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Hope without certainty

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Essay/Personal Reflection

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Personal reflection: Hope without certainty

After my third brain tumor recurrence, my care team recommended radiation and chemotherapy. Treatment might offer temporary disease control, but there was no reliable way to predict the outcome. My husband worried about the potential harms, including cognitive decline and diminished quality of life. I chose treatment anyway. The decision exposed a central tension in serious illness: hope is often framed around anticipated futures, while patients must live within profound uncertainty.

Dominant clinical models of hope are structured around anticipation, goal orientation, and pathways toward future outcomes. C. R. Snyder's Hope Theory conceptualizes hope in terms of agency and pathways toward desired goals (Snyder 2002), and widely used instruments such as the Herth Hope Index operationalize hope through future-oriented expectation and goal attainment (Herth 1992). Within these frameworks, hope is closely tied to the capacity to imagine and move toward desired futures.

These frameworks primarily emphasize future-oriented cognition and goal attainment as markers of adaptation. The Herth Hope Index includes items such as "I feel scared about my future," which are reverse scored, reflecting an assumption that fear of the future is inversely related to hopefulness (Herth 1992; item wording reproduced in NovoPsych assessment form). In serious illness, fear about the future may reflect realistic prognostic awareness rather than diminished existential well-being.

When hope is defined primarily through anticipated outcomes, it may become unstable under conditions of prognostic uncertainty, limiting its usefulness as a durable source of meaning and engagement.

These distinctions have important implications for clinical communication and decision-making in serious illness. In research and clinical care, hope is treated as a measurable construct, yet serious illness often unfolds outside stable prediction, producing tension between standardized definitions and lived experience. When instruments designed to quantify hope are used to interpret distress or adaptation, they may privilege future-oriented expectation over forms of engagement grounded in uncertainty, relational continuity, and present-moment experience.

These frameworks may shape how uncertainty, suffering, and adaptation are interpreted, and how patients' experiences are understood within clinical encounters.

In serious illness, these frameworks may risk conflating diminished future orientation with hopelessness, poor adjustment, or reduced treatment tolerance. Yet patients may continue to experience meaning, relational continuity, dignity, and engagement even when confidence in future outcomes diminishes. Under these conditions, future-oriented definitions of hope may insufficiently capture lived adaptation.

Meaning and relational continuity can remain intact even in the absence of stable or positive future projection. This suggests a gap between lived experience and dominant models of hope, and points toward meaning-making as a more stable basis for understanding well-being under conditions of serious illness (Park 2010).

Existential and clinical accounts offer alternative emphases. Frankl locates meaning in attitudinal engagement with unavoidable suffering rather than outcome attainment, emphasizing orientation within constraint rather than control (Frankl [1946] 1963).

In psycho-oncology and palliative care, meaning is further supported through relational and dignity-oriented frameworks. Dignity-conserving care emphasizes that dignity is shaped through relational recognition and continuity of self (Chochinov 2002). Meaning-Centered Group Psychotherapy adapts Frankl's work, emphasizing meaning through experience, creation, and attitudinal engagement with suffering (Breitbart et al. 2010). These approaches suggest that meaning may remain clinically and existentially significant even when future-oriented hope becomes destabilized.

Related work in serious illness similarly emphasizes presence, compassion, connectedness, and relational continuity as sources of existential well-being (Bauer-Wu 2025).

A reorientation toward presence also appears in contemplative approaches to illness and mortality. Joan Halifax describes "wise hope" as a form of engaged presence grounded in clarity

and compassion rather than anticipated outcomes (Halifax 2021). Within this framework, hope is not abandoned, but loosened from the expectation of cure or certainty.

Narrow constructions of hope may affect clinicians as well as patients. When hope is implicitly tied to cure, response, or future improvement, the inability to alter disease trajectory can be experienced as therapeutic limitation or failure. Related work in oncology has similarly questioned how dominant frameworks of treatment response, tolerance, and failure may shape clinicians' and patients' interpretations of adaptation under uncertainty (Shteynberg in press). Expanding clinical understandings of hope may create greater space for forms of care grounded in presence, accompaniment, meaning, and relational continuity rather than resolution alone.

Disentangling hope from future resolution does not consign patients to despair. Instead, it may make visible forms of meaning, connection, and engagement that remain possible even when outcomes are uncertain. Wise hope, by contrast, is not dependent on desired futures, though it does not exclude them. It describes a way of remaining engaged with life even when outcomes cannot be known.

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