



Dignity therapy for effective palliative care: a literature review

Se-Ryun Park¹, Yu-Jung Cha²

¹Kosin University College of Medicine, Busan, Korea

²Department of Pharmacology, Kosin University College of Medicine, Busan, Korea

Dignity therapy for terminally ill patients in end-of-life care helps improve their psychological and spiritual well-being. In this study, the effectiveness and feasibility of dignity therapy in terminally ill patients were analyzed by reviewing previous studies. The review's findings show that dignity therapy alleviates psychological distress and improves patients' spiritual well-being and dignity. In addition, many patients and their families found emotional support in generativity documents created through dignity therapy. Finally, the possibility of applying dignity therapy to palliative care in Korea in the future was explored. The findings indicate the influence of Eastern culture on recognizing death in patients who receive dignity therapy. Thus, dignity therapy shows promise as a contribution to improving palliative care; however, additional studies are needed to implement effective dignity therapy in the Korean context.

Keywords: Death; Hospices; Palliative care; Psychotherapy

Introduction

Palliative care refers to medical services that relieve or prevent the pain caused by the various physical and psychological issues faced by patients with terminal diseases, and their families [1,2]. In particular, psychotherapeutic interventions have been used to relieve distress. Among these interventions, dignity therapy has shown potential as a new therapeutic regimen for improving patients' emotional states toward the end of their lives [3,4]. First proposed by Canadian psychiatrist Chochinov et al. in 2002 [3], dignity therapy is a brief form of narrative psychotherapy designed to enhance dignity and alleviate psychological distress in terminally ill patients through reminiscence on their lives [5]. It aims to alleviate patients' psychological distress and assist in leading assist them in a more dignified ending pe-

riod by allowing them to reflect on meaningful moments in their lives [6]. In end-of-life care, dignity is important because it is a human right to be guaranteed and is closely related to well-being [7-9]. Chochinov [6] suggested three major factors affecting dignity: illness-related concerns, a dignity-conserving repertoire, and a social dignity inventory. Illness-related concerns include themes related to suffering from disease and autonomy [6]. The dignity-conserving repertoire focuses on the spiritual state of patients and includes themes such as hopefulness, continuity of self, and generativity [6,10]. The social dignity inventory is related to relationships with other people surrounding the patient. Themes such as social support and quality of care, burden to others, and aftermath concerns are included in the social dignity inventory [6].

In this study, the feasibility and effectiveness of dignity

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Corresponding Author: Yu-Jung Cha, MD, PhD

Department of Pharmacology, Kosin University College of Medicine, 262 Gamcheon-ro, Seo-gu, Busan 49267, Korea

Tel: +82-51-990-6488 Fax: +82-51-241-0145 E-mail: miacha0128@gmail.com

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therapy in patients with terminal diseases are investigated. Furthermore, its potential applications in Korea were examined by identifying cases from Eastern cultures. In this narrative review, an in-depth examination of qualitative and quantitative research on the effectiveness and feasibility of dignity therapy is conducted.

Taxonomy of dignity therapy

1. Implementing dignity therapy

Before the interview, patients are introduced to the process of dignity therapy, and presented with the questions from the Dignity Therapy Question Protocol (DTQP) so that they could consider their responses to the interview questions in advance. Subsequently, they are interviewed using the DTQP, consisting of nine questions. DTQP questions are presented in [Table 1](#).

During the interviews, the therapists present the questions to the participants, flexibly, according to the situation. The interviews typically last approximately 60 minutes, and all interviews are recorded. Afterwards, the recorded content is transcribed and produced in document form. The “generativity document,” containing the interview details, is cross-checked by each participant for any omissions or errors. The revised generativity document is then, delivered to patients or those designated by the patient.

2. Characteristics of the generativity document

The four main characteristics of the generativity document describing the interviews with patients in dignity therapy are generativity, care tenor, hopefulness, and continuity

of self. Generativity originates from the messages that patients wish to leave for their family or friends after their death, and the generativity document, which contains such messages, serves as a “legacy.” The characteristics of dignity therapy, in which patients are allowed to disclose their narratives during the interview in an atmosphere of respect and empathy, serve as the sources of care tenor [3,11]. Hopefulness derives from a positive view of their future and by discovering meaning and purpose of their lives through therapy sessions [11,12]. Continuity of self is derived from the opportunity to reflect on their feelings and self-images that the therapy gives.

Methods

PubMed, PsycINFO, Google Scholar, and KoreaMed databases were used to search for studies published up to December 31, 2021. “Dignity therapy,” “efficacy,” “feasibility/acceptability,” “adaptation,” and “culture” were the search keywords, and Boolean operators (e.g., OR, AND, NOT) were used in the search. The inclusion criteria were as follows: (1) publications on the effectiveness, feasibility, acceptability, or cultural adaptation of dignity therapy, and (2) published in English or Korean. The exclusion criteria were (1) papers not related to dignity therapy, (2) duplicate papers, and (3) papers presented at conferences or symposiums. The first author conducted the initial and secondary comprehensive literature review in 2021. After screening the abstracts, the full text of the relevant articles was reviewed. The first search identified 40 distinct publications. Eighteen papers were excluded from the review,

Table 1. Dignity Therapy Question Protocol

Questions
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?

including those that were not relevant to dignity therapy, duplicate papers, and papers presented at conferences or symposiums. Thus, 22 papers were finally chosen for the narrative review. The information in each publication was summarized by author's name, year of publication, research purpose, research subjects, study design, outcome measurements, and study results in the selection process.

Results

1. Effectiveness of dignity therapy

Chochinov et al. [3] conducted a quasi-experimental study to examine the effects of dignity therapy on psychosocial and existential distress, as well as determine its feasibility. The study included 100 patients with terminal diseases whose life expectancy was ≤ 6 months. To assess patients' symptom levels, a questionnaire assessing anxiety, depression, and dignity, a quality-of-life instrument (two-item), and the revised Edmonton Symptom Assessment Scale (ESAS) were administered.

Approximately 90% of the participants stated that they were satisfied with the therapy. In addition, the therapy had a significant effect on reducing pain and depression in patients with cancer and increased their willingness to live.

In a subsequent randomized controlled trial [13], the effectiveness of dignity therapy was confirmed in 441 patients with terminal diseases who received palliative care with a life expectancy of ≤ 6 months to investigate whether the therapy can contribute to alleviating the distress of the patients and providing better end-of-life care. The participants were assigned to dignity therapy ($n=108$), client-centered care ($n=107$), and standard palliative care ($n=111$). The counseling therapy received by participants assigned to client-centered care was different from that received by those assigned to dignity therapy and helped clients focus on their current condition. The Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp) scale, which measures spiritual well-being, and the Patient Dignity Inventory (PDI), which measures a patient's sense of dignity, were implemented to evaluate the effectiveness of the therapy. The Hospital Anxiety and Depression Scale (HADS) was used at baseline and post-intervention to examine the anxiety and depression experienced by hospital patients. In addition, the ESAS and a 7-item Structured Interview for Symptoms and Concerns (SISC) were used. This

study found that dignity therapy helped participants reduce psychological distress such as depression and anxiety; however, according to the surveys, no statistically significant differences between the groups across all measurements.

In a study in the United Kingdom [5], 45 patients with advanced-stage cancer were randomly assigned to one of two groups: one receiving standard palliative care and dignity therapy ($n=22$), and the other receiving only standard palliative care ($n=23$). The PDI was used at baseline, and the following measurements were used at 1 and 4 weeks after completion of the intervention: the Herth Hope Index (HHI), HADS, and EuroQol 5-dimension (EQ-5D) to measure quality of life and two 10-point Likert scales. The participants' level of psychological distress was low at baseline, and there was no significant effect of any other index on the participants who received dignity therapy at the 1-week follow-up; however, the only positive effect was an increase in participants' levels of hope.

Juliao et al. [14] conducted a randomized controlled trial of 80 patients with terminal illnesses. The intervention group ($n=39$) received both standard palliative care and dignity therapy, whereas the control group ($n=41$) only received standard palliative care. Participants' psychological symptoms were measured using the HADS at baseline and on days 4, 15, and 30 after the intervention. The results showed that participants who received dignity therapy had significantly lower anxiety and depression scores than the control group at all time points. Additionally, the average survival period of the control group was only 20.8 days compared to that of the dignity therapy group, which was 26.1 days [15]. Therefore, researchers have speculated that dignity therapy may help patients live longer lives.

In a study of 70 patients with advanced diseases and a life expectancy of less than 12 months [16], participants were randomly assigned to one of three groups: a group receiving dignity therapy, those receiving a life review intervention, and a waitlist control group. In contrast to the other groups, participants in the dignity therapy group received legacy documents [17] containing memories or words meaningful to their families and could send the documents to anyone. The Brief Generativity and Ego-Integrity Questionnaire, PDI, Functional Assessment of Cancer Therapy-General (FACT-G), and treatment evaluation questionnaires were used to measure the outcomes. Although there were no significant differences in physical or mental health

Table 2. Summary of the literature review on the effectiveness of dignity therapy

Author (year)	Purpose	Study design	Participants	Outcome measurements	Results
Chochinov et al. (2005) [3]	Determine the viability of DT and its impact on various psychosocial and existential distress measures	Quasi-experimental study	Terminally ill cancer patients (n=100)	Depression, dignity, anxiety, pain, hopefulness, willingness to die, suicide, and sense of well-being questionnaires Quality of life (2 items) ESAS	91% were satisfied with DT. 76 % expressed a heightened sense of dignity. Significant improvements in suffering, reduced depressive symptoms, and so on, were observed in post-intervention measures.
Chochinov et al. (2011) [13]	Investigate whether DT can reduce distress or improve patients' quality of life	Randomized controlled trial	Patients receiving palliative care (n=441) DT (n=165) CCC (n=136) SPC (n=140)	FACIT-Pal, PDI, HADS, SISC (7 items), ESAS	No significant difference in distress before and after intervention in any group. Patients reported that DT was more likely to be perceived as helpful.
Hall et al. (2011) [5]	Evaluate the effect of DT on reducing distress in advanced cancer patients	Randomized controlled trial	Advanced cancer patients (n=45) DT (intervention; n=22) SPC (control; n=23)	Primary outcome: PDI Secondary outcomes: HHI, HADS, quality of life (EQ-5D), Likert scales, surveys for feedback	No significant difference in dignity-related distress between groups. The intervention group reported higher hopefulness than the control group at both follow-ups.
Juliao et al. (2014) [14]	Determine the impact of DT on depression and anxiety in highly distressed inpatients with a terminal illness	Randomized controlled trial	Terminally ill patients (n=80) Intervention (DT+SPC; n=39) Control (SPC; n=41)	HADS	DT was associated with a significant decrease in depression and anxiety scores at all follow-ups.
Vuksanovic et al. (2017) [16]	Evaluate the effects of legacy documents of DT comparing the intervention group (DT) with LR and WC groups	Randomized controlled trial	Patients with terminal diseases (n=70) DT (n=23) LR (n=23) WC (n=24)	Brief Generativity and Ego-Integrity Questionnaire, PDI, FACT-G, questionnaires for treatment evaluation	Unlike LR and WC groups, DT recipients demonstrated significantly increased generativity and ego-integrity scores at study completion. No significant changes in dignity-related distress or physical, social, emotional, and functional well-being in any groups.

DT, dignity therapy; ESAS, Edmonton Symptom Assessment Scale; CCC, client-centered care; SPC, standard palliative care; FACIT-Pal, Functional Assessment of Chronic Illness Therapy-Palliative Care; PDI, Patient Dignity Inventory; HADS, Hospital Anxiety and Depression Scale; SISC, Structured Interview for Symptoms and Concerns; HHI, Herth Hope Index; EQ-5D, EuroQol 5-dimension; LR, life review; WC, waitlist control; FACT-G, Functional Assessment of Cancer Therapy-General.

among the three groups, participants who received dignity therapy tended to have higher ego-integrity and generativity than others.

A summary of the reviews on the effectiveness of dignity therapy is presented in [Table 2](#).

2. Satisfaction of dignity therapy

Hall et al. [12] identified the subjective benefits of dignity therapy as reported by participants in a randomized trial of elderly people aged ≥ 65 years, living in nursing facilities. Participants in both the dignity therapy (n=25) and control (n=24) groups experienced positive changes in their outlook on life, and increased self-esteem and self-efficacy. However, significant improvements in the interaction

between participants and their families were only found in the dignity therapy group. Some participants reported that the legacy documents created during therapy sessions helped them recall pleasant memories and share their life stories with their families. Talking to therapists who empathized with their feelings made them feel important. In another study [18], both the intervention and control groups observed the formation of positive self-values and a sense of purpose, whereas only those who received the intervention demonstrated the generativity effect of dignity therapy. The participants stated that therapy allowed them to leave a legacy even after death.

A pre-and post-intervention study of 10 patients with metastatic cancer and their families [19] used the Beck

Depression Inventory-II (BDI-II) and the Functional Assessment of Chronic Illness Therapy-Palliative Care (FACIT-Pal). Measurements were used to assess participants' quality of life and psychological state. Consequently, 75% of participants who completed the post-measures expressed satisfaction with dignity therapy. Participants also stated that the intervention made their lives more meaningful, and that it benefitted them and their families. Families who had lost a loved one stated that legacy documents were a source of comfort.

In a study of 60 family members of terminally ill patients who received dignity therapy [20], more than 70% of the participants reported that it improved their dignity and sense of purpose. It was observed that generativity documents dealing with the lives and memories of patients contributed to reducing the distress caused by the patient's death and assisted the patients' families in overcoming their grief.

Montross et al. [21] conducted a transverse study on the effects of dignity therapy on 18 hospice workers. According to 92% of the staff members at hospice care, it was considered meaningful because it relieved patients' pain and provided care to their families. Furthermore, it helped the hospices to develop relationships with patients and instilled a sense of pride in their profession.

A summary of the reviews on the satisfaction with dignity therapy is presented in Table 3.

3. Feasibility and acceptability of dignity therapy

A randomized controlled trial of 60 nursing facility residents aged ≥ 65 years revealed the feasibility and acceptability of dignity therapy [22]. To determine feasibility, the study measured the number of patient visits by a therapist for intervention as well as the duration of therapy. To determine acceptability, the researchers asked participants whether the intervention helped them or their families. Though the

Table 3. Summary of the literature review on satisfaction with dignity therapy

Author (year)	Purpose	Study design	Participants	Outcome measurements	Results
Hall et al. (2013) [12]	Investigate and contrast participants' perspectives on participating in DT	Qualitative study	Nursing home residents (1-week follow-up; n=49, 8-week follow-up; n=36)	Semi-structured interviews	Six themes, including refocusing, interaction with the researcher or therapist, and diversion, were shown in the intervention and control group interviews. Only the intervention group interview included responses on the generativity document, generativity, and reminiscence themes.
Hall et al. (2013) [18]	Investigate intervention and control participants' views of the advantages of participating in DT	Qualitative study	Cancer patients (1-week follow-up (n=29), 4-week follow-up (n=20)) Family members of the intervention group (n=9)	Semi-structured interviews	Five themes, including continuity of self, hopefulness, and care tenor, appeared in the interviews. The intervention group interviews included reminiscing and a "pseudo-life review."
Johns (2013) [19]	Explore the implementation of DT in clinical practice	Pre-post evaluation	Metastatic cancer patients (n=10) Family members of patients (n=6)	Questionnaires on distress, BDI-II, FACIT-Pal, surveys for feedback from patients and their families	Participants considered DT feasible and acceptable. 75% of patients reported that DT was helpful to their families, and all family members agreed that the generativity document was beneficial to them.
Montross et al. (2013) [21]	Explore the effect of DT from the viewpoints of hospice staff	Qualitative study	Hospice staff members (n=18)	Individual interviews	DT was reported to be beneficial to patients and able to provide positive end-of-life experiences.
McClement et al. (2007) [20]	Investigate the opinions of family members on the influence of DT on patients and themselves	Qualitative study	Family members of deceased patients who participated in DT (n=60)	Individual interviews Feedback questionnaires	The majority of participants reported that DT reduced patients' distress, as well as helped patients' family members cope with grief.

DT, dignity therapy; BDI-II, Beck Depression Inventory; FACIT-Pal, Functional Assessment of Chronic Illness Therapy-Palliative Care.

researchers anticipated that dignity therapy would take longer to be implemented, most participants completed all therapy sessions in a timely manner. Furthermore, participants who received therapy demonstrated a positive change in their attitude toward life compared to the control group. They reported that dignity therapy made their lives more meaningful and supported their families.

Dignity therapy was implemented in a different study by Chochinov et al. [23] with frail elderly participants without cognitive problems (n=11) and those with cognitive impairment who received therapy with family support (n=12). Based on the findings, it was proposed that dignity therapy could be widely used in the elderly population.

In a study of 29 patients with motor neuron disease (MND) [24], it was found that dignity therapy can be helpful. Since MND is an incurable disease that restricts movement and has limited treatment options, it can cause physical and psychological suffering in MND patients, thereby threatening their well-being. Dignity therapy's acceptability was investigated using a 25-item feedback questionnaire that examined whether it improved participants' spiritual well-being and quality of life. Furthermore, the feasibility of dignity therapy was investigated based on its duration and the effect of MND symptoms on participation in the intervention. Participants' self-reports indicated that the intervention was effective and, provided a solid foundation for acceptability. According to the researchers [24], when dignity therapy is administered to patients with MND, the intervention may take longer than it does for cancer patients, and communication issues may arise. They remarked that overcoming these barriers could benefit patients undergoing MND.

Johnston et al. [25] found that dignity therapy is effective in patients with early-stage dementia. In this mixed-method study using interviews and measures for patients in the early stages of dementia, dignity therapy, improved their quality of life and, relieved their psychological distress. The intervention was also performed without major difficulties. Given the symptoms of early dementia, it is expected that the therapy may have a greater impact if it is modified such that participants can easily recall their memories.

Nonetheless, dignity therapy may be difficult to implement in clinical practice because of its inefficiency in terms of time and money [19]. To overcome these constraints, Bentley et al. [26] conducted a study on patients with ter-

minal illnesses to determine whether dignity therapy can be implemented online to save money and time. The research team confirmed its feasibility and applicability over the Internet, while highlighting the technical issues caused by online delivery.

A summary of the review in the feasibility and acceptability of dignity therapy is presented in [Table 4](#).

4. Dignity therapy in East Asian cultures

A Japanese study [27] suggested that the low participation rate in dignity therapy among patients with terminal illnesses was due to differences between Western and Japanese cultures. According to this study, Japanese patients with terminal diseases prefer situations where death is not recognized. Furthermore, because Japanese culture values nonverbal communication, Japanese patients may be hesitant to talk explicitly about death with their family members. Lee and Rhee [28] also found a tendency to avoid death due to fear of death in patients among terminal cancer in Korea. Negative attitudes toward death have reportedly prevented patients from accepting death and reflecting on their lives.

In a Chinese study, Wang et al. [29] investigated the efficacy and limitations of family participatory dignity therapy (FPDT) in patients with hematological cancer and their families. The DTQP was modified in the FPDT, and the treatment target was extended to the patient's family. The overall treatment was similar to Chochinov's treatment procedure [3] for dignity therapy. However, the FPDT includes a step in which patients and their families choose photos and music to create and appreciate audiovisual materials. The patients and their families reported that the intervention improved their emotional and health status, allowing them to communicate with their families. The researchers also discovered that communication between patients and their families was difficult due to the Chinese culture, which forbids discussions regarding cancer and death. They proposed that FPDT, which facilitates communication with patients and their families and prepares them for death, may help solve these issues. In a randomized study in China [30], it was found that dignity therapy improved psychological health and hopefulness in patients. However, there were difficulties in implementing dignity therapy because the patients preferred not to express their thoughts about death.

Table 4. Summary of the literature review on the feasibility and acceptability of dignity therapy

Author (year)	Purpose	Study design	Participants	Outcome measurements	Results
Hall et al. (2012) [22]	Evaluate the feasibility, acceptability, and potential efficacy of DT in reducing distress in the elderly in nursing facilities	Randomized controlled trial	Care home residents aged 65 or older (n=60) Intervention (DT; n=31) Control (n=29)	Potential efficacy: PDI Potential effectiveness: GDS (15 items), HHI, etc. Feasibility: The number of visits by therapists, time taken to deliver the therapy, etc. Acceptability: Ratings of participants' views on DT	No significant differences in potential effectiveness at any time. Reduction in dignity-related distress in both groups. The intervention group outscored the control group on all the acceptability items at both follow-ups. Significant ratings for the efficacy of DT in increasing the meaningfulness of life for patients and helping families overcome distress caused by their deaths.
Chochinov et al. (2012) [23]	Determine the feasibility of DT for the elderly	Transversal study	Cognitively intact (n=12) Cognitively impaired (n=11) Families (n=24) HCPs (n=12)	Feedback questionnaires	All participants completed DT sessions. Most of the cognitively intact and proxy residents found DT to be helpful. HCPs reported the benefits of DT in terms of positively changed perceptions toward residents.
Bentley et al. (2014) [24]	Evaluate the feasibility, acceptability, and potential effectiveness of DT for MND patients	Pre-test post-test design	MND patients (n=29)	Effectiveness: HHI, PDI, FACIT-Sp-12 Feasibility and acceptability: Feedback questionnaires, the time for therapy sessions, reasons for non-completion, etc.	Changes in hopefulness were observed on the individual level. Better family relationships, a stronger sense of self, and greater acceptance were reported to be advantages of DT.
Johnston et al. (2016) [25]	Explore the feasibility, acceptability, and potential effects of DT on early-stage dementia patients	Mixed-methods study	Early-stage dementia patients (n=7) Family members (n=7) Stakeholders (n=7) Focus group members (n=6)	HHI, PDI, quality of life ratings	DT was found to be feasible, acceptable, and potentially effective for patients with dementia in terms of improving quality of life and sense of dignity. Patients had no problems in completing DT sessions and reported that the therapy was helpful to them.
Bentley et al. (2020) [26]	Assess the feasibility and acceptability of DT delivered online	Pre-test post-test design	Patients with terminal illnesses (n=6)	HADS, HHI, FACIT-Pal, feedback questionnaires	High levels of acceptability, efficacy, and convenience were reported. The time for therapy was cut by approximately 40%.

DT, dignity therapy; PDI, Patient Dignity Inventory; GDS, Geriatric Depression Scale; HHI, Herth Hope Index; HCPs, healthcare providers; MND, motor neuron disease; FACIT-Sp-12, Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being 12 Item Scale; HADS, Hospital Anxiety and Depression Scale; FACIT-Pal, Functional Assessment of Chronic Illness Therapy-Palliative Care.

A Korean study [31] investigated the effect of a short-term life review that partially applied the dignity therapy protocol on distress in patients with terminal illnesses. Patients were first interviewed using items from the DTQP in the first session of the short-term life review. After the patients confirmed the documented interview a week later, they created a photo album to reflect on their lives in the second session, using their chosen photographs. After the intervention, anxiety and depression were significantly reduced

in the experimental group compared to the control group, and spiritual well-being was significantly improved. However, some patients were not allowed to receive intervention because of objections from their families [31], which is assumed to be related to the family's negative perception of dignity therapy.

A summary of the review on the implementation of dignity therapy in East Asian cultures is presented in Table 5.

Table 5. Summary of the literature review on dignity therapy implemented in East Asia

Author (year)	Purpose	Study design	Participants	Outcome measurements	Results
Akechi et al. (2012) [27]	Explore the feasibility of DT in Japan	Transversal study	Adults with terminal cancer (n=11)	The DT participation rate, feedback questionnaire	86% refused to participate in DT. 78% reported the usefulness of DT for the sense of well-being. 67% reported the usefulness of DT for improving dignity. 56% reported the benefits and usefulness of DT in terms of overall well-being.
Wang et al. (2020) [29]	Explore the feasibility and advantages of FPDT	Mixed-methods study	Hematologic cancer patients (n=10) and their family members (n=10)	HHI, FACIT-Sp, EORTC QLQ-C30, semi-structured interviews	HHI, FACIT-Sp, and EORTC QLQ-C30 scores tended to increase after DT. DT was shown to be meaningful in improving the well-being of both patients and their family members according to the interviews.
Chen et al. (2021) [30]	Investigate the satisfaction and effectiveness of DT with cancer patients in China	Randomized controlled trial	Hematologic cancer patients (n=66) DT group (n=32) Control group (n=34)	FACIT-Sp-12, HHI, EORTC QLQ-C30, Likert scale for investigating satisfaction with DT	Significant increases were found in spiritual well-being and hope scores at the 1-week and 4-week follow-ups. The majority of participants reported that they were satisfied with DT.
Ahn et al. (2012) [31]	Explore the effects of a short-term life review on the spiritual well-being and distress of patients with terminal cancer	Quasi-experimental design	Terminal cancer patients (n=32) Experimental group (n=18) Control group (n=14)	FACIT-Sp-12, HADS	Significant improvements in spiritual well-being and decreased levels of depression and anxiety were shown in the experimental group compared to the control group.

DT, dignity therapy; FPDT, family participatory dignity therapy; HHI, Herth Hope Index; FACIT-Sp, Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being; EORTC QLQ-C30, European Organization for the Research and Treatment of Cancer Quality of Life Questionnaire; FACIT-Sp-12, Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being 12 Item Scale; HADS, Hospital Anxiety and Depression Scale.

Discussion

In some of the studies reviewed, dignity therapy was shown to be effective in reducing psychological distress in end-of-life patients [5,13,14,16]. Subjective reports of improved spiritual well-being, increased hope, and dignity were also reported in patients who participated in the therapy [3,5,13]. Furthermore, the results of several quantitative findings revealed that dignity therapy has the ability to alleviate negative moods or improve emotions, which contributes to the improvement in the quality of life of patients with terminal illnesses, through self-integration and generativity, among others [14,16].

However, there are some limitations to these previous studies. In some studies, the baseline scores of the study participants were low in the factors to measure the effect of dignity therapy (e.g., dignity-related distress). Therefore, the ceiling and floor effects did not show statistically significant differences after therapy [5,13,32]. One study reported that the measurements used had limitations in capturing

the changes in patients' psychological state after dignity therapy [13]. Regarding quality of life, it is argued that existing measurements have difficulty in properly measuring the quality of life in patients receiving palliative care [33,34]. To evaluate the positive benefits of dignity therapy on end-of-life patients' quality of life and emotional improvement, further research is needed to provide evidence for implementing this therapy. The development of adequate scales and research design to capture the effects of therapy would be required. To develop tools that can successfully find dignity therapy's effects, we suggest referring to qualitative studies of dignity therapy and creating suitable items as shown in various qualitative studies. For example, items can be designed to identify changes in the sense of self-integrity based on participants reporting that they have gained an opportunity to perceive their life and self in a positive way through dignity therapy [16]. In addition, questionnaires could also be developed to understand the emotional connection and generativity with the family that may arise in the process of sharing records of dignity therapy.

py with family members [18,20,30].

Subjective satisfaction with dignity therapy was shown to be high in studies conducted on patients and their family members [12,18,19,21]. Generativity documents were viewed as a crucial component in promoting high satisfaction with the therapy. The patient can use generativity documents to reflect on their lives and give them significance by recalling the answers to the questions in the DTQP questions. In addition, the patients' loved ones could also build emotional relationships with the patient and find consolation in the life narratives they provided by the patient in generative documents. Therefore, the document was shown to contribute to the therapeutic effects of the therapy. We suggest to investigate the therapeutic features of the document and exploring how its receivers can more effectively embrace its content and meaning (e.g., making artwork based on a patient's joyful memories) in further studies.

Participants in early investigations of dignity therapy were patients with terminal cancer having a life expectancy of approximately 6 months [3,5,13]. However, studies with a broad scope of therapy have begun to be conducted [22-25]. It has been administered to patients with advanced cancer, MND, or early-stage dementia, and the elderly [22-25]. Previous studies that assessed dignity therapy's feasibility and acceptability for these patients supported its benefits. Factors such as the patient's cognitive abilities, as well as the intervention and cooperation of the patient's family in the treatment process, must be taken into consideration for the patient to receive the therapy. In addition, a feasibility study of its online implementation has been performed [26]. Given the high practicality and acceptability of online therapy shown in the study, as well as the advantages of reducing the time for the therapy, it is presumed that dignity therapy in an online environment merits cost-effectiveness. However, for appropriate and efficient online delivery, patients' objections to the online environment and personal information protection issues should be carefully considered.

To examine the possibility of implementing dignity therapy in Korea, we analyzed studies that investigated its effectiveness and feasibility in Japan, China, and Korea [27,29-31]. These studies indicated that patients often avoid direct discussion of death, and it was difficult for patients toward the end of their lives to accept death. In Korea, there is a traditional tendency to perceive death negatively, fearing

death, or try to distance it from life [28,35,36]. Thus, for effective dignity therapy in Korea, which belongs to the East Asian cultural context, a protocol that can assist people in accepting death and positively reflecting on life should be applied.

We suggest modifying the DTQP to successfully implement dignity therapy in Korea. Some questions can be modified or reduced, or the order can be changed, rather than directly translating the DTQP's nine questions and using them in the interview. We expect such changes to ease the burden on patients who have difficulties with long interview and to make it easier for them to understand the questions. For example, the first question ("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?") can be divided into two, as follows: "Please tell me about happy and pleasing moments in your life." and "Please tell me about difficult moments of your life." In addition, because questions 2, 5, and 6 express a similar line of questioning, a new question can be created by integrating these. Considering Korean culture, which regards humility as a virtue, patient responses may be elicited more successful if the expressions "proud of" in question 4 is translated into "feeling great" rather than "boastful."

Furthermore, the therapeutic potential may be strengthened in future studies by properly adapting the dignity therapy protocol to the unique concept of the "good death" that each culture shares. The Institute of Medicine [37] defines good death as "one that is free from avoidable suffering for patients, families, and caregivers in general accordance with the patients' and families' wishes." However, these definitions are not absolute, and may vary from culture to culture or individual. The Western view of the good death shows an individualistic tendency to value autonomy and the right to make decisions about one's own situation [38]. In the Muslim cultural context, for example, good death has been shown to be related to religious beliefs and appearances to relatives [39]. On the other hand, in Japan, unlike in other cultures, patients tend to perceive unawareness of death as a good death rather than accurately recognizing their own physical situation [40]. In China, the cultural characteristics of valuing family bonds affect patients' perception of forming good relationships with their families as a determinant of a good death [41]. Similarly, Koreans value their affiliation with their families

[42]. Considering this perspective, integrating the characteristics that determine a good death in the Korean context with dignity therapy, such as creating a framework with more family participation, is expected to result in higher efficacy and satisfaction in Korea.

Conclusion

This study reviewed previous research on the effectiveness, feasibility, and acceptability of dignity therapy and, psychological treatment in palliative care. The review findings indicate that dignity therapy may help reduce psychological distress, such as depression and anxiety in patients with terminal illnesses, thereby enhancing their end-of-life experience. Legacy documents created during the therapy sessions can provide emotional support to patients and their families. An examination of dignity therapy implemented in East Asian cultures revealed that it has the potential to be adapted to the Korean context if it is preceded by an understanding of the culture in which patients recognize death and considering of their perception of a good death.

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ORCID

Se-Ryun Park, <https://orcid.org/0000-0002-5926-1649>

Yu-Jung Cha, <https://orcid.org/0000-0001-9416-7693>

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