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The Impact of Dignity Therapy on Psychological Well-Being and Quality of Life in Terminally Ill Cancer Patients: A Systematic Review

Dimas Ria Angga Pribadi[1]*, Ekan Fauzi[2], Thomas Ari Wibowo[3]
[1,2] Department of Nursing, Faculty of Health Sciences, Muhammdiyah University of Surakarta
[3] Department of Nursing, Muhammadiyah Kalimantan Timur University

Corresponding Author : dra632@ums.ac.id

ABSTRAK

Dignity therapy (DT) aims to enhance the dignity, meaning, and emotional well-being of terminally ill cancer patients. While research investigates DT's application in palliative care, a comprehensive systematic review synthesizing its effects remains lacking. Objective: This systematic review assesses the efficacy of DT in improving psychological and existential outcomes for terminally ill cancer patients. Methods: A systematic review adhering to the PRISMA guidelines was conducted. Searches across Medline, PubMed, Scopus, and CINAHL databases yielded 113 references, which were screened against 10 studies meeting inclusion criteria. Results: DT demonstrates positive effects on dignity, sense of purpose, meaning in life, and hope. However, its impact on psychosocial distress, particularly depression and anxiety, is inconclusive. DT's acceptance rate was high, with over 80% of participants reporting satisfaction. Quality of life improvements varied, with some significant enhancements and others exhibiting minimal impact. Conclusion: DT is a feasible intervention that offers psychosocial benefits for terminally ill cancer patients in palliative care settings.It enhances dignity, facilitates family communication, and offers existential relief. Further research is necessary to standardize protocols, conduct long-term follow-ups, and integrate DT into interdisciplinary palliative care models.

Keywords: ***Dignity therapy, Palliative care, Terminal cancer, End-of-Life care, Psychological well-being***

INTRODUCTION

Cancer, a leading cause of global mortality, accounts for approximately 10 million annual deaths, with nearly one in six deaths attributed to it (Bray et al. 2024) . Cancer patients often experience significant distress, including loss of dignity, which adversely impacts their quality of life, emotional well-being, and end-of-life decisions (Scheffold et al. 2019) . (Mergler et al. 2022) . Studies demonstrate that patients experiencing dignity loss are more inclined to consider euthanasia or assisted suicide, with dignity-related suffering serving as a primary motivator in 57% of cases (Maas, 1991).

As defined by (Chochinov et al. 2011), dignity encompasses a state of worthiness and respect. For terminally ill patients, dignity is not merely a concept but a lived experience that shapes their perceptions of worth, autonomy, and meaning. Dignity Therapy (DT) is a psychotherapeutic intervention specifically designed to address these concerns. DT entails structured life reflections, enabling patients to articulate their values, relationships, and legacy, thereby fostering a sense of meaning and enhancing psychological resilience (Harvey Max Chochinov et al., 2012).

Psychosocial interventions have been shown to improve psychological outcomes and overall well-being for cancer patients, yet only approximately 10% of European and Canadian cancer patients engage in these interventions (Tian et al. 2024) . Despite this, a study by (Houmann et al. 2014) revealed that while 29% of Danish cancer patients required psychosocial support, only 37% received counseling, underscoring an unmet need. (Lim 2023))

emphasized the necessity of interventions explicitly targeting dignity-related suffering in advanced cancer.

Dignity Therapy (DT) is a structured, patient-centered intervention designed to assist terminal illness patients in maintaining their sense of purpose, meaning, and connection with their loved ones (Weru, Gatehi, and Musibi 2020) . The therapy involves a structured interview process guided by a standardized question protocol, wherein patients share significant life experiences, personal values, and messages they wish to convey to their families. The responses are transcribed, edited, and compiled into a legacy document for patients to share with their support system (Weru et al. 2020).

Numerous studies have investigated the efficacy and acceptability of DT among cancer patients receiving palliative care. DT has been associated with increased hope, meaning, and a stronger determination to endure (Li et al. 2020) . Additionally, it reduces existential distress, depression, and anxiety, providing psychological support for terminally ill individuals. While qualitative studies have demonstrated high patient satisfaction, quantitative evidence remains limited and inconclusive. A systematic review is warranted to evaluate DT's effectiveness in enhancing psychological and existential outcomes for terminally ill cancer patients(Li et al. 2020).

This systematic review aims to comprehensively synthesize current evidence on DT's impact on terminally ill cancer patients, specifically focusing on psychological distress, dignity-related concerns, and quality of life. Through analyzing data from experimental and quasi-experimental studies, this review provides an evidence-based assessment of DT's clinical utility within the context of palliative care (Pribadi et al. 2023).

PURPOSE

This systematic review synthesizes findings from studies investigating Dignity Therapy (DT) to evaluate its effects on terminally ill cancer patients. The review examines DT's impact on psychological distress, quality of life, dignity concerns, and overall well-being. Analyzing data from experimental and quasi-experimental studies, the review assesses DT's effectiveness in improving emotional and existential outcomes.

METHODS

SEARCH STRATEGY

A comprehensive literature search was conducted using Medline, PubMed, Scopus, and CINAHL databases up to February 10, 2025. Keywords included 'dignity therapy,' 'dignity psychotherapy,' 'Chochinov,' 'terminally ill cancer patient,' and 'dignity care.' The systematic review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

SELECTION CRITERIA

Studies were included if they specifically investigated Dignity Therapy as an intervention, involved cancer patients, had full-text articles published in English or Indonesian, and employed an experimental or quasi-experimental design. Studies were excluded if they did not utilize Dignity Therapy as the primary intervention, focused on theoretical development, or lacked full-text accessibility.

SETTINGS

The included studies were conducted in diverse geographic locations, including Switzerland, China, Iran, Kenya, Australia, Canada, Taiwan, Portugal, and the United States. The sample sizes varied from 30 to 165 participants. All participants were diagnosed with advanced or terminal cancer, with the majority receiving palliative care in hospital settings, hospice care units, or home-based care. Most studies focused on patients with a prognosis of less than six months, ensuring that the intervention was applied in the context of end-of-life care.

STUDY Design

Six of the ten included studies employed randomized controlled trials (RCTs), while four

utilized a quasi-experimental design. The majority of studies (eight) conducted baseline assessments before the intervention, while seven studies implemented post-intervention evaluations within the first week following Dignity Therapy (DT). Additionally, six studies included follow-up assessments between two- and four weeks post-intervention to examine the longer-term effects of DT on psychological distress, quality of life, and dignity-related concerns. These methodological approaches ensured that the impact of DT was systematically measured over time, enhancing the reliability of the reported findings.

INTERVENTION

All included studies utilized Chochinov's Dignity Therapy (DT) protocol as the primary intervention framework (Chochinov et al. 2011) . This therapy entailed structured life reflection interviews conducted by trained healthcare professionals, with a primary focus on preserving dignity and addressing psychological and existential distress. Notably, there were variations in the intervention, including the number of DT sessions, the delivery methods (face-to-face or telemedicine), and the involvement of family members in certain studies. Furthermore, some studies incorporated follow-up sessions to assess the long-term impact of DT on patients' well-being.

MEASURES

Researchers employed standardized assessment instruments to evaluate both primary and secondary outcomes in the included quantitative studies. Depression was assessed using the Hospital Anxiety and Depression Scale (HADS) in six studies, anxiety using HADS in five, hope using the Herth Hope Index in two, dignity using the Patient Dignity Inventory (PDI) in five, quality of life using the EORTC QLQ-C30 and FACT-G in four, and spiritual well-being using the FACIT-Sp in two.

The primary efficacy measures included the PDI (three studies), HADS (four studies), and DTPFQ (three studies). Eight studies utilized supplementary instruments. The DTPFQ was extensively employed to assess intervention acceptability and outcome evaluation.

RESULT

A systematic review of 113 articles identified 10 studies that met inclusion criteria. These studies included six randomized controlled trials and four quasi-experimental studies. Primary outcomes assessed included depression, anxiety, quality of life, dignity, and overall well-being. Assessment tools utilized included the HADS, PDI, and DTPFQ.

The majority of studies reported statistically significant reductions in depression and anxiety following DT, with sustained benefits persisting at follow-up. Additionally, some studies demonstrated improvements in patient's sense of dignity, meaning in life, and emotional well-being. However, quality of life outcomes exhibited variability.

Feasibility and acceptability of DT were high, with over 80% of patients reporting a meaningful and beneficial experience. Some studies suggested that DT contributed to enhanced family communication and strengthened relationships. Variations in study design, sample sizes, and cultural adaptations underscore the necessity for standardized protocols and long-term efficacy research. In summary, DT supports a valuable psychosocial intervention for terminally ill cancer patients, mitigating psychological distress and enhancing dignity during the final stages of life.

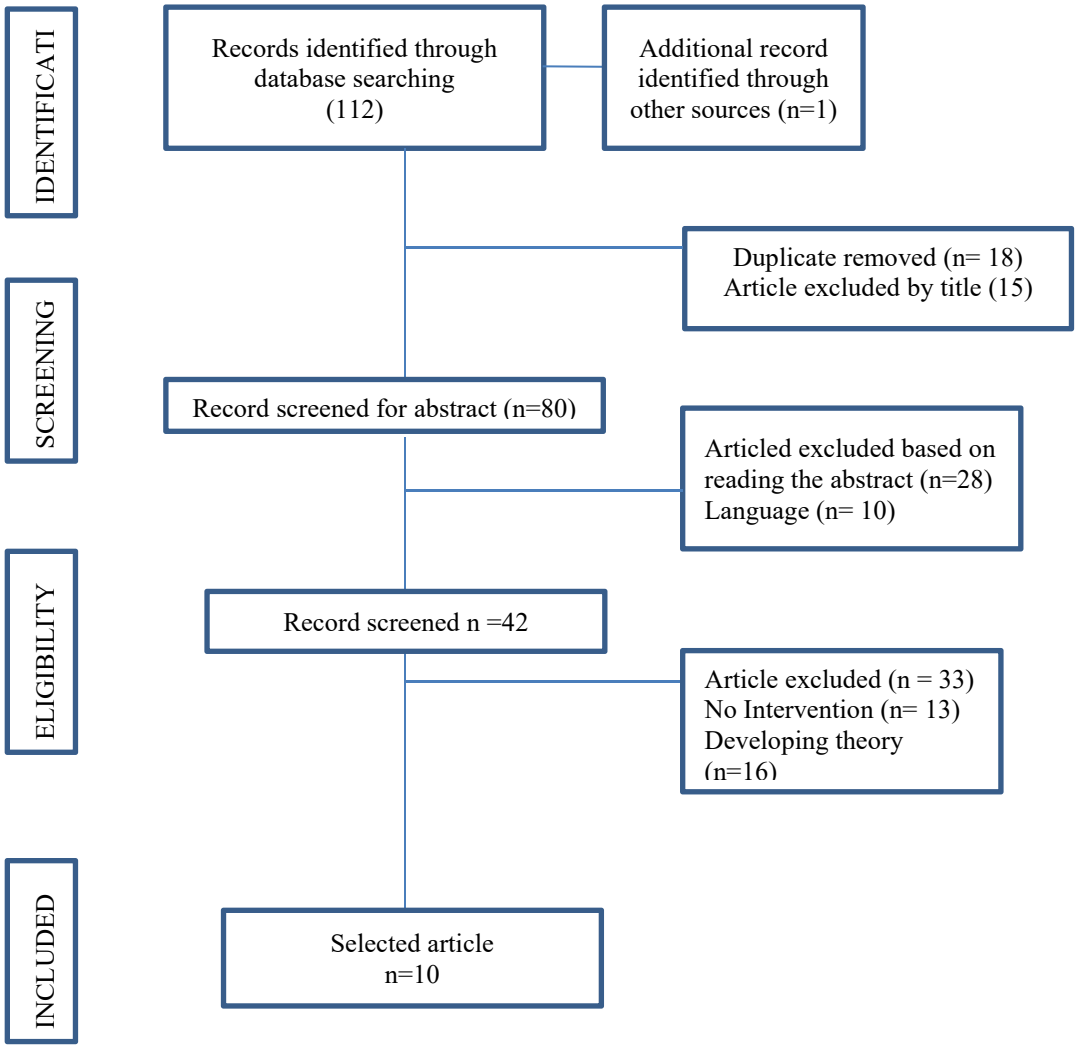

Figure 1 Flow diagram of the systematic review process

Table 1: Risk of Bias (RoB)

Study ID	Randomization Process	Deviations from Intended Interventions	Missing Outcome Data	Measurement of the Outcome	Selection of the Reported Result	Overall
S1	⊕	⊕	⊕	⊕	⊕	⊕
S2	©	⊕	⊕	⊕	⊕	©
S3	⊕	⊕	⊕	⊕	⊕	⊕
S4	©	⊕	⊕	⊕	⊕	©
S5	⊕	⊕	⊕	⊕	⊕	⊕
S6	⊕	⊕	⊕	⊕	⊕	⊕
S7	⊕	⊕	⊕	⊕	⊕	⊕
S8	⊕	⊕	⊕	⊕	⊕	⊕
S8	⊕	⊕	⊕	⊕	⊕	⊕
S9	⊕	⊕	⊕	⊕	⊕	⊕
10	©	⊕	⊕	⊕	⊕	©

⊕ = Low Risk
© = Some Concern
® = High Risk

Table 2: Characteristics of the 10 included studies.

Study ID	Author(s), Year	Country	Sample Size	Cancer Type	Study Design	Intervention
S1	Seiler et al., 2024	Switzerland	68 (DT and DT+ groups)	Terminal cancer	RCT	DT and DT+ compared to Standard Palliative Care (SPC)
S2	Zhang et al., 2022b	China	120	Lung cancer undergoing chemotherapy	RCT	Family-oriented DT vs. attention control
S3	Zaki-Nejad et al., 2020	Iran	50	Various cancer types	Quasi-experimental	DT with structured DT protocol
S4	Weru et al., 2020	Kenya	144	Advanced cancer	RCT	One-session DT with follow-up at 6 weeks
S5	Vuksanovic et al., 2017	Australia	47	Various cancer types	RCT	DT by a clinical psychologist vs. waitlist control
S6	Chochinov et al., 2011	Canada	108	Terminally ill cancer patients	RCT	DT vs. client-centered care vs. SPC
S7	Li et al., 2020	Taiwan	30	End-of-life cancer	Quasi-experimental	DT with assessments at 7- and 14-days post-intervention
S8	Julião et al., 2015	Portugal	80	Terminally ill cancer	RCT	DT vs. SPC; assessed survival impact
S9	Chochinov et al., 2011	Canada, USA, Australia	165	Terminally ill cancer patients	RCT	DT vs. standard palliative care vs. client-centered care
S10	Julião et al., 2013	Portugal	60	Terminal cancer patients	RCT	DT vs. SPC; assessed depression and anxiety

Table 3: Continued of Characteristics of the 10 included studies.

Study ID	Assessment Timepoints	Measures Used	Key Findings
S1	Baseline (T0), 1-week (T1), 2 weeks (T2), 3 months post-death (T3)	HADS, PRISM, FACIT-Pal-14, Distress Thermometer, WHOQOL-BREF	Improved QoL, reduced suffering, prevented mental health decline
S2	Baseline, 1-week, 4-week follow-up	PDI, PHQ-9, FACIT-Sp	Reduced existential distress and depression, increased spiritual well-being
S3	Three sessions, 30-60 min each	EORTC QLQ-C15-Pal	Improved QoL, significant emotional and physical functioning improvements
S4	Baseline and 6-week post-intervention	ESAS	Trends toward improvement in anxiety and well-being ($p = 0.059$)
S5	Three sessions, avg. 58.05 min	PDI, FACT-G	No significant change in dignity-related distress or QoL
S6	Multiple contacts over 7-10 days	FACIT-Sp, PDI, HADS, QOL Scale	No significant change in distress; patients found DT meaningful and helpful
S7	Baseline, Day 7, Day 14	Dignity, Demoralization, Depression Scales	Increased dignity, reduced demoralization and depression
S8	Baseline, survival follow-up	Kaplan-Meier survival estimates, HADS	DT group had increased survival (26.1 days vs. 20.8 days, $p = 0.025$) and reduced depression and anxiety
S9	Baseline, multiple follow-ups	FACIT-Sp, PDI, HADS, QOL Scale	DT significantly improved dignity, family appreciation, and QoL measures
S10	Baseline, Day 4, Day 15, Day 30	HADS	DT reduced depression and anxiety at early follow-ups, but effects diminished by Day 30

DISCUSSION

The findings from this systematic review indicate that dignity therapy (DT) provides significant psychosocial benefits for terminally ill cancer patients. However, its effects on depression, anxiety, and quality of life remain inconsistent across studies. The majority of included studies reported that DT significantly reduced depression and anxiety levels, particularly in randomized controlled trials with more extended follow-up periods (Chochinov et al. 2011; Julião, Nunes, and Barbosa 2015) . However, some quasi-experimental studies found no significant effect or worsening psychological symptoms at follow-up, suggesting that study design and sample size might influence outcomes (Houmann et al. 2014).

DT consistently demonstrated high levels of patient satisfaction, with over 80% of participants across studies reporting that the therapy was beneficial (Chochinov et al. 2012) . Patients frequently cited DT as a meaningful intervention that provided a sense of dignity, and purpose, and enhanced family communication. In addition, DT was shown to increase the will to live and hope, particularly in studies where follow-up assessments were conducted beyond the immediate post-intervention period (Julião et al. 2013).

Despite these positive findings, the impact of DT on quality of life was less clear. While some studies reported significant improvements, others found no effect or even a decline in quality-of-life measures (Zaki-Nejad et al. 2020) . This variability may be attributed to differences in patient populations, assessment tools, and follow-up durations (Seiler et al. 2024).

A key strength of DT is its flexibility and adaptability across diverse cultural and healthcare settings (Weru et al. 2020; Zhang, Li, and Hu 2022) . However, standardization in delivery methods, session structure, and follow-up assessments is necessary to strengthen the evidence base. Future research should prioritize larger, well-controlled trials with extended follow-up to assess the long-term effects of DT. Additionally, investigations into the mechanisms underlying DT's benefits—such as its role in facilitating emotional expression, improving patient-family relationships, and reducing existential distress—are warranted(Vuksanovic et al. 2017).

Overall, this systematic review supports dignity therapy as a valuable and acceptable psychosocial intervention for terminally ill cancer patients. While its efficacy in reducing psychological distress is promising, further studies are needed to establish standardized protocols and optimize its application in palliative care settings.

CONCLUSION

This systematic review highlights the potential benefits of Dignity Therapy (DT) in improving psychological well-being, dignity, and quality of life among terminally ill cancer patients (Mergler et al. 2022) . The findings suggest that DT provides meaningful psychosocial support, enhances patient-family communication, and fosters a sense of purpose and legacy at the end of life. While some studies demonstrate significant reductions in depression and anxiety, others report no substantial changes, indicating a need for further investigation into the factors influencing DT's effectiveness(Vuksanovic et al. 2017).

Despite its widespread acceptance and high patient satisfaction rates, the impact of DT on quality of life and spiritual well-being remains unclear. Future research should focus on large-scale, randomized controlled trials with extended follow-up periods to provide more conclusive evidence on DT's efficacy (Xiao et al. 2022) . Additionally, integrating DT into family-centered care models may enhance its effectiveness by addressing not only the patient's needs but also the well-being of their loved ones.

Overall, DT represents a promising intervention for enhancing dignity and alleviating existential distress in palliative care settings. However, continued efforts are needed to standardize DT protocols, expand its application, and explore its long-term

impact on the well-being of both patients and their families

RELEVANCE TO CLINICAL PRACTICE

Dignity Therapy (DT) is a structured psychosocial intervention designed to address the emotional distress, existential suffering, and quality-of-life concerns experienced by terminally ill cancer patients. DT has demonstrated high patient satisfaction and cultural acceptability, making it a practical approach for healthcare providers. Its brevity, adaptability, and facilitation of legacy-building and communication with family members contribute to its effectiveness.

Despite its advantages, standardization challenges exist, necessitating future clinical applications that include training and standardized protocols. Integrating DT into interdisciplinary palliative care teams enhances holistic patient care..

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