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Correspondence Letters submitted for publication should be emailed to Dr Joe Bouch at apt@rcpsych.ac.uk or posted to Advances in Psychiatric Treatment, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.

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Hopefulness

FROM THE EDITOR

By Joe Bouch

The absence of hope is an ominous clinical sign. Clinicians are well aware of the central significance of hopelessness in suicidal ideation: 'the distorting influence of acute distress and depression on cognition [makes] the future appear bleaker than is in fact likely' (Kelly & Dale, pp. 214–219). As clinicians, we too can be vulnerable to losing hope. In this issue of *Advances* there are articles on clinical areas where 'therapeutic optimism' is challenged and hope may be in short supply. For the purposes of serving and reassuring us, 'the best kind of patient […] is one who, from great suffering and danger of life or sanity responds quickly to a treatment that interests his doctor and thereafter remains completely well' (Main 1957). Patients with personality disorder have often seemed the opposite: 'untreatable', difficult to engage, 'abusers' of services, engendering anger and hopelessness in therapists (Evershed, pp. 206–213).

Given our close acquaintance with hopelessness, it seems surprising that 'little attention has been paid to the concept [of hope] in psychiatry' (Schrank *et al*, pp. 227–235). Schrank *et al* explore meanings and research findings and their implications for psychiatry. Hope has been identified by both patients and therapists as a key factor in psychotherapy. Hope 'restores the unification between past, present and future that can be lost during illness'. The past cannot be undone, but new meanings can be attributed as a means of overcoming it. Thus, Syrett (pp. 201–205) sees the 'lived experience' of the service user becoming a 'resource': a resource for research, peer support and the person's own recovery.

Hope, recovery and working with offenders

Recovery may be 'open to all' (Roberts 2004), but there are challenges. One context in which 'the term "recovery" remains awkward and uncomfortable' is old age psychiatry (Hill 2010). Another is working with offenders – the focus of the article and accompanying commentary that are my Editor's pick (Dorkins & Adshead, pp. 178–187; Roberts, pp. 188–190). Dorkins & Adshead write that here 'it is not always clear whether the professional is the true supporter of the patient, the dupe or the social oppressor'. Clinicians may need to tolerate 'being seen by the patient as "the enemy"'. Maintaining equanimity in such circumstances may be difficult enough, never mind being hopeful or trying to instil hope in others. But hope is a key domain of recovery. Is there a need to alloy hope with pessimism? Roberts (pp. 188–190) is not convinced. Perhaps of help is the paradoxical notion of 'hop[ing] against hope […] that there is something for me that sustains hope even when all occasions for hope seem to have been exhausted' (Steinbock 2003).

Hill L, Roberts G, Wildgoose J, et al (2010) Recovery and person-centred care in dementia: common purpose, common practice? *Advances in Psychiatric Treatment* **16**: 288–98.

Main T (1957) The ailment. *British Journal of Medical Psychology* **30**: 129–45.

Roberts G, Wolfson P (2004) The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment* **10**: 37–48.

Steinbock AJ (2003) Hoping against hope. In *Essays in Celebration of the Founding of the Organization of Phenomenological Organizations* (eds C-F Cheung, I Chvatik, I Copoeru, et al). Web-published (http://www.o-p-o.net/essays/SteinbockArticle.pdf).