



Factors and topics associated with empathic self-disclosure in dignity therapy of cancer patients[☆]

Alyssa Crowe^a, Mary Kate Koch^b, Susan Bluck^b, Tithi Amin^a, Lyndsey Thomas^a, George Fitchett^c, Diana J. Wilkie^d, Carma L. Bylund^{a,*}

^a Department of Health Outcomes and Biomedical Informatics, College of Medicine, University of Florida, United States of America

^b Department of Psychology, College of Liberal Arts and Sciences, University of Florida, United States of America

^c Department of Religion, Health & Human Value, College of Health Sciences, Rush University Medical Center, United States of America

^d Department of Nursing, College of Medicine, University of Florida, United States of America

ARTICLE INFO

Keywords:

Empathy

Empathic self-disclosure

Dignity therapy

ABSTRACT

Objective: During Dignity Therapy a trained provider guides a patient to share their life story and legacy. Providers can demonstrate empathy through empathic self-disclosure (ESD), sharing something substantial and personal about themselves in response to the patient. The current study aims to identify the topics of ESDs and determine whether ESD frequency varied by patient and/or provider characteristics.

Methods: Two coders analyzed 203 audio-recorded, transcribed Dignity Therapy sessions of palliative care patients ($M = 65.78$ years; $SD = 7.43$ years, 65.69% women) for ESD. Topic modeling characterized themes of ESD and multilevel modeling examined ESD frequency based on several patient and provider characteristics.

Results: ESD occurred in 37% of interviews ($M = 0.59$, $SD = 1.21$). Topic modeling revealed five main themes: family, memory, school, geographical experiences, and values/beliefs. Multilevel modeling indicated patient-level differences, including greater rates of ESD when patients were men and older.

Conclusion: ESD seems to be dependent on the context of the patient rather than individual communication style differences. Providers may use ESD in multiple instances, including when similar and different from patients.

Innovation: This study introduces and defines the novel concept of ESD. It is among the first to examine patient-provider communication during Dignity Therapy, and the first to specifically examine self-disclosure.

1. Introduction

Preserving patient dignity, or respect for personhood, during serious or terminal illness, such as advanced cancer, is a critical aspect of high-quality palliative care [1,2]. A compelling intervention to address this challenge is Dignity Therapy. Dignity Therapy is a psychotherapy designed for individuals nearing the end of life [3]. During Dignity Therapy, a trained provider guides a patient to share their life story and legacy in a semi-structured interview. Interviews are then edited into legacy documents, which are returned to the interviewee to share with their loved ones. While Dignity Therapy has been shown to foster dignity [4,5], understanding how Dignity Therapy providers communicate empathy during the Dignity Therapy interview is valuable for future implementation.

Empathy in health care communication has been shown to improve outcomes for patients and clinicians [6,7]. The social nature of Dignity Therapy suggests that a provider's empathic communication skills are critical. According to the model of empathic response in healthcare, patients create empathic opportunities through emotional cues that providers can recognize and choose to expand upon or not [8]. The goal of an empathic encounter is for the patient to feel known and understood [8]. One way a provider can respond empathically, given an empathic opportunity, is through shared experience. This refers to sharing a similar emotion or life situation as the patient [9]. Sharing personal memories with others has been shown to increase empathy [10], and research on the hierarchy of empathic communication suggests that shared experience may convey more empathy than other types of empathic responses, such as validation or acknowledgment [11]. One

[☆] Given her role as the Editor in Chief, Carma L. Bylund had no involvement in the peer-review of this article and has no access to information regarding its peer-review. Full responsibility for the editorial process for this article was delegated to Jordan Alpert and Emily Mroz.

* Corresponding author at: 7004 Malachowsky Hall, Gainesville, FL 32603, United States of America.

E-mail address: carma.bylund@ufl.edu (C.L. Bylund).

<https://doi.org/10.1016/j.pecinn.2024.100289>

Received 30 November 2023; Received in revised form 29 March 2024; Accepted 24 April 2024

Available online 14 May 2024

2772-6282/© 2024 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY-NC license (<http://creativecommons.org/licenses/by-nc/4.0/>).

reason for this may be that shared experience is a form of self-disclosure since it involves the provider sharing personal information or life experiences [12], which patients may perceive as creating interpersonal closeness.

Generally, self-disclosure has been associated with numerous positive outcomes in physician-patient contexts [12]. In several studies, self-disclosure was associated with positive perceptions of physician communication skills, empathy, trust, rapport and the patient's intention to disclose [12-14]. Self-disclosure has also been associated with positive outcomes in therapist-patient contexts. A review of therapist self-disclosure found positive associations with patient's mental health functioning and therapeutic relationships [15]. Studies in both physician-patient and therapist-patient contexts suggest that self-disclosure, when centered on the patient's needs and preferences (e.g., considering the client's culture or treatment needs), promotes positive outcomes such as greater patient goal achievement compared to self-disclosure that is centered on the physician's preferences [16-18]. Accordingly, Dignity Therapy providers may need to center self-disclosure empathically on the patient's needs and preferences, which may be especially critical for palliative care contexts.

We propose a novel concept, empathic self-disclosure (ESD), that merges the idea of shared experience and self-disclosure as an empathic and patient-centered means of deeper connection. ESD involves disclosing information that is both substantial and personal (i.e., new information is learned about the provider as a person through the disclosure) as a direct response to a topic that the patient raises when talking about their own life. ESD can be accomplished by the provider disclosing a shared experience, value, or feeling in order to relate to the patient's life story. ESD may be an especially useful empathic communication strategy in the context of Dignity Therapy, where Dignity Therapy providers do not have a pre-existing relationship with the patient, and have limited time to elicit a rich and personal life narrative from the patient. As such, it is important to explore how ESD currently functions in Dignity Therapy.

The aim of the current study was to investigate and analyze ESD in Dignity Therapy interview transcripts. Our research questions were as follows:

- RQ 1: (a) When provider ESD occurred, what topics were disclosed?
- (b) Did the frequency of topics vary based on Dignity Therapy modality, provider gender, provider occupation, and patient gender?
- RQ 2: (a) Was variance in ESD due to individual differences of patients and providers, or was variance due to site level differences?
- (b) Across all providers, did the use of ESD differ based on provider gender and provider occupation?
- (c) While accounting for provider-level variables, did ESD frequency vary based on patient gender, patient age, and session modality? Further, was ESD frequency associated with the interaction between provider gender and patient gender to reflect effects of gender concordance?

2. Methods

We conducted a secondary analysis of audio recorded and transcribed Dignity Therapy sessions conducted with adult cancer palliative care outpatients who were participating in a randomized clinical trial of Dignity Therapy [19].

2.1. Participants

Patients were 203 older adults with cancer ($M = 65.78$ years; $SD = 7.43$ years, min-max = 55–87 years). The sample consisted of majority women (65.69%). Patients self-identified their race and ethnicity as 77.94% White, 11.76% Black or African-American, 7.84% Hispanic or Latino, 0.49% American Indian or Alaska Native, 0.49% Asian, 0.49% Native Hawaiian or other Pacific Islander, and 0.98% declined to self-identify. Fourteen trained Dignity Therapy providers ($n = 10$ women,

$n = 9$ chaplains, $n = 5$ nurses) administered Dignity Therapy across the six study sites. Dignity Therapy providers were trained through background reading, a two-day training session with practice interviews; and a standardized patient-interview session with feedback. Additionally, a written training manual, individual feedback, and quarterly support sessions were provided [20].

Recruitment occurred in-person at outpatient palliative care clinics across six university medical centers. Patients were considered eligible for inclusion in the original study if they were (1) diagnosed with cancer, (2) receiving outpatient palliative care, (3) 55 years or older, (4) able to speak and read English, and (5) physically able to complete the study. Participants provided written consent prior to participation and received \$150 for their participation. Dignity Therapy was implemented in a stepped-wedge design. After Step One, one chaplain-led site and one nurse-led site were randomly selected to begin the intervention at each successive step, for a total of six sites participating in the intervention. Data and Dignity Therapy interviews were collected in-person from 2019 to 2020 and remotely from 2020 to 2022 due to the COVID-19 pandemic. All study procedures were approved by the Institutional Review Boards at all study sites.

2.2. Procedure

Patients completed survey measures capturing their demographic information. Patients engaged in an initial rapport building and goal setting conversation with a trained Dignity Therapy provider via phone. Dignity Therapy providers were not trained to engage in ESD, and in some cases may have received feedback to avoid referring to their own stories [20]. Several days later, at the medical center where the patient was receiving care, patients completed a one-on-one interview with the same Dignity Therapy provider, guided by established Dignity Therapy protocol [4]. Interviews were audio-recorded and subsequently transcribed. Interviews lasted an average of 42.60 min (Range = 23–57 min, $SD = 10.50$). From 2019 to 2022, 46 interviews (22%) were completed in-person and 157 were completed in virtual sessions (i.e., Zoom or telephone). Therapists completed 14.50 sessions on average ($SD = 15.10$, Range = 2–45).

2.3. Empathic self-disclosure

We segmented transcripts into idea units for coding. Idea units represent a shift in content based on initiation of new topics, ideas, or memories. This could be the provider asking a new Dignity Therapy interview question, or the patient organically changing the subject. Two independent coders double-coded all units for the presence or absence of ESD while simultaneously reading the transcript and listening to interview audio. Coding followed a version of the Empathic Communication Coding System [9], which had previously been modified for use with Dignity Therapy interviews [21]. We considered ESD to be present in instances where the provider disclosed a substantial and personal detail about themselves, only when in response to a topic the patient raised. ESD could occur through the provider sharing a common experience, value, or feeling. ESDs could be as short as one sentence and did not have to be a long statement to be coded. ESD was not coded if the response did not convey empathy, for example, if the provider disclosed something not in response to the patient, simply gave their opinion, or contested or tried to reshape the interviewee's experience. Any discrepancies between the coders were resolved by consensus. 30 codes from the transcripts of dropped out participants were used as reliability check material; interrater reliability was excellent ($\kappa = 0.80$, ICC = 0.80). In the sample, 37% ($n = 76$) of interviews included at least one instance of ESD.

2.4. Statistical analyses

To address RQ1a, we conducted topic modeling to characterize main

themes of the content that was empathically self-disclosed by Dignity Therapy providers. The topic model was fit with the *lda* package in R. Topic modeling processes large amounts of text into a select number of topics to provide an interpretable summary of main themes. Dignity Therapy interviews were transformed into a document-term-matrix in which each row represented one instance of ESD and each column represented the text of that ESD instance. We conducted standard pre-processing of the text before fitting the model to facilitate interpretability of the model. Pre-processing included removing punctuation, transforming words to lower case, and removing a set of common English stop words. Number of topics was determined using an adaptive density-based statistic that calculates the number of topics resulting in minimal overlap of terms [22]. Topics were interpreted and labeled using their top-10 terms and quotes from responses that were a strong fit with the topic [23]. Topic modeling also produces a posterior topic distribution, which indicates the proportion of ESD that falls into each topic. To address RQ1b we conducted correlations between the posterior topic distribution and Dignity Therapy provider and patient attributes to explore whether any ESD topics were significantly related to these attributes.

To address RQ2a-c, we conducted multilevel modeling to examine whether individual Dignity Therapy providers varied in their use of ESD across sessions with different patients, by patient and provider characteristic variables. Multilevel modeling was necessary since data were nested within Dignity Therapy providers. Patients were not even nested within providers due to variability in study sites and Dignity Therapy provider availability. See Table 1 for further details on how many Dignity Therapy sessions each provider completed (Range = 2–45). All Dignity Therapy interviews were included in the analysis. Because ESD is a continuous variable, positive values in the model represented a greater extent of ESD, which is necessary to examine factors that predicted when ESD was more present versus less present. The first step was a random intercept only model to determine the degree to which Dignity Therapy providers showed intra-individual variability. We compared this to a random intercept only model nested within sites to determine whether variability came from individuals or sites (RQ2a). Next, we ran a model with provider variables (i.e., provider gender and occupation) (RQ2b). The final model step included patient variables (i.e., patient gender, modality of session, and patient age) in addition to provider gender and occupation (RQ2c). To indicate the magnitude of effect, we report the pseudo R^2 of the full model compared to the model in the absence of each focal variable.

2.5. Empathic self-disclosure ratio

Idea unit codes were summed to obtain a total ESD score in each patient transcript. The final ESD ratio was the total ESD score for an interview divided by the total number of idea units in that interview.

Table 1
Variance in empathic self-disclosure, interview length, and demographics by Dignity Therapist provider.

Provider	ESD Mean	ESD SD	ESD Range	Number of sessions	Interview Length Range (min)	Provider Gender	Provider Profession
1	0.24	0.44	0–1	45	38–73	Male	Nurse
2	0	0	0	3	44–66	Female	Nurse
3	0.17	0.38	0–1	24	19–94	Female	Nurse
4	0.24	0.44	0–1	17	21–55	Female	Nurse
5	0.50	0.71	0–1	2	45–56	Female	Nurse
6	0.80	0.45	0–1	5	36–61	Female	Chaplain
7	0.75	0.89	0–2	8	46–83	Female	Chaplain
8	1.10	1.54	0–8	30	30–88	Female	Chaplain
9	4.25	4.65	0–10	4	44–62	Female	Chaplain
10	0	0	0	3	23–39	Male	Chaplain
11	2.50	2.12	1–4	2	47–50	Female	Chaplain
12	0.67	1	0–3	9	36–61	Male	Chaplain
13	0.67	0.99	0–5	43	28–65	Female	Chaplain
14	0	0	0	8	44–75	Male	Chaplain
All providers	0.59	1.21	0–10	203	19–94	–	–

This accounts for variability in transcript length.

2.6. Provider characteristic variables

Provider variables were gender (0 = woman, 1 = man) and occupation (0 = chaplain, 1 = nurse). Gender was selected as a variable because previous empathic communication research found that when an empathic opportunity arose, female physicians responded with higher degrees of empathy [11]. While chaplain and nurse-led Dignity Therapy was found to be effective at improving patient dignity in older adult cancer patients [24], we wanted to examine if their use of ESD as an empathic communication strategy differed.

2.7. Patient characteristic variables

Patient characteristic variables were gender (0 = woman, 1 = man), interview modality (0 = virtual, 1 = in-person), and a continuous variable of patient chronological age. Patient gender was selected as a variable because previous empathic communication research found that female patients had more emotional intensity in their empathic opportunities when compared to male patients [11]. Interview modality was selected as a variable because a systematic review on clinician telehealth behavior found varied results on the verbal communication between clinicians and patients; in some cases, physicians increased self-disclosure and verbal behaviors in telehealth visits, while in other cases telehealth visits resulted in less verbal behavior and lower empathy [25]. Patient age was selected as a variable because in a systematic review of self-disclosure in a primary care setting, no study focused on older adults, highlighting a need for more self-disclosure research in this population [26].

3. Results

3.1. Descriptive statistics

ESD occurred in approximately one-third of all interviews and the average number of ESD per interview was 0.59 ($SD = 1.21$) (see Table 1). Mean and variance descriptive statistics across Dignity Therapy providers indicated that, on average, most Dignity Therapy providers engaged in less than one self-disclosure per Dignity Therapy interview (Table 1). Further, descriptive statistics indicated eight Dignity Therapy providers had a limited ESD range of 0 or 1, whereas six Dignity Therapy providers had a wider ESD range of 0–10.

3.2. Topic model: Content of ESD

Topic modeling resulted in a six-topic model. Of the resultant six topics, five reflected different content included in ESD and one reflected

speech differences between Dignity Therapy providers (e.g., “y’all”). Accordingly, we report only the five topics pertaining to ESD content. These include shared family experiences (top-5 topic terms: kids, made, children, together, fun), memory experiences (top-5 topic terms: remember, got, sounds, brother, boy), school experiences (top-5 topic terms: school, high, public, went, early), geographical experiences (top-5 topic terms: town, city, state, bit, used), and values and beliefs (top-5 topic terms: know, right, yes, good, think), (see Table 2). There were no significant correlations between topics and patient or provider variables.

3.3. Multilevel modeling

The random intercept only model indicated that there was considerable variance within Dignity Therapy providers ($ICC = 0.44$). We compared this to a random intercept only model within treatment site and found that there was limited variance within sites ($ICC = 0.07$). These results suggest that ESD is not a byproduct of site differences, but provider-level differences. At the provider level, modeling results indicated no significant differences in frequency of ESD by provider gender or occupation (see Table 3). When examining patient variables, we found greater rates of provider ESD when patients were men and when patients were older in age. We added an interaction to the patient and provider variables model between provider gender and patient gender to test for effects of gender concordance but did not find an effect ($B = -0.01, p = .65$).

4. Discussion and conclusion

4.1. Discussion

The present study investigated the novel concept of ESD as a means of conveying empathy within the patient-centered intervention of Dignity Therapy to better understand the empathic communication processes involved in the palliative care context. Prior work establishes that palliative care patients provide frequent empathic opportunities [27], but there is a gap in understanding how specific empathic processes like ESD are employed in palliative care settings, particularly in Dignity Therapy. Our goals were to define ESD, identify the content discussed when provider ESD occurred, and determine whether ESD frequency varied based on patient and provider demographic differences. We found that Dignity Therapy providers disclosed a range of topics, most

commonly shared family experiences, shared geographical experiences, and shared values and beliefs. Content of topics was not associated with gender, patient age, provider occupation, or interview modality. Similarly, frequency of ESD was not significantly associated with any provider variables. Rather, patient age and gender were weakly associated with ESD frequency.

At the descriptive level, we found that ESD, while not rare, was not commonly used, which suggests that one ESD does not typically lead to a cascade of ESD. ESD occurred at least once in approximately a third of all interviews, yet only 18 transcripts (9.87% of all interviews) included two or more instances of ESD, demonstrating that ESD is rarely used multiple times within the same interview. It may be that one or two instances of ESD could be sufficient for building a sense of connection or warmth with the patient, while engaging in too much ESD may detract from the patient’s story. This could have useful clinical applications because it suggests providers may increase empathic communication with patients with little additional time burden. However, future research should examine the extent to which ESD could derail the conversation from what the patient is saying.

The relatively uncommon occurrence of ESD across interviews may also be explained by training and cognitive load. According to training protocol documentation, Dignity Therapy providers may have received feedback to not share their own stories during the interview [20]. Depending on how they interpreted this, Dignity Therapy providers may have deliberately held back from engaging in any form of self-disclosure, including ESD. Additionally, ESD requires a high amount of cognitive load compared to other forms of empathic communication. For example, engaging in empathic communication through recognition can be achieved with a brief phrase like “I hear you,” and this phrase can be deployed similarly across all patients because it is not content specific [9]. In contrast, ESD requires more effort from the provider to make a specific connection about the patient to their own life. Accordingly, patients may feel more heard and less isolated in the conversation, which may lead to greater rapport than other forms of empathic communication. However, repeated disclosure across multiple Dignity Therapy sessions a day could negatively impact Dignity Therapy providers. Future research should measure the impact of ESD on Dignity Therapy outcomes, including the minimum and maximum instances of ESD that facilitates beneficial outcomes like increased rapport or trust. Additionally, future work should examine the impact of ESD on provider variables like burnout and job satisfaction, in consideration with Dignity

Table 2
Summary of topic words, themes, and illustrative quotes in ESD by DT providers.

Topic	Top-5 topic terms	Topic theme	Illustrative quote
1	kids, made, children, together, fun	Shared family experiences	Patient 1230–87: Oh, yeah, I made all of [my children’s] Halloween costumes. Provider 4: Did you?... Do you remember some of the costumes you made? ... Patient: I made Cookie Monster, Mickey Mouse. [daughter] was a strawberry. Provider: [Laughter] That’s wonderful... My mother made me a strawberry.
2	remember, got, sounds, brother, boy	Shared memory experiences	Patient 1228–141: We moved there and got a trailer and he got a started his own business so working on trailers and stuff like that. I went to work for a department store, [store]. Kinda like a Kmart. Provider 6: I remember [that store]. Provider 6: Have you sung all your life? Patient 1228–139: Yes, mm-hmm. I’m not a soloist, but I love to sing. I can read music. I’m an alto now because I can read music. Provider: Oh, that’s right.
3	school, high, public, went, early	Shared school experiences	Patient: And I play the piano. Provider: Yes. I remember that grade school thing. If you could read music, you became an alto. Provider 1: Super. Let’s start with the easy question. Where were you born?
4	town, city, state, bit, used	Shared geographical experiences	Patient 1231–131: Israel... In a town named [town]. Provider: I know [town], beautiful town... It reminds me of Florida.
6	know, right, yes, good, think	Shared values and beliefs	Patient 1229–71: [A friend] gave me a beautiful prayer to say when the chemo comes, and she said, “Don’t treat the chemo as poison. This is God medicine.” I’ve always seen chemo as poison. I think most people do....The way I feel is that if I have to go through this, I’d rather go through it that way. Provider 5: I have a very dear friend who also is a very spiritual person, but he always would hold chemo as waters of life when he had that... Any time he would go for an infusion, he would see that as the waters of life that are healing him. I think that’s a brilliant shift from what we usually would think.

Note. Topic 5 is not presented since it pertained to differences in speech rather than content.

Table 3
Multilevel models for provider and patient variables predicting empathic self-disclosure.

Parameters	Step 1: Random Intercept Only			Step 2: Provider Variables			Step 3: Patient and Provider Variables		
	B (SE)	Δ Pseudo R^2	p	B (SE)	Δ Pseudo R^2	p	B (95% CI)	Δ Pseudo R^2	p
Intercept	0.03 (0.01)	–	0.005	0.02 (0.01)	–	0.12	–0.09 (0.03)	–	0.01
Provider gender (Women)	–	–	–	0.03 (0.01)	–0.09	0.12	–0.02 (0.01)	–0.10	0.13
Provider occupation (Chaplain)	–	–	–	–0.03 (0.01)	–0.11	0.08	0.03 (0.01)	–0.08	0.13
Patient gender (Women)	–	–	–	–	–	–	0.02 (0.01)	0	0.025
Patient age	–	–	–	–	–	–	0.002 (0.001)	–0.06	0.001
Session modality (Virtual)	–	–	–	–	–	–	0.01 (0.01)	0	0.36

Note. Reference group reported in parentheses. SE = standard error. Change in Pseudo R^2 indexes change in variance explained by the fixed effects in the full model compared to the model without that fixed effect.

Therapy session caseload.

Because there were no content differences in ESD by patient or provider variables, it may be that providers use ESD in multiple ways as a means to connect with patients who are especially different from themselves and to expand on similarities they share with patients. For example, the topics that emerged in the topic model encompassed common themes that most people have experienced throughout their lives (e.g., family, memories, school). Notably, the memory experiences topic of ESD stood out as a representation of mutual nostalgia and connection. Providers may have used these kinds of nostalgic disclosures for several reasons, including indicating generational similarities and connecting when an age gap may have been present. The structure of the Dignity Therapy interview may have also impacted the topics that providers were able to disclose about. Because Dignity Therapy is a semi-structured interview, with questions all participants are asked, patients may disclose about common life events that are experienced by many. This may result in less individual differences in provider ESD content than a clinical or therapeutic context where there is more variability in topics discussed.

Because patient age and gender were weakly associated with ESD frequency, it suggests that ESD may be driven, in part, by patient characteristics. Previous studies have found gender and age differences in how men and older adults narrate their life events [28]. It may be that these differences are present during Dignity Therapy, and accordingly, Dignity Therapy providers vary in ESD frequency across interviews as a way to adapt to patients, rather than implement a set communication style. Accordingly, this suggests that Dignity Therapy providers could be broadly trained to recognize instances in Dignity Therapy settings where they can use ESD. Although there was interindividual variation in ESD frequency across Dignity Therapy providers, including three Dignity Therapy providers who did not engage in any ESD, this variation did not result in significant associations with provider gender, occupation, or interview modality in this small sample.

Ultimately, Dignity Therapy providers changed their behavior based on with whom they were talking, which is in line with the general healthcare literature. Physicians adjust their communication style, according to how effectively their patients communicate [29]. This is in line with communication accommodation theory, which posits that individuals alter their communication behaviors to be more similar to someone they want to be liked by through a process called convergence [30,31]. Future research should examine providers' motivations for engaging in ESD to determine if or to what degree Dignity Therapy providers are trying to be liked by patients, support patients in talking about difficult topics, and encourage patients to share more information.

While the present study yielded a number of novel findings, there were a few notable limitations. The present sample size of 14 Dignity Therapy providers, 10 of which were women, limits the generalizability of our findings. Further, it is possible provider gender may play a more direct role in ESD occurrences than we have the power to report in the present study. Additionally, there were more virtual sessions than in-person sessions, which may have affected comparisons due to uneven cell sizes. Finally, it is important to remember that the context of our

study of ESD was specific to cancer patients receiving palliative care. Further research should examine if ESD presents differently in other types of health care settings.

4.2. Innovation

In this paper we have built on previous literature about both self-disclosure and empathy in clinical settings to introduce and study a new concept: empathic self-disclosure. Our definition of empathic self-disclosure as a type of self-disclosure used to connect with patients' narratives is innovative in that it focuses on the patient-centered potential of self-disclosure in a clinical setting. It further defines ESD as a specific type of response to patient-created empathic opportunities [9].

This study is also innovative because it is only the second published study to examine in detail the specific communication that happens during Dignity Therapy interviews [21]. Due to the demonstrated impact of Dignity Therapy on patient dignity, purpose, and meaning [4] outcomes, it is critical to better understand these communication mechanisms.

4.3. Conclusion

We highlighted the new, innovative communication process of ESD and found that it was present in a third of Dignity Therapy interviews. ESD seems to be dependent on the context of the patient rather than an individual difference in communication style. Accordingly, providers may need to be trained to better recognize when such patient contexts arise. Providers may use ESD to connect with patients in multiple instances, including those in which they are similar and different.

Funding Acknowledgment

Research reported in this publication was supported by the National Cancer Institute of the National Institutes of Health under Award Numbers R01CA200867 and R01CA253330. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The final peer-reviewed manuscript is subject to the National Institutes of Health Public Access Policy.

CRedit authorship contribution statement

Alyssa Crowe: Writing – review & editing, Writing – original draft, Formal analysis, Conceptualization. **Mary Kate Koch:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Susan Bluck:** Writing – review & editing, Funding acquisition, Conceptualization. **Tithi Amin:** Writing – review & editing, Project administration, Investigation. **Lyndsey Thomas:** Writing – review & editing, Project administration, Investigation. **George Fitchett:** Writing – review & editing, Funding acquisition, Conceptualization. **Diana J. Wilkie:** Writing – review & editing, Funding acquisition. **Carma L. Bylund:** Writing – review & editing,

Writing – original draft, Supervision, Methodology, Investigation, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

- [1] Chochinov HM. Dignity-conserving care—a new model for palliative care: helping the patient feel valued. *JAMA* 2002;287(17):2253–60. <https://doi.org/10.1001/jama.287.17.2253>.
- [2] Chochinov HM, et al. Dignity in the terminally ill: a developing empirical model. *Soc Sci Med* 2002;54(3):433–43. [https://doi.org/10.1016/S0277-9536\(01\)00084-3](https://doi.org/10.1016/S0277-9536(01)00084-3).
- [3] Chochinov HM. *Dignity therapy: Final words for final days*. Oxford University Press; 2012.
- [4] Chochinov HM, et al. Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *J Clin Oncol* 2005;23(24):5520–5. <https://doi.org/10.1200/JCO.2005.08.391>.
- [5] Chochinov HM, et al. Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: a randomised controlled trial. *Lancet Oncol* 2011;12(8):753–62. [https://doi.org/10.1016/S1470-2045\(11\)70153-X](https://doi.org/10.1016/S1470-2045(11)70153-X).
- [6] Trzeciak S, Mazzei A. *Compassionomics: The Revolutionary Scientific Evidence that Caring Makes a Difference*. Studer Group; 2019. p. 375.
- [7] Neumann M, et al. Analyzing the “nature” and “specific effectiveness” of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda. *Patient Educ Couns* 2009;74(3):339–46. <https://doi.org/10.1016/j.pec.2008.11.013>.
- [8] Suchman AL, et al. A model of empathic communication in the medical interview. *JAMA* 1997;277(8):678–82. <https://doi.org/10.1001/jama.1997.03540320082047>.
- [9] Bylund CL, G.. Makoul examining empathy in medical encounters: an observational study using the empathic communication coding system. *Health Commun* 2005;18(2):123–40. https://doi.org/10.1207/s15327027hc1802_2.
- [10] Bluck S, et al. Eliciting empathy for adults in chronic pain through autobiographical memory sharing. *Appl Cogn Psychol* 2013;27:81–90. <https://doi.org/10.1002/acp.2875>.
- [11] Bylund CL, G.. Makoul empathic communication and gender in the physician–patient encounter. *Patient Educ Couns* 2002;48(3):207–16. [https://doi.org/10.1016/S0738-3991\(02\)00173-8](https://doi.org/10.1016/S0738-3991(02)00173-8).
- [12] Zink KL, et al. “Let me tell you about my...” provider self-disclosure in the emergency department builds patient rapport. *West J Emerg Med* 2017;18(1):43–9. <https://doi.org/10.5811/westjem.2016.10.31014>.
- [13] Nazione S, Perrault EK, Keating DM. Finding common ground: can provider–patient race concordance and self-disclosure bolster patient trust, perceptions, and intentions? *J Racial Ethn Health Disparities* 2019;6:962–72. <https://doi.org/10.1007/s40615-019-00597-6>.
- [14] Kadji K, M.S.. Mast the effect of physician self-disclosure on patient self-disclosure and patient perceptions of the physician. *Patient Educ Couns* 2021;104(4):2224–31. <https://doi.org/10.1016/j.pec.2021.02.030>.
- [15] Hill CE, Knox S, K.G.. Pinto-Coelho therapist self-disclosure and immediacy: a qualitative meta-analysis. *Psychotherapy* 2018;55(4). <https://doi.org/10.1037/pst0000182>.
- [16] Mann B. Doctor self-disclosure in the consultation. *J Prim Health Care* 2018;10(2). <https://doi.org/10.1071/HC17010>.
- [17] Barnett JE. Psychotherapist self-disclosure: ethical and clinical considerations. *Psychotherapy* 2011;48(4):315–21. <https://doi.org/10.1037/a0026056>.
- [18] McDaniel SH, et al. Empathy and boundary turbulence in cancer communication. *Patient Educ Couns* 2021;104(12):2944–51. <https://doi.org/10.1016/j.pec.2021.04.002>.
- [19] Kittelson S, et al. Dignity therapy led by nurses or chaplains for elderly cancer palliative care outpatients: protocol for a randomized controlled trial. *JMIR Res Protocols* 2019;8(4). <https://doi.org/10.2196/12213>.
- [20] Schoppee TM, et al. Description of a training protocol to improve research reproducibility for dignity therapy, an interview-based intervention. *Palliat Support Care* 2022;20(2):178–88. <https://doi.org/10.1017/S1478951521000614>.
- [21] Bylund CL, et al. Empathic communication in dignity therapy: feasibility of measurement and descriptive findings. *Palliat Support Care* 2022;20(3):321–7. <https://doi.org/10.1017/S1478951521001188>.
- [22] Cao J, et al. A density-based method for adaptive LDA model selection. *Neurocomputing* 2009;72:1755–81. <https://doi.org/10.1016/j.neucom.2008.06.011>.
- [23] Blei DM, Ng AY, M.L.. Jordan latent Dirichlet allocation. *J Mach Learn Res* 2003;3:993–1022.
- [24] Wilkie DJ, et al. Engaging mortality: effective implementation of dignity therapy. *J Palliat Med* 2024;27(2). <https://doi.org/10.1089/jpm.2023.0336>.
- [25] Henry BW, et al. Clinician behaviors in telehealth care delivery: a systematic review. *Adv Health Sci Educ* 2017;22:869–88. <https://doi.org/10.1007/s10459-016-9717-2>.
- [26] Arroll B, E.-C.F.. Allen to self-disclose or not self-disclose? A systematic review of clinical self-disclosure in primary care. *Br J Gen Pract* 2015;65(638). <https://doi.org/10.3399/bjgp15X686533>.
- [27] Mroz E, et al. Empathic communication in specialty palliative care encounters: an analysis of opportunities and responses. *J Palliat Med* 2022;21(11):1622–8. <https://doi.org/10.1089/jpm.2021.0664>.
- [28] McLean KC. Stories of the young and the old: personal continuity and narrative identity. *Dev Psychol* 2008;44(1):254–64. <https://doi.org/10.1037/0012-1649.44.1.254>.
- [29] Cegala DJ, Jr RLS, C.R.. Clinch the impact of patient participation on physicians' information provision during a primary care medical interview. *Health Commun* 2007;21(2):177–85. <https://doi.org/10.1080/10410230701307824>.
- [30] Gallois C, Ogay T, Giles H. *Communication accommodation theory: a look back and a look ahead*. In: Gudykunst WB, editor. *Theorizing About Intercultural Communication*. Fullerton, USA: Thousand Oaks: Sage: California State University; 2005. p. 121–48.
- [31] Giles H, Ogay T. *Communication Accommodation Theory*. In: Whaley BB, Samter W, editors. *Explaining Communication: Contemporary theories and exemplars*. Mahwah, NJ: Lawrence Erlbaum; 2007. p. 293–310.