Dignity Therapy within a Mood In- Patient Population

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Introduction

Dignity Therapy is a form of psychotherapy developed by Dr. Harvey Chochinov. It is currently used within the context of palliative care to aid patients struggling with existential issues. The therapy enhances the patient's self- perceived dignity by helping them identify areas of value in their life.[1] This type of therapy has proven to be effective in reinforcing self- esteem, and decreasing rates of depression and anxiety in end of life patients.[2,3] However, it is this writer's belief that the benefits of such a therapy should not be restricted to the palliative population. During my rotation through the Mood In-patient Unit, it became apparent to me that there could be a broader application of this therapy.

The Mood In-patient population certainly were not at the end of their lives. But they too were struggling with feelings of uselessness and disillusionment. During their discharge interviews I sensed undertones of trepidation. These patients seemed to lack confidence in themselves. There was an air of disappointment-- either because they felt complacent in the disease's process, or frustrated that they once again lost ground in what is a constant battle. I noticed that psychiatric patients' discharges were unique compared to other areas of medicine. Patients did not see themselves as the survivors they were; emerging at the other side of a mood crisis. Instead, I think they viewed themselves as perhaps weaker because of their struggle. I deeply wished I could give them something to re-new their battered sense of dignity. It seemed obvious that Dignity Therapy was exactly what they needed. I believe this underutilized therapy would serve to re-enforce a sense of value and hope that sometimes gets lost in the world of mental illness.

What is Dignity Therapy?

Dignity Therapy, as it currently stands, is specifically designed for a palliative population. It is a form of psychotherapy that can be led by any trained health care professional. It involves engaging in active dialogue with an eligible patient. This dialogue consists of questions meant to elicit strong memories or evoke important life lessons. Dr. Chochinov provides a list of questions around which to structure the interview. These questions span from the broad: "Tell me a little about your life history; particularly the parts that you either remember most or think are the most important" to the specific: "What are your most important accomplishments". [1] The role of the psychiatrist is to help guide the patient in their walk down this metaphorical memory lane. An analysis of feelings may also take place especially because this type of therapy can unearth unresolved emotions. The recorded interview is then transcribed into a manuscript. The transcript is then edited, to achieve clarity, and then given back to the patient for approval. Upon approval the final draft of the manuscript can then be shared with the patient's chosen loved ones and/or circle of care providers. It gives the patient an opportunity to share their perspective, as well as a chance to express love and affection.[1] It is also an opportunity for the patient to leave behind a tangible document of their lives.[1]

Dignity Therapy's success

Dignity Therapy is beneficial within a palliative care setting because it encourages the shift from looking at the individual as a patient to a person.[1] When a patient is asked by their therapist to share their own insights from life, it communicates a clear message that the patient

has something of value to share. Research has shown that the greatest predictor for how dignified a patient feels, is how dignified s/he is made to feel by their health care provider.[1]

What would modified Dignity Therapy look like?

Modified Dignity Therapy would involve mood in-patients who have been stabilized and are nearing discharge. They would be invited to create a "Generativity" document with their therapist. It could include lessons learned, proud moments or meaningful memories. Very similar questions that are asked to the palliative care population could still work well in this cohort. Of course modifications would need to be made. The questions should explore less the legacy the patient wants to leave behind and rather the legacy they can and should be creating now. Instead of asking, "Are there words or perhaps even instructions that you would like to offer your family to help prepare them for the future?",[1] the interviewer could ask, "Are there words or thoughts you find difficult sharing with your loved ones and would like to take this opportunity to share". The final draft of the manuscript can then be disseminated among the patient's chosen loved ones. The patient could also keep the document as a private piece of work meant to remind them of what they have accomplished.

Mental illness continues to be stigmatized in our society today. Patients often feel their opinions are overshadowed by their psychiatric labels. Encouraging a patient to share their insights would help in undermining this belief. The creation of the document itself is an exercise in repairing broken self- worth. It is an opportunity to reflect on how much the patient has grown as a person because, not in spite of, their mental illness. Finally, the shared document would encourage further understanding and empathy from family members and their care team who may not fully comprehend the patient's experience.

Literature Review

Studies show that attack on one's dignity leads to depression, anxiety, hopelessness and lower quality of life in general within the palliative population.[4-7]

Unfortunately, the literature on Dignity Therapy is mostly limited to the palliative setting. There are two case reports documenting the use of Dignity Therapy on a patient suffering from schizophrenia and major depressive disorder, respectively.[8,9] The patient suffering from depression was 61 years old and the loss of her job precipitated a severe depression. She was initially treated with an anti-depressant which improved her mood but did not alleviate her sense of hopelessness. She questioned where her life's meaning would come from now that she was unemployed. She agreed to participate in Dignity Therapy. The product of which was a manuscript that highlighted her children and volunteerism as alternative sources of meaning for her. She improved on the anti-depressant but it was only after creation of her Dignity Therapy manuscript that her hope in the future was restored.[9]

The second report documents a case of a 55 year old man suffering from schizoaffective disorder. [8] It greatly concerned this patient that he was unable to spend quality time with his children. He engaged in Dignity Therapy in order for his children to better understand his story. After creating the document and disseminating copies to his loved ones he stated that "dignity therapy had restored hope".[8]

Not surprisingly, quite a few studies can be found that document the loss of dignity felt by patients with mental illness. One such study, by Martinsson's et al, was qualitative in nature and aimed to "illuminate the meaning of the life situation as experienced by older persons with mental disorders".[10] A phenomenological hermeneutical approach was employed to identify the main themes in these individuals' narratives. The themes identified included a sense of

loneliness, feeling that life was void of meaning and that they were helpless.[10] These patients also were concerned about the stigma attached to mental illness. They felt misunderstood and excluded. The overarching theme was defined as "Struggling for existence" and this included the themes of "being vulnerable", "being powerless" and "wanting to be respected as a person". [10] In particular the author notes that these patients' "struggling for existence meant wanting and trying to obtain respect and help in order to facilitate the mastering of their own existence". [10] They go on to state that a patient's dignity was not tied to their mental disorder but rather to how they were treated and perceived to be viewed by those around them. [10] Interestingly, it was noted that what hurts a patient's dignity was being treated as an illness rather than a person. [10] Dignity therapy can serve to address these concerns. The therapy strives to understand the individual apart from the disease. The therapy would reinforce the notion of respect for the patient's ideas and feelings. Asking the patient to share advice they have gained from their life experience is a way to reflect respect for their experience.

Another qualitative study done by Chambers et al, investigated the extent to which patients who were detained in psychiatric institutions could maintain feelings of dignity and self-respect. [11] The authors discuss the common experience of psychiatry patients who are formed, and the resulting feelings of powerlessness from not being able to play an active role in their recovery. They talk about how this loss of confidence in oneself can undermine the recovery process itself. [11] Unfortunately, a common theme found among those interviewed was a sense that they were not respected and treated with dignity during their hospitalization.[11] This is a side effect of having to detain someone and temporarily suspend their rights in order to treat them. However, I feel at the end of their stay these patients should receive some form of restorative dignity. A sign that health care professionals do indeed see the patient as an individual who is

worthy of sharing their story and being heard. Dignity Therapy would be a fitting project with which to end ones stay.

Translating into practice

Dignity Therapy is a time consuming process that may not be feasible for psychiatrists to provide to each patient. It is important to acknowledge that our system is one that is constrained by limited resources. However, restoration of dignity should be an integral part of the re-integration process and therefore important enough to bear modification. Such modifications can be as simple as being flexible about who provides this therapy. The easiest change would be to include other health care professionals, like social workers and nurses, in the Dignity Therapy training process. An annual workshop is held by Dr. Chochinov which can be attended by any interested health care provider.

Additionally, the therapy could be further modified so that it can be done in a group rather than individually. In- patients often turn to their co-patients as a support system. They appear to benefit from sharing with each other and sincerely care to hear about others' stories. Not only would the audience provide the necessary validation of the speaker's stories, but the audience themselves would feel useful through playing a role in the process. The psychiatrist role at a minimum could involve discussing the end product with the patient during their exit interview. Further exploring any unresolved issues the sessions may have exposed.

Conclusion

It is time to push past the boundaries of Dignity Therapy. Examination of one's worth should not only occur at the end of life. It is a worthy pursuit throughout life, especially after a

debilitating mood crisis. As Dr. Harvey Chochinov, the founder of Dignity Therapy, wisely stated, “The seemingly ‘ordinary life’ becomes extraordinary when we take the time to look at it closely”. [1]

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