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Brief Communication

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Dignity and Dignity Therapy in End-of-Life Care

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Preserving dignity is a significant concern for individuals approaching the end of their lives, as they face an increasing number of conditions that can potentially compromise their dignity. This article discusses dignity therapy as one intervention method aimed at enhancing the psychological and spiritual well-being of patients with terminal illnesses. Dignity therapy is an empirically supported therapeutic intervention that interviews patients with nine questions about what is important to them and what they want to remember, culminating in the production of a document based on these conversations. This intervention serves as a valuable tool and framework, enabling clinical professionals to reflect on dignity. It also provides clinicians with a medium to connect with patients on a deeply human level.

Key Words: Quality of life, Psychotherapy, Hospice care, Palliative care, Terminal care

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INTRODUCTION

Every clinician involved in end-of-life care contemplates the nature of human dignity and the best ways to help patients maintain their dignity until their final moments. Hospice and palliative care place a high priority on safeguarding human dignity and values, assisting patients and their families in achieving an improved quality of life through a variety of care strategies. Dignity therapy has emerged as a widely used intervention for alleviating the distress of terminally ill patients while enhancing their psychological, existential, and spiritual well-being [1]. This psychological intervention, devised by Dr. Harvey Max Chochinov, a Canadian psychiatrist and expert in palliative care, is a short-term, individualized intervention. A multitude of international studies on dignity therapy have been conducted, with some reporting positive outcomes in terms of patient satisfaction and reductions in anxiety and depression [1,2].

Understanding the importance of dignity during end-of-life care, along with the specific methods and impacts of intervention, can significantly enhance the quality of care provided to terminally ill patients in healthcare environments.

DIGNITY MODEL AND DIGNITY THERAPY

Dignity holds significance at every stage of life, as it is an inherent right and value of every human being. However, its importance becomes particularly pronounced when caring for patients nearing the end of their lives, due to their increased vulnerability to conditions that may compromise it. This has led to the development of the dignity model [3-5], which is segmented into three categories: illness-related concerns, dignity-conserving repertoire, and social dignity inventory. Each category encompasses various themes and sub-themes (Table 1) [3]. This model outlines the key elements necessary for preserving or enhancing dignity, and it forms the foundation for the structure, tone, and content of dignity therapy [6].

Each component of dignity therapy is linked to the dignity model. To fully comprehend this connection, one must un-

derstand the structure and procedure of the therapy. During dignity therapy, an interview is conducted, in which the patient is asked nine dignity-related questions (Table 2) [1]. This is followed by an interview that typically lasts between 30 and 60 minutes. The entire conversation, the length of which may vary based on the patient's condition, is recorded. The clinical professional then consolidates the content into a well-structured and coherent document, which is subsequently shared with the patient for review. After incorporating revisions based on the patient's feedback, the final version is handed over to the patient [6]. The patient is then free to share this document with anyone they choose. On average, the entire process takes about two to three sessions to complete.

The content of the questions pertains to the intrinsic qualities and social dignity-conserving repertoire of the dignity model [6]. These qualities encompass continuity of self, role preservation, generativity/legacy, maintenance of pride, hopefulness, autonomy/control, acceptance, and resilience/fighting spirit [3]. Some questions are autobiographical in nature, while others provoke deeper contemplation. Rather than encompassing the patient's entire life, the questions focus on their significant moments or aspects. This method enables patients to reflect on their life as a whole, beyond their individual role, and contemplate what they wish to leave behind after their demise.

A "generativity document" is produced during dignity therapy. This document communicates the patient's significant values that extend beyond their lifetime [6]. Moreover, the therapy's content and form allow patients to perceive their lives as having made a substantial impact.

Finally, an important distinction between dignity therapy and personal journals or letters lies in the interactive interview conducted with a professional. This interaction, grounded in the

Table 1. The Dignity Model.

Categories	Themes and sub-themes
Illness-related concerns	[Level of independence]
	Cognitive acuity
	Functional capacity
	[Symptom distress]
	Physical distress
	Psychological distress
Dignity-conserving repertoire	Dignity-conserving perspectives
	- Continuity of self
	- Role preservation
	- Generativity/legacy
	- Maintenance of pride
	- Hopefulness
	- Autonomy/control
	- Acceptance
	- Resilience/fighting spirit
	Dignity-conserving practices
	- Living in the moment
	- Maintaining normalcy
	- Seeking spiritual comfort
Social dignity inventory	Privacy boundaries
	Social support
	Care tenor
	Burden to others
	Aftermath concerns

Source: Chochinov HM, Hack T, McClement S, Kristjanson L, Harlos M. Dignity in the terminally ill: a developing empirical model. Soc Sci Med 2002;54:433-43.

Table 2. Dignity Therapy Question Protocol.

Dignity therapy question protocol
1. Tell me a little about your life history: particularly the parts that you either remember most or think are the most important? When did you feel most alive?
2. Are there specific things that you would want your family to know about you, and are there particular things you would want them to remember?
3. What are the most important roles you have played in life (family roles, vocational roles, community-service roles, etc.)? Why were they so important to you, and what do you think you accomplished in those roles?
4. What are your most important accomplishments, and what do you feel most proud of?
5. Are there particular things that you feel still need to be said to your loved ones or things that you would want to take the time to say once again?
6. What are your hopes and dreams for your loved ones?
7. What have you learned about life that you would want to pass along to others? What advice or words of guidance would you wish to pass along to your (son, daughter, husband, wife, parents, other[s])?
8. Are there words or perhaps even instructions that you would like to offer your family to help prepare them for the future?
9. In creating this permanent record, are there other things that you would like included?

Source: Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M. Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. J Clin Oncol 2005;23:5520-5.

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caring tone of the repertoire [6], involves the professional as an active participant, engaging in genuine, attentive listening. This allows patients to feel respected and connected, thereby enhancing their sense of dignity. This interaction encompasses both verbal communication and subtle non-verbal communications [6]. The final element of the repertoire imparts a significant insight to clinicians: their role goes beyond merely guiding the process, enriching the narrative, and creating a meaningful document. They are actively and authentically involved in conversations with patients, facilitating reflection on significant aspects of their lives [6]. Therefore, it is imperative for clinical professionals to profoundly comprehend and appreciate the patient's personhood, acknowledging their holistic existence as a human being.

THE PRACTICE OF DIGNITY THERAPY

Several key considerations for the effective implementation of dignity therapy are outlined in a book authored by Chochinov [6]. This comprehensive guide includes both documentation and case studies. Consequently, it is highly recommended for those interested in studying dignity therapy to either read this book or attend a workshop on the subject. As with all psychotherapeutic approaches, the mastery of dignity therapy necessitates the clinical professional's maturity, extensive experience, and continuous learning. This section offers a concise summary of the handbook for those implementing dignity therapy in clinical settings.

First and foremost, it is essential to identify suitable candidates for dignity therapy, a practice that has emerged from palliative care. Those nearing the end of their life or suffering from a life-threatening condition are eligible. However, participants must be capable of responding to questions. Patients who can write or use a keyboard may be considered, even if they are unable to communicate verbally. Additionally, the patient must have a personal motivation to participate, and both the clinical professional and patient must understand each other's language. If the disease causes pain so severe that it depletes cognitive and physical energy, full participation may be challenging. For patients with a very short life expectancy (less than two weeks), it may be beneficial to discuss with them in advance how to expedite the process or address if the entire process is not completed. For participants with seriously limited cognitive function and meaningful responses may be difficult, it should be considered whether dignity therapy is definitely beneficial. Once a patient's eligibility is determined, the patient and their family should be informed about dignity therapy and given the opportunity to discuss any questions or concerns. Following this, the patient should be presented with the patient dignity question to review and reflect upon. When they decide to participate, the basic information should be collected from them. Subsequent appointments are scheduled to conduct interviews, which, should occur in a private, comfortable, and secure setting. Even if accessing a separate consulting room is not available and the interview is conducted at bedside, it should be confirmed that the patient feels comfortable and can talk openly, and it will be helpful to establish minimal boundaries. Moreover, it is necessary to coordinate the schedule to allocate sufficient time. Lastly, the recorded files or revised documents should also be protected.

CONCLUSION

Dignity therapy is an effective psychotherapeutic approach that aids terminally ill patients in enhancing their psychological, existential, and spiritual well-being. Although this therapy is not a cure-all, it enables many patients to live their lives without compromising their dignity, and potentially discover alternative methods to leave a lasting legacy. It is clear that dignity therapy can serve as an effective tool by offering a framework for reflecting on dignity. Primarily, its worth derives from its capacity to foster authentic human interactions between clinicians and patients. Significantly, if dignity therapy becomes more prevalent and researched in clinical settings in Korea, it can contribute to elevating the quality of end-of-life care.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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SUPPLEMENTARY MATERIALS

Supplementary materials can be found via https://doi.org/10.14475/jhpc.2023.26.3.145.

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