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Article / Artículo

Effectiveness of Dignity Therapy in Patients with Advanced Cancer Receiving Palliative Care: A Systematic Review

Efectividad de la terapia de la dignidad en pacientes con cáncer avanzado que reciben cuidados paliativos: una revisión sistemática

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ABSTRACT

Introduction: Dignity Therapy (DT) is a brief psychotherapeutic intervention designed to relieve existential suffering and enhance identity and self-worth in end-of-life patients. Its application in palliative oncology has yielded variable results, warranting an updated synthesis of evidence. **Material and Methods:** A systematic review was conducted following PRISMA 2020 and registered in PROSPERO (CRD420251109555). Randomized controlled trials and quasi-experimental studies evaluating DT in adults with advanced or terminal cancer were included. The primary outcome was perceived dignity; secondary outcomes included anxiety, depression, spiritual well-being, hope, and quality of life. Methodological quality was assessed using ROB2 and ROBINS-I tools. **Results:** Ten studies with 904 patients from America, Europe, and Asia were analyzed. No statistically significant differences were found in perceived dignity; however, most studies reported improvements in emotional well-being, hope, and spirituality, with good feasibility and acceptability of the intervention. **Conclusions:** Despite heterogeneity across studies, DT provides meaningful emotional and existential benefits for patients with advanced cancer. It represents an ethical and humanizing intervention that should be integrated into palliative care programs, while further multicenter research is encouraged to strengthen current evidence.

Keywords: Neoplasms; Dignity therapy; Palliative care; Terminal care; Psychotherapy.

RESUMEN

Introducción: La terapia de la dignidad es una intervención psicoterapéutica breve desarrollada para aliviar el sufrimiento existencial y fortalecer la identidad y el sentido de valor en pacientes al final de la vida. Su aplicación en cuidados paliativos oncológicos ha mostrado resultados variables, por lo que es necesario evaluar su efectividad global. **Metodología:** Se realizó una revisión sistemática conforme a la declaración PRISMA 2020, registrada en PROSPERO (CRD420251109555). Se incluyeron ensayos clínicos aleatorizados y estudios cuasiexperimentales que aplicaron la terapia en pacientes adultos con cáncer avanzado o terminal. El desenlace principal fue la dignidad percibida, y los secundarios incluyeron ansiedad, depresión, bienestar espiritual, esperanza y calidad de vida. La calidad metodológica se evaluó con las herramientas ROB 2 y ROBINS-I. **Resultados:** Se analizaron diez estudios con 904 pacientes de América, Europa y Asia. No se encontraron diferencias estadísticamente significativas en la dignidad percibida; sin embargo, la mayoría de los estudios reportó mejoras en bienestar emocional, esperanza y espiritualidad, con buena aceptación y factibilidad de la intervención. **Conclusiones:** Aunque los resultados cuantitativos son heterogéneos, la terapia de la dignidad ofrece beneficios emocionales y existenciales relevantes en pacientes con cáncer avanzado, lo cual constituye una estrategia ética y humanizadora. Se recomienda su integración en los programas de cuidados paliativos y la realización de investigaciones multicéntricas con mayor rigor metodológico.

Palabras clave: neoplasias; terapia de la dignidad; cuidados paliativos; atención terminal; psicoterapia.

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1. Introduction

The terminal phase of cancer represents a complex process, in which physical suffering coexists with emotional distress, a high likelihood of loss of meaning, and an existential crisis linked to the imminence of death. In this context, palliative care constitutes a comprehensive approach (physical, psychological, social, and spiritual) aimed at improving quality of life for patients and their families [1].

Among emerging interventions in this field, Dignity Therapy (DT) has gained recognition as a brief, person-centered psychotherapeutic tool designed to alleviate existential distress and promote a sense of worth, continuity of self, and legacy in patients at the end of life [2,3]. Developed by Chochinov et al. in 2005, DT is structured around a semi-structured interview whose responses are transcribed and edited to generate a document that can be shared with whomever the patient chooses, functioning as a “life testimony” [4,5].

Numerous studies have described benefits of DT, such as reductions in anxiety and depression, improvements in spiritual well-being, and enhanced perception of meaning and personal control in the face of impending death [6–8]. However, its implementation across different clinical settings and specific populations, such as patients with advanced cancer, has yielded variable results, thus making it necessary to systematize the available evidence.

Recent studies conducted in different regions (Asia, Europe, and Latin America) reinforce their usefulness in various cultures and clinical contexts by improving emotional well-being and generating high levels of satisfaction [9,10]. Likewise, a culturally adapted version of DT for ambulatory oncology patients has shown effectiveness in enhancing the sense of dignity and reducing distress in patients with advanced-stage disease [11]. Among patients in a terminal condition, DT has been useful in reducing emotional symptoms and, although no survival benefit was observed, its relevance has been consolidated as an ethical and humanizing intervention in end-of-life care [12].

The increasing prevalence of patients with advanced cancer and the importance of comprehensively addressing suffering in palliative care justify the need for a systematic review of the effects of dignity therapy [13].

In this context, the aim of this systematic review was to evaluate the effectiveness of Dignity Therapy in adult patients with advanced cancer receiving palliative care, and to analyze its impact on perceived dignity, psychological and spiritual well-being, and quality of life, compared with standard care.

2. Methodology

This systematic review was conducted in accordance with the PRISMA 2020 (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines [14]. The protocol was prospectively entered in the PROSPERO (International Prospective Register of Systematic Reviews) database under registration number CRD420251109555.

2.1 Inclusion criteria

Randomized controlled trials and quasi-experimental studies evaluating Dignity Therapy in adults (≥18 years) with advanced or terminal cancer receiving palliative care were included. The intervention must correspond to the original Chochinov model, administered in person or in a culturally adapted format. The comparison group was standard palliative care. The primary outcome was perceived dignity, and secondary outcomes included anxiety, depression, hope, spiritual well-being, and quality of life.

2.2 Exclusion criteria

Studies involving patients with severe cognitive impairment, combined psychosocial interventions, pilot studies without complete results, review articles, short communications, conference abstracts, and duplicate publications were excluded.

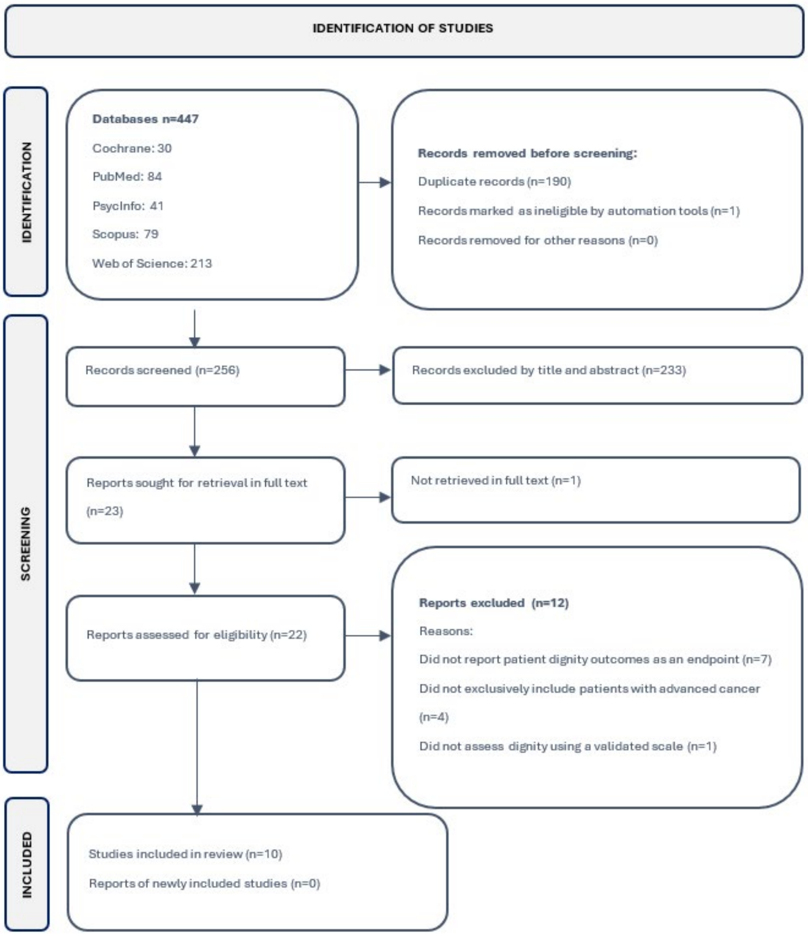
2.3 Search strategy

The literature search was completed on 20 July 2025. It was conducted without language or date restrictions in five databases (PubMed, Cochrane Library, PsycINFO, Scopus, Web of Science). Search terms included MeSH (Medical Subject Headings) and free-text terms related to dignity therapy, cancer, and palliative care. The main search string was: ("Dignity Therapy" OR "dignity intervention") AND ("Neoplasms" OR "Cancer") AND ("Palliative Care"). It was adapted for each database.

2.4 Study selection

A total of 447 records were identified in electronic databases. After removing duplicates (n = 190) and one ineligible record identified by automation tools, 256 titles and abstracts were screened. Out of these, 233 were excluded for not meeting inclusion criteria. Twenty-three full-text articles were assessed; 17 met the eligibility criteria and were included in the qualitative synthesis [4,9–12,15–26]; ten provided adequate data for meta-analysis. The entire selection process is detailed in Figure 1. Reference management was performed using Mendeley Reference Manager.

Figure 1. PRISMA flow diagram of study selection for the systematic review.



2.5 Risk of bias assessment

Risk of bias was independently assessed by two reviewers using ROB 2 (Risk of Bias 2) for randomized controlled trials (RCTs) [27] and ROBINS-I (Risk of Bias in Non-randomized Studies of Interventions) for non-randomized studies [28]. Discrepancies were resolved by consensus or through a third reviewer (an independent methodological and statistical consultant).

2.6 Data extraction

Information from each study was collected using a structured Excel template to ensure uniformity and accuracy. General data (author, year, country, design, and sample size), participant characteristics, cancer type, and care setting were extracted. Regarding the intervention, the main features of Dignity Therapy (mode of delivery, duration, professional in charge, and cultural adaptations) and the comparison group were recorded. Primary and secondary outcomes (perceived dignity, psychological well-being, spirituality, hope, and quality of life) were documented with the scales used and pre- and post-intervention values. Data were verified by two independent reviewers, and disagreements were resolved through consensus.

2.7 Data analysis

Quantitative analyses were performed using Jamovi (version 2.3.28). For continuous outcomes (Patient Dignity Inventory scores and other scales), mean differences (MD) with 95% confidence intervals (95% CI) were calculated. For paired measures (pretest–posttest), mean and standard deviation (SD) of the differences were used or derived from means and SDs at each time point using standard formulas for repeated measures, assuming a correlation coefficient based on the literature. Between-group comparisons (intervention vs. control) used unstandardized mean differences. Random-effects models (DerSimonian and Laird) were applied as the main estimator. Heterogeneity was assessed using I^2, Cochran’s Q test, and 95% prediction intervals, following the recommendations of Higgins and Thompson [29]. Due to the small number of studies included in the comparative meta-analysis, publication bias could not be reliably assessed.

3. Results

Ten studies published between 2011 and 2024 were included: five randomized controlled trials and five pre–post quasi-experimental studies. Together, they comprised 904 adult patients with advanced or terminal cancer enrolled in palliative care programs in North America (Canada, Mexico), Europe (Denmark, Italy, Switzerland), and Asia (China, Taiwan). Sample sizes ranged from 24 to 326 participants, with a predominance of women (53%) and an overall mean age of 63 years. Follow-up periods were short (7–30 days).

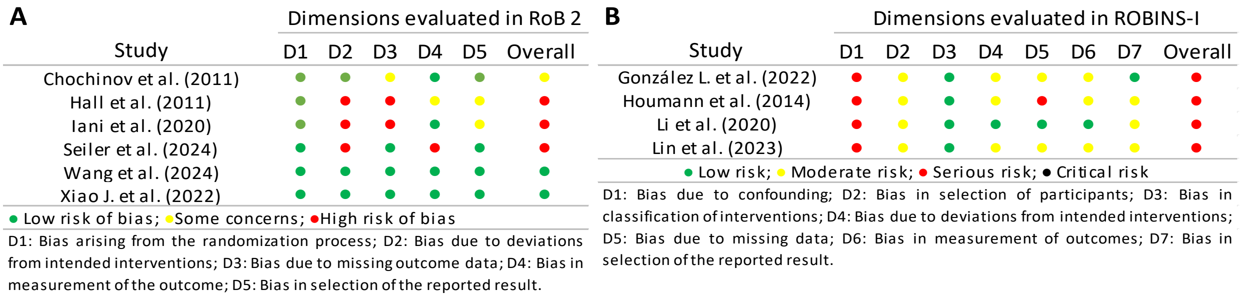
All studies implemented Dignity Therapy based on the original 2005 Chochinov model. In general, the intervention consisted of an individual semi-structured interview conducted by a trained professional (clinical psychologist, palliative care physician, or nurse with specific training), usually in one or two sessions of 30–60 minutes, transcribed into a legacy document. Most interventions were delivered in hospital settings and focused on patients with advanced or terminal cancer, compared with standard palliative care without a structured psychotherapeutic intervention. In some studies, the protocol was linguistically or culturally adapted while preserving the essence of the intervention.

In eight studies, the control group received only standard palliative care, consisting of symptom control, non-structured psychosocial support, and clinical follow-up. In two quasi-experimental studies, the intervention was evaluated using a pretest–posttest design without a control group. No study used another structured psychotherapy as a comparator, with the aim of isolating the specific effect of DT.

3.1 Risk of bias in the included studies

Methodological quality was variable. Among RCTs assessed with ROB 2 (Figure 2a), three showed high risk of bias due to lack of blinding and attrition, while two presented an overall low risk of bias. Quasi-experimental studies, evaluated with ROBINS-I, were classified as having a serious overall risk of bias, mainly due to lack of a control group and non-random selection (Figure 2b).

Figure 2. Risk of bias in the included studies: RCTs assessed with ROB 2 (a) and quasi-experimental studies assessed with ROBINS-I (b).



A

Study	Dimensions evaluated in RoB 2					
	D1	D2	D3	D4	D5	Overall
Chochinov et al. (2011)	🟢	🟢	🟡	🟢	🟢	🟡
Hall et al. (2011)	🟢	🔴	🔴	🟡	🟡	🔴
Iani et al. (2020)	🟢	🔴	🔴	🟢	🟡	🔴
Seiler et al. (2024)	🟢	🔴	🟢	🔴	🟢	🔴
Wang et al. (2024)	🟢	🟢	🟢	🟢	🟢	🟢
Xiao J. et al. (2022)	🟢	🟢	🟢	🟢	🟢	🟢

🟢 Low risk of bias; 🟡 Some concerns; 🔴 High risk of bias

D1: Bias arising from the randomization process; D2: Bias due to deviations from intended interventions; D3: Bias due to missing outcome data; D4: Bias in measurement of the outcome; D5: Bias in selection of the reported result.

B

Study	Dimensions evaluated in ROBINS-I							
	D1	D2	D3	D4	D5	D6	D7	Overall
González L. et al. (2022)	🔴	🟡	🟢	🟡	🟡	🟡	🟢	🔴
Houmann et al. (2014)	🔴	🟡	🟢	🟡	🔴	🟡	🟡	🔴
Li et al. (2020)	🔴	🟡	🟢	🟢	🟢	🟢	🟡	🔴
Lin et al. (2023)	🔴	🟡	🟢	🟡	🟡	🟡	🟡	🔴

🟢 Low risk; 🟡 Moderate risk; 🔴 Serious risk; ⚫ Critical risk

D1: Bias due to confounding; D2: Bias in selection of participants; D3: Bias in classification of interventions; D4: Bias due to deviations from intended interventions; D5: Bias due to missing data; D6: Bias in measurement of outcomes; D7: Bias in selection of the reported result.

3.2 Effects on patient dignity

Meta-analysis of the ten included studies showed that Dignity Therapy did not produce statistically significant differences in perceived dignity, either relative to baseline or compared with standard palliative care.

In the pretest–posttest analysis, the mean difference was 0.96 (95% CI: –9.5 to 11.4), whereas in the comparison with control groups the mean difference was –3.91 (95% CI: –12.4 to 4.6) (Figures 3 and 4).

Both analyses showed high heterogeneity ($I^2 > 90\%$), reflected in the wide dispersion of confidence intervals in the forest plots.

Despite the absence of statistical significance, most studies reported favorable trends in emotional well-being and sense of dignity. Therefore, it suggests a positive clinical impact, although variable according to cultural context, methodological design, and patient characteristics.

Figure 3. Forest plot of the pretest–posttest effect of Dignity Therapy. The large dispersion of confidence intervals reflects considerable heterogeneity.

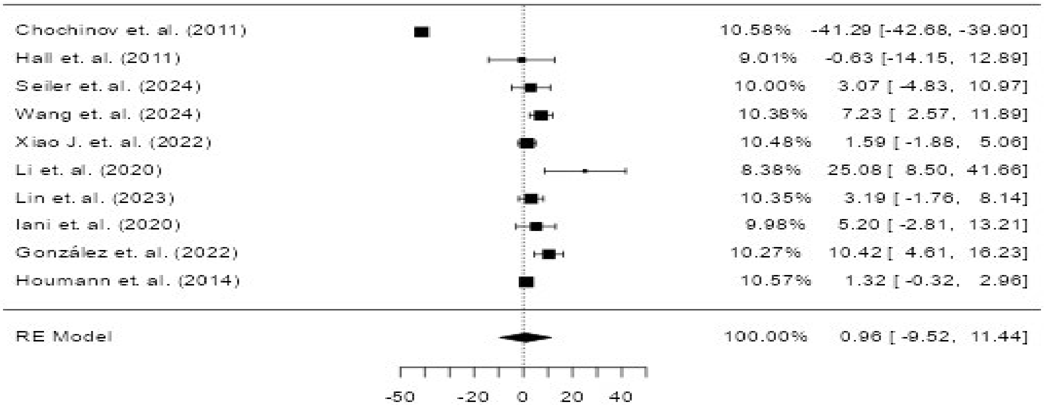
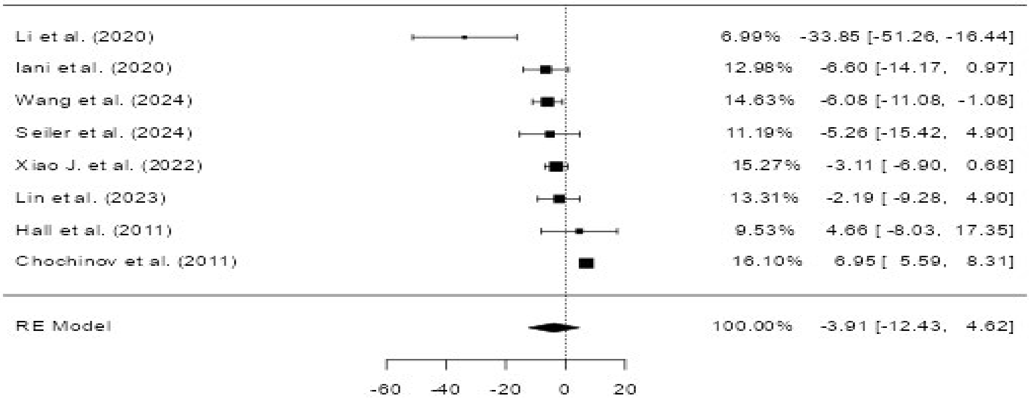


Figure 4. Forest plot of the effect of Dignity Therapy compared with control groups (8 studies). The width of the confidence intervals reflects the observed heterogeneity.



3.3 Effects of Dignity Therapy on other outcomes

Beyond its effect on patient dignity, evidence was found for other outcomes such as reductions in anxiety and depression, improvements in spiritual well-being, hope, quality of life, preparation for death, reduction of existential suffering, and fatigue. A synthesis of the evidence for these outcomes is presented below.

3.3.1 Anxiety and depression

Several studies used the Hospital Anxiety and Depression Scale (HADS) to measure anxiety and depression. In the trial by Chochinov et al. (2011), no statistically significant differences were found between patients who received DT and those in the control group, although there was a trend toward lower symptomatology in the intervention group [26]. Similar findings were reported by Houmann et al. [23] and Hall et al. [24]; in these, DT did not yield significant changes compared with control groups but did provide qualitative benefits reported by participants.

By contrast, studies by Li et al. [20] and Iani et al. [25] showed significant reductions in both anxiety and depression following DT. More recently, Seiler et al. [18] and Wang et al. [17] also confirmed statistically significant improvements in these outcomes, thus suggesting that the impact of DT may depend on cultural factors and the context in which it is implemented.

3.3.2 Spiritual well-being

The Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being (FACIT-Sp) was used in studies by Chochinov et al. [23] and Houmann et al. [26]. Although no significant differences were found compared with controls, both studies reported that patients perceived a greater sense of purpose and inner peace after DT. This is a relevant qualitative contribution.

3.3.3 Hope, preparation for death, and existential suffering

The Herth Hope Index (HHI) was evaluated by Hall et al. [24], who found significant increases in hope levels in the DT group compared with controls. Chochinov et al. [26] assessed preparation for death and reported that patients who received DT felt better prepared, although quantitative comparisons did not reach statistical significance. Similarly, Houmann et al. [23] documented improvements in perceived existential control and adaptation to the end-of-life process. Together, these findings reinforce the qualitative dimension of DT as supportive therapy in the transition toward death.

3.3.4 Quality of life

Quality of life was assessed in several studies using different instruments, including the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire – Core 15 Palliative (EORTC-QLQ-C15-PAL). Houmann et al. [20] and Li et al. [23] reported improvements in specific domains (emotional well-being and social functioning), although findings were not consistent across all dimensions of the questionnaire. Wang et al. [17] reported significant global improvements when DT was combined with family-focused interventions.

3.3.5 Fatigue and physical suffering

Xiao et al. [19] included measures of fatigue and physical symptoms associated with advanced cancer and observed clinically relevant reductions after the intervention. Although results were not consistent across all domains, these findings suggest that DT may indirectly contribute to the reduction of physical suffering through psychological relief.

4. Discussion

Findings reported in this systematic review indicate that Dignity Therapy is a brief, patient-centered intervention designed to address existential and psychological suffering in the context of advanced disease. Although the review did not demonstrate a statistically significant effect on the primary outcome of perceived dignity, relevant benefits were observed in reducing anxiety and depression and increasing hope and spiritual well-being. These results suggest that DT may have an important clinical impact on emotional and existential domains, even when quantitative findings are heterogeneous.

The high heterogeneity observed ($I^2 > 90\%$) reflects methodological differences between studies, including diverse designs (RCTs vs. quasi-experimental studies), small sample sizes, and the use of different scales to measure dignity, spirituality, and quality of life. Such limitations are common in reviews of psycho-spiritual interventions, where the subjectivity of outcomes and cultural variation hinder comparability [2,3].

In randomized controlled trials assessed with ROB 2, risk of bias was identified in domains such as blinding and loss to follow-up [18,24,25]. Nonetheless, studies with greater methodological rigor, such as those by Wang et al. [17] and Xiao et al. [19], demonstrated significant reductions in anxiety and depression, underscoring the potential effectiveness of DT when more controlled designs are implemented.

Quasi-experimental studies assessed with ROBINS-I showed a serious risk of bias due to participant selection and lack of control for confounding [10,23]. Even so, they provide valuable information regarding the feasibility and acceptability of DT in real-world clinical practice. Experiences in Mexico and China are particularly illustrative of the relevance of cultural factors in perceived effectiveness, where family and community play a central role in the end-of-life experience.

Another notable aspect is the consistency of qualitative findings reporting significant benefits: a greater sense of being accompanied, reaffirmation of identity, resolution of unfinished business, and creation of a legacy for family members [4,8]. Although difficult to quantify, these dimensions reflect the ethical and humanizing value of DT, aligned with Chochinov's dignity-conserving care framework [30], which considers identity, autonomy, and continuity of self as pillars of compassionate end-of-life care.

European evidence, particularly the work of Julião et al. [12] in Portugal, shows that DT does not impact survival but does reduce psychological distress and improve emotional well-being. This confirms that the main contribution of DT lies in the existential domain, reinforcing patients' dignity and autonomy at the end of life.

Finally, it should be emphasized that DT does not replace conventional medical or psychosocial care but rather complements it, enhancing comprehensive management. Integrating DT into palliative care protocols would strengthen holistic care, especially in Latin American contexts where family, spiritual, and cultural values are central to the experience of illness and death [31].

5. Conclusions

Dignity Therapy emerges as a feasible, safe, and well-accepted intervention for patients with advanced cancer, with consistent benefits in emotional and existential domains. Its effects are expressed mainly through reductions in anxiety and depression, increased hope, and strengthened spiritual well-being—components that influence quality of life and coping with end-of-life processes.

Although quantitative results for perceived dignity did not reach statistical significance, qualitative evidence and the consensus of the reviewed studies indicate that DT provides clinical and human value, reaffirming patient identity and contributing to more compassionate, person-centered care.

Methodological heterogeneity, small sample sizes, and identified risks of bias limit the generalizability of findings; however, the convergence of qualitative and quantitative results supports the usefulness of DT as an ethical and humanizing intervention in palliative care. Taken together, DT improves the quality of the dying process by facilitating biographical closure, expression of meaning, and preservation of the patient's personal legacy.

6. Recommendations

It is recommended to integrate Dignity Therapy as a complementary component of palliative care programs, with protocols adapted to the cultural, spiritual, and family idiosyncrasies of each population. Training health professionals in DT within interdisciplinary teams would help strengthen comprehensive, person-centered care models.

In addition, multicenter studies with greater methodological rigor—particularly randomized controlled trials with larger samples and longitudinal follow-up—are needed to confirm the observed benefits and explore DT's mechanisms of action across different clinical and cultural contexts.

The use of mixed methods (quantitative and qualitative) should be promoted to capture the full range of intervention effects, given that many of DT's benefits transcend what can be measured quantitatively. Finally, the generation of evidence in Latin America should be encouraged, as DT has shown high acceptability and cultural relevance in this region, where its integration may foster more humane, compassionate, and spiritually sensitive end-of-life care.

7. Abbreviations

DT: Dignity Therapy

RCT: Randomized controlled trial

MD: Mean difference

SD: Standard deviation

95% CI: 95% confidence interval

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PROSPERO: International Prospective Register of Systematic Reviews

ROB 2: Risk of Bias 2

ROBINS-I: Risk of Bias in Non-randomized Studies of Interventions

HADS: Hospital Anxiety and Depression Scale

HHI: Herth Hope Index

EORTC QLQ-C15-PAL: European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire – Core 15 Palliative

FACIT-Sp: Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being

8. Administrative information

8.1 Additional files

None.

8.2 Acknowledgment

Not applicable.

8.3 Author contributions

Wagner Fiallos Coque: Conceptualization, methodology, investigation, data curation, formal analysis, project administration, writing – original draft.

Ericka Parra Gavilánez: Project administration, methodology, validation, writing – review and editing.

Mariana Vallejo Martínez: Supervision, validation, visualization, writing – review and editing.

All authors read and approved the final version of the manuscript.

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8.5 Availability of materials

None.

8.6 Conflict of interest

The authors declare no conflicts of interest related to the publication of this article. None of the authors has received financial or personal benefits that could have influenced the results or interpretation of the study.

8.7 Disclaimer of liability

The opinions, analyses, and interpretations expressed in this article are solely the responsibility of the authors and do not necessarily reflect the official position of the institutions to which they belong.

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