

THE ROLE OF DIGNITY THERAPY IN ELDERLY PATIENTS: A COMPREHENSIVE SYSTEMATIC REVIEW

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ARTICLE HISTORY

Received: 7 December 2022

Accepted: 27 January 2023

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ABSTRACT

Introduction: Dignity therapy is a brief psychotherapy that can reduce dignity-related distress and improve the quality of life for cancer patients. However, the experience of older patients is comparable to that of those with advanced cancer, little emphasis has been devoted. **Aim:** To evaluate and summarize the effectiveness of dignity therapy in managing elderly non-cancerous patients

Method: A mixed methods systematic review was conducted and assess their quality using the Joanna Briggs Institute's evaluation tools. 8 databases of literature including Cochrane Library, PubMed, SCOPUS, Web of Science, EMBASE, CINAHL(EBSCO), PsycINFO(OVID), and CBM were searched with search terms of "Dignity therapy" and "elderly".

Results: 12 studies—3 RCTs, 5 qualitative studies, 2 mixed-methods studies, and 2 cross-sectional studies—out of 1615 studies were screened. Quantitative and qualitative results were separated into groups with quantitative groups containing the dignity-related distress, depression, and quality of life, and qualitative groups including remembrance of the past, meaning of life, pain of illness, and wishes for family members.

Conclusion: Evidence suggests that dignity therapy is beneficial and can be applied to non-cancer patients. The patient's baseline level of distress may affect outcomes, making it more difficult to intervene with patients if they are too distressed, but the effect may be less pronounced if the patient's distress level is low.

Keywords: *Dignity therapy; elderly; psychotherapy; terminal*

Cite as:

Mengyao, Z, Lamei, L., Tongyao, X., Yumeng, Q., Mengjie, S., Jianan, W., Rosa, R. D., Peng, W. (2023). *The role of dignity therapy in elderly patients: a comprehensive systematic review. Indonesian Journal of Community Health Nurs.*, 8(1), 1-12. [Doi: 10.20473/ijchn.v8i1.41306](https://doi.org/10.20473/ijchn.v8i1.41306)

INTRODUCTION

In China, there will be 500 million people over the age of 60 by the year 2050^[1], up from the current estimate of 264 million^[2]. Additionally, as senior people's physical and psychological abilities continue to diminish, so does their risk of contracting numerous diseases^[3, 4]. Some elderly individuals have chronic illnesses^[5], and others are too frail^[6]. Some studies have shown that the prevalence of chronic diseases among the elderly in China is as high as 80%^[7]. In order to prevent and better manage chronic diseases, the healthy China 2030 plan^[8] has

incorporated the goal of reducing premature mortality of four major chronic diseases emphasized in the United Nations 2030 agenda for sustainable development^[9] into the main indicators of building a healthy China.

Additionally, chronic illnesses affecting the elderly have emerged as the biggest threat to human health. However, people with chronic conditions are living longer because of ongoing advancements in medical treatment but when chronic illnesses worsen, older people's situations deteriorate. People with chronic diseases coexist with diseases, which

poses a significant impact on their psychology, daily life, and family^[10-12]. Chronic diseases may cause psychological damage, such as decreased self-confidence^[13], leading to loss of activity or lifestyle change. Some severe symptoms might interfere with a person's ability to manage their work, family, and social obligations, create social isolation and despair, and lower their quality of life^[14, 15]. Some scholars have proved that patients with chronic diseases are more prone to experience depression^[16, 17] with a high proportion of suicide and losing their dignity. When they are too frail to live alone, they may feel worthless as an older person and, more crucially, as a family member. Their mentality is not as strong as that of average people since they have endured the destruction of chronic illnesses for a very long period. The necessity for psychological assistance in older patients with terminal illnesses is currently supported by a significant body of literature^[18, 19], which is too significant to influence the patients. Additionally, it demonstrates the necessity for dignity-centered nursing in patients who have lost physical function, diminished psychological capacity, decreased autonomy and role, and unknown prognoses.

Most elderly patients like to pass away in a manly manner as they reach the end of their lives. And as we all know, dying senior patients who are too frail often find it difficult to communicate their true feelings to their loved ones. However, we must honor the patients' preferences. Pursuing a decent death is a cultural practice in China. Elderly people may have discomfort throughout the course of the disease as a result of the symptoms' progressive intensity and physical weakening. Patients lose their independence and feel helpless and worthless if they require assistance in their everyday life. But, there is a saying that an old man is a treasure, they have too much experience in life, and they can recall events and emotions in their life, they can affirm themselves, find the meaning of life, reconcile with themselves, have no regrets and accept death.

Dignity Therapy (DT) was developed by Professor Chochinov^[20] and his team in Canada based on a series of studies on chronic terminal illnesses^[21] using the Dignity Model as a theoretical basis. Initially applied to patients with advanced cancer^[22], dignity therapy was conducted by trained medical professionals who conducted and recorded interviews based on nine questions in three dimensions: disease-related, dignity-protective and social dignity dimensions, patients were given the

questions in advance to familiarize themselves with the possibilities DT provides in terms of broaching areas they might wish to discuss. Additionally, DT provided patients a chance to discuss significant life events and express their feelings, which are eventually converted into text files and shared by patients with their consent. DT aimed to strengthen patients' sense of self meaning and life value, reduce negative emotions and illness-related psychological distress, and helped them achieve a sense of inner peace and dignity, which was conducive to improving their quality of life. However, DT is not widely used in clinical practice in China^[23], and scholars have only applied dignity therapy to cancer patients^[24], without considering the applicability of DT to other disease populations.

Although dignity treatment was initially designed for cancer patients, several researchers believed that it may also be used for other chronic diseases that affect elderly and frail individuals^[25-27]. Such people also have a sense of dignity, and they are committed to living according to their values even in the face of adversity.

Considering that everyone grows old and that some people may suffer from COPD or dementia or neuronal disease in their aging condition, there will be some people who spend the rest of their lives in nursing homes that they are troubled by dignity, psychological and other conditions, the objective of this study was to analyze evidence on the effects of Dignity Therapy on elderly ill patients. To achieve this, the following study question was developed: What are the spiritual benefits of dignity treatment for elderly patients, and is it effective for them?

METHOD

Design

A mixed methods systematic review integrating quantitative and qualitative evidence was conducted in accordance with Joanna Briggs Institute (JBI) methodology^[28]. The quantitative and qualitative results were integrated after using a convergent segregation technique to synthesize the quantitative studies and the quantitative part of the mixed studies as well as the qualitative studies and the qualitative part of the mixed methods studies. This review was registered on the international prospective register of systematic reviews (PROSPERO) (CRD 42022331868).

Literature Search

Eight electronic databases (Cochrane Library, PubMed, SCOPUS, Web of Science, EMBASE, CINAHL(EBSCO), PSYCLINFO(OVID), and CBM) were systematically searched from 2002 when the dignity therapy was developed by Chochinov through 2022. In addition, by snowballing, we selected some literature that met our inclusion criteria when we paid attention to the appropriate references. The Medical Subject Headings (MeSH) search terms and strategies were as follows: ("dignity therapy" OR "dignity care" OR "dignity psychotherapy") AND ("aged" OR "frail elderly" OR "Aging" OR "geriatric" OR "old age" OR "senescence" OR "older adults" OR "older people") AND ("Terminal Care" OR "Palliative Care" OR "Hospice Care" OR "Hospice and Palliative Care Nursing" OR "Advance Care Planning").

Inclusion and exclusion criteria

In this study, we selected randomized controlled trials (RCT), cross-sectional studies, mixed methods studies, and qualitative studies that evaluated dignity therapy as a treatment modality for non-cancer patients. The inclusion criteria were as follows: (a) the studies evaluated the elderly patients; (b) the experimental group "accepted dignity therapy and" the control group "accepted standard care (standard palliative care, standard psychological care, or routine care); (c) the quantitative studies assessed measurable dignity, anxiety, depression, or quality of life outcomes and the qualitative studies described the effectiveness, feasibility or satisfaction. And the exclusion criteria were as applied: (a) duplicate reports of a study; (b) the participants of the study were cancer patients; (c) studies with insufficient data without the author's response; (d) academic dissertations.

Study selection and data extraction

Study screening and data extraction were performed independently by two reviewers (Author 1 and Author 3). When the opinions of the two reviewers were divided, a third reviewer (Author 2) was consulted to settle disagreements. The publications were screened using the EndNote X20 software according to the titles and abstracts of the included studies before the duplicates were rejected by the two reviewers. Studies were not subjected to additional assessment if they were rejected by both reviewers. The full article was received for review if at least one reviewer referenced the source or if there was insufficient data to draw a conclusion from the

title and abstract. The two reviewers looked over each article's whole content to determine its appropriateness for inclusion.

We used a table that was pre-designed to extract the data, including general information about the year of publication and the first author name, as well as, the details of the study, including the duration and treatment techniques, the sample size, the participants, and why, what, how, when of the study, in addition to outcome data for dignity, anxiety, depression or quality of life as for the quantitative studies.

Risk of bias assessment

Study quality was assessed independently by two bilingual reviewers (Author 1 and Author 3) through the Joanna Briggs Institute (JBI) critical appraisal checklists for RCTs and cross-sectional studies (no control group) and qualitative research from the 2020 edition of the JBI Review Manual^[29]. The JBI critical appraisal checklist is designed to assess the risk of bias rather than serve as a grading system for the study, the checklist consists of items to assess selection, performance, detection, and attrition bias, as well as trial designs. Items in the three checklists have four possible responses, as follows: "yes", "no", "unclear", and "inapplicable". Any disagreement about appraisal was resolved through discussion among the two reviewers (Author 1 and Author 3) and if necessary, through discussions with the authors.

Data synthesis and analysis

We employed the convergent segregated strategy to synthesize the data in accordance with the JBI^[28] standards because this was a mixed methods systematic review that included qualitative, quantitative, and mixed method studies. Firstly, we synthesized the data from the quantitative studies and the quantitative component of mixed method studies, and then the data of the qualitative studies and the qualitative component of mixed method studies were synthesized. Finally, we combined the quantitative results with qualitative results for a comprehensive analysis. The quantitative data were analyzed by Review Manager Software (version 5.4). Heterogeneity tests and meta-analysis were carried out first if three or more RCTs reported the same outcome. A fixed effect model was used to pool the data when $I^2 < 50\%$; however, when $I^2 > 50\%$, a random effects model was employed if the studies were considered clinically similar. A two-sided

$P < 0.05$ was considered to indicate a significant difference in the overall effects. And we analyzed the qualitative component of these qualitative and mixed studies to derive themes.

RESULTS

Study selection

A flow diagram of the literature selection process is displayed in **Figure 1**. The search identified 1615 articles (1559 articles in English and only 56 in Chinese), and one additional citation through references in published articles. Following the elimination of duplicates and a study of the titles and abstracts of these articles, 50 possibly pertinent publications were selected for in-depth analysis. And full-text screening excluded 36 articles that did not meet the selection criteria. Finally, a total of 15 articles^[25, 26, 30-42] were included and accepted the methodological quality appraisal, of which, 3

articles^[40-42] were incredible. Consequently, 12 articles were selected including 3 RCTs^[30-32], 2 cross-sectional studies^[26, 33], 2 mixed methods studies^[25, 34] and 5 qualitative studies^[35-39]. And our quality evaluation of these 12 studies is shown in **Table 1**.

Study characteristics

The general characteristics of the included trials are shown in **Table 2**. Our investigation comprised a total of 12 studies that evaluated 421 patients^[25, 26, 30-39]. 41.7% of the chosen studies^[27, 33, 38, 40, 41] were conducted in the UK, while the remaining were conducted in Australia (16.7)^[26, 33], China (8.3%)^[30], Switzerland (8.3%)^[32], Italy (8.3%)^[34], Canada (8.3%)^[35], and Poland (8.3%)^[37]. Elderly patients in nursing homes or care facilities made up 33.3% of the studies^[31, 35, 36, 39], 33.3% reported the early stage dementia or mild cognitive impairment^[25, 30, 32, 38], 16.7% reported the Motor Neurone Disease^[26, 33], followed by chronic obstructive pulmonary disease (COPD) (8.3%)^[37] and the elders (8.3%)^[34].

In these studies, a total of 14 different questionnaires were identified as measuring targeted outcome variables. The Patient Dignity Inventory (PDI)^[43] was used to assess patients' dignity, including symptom distress, existential distress, dependency, peace of mind, and social support. The depression and anxiety were measured by the Hospital Anxiety and Depression Scale^[44]. And depression was measured by the 15-item Geriatric Depression Scale^[45]. Additionally, the WHO Quality of Life Questionnaire (WHOQOL-BREF)^[46] was adopted to measure the elders' quality of life.

Effects of dignity therapy (quantitative results)

Software analysis results

Dignity

3 RCTs^[30-32] including 182 participants were employed to assess the changes in dignity after dignity therapy, and the heterogeneity among the studies ($I^2 = 100\%$, $P < 0.000$) was too high, so the random effect model was used to analyze the combined effect (**Figure 2**). And the results showed that compared with the standard care, the dignity therapy significantly increased the dignity score of the patients with elderly patients (MD = -13.32, 95% CI: -37.48, 10.48).

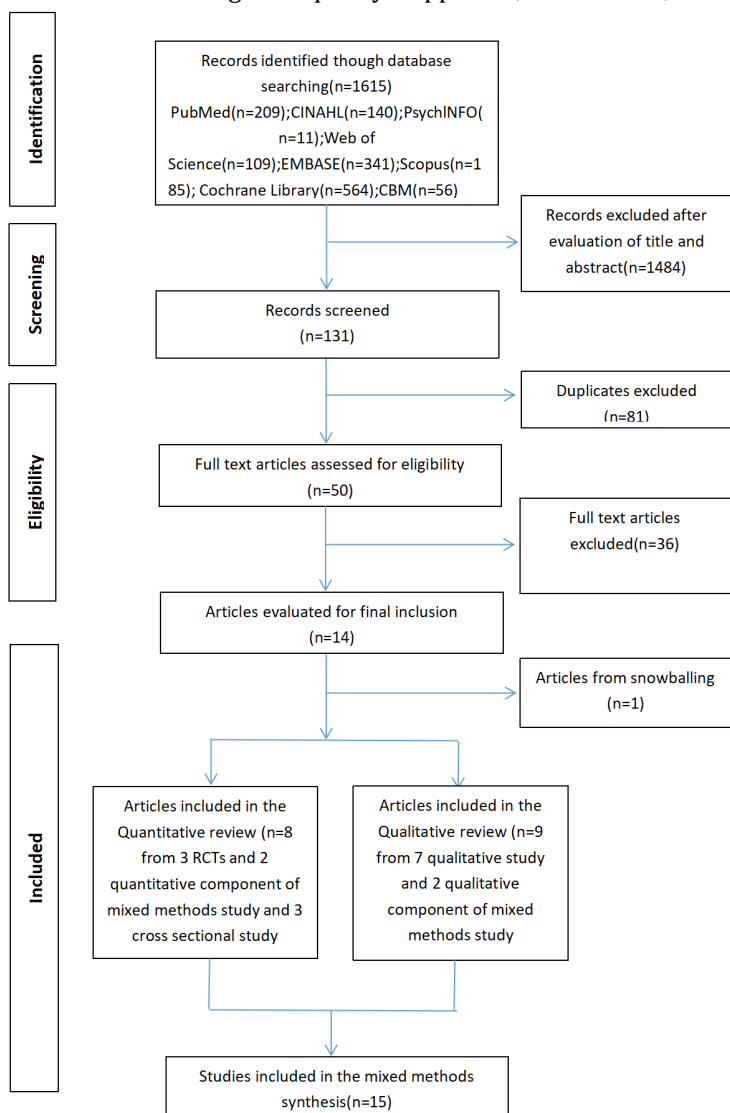


Figure 1. PRISMA flow chart of screening and selection

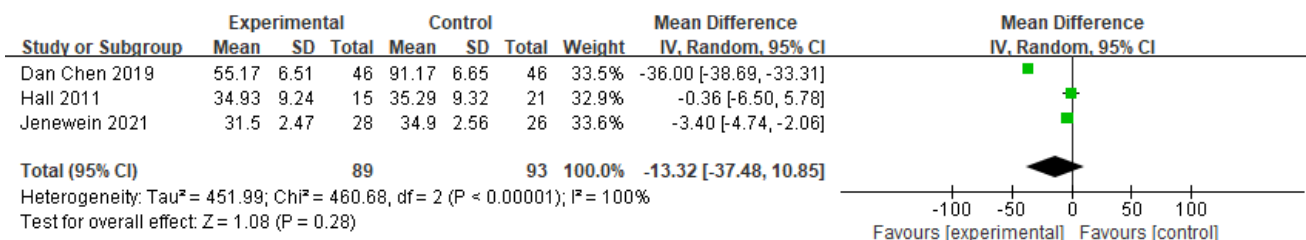


Figure 2

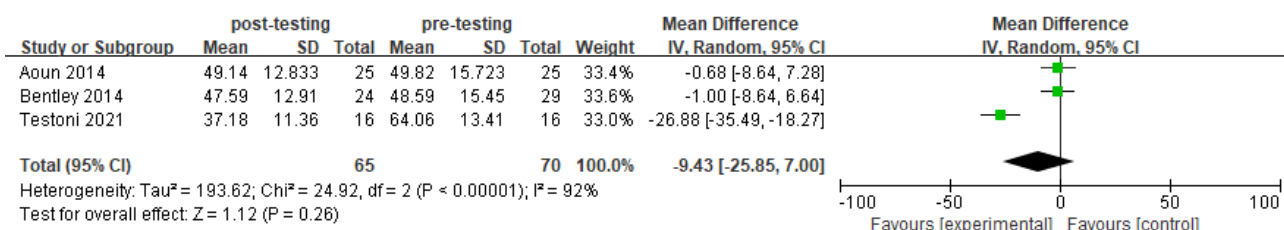


Figure 3

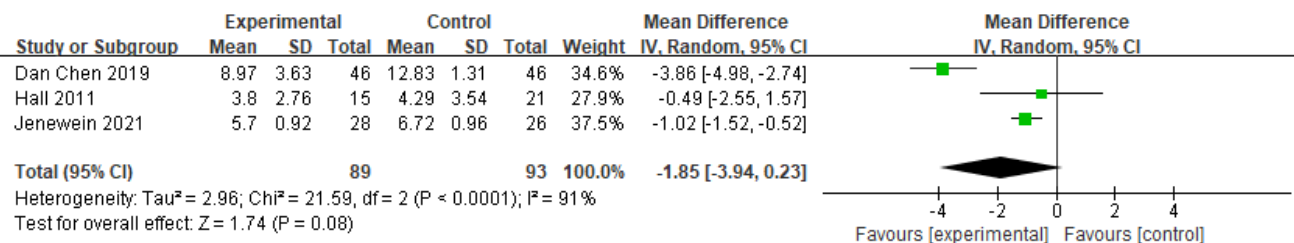


Figure 4

There were 3 articles^[26, 33, 34] using pre-testing and post-testing including 135 patients, showing heterogeneity among the studies (I²=92%, P<0.000), and we selected the random effect model (Figure 3), revealing that the dignity therapy significantly reduced the patients with elderly patients' dignity-related distress scores in comparison to before the intervention (MD=-9.43, 95%CI:-25.85,7.00).

Depression

There were 3 RCTs^[30-32] with 182 participants, and because there was too much heterogeneity across the studies (I²=91%, P < 0.000) was too high, the combined effect was examined using the random effect model (Figure 4). And the findings revealed that dignity treatment considerably reduced the depression score of patients with senior patients when compared to conventional care (MD= -1.85, 95%CI: -3.94,0.23).

Descriptive results

There were five quantitative studies and two mixed methods studies^[25,26, 30-34] including 313 participants, all of which reported the dignity of the

participants using the Patient Dignity Inventory (PDI). The duration of the intervention and follow-up in the three RCTs^[30-32] of these quantitative investigations varied, ranging from one week to two weeks to 15 weeks, and included subjects with moderate cognitive impairment, early-stage dementia, and elderly patients in nursing homes. We were able to identify differences between the intervention and control groups in these RCTs. However, there was no difference or a negligible impact in the intervention group when comparing before and after the intervention. Additionally, the control group's patients receiving conventional treatment also benefited. Despite the low participation rate (8%) and strong acceptance of the dignity therapy, the researchers described how the participants were selected. On the aspects of depression and quality of life, one research found that DT might lessen the depressive symptoms experienced by inpatients, another reported there were small effects on the depression and quality of life after one week following up and the control group was even expressed optimism after 8-week following up, and the third study revealed the depression and QOL had a small improvement. And we found that the patients were willing to accept DT. There were 4 trials^[25,26,33,34] using pre-testing and post-testing

including motor neuron diseases, dementia, and elderly in care homes. These studies indicated the PDI scores were slight decrease showing DT had an improvement in these patients, and one study proved that some people's dignity improved while others did the opposite, suggesting ING that DT made no difference in groups but it was effective at the individual level.

Effects of dignity therapy (qualitative results)

There were 5 qualitative and 2 mixed methods studies^[25, 34-39] including 151 participants suffering from dementia, COPD, and the others were elder patients in nursing homes. Four articles, describing elder adults in nursing homes without specifically indicating what illnesses they suffered from, were grouped. Only one article^[35] in which the participants were divided into patients with cognitive integrity as well as cognitive impairment, while participants in other papers were only those with cognitive integrity. And the patients who had cognitive impairment did not describe the experience of their life, and some were their family caregivers helping them answer the questions. Actually, the disease's effects on people with cognitive impairment were the most severe. And their caregivers always described the personal characteristics of the patients. Despite this, our study of other research revealed that older people's symptoms are similar to those of cancer patients since the elderly are concerned about their independence and health as a result of the deterioration of their somatic functioning. But it was also normal some elders thought their symptoms were caused by their old age rather than the disease. Some participants did not worry about death since they believed that everyone would experience it, while others found it uncomfortable or had symptoms that would not have appeared when they were younger. If the patients in retrospect found that they have done something very meaningful, such as getting something accomplished at work, raising their children and that those children were currently living well in life, helping some others and leaving behind a fortune or passing good character on to their children, they were delighted with their own previous experience.

The others, on the other hand, were more painful since they lacked any positive experience or accomplishments. In nursing homes, there is only 9% elderly died of a definite advanced disease, and others have normal death due to gradual weakening of the body due to old age^[47]. Most of them experienced

many things and lose something but also acquired something, they may be depressed or lost dignity. Additionally, some patients lost their dignity since they were too old to care for themselves and needed assistance with everyday tasks. And during the conversation, we learned that the patients' families found the dignity therapy to be beneficial. Because the generative documents every patient had could increase the family's understanding of the patient. And the patients described how they were unable to speak with their family members in person. Some elderly people had the opinion that "aging is incurable." For the majority of elders, the past was significant, and they used their prior experiences to both educate and enrich their children's lives.

There were 2 papers^[25,38] describing the applicability and perception of dignity therapy for patients with dementia. The loss of dignity may be a little more severe for those who have dementia because the disease has an impact on every aspect of their lives. Some patients were interested in sharing the emotion, reaction, and their values. They all hoped that the family members had a good life. And dignity therapy was helpful for these dementia patients. And for the COPD participants^[37], DT had a positive impact on them. The therapists' conversations made it simpler for them to comprehend their own emotions. Additionally, it could enhance life's purpose and foster closer ties with loved ones. Although the patients had various conditions, dignity treatment had a comparable effect on all. It may be broadly classified into remembering the past, considering the purpose of life, coping with sickness, and making wishes for family members (**Table 3**).

Pain of illness

The diseases or weak conditions will not only cause physical pain but also mental pain. They worried about the damage to the body, someone had difficulty breathing, vomited, ached, or sensory loss. These conditions were bothering them and they lost their independence. As elder patients, they had too much to lose and too much to accept. And they couldn't do anything by themselves, and even changed their previous image because of illness and pain. Family members indicated that her father became less friendly after his illness. Patients with gradually declining memory were lonely and always felt lost.

Remembrance of the past

When it comes to the elderly, they frequently recall their youth and like talking about it. Participants in these events either felt joy or regret. The interviews could awaken the patient's memory which was good or bad. Although somebody felt depressed, they also realized it couldn't be corrected. And the others recalled the interesting activities they enjoyed. Someone enjoyed having the freedom to do anything they pleased, such as playing football or dancing. And some patients dedicated their lives to their kids or work and when they remembered they would be proud of themselves. Even if someone was hurt when they were young, when they accepted the DT interviews, they came to terms with themselves. There was some pity in everyone's life, someone couldn't play football someone didn't have a family someone lost her daughter or others. And it helped the patients reflect over the past. They would get some courage to spend the rest of life.

Meaning of life

The majority of the literature stated that being alive in the world, having useful life, and having excellent relationships with friends and family was what life was all about. The elderly sufferers desired to reside with their spiritually pillar-lovers. They were brave enough to endure their body's deteriorating condition. A positive connection may enable patients to live better and set goals for themselves. Maybe the important person was the nephew, the old friend, or the family members. But if the person died or got hurt, the patients would get lost or be too negative making it meaningless to live. Some participants didn't have a good relationship with others, they had a tense relationship. The patient felt ashamed and downhearted as a result. And a purposeful life was meaningful which brought satisfaction just like doing housework or gardening. Some patients thought they didn't have a choice to select the life they wanted to live due to their diseases or weak bodies. And they didn't like to rely on others in daily life, they even wanted to die quickly, because they thought they had lost the dignity. However, if the patients could stand they stood, if they could get the bed by themselves they did this if they liked drinking they drank and if they could help others they tried their best to help others. That is to say, they were making their lives worthwhile. In the remaining time, they knew what their final destination was. DT could assist them in concentrating on the most significant elements of life and significant people.

Wishes for family members

The seniors' closest friends and family members were most significant to them. And the patients offered them advice based on their own experiences. One patient expressed to their family how essential independence and the ability to do as they pleased were. And some members talked about the patients and their hopes for happiness. The family members received some inspiration from the elders—parents, grandparents, or others—through the documents.

DISCUSSION

The study is a mixed methods systematic review of qualitative and quantitative dignity therapy for elderly patients. We identified 12 published studies with a total of 674 elderly patients from Australia, Canada, the United Kingdom, and China. Quantitative results and comparisons to the effects of conventional treatment revealed that, despite statistical heterogeneity being considerable, dignity therapy may be effective in reducing older patients' anxiety, depression, and lack of dignity. And we hypothesized that the heterogeneity was brought on by different types of diseases or scales. Not every article conducted a quality of life analysis, the effect was unclear. Additionally, neither the intervention group nor the control group's outcomes were significant. Shorter interventions are more beneficial for preserving dignity and the baseline level of patients will affect the results. Studies have shown that individuals with moderate to severe pain respond better to intervention^[48]. And in our qualitative studies, we got 4 categories pain of illness, remembrance of the past, meaning of life and wishes for family members. The elderly patients were satisfied with DT with the majority claiming that DT could raise their self-esteem and make them happier by providing them with documents^[49]. Because the depression and anxiety status was measured using a self-rating and subjective scale, sometimes the results were not very credible. The accuracy of the results might be impacted by patient interpretation discrepancies or an incident that occurred while they were completing the scale on that particular day. Therefore, based on the patient's typical performance changes, we believe it is feasible to design a heterogeneous scale.

Furthermore, it could be beneficial to consider the best duration for proposing DT. Because the duration and follow-up time in these quantitative

research varied, so did the degree of change. One study^[30] reported a two-week intervention and a follow-up on day 15, finding that the fear of losing one's dignity had decreased. Another study^[31] follow-up at the first and eighth weeks after the intervention, finding that the fear had increased at the first week and had decreased by 5. A third study^[32] reported follow-up at the fifteenth week after the intervention, finding that the fear had decreased about 5. The duration of follow-up after the intervention could have an impact on the outcomes because the patients and their families will receive a targeted document with the most remarkable details as well as some things and experiences that they want to recollect. And it may have some influence on the patients in the future. Thus, even though they will recall negative experiences or emotions, if the follow-up time-frame is long enough, the patients will use these documents to recollect positive memories from the past to maintain their pride and sense of dignity, therefore, their sense of dignity may increase with the increase of follow-up time. However, the exact time-frame remains unclear. Measuring patients' dignity, depression, anxiety and other emotions in a short time after the intervention may lead to effective results, but few researchers were involved in long-term measurement because dignity therapy is aimed at end-stage patients with no prolonged time-frame. But what about the long-term effects on elderly people who have not reached the end of their lives? If the impact of dignity therapy on patients has accumulated effect over time, the impact on patients at the end stage is positive and effective.

These studies mainly focused on mild cognitive impairment, early dementia, COPD, and motor neuron diseases. The research sites were mainly hospitals, families, and long-term care institutions. The incidence of cognitive impairment is significant in the elderly due to their advanced age and deteriorating physiological function, which affects not only the patients' quality of life but also their mood, escalating anxious and depressive feelings, and heightening feelings of uselessness. They may lose their sense of dignity as a result of their growing reliance. Therefore, it is necessary to intervene in these people to reduce their negative emotions and improve their quality of life and sense of dignity. Dignity therapy may alleviate the pain of patients with mild cognitive impairment and maintain their sense of dignity. Patients with COPD and motor neuron diseases can be intervened by dignity therapy because of the gradual aggravation of disease symptoms and physical and psychological pain. At the same time, it is worth

noting that, like dementia and COPD which are progressing continuously, reducing the influence of the development of the disease on the intervention is very important. Though our quantitative results were not positive, the patients consistently stated that the dignity therapy was effective and useful. However, in order to improve the quantitative results, we need to determine the ideal window of opportunity for intervention and use a scale that is specifically designed for patients with various diseases.

As the population ages, an increasing number of seniors opt to live in long-term care facilities. Studies have revealed, however, that senior residents in long-term care facilities depend heavily on caregivers^[47], and have less contact with their families. Because they are losing the capacity to take care of themselves and require assistance, many elderly persons experience feelings of humiliation. In a study in China, it was found that about 70.3% of patients in old-age care institutions have a need for psychological communication^[50], demonstrating the critical need for our attention for this group of older people. Old age is the last stage of life, and the most useful thing we can do is to help patients spend this special and important period more comfortably.

Dignity therapy is a special way of communication. For certain patients who find it difficult to communicate or even have conflict in their families, it can save what the patient wants to say and what he wants to leave in a document, and share it with family members or friends under the instructions of the patient. When they see these documents and know more about patients, they will also know what are important or memorable life experiences to patients. In actuality, getting to know others is intriguing. Even yet, the patient's death will result in the retention of these records, which can be a loss for the patient's family. Even if an intervention could only last a brief time, its effects need to be long-lasting. The effects of dignity treatment on illness should be investigated further, as should the timing of interventions.

Based on the evidence, DT is effective for elderly patients, thus patients with chronic conditions should be given the option. Actually, elderly patients benefit from dignity therapy. Cognitive impairment, COPD, and motor neuron diseases can bring physical and mental pain to patients, and patients in nursing homes are separated from their family and friends, and their social support is relatively weakened, so they require additional assistance. Although dignity

therapy is developed for cancer patients, it is of great research value if patients with other diseases have similar experiences to cancer patients. So future research should determine what diseases patients suffer from and in what states are suitable for intervention, and conduct some mixed research to better understand the role of dignity therapy and the needs of patients and their families. Additionally, it is crucial to provide evidence to determine whether the intervention population has similar experiences with cancer patients in the studies.

CONCLUSION

The available evidence suggested that DT is beneficial and adapted to different populations. Patients and families claimed that it has a variety of effects and can go beyond traditionally considered variables like anxiety or depression. The findings imply that treatment is most effective for patients with medium-to-high levels of distress, although further research is required to substantiate these findings.

One disadvantage of this review is that no grey literature about dignity therapy was found when searching the literature. And since there is a propensity to withhold the publishing of negative results, one constraint identified in this review relates to the potential for publication bias. It is noteworthy that the majority of the studies do not provide detailed information about how DT was conducted and therapists' skills. Most articles include directly Chochinov's protocol reference with no additional information about how it was conducted, preventing an assessment of DT protocol application which might influence the results. The research should make the necessary alterations to better fit other different patients because DT was created for cancer patients even though it also helped individuals with other ailments.

Relevance to Clinical Practice

This study systematically studied the non-cancer elderly patients, and found that dignity therapy is suitable for the elderly patients with mild cognitive impairment, dementia, COPD, motor neuron diseases and patients in nursing homes, but the quantitative results were not biased towards the intervention group, and we guessed it may be related to the evaluation tools. Besides, for patients with the same disease, the follow-up time was different, and the results may be different

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