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Providing Dignity Therapy Integrated Care to Cancer Patients Receiving Palliative Care: A Feasibility Study within the Setting of a Selected Hospital Palliative Care Unit, West Bengal - A Pilot Study

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Abstract: ***Introduction: Dignity therapy integrated care is an individualized psychotherapeutic intervention that is unquestionably aimed at improving the well-being of cancer patients receiving palliative care. Dignity therapy focused in this mainly on how it reduces the physical, psychological, and dignity related distress among the cancer patients receiving palliative care. The aim of this study is to determine the effectiveness and feasibility of dignity therapy integrated intervention in improving the dignity and reducing the various distress experienced by the cancer patients receiving palliative care. Methods: This study was a non-randomized quasi-experimental study design in a selected palliative care unit of outpatient department of SSKM, Hospital, Kolkata, West Bengal. Dignity therapy integrated care was applied as an intervention in the study group andgeneral visit was employed in the control group. Total of 30 cancer patients receiving palliative care were recruited among which 15 cancer patients in the study group and another 15 was in control group by adopting purposive sampling technique. Patient Dignity Inventory (Standardized tool) mainly was dignity related distress consisted with physical distress, psychological distress, existential distress and dignity concerning distress. Measurements were obtained by pre intervention and post intervention (on 10th day of intervention). General visit was done after doing pre- test for control group and posttest was conducted on (10th day of intervention). Feasibility was evaluated by Patients' Feedback responses. The effectiveness ofthe dignity therapy integrated care in the two groups was analyzed using independent t" test at 0.05 level of significance and comparing the mean difference with effect size by Cohen's d test. Results: After dignity therapy integrated care, the cancer patients receiving palliative care reflected decreased dignity related distress significantly in comparison of control groupof cancer patients receiving palliative care. Conclusion: Dignity therapy integrated care could be adopting by the palliative care nurses in clinical setting to improve the well-being of the cancer patients receiving palliative care by reducing their dignity related distress that could relieve patients physical, psychological, existential and dignity concerning distress and thus improving their sense and purpose of living.***

Keywords: Dignity therapy integrated care, cancer patients receiving palliative care, dignityrelated distress

1. Introduction

Cancer is currentlythe second leading cause of death in the world, following only cardio vascular diseases.[1] cancer is a multifaceted consideration that affects one's quality of life, and coping ability. Inclusive of dealing with a variety of physical problem, patients with cancer may encounter different types of distress, together with psycho-social problem, and existential distress.[2, 3] quality of life is a complicated concept in respect of its objective, subjective and spiritual expression and it implicates a great impact on individual's physical, emotional, spiritual, and social well-being [4].

Palliative care improves healthcare quality in three domains: the relief of physical and emotional suffering; improvement and strengthening of the process of patient–physician. Dignity therapy integrated care is an individualized psychotherapeutic intervention that is unquestionably aimed at improving the well-being of cancer patients receiving palliative care. Dignity therapy focused in this mainly on how it reduces the physical, psychological, and dignity related distress among the cancer patients receiving palliative care.

Objectives of the study:

1) To assess the dignity related distress before and after dignity therapy integrated care among cancer patients receiving palliative care in study group.
2) To evaluate the effectiveness of dignity therapy integrated care among cancer patients receiving palliative care after intervention in both study group and control group.
3) To measure the effect of dignity therapy integrated care among cancer patients receiving palliative care of study group for feasibility.

Hypothesis:

The null hypotheses will be tested at 0.05 level of significance.

H01: There is no significant difference of post intervention dignity related distress scores between study group and control group of cancer patients receiving palliative care.

2. Methodology

Research design: Non- randomized pre and posttest quasi experimental design was adopted. The feasibility was assessed through patient feedback questionnaire.

Sample:
In order to achieve the objectives of the pilot study 30 cancer patients receiving palliative care were selected by using purposive sampling technique in selected palliative outpatient department of SSKM hospital, Kolkata, West Bengal, who satisfied the inclusion and exclusion criteria.

Tools used for the study:
- Tool 1: Socio-demo graphic proforma of cancer patients receiving palliative care.
- Tool 2: Patient Dignity Inventory to assess the dignity related distress before and after intervention.
- Tool 3: Patient Feedback Questionnaire on experience of dignity therapy integrated care.

Intervention:
Dignity therapy integrated care conducted by applying Dignity therapy questions protocol. Patient Dignity Inventory was applied to assess dignity related distress before conducting dignity therapy integrated care. Each participant was interviewed for 15-20 minutes on an average to collect required information. In the study group, dignity therapy was used among the participants. The researcher used interviews and audio recording to help the participants create a generativity document that was then passed on to the participants. Patient Dignity Inventory was administered again after dignity therapy integrated care to the same participants. Patient feedback questionnaire was applied to each participant to assess the patients experience regarding dignity therapy integrated care after seven days of intervention. In similar manner Patient Dignity Inventory was applied to the patients receiving palliative care who were recruited for control group and general visit.

Ethics Committee Approval:
This study was approved by the ethics committee of Manipur International University and administrative approval was obtained from SSKM, Hospital.

3. Results and Discussion

Prior to specific statistical analysis, data were assessed for its normality by examining the skewness of distribution for each measure. It was deemed normally distributed.

Table 1 depicts that maximum 46.66% participants belonged to the age group of 40-50 years in study group and 53.33% in control group. Most of the participants 60% were in study group and 46.66% in control group. Most of the participants had an education level (33.3%) of higher secondary and graduation both in study group whereas maximum 40% in control group. According to occupational status 40% were employed and 26% were retired employee in the study group on the other hand maximum 53.33% were unemployed in control group. Data presented in table 1 reflects that, majority 60.00% of cancer patients receiving palliative care had family income rupees 20,000 and above in the study group but in control group most of the participants 46.66% had a monthly family income of below and equal of rupees 5000.

Table 1: Frequency and percentage distribution of study group and control group of patients receiving palliative care according to their age in years, occupation, monthly family income, educational status, and marital status, n= 30(15S+15C)

Characteristics	Study group		Control group	
	Frequency	Percentage (%)	Frequency	Percentage (%)
Age in years				
40-50	07	46.66	06	40.00
50-60	05	33.30	08	53.33
>60	03	20.00	04	26.60
Occupation				
Employed	06	40.00	05	33.30
Unemployed	05	33.30	08	53.33
Retired	04	26.60	02	13.33
Monthly family income (in rupees)				
≤ 5000	01	6.60	07	46.66
5001-10000	04	26.60	05	26.60
10001-20000	01	6.60	02	13.33
>20000	09	60.00	01	6.60
Educational status				
Below Primary	04	26.60	06	40.00
Upto Madhyamik	01	6.60	03	6.60
Higher secondary	05	33.30	05	33.30
Graduate and above	05	33.30	01	6.60
Marital status				
Married	09	60.00	07	46.66
Unmarried	03	20.00	06	26.60
Others	03	20.00	02	13.33

Figure 1 shows that maximum 73% of participants had a religious belief of Hinduism, followed by 20% Islam and 7% Christian in study group. In control group 78% belonged to Hindu religion followed by 18% Muslim and 4% Christian respectively.

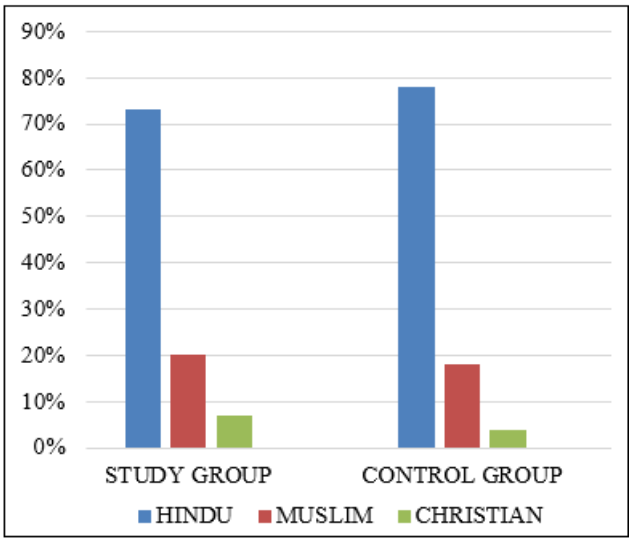

Figure 1: Bar diagram showing percentage distribution according to religion among cancer patients receiving palliative care both in the study group and control group.

Figure 3 depicts that majority of the participants 67% were female and rest 33% male in study group whereas 70% participants were male and 30% were female in control group.

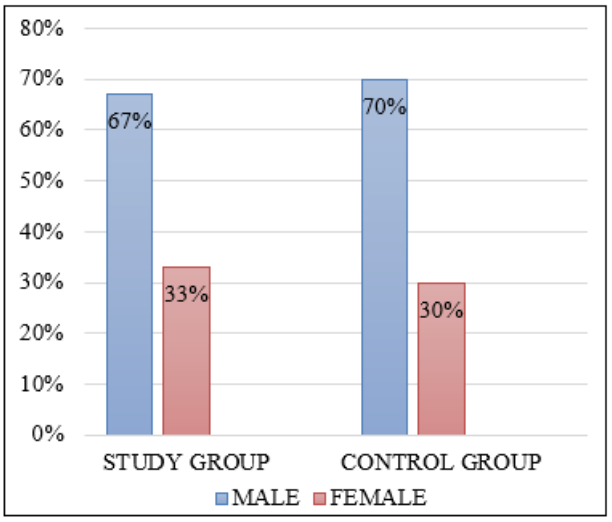

Figure 2: Bar diagram showing percentage distribution according to gender among cancer patients receiving palliative care both in the study group and control group.

The data presented in table 2 depicts that most of the patients 33.3% suffered from breast cancer followed by both uterus cancer and prostate cancer (20%), 13.33% with Anal cancer, 6.60% carcinoma in ovary and oral cancer among the patients receiving palliative care in study group. On the other hand maximum 40% patients were suffered from breast cancer followed by 20% both from carcinoma in ovary and prostate cancer, 13.33% from Uterus cancer and 6.60% both from oral cancer and anal cancer in control group. Duration of sufferings accounted maximum 73.30% were suffering more than one year in the study group and majority 66.66% were suffering from less than one year in control group. Data also show that in case of initiation of palliative care most of the patients in the study group were in palliative care unit (86.6%) for six months and less and most of the patients (53.33%) were getting palliative care in control group for six months and less than six months.

Table 2: Frequency and percentage distribution of patients receiving palliative care according to their age in years, occupation, monthly family income, educational status, and marital status both in study group and control group**,** n=30(n_s15+ nc15)

Clinical profile characteristics	Study group		Control group	
Type of cancer	Frequency	Percentage (%)	Frequency	Percentage (%)
Breast cancer	05	33.33	06	40.00
Oral cancer	01	6.60	01	6.60
Uterus cancer	03	20.00	02	13.33
Ovary cancer	01	6.60	03	20.00
Prostate cancer	03	20.00	02	20.00
Anal cancer	02	13.33	01	6.60
Duration of sufferings				
≤ 1 year	04	26.60	10	66.66
> 1year	11	73.30	05	33.33
Initiation of palliative care				
≤ 6 months	13	86.60	08	53.33
>6 months	02	13.30	07	46.66

Data presented in table 6 depicts that post intervention Mean and SD of Dignity related distress was 60.26 and (±3.91) in the study group, and 82.30 and (±3.79) in control group. Mean Difference observed (22.04). There is a statistically significant difference in the areas of dignity related distress scores after administration of dignity therapy integrated care in study group and routine care in control group with t value (t=3.25) that is higher than table value (2.05, df=29) at 0.05 level of significance. The data reveal that the effect of dignity therapy integrated care is significant in reducing the dignity related distress among cancer patients receiving palliative care. Therefore, it could be said that this mean difference is true difference, not by chance and thus null hypothesis is rejected.

Although the results presented above shows the difference between two sets of post-test among cancer patients receiving palliative care both in study group and control group but the magnitude of the effect of intervention could not be established. The magnitude of effect can be calculated by Cohen's d (Cohen J, 1998) that indicates the size of the difference between two means in standard deviation units.[5] Cohen's d-0.88

This means a large difference between two groups. It can conclude that there was a large effect, with a substantial difference in reducing the dignity related distress and improving the dignity of cancer patients receiving palliative care. It is therefore suggested that providing dignity therapy integrated intervention among the cancer patients receiving palliative care improved the condition as reflected by the effect size.

Table 6: Comparison of Mean and Standard Deviation, Mean Difference (MD), and t-test of post intervention score regarding dignity related distress between intervention group and control group of patients receiving palliative care.
n= 30(ns15+ nc15)

Areas of dignity related distress	Min- Max (25-125)	Mean ±SD	MD	df	t value
Study group (Post-test)		60.26 ±3.91	22.04	29	3.25
Control group (Post-test)		82.30 ±3.79			

t (df 29)= 2.05, at 0.05 level of significance.

Table 7 reflects that majority (60%) of cancer patients receiving palliative care were satisfied with the comment of Dignity Therapy (DT) was helpful, 80% responded they were satisfied with DT, 73.33% commented DT has given highest sense of purpose, 66.66% reported DT has highest sense of dignity. Regarding family concern, 40% cancer patients receiving palliative care commented on DT was helpful for their family. Overall response reflected that 80% of cancer patients receiving palliative care have been satisfied with psychosocial care by Dignity Therapy.

4. Discussion

The results of this study revealed that Mean and SD of Dignity related distress was 60.26 and (±3.91) in the study group, and 82.30 and (±3.79) in control group. Mean Difference observed (22.04). There is a statistically significant difference in the areas of dignity related distress scores after administration of dignity therapy integrated care in study group and routine care in control group with t value(t=3.25) that is higher than table value (2.05, df=29) at 0.05 level of significance. The data reveal that the effect of dignity therapy integrated care is significant in reducing the dignity related distress among cancer patients receiving palliative care. A total of 12(80%) patients in the study group reported that dignity therapy integrated care was satisfactory to them.

5. Conclusion

Evidence reports that dignity therapy integrated care is fruitful for the cancer patients receiving palliative care. This pilot study was carried out to measure the feasibility, and effectiveness in reducing dignity related distress among the cancer patients receiving palliative care in palliative care setting in West Bengal.

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