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Review article

Dignity Therapy for Individuals with Severe Mental Illness: A Holistic Approach to Care -A Narrative Review

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ABSTRACT

Dignity therapy (DT) is an evidence-based psychotherapeutic approach originally designed to alleviate emotional and existential distress in patients with terminal illnesses. While dignity therapy has been well documented in palliative care, emerging perspectives suggest that its principles such as promoting autonomy, meaning, and self-worth can be beneficial for persons with severe mental illness (SMI) who often experience stigma, identity loss, and existential suffering. Although severe mental illness and terminal illness are distinct conditions both may involve the profound psychological and existential challenges that affect personal dignity. This paper explores the philosophical foundations and therapeutic benefits of dignity therapy, with a particular focus on its potential application in mental health settings. It highlights the significance of preserving dignity in psychiatric care and emphasizes the need for compassionate, person-centered mental health support tailored to the lived experiences of the person with severe mental illness.

Key words: Dignity Therapy, Palliative Care, Severe Mental Illness, Autonomy

INTRODUCTION

Dignity therapy (DT) is a brief, evidence-based psychotherapeutic intervention initially developed in palliative care settings. It provides individuals with opportunities to reflect on existential concerns, find meaning and purpose in their lives, and create a legacy document that encapsulates their life stories and values. [1] The World Health Organization's (2017) data and the National Institute of Mental Health and Neuro Sciences (NIMHANS) performed a study in 12 states including 34,802 persons in 2015 and 2016, indicating that mental health problems are a major concern in India. [2] According to a survey, 1.9% of people have severe mental illnesses and 10% of people have common mental disorders. [3] In today's world, mental health issues are increasingly prevalent in the general population. [2]

These include schizophrenia, bipolar affective disorder (BPAD), depression, anxiety disorders, psychoses, phobias, suicide, mood disorders, neurotic or stress-related disorders, PTSD, marital discord, sleep disorders, substance use disorder, and dementia. Because mental health statistics could increase and impact roughly 20% of the population by 2020, up from estimates in 2015 that suggested roughly 7.5% of Indians suffered from mental illness, the World Health Organization (2017) has released a report recommending immediate expert intervention. The lifetime prevalence of mental disorders, according to the study, is 13.7%, and 10.6% of those cases require immediate interventions. [2, 3]

Although SMI and terminal illness are essentially different—the terminal illness usually refers to conditions with a limited life expectancy, while SMI includes chronic mental illnesses like severe depression, bipolar disorder, and schizophrenia—both groups frequently experience severe existential distress, identity loss, and low self-esteem. Exploring therapeutic modalities like DT, which seeks to restore meaning, autonomy, and human dignity, is justified by these common experiences. To establish DT as a potentially transformational intervention in psychiatric settings for people with SMI who continue to encounter psychosocial and existential issues. Given the rising prevalence of mental health disorders in India and the significant burden they place on individuals and society as a whole, there is an urgent need for effective interventions. DT emerges as a promising intervention that could address the unique psychological and emotional needs of individuals with mental illness. At the same time, DT has shown significant benefits in improving the quality of life and reducing existential suffering, particularly in patients with terminal illnesses. However, its application in persons with severe mental illness (SMI) remains relatively unexplored.

Several factors make DT a promising intervention for individuals with mental illness. Firstly, mental health disorders often lead to profound existential distress, loss of identity, and feelings of hopelessness and despair. DT provides a structured framework for individuals to explore and articulate their innermost thoughts, feelings, and values, thereby promoting a sense of meaning and purpose in life. By affirming their personhood and validating their lived experiences, DT helps individuals with mental illness regain a sense of dignity and self-worth. [4] Secondly, individuals with mental illness often face stigma, discrimination, and violations of their human rights in healthcare settings. [5] Medical professionals may hold negative attitudes toward psychiatric patients, leading to dehumanization, depersonalization, and a lack of dignity maintenance. These negative attitudes may stem from factors such as inadequate training in mental health, stigma associated with mental illness, fear of unpredictable behavior, and a lack of personal experience with positive outcomes in psychiatric care. DT can help address these challenges by fostering a therapeutic environment characterized by empathy, compassion, and respect for the individual's autonomy and dignity. [6]

Furthermore, DT can serve as a valuable adjunct to existing mental health interventions by addressing the unique existential and relational needs of individuals with mental illness. By providing a platform for individuals to reflect on their life stories, values, and aspirations, DT enhances self-awareness, self-esteem, and resilience, thereby empowering individuals to cope more effectively with their mental health challenges. [7] DT holds immense promise as an effective intervention for individuals with mental illness in India. By promoting a sense of meaning, purpose, and dignity, DT can help address the existential distress and psychological suffering experienced by individuals with mental illness, thereby enhancing their overall quality of life and well-being. [8]

Rationale of the study

Severe mental illness (SMI) significantly impacts individuals' psychological well-being, often leading to existential distress, stigma, and diminished self-worth. Conventional psychiatric interventions primarily focus on symptom management, frequently overlooking the fundamental need for dignity, meaning, and purpose in patients' lives. Dignity Therapy (DT), an evidence-based psychotherapeutic intervention originally developed for palliative care, offers a structured approach to fostering self-worth and alleviating existential suffering by allowing individuals to reflect on their life experiences and create a legacy document. While DT has shown positive outcomes in palliative and geriatric care, its application in mental health settings remains largely unexplored. Given the increasing emphasis on holistic, patient-centered care, there is a pressing need to examine the feasibility and effectiveness of DT in psychiatric populations, particularly among individuals with SMI. This review explores DT's philosophical foundations and therapeutic benefits. Additionally, it highlights the significance of preserving patient dignity, particularly in mental health care, stressing the need for respectful, patient-centered healthcare practices that honor individual experiences and promote compassionate, recovery-oriented mental health care.

METHODOLOGY

This study employs a narrative review approach to explore the application of Dignity Therapy (DT) for individuals with severe mental illness (SMI). A narrative review synthesizes existing literature to provide a comprehensive understanding of a topic without conducting statistical meta-analysis. The review followed PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines to ensure a structured and transparent process. The literature search and analysis were conducted between 2010 and 2024. This time framework was chosen to capture the contemporary developments in the field, as research on dignity therapy and its application in the context of severe mental illness and palliative care has gained momentum primarily in the last 15 to 20 years. A systematic search was conducted across electronic databases, including Google Scholar, PubMed, PsycINFO, and Scopus, using keywords such as "Dignity Therapy," "Severe Mental Illness," "Palliative Care," "Patient Dignity," and "Mental Health Interventions." Boolean operators (AND, OR) were utilized to refine the search and ensure a broad yet relevant selection of studies. The selected literature was critically analyzed to assess the effectiveness, feasibility, and ethical considerations of DT in mental health settings. The study also examined the

role of DT in promoting dignity, reducing existential distress, and improving psychological well-being among individuals with SMI.

Inclusion and exclusion criteria

The inclusion criteria for this study were individuals diagnosed with severe mental illness (SMI) based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) who were receiving care in psychiatric or palliative care settings. studies focusing on the implementation and impact of Dignity Therapy (DT) in these populations, and articles published in peer-reviewed journals between 2010 and 2024. Studies included had to assess dignity-related interventions, particularly DT, and their effectiveness in improving psychological well-being, reducing existential distress, and promoting dignity in individuals with SMI. Exclusion criteria encompassed studies that did not explicitly assess DT or dignity-related interventions, articles focusing on physical illnesses without a mental health component, studies with insufficient methodological rigor (e.g., lack of clear outcome measures or control groups), and non-peer-reviewed sources such as opinion pieces, letters to editors, or conference abstracts.

Study selection

Titles and abstracts of the initial search results were independently screened by two reviewers. Studies that appeared to meet inclusion criteria were retrieved for full-text review. The reviewers brought any disagreements to discussion or consulted with a third reviewer to resolve them.

Data extraction and analysis

Relevant studies were reviewed and analyzed based on their objectives, methodology, key findings, and implications. Thematic analysis was conducted to identify recurring themes, including the impact of DT on patient dignity, autonomy, and psychological well-being. The review also considered challenges in implementing DT in psychiatric settings and potential recommendations for future research and practice.

Quality assessment

These studies were evaluated in a systematic manner based on six criteria. Scores against each of the quality criteria were rated on a scale from 1 to 5, where scores are taken as lowest=1 and highest=5, used for the total score to provide an overall quality rating for each study included in this review.

Criteria for quality

Assessment: Clear *definition of the study population (1-5)*

- **1**: Vague or unclear population definition.
- **3**: Somewhat clear, with minor ambiguities.
- **5**: Well-defined population with clear inclusion and exclusion criteria.

Appropriateness of the study design and methods (1-5)

- **1**: Inappropriate or poorly chosen study design/methods.
- **3**: Adequate design/methods with some limitations.
- **5**: Highly appropriate and well-justified design/methods.

Adequacy of the sample size (1-5)

- **1**: Insufficient sample size to draw meaningful conclusions.
- **3**: Moderate sample size with some limitations in power.
- **5**: Large and adequate sample size providing robust results.

Validity and reliability of the measurement tools (1-5)

- **1**: Use of non-validated or unreliable tools.
- **3**: Mixed validity and reliability of tools.
- **5**: Use of well-validated and reliable tools.

Control for potential confounding factors (1-5)

- **1**: No control for confounding factors.
- **3**: Partial control with some confounders unaddressed.
- **5**: Comprehensive control for all relevant confounding factors.

Transparency in reporting results and conclusions (1-5)

- **1**: Poor reporting with lack of clarity.
- **3**: Adequate reporting with some gaps.
- **5**: Clear and transparent reporting of all results and conclusions.

DISCUSSION

Patient's dignity in mental health care

Mental illness impacts one in three people at some point in their lives and is a major worldwide health burden. [9, 10] Every nation's healthcare system has a fundamental obligation to protect patients' human dignity while delivering high-quality care, especially since people with mental illnesses are more likely to lose their dignity. [6, 11] The patient-caregiver connection revolves around two key elements, which are dignity and respect. The World Mental Health Federation declared 2015 to be the Year of Mental Health Dignity to highlight the need to maintain dignity in mental health care. [12] Dignity is treating someone with honor, integrity, and courtesy in a way that is neither patronizing nor demeaning, but rather with equality and the respect that every other person deserves. It is a mutual respect that requires both people to be involved in it to be realized. Respecting the autonomy and individuality of each patient by acknowledging their feelings and choices is essential to maintaining their dignity. [13, 14]

Based on an individual's sense of self-worth, the framework for human dignity holds that dignity is a subjective concept. Numerous social, cultural, and psychological elements also have an impact on it. A vital component of delivering high-quality treatment is upholding patients' dignity. [15] Individuals receiving care perceive dignity as a crucial component of their care, and they establish a correlation between their level of respect and dignity and the general caliber of their treatment. [16] Involving the patient in their care, respecting their authority and control over the treatment process, regarding them as a person, enabling them to make decisions, and maintaining privacy, confidentiality, and honest communication are all important aspects of maintaining patient dignity. [17] The 1984 General Assembly Declaration makes clear how important it is to uphold human dignity and status. [18] Human dignity is acknowledged by the World Health Organization as a crucial element in enhancing patient well-being. In a 1994 declaration, the organization listed the most significant rights as informed consent, access to healthcare services, privacy, and confidentiality of information. [18]

Outline of dignity therapy

DT is a therapeutically successful and evidence-based psychotherapy modality for patients with terminal illnesses. [19] DT is a one-of-a-kind, non-invasive, and practical therapeutic approach that can help patients with end-stage illnesses. [20] Irreversible illnesses can cause extreme physical discomfort, a loss of autonomy, difficult existential and spiritual experiences, and a breakdown in the patient's sense of self. [1, 21] In rare cases, these symptoms can even result in suicidal thoughts or a desire for a hastened death. [22] DT was originally developed for patients with terminal illnesses; its underlying principles of dignity, autonomy, and personhood may have significant therapeutic relevance for individuals with SMI as well. [22] The philosophy and practice of DT are mostly attributed to Canadian psychiatrist Harvey Chochinov, a specialist in palliative care. [23] Terms like self-worth, self-esteem, and self-respect are frequently used interchangeably with the concept of dignity. It may be argued that it is a multifaceted and complex idea that encompasses ideas like autonomy, self-pride, physical independence, and cognitive acuity. [23] DT is a brief, tailored intervention that decreases suffering and distress in people with terminal illnesses by giving them a feeling of purpose and meaning. Fundamentally, it provides a platform for patients to discuss matters that are important to them and life events they would like to be remembered. DT is a therapeutically meaningful technique to repair and promote fundamental but damaged components of the self, and it produces creative records that outlive the patient's death. [24]

Process of dignity therapy

DT focuses on tasks that preserve dignity, such as resolving relationships, expressing affection, sharing words of love, and establishing legacies of memory and shared ideals. These efforts become even more important as a person nears death. [25] A manualized DT guide was created by Dr. Chochinov and his associates. [26] There were 10 fundamental interview questions used by the intervention, one of which was, "What are your most significant achievements, and what do you feel most proud of? For your loved ones, what aspirations and hopes do you have? What life lessons have you learned that you would like to share with others? [26] The individual uses the responses to compile a written legacy document that they may distribute to those who hold special meaning for them. Every year, DT receives standardized training from Dr. Chochinov and his colleagues. Attendees at this course include professionals from all around the world who are determined to have appropriate prior training relating to mental health from a variety of fields (such as psychologists, social workers, or physicians).

To ensure intervention fidelity, they provide a detailed description of each step in the DT intervention manual. [27] The interventionist frames DT as a means of addressing topics that are most important to them and that they would like to document as a legacy-building activity. This is done during consent and the DT process introduction. The audio recording of the DT session is completed, edited, transcribed, and returned to the patient, who can then share it with friends or family. [27] The editing process allows the patient to speak freely during the interview because they know that the transcript will be reorganized and edited to create a legacy document that they believe is accurate, aesthetically pleasing, and won't harm anyone. After the document has been changed, the patient can send it to friends and relatives. [27]

Persons with severe mental illness (SMI) and dignity therapy

DT was established in palliative care settings as a brief, scientifically based treatment that allows participants to reflect on important existential and relational difficulties as well as examine areas of their lives that they want to be remembered for. [28] Randomized clinical trials (RCTs) involving DT have been conducted in a range of clinical settings, including neurology, geriatrics, palliative care, and oncology. Reviews have confirmed that DT improves patients' quality of life, validates their personhood, increases their sense of meaning and purpose, and lowers their levels of demoralization and existential suffering. [4] While it has been highlighted that stigma, discrimination, and disrespect for human rights are elements that undermine the dignity of persons with severe mental illness (SMI) such as schizophrenia, bipolar affective disorders (BPAD), and obsessive-compulsive disorder (OCD), a smaller number of research studies have looked into the use of DT in this population. 5 There are very few case reports of DT patients with mental problems, such as schizoaffective disorder, and one randomized controlled trial (RCT) with major depressive disorder. [7, 29]

As stated in the Charter of Patients' Rights, one research study shows that the dignity of psychiatric patients while they are in hospitals is not sufficiently addressed. [30] The results of that study show that medical professionals have a negative guardianship attitude toward their patients, which results in dehumanization, depersonalization, rights violations, and the

deprivation of patients' power. This can lead to a lack of dignity maintenance for patients in mental health facilities, which would be detrimental to the standard of treatment. [4, 30] Another study done in the UK highlights that patients' experiences indicated that several things affected their sense of dignity, such as staff members who did not listen to their worries, who did not participate in decisions about their care or treatment, who did not provide adequate information about treatment plans and medications, who did not have easy access to therapists, and who did not provide a supportive physical environment for physical activity. [6] A patient's dignity is violated when they are not included in decision-making or treatment. [6]

Anger can arise from interpersonal imbalances when patients and their families get treatment that is consistent with ideals like equality and respect. [30-31] Patients need to be respected, acknowledged as fellow human beings, and encouraged to make comparisons between themselves and other patients who are suffering from physical illness. According to a study conducted by Gastfson, Wigerblad, and Lindwall (2014), [32] seven major themes emerged highlighting the ways in which patients' dignity can be compromised in health care settings. [32] These includes, patients not being taken seriously, where their concerns and experiences were dismissed or minimized by healthcare professionals, patients being ignored, leading to feelings of invisibility and neglect, breach of confidentiality, where patients' personal and sensitive information was disclosed without consent, aggression against patients either verbally or physically, the victimization of patients, the abuse of patients' trust, involving situations where confidence placed in healthcare providers was violated; and the predefinition of patients, where individuals were stereotyped or judged based on their diagnoses rather than being seen as unique persons with distinct needs and experiences. Patients felt dehumanized when their diagnoses were revealed to their relatives and they were ignored. By preserving a patient's dignity, one may help them feel more at ease, self-assured, and valuable when making decisions about their care and treatment. However, when a patient's dignity is violated, treatment and care results may suffer due to emotions of ambiguity, embarrassment, and shame. [33] In healthcare settings, dignity includes autonomy, truthfulness, fairness, respect for human rights, consciousness, and proactive patient advocacy. [34] Despite being initially created in the context of terminal care, DT is highly relevant for people with SMI due to its fundamental focus on meaning, autonomy, and personhood. Persons with SMI and those facing terminal illness frequently experience existential distress, identity disruption, and a diminished sense of self-worth. Therefore, DT's therapeutic utility is expanded when used in psychiatric settings, and it also supports the larger objective of promoting humanization and dignity in mental health treatment.

Impact of dignity therapy on patients and families

DT is a valued and essential addition to the overall care of individuals with palliative care requirements. Even in acute care facilities, with open communication, treatment can address the disease's life-limiting aspects. [35] Therapy outcomes are promising, helpful, and successful in improving the end-of-life experience for patients seeking to leave a legacy. DT was crucial in helping family care members to cope with the depression, stress, anxiety, and burden associated with end-of-life care. DT was proposed to have an impact on a number of significant components of the family's experience of the dying process. [36] This included making patients feel like they were still themselves and assisting them in completing unfinished business. [37] Patients with terminal illnesses across various age groups were given DT. These patients included those receiving a home-based bone marrow transplant (BMT), chronic obstructive pulmonary disease, advanced cancer, and other neurological disorders. While cultural factors may play a role in DT, patients who wish to leave a legacy may find this form of treatment encouraging. [38]

Family members or friends frequently accompany patients who have been diagnosed with a serious disease for the duration of that illness. Improving the patient's and their family members' quality of life is one of the primary objectives of palliative care. A family member may experience physical and mental health problems as a result of caring for a loved one. Family members can now get supporting assistance from certain patient services as part of all-inclusive care. DT may be advantageous to the patient's family as well. Bentley and colleagues found that while 33% of the 18 family members said DT increased their feelings of optimism for the future, 28% of the family members said it helped them feel less stressed or prepared for the death of their loved one. [37] In addition to recommending DT to other friends and family, the majority of family members thought the DT document would continue to provide comfort to them and their families. The impact of DT on family members was largely well-received by them. [39] However, some family members expressed concerns about incomplete or inaccurate documentation, the fact that the process was physically and emotionally taxing on their loved one, and the fact that they felt bad about reading the document. [27, 39]

Involvement of family members in dignity therapy

The patient is the center of attention in DT; family members play a significant role as well. DT has been utilized in a wide range of groups, such as fragile elderly persons and patients with amyotrophic lateral sclerosis and cancer. [40, 41] Since family members are frequently the recipients of legacy documents, they play a significant role in DT. According to the patient's wish or because the patient had a speech or cognitive disability that prevented them from finishing the legacy document without help from family, several researchers included family members in the legacy document's preparation. [41] The majority of research has examined the impact of DT on the patient; several studies have also looked at the impacts on family members. [4] Since family members often experience emotional distress as well as caregiver burden, they could benefit from participating in the creation of the DT document or receiving it or possibly creating their statement to the patient. The majority of family members experienced favorable benefits, but others experienced negative

emotions, according to the research that was examined. Fitchett et al (2015), [4] highlighted mourning,

transgenerational relationships, family communication, and a sense of dignity and purpose as possible focal points for the impacts of DT. [4] Grijo, Tojal, and Rego (2021) [42] observed that the families found DT to be beneficial in helping them assist their loved ones as they approached the end of their lives and heal from their loss. [42] Along with the positive impacts on patients and their families, DT also improved the patient-hospice staff interface and the staff members' work satisfaction. [43] Patients with diverse clinical statuses, such as those with cancer, motor neuron disease, and the elderly, have demonstrated that DT is both practical and well-tolerated. [36, 40]

Applying DT revealed that the therapy significantly improved the subject's quality of life, dignity, and ability to cope with sadness and anxiety. [44, 45] Involving families in DT is essential to provide terminally ill patients with a more unique and fulfilling experience and to assist them and their loved ones as they approach the end of their lives. It also enables family caregivers to offer deeper assistance in the last stages of the patient's life by being aware of their values and wishes. [44, 45] Importantly, family participation in DT can aid in the grieving process by supporting loved ones as they learn to live with their loss and manage with grief.

Preserving patients' dignity and autonomy in hospital wards

Maintaining the dignity of patients in different hospital wards is essential, and upholding the rights associated with personal dignity is a fundamental aspect of professional and work ethics. Research has indicated that hospitalized individuals are vulnerable to losing their sense of self or human dignity. [46] The majority of healthcare professionals, it appears, only see the world through a professional lens, which restricts their ability to think critically, judgment, and ultimately their performance. To attain maximum performance, they must broaden their comprehension of the phenomena through several approaches. [47] Therapy for individuals with mental illnesses may be administered against their will, at the therapist's discretion, and by the utility principle.

Patients hospitalized in mental health wards may forget that they have the right to preserve confidentiality, exercise authority, and participate in treatment choices. [48] This carelessness may cause the patient to feel powerless and abandoned, which might hinder their ability to recover. [48, 49] It has also been demonstrated by studies that a patient's will to survive and rehabilitate may be negatively impacted by being deprived of their dignity. Improving human dignity is therefore essential. While violating someone's human dignity can result in serious physical and mental health problems, upholding dignity in medical care recipients can boost their self-confidence. [46, 50]

Cultural and ethical aspects of dignity therapy

When applying DT to individuals with mental illness, it is important to carefully examine cultural, ethical, and legal factors. [51] DT has been utilized extensively in palliative care settings. Diverse cultural backgrounds give rise to distinct attitudes, values, and beliefs toward disease, death, and dignity. The cultural background, interests, and individuality of each person, as well as their community, must be respected while designing DT. [51] Cultural nuances might have an impact on the language and question structure utilized in DT sessions. Cultural inclusion requires translating resources and making sure that there is good communication. [52] The entire family or community is involved in choices regarding illness and end-of-life care in many cultures. The role and participation of family members or community leaders in the process should be taken into account by the therapies. [53]

The ability to make decisions can vary widely among people with mental illnesses. Even when a legal guardian or family member is present, it is crucial to respect their autonomy and acquire informed consent before participating in therapy. [54] Confidentiality and privacy must always be respected in therapy, particularly when addressing sensitive topics like mental health and personal experiences. The confidentiality of the participant should be safeguarded by clearly defined norms. Therapists must make sure that therapy is beneficial to the patient and does not cause damage. [55] To avoid discomfort, it is important to carefully evaluate the person's mental health and preparation for the intervention.

Different legal frameworks have different views on the ability of people with mental illness to make decisions about their treatment. According to Series (2015) [56], it is crucial to evaluate capability and confirm that the patient is capable of comprehending the goals and consequences of treatment. [56] A person's legal status and the jurisdiction in which they live might affect the criteria for informed consent. It is essential to make sure that participants or their legal representatives comprehend the nature and intent of DT. [56] Maintaining accuracy, secrecy, and compliance with pertinent rules or professional standards necessitates adhering to legal norms for documentation and record-keeping. [57] Incorporating these factors into the implementation of DT for those suffering from mental illnesses can assist in guaranteeing that the intervention is culturally sensitive, morally sound, and legally suitable.

CONCLUSION

The pervasiveness of mental health disorders in India underscores the critical need for effective interventions to address the significant burden they impose on individuals and society. Although DT has emerged as a valuable intervention in palliative care, this paper emphasizes its potential in psychiatric settings for persons with SMI. At the same time, DT has shown significant benefits in various clinical settings, including oncology, neurology, and geriatrics. DT addresses these challenges by affirming personhood and validating lived experiences, thus promoting a sense of dignity and self-worth. Moreover, DT fosters a therapeutic environment characterized by empathy and respect, countering stigma and discrimination prevalent in healthcare settings. Research into DT efficacy for severe mental illness (SMI) populations such as schizophrenia, bipolar affective disorder (BPAD), and obsessive-compulsive disorder (OCD) is limited, highlighting

the need for further investigation. Although DT is grounded in palliative care, its potential role in enhancing dignity and well-being in psychiatric settings, particularly for persons with SMI, deserves further research and clinical attention. DT has the potential to alleviate existential distress and enhance overall well-being, ultimately improving the quality of life for individuals grappling with mental health disorders and their families.

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AUTHORS' CONTRIBUTION

All authors have significantly contributed to the work, whether by conducting literature searches, drafting, revising, or critically reviewing the article. They have given their final approval of the version to be published, have agreed with the journal to which the article has been submitted, and agree to be accountable for all aspects of the work.

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