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Description of a training protocol to improve research reproducibility for dignity therapy: an interview-based intervention

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Abstract

Background. Dignity Therapy (DT) has been implemented over the past 20 years, but a detailed training protocol is not available to facilitate consistency of its implementation. Consistent training positively impacts intervention reproducibility.

Objective. The objective of this article is to describe a detailed method for DT therapist training.

Method. Chochinov's DT training seminars included preparatory reading of the DT textbook, in-person training, and practice interview sessions. Building on this training plan, we added feedback on practice and actual interview sessions, a tracking form to guide the process, a written training manual with an annotated model DT transcript, and quarterly support sessions. Using this training method, 18 DT therapists were trained across 6 sites.

Results. The DT experts' verbal and written feedback on the practice and actual sessions encouraged the trainees to provide additional attention to eight components: (1) initial framing (i.e., clarifying and organizing of the patient's own goals for creating the legacy document), (2) verifying the patient's understanding of DT, (3) gathering the patient's biographical information, (4) using probing questions, (5) exploring the patient's story thread, (6) refocusing toward the legacy document creation, (7) inviting the patient's expression of meaningful messages, and (8) general DT processes. Evident from the ongoing individual trainee mentoring was achievement and maintenance of adherence to the DT protocol.

Discussion. The DT training protocol is a process to enable consistency in the training process, across waves of trainees, toward the goal of maintaining DT implementation consistency. This training protocol will enable future DT researchers and clinicians to consistently train therapists across various disciplines and locales. Furthermore, we anticipate that this training protocol could be generalizable as a roadmap for implementers of other life review and palliative care interview-based interventions.

Although Dignity Therapy (DT) has been implemented and studied over the past 20 years (Fitchett et al., 2015; Martinez et al., 2017), a detailed training protocol has not been available to facilitate consistency of its implementation. Chochinov, the creator of DT, published a textbook that describes the background, therapeutic process, and evidence regarding DT (Chochinov, 2012), and there are more than two dozen journal articles with varying information about DT therapist training (Chochinov et al., 2002; Chochinov, 2012; Fitchett et al., 2015; Martinez et al., 2017). However, there are no specific training details in the literature sufficient to ensure a high degree of consistency in DT implementation. This gap is of particular concern since common challenges faced by researchers include failure to attain intervention fidelity and drift over time (Santacroce et al., 2004; Hasson, 2010; Allen et al., 2012). Consistent and effective intervention training has been recognized as imperative for facilitating intervention reproducibility (Bellg et al., 2004; Taylor et al., 2015; McGee et al., 2018). Consistent intervention delivery is vital to ensure that patients receive the intervention as it was intended and to maintain internal validity (Hasson, 2010). The purpose of this article is to describe a systematized DT training protocol.

DT is an empirically based therapeutic intervention that consists of interview sessions with a trained DT therapist (Chochinov et al., 2002). The purpose of the DT intervention is to provide an opportunity for the individual to tell his/her story in a way that can be captured in a

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legacy document (Chochinov, 2012). Important components of this process are the telling of his/her story, being heard by another person (the DT therapist), hearing and editing the story, and receipt of the resulting legacy document, which he/she may give to a significant other if desired. Research has demonstrated that DT participants and their families have reported enhanced sense of meaning and purpose (Fitchett et al., 2015), improved quality of life and sense of dignity (Donato et al., 2016), and decreased anxiety (Martinez et al., 2017).

The DT interview (Table 1) leads the individual through a guided review of meaningful elements of his/her life. The role of the therapist is vitally important as he/she guides the individual through the DT questions in a manner that is interactive. Therapists must be responsive to the individual's cues, seamlessly moving into areas the individual deems are important elements of his/her personal story. The therapist must maintain an attitude that is self-reflective and self-aware. Her/his behavior must be kind and respectful, expressing interest in the individual's life experience and compassion for his/her suffering. The therapist should use language that communicates compassion and connects with the person beyond their present frailty or challenges. To do so, the therapist must convey a stance that is respectful, non-judgmental and affirming.

The ultimate goal is to assist the individual to create a legacy document containing his/her story and words of wisdom or key messages that he/she may choose to give to a significant person. The transcript of the DT session will be edited, weaving the patient's interview into a cohesive story. At the start of DT, the individual is asked to consider the person/people with whom he/she would want to share the Legacy Document. While many interviews primarily reflect sentiments such as love, joy, and gratitude, others may be fraught with complexities due to challenging health and psychosocial issues that arise as the individual reviews the elements of his/her life. It is imperative that the therapist training includes sufficient preparation to keep the interview focused on content that is relevant to the purpose of creating a personal legacy.

At the start of our large DT randomized controlled trial (RCT), we recognized the importance of providing a reproducible training protocol for all therapists across the multiple sites to ensure consistency in implementing the DT intervention. An effective training protocol would include the components, process, and materials to support consistent implementation across therapists, across sites, and over time.

We conducted a systematic review of DT literature to discover what had been reported regarding therapist training. A PubMed search was initiated for "Chochinov" and "Dignity Therapy" (peer reviewed, no time limitation), which resulted in a collection of 77 references. The studies included results from various settings in nine countries over the past two decades (Fitchett et al., 2015; Martinez et al., 2017). After the initial review of all articles, the collection was narrowed to the 35 articles that presented DT interventions. As our goal was to implement consistent training that would facilitate intervention reproducibility, these 35 articles were appraised for details regarding training protocols as well as the strategies researchers implemented to validate consistency with the DT intervention. There were 14 articles that met this search criteria. The terms that authors used to describe evaluation strategies included assessment (Bentley et al., 2012), adherence (Hall and Chochinov, 2009; Hall et al., 2009; Chochinov et al., 2011; Hall et al., 2011; Bentley et al., 2014a; Juliao et al., 2014), protocol integrity (Chochinov et al., 2005), quality assurance (Hall et al., 2013) recording of deviations (Hall et al., 2012), fidelity (Juliao et al., 2014), monitoring (Vuksanovic et al., 2017), and reviewing (Vuksanovic et al., 2017). Table 2 delineates the 13 articles that include some reference to the manner in which DT therapists were trained. While most of the articles indicated that the DT therapists had attended a workshop or trained with Dr. Chochinov, none provided details of the training protocol for the therapists. In summary, although there has been a good deal of research focused on the impact of DT, there is a deficit in recorded details regarding consistency in training therapists (Lindqvist et al., 2015).

Table 1. Dignity therapy protocol questions (Chochinov et al., 2005)

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 had in life (e.g., family roles, vocational roles, community-service roles)? 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, or 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?

Recognizing the importance of specificity and consistency in training, we looked to other DT resources. Chochinov's Web site, DignityinCare.ca, does not provide a training protocol. The DT textbook (Chochinov, 2012) advocates for the importance of training and makes reference to training sessions held at the author's site in Winnipeg, Canada, but does not provide a training protocol. A protocol for comprehensive training is sorely needed for this type of therapy. It is the fine balance of this process — as the therapist poses questions, clarifies, probes the story further, and speaks reflectively — that creates the environment for the positive effects of the intervention to emerge (Schryer et al., 2012). The early implementation of DT was primarily provided by mental health professionals, but in order to provide the intervention more broadly, it is necessary to train others who may not have this same expertise. This makes systematized training particularly imperative.

We established a clearly defined DT training protocol, based on the National Institutes of Health (NIH) four recommended components: (a) provide standardized training and training materials; (b) ensure skill acquisition by use of standardized patients, role play, and an adherence checklist; (c) minimize "drift" over time by reviewing audio-recorded interventions, providing expert supervision and skill "boosters" as needed; and (d) accommodate differences between interventionists by providing specialized support and additional guidance as needed (Bellg et al., 2004).

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Table 2. Dignity therapy literature review

Article Author, Year	Study purpose	Method to validate consistency with original DT intervention	Info regarding therapist training
Bentley et al., 2012	Examination of immediate impact of DT for patients with motor neuron disease and their families	• Assessment of time required to conduct the DT process and any deviations from the protocol (no details re: how this was done)	• Researcher (sole interventionist) was trained in DT at an intensive workshop with Chochinov; no specific details
Bentley et al., 2014a	Feasibility, acceptability, and potential effectiveness of DT for families of people with motor neuron disease	• The researcher reviewed 3 (10%) recordings to check for consistency with DT protocol and engaged in supervision with DT author, Chochinov	• Researcher (sole interventionist) was trained in DT at an intensive workshop with Chochinov; no specific details
Bentley et al., 2014b	Feasibility, acceptability, and potential effectiveness of DT in EOL for people with motor neuron disease	• Researchers reviewed 3 (10%) recordings to check for consistency with DT protocol	• Researcher (sole interventionist) was trained in DT at an intensive workshop with Chochinov; no specific details
Chochinov et al., 2005	Examination of DT to address psychosocial and existential distress among terminally ill patients	• 25% of transcripts were reviewed by the principal investigator (Chochinov)	• One researcher was DT author Chochinov; no details given regarding the training of the other four interventionists
Chochinov et al., 2011	Exploration of DT to mitigate distress or bolster the experience in patients nearing the end of their lives	• Continuous supervision of therapists by a lead investigator at each of three sites until competence determined; then video-conferenced group supervision every six to eight weeks; review of about one in six transcripts to ensure consistency to DT protocol	• Three-day training workshop, led by the Chochinov; no specific details
Hall and Chochinov, 2009	Feasibility, acceptability, and potential effectiveness of DT for people with advanced cancer in hospital-based palliative care: study protocol	• Quality assurance protocol developed to evaluate for adherence to DT protocol, reviewing for therapist's respectfulness toward patient, his/her consistency in asking DT questions, and whether editing process followed	• Training by Chochinov, including theoretical basis of DT, demonstrations of the intervention, and provision of the DT textbook
Hall et al., 2009	Feasibility, acceptability, and potential effectiveness of DT for older people reaching the end of life in care homes: pilot for a Phase III RCT	• 33% transcripts randomly selected for review by PI; quality assurance protocol developed to evaluate for adherence to DT protocol, reviewing for therapist's respectfulness toward patient, consistency in asking DT questions, and whether editing process followed	• Training by Chochinov, including theoretical basis of DT, demonstrations of the intervention, and provision of the DT textbook
Hall et al., 2011	Acceptability and potential effectiveness of DT for people with advanced cancer who have been referred to hospital-based palliative care teams in the UK; Phase II RCT	• Review of 33% transcripts, randomly selected; citation provided for further details in the published protocol	• Training by Chochinov, including theoretical basis of DT, demonstrations of the intervention, and provision of the DT textbook
Hall et al., 2012	Feasibility, acceptability, and potential effectiveness of DT for people with advanced cancer in hospital-based palliative care: study protocol	• 52% of transcripts were reviewed by a PI or one of Chochinov's colleagues; no other details were provided	• Training by Chochinov; citation provided for training details in the published protocol
Hall et al., 2013	Exploration and comparison of residents' views on DT and taking DT trial — Qualitative	• 52% of transcripts were reviewed by a PI or one of Chochinov's colleagues; no other details were provided	• Training by Chochinov, including theoretical basis of DT, demonstrations of the intervention, and provision of the DT textbook
Juliao et al., 2014	Determination of the influence of DT on depression and anxiety in palliative care unit inpatients with a terminal and a high level of distress	• A psychiatrist familiar with DT reviewed randomly selected transcripts; no other details provided	• The sole interventionist was trained by the "originators" of DT; no other details provided
Vuksanovic et al., 2017	Exploration and comparison of standard DT, waitlist DT, and Life Review that did not create a legacy document	• DT interviews were recorded and transcribed, protocol was followed and regular monitoring was conducted; no other details provided	• Sole interventionist had previously attended a DT training workshop; no other details provided
Vuksanovic et al., 2017	Evaluation of the legacy creation component of DT	• Randomly selected transcripts reviewed by an independent supervisor experienced with DT	• Sole therapist completed a three-day training workshop led by Chochinov; no other details provided

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Objective

This article describes a detailed training protocol for the DT intervention that is designed to facilitate consistent and accurate implementation of the interview procedure. The training protocol provides a framework for future DT researchers and clinicians to train the DT therapists who will implement the intervention.

Methods

This detailed training protocol was created as part of a multisite, randomized controlled trial with a stepped-wedge design testing efficacy of DT (Kittelson et al., 2019). Throughout this report, we refer to the contributions of various team members. The primary trainer and four researchers served as DT experts to provide guidance and support in the training, mentoring, and quality assurance of the intervention implementation. A PhD candidate collaborated in the development of the training protocol and its documentation and then worked as the auditor to analyze the transcripts for quality assurance and communicate findings to the DT experts.

We included seven components in the DT therapist training protocol that addressed the previously mentioned NIH recommendations (a–d): (1) the original DT textbook (NIH a); (2) initial in-person intensive training (NIH a, b); (3) practice interviews (NIH b, c); (4) general and individual feedback (NIH c, d); (5) process tracking form (NIH b, c); (6) a training manual (NIH a, b); and (7) quarterly support sessions (NIH c, d). Protocol components 1 and 2 are based on the annual training that Chochinov presents in Winnipeg. Components 3–7 were developed specifically for the multisite trial. The following sections detail these components.

Original DT textbook

In preparation for the face-to-face initial training, we followed Chochinov's recommendations to provide each therapist-trainee with a copy of the book *Dignity Therapy: Final Words for Final Days* (Chochinov, 2012). This DT textbook provided a detailed overview of the background, rationale, and protocol for the DT intervention.

Initial in-person intensive training

The next training component was Chochinov's two-day in-person intensive therapist training. The primary trainer (HMC) was highly qualified in DT and employed a variety of teaching methods including lecture, discussion, demonstration, multimedia presentation, role play, and work with case examples (Table 3). The agenda was crafted to incorporate activities and content that he deemed vital to facilitate successful DT implementation. Each activity provided an opportunity to practice and demonstrate understanding and achievement of skills for the previous segments in a manner that built progressively as the training advanced.

The training event began with an introduction and background session, to provide the purpose, rationale, and history of DT including its empirical foundation. The trainer led a discussion of the key elements and techniques of the procedure. Next, a previously video-recorded DT interview was presented, so the trainees could observe a complete therapeutic session. Following this, the trainer and mock patient demonstrated the key elements of engaging in and commencing a DT interview, along with teaching the use of a photo album metaphor. This technique invites the DT recipient to imagine looking back through a photo album and describe the experiences that stood out as significant, which he/she would want to share. After sharing memories of this first "picture," the trainer asked the mock DT recipient to flip through the imaginary album and tell him about the next picture she would want to include as part of constructing her legacy. This method of interviewing guided the DT recipient to translate significant memories into a narrative, facilitating the DT recipient's expression of her story thread.

Following this demonstration, the trainees took turns leading parts of the session with the mock DT recipient. The training sessions each had between four and six trainees that took turns cycling through the interview scenario. After completing their portion of the interview, the trainer provided trainees feedback, offering insights to help guide their development as DT therapists. Had there been more attendees, a mock DT recipient would have been needed for every four to six trainees. Prior to the training, the trainer advised the mock DT recipient to establish a clear and detailed scenario to maintain consistency throughout the exercise. A well-established story assists the person presenting the role so that they can remain consistent in their presentation (Block et al., 2018). One trainee began with the initial greeting and review of the goals for the session and then another trainee

Table 3. DT therapist training components

Initial training components topic	Presentation format	Time allotted
Introduction and DT background	Lecture	1.5 h
Key elements and techniques	Discussion	1 h
DT demonstration	Video with Q & A	1.75 h
DT practice	Progressive role play with mock patient	1 h
DT demonstration	Live interview and debrief	1.75 h
Experiential role play	Role play in pairs and debrief	1 h
Overview of editing process	Case examples and discussion	1 h
Opportunities and challenges	Discussion	1.5 h
Interview with a DT recipient	Pre-recorded video	0.5 h
Other training components topic	**Presentation format**	
DT Textbook	Written text	
Practice Interviews	Virtual meetings with standardized patient	
General and Individual Feedback	Phone calls with DT experts	
Process Tracking	Documentation form	
DT Training Manual	Electronic document	
Quarterly Support Sessions	Virtual meetings with DT experts	

DT, Dignity Therapy.

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stepped in to lead the next part of the session, and so on until all trainees had an opportunity to practice a small portion of the interview. This activity segued to the trainer demonstrating a pre-arranged session with an actual patient who had agreed to participate in the DT training process. This example provided a thorough presentation of the structure of the intervention. At the end of the session, the trainees had the opportunity to ask questions of both the trainer and the patient.

In the next segment, pairs of trainees engaged in a role play of the DT interview and debriefed about their experiences. Each member of each pair took turns portraying the therapist and the DT recipient, affording them the chance to practice the therapist role and allowing them to gain understanding regarding the potential experience of the DT recipient. This activity allowed the expert trainer to assess the trainees level of understanding (Bellg et al., 2004). At times during this experience, trainees encountered dialogue with the "mock patient" that enlightened them to questions they had about the various DT techniques. This offered an ideal time for them to query the trainer.

As the training continued, the trainer provided a general overview of the editing process, using examples from verbatim transcripts and final legacy documents. In this activity, the trainees examined how responses to various questions would later be woven into a cohesive narrative. This led to the discussion of opportunities and challenges of the intervention. Then, a presentation of a pre-recorded video interview with a woman who had received the DT intervention provided a moving description of her experience and the impact that the DT process had upon her and her family. This first-person report helped trainees to see the potential impact of DT for the patients they would encounter.

The in-person training wrapped up with the attendees receiving information regarding the remainder of the training protocol, including the written training manual, an annotated interview transcript, and instruction on use of a process form. Participants were told that they would take part in a standardized mock patient session and that there would be subsequent virtual meetings with DT experts who would review their session transcripts and provide feedback.

Practice interviews

Following this intensive training, another DT expert (DJW) engaged each therapist in a simulation in which she portrayed a standardized mock patient. Carefully prepared standardized patients (SPs) who have a clear and detailed patient story are able to respond with deep authenticity and flexibility to varied interactions with the learners (Lewis et al., 2017). Furthermore, SPs who develop a deep connection to the character they portray maintain strong levels of consistency over time, both in story and in affect (Erby et al., 2011; Block et al., 2018). This session was scheduled as closely as possible following the initial training to provide the therapist-trainees an opportunity to practice their interview skills. The therapist-trainees were required to follow each component of the intervention. This included the initial framing conversation — in which they phoned the mock patient to describe the process, ensure that she understood the intervention, what her goals were in taking part in DT, gather details about the significant people in her life and to whom she would present the completed legacy document. The therapist-trainees then completed a DT interview with the mock patient. In the interview, they had the chance to go "off script" at the beginning or end of the session to ask questions of the mock patient/expert. These interviews were audio-recorded and verbatim transcripts were given to the therapist-trainee for self-reflection before receiving written and verbal feedback from one or two other DT experts who had reviewed the transcript.

General and individual feedback

In addition to the mock patient feedback, the trainer and another of the DT experts reviewed the initial patient/participant transcripts and provided written and verbal feedback to individual therapist-trainees regarding the process and techniques of the therapists, as well as the therapists' consistency in remaining focused on the creation of a legacy document. Written and verbal individual feedback were provided until the therapist demonstrated competence in adherence to the DT protocol.

Table 4 displays exemplars of the most significant constructive feedback that experts provided via a group call, affording an opportunity for all trainees to learn from each other's practice sessions. An advantage to this approach was the camaraderie and "ownership" developed through peer-to-peer learning. Individual performance issues, however, were addressed in private conversations.

Verification that each patient understood the purpose of the intervention was emphasized in the individual and group feedback. It was also imperative for the therapist to ask the questions directed by the DT intervention and to avoid turning the focus to topics that were distracting and not pertinent to legacy. The therapist's ability to remain simultaneously neutral yet actively supportive of the patient was another vital skill. It was also imperative for the therapist to use elaborative techniques as defined in the DT textbook (Chochinov, 2012) to elicit the richness of the individual's story. Furthermore, the therapist was expected to remain empathically attuned to the patient. All of these areas are integral to maintaining consistency of the DT intervention.

Initially, the DT experts reviewed all transcripts and provided feedback to the therapists. Throughout the DT intervention, all transcripts continued to be analyzed by the auditor and those with issues were referred to the DT experts for retraining of the therapists. The primary goal was to support the therapists to focus their interviewing skills toward achieving the goals of the DT intervention. Although it is rare, previous researchers (Kruzinga et al., 2016) have observed occasions in which care providers who were not accustomed to interview-based interventions (such as DT) have felt the structure inconsistent with their philosophy of care. It was a priority in our study that any therapist who decided to discontinue their involvement would be supported in their decision to withdraw and that the feedback process would provide for them to debrief their challenges.

Process tracking

The DT Contact and Process Tracking Form (Appendix) was provided to guide the therapists during their training so that all components of the interview process were clearly outlined for ease of completion. This guide then continued to be used for all DT patients to safeguard against drift for the duration of the multisite trial.

Training manual

A comprehensive 30-page training manual was developed to provide a detailed step-by-step guide to implementing the DT

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Table 4. Expert feedback for therapist-trainees

Dignity therapy technique	Occasion	Exemplar feedback (*Suggested language is in italics*)	Rationale
Framing	Pre-Interview Call	• Always make a pre-call to patient to explain DT, gather names/relationships of significant people, and learn the patient's reason for wanting to participate in DT (their goal). • If the patient does not identified recipient for the document, discuss with them their purpose for participating in the DT intervention.	• Prepares patient for conversation and enables therapist to focus interview on patient's goal. • It is possible that the person may want to participate as a way to "tell their story" even if there is not a person to whom they will give the document; this can still be beneficial, but we should be aware so that our focus will be on target.
Verifying DT Purpose	Practice	• Confirm patient understands DT. • *Can you tell me what you understand about Dignity Therapy and what our purpose is today?*	• Verifies patient is informed, that they want the intervention, that we can guide them to tell their story • If we do not know the goal upfront, we are not likely to meet it.
	Patient	• Review goals and names/relationships of significant people at the beginning of the interview.	• If therapist must go back mid-stream to get basic info, we are not prepared to address patient's goal for session.
Gathering Biographic Info	Practice	• If "Framing" call, not done, gather info now. • Recommendation to spend 1/3 of time gathering bio.	• Vital to have the names of the significant people. • This portion of the interview should not be rushed.
	Patient	• Present patient with opportunity to address each question in DT protocol, but respect their lead if there is a particular topic they do not want to discuss.	• Follow patient's thread of their own story to honor the dignity of the person. • Be aware of gaps in the story and explore if for important info.
Using Probing Questions	Practice	• Ask for specific examples • Be sure to use the opportunities to go back and flesh out broader biographical story.	• Specific examples will help patient to tell their personal story and will help create story in which family/friends will see the person.
	Patient	• Ask if there is a particular memory that comes to mind.	• This invites patient to make the legacy document their own story, told in their way.
Exploring Patient's Thread	Practice	• Consider using the photograph metaphor.	• Approach helps therapist to get patient's own personal thread; this affirms person's dignity.
	Patient	• Therapist should avoid too much interpretation of how patient felt. • Try to direct conversation with some chronology; try to start with early memories unless patient seems to want to begin with later events. • Therapist should avoid referring to their own stories.	• Every memory or detail recalled must be interpreted by the patient alone; our goal is to get at their experiences and what it means to them. • Chronology will help the flow of the story when it comes to editing. • This session must stay focused on the patient in order to meet their goal(s).
Refocusing toward Legacy	Practice	• Verify whether patient wishes sensitive material to be included. • Remember that this is a generativity document.	• There can be risk of losing flow of story and most meaningful elements. • Therapist must help patient stay focused on end-goal.
	Patient	• When major event/sensitive event is mentioned, confirm whether significant people are aware; and ask whether this is info they want to include in their document.	• This will both help the patient to stay focused on the message they wish to leave and help protect the significant people from information that could be hurtful.
Inviting Messages	Practice	• *Are there hopes or dreams you wish to convey?* • *Are there lessons you wish to share with people in your life?*	• These will help therapist to ensure that person has shared messages that are most important for them to share with significant people in their lives.
	Patient	• *You have said some words for one of your daughters…are there hopes or advice you wish to record for your son?*	• These will help therapist to guide patient so they will not forget important message they wished to include for someone.
General Process	Practice	• Know goals at the start — To whom will they give the document? Names/ relationships of important people? What is goal for going through DT process? • Deal with issues needing clarification in the moment rather than deferring too much to the editorial process. • Confirm at end that patient addressed goals they set out at beginning.	• If you are not clear on the goal, the "framing" and the important people in patient's life, you will likely miss a vital part of story. • The greater the amount of editing required later, the greater the cost of resources (time and financial). • Be sure that person feels they met goals they had set; we do not want to make an assumption here.
	Patient	• Cover all the major DT questions in the interview • Follow the patient's cues; avoid asking questions/taking a direction that deviates away from DT protocol • Avoid advice-giving	• This will increase potential for capture of a generativity document • Deviation is likely to hinder creation of generativity document • Giving advice does not help move toward legacy document

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intervention. It included information regarding which team member was responsible for each step, so as to remove any ambiguity. The detailed instructions covered each step in the procedure, from the initial screening of the potential patient to the delivery of the final legacy document. The DT experts and the auditor were intentional in developing a training manual with examples that the therapists could easily compare to their own practice in order to identify any deviations in their implementation of DT. The manual also provided a clear plan that the therapists could follow to achieve DT protocol consistency.

Included in the manual was an annotated transcript of an exemplar session that the primary trainer had conducted. It provided specific annotation of the interview techniques he used as he guided the patient through the session. This practical demonstration provided a standard after which the therapists could model their own sessions. The manual was revised as needed to incorporate details that the DT experts and the auditor recognized needed clarification or strengthening.

Quarterly support sessions

In line with the NIH recommendation for "skill boosters" for interventionists (Bellg et al., 2004), the DT therapist-trainees, DT trainer, and other DT experts attended a quarterly videoconference meeting. This meeting provided the opportunity for the therapist-trainees to participate in peer-to-peer learning as well as to discuss their experiences and challenges and hear from the trainer and experts as needed. These sessions also helped identify and/or prevent protocol drift as the trial progressed.

Early training outcomes

Eighteen DT therapists were trained across six sites to conduct the intervention using the training protocol. The group included 13 chaplains and 5 nurses. Seven of the chaplains and two of the nurses joined the team after the initial training session and were provided access to the video recording of the initial two-day training session; thereafter, their training followed the identical sequence of prior trainees.

Although all therapist-trainees received information regarding the purpose, goals, and requirements for the DT intervention, two chaplains who joined the team subsequently decided that the intervention was not consistent with their spiritual care practice and withdrew from participation as therapists. They reported feeling that the intervention did not fit with their chaplaincy practice. Time conflicts and emergencies had allowed them to attend only intermittently at the initial training and it is not known whether they viewed any of the recorded portions that they missed. These withdrawals emphasize the importance of making sure therapist-trainees understand that DT is an intervention with which protocol adherence is essential.

The DT experts reported that the mock patient interviews generally went well. Compassion for the individual was noted across the interviews. The auditor expressed that the interactions reflected respect for the personhood of the patients. Additionally, to facilitate excellence and efficiency in future DT interviews, the experts provided detailed feedback for the therapist-trainees regarding the interview process and communication.

The feedback was categorized into eight basic techniques for further implementation. The feedback categories included the initial framing conversation in which the therapist-trainees gathered the names/relationships of the patient's significant people, whether the therapist-trainees verified the patient's purpose for participating in DT, the gathering of the patient's biographical information, the use of probing questions, the therapist-trainee's exploration of the patient's story thread, the skill of the therapist-trainee in refocusing toward the legacy document creation, the therapist-trainee's invitation of special messages the patient would want to express to their significant people in their document, and attention to general processes. Table 4 shows exemplars from the feedback in each category as well as the rationale.

Findings

Our careful attention to and frequent evaluation of the process allowed us to fine-tune the procedure until we had developed an integrated training protocol. Our multi-faceted training provided foundational knowledge of the DT intervention, addressed the learning needs of the various therapist-trainees, and enabled reinforcement of learning and skill development, as well as recurrent review of the adherence of our process. Initial in-person (or via video) training with an expert in the intervention was indispensable in communicating the vision, passion, and nuances of DT. Although we would prefer face-to-face initial training for all therapist-trainees, we recognize that just as with our trial, other researchers also encounter situations in which there is unavoidable team member attrition, therefore a contingency plan is necessary to train replacement therapists. Our consideration of this need was especially beneficial as the final live training had to be canceled due to travel limitations related to Covid-19. As we already had a plan in place for distance training, we were able to flex our plans with relative ease and maintain detailed preparation for the therapist-trainees. The video recordings of the in-person training provided the opportunity for the distance-learning therapist-trainees to virtually experience the same information that was presented live. The actual patient demonstrations, both video-recorded and live, allowed the trainees to see the intervention at its best. The didactic and activity portions provided therapist-trainees with the concepts and then allowed them the opportunity to begin practicing the skills. Following both practice and actual interviews, the feedback from the DT experts provided reinforcement of learning and development of interviewing proficiency.

Although trainings for interview-based interventions cannot always be led by the intervention author (we were fortunate in this regard), it is vital that all trainings be led by an *expert* in the intervention (Bellg et al., 2004). Furthermore, although experts with decades of proficiency are not always available to provide mentoring and guidance during the learning process, we assert that expert guidance is necessary (Beidas and Kendall, 2010; Hasson, 2010) and every effort should be made to collaborate with experts in the intervention being implemented. A clear understanding of the intervention enables the experts to quickly assess when trainees' understanding deviates from the original or when intervention consistency is failing. Furthermore, it is our assumption that those who have been invested in a particular intervention — having practiced and researched it — would be more likely to hold a high standard regarding implementation and are in the best position to identify aspects that are imperative and those that are less essential.

As with other life review interventions, there may be challenges related to the health condition of the patient or complex personal/family dynamics (Haber, 2006). DT has the added intricacy that the DT therapist is constrained by a 1-h time limit and

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the awareness that the final document has a specific audience. Providing expert feedback allowed therapist-trainees the opportunity to discuss the challenges and learn the intricacies of therapeutic communication and legacy document creation. This guidance reinforced the DT training, including the importance of questions (Table 1) intended to direct the patient toward an exploration of the experiences he/she found most meaningful in life (Chochinov et al., 2005; Chochinov, 2012; Chochinov et al., 2012; Fitchett et al., 2015).

The DT Contact and Process Tracking Form and the training manual were vital documents to itemize process steps and to clarify process flow, assisting all team members to adhere to the same procedure. These tools were beneficial for training and necessary for monitoring protocol adherence and assurance of quality interventions.

We recognize that a limitation of this article is that it does not provide final results in terms of achieving fidelity following the implementation of this training protocol; fidelity outcomes will be reported in a separate article. Another limitation in this methodological report is that we did not directly ask each therapist-trainees to report if they had read every training document. It may be helpful for future teams to add this compliance check into their procedures. As two of our therapist-trainees were distracted away from the in-person training by phone calls it became apparent that there is a need for trainees to be adequately relieved of responsibilities in order to be present.

The primary goal of this report is to clearly describe a detailed training protocol for DT. The training components were designed to provide the trainees with a foundation of skills to implement the DT interview regardless of the therapist-trainees' professional discipline. Toward this objective, a variety of teaching methods was used and opportunities for reinforcement and fine-tuning were provided. The clearly established training protocol promoted structure in which the DT experts could provide oversight and process review. The DT Contact and Process Tracking Form provided a guide for the therapist-trainees and assisted the research team to ensure that each step in the process was conducted and documented.

Discussion

We approached this work with the knowledge that DT has a long history as an intervention that draws on life review practices to facilitate the creation of a legacy document. As we prepared to initiate a multisite DT randomized controlled trial, it was of primary importance to ensure consistent and reproducible training. Our exploration of the literature illuminated gaps regarding a documented training protocol, despite the imperative role that such training plays in maintaining fidelity to the intervention. Although the original DT textbook describes necessary elements of training, there were not sufficient details to ensure replication. Furthermore, subsequent DT researchers provided only limited details of their training procedures. We recognized that a consistent training protocol was imperative for us to ensure that the DT therapists in our study would be prepared to implement the intervention consistently. Furthermore, we recognized that the lack of a detailed training protocol could impair other researchers' and clinicians' efforts to effectively replicate the intervention. We rectified this gap with a detailed training protocol for the DT intervention so that implementation would be consistent and accurate as our study progressed from four to six sites.

Our contribution of the Refined DT Training Protocol will enable the broadening of DT implementation with fidelity to the original intervention. This augmentation to the DT training process is vital in a time when resource constraints may require that a variety of clinical disciplines be called upon to step into the role of the DT therapist. This training protocol description establishes details for implementing DT with intervention fidelity. Other researchers and clinicians may utilize this DT therapist training protocol and set of procedures to fortify the rigor of their work. This work is poised to make a notable impact in both research and clinical care. The training protocol delineates important components of therapist training that can readily be replicated and the elements can be adjusted to apply to the training of therapists for other life-review or palliative interview-based interventions.

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Appendix

Palliative Care for the Elderly

Dignity Therapy Contact & Process Tracking Form

Contact #1 – Pre-Interview Call – By Phone:

Patient Name		Today's Date (Phone Call)	
Phone Number		Name of Caller Today	
Email Address (optional)		Role of Above (RA, RN, Chaplain)	
Age		Confirm Consent has been Completed	Yes ☐ No ☐
Cancer – Diagnosis (Type)		Next Appointment (DT Interview)	
Date of Diagnosis			
Stage			

Before beginning, confirm patient's understanding about the Dignity Therapy interview:

- Do you know what Dignity Therapy is? (If no, say: **The purpose of Dignity Therapy is to create a written document with the thoughts and words that you want to share with your loved ones.**)
- Would creating a legacy document be meaningful to you at this time?
- Would you like me to review this with you before I proceed with my questions?

Goals for this call:

- Learn a little something about who the patient is (e.g., marital status; living arrangements, vocation; understanding of diagnosis; for whom their legacy document is intended)
- Inform the patient that the goal for the call is to review what the patient would want included in his/her legacy document
- Encourage the patient to think about the questions in advance of the session
- Remind the patient it is not all about biography; for many it is about lessons learned, passing along wisdom, providing comfort to loved ones, etc.

Learn from Patient:

1. What are your important goals of creating the legacy document?

2. Who are the family members in your immediate circle (names, relationships)?

3. Are there things I should be aware of that you hope to avoid speaking about in our conversation?

4. Confirm the patient has the list of Questions and orient him/her to think about the things he/she wants to address when you meet in person for the interview session—the important goals of creating this legacy document.
   Yes ☐ No ☐

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Contact #2 – DT Interview – In Person:

Update Contact Info		Today's Date (Interview)	
Patient prefers to receive final document via -	In person ☐ Mail ☐ Email ☐	Name of DT Therapist	
Does patient wish to designate another to receive their Legacy Document if they are not available when it is completed?	Yes ☐ No ☐	Role (RN, Chaplain)	
If Yes to above, note the Designee's Name, Relationship, Phone & Email			

Contact #3 – Review of Edited Draft Legacy Document – In Person:

Update Contact Info		Today's Date (Transcript Review)	
Editing completed per protocol	Yes ☐ No ☐	Name of DT Therapist	
Legacy Document read to patient?	All ☐ Part ☐ None ☐ If not read, note reason _____	Role (RN, Chaplain)	
Does the patient wish to make any changes to the document?	Yes ☐ No ☐		
If Yes, have changes been made and submitted to Amelia?	Yes ☐ No ☐ N/A ☐		

Contact #4 – Legacy Document Presentation – In Person, by Mail, or by Email:

Update Contact Info		Today's Date (Legacy Document Presentation)	
Format of Document	Hardcopy In Person ☐ Hardcopy by Mail ☐ Email ☐	Role of Above (RA, RN, Chaplain)	
Recipient of Document (Name & Relationship to Patient):			
Recipient's Address & Phone:			

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