Nurs Midwifery Stud. 2016 December; 5(4):e38288. doi: 10.17795/nmsjournal38288.

Published online 2016 September 27. **Research Article**

# The Effect of Dignity Therapy on Perceived Dignity in Patients With Major Depression Disorder

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**Received** 2016 April 09; **Revised** 2016 June 06; **Accepted** 2016 June 11.

## Abstract

**Background:** Because of the scarcity of studies on the effect of dignity therapy in patients with depression, and the conflicting results of the available studies, it is still unclear whether dignity therapy improves perceived dignity in patients with major depression disorder.

**Objectives:** This study aimed to examine the effect of dignity therapy on the perceived dignity of patients with major depression disorder.

**Methods:** In this randomized controlled trial, 58 patients with major depression disorder were randomly separated to an intervention group (28 patients) and a control group (30 ones). The intervention group received dignity therapy, according to a standard protocol and the control group only received routine care. A questionnaire for examining perceived human dignity was implemented immediately before and two months after the intervention. Descriptive statistics, Fischer's exact test, Chi square, independent samples t-test, paired t-test, Mann-Whitney and Wilcoxon tests were used in data analysis.

**Results:** Of the 58 patients under study, 65.5% were female. No significant difference was found between the mean overall perceived dignity scores of the intervention group ($100.2 \pm 6.6$) and the control group ($99.8 \pm 4.5$) before the intervention ($P = 0.78$). However, two months after the intervention, the mean overall dignity scores were significantly different in the two groups (intervention group: $87.2 \pm 3.8$, control group: $98.9 \pm 3.7$, $P < 0.001$). Dignity therapy was effective on the subscales of dependency, peace of mind and social protection ($P < 0.001$), however, it did not affect distress signs ($P = 0.10$) and existential distress subscales ($P = 0.09$).

**Conclusions:** Dignity therapy can improve perceived dignity in patients with major depression disorder. Therefore, this method can be implemented to improve perceived dignity in patients with major depression.

*Keywords:* Dignity Therapy, Human's Dignity, Major Depression Disorder, Clinical Trial

## 1. Background

Major depression disorder is one of the most common mental disorders, affecting 121 million people worldwide (1). It also is estimated that 4.1% of Iranian people have this disorder (2).

Major depression disorder comes with high levels of cognitive and performance disabilities and forces a high economic and social load on the patient, the family and society because of its direct and indirect expenses such as unemployment and efficiency reduction both in the patients and in their caregivers (3, 4).

Stressful life events, especially interpersonal stresses and social rejection are the most important predicting factors for the onset of major depression disorder (5). According to psychoanalytic theories, causes of depression in adults relate to external sources such as lack of social acceptance and protection (6), which consequently result in feeling of humility and low self-value in interpersonal communication (7). In fact, depression comes with a low self-concept and subjective lack of dignity, which affects the patient's view of his/her abilities in the society and results in dependency and disability in the control of life affairs (8). Therefore, nurses should deal with these patients in such a way that preserves their dignity, makes them develop a positive life view and feel valuable (9). However, evidence shows that the dignity and the rights of these patients are being neglected during the hospitalization period (10). Additionally, the stigma related to mental disorder results in a discriminative view and prejudice, which increments the disorder and decreases the patients' life quality (11). A recent phenomenological study on the experience of dignity in people with psychological illnesses showed the negative effects of social communication disruption, age increment, stigma, discrimination and loneliness on the dignity of such patients (12).

Preserving human dignity is one of the cornerstones of providing quality nursing care. Therefore, it is necessary for nurses to first understand its meaning (13).

Dignity has various definitions. In a qualitative metasynthesis, dignity was defined as considering people's val-

ues, reverence, prestige and position (13). It has also been defined as feelings, thoughts and behavior of individuals toward themself and others. The concept of dignity has four constituents including respect (i.e. self-respect, respect for others, respect for peoples' privacy), autonomy (i.e. having choice, giving choice, having the right and competence to make decisions), empowerment (i.e. feeling of being important, self-esteem, modesty and pride), and communication (i.e. verbal or nonverbal; also includes explaining and understanding information, feeling comfort and giving time to the audience) (14). Considering the importance of preserving patients' dignity (15), Chochinov et al. presented a model for 'dignity therapy' to improve the patients' dignity throughout the therapy periods (16). This model can be employed for all people that are experiencing high levels and long durations of stress (16). It has a story-like approach and consists of elements such as life reviewing and talking about the memories (17). This approach pursues the patient to feel that they are important by focusing on the human relations improvement and love phrases (18). Hence it enhances human dignity by engaging the patient in telling his/her life story and their most important thoughts, feelings and dreams (16). This model was implemented in patients with a range of disorders such as chronic renal failure (19), motor neuron disorder and their family caregivers (20) and other chronic somatic disorders (16). Furthermore, through enhancing the peoples' abilities and feeling of self-worth, this method can be used as the antidote of depression. Studies are available on the beneficial effects of dignity therapy on decreasing the signs of depression (21) and increasing self-esteem and independence in these patients (8). However, in a systematic review, Fitchett et al. reported conflicting results about the effects of dignity therapy in patients with major depression (18).

Because of scarcity of studies on the effect of dignity therapy in patients with depression, and the conflicting results of the available studies, and considering the crucial role of psychiatric nurses in enhancement of dignity of depressed patients, it is still unclear whether dignity therapy can improve perceived dignity in patients with major depression disorder.

## 2. Objectives

This study aimed to examine the effect of dignity therapy on perceived dignity of patients with major depression disorder.

## 3. Method

### 3.1. Design and Sampling

A randomized controlled clinical trial was conducted on a sample of 60 patients with major depression disorder referred to Ibn-e-Sina Psychiatric hospital of Mashhad, Iran, from September 2015 to December 2016. The sample size was estimated based on a pilot study on 20 patients with major depression that were equally placed in two groups of ten people. After administering the human dignity evaluation questionnaire, two sessions of dignity therapy similar to the main study were conducted in one group, and after one month, the human dignity evaluation questionnaire was again administered to both pilot groups. The mean score in the intervention group was changed from $97.7 \pm 2.5$ to $86.3 \pm 8.5$, while it did not significantly change in the control group ($95.3 \pm 2.3$ vs. $93.6 \pm 8.8$). Using the following parameters ($\beta = 0.15$, $\alpha = 0.05$, $\mu_1 = 86.3$, and $\mu_2 = 93.6$, $S_1 = 8.5$, and $S_2 = 8.8$, twenty-six subjects were estimated to be needed in each group. However, considering the possible 15% dropouts, we recruited 30 subjects in each group.

The inclusion criteria consisted of willingness to participate in the study, a definite medical diagnosis of major depression disorder for more than three years, being in the age range of 18 to 60 years, having the ability to read and write in Farsi language, existence of no additional mental and somatic co-morbidity, having a stable mood (in the last 10 - 15 days of the patient's hospitalization) confirmed by the psychiatrist, and no intention to travel or immigrate to another city for two months after hospital discharge. The exclusion criteria consisted of not following the therapy protocol, a subject's decision to withdraw from the study, absence from even one of the dignity therapy sessions and lack of cooperation of the patient's family, and being diagnosed with another mental disorder during the research period.

Sampling was performed consecutively among the patients that had the inclusion criteria and were hospitalized at the Ibn-e-Sina hospital for one month and were in a stable mood. Patients were assigned to the control or intervention groups using a simple random sampling method. In total, we assessed 72 patients for eligibility and recruited 60 (30 in each group). However, two patients from the dignity therapy group were excluded because one could not attend the posttest examination and one decided to withdraw from the dignity therapy sessions (Figure 1).

### 3.2. The Study Instrument

The data collection instrument consisted of two parts. The first part included questions on patients' demographic information (i.e. age, gender, education level, mar-

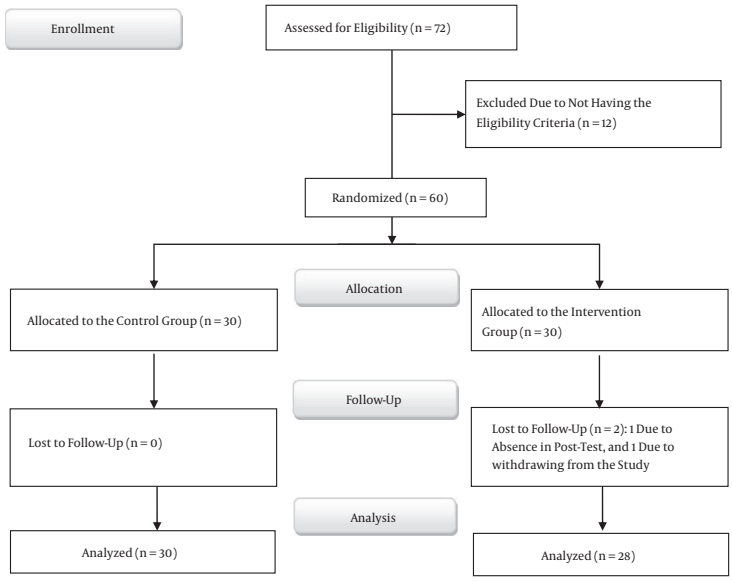


**Figure 1.** The CONSORT Flow Diagram

ital status and job status). The second part of the instrument was the human dignity evaluation questionnaire (HDEQ). The HDEQ is composed of 25 items in five subscales including distress signs (five items), existential distress (five items), dependency (five items), mental relaxation (five items) and social protection (five items). All items were responded on a five-point Likert scale, ranging from one (= no problems) to five (= many problems). The total score is between 25 and 125; higher scores indicate lower levels of perceived dignity. This scale was translated to Farsi by Vaghees et al. and its validity and reliability were confirmed by ten academic members of Mashhad University of Medical Sciences and by test-retest (correlation coefficient = 0.84) (20).

### 3.3. The Procedure

Each patient answered the questionnaire when they entered the study. To this end, a structured individual interview was conducted with each patient and the researcher recorded their responses on the questionnaires. All interviews were conducted by the first researcher and in the examination room of the psychiatric unit.

In the intervention group, dignity therapy was conducted according a standard protocol. All dignity therapy sessions were held individually for each patient. Each patient in the intervention group participated in four sessions to complete the dignity therapy protocol. The dignity therapy protocol consisted of 12 questions, which helped patients remember their life experiences. In the first session, the structure of the dignity therapy sessions, type and style of the questions and answers were reviewed during a 30-minute session. Then, in two 30- to 45-minute sessions that were held on two subsequent days, the protocol's questions (including 12 questions) were proposed one by one and the patient had the opportunity to answer these questions. The protocol questions were presented one by one and the patient answered each in about five minutes. The answers included remembering and telling life experiences focusing on aspects in which he/she has been proud or the problems that were meaningful to him/ her or a life's period or his or her demands. The patient's answers were recorded using a voice recorder, transcribed and edited, and then in the fourth session, the text was prepared from the patients interviews and returned to him/her as the "generating document" to be completed or revised. This was then shared with a family member or friend of the patient after the patient's approval. The patient's family member or his/her friend was asked to review the generated document, share it with other family members or friends, try to understand the patient messages and desires and modify their conducts so that the patients desires and his/her dignity were considered.

After two months, all patients in the both groups were invited to the hospital to complete the post-test.

### 3.4. Ethical Considerations

Ethical considerations and the study protocol were approved by the research ethics committee of Mashhad University of Medical Sciences (No. 940193/222, issued on July

6th 2015). Permission was also obtained from the authorities of the Ibn-e-Sina Psychiatric hospital. All participants were told that they are under investigation, but they did not know the group they were assigned to. They were all also informed about the voluntary nature of their participation. All patients signed a written informed consent before participation, were assured of the anonymity and confidentiality of the data, and were also reminded that they can withdraw from the study at any time. To observe ethics, at the end of the study, two educational sessions on "major depression disorder and its signs and therapy methods" were also held for the control group.

### 3.5. Data Analysis

Data analysis was performed using the SPSS 11.5 software. Descriptive statistics were calculated for demographic variables. Kolmogorov-Smirnov test was used to examine the normality of the Data. Fischer's Exact test, Chi square, and independent t-test were implemented to investigate the homogeneity of the qualitative and quantitative variables. Independent samples t-test (for normally distributed variables) and Mann-Whitney U test (for abnormally distributed variables) were employed for comparison between the two groups, and paired t-test (normal distribution) and Wilcoxon test (abnormal distribution) were used for inter-group comparison. Statistical significance was considered at P value < 0.05.

## 4. Results

The two groups were homogeneous in terms of demographic variables and no significant differences were found between the two groups in terms of their gender, marital status, employment status and education level (Table 1).

No significant difference was found between the mean overall perceived dignity scores of the intervention and the control groups before the intervention (P = 0.78). However, two months after the intervention, the mean overall dignity scores were significantly different in the two groups (P < 0.001), so that this score was increased in the intervention group while it did not change in the control group (Table 2).

Table 2 also shows that before the intervention, the two groups were not significantly different with regards to their mean scores in different subscales of human dignity (P > 0.05). However, after two months, significant differences were observed between the two groups in three subscales of dependency (P < 0.001), peace of mind (P< 0.001) and social protection (P < 0.001). Similar patterns were also observed in the mean differences of the latter three subscales.

**Table 1.** The Characteristics of the Patients With Major Depression Disorder in the Intervention and Control Groups[a]

| Variable | Group | | P Value |
|---|---|---|---|
| | Control | Intervention | |
| **Gender** | | | 0.46[b] |
| Male | 9 (30) | 11 (39.3) | |
| Female | 21 (70) | 17 (60.7) | |
| **Education level** | | | 0.82[b] |
| Elementary school | 14 (46.7) | 12 (42.8) | |
| 8th grade in high school | 6 (20) | 6 (21.4) | |
| Diploma | 7 (23.3) | 5 (17.9) | |
| Academic education | 3 (10) | 5 (17.9) | |
| **Marital status** | | | 0.70[b] |
| Divorced | 22 (73.3) | 19 (67.8) | |
| Single | 4 (13.4) | 5 (17.9) | |
| Married | 3 (10) | 4 (13.4) | |
| Widowed | 1 (3.3) | 0 (0.0) | |
| **Working status** | | | 0.63[c] |
| Employed | 3 (10) | 3 (10.7) | |
| Unemployed | 27 (90) | 25 (89.3) | |
| **Age** | 44.3 ±10.7 | 42.1 ±11.6 | 0.47[d] |

[a] Values are presented as No. (%) or mean ± SD.
[b] Chi-Square Test.
[c] Fisher Exact Test.
[d] Independent samples t-test.

Table 2 also presents the results of within-group comparisons in the study groups. In the intervention group, significant differences were observed between the pretest and posttest mean scores not only in overall dignity scores, but also in its subscales (P< 0.001). However, no significant differences were found between the pretest and posttest mean scores in the control group.

## 5. Discussion

The present study showed that dignity therapy was effective for patients with major depression disorder, so that the mean posttest dignity scores were decreased in the intervention group that indicates an increase in the perceived dignity. However, the mean scores did not significantly change in the control group. These findings were consistent with previous studies on patients with chronic renal disease (19), patients with motor neuron disorders and their caregivers (20), older people residing in rest homes (22) and those with dementia (23). Juliao et al. also reported the beneficial effects of dignity therapy on signs

**Table 2.** The Comparison of Perceived Dignity and its Aspects in the Intervention and Control Groups, Before and After the Intervention[a]

| Scale/Group | Before Intervention | Two Months After Intervention | P Value[b] | Mean Difference |
|---|---|---|---|---|
| **Distress signs aspect** | | | | |
| Intervention | 20.61 ± 1.42 | 19.21 ± 1.93 | < 0.001 | 1.42 ± 1.91 |
| Control | 20.53 ± 2.15 | 19.94 ± 1.52 | 0.06 | 0.63 ± 1.71 |
| P value[c] | 0.88 | 0.11 | | 0.10 |
| **Existential distress aspect** | | | | |
| Intervention | 21.53 ± 1.95 | 20.21 ± 1.33 | < 0.001 | 1.32 ± 1.84 |
| Control | 21.21 ± 1.44 | 20.64 ± 1.72 | 0.08 | 0.62 ± 1.73 |
| P value[c] | 0.41 | 0.30 | | 0.09 |
| **Dependency aspect** | | | | |
| Intervention | 19.85 ± 1.54 | 17.31 ± 1.23 | < 0.001 | 2.52 ± 2.41 |
| Control | 19.71 ± 2.34 | 19.91 ± 1.52 | 0.38 | 0.33 ± 1.34 |
| P value[c] | 0.81 | < 0.001 | | < 0.001 |
| **Peace of mind aspect** | | | | |
| Intervention | 18.32 ± 1.84 | 15.61 ± 2.12 | < 0.001 | 2.62 ± 2.71 |
| Control | 18.71 ± 2.32 | 18.44 ± 1.71 | 0.16 | 0.31 ± 1.32 |
| P value[c] | 0.45 | < 0.001 | | < 0.001 |
| **Social protection aspect** | | | | |
| Intervention | 19.96 ± 6.92 | 15.01 ± 2.93 | < 0.001[d] | 5.03 ± 6.63 |
| Control | 19.71 ± 1.75 | 20.13 ± 1.24 | 0.18[d] | -1.12 ± 1.91 |
| P value[e] | 0.09 | < 0.001 | | < 0.001 |
| **Overall perceived dignity** | | | | |
| Intervention | 100.24 ± 6.63 | 87.23 ± 3.81 | < 0.001 | 12.92 ± 7.53 |
| Control | 99.81 ± 4.54 | 98.92 ± 3.71 | 0.13 | 0.87 ± 0.31 |
| P value[c] | 0.78 | < 0.001 | | < 0.001 |

[a] Values are presented as mean ± SD.
[b] Paired t test.
[c] Independent sample t-test.
[d] Wilcoxon test.
[e] Mann-Whitney U test.

of depression in terminally ill patients (24). Radu et al. also reported that increasing self-esteem and autonomy could increase perceived dignity in patients with major depression disorder (8).

Psychoanalytic theories, interpret depression as a reaction to loss. The depressed individual reacts to the loss severely despite the nature of the loss, because it recalls all of the patient's fears about the losses in his/her childhood. An unmet need in a depressed person is the need for love (6). Dignity therapy responds to this need by preparing a generating document of the patient's memories and dreams, which show the patient's need of his/her loved ones. On the other hand, patients with major depression disorder (25) have low self-respect. They feel guilty and criticize themselves even for small subjects. Usually, the individual does not easily accept what is different with his/her self-thoughts and tries to change for good (25). Dignity therapy schedule induces a feeling of love and being important, and the generating document, when it is read in a calm and private circumstance, facilitates an internal communication in the patient and his/her internal self. It also prepares the conditions for self-thoughts about good changes and consequently enhances the patient's perceived dignity.

The intervention in the present study improved all aspects of the dignity subscales except for the two aspects of distress signs and existential distress aspects. This finding was different from previous studies in which dignity

therapy was implemented for patients with motor neuron disease (20) and older individuals (22). The distress signs aspect of dignity represents physical and mental sources of distress and the existential distress aspect refers to the individual's feelings about how changes (including being valuable and the ability to perform important tasks) are seen in others views. It seems that dignity therapy implemented in this study could not change the circumferential distresses or others and family's view of the patient. It appears that families and friends of the patients with chronic somatic disorder can more easily understand the patient's conditions to empathy with them. However, the entity of mental disorders together with its social stigma makes it difficult for families and friends to understand the condition of patients with depression.

On the other hand, in the present study, the three aspects of peace of mind, dependency, and social protection were improved after the intervention. It seems that dignity therapy can help the patient increase his/her feeling of having a target and a meaningful life by forcing them to think about the joyful and successful memories, life after death and what remains after them (21, 26). Moreover, as confirmed by some previous studies (20, 24) dignity therapy might affect the communication between patients and their caregivers that in turn improved the patients' feelings of social protection.

In conclusion, this study showed that dignity therapy could improve perceived dignity in patients with major depression disorder. Hence, this short-term and unique method can be implemented to improve perceived dignity in these patients.

However, there were some limitations in this research. For instance, the patients' individual characteristics and mental condition during pretest and posttest might affect their answers and these variables were not under the control of the researchers. Second, we did not examine the changes in the patients' signs of depression. Thus, examining the effect of dignity therapy on depression, especially for those in their first days of hospitalization, is suggested.

## Acknowledgments

This research was registered at the Iranian registry of clinical trials and the registry number was IRCT2015112625250N1. The authors sincerely acknowledge the financial support of the Mashhad Medical University. They would also acknowledge the cooperation of the nursing and midwifery school of Mashhad and the staff of Ibn-e-Sina psychiatric Hospital of Mashhad.

## Footnotes

**Authors' Contribution:** Study concept and design: Saeed Vaghee and Abbas Heydari; acquisition of data: Saeed Vaghee; statistical analysis, interpretation and drafting of the manuscript: Saeed Vaghee; critical revision of the manuscript for important intellectual content: Abbas Heydari; administrative, technical, and material support: Saeed Vaghee and Abbas Heydari; study supervision: Abbas Heydari.

**Financial/Support:** This project was funded by the research deputy of Mashhad University of Medical Sciences, Mashhad, IR Iran.

**Financial Disclosure:** The authors declare that they had no competing interests.

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