



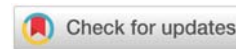
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Letter to Editor

Dignity therapy for non-terminally ill elderly

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Dignity Therapy (DT) is a psychotherapeutic approach designed to increase patient's sense of meaning and purpose, offering the opportunity to talk about issues that matter most to them, to share moments they feel were most important and to speak of things they would like to be remembered [1]. DT has been developed and trialled for those near death and had shown efficacy on several psychosocial outcomes [1,2]. However, some recent case reports have been published about the use of DT in non-terminal ill patients with mental disorders such as major depressive disorder and alcohol use disorder [3-5].

We briefly report the case of Mrs. P, an 84-year-old female, undergoing geriatric psychology consultations and counselling therapy due to Mrs. P's persistent memory losses and increasing marital conflicts.

After her initial geriatric and psychological evaluations, Mrs. P was diagnosed with both depressive and grief disorders and persistent insomnia, all due to her recent brother's loss and by confronting herself with her advanced age and terminality. She was placed on lorazepam 2.5mg PRN by her family physician. Mrs. P began to improve her sleep disorder, although persisting in her brother's loss as something restraining her from living her life to the fullest, loving her husband and family, her relationships, and her future. As part of her regular psychotherapeutic sessions, Mrs. P was introduced to DT by a trained DT therapist (F.B) and accepted it.

Mrs. P performed DT protocol in separate sessions of 60-90minutes each, expressing a genuine interest in her own life story, re-directing her attention for significant vital aspects, gradually improving her mood. She was able to value the genuine relationships with her loved ones: her husband, children, granddaughters, and her deceased brother. She positively remembered unvalued past moments and felt her marital relationship gained new stability. She also gave meaning to her professional roles and felt proud of her achievements.

At the end of DT protocol, she was "filled with memories, she once thought forgotten" and was happy to have found hidden letters and artifacts that she considered unimportant, giving it new meaning. She looked at her life not as separated events trapped in suffering, but as meaningful and relevant. Mrs. P expressed profound joy by passing her legacy through DT generativity document, where she laid teachings and moral values for her granddaughters, her husband and friends.

Although anecdotal at present, evidence mounts for other clinical DT applications, beyond terminal illnesses. Non-terminally ill elderly, whose predictions of terminality seem to lead to psychological and existential suffering, are eligible for DT and might benefit from it, as this brief psychotherapeutic intervention reinforces life's sense of value in a supportive and structured framework. Future research starts to be warranted to investigate DT's clinical value in other areas besides end-of-life care, like the elderly or mental disorders in the general population.

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