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Comparing counseling and dignity therapies in home care patients: A pilot study

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ABSTRACT

Objective: Several studies have successfully tested psychosocial interventions in palliative care patients. Counseling is the technique most often employed. Dignity therapy (DT) has recently emerged as a tool that can be utilized to address patients' needs at the end of life. The aims of our study were to examine the effects of DT and counseling and to offer useful information that could be put into practice to better meet patients' needs.

Method: We developed a pilot randomized controlled trial at the Home Care Unit of the General University Hospital of Valencia (Spain). Some 70 patients were assigned to two therapy groups. The measurement instruments employed included the Patient Dignity Inventory (PDI), the Hospital Anxiety and Depression Scale (HADS), the Brief Resilient Coping Scale (BRCS), the GES Questionnaire, the Duke–UNC-11 Functional Social Support Questionnaire, and two items from the EORTC Quality of Life C30 Questionnaire (EORTC–QLQ–C30).

Results: The results of repeated-measures t tests showed statistically significant differences with respect to the dimensions of dignity, anxiety, spirituality, and quality of life for both groups. However, depression increased in the DT group after the intervention, and there were no differences with respect to resilience. Therapy in the counseling group did not negatively affect depression, and resilience did improve. When post-intervention differences between groups were calculated, statistically significant differences in anxiety were found, with lower scores in the counseling group ($t(68) = -2.341$, $p = 0.022$, $d = 0.560$).

Significance of Results: Our study provided evidence for the efficacy of dignity therapy and counseling in improving the well-being of palliative home care patients, and it found better results in the counseling therapy group with respect to depression, resilience, and anxiety.

KEYWORDS: End-of-life care, Counseling, Dignity therapy, Quality of life, Psychosocial intervention

INTRODUCTION

A significant amount of research has pointed out the importance of adopting a holistic approach in the palliative care context (Callahan, 2000; National Consensus Project, 2009). As underlined in almost every international definition of palliative care and in all guidelines for end-of-life care, one needs to take into account not only patients' physical needs and resources but also their social, psychological, and spiritual situations in order to provide complete and high-quality care (National Consensus Project, 2009; National Quality Forum, 2006; WHO, 2002).

Several studies have successfully tested psychosocial interventions for palliative care patients (Breitbart et al., 2010; 2012; 2015; Fegg, 2006; Gysels & Higginson, 2004; Houmann et al., 2014; Li et al., 2012; Lorenz et al., 2008; Newell et al., 2002; Price & Hotopf, 2009; Uitterhoeve et al., 2004). These models aim to relieve patients' suffering based on such constructs as meaning, purpose, dignity, spirituality, and existential well-being (Bayés et al., 2000).

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Counseling is one of the therapies most widely reported on in the literature (Gysels & Higginson, 2004; National Comprehensive Cancer Network, 1999; Newell et al., 2002; Porche et al., 2014). Meaning-centered psychotherapy, for instance, seeks to help patients with advanced cancer by enhancing their sense of meaning, peace, and life purpose. This type of counseling therapy has shown its efficacy for improving patients' quality of life, for treating depression, and in ameliorating hopelessness (Breitbart et al., 2010; 2012; 2015). Along the same lines, research on cognitive-existential group psychotherapy has yielded good results among caregivers (Kissane et al., 2003; 2006). Another type of counseling therapy, CALM (managing cancer and living meaningfully; Li et al., 2012), consists of brief, manualized, semistructured individual psychotherapy for patients with advanced cancer. Li and colleagues (2012) employed this technique and found that it led to reductions in depressive symptoms and death anxiety, and in increased spiritual well-being. Using such techniques as exposure, treatment, operant conditioning, roleplaying, progressive relaxation, attentional training, thought stopping, and stress inoculation, classical behavioral therapy has also yielded promising results in palliative care patients (Holland, 2002; Kidman & Edelman, 1997; Spirito et al., 1988). To the best of our knowledge, third-wave psychotherapies (e.g., mindfulness, acceptance and commitment therapy) and therapy focused on values have not yet been explored in palliative care patients. It is possible that some of the aspects of these interventions could be modified for appropriate use in this context (Fegg, 2006).

A new therapy focused on patient dignity has emerged over the previous decade as a tool for addressing the needs of palliative care patients at the end of life (Chochinov, 2002; Chochinov et al., 2002). Dignity therapy (DT) is based on Chochinov and colleagues' model of dignity (Chochinov, 2002; Chochinov et al., 2002), which incorporates a wide range of physical, psychological, social, and existential concerns that affect an individual's perception of dignity. It consists of discussing the questions that patients believe are more important, and those they think should be remembered, and its aims are to relieve the suffering inherent to the dying process and to promote hope, self-esteem, and a clear sense of life and death (Chochinov, 2004). Studies on DT have demonstrated an improved sense of dignity (Chochinov et al., 2005; Houmann et al., 2014; Rudilla et al., 2015) and a better quality of life (Chochinov et al., 2011; Rudilla et al., 2015), as well as decreased depression (Chochinov et al., 2005; Houmann et al., 2014; Julião et al., 2014), anxiety (Houmann et al., 2014), hopelessness (Houmann et al., 2014), and suffering (Chochinov et al., 2005; Houmann et al., 2014; Rudilla et al., 2015). In cross-sectional studies, dignity has also been correlated with demoralization and symptom burden (Vehling & Mehnert, 2014).

The objectives of our current study were twofold: (1) to examine the effects of two different popular psychological therapies in palliative care (dignity therapy and counseling) in a sample of Spanish home care patients; and (2) to compare the effects of these therapies and thus offer useful information upon which therapy could be designed to better fit patients' needs.

METHODS

Procedure, Setting, and Participants

Our study focuses on a sample of palliative care patients from a home care unit at the Hospital General Universitario de Valencia (Valencia, Spain). Once we obtained permission from the hospital ethics committee and patients and relatives gave their informed consent, some 80 patients were assessed for eligibility. The inclusion criteria were: (1) patients admitted to the home care unit of the General University Hospital of Valencia for palliative treatment; (2) adult patients (18 years old or older); (3) patients with advanced/terminal illness; (4) patients with knowledge of their diagnosis and prognosis; and (5) patients with an interest in dignity. The exclusion criteria were: (1) less than two weeks of predicted survival; (2) evidence of a conspiracy of silence; and (3) cognitive impairment (comprehension/expression problems). A total of 75 patients met the inclusion criteria and were randomly assigned to both study groups. For randomization, the CONSORT criteria for nonpharmacological trials were followed (Boutron et al., 2008) (see Figure 1). The randomization process was basic in design: when a psychologist interviewed a patient for the first time, the patient was alternately included in one of the two groups. This process was carried out by the psychologist of the home care unit, under the supervision of the research team.

Patients completed surveys during the therapy sessions, as well as before and after interventions. The interventions took place in patients' homes and were conducted by the same psychologist. The study was undertaken over a three-month period (from April to June of 2013). The number of sessions for both interventions was based on a schedule designed by the psychologist of the home care unit. A patient was visited two to three times a week for 30- to 60-minute sessions. The counseling intervention was based on the guidelines for counseling proposed by Arranz et al. (2005). The dignity therapy followed the psychotherapeutic protocol proposed by the original authors of this type of therapy (Chochinov et al., 2005) (see Table 1).

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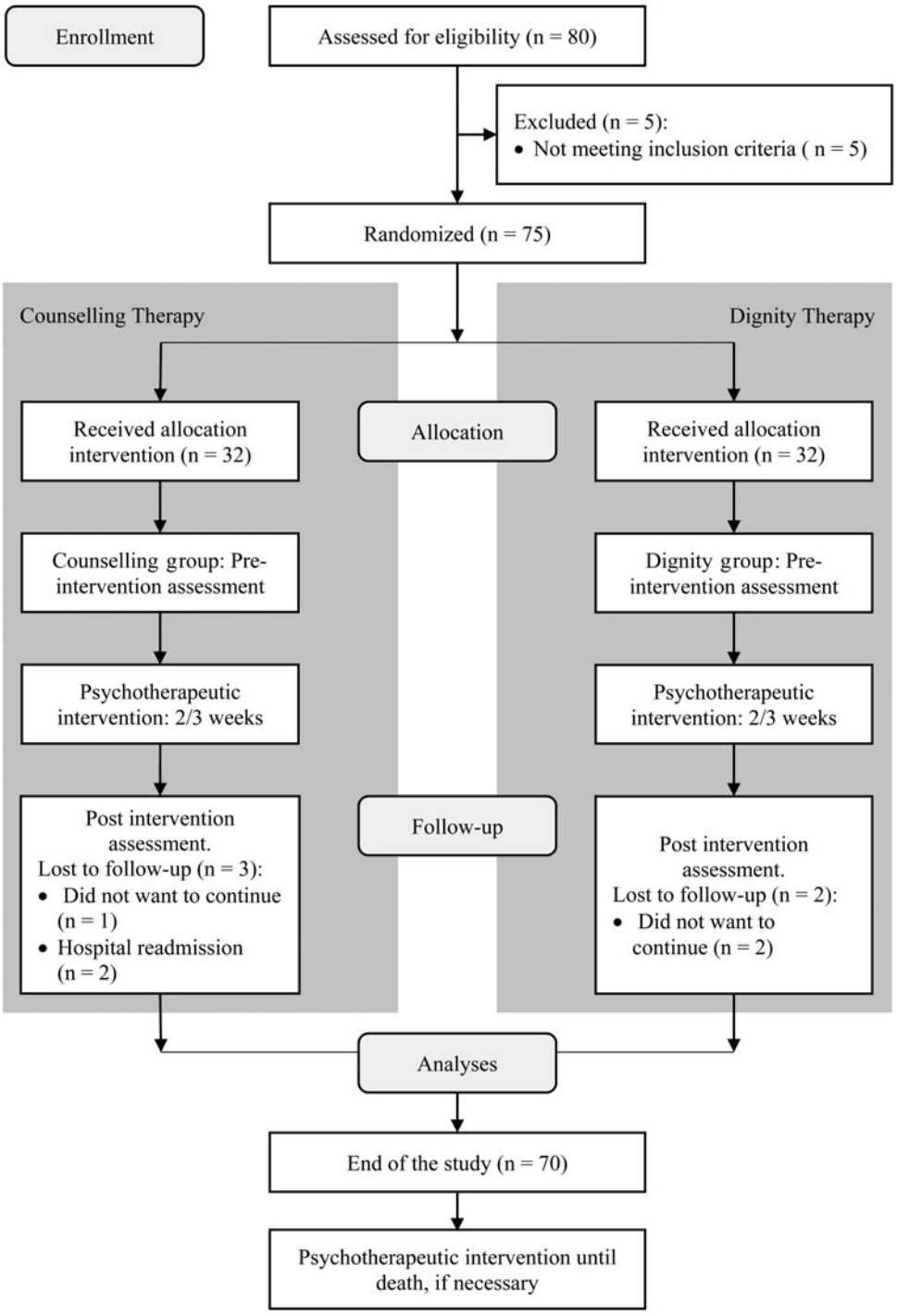

Fig. 1. Diagram of the CONSORT protocol.

Some 70 participants completed the study, 35 in each group. The characteristics of participants at baseline are described in Table 2.

Outcome Measures

Along with the sociodemographic and clinical data, we gathered information on several variables.

Sense of Dignity

Patients' sense of dignity was assessed using the Patient Dignity Inventory (PDI; Chochinov et al., 2008) and was designed to identify patients' dignity resources at the end of life. It has been broadly employed in the palliative care literature (Chochinov et al., 2005; 2011; Houmann et al., 2014; Vehling & Mehnert, 2014) and is composed of 25 items,

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Table 1. *Intervention guidelines*

Guidelines for a Counseling Session (Arranz et al., 2005)	Psychotherapeutic Survey Protocol for Dignity Therapy (Chochinov et al., 2002)
1. Identify age, family situation, and/or illness.	1. Tell me a little about your life history, particularly the parts that you either remember the most, or think are the most important? When did you feel most alive?
2. Identify preoccupations, fears, and needs in an accurate manner. Facilitate emotional expression.	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. Help to rank what has been previously identified, starting with feelings and underlying values.	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. Identify resources and abilities, both internal and external.	4. What are your most important accomplishments, and what do you feel most proud of?
5. Give information. Identify what the patient wants to know and what he/she understands about what they are worried about.	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. Address the concerns, once ranked, combining them with the resources and capabilities available to the person, and any others we can suggest.	6. What are your hopes and dreams for your loved ones?
7. Clarify the options, assessing the pros and cons.	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. Help in the decision-making process in congruence with the patient's values and resources.	8. Are there words or perhaps even instructions you would like to offer your family to help prepare them for the future?
9. Summarize and plan ahead.	9. In creating this permanent record, are there other things you would like have included?

assessing 5 dimensions of dignity: symptom distress (Cronbach's $\alpha = 0.89$), existential distress ($\alpha = 0.84$), dependency ($\alpha = 0.71$), peace of mind ($\alpha = 0.63$), and social support ($\alpha = 0.70$).

Emotional Distress

Anxiety and depression were assessed with the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), which measures anxiety and depression in patients with comorbid physical illness. It is composed of 14 items that evaluate anxiety ($\alpha = 0.73$) and depression ($\alpha = 0.45$).

Emotional Well-Being

Resilience, spirituality, social support, and quality of life were also evaluated. Resilience was assessed using the Brief Resilient Coping Scale (BRCS; Sinclair & Wallston, 2004), which is composed of four items ($\alpha = 0.92$). Developed by the Grupo de Espiritualidad de la SECPAL (Benito et al., 2014), the GES questionnaire is composed of eight items and was utilized to assess three dimensions of spirituality: intrapersonal, interpersonal, and transpersonal spirituality ($\alpha = 0.85$). The Duke–UNC-11 Functional Social Support Questionnaire (Broadhead et al., 1988) included 11 items and was employed to evaluate two dimensions of social support: confidential support (support for communicating intimate feelings, $\alpha = 0.93$) and affective support (support for positive empathy, $\alpha = 0.80$). Finally, two items of the EORTC Quality of Life C30 Questionnaire (EORTC–QLQ–C30; Bjordal et al., 2000) were used to assess quality of life: "How would you rate your overall health during the past week?" and "How would you rate your overall quality of life during the past week?" ($\alpha = 0.85$).

Analyses

Equivalence between groups was tested with t tests for mean differences and chi-square tests. Effect sizes were calculated with the coefficient phi (ϕ) for the chi-square tests and with Cohen's d for the t tests. A phi value of 0.10 is considered a small effect, a value

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Table 2. *Sample characteristics and baseline differences between intervention groups*

	Dignity		Counseling		Differences Between Groups			
	n	%	*n*	%	χ^2	*df*	*p*	ϕ
Gender								
Men	20	57.1	22	62.9	0.238	1	0.626	0.058
Women	15	42.9	13	37.1				
Diagnosis								
Oncological	27	77.1	28	80	0.085	1	0.771	0.035
Nononcologic	8	22.9	7	20				
	M	*SD*	*M*	*SD*	*t*	*df*	*p*	*d*
Age	72.14	14.29	68.29	10.36	−1.292	68	0.201	0.31
Symptom distress	3.92	0.74	3.90	0.97	−0.083	68	0.934	0.02
Existential distress	3.36	0.59	3.18	0.85	−1.027	68	0.308	0.24
Dependency	3.90	0.60	3.83	0.84	−0.381	68	0.704	0.09
Peace of mind	2.52	0.75	2.46	0.95	−0.277	68	0.782	0.06
Social support	2.11	0.99	1.74	0.77	−1.744	68	0.086	0.42
Anxiety	14.00	3.77	13.11	4.17	−0.931	68	0.355	0.22
Depression	11.54	2.40	12.54	2.68	1.642	68	0.105	0.39
Resilience	11.51	4.23	11.57	4.78	0.053	68	0.958	0.01
Intrapersonal spirituality	2.89	0.56	2.91	0.62	0.151	68	0.880	0.03
Interpersonal spirituality	3.31	0.77	3.38	0.79	0.380	68	0.705	0.09
Transpersonal spirituality	2.32	0.86	2.14	0.83	−0.913	68	0.365	0.22
Confidential support	23.05	5.15	23.51	4.91	0.380	68	0.705	0.09
Affective support	18.62	3.84	19.20	3.54	0.646	68	0.520	0.15
Quality of life	3.31	1.50	3.35	1.70	0.112	68	0.911	0.02

of 0.30 is considered a medium-sized effect, and a value of 0.50 is considered a large effect. Cohen's *d* values around 0.20 indicate small differences, values of 0.50 indicate medium-sized differences, and values of 0.80 indicate large differences (Cohen, 1988).

Paired-samples *t* tests were employed in order to assess pre- and post-intervention differences for each of the variables of interest, and independent-samples *t* tests were utilized to compare the results of the two interventions. Cohen's *d* was calculated for each of the analyses.

RESULTS

Baseline Scores

The first comparisons showed equivalence between the two groups at baseline and prior to intervention, with no differences for any of the measured variables (see Table 2).

Intervention Results

With regard to changes after an intervention, the repeated-measures *t* test in the DT group showed statistically significant differences for all variables of interest, except for resilience. Dignity improved in the five domains measured with the PDI, with patients reporting fewer problems in terms of symptom distress, existential distress, dependency, peace of mind, and social support. The effect sizes for the intervention were all large. Anxiety was lower after the DT intervention, but depression was not improved (in fact, levels of depression were higher). Spirituality, social support, and quality of life also improved after the intervention, with large effects in the three dimensions of spirituality and social support and a medium-sized effect for quality of life. Similarly, post-intervention results for the counseling group showed improvement in terms of dignity, anxiety, spirituality, social support, and quality of life. There was a significant though small improvement in resilience with counseling, and there were no effects for depression. The details of these results are presented in Table 3. Figure 2 depicts the improvements in mean scores for each therapy group.

Comparison Between Interventions

Differences between the groups following the intervention were then estimated. The results with respect to anxiety yielded statistically significant differences, which favored the counseling group. This group of patients had lower levels of anxiety following the intervention, with a medium effect size.

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Table 3. *Counseling and dignity therapy results*

	Dignity Therapy Group								
	Pre-Intervention (Baseline)		Post-Intervention		Change in Evaluations				
	M	*SD*	*M*	*SD*	*t*	*df*	*p*	*r*	*d*
Symptom distress	3.92	0.74	3.04	0.60	6.124	34	<0.001	0.217	1.29
Existential distress	3.36	0.59	2.48	0.67	7.499	34	<0.001	0.410	1.37
Dependency	3.90	0.60	3.13	0.49	6.401	34	<0.001	0.165	1.39
Peace of mind	2.52	0.75	1.76	0.58	5.795	34	<0.001	0.350	1.11
Social support	2.11	.99	1.38	0.45	4.555	34	<0.001	0.322	0.89
Anxiety	14.00	3.77	12.02	2.50	3.630	34	0.001	0.539	0.58
Depression	11.54	2.40	13.11	1.77	−3.736	34	0.001	0.322	0.73
Resilience	11.51	4.23	12.71	3.32	−1.961	34	0.058	0.564	0.31
Intrapersonal spirituality	2.89	0.56	3.50	0.50	−7.332	34	<0.001	0.585	1.12
Interpersonal spirituality	3.31	0.77	3.82	0.26	−3.943	34	<0.001	0.194	0.84
Transpersonal spirituality	2.32	0.86	3.02	0.81	−4.365	34	<0.001	0.362	0.83
Confidential support	23.05	5.15	26.82	3.07	−4.576	34	< 0.001	0.387	0.85
Affective support	18.62	3.84	23.05	1.90	−6.487	34	<0.001	0.143	1.43
Quality of life	3.31	1.50	4.07	1.17	−2.698	34	0.011	0.246	0.56
	Counseling Group								
	Pre-Intervention (Baseline)		Post-Intervention			Change in Evaluations			
	M	*SD*	*M*	*SD*	*t*	*df*	*p*	*r*	*d*
Symptom distress	3.92	0.74	2.73	0.98	8.313	34	<0.001	0.639	1.19
Existential distress	3.36	0.59	2.25	0.69	8.219	34	<0.001	0.644	1.17
Dependency	3.90	0.60	3.17	0.78	5.005	34	<0.001	0.535	0.81
Peace of mind	2.52	0.75	1.52	0.62	5.498	34	<0.001	0.226	1.15
Social support	2.11	0.99	1.36	0.61	2.453	34	0.019	0.134	0.54
Anxiety	14.00	3.77	10.77	1.95	3.720	34	0.001	0.453	0.65
Depression	11.54	2.40	13.40	2.11	−1.652	34	0.108	0.199	0.35
Resilience	11.51	4.23	13.40	4.58	−3.025	34	0.005	0.709	0.39
Intrapersonal spirituality	2.89	0.56	3.65	0.48	−7.662	34	<0.001	0.483	1.31
Interpersonal spirituality	3.31	0.77	3.88	0.29	−3.596	34	0.001	0.098	0.81
Transpersonal spirituality	2.32	0.86	3.28	0.65	−9.482	34	<0.001	0.566	1.49
Confidential support	23.05	5.15	27.20	2.18	−5.245	34	<0.001	0.542	0.84
Affective support	18.62	3.84	22.42	1.98	−6.365	34	<0.001	0.534	1.03
Quality of life	3.31	1.50	4.10	1.16	−3.673	34	0.001	0.711	0.47

See Table 4 for more information related to these analyses.

DISCUSSION

Two main conclusions can be drawn from the results of our study: (1) there is new evidence on the efficacy of dignity therapy and counseling for improvement of the well-being of palliative home care patients, and (2) particularly good results can be obtained with counseling for depression, resilience, and anxiety.

When the efficacy of dignity therapy was tested, our results showed a positive effect for almost every variable related to well-being, in line with information gathered in previous studies (Chochinov et al., 2005; Houmann et al., 2014; Vehling & Mehnert, 2014). Dignity therapy improved one's sense of dignity and lessened anxiety, as found by Houmann et al. (2014), and enhanced patient quality of life, as reported by Chochinov et al. (2011). Such variables related to the holistic well-being of palliative care patients as spirituality (Broadhead et al., 1988; Edmondson et al., 2008; Barreto et al., 2015), social support (Edmondson et al., 2008; Peterman et al., 2002), and resilience (Barreto et al., 2015; Benito et al., 2014) were also measured, which was the first time that the effect of DT on these variables has been ascertained. As expected, dignity therapy had large and positive effects on spirituality and social support, though resilience was not affected. Counseling therapy also had a positive effect on spirituality and social support, as well as on resilience.

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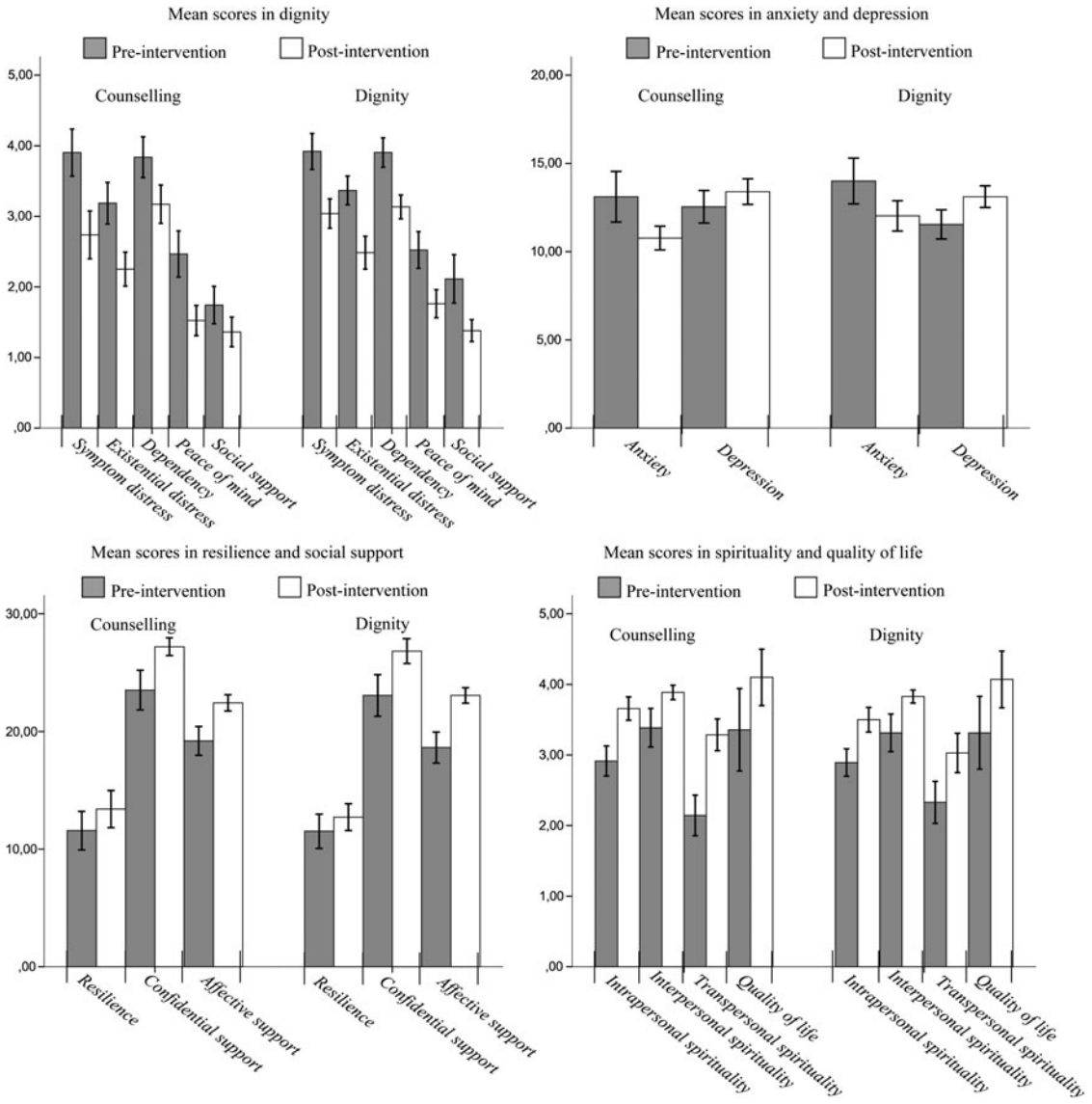

Fig. 2. Improvements in mean scores after interventions for each therapy group (95% confidence intervals).

Table 4. *Comparison of results with the two therapeutic interventions*

	Dignity Therapy		Counseling		Differences			
	M	*SD*	*M*	*SD*	*t*	*df*	*p*	*d*
Symptom distress	3.04	0.60	2.73	0.98	−1.552	68	0.125	0.37
Existential distress	2.48	0.67	2.25	0.69	−1.416	68	0.161	0.34
Dependency	3.13	0.49	3.17	0.78	0.242	68	0.809	0.05
Peace of mind	1.76	0.58	1.52	0.62	−1.655	68	0.103	0.40
Social support	1.38	0.45	1.36	0.61	−0.148	68	0.883	0.03
Anxiety	12.02	2.50	10.77	1.95	−2.341	68	0.022	0.56
Depression	13.11	1.77	13.40	2.11	0.611	68	0.543	0.14
Resilience	12.71	3.32	13.40	4.58	0.717	68	0.476	0.17
Intrapersonal spirituality	3.50	0.50	3.65	0.48	1.329	68	0.188	0.32
Interpersonal spirituality	3.82	0.26	3.88	0.29	0.839	68	0.404	0.20
Transpersonal spirituality	3.02	0.81	3.28	0.65	1.456	68	0.150	0.35
Confidential support	26.82	3.07	27.20	2.18	0.583	68	0.562	0.14
Affective support	23.05	1.90	22.42	1.98	−1.349	68	0.182	0.32
Quality of life	4.07	1.17	4.10	1.16	0.102	68	0.919	0.02

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Along the same lines as Houmann et al. (2014), counterintuitively, current research reports a large and negative effect of dignity therapy on depression, which increased significantly after DT intervention. Despite the reported beneficial effects of dignity therapy, Chochinov et al. (2011) found that its ability to mitigate severe distress (e.g., major depression and suicidality) remained unproven. Julião et al. (2014) found evidence of a positive effect of DT on depression over the short term but not by the end of the intervention (day 30). Our current research continued assessment out to two to three weeks after the intervention. An explanation for these counterintuitive effects on depression could be provided by the fact that some psychiatric syndromes (e.g., depression, anxiety, confusion, suicidal ideation, and a desire for hastened death or assisted suicide) occur in a significant percentage of patients with advanced disease (Tremblay & Breitbart, 2011). However, other studies have demonstrated low rates of increased incidence of depressive and anxiety disorders as patients approach death (Lichtenthal et al., 2009). Counseling therapy did not have a negative effect on depression in our study. Further research in this arena is clearly required (Chochinov et al., 2011; Fitchett et al., 2015; Hall et al., 2009; 2011).

The participants who received dignity therapy and counseling in our study reported a positive effect on perception of meaning in life, quality of life, and spiritual well-being. We should also stress the fact that the results for depression and resilience were better in the counseling group. When we compared the effects of the two interventions, a significantly higher effect on anxiety was found, showing a clear benefit for the counseling group. Even though there was a significant decrease in anxiety after both interventions, the palliative care patients receiving counseling experienced a higher benefit. Counseling therapy thus seems most appropriate for treating the symptoms of anxiety in a home care context.

Our study has some strengths and some limitations. The use of an inclusion criterion related to dignity (patients' interest in dignity) may have produced some bias, which would limit the generalizability of our results. In addition, though with research team supervision, the randomization process, interventions, and data gathering were carried out by the same professional, making it difficult to the assess treatment adherence and fidelity. Finally, following Chochinov's (2012) guidelines, the dignity therapy was based on the counseling element of positive communication. This could tend to make the results with both therapies similar. Further research addressing these shortcomings would be most welcome.

Nevertheless, the findings of our study are indeed valuable, since they offer evidence for the importance of psychological therapies in enhancing the well-being of palliative care patients. We also demonstrated the superior efficacy of counseling compared to dignity therapy. Our conclusions can help professionals to design better-tailored interventions and thus more effectively customize their tools so as to achieve specific goals (e.g., management of anxiety and depression).

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