total variance. In this patient sample, depression, preparatory grief, and patients' age were predictors of hopelessness.

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FEELINGS OF HOPELESSNESS are common reactions of patients as they approach to

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terminal illness (Akechi, Okamura, Nishiwake, & Uchitomi, 2002). It has also been suggested that hopelessness may be an important psychological construct for understanding adaptations to stress and illness (Green, O'Mahoney, & Rungasamy, 1982). Hopelessness is of special concern because it has been found to be a risk factor for suicidal ideation and suicide and desire for hastened death (Bostwick & Pankratz, 2000; Papakostas et al., 2003; Rosenfeld, Gibson, Kramer, & Breitbart, 2004). Improving end-of-life care requires looking beyond prognosis and preferences to understand the dynamics of hopelessness (Sullivan, 2003).

Hopelessness at the end of life is not simply the absence of hope but attachment to a form of hope that is lost. Nunn, Lewin, Walton, and Carr (1996) defined *hope* as "that construction of, and response to, that perceived future in which the desirable is subjectively assessed to be probable" (p. 531). It is

future orientated and expectant, involving cognitive and affective aspects of longing and believing for something that is not certain but at least possible (Nunn, 1996). Hope can be generalized or particularized (Kim, Kim, Schwatz-Barcott, & Zucker, 2006).

Generalized hope preserves the meaning of life when specific hopes are quashed, as with the diagnosis of an incurable cancer, and can enable a person to find value in the most negative situation and to accomplish things others might have thought impossible. In this way, the reality of an approaching death may serve as a catalyst in reinvigorating life, valuing relationships, and engaging in life with purpose (Kissane, 1998).

It has been suggested that hopelessness may be an important psychological construct for understanding adaptations to stress and illness (Abbey, Rosenfeld, Pessin, & Breitbart, 2006). Low hopelessness has been found to be the key variable in predicting good-health-related quality of life (QoL; Gustavsson-Lilius, Julkunen, & Hietanen, 2007). Beck, Weissman, Lester, and Trexler (1974) conceptualized hopelessness as a cognitive pattern with negative expectations about the future as its core feature. Little is known regarding the construct of hopelessness in the context of medical or terminal illness despite the importance of this construct for patients who are terminally ill (Rosenfeld et al., 2004).

There is empirical evidence that a hopeless coping style is associated with unfavorable disease outcome in patients with certain cancers (Greer, 1999). Another follow-up study revealed that those patients who responded to cancer with hopelessness were less likely to be alive and free of recurrence at a 15-year follow-up (Schou, Ekeberg, Ruland, Sandvik, & Kåresen, 2004). Therefore, the coping response (i.e., hopelessness) may be one of the most important targets for alleviating patients' psychological distress (Akechi, Okuyama, Imoto, Yamawaki, & Uchitomi, 2001). Other than psychiatric studies, the identification of hopelessness attributes in medical research has been more limited than that in psychology or nursing (Dunn, 2005).

Apart from hopelessness, feelings of depression and anxiety are also common reactions of patients as they approach the terminal phase of their illness (Akechi et al., 2002; Pessin, Rosenfeld, & Breitbart, 2002). Hopelessness is a key variable that links depression to suicidal ideation and suicide in

patients with cancer (Bostwick & Pankratz, 2000; Foley, 1995; Papakostas et al., 2003).

Psychological distress reduces the patient's ability to do the emotional work of separating and saying goodbye and causes anguish and worry in family members and friends (Block, 2000). In this context, the concept of preparatory grief has been suggested that may help us interpret hope and hopelessness at the end of life (Sullivan, 2003). Hopelessness mirrors a grief reaction. Unequivocally, bound up with grief is hope-hopelessness (Cutcliffe, 1998). Moreover, in the North American Nursing Diagnosis Association (1996) system, a perceived or actual stressor or loss can be an antecedent of hopelessness. Preparatory grief (Casarett, Kutner, & Abraham, 2001) encompasses grief for losses that have already befallen or are currently being experienced and losses that will or might ensue in the future after the death as a consequence of it (e.g., the lifestyle alterations of the loved ones). Patients may mourn the changes in their physical and mental capacities or how their role in the family will change as they become more debilitated. During the course of a terminal illness, there will be many losses for the patients. These might include loss of privacy, independence, dreams, dignity, money, control, friendship or family role, autonomy, and life itself (Egan & Arnold, 2003). A grief reaction contains an element of hopelessness, and it is therefore worth examining if the patient's experience of grief reactions influences hopelessness.

Values, attitudes, and behaviors differ greatly across cultures and have implications for how patients grieve (Bloom, 1996; Wilkie et al., 2001). Preparatory grief has been defined as the total set of cognitive, affective, cultural, and social reactions to expected death felt by the patient and the family (Knott & Wild, 1986; Kalish, 1985). Given the uniqueness and individuality of each person, even people of the same culture may have different backgrounds, experiences, needs, concerns, and interpretations of illness (Doka & Morgan, 1993). Attention to culturally specific rituals germane to end-of-life rituals is important for the nurse who is delivering culturally competent care (Giger, Davidhizar, & Fordham, 2006). Culturally congruent care has to be planned and conducted in agreement with the patient's worldviews. According to Leininger's (1995, 2001) definition, culturally congruent care is tailored to patient's cultural values and lifestyle.

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