

Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: a randomized controlled trial.

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Abstract:

BACKGROUND: Dignity therapy is a unique, individualized, short-term psychotherapy that was developed for patients (and their families) living with life-threatening or life-limiting illness. We investigated whether dignity therapy could mitigate distress or bolster the experience in patients nearing the end of their lives.

METHODS: Patients (aged ≥ 18 years) with a terminal prognosis (life expectancy ≤ 6 months) who were receiving palliative care in a hospital or community setting (hospice or home) in Canada, USA, and Australia were randomly assigned to dignity therapy, client-centered care, or standard palliative care in a 1:1:1 ratio. Randomization was by use of a computer-generated table of random numbers in blocks of 30. Allocation concealment was by use of opaque sealed envelopes. The primary outcomes--reductions in various dimensions of distress before and after completion of the study--were measured with the Functional Assessment of Chronic Illness Therapy Spiritual Well-Being Scale, Patient Dignity Inventory, Hospital Anxiety and Depression Scale, items from the Structured Interview for Symptoms and Concerns, Quality of Life Scale, and modified Edmonton Symptom Assessment Scale. Secondary outcomes of self-reported end-of-life experiences were assessed in a survey that was undertaken after the completion of the study. Outcomes were assessed by research staff with whom the participant had no previous contact to avoid any possible response bias or contamination. Analyses were done on all patients with available data at baseline and at the end of the study intervention.

FINDINGS: 165 of 441 patients were assigned to dignity therapy, 140 standard palliative care, and 136 client-centered care. 108, 111, and 107 patients, respectively, were analyzed. No significant differences were noted in the distress levels before and after completion of the study in the three groups. For the secondary outcomes, patients reported that dignity therapy was significantly more likely than the other two interventions to have been helpful ($\chi^2=35.50$, $df=2$; $p<0.0001$), improve quality of life ($\chi^2=14.52$; $p=0.001$), increase sense of dignity ($\chi^2=12.66$; $p=0.002$), change how their family saw and appreciated them ($\chi^2=33.81$; $p<0.0001$), and be helpful to their family ($\chi^2=33.86$; $p<0.0001$). Dignity therapy was significantly better than client-centred care in improving spiritual wellbeing ($\chi^2=10.35$; $p=0.006$), and was significantly better than standard palliative care in terms of lessening sadness or depression ($\chi^2=9.38$; $p=0.009$); significantly more patients who had received dignity therapy reported that the study group had been satisfactory, compared with those who received standard palliative care ($\chi^2=29.58$; $p<0.0001$).

INTERPRETATION: Although the ability of dignity therapy to mitigate outright distress, such as depression, desire for death or suicidality, has yet to be proven, its benefits in terms of self-reported end-of-life experiences support its clinical application for patients nearing death.

Strengths: The study provides a clear picture of the methods used within the different study groups as well as a large number of different outcome measures. There are no obvious flaws in the randomization or blinding process and the distribution of participants appears appropriate. Outcome measures obtained can be compared in an objective fashion.

Weaknesses: Several have been identified by the authors. The ineligibility criteria exclude a significant percentage of the patient population. The small sample numbers also cause some of the differences in outcome results to be difficult to interpret. The baseline distress levels of the patient population were quite low, making measurement of improvements in distress levels difficult to compare. Outcome measures regarding family members' experiences are not reported (though they note that this will be addressed in a future publication). Also of note, the paper does not provide information regarding the site distribution of the various participants (Winnipeg, Perth, New York). Regarding outcome measures, some of the differences between groups are quite small between a "neutral" and "agree" response. The relative use of resources between study groups is also not discussed within the article.

Relevance to palliative care: This article presents a novel approach in the management of terminally ill patients with regard to coping with distress. The data does show a significant improvement in patient distress levels at this time, but there is evidence that dignity therapy may provide and improved quality of life and increased sense of dignity for patients. At this point, further exploration into this psychotherapeutic approach could be considered and other studies could be implemented to assess for benefit of dignity therapy in the patient population.