Psychiatria Danubina, 2022; Vol. 34, Suppl. 8, pp 71-74 *Conference paper*
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DIGNITY-THERAPY IN BIPOLAR DISORDER AND MAJOR DEPRESSION: AN OBSERVATIONAL STUDY IN A PSYCHIATRIC REHABILITATION CENTER

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SUMMARY

Dignity Therapy (DT) is a multi-dimensional, brief and individual psychotherapeutic intervention, designed to increase the sense of dignity in patients. The aim of our study was to evaluate the effectiveness of Dignity Therapy in a group of patients suffering from major depressive disorder or bipolar disorder. The results of the study in a small group of patients showed the effectiveness of DT. The PDI (Patient Dignity Inventory Scores) showed a statistically significant difference in the whole group of patients with a reduction in the mean overall score (T0 vs T1 = Mean Difference: 13.700, T-Score: 4.834, Eta squared: 0.709, p: 0.001, statistically significant). However, there is a need to deepen the study to try to offer an opportunity for treatment in this group of patients.

Key words: *Dignity Therapy - major depressive disorder - bipolar disorder – PDI - palliative medicine*

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INTRODUCTION

Attention to individual's psychological and spiritual aspects during severe physical or mental illness is an essential component of patient-centered care (Banerjee et al. 2021, Fitchett et al. 2015). A guideline from 2018 National Consensus Project for Quality Palliative care (2018) recommends an interdisciplinary approach that ideally includes spiritual care professionals to assess and address spiritual, religious, and existential dimensions of care (Lolak et al. 2016). These guidelines underline that an interdisciplinary approach maximizing functional status and enhancing quality of life is developed in the context of the patient's goals of care, disease, prognosis, functional limitations, culture, and care setting. The growing debate on the dignity of care while respecting the dignity of the patient has led to an increase in the need for correct clinical practice. In this context, there is a need for a practice that combines not only the scientific knowledge necessary to put them into practice, but also the relationship of mutual collaboration between user and healthcare worker. In relation to the ethical, moral, and spiritual question, everyone is obliged to address the issue of the patient's dignity. Dignity finds descriptive, ethical, moral, religious and political boundaries and limits. The problem of dignity in psychiatry is subjected to an exponential increase as new nosological, diagnostic, therapeutic and social difficulties have to be added. The doctor-patient relationship and, above all, the problem of stigma are intertwined with these. Michael Rosen affirms that " *to be respected the patient must be treated with dignity* ", he/she must be made the protagonist, in the context of a ritual and a normative and social ethics" (Rosen 2012).

Dignity Therapy (DT) is a multi-dimensional, brief and individual psychotherapeutic intervention, designed to increase the sense of dignity *at end of life*. It helps manage the psychosocial and existential stress of dying patients or patients who are in life threatening conditions (Chochinov et al. 2002, 2007). The scientific literaure has defined the importance of DT in these terminally ill patients, as well as in cancer patients (Nunziante et al. 2021, Houmann et al. 2014, Chochinov et al. 2011, 2005). Conceived for the use in end-of-life patients, it has seen its application in other pathologies (e.g., Lateral Amyotrophic Sclerosis; Chronic Obstructive Pulmonary Disease (COPD), severe renal insufficiency and institutionalized frail elderly patients (Chochinov et al. 2016, Johnston et al. 2017). In addition, new clinical evidence is emerging on its possible use of DT in psychiatric patients (Grassi et al. 2022, Solomita et al. 2017, Avery & Savitz 2011). The aim of our study was to evaluate the effects in terms of efficacy of DT in a group of patients in a psychiatric rehabilitation center.

METHODS

Ten patients [total 10 (mean age: 53.88 years, ±SD 16.66 yrs), 4 men (mean age: 62.67 years, ±SD 4,04 yrs), 6 females (mean age: 48.60 years ± SD 18.42yrs)] with psychiatric disorders, in the Psychiatric Rehabilitation Center "Villa dei Pini", of Avellino, Italy were recruited for our observation study. All patients had mood disorders (bipolar disorder or major depressive disorder) and met the DSM-5 diagnostic criteria for bipolar disorder and MDD. Inclusion criteria were ≥ three years of disease and a stabilization phase during the DT administration period. Patients with a CGI-S score less than 3, with adequate cognitive abilities (evaluated with Epitrack), were included in the study. Patients in the phase of exacerbation of the pathological episode were excluded.

Before administering the DT (T0), all patients were given the following rating scales:

- CGI (Guy 1976), BPRS (Overall & Gorham 1962), and PDI.
- PDI (Chochinov et al. 2007): is a tool designed to measure various sources of distress related to dignity in patients near the end of life.
- Epitrack to measure the cognitive skills needed for DT.

Before starting the study, pilot sessions were conducted to ensure the validity of the administration of the Dignity Therapy.

DT consists of a structured interview recorded, transcribed, printed, and returned to the patient who will give it to a family member or friend. Recording interview will give the patient the opportunity to freely express their thoughts, knowing that there will be subsequent steps to correct, develop and aesthetically improve the document to be printed, with accurate content and without causing harm to anyone. The patient double-checks the document and so he can give it to his loved ones. CGI, BPRS, and PDI were re-administered within 15 days (T1) of DT administration.

The rating scales are administered by qualified staff. The results of the scales are collected in an Excel sheet for later evaluation.

All the relevant data were analysed using EZAnalyze Version 3.0, Microsoft Excel Add-ln (Suffolk University in Boston, Massachusetts, USA). The Dependent Samples t-Test used for analyzing BHS scores. Test: $p<0.05$ was taken as statistically significant.

RESULTS

The results of our study showed in table 1. The data obtained from the PDI scores showed a statistically significant difference in the whole group of patients with a reduction in the mean overall score (T0 vs T1 = Mean Difference: 13.700, T-Score: 4.834, Eta squared: 0.709; p: 0.001, statistically significant). Similar results, statistically significant, were found with the other evaluation scales. GAF Data Score indicate Statistically significant difference found in GAF data score (T0 vs T1 = Mean Difference: -2.700, T-Score: 2.560, p:0.031) and BPRS ((T0 vs T1 = Mean Difference: 6.700, T-Score: 2.356; p:0.043). Finally, in one sample T-Test Epitrack scores, the difference between the observed mean and the NTV (=25) is significant (T0 = Mean 29.300 Std Dev. 3.529, Eta squared: 0.623, p: 0.004)

Highlight meaningful responses to DT

Some answers to the DT's questions, considered most significant for the purpose of the investigation of our study, have been selected and reported below.

DT invites the patient to tell the most important things in his life:

During my hospital stay I feet alive. I have learned to accept myself and stay and dialogue with others.(FA)

I felt alive when I was well, when my children received the first communion and I bought the dress to my daughter. I felt alive when there wasn't the depression. I stopped working when this monster arrived (DAC).

I remember sporadic moments of my life when I was normal because when I was 9 I started hearing voices. Above all I remember bad facts but I don't remember the good ones. I just remember that everyone loved me. I had a future planned, I wanted to be a math teacher before I started hearing voices and I would have succeeded (DVG).

The patient exposes the things he would like his family know about his life:

Nobody understood me, my goals. It's like where you prepare a banquet but you can't have dinner or the end a party. (MF)

I'm able to be independent and to go to work. I'm able to make wright decisions and I'm not afraid I will hurt myself (MLM)

My family wants me to be well but unfortunately it is not (ADA).

I'd like to tell my family that I'm paying for my mistakes for many years. I don't ask for forgiveness but I'd like a little pity because it is not all my fault (DVG).

Table 1. DATA mean total scores of PDI, GAF, BPRS scales (T0 vs T1)

		T0	T1	Mean difference	SE of diff.	Eta squared	T-score	P	Statatist. significant
PDI	Mean	66.90	53.20	13.70	2.83	0.71	0.84	0.001	+
	±*SD*	*22.56*	*23.79*						
GAF	Mean	58.30	61.00	-2.70	1.05	0.39	0.56	0.031	+
	±*SD*	*7.91*	*6.86*						
BPRS	Mean	47.90	41.20	6.70	2.84	0.36	0.36	0.043	+
	±*SD*	*7.781*	*9.355*						
		T0	NTV						
Epitrack	Mean	29.300	25.00	4.30		0.62	0.85	0.004	+
	±*SD*	*3.529*							

The position and importance of the roles of his family members in his life are described:

... I have so many thoughts and emotions to give to people of different age, type, and gender. In my opinion the word "sentence" means "to be righteous" , being righteous in in oneself, a person who goes beyond darkness. (MM)

Every life has a a beginning and an end. I changed, I have paid, and I paid I'm paying the consequences of my disease. Addiction is very difficult thing to break free. It is like a vortex that drags you down and prevents you from living. I ask you to forgive me. This the truth. I love you (AR).

In the narration of his life the patient dwells on what he would like to say to his family.

When my children went to school I was depressed and I always set down and they had to cook. Depression ruined my life (DAC)

I apologize to my family members if I did bad things during disease, if I was aggressive. I couldn't stand anyone and I felt the best of all. (CA)

Having a disease is not easy, but being aware of having it is already a step towards being able to overcome it. (MM)

The patient is asked to convey advice to their family members:

Perhaps life has taught me to relate to strangers, too, and I have understood that it is important willpower in what me decide to do, above all by emphasizing the path of psychiatric growth. /DT)

Life has taught me that it is very hard because there are many problems and to move on you to be very courageous (ADA).

Anyway in life you fall and get up (DVG).

Then, the patient continue describing and passing on advice and instruction to family members to prepare them for the future:

I'd like to tell my mother that apart from the suffering of these recent years, she left me a very large life experience and I thank her if I am the man I are now. (DT)

I'm not as happy as when I could use my legs.

I'd like to tell my daughter, Alessia to be close to me because together we run achieve more goals and fewer disappointments. (MM)

When there is a difficulty, we have to ask for help immediately to a doctor, a priest, a psychiatrist or to a psychotherapeutics, otherwise we put our faults on others (CA).

Finally, the patient is asked to finish with the description of the final advice and events or things that he wishes his family members to know about his life:

... I have so many thoughts and emotions to give to people of different age, type, and gender. In my opinion the word "sentence" means "to be righteous" , being righteous in in oneself, a person who goes beyond darkness. (DT)

I have never thought to be in such a situation. It wasn't my fault. My disease prevents me from doing many things, all the things I did before. My greatest regret was not being able to look after my mother when she was ill because I was already hospitalized. A kiss to everyone. (M))

Many years thinking that something could change but in reality you swim upstream.

The world needs selfless people. People are like a piano. You don't have to play some piano keys. We need to set a good example. (MF)

It isn't easy to have a disease but the awareness of having is already a step forward in order to overcome it. (FA)

My love is the same for all my children. I wasn't present mother because of my disease and I couldn't play with them (DAC).

CONCLUSION

Dignity Therapy has the potential to improve patients' personal stories. The future research to tailor dignity therapy to people with mental illness can boost patients' self-esteem and coping skills.

Our study analyzed DT interviews and its effects in a group of patients with bipolar disorder and major depressive disorder. The clinical efficacy was supported by the evaluation of the data of PDI. Dignity Therapy (DT) can represent an ethical will, a life review, a personal narration. DT can promote spiritual and psychological well-being, give meaning and hope, it can improve personal experience at the end of one's life. Thus, among palliative care, Dignity Therapy can help patients have a purpose and desire to live and reduce their suffering and depression.

Acknowledgements: None.

Conflict of interest: None to declare.

Contribution of individual authors:

Barbara Solomita: contribution to writing and to bibliographic research.

Francesco Franza: revision of the manuscript.

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