

The Effect of Dignity Therapy on the Quality of Life of Patients with Cancer Receiving Palliative Care

Abstract

Background: Patients with cancer deal with physical, psychosocial, spiritual, and existential problems that impact on their quality of life. This study aimed to assess the effect of dignity therapy on the quality of life of mentioned patients. **Materials and Methods:** In this quasi-experimental study, 50 patients with cancer hospitalized in a palliative care center in Tehran, Iran, in 2017-18 who fulfilled inclusion criteria were selected through convenience sampling. The European Organization for Research and Treatment of Cancer Quality of Life-C15-Palliative (EORTC-QLQ-C15-PAL) questionnaire was filled by patients before and 2 weeks after dignity therapy. Data were analyzed using descriptive statistics such as frequency, mean, and standard deviation, as well as inferential statistics, including independent t-test and Chi-square test. **Results:** Results showed that dignity-therapy led to more improvement in the quality of life of the intervention group ($t_{35,18} = 4.82, p = 0.001$). There was also a significant difference between the two groups in terms of the physical functioning scale ($t_{32,96} = -2.60, p = 0.01$) and emotional functioning ($t_{45,69} = 6.54, p < 0.001$). We also found that dignity-therapy led to more improvement in nausea and vomiting ($\chi^2 = 5.71, p = 0.02$), insomnia ($\chi^2 = 15.78, p < 0.001$), appetite ($\chi^2 = 5.09, p = 0.02$), and constipation ($\chi^2 = 12.50, p < 0.001$). **Conclusions:** The application of new approaches like-dignity therapy could benefit patients with cancer in terms of reducing their distress, improving symptom severity, physical and emotional functioning, and total quality of life.

Keywords: Iran, oncology nursing, palliative care, personhood, quality of life

Introduction

Cancer is a multidimensional concern that affects individuals' quality of life and coping ability.^[1,2] Along with dealing with a variety of physical problems, patients with cancer may experience different types of distress, including psychosocial, spiritual, and existential aspects.^[3,4]

Supportive and palliative care in patients with cancer is of great importance to these patients. It is noteworthy that improving patients' quality of life is as important as providing routine treatment such as chemotherapy.^[5] Supportive and palliative treatments guarantee only to improve patients' quality of life.^[6,7] Several studies insist on the important role of nurses in improving quality of life at the end of life of patients with advanced cancer.^[2,6,7] Quality of life is a multidimensional concept in terms of its objective, subjective, and spiritual aspects and affects the

individual's physical, emotional, and spiritual well-being.^[8] Quality of life is an integral concept in nursing which, together with interdisciplinary collaboration in different aspects of patient care, is helpful in improving quality of care and enhancing knowledge in this field.^[9] Dignity therapy is considered a developed intervention to deal with psychological and physical distress in patients with incurable diseases, such as cancer.^[10,11] Dignity-therapy is a psychological standard protocol that was first developed in 2006 by Harvey Chochinov.^[11] The framework of this novel intervention is based on his empirical dignity model of palliative care at the end of life.^[10] Based on Chochinov's previous studies, dignity therapy is beneficial for patients with high levels of distress.^[11] The approach was used for the patients with a wide range of diagnoses, including cancer,^[12] motor neuron disease,^[13] on hemodialysis,^[14] and also healthy elderly

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individuals.^[11] Dignity therapy is a method in which a trained therapist asks patients a series of open questions in a 30-60-minute session and encourages patients to speak about their lives and important events.^[10] The patients' words are recorded, transcribed, and reviewed. These are then reflected to the patients in a few days so that there is enough time before preparation of the final version. The final version is then given to patients' family members and relatives as a memento.^[11] Dignity therapy is an effective way for patients to find meaning and goal in the last stages of their lives and to have a chance of sharing their life story and experiences with their families. This intervention can be helpful in maintaining patient dignity at the end of life by paying attention to the sources of psychological distress and internal turmoil of patients. With the help of dignity therapy it is possible to record the meaningful aspects of patients' lives for their loved ones.^[11-14]

Although this intervention is used in different contexts and countries including Canada, Australia, England, China, Denmark, etc. evidence suggests that research conducted in the field of dignity therapy in Iran is still limited.^[2,14] As dignity is influenced by cultural, social, and spiritual constructs and contexts and expressed variously in diverse cultural settings,^[15] the impact of cultural diversity on the sense of dignity should be respected with great consideration in terminally ill patients.^[2] There is, however, a dearth of literature regarding this intervention in the Iranian context. The current study aimed to assess the impact of dignity therapy on the quality of life of Iranian patients with cancer in order to address this knowledge-gap.

Materials and Methods

This quasi-experimental study was conducted from May 2017 to June 2018. The research population consisted of all the patients with cancer who had been referred to the palliative care center at Firozgar Hospital (affiliated to Alae Charity Center). In this study, candidates were selected by convenience sampling. The sample size was calculated using the 95% confidence interval and 80% statistical power ($z_1 = 1.96$, $z_2 = 0.84$). Accordingly, 25 patients were selected for each group (25 for intervention and 25 for control). The eligible participants who fulfilled the inclusion criteria were entered into the study after obtaining written consent from them. The study inclusion criteria were having medical records with a diagnosis of stage III or IV cancer, being aware of their illness and interested in participating in the study, being at least 18 years of age, have no cognitive impairment, and no known mental illness confirmed by a physician or according to the medical records. The exclusion criteria were being critically ill, and the patient's unwillingness to continue participating in the study. To avoid contamination in the control group, we selected them as the first group and asked them to complete the questionnaires twice (at the baseline and 2 weeks after receiving routine care). The intervention group was then chosen from the study

population. The questionnaires were also completed twice by the intervention group (at the baseline and two weeks after intervention). The data gathering method included self-reporting and verbal interview. The questionnaire consisted of two parts: a) Demographic information (age, gender, education, marital status, etc.); b) the European Organization for Research and Treatment of Cancer Quality of life-C15-Palliative (EORTC-QLQ-C15-PAL) is a "core questionnaire" for palliative care. The shortened version of EORTC QLQ-C30 was developed in 2006,^[16] consisting of 15 items based on a 4-point Likert scale (not at all: 1; a little: 2; quite a bit: 3; very much: 4). This questionnaire consists of two functional scales: physical functioning, and emotional functioning. One global quality of life item (ranging from 1 for the lowest quality of life to 7 for the highest quality of life) and some symptom scales (such as nausea and vomiting, insomnia, constipation) are also included. In order to generate the scores of the different scales of the EORTC-QLQ-C15-PAL, the EORTC QLQ-C30 scoring manual and the EORTC-QLQ-C15-PAL addendum were used^[16,17] with the scores ranging between 0 and 100. Higher scores for physical and emotional function and global quality of life item indicate better well-being, but higher scores for the remaining scales indicate higher symptomatology.

The EORTC-QLQ-C15-Pal questionnaire was directly translated into Persian by professors of Tehran University of Medical Sciences who were fluent in English. Then it was back-translated into English by another person fluent in English. Subsequently, it was compared with the original Persian translation. The translations were then given to 10 professors of Tehran University of Medical Sciences to compare and comment on the face-validity of the questionnaire. To determine its reliability prior to the current study, 25 patients with advanced cancer receiving palliative care completed the questionnaire and Cronbach's alpha coefficient was calculated ($\alpha = 0.96$). Three 30–60 minute sessions were considered for dignity therapy implementation. The interval between sessions was scheduled at the patients' convenience, usually within 1 to 3 days. In the first session, a dignity therapy trained healthcare professional introduced the objectives of the dignity therapy method, made the participants familiar with the questions of this protocol [Table 1], and provided the opportunity for patients to think about what they might talk about in the next interview session. In the second session (24 to 48 hours later), as the implementation of this method started, the researchers guided the participants with the help of specific questions form of the dignity therapy protocol. Participants were free to speak about important aspects of their life and anything they wanted to record as a memory. At the end of the recorded interview it was transcribed and reviewed. At the third session (3 days later), the prepared text was read to the participants and corrected if necessary. Lastly, a version of the final text was given to the participants to share with any loved person (family

Table 1: Dignity therapy questions protocol^[12]

1. Tell me a little about your life history; particularly those parts that you either remember most or think are the most important?
2. When did you feel most alive?
3. Is there anything that you would want your family to know about you, and are there things, you would want them to remember?
4. What are the most important roles you have played in life, e.g., in the family, job wise, or in the community?
5. Why were they so important to you and what do you think you accomplished in those roles?
6. What is the most important thing that has resulted from what you have done, and what are you most happy about?
7. Is there anything that you feel needs to be said to your loved ones, or things that you would want to say once again?
8. What are your hopes and dreams for your loved ones?
9. What have you learned about life (that you would want to pass along to others)?
10. What advice or words of guidance would you wish to pass on to your [son, daughter, husband, wife, parents, other(s)]?
11. Is there anything you could say, to help prepare your family for the future?
12. In creating this record, is there more that you would like included?
13. To be asked after the completion of the interview: If you are too ill or unable to complete this document, what would you prefer happened?

members, friends, relatives, etc.). Finally, the questionnaire was re-done 2 weeks after dignity therapy was finished.

Data were analyzed using descriptive statistics such as frequency, mean, and standard deviation, as well as inferential statistics including independent t-test and Chi-square test in the Statistical Package for Social Sciences software (version 16, SPSS Inc., Chicago, IL, USA). The significance level was considered $p < 0.05$ for all tests.

Ethical considerations

The ethics approval code given was IR.TUMS.FNM.REC.1396.4700 and received from the Ethics Committee of Tehran University of Medical Sciences. Written informed consent forms, and signed anonymity, confidentiality, and the right to leave the research at any desired time forms were also preserved.

Results

The demographic characteristics included the age, gender, marital status, and educational level; employment status, settlement area, and cancer duration and type of cancer are shown in Table 2. The mean (SD) age of patients was 52.56 (10.22). Female patients accounted for 54% of all participants. The majority of patients were married (74%) with the educational level of primary school (68%). Most patients were jobless (66%) and had settled in urban areas (90%). The most common type of cancer was gastric (26%) and the mean (SD) duration of cancer was 2.01 (1.28) years.

The mean (SD) score of EORTC-QLQ-C15-Pal scale was 50.76 (14.82) and 63.52 (10.28) before and after intervention respectively with a mean (SD) difference of 12.76 (6.94) in the intervention group. The mean (SD) score of EORTC-QLQ-C15-Pal scale was 45.90 (12.27) and 46.67 (12.26) at the baseline and 2 weeks after receiving routine care respectively with a mean (SD) difference of 0.76 (3.68) in the control group. The independent *t*-test for the two groups showed that there is a significant statistical difference in the post intervention between the two groups ($t_{35,18} = 4.82, p = 0.001$), meaning that dignity therapy led to more improvement in quality of life of the intervention group compared to the control group [Table 3]. Hence the mean (SD) difference of global quality of life was significant between the two groups ($t_{36,53} = 7.64, p = 0.001$).

The results presented in Table 4 show that there was a significant difference between the two groups in terms of the physical functioning scale ($t_{32,96} = -2.60, p = 0.01$) and the emotional functioning scale ($t_{45,69} = 6.54, p < 0.001$) of EORTC-QLQ-C15-Pal.

Table 5 shows that there was a significant difference between the two groups in terms of symptoms, meaning that dignity therapy led to more improvement in the nausea and vomiting ($\chi^2 = 5.71, p = 0.02$), insomnia ($\chi^2 = 15.78, p < 0.001$), appetite ($\chi^2 = 5.09, p = 0.02$), and constipation ($\chi^2 = 12.50, p < 0.001$) scales.

Discussion

This study aimed to determine the effects of dignity therapy on the quality of life of patients with cancer. The results showed that after the intervention, the quality of life in the intervention group was significantly higher than that of the control group. Several studies have assessed the effects of dignity therapy on quality of life of patients, all of which emphasize the importance of dignity therapy as a supportive treatment in the quality of life of patients with cancer.^[2,3,11,12,18,19]

The diagnosis of advanced cancer can have a severe impact on patients' physical, mental, and emotional states that lead to loss of control over patients' body and activities of daily living. The diminished functionality and quality of life often associated with feelings of being useless can lead to lose one's dignity and value of life.^[3,20,21] There are some meaning-centered psychological interventions to help patients to reflect on issues that are important to them and also to deal with multidimensional problems they face. In this regard, dignity therapy – the current intervention we used in our study – is a standard protocol that can be applied by healthcare professionals to reduce the distress caused by cancer and improve quality of life.^[2,3,19]

The present study revealed significant differences regarding scores on emotional and physical aspects of quality of life between the two groups, which showed better functional status of the patients receiving dignity therapy. However, patients with advanced cancer experienced a different

range of emotional and existential pain accompanying their diagnoses at the end of life.^[18-20] Dignity therapy helps the

patients to reflect on fears, disappointments, regrets, or issues related to death or loss. The process of hearing their story back can be considered as a therapeutic method as it could help the patients to identify their strengths to find better coping mechanisms.^[20,22]

Table 2: Demographic characteristics of participants

Variables	Total participants (50)
Age (years), Mean (SD*)	52.56 (10.22)
Gender (%)	
Male	46
Female	54
Marital status (%)	
Single	12
Married	74
Divorced	4
Widowed	10
Educational level (%)	
University	10
High school	22
Primary School	68
Employment status (%)	
Employed	16
Jobless	66
Retired	18
Settlement area (%)	
Urban	90
Rural	10
Cancer Duration (years), Mean (SD)	2.01 (1.28)
Type of Cancer (%)	
Breast cancer	18
Gastric cancer	26
Lung	14
Colorectal	8
Gynaecological cancer	8
Urological and Nephrological	6
Other types	20

*SD: Standard Deviation

In the current study, significant improvement of symptoms was found in the patients receiving dignity therapy that was confirmed by similar studies.^[23-25] Indeed, the use of psychological care, including dignity therapy, could lead to disease-specific symptom management and quality of life improvement.^[19] In line with our findings, Xiao *et al.*^[26] reported that life narrative therapeutic approaches, like life review interventions, have a significant effect on overall quality of life, support, negative emotions, existential distress, and value of life.

The findings of the current study must be considered within their limitations. One of these limitations was concerning the 2 weeks interval to assess quality of life changes that may be considered insufficient; but indeed it was because of the poor disease prognosis. It is also noteworthy that a 2 weeks interval was also used in previous similar studies.^[12] Another limitation was sampling from only one palliative care center in Tehran. Despite these limitations, the current study provides evidence supporting the beneficial effects of dignity therapy as a valuable approach to decrease associated physical symptoms and improve physical and emotional functioning, and also for better quality of life for patients.

Conclusion

The results of the current study indicate that dignity therapy has a significant effect on the quality of life of patients with advanced cancer. Thus the application of new therapeutic approaches like dignity therapy not only benefit the patients with advanced cancer in terms of reducing their distress,

Table 3: Between-group comparisons respecting mean (SD) of differences of QOL* after intervention

Variables	Intervention group (25)			Control group (25)			t-Independent		
	Before intervention Mean (SD**)	After intervention Mean (SD)	Difference Mean (SD)	Before intervention Mean (SD)	After intervention Mean (SD)	Difference Mean (SD)	t	df	p
Quality of life	50.76 (14.82)	63.52 (10.28)	12.76 (6.94)	45.90 (12.27)	46.67 (12.26)	0.76 (3.68)	4.82	35,18	0.001
Global quality of life (1-7 range)	4.20 (0.71)	4.88 (0.78)	0.68 (0.56)	4.20 (0.87)	4.28 (0.79)	0.08 (0.28)	7.64	36,53	0.001

*QOL: Quality of Life. **SD: Standard Deviation

Table 4: Between-group comparisons respecting mean (SD) of differences of physical and emotional scales of QOL* after intervention

Quality of life scales	Intervention group Mean (SD)	Control group Mean (SD)	t-Independent test			Interval of the difference		
			t	df	p	Mean difference	Lower	Upper
Physical Function	-4.00 (6.09)	-0.54 (2.68)	-2.60	32,96	0.01	-3.46	-6.17	-0.76
Emotional function	23.33 (16.33)	-4.00 (12.99)	6.54	45,69	<0.001	27.33	18.93	35.73

*QOL: Quality of Life

Table 5: Between-group comparisons respecting mean of differences of symptom improvement after intervention

Symptoms	Intervention Group n (%)	Control Group n (%)	Chi-square		
			χ^2	df	p
Nausea and vomiting	9 (36.00)	2 (8.00)	5.71	1	0.02
Insomnia	12 (48.00)	0 (0.00)	15.78	1	<0.001
Appetite	10 (40.00)	3 (12.00)	5.09	1	0.02
Constipation	15 (60.00)	3 (12.00)	12.50	1	<0.001

improving symptom severity and emotional well-being, but may also lead to more positive outcomes, including distress reduction for the patients' family members, which need to be assessed by further research.

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Conflicts of interest

Nothing to declare.

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