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DIGNITY THERAPY IN A CHRONIC KIDNEY PATIENT IN PALLIATIVE CARE: CASE REPORT

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ABSTRACT

This study aimed to evaluate the effects of the Dignity Therapy intervention to alleviate suffering and preserve the dignity of a patient in palliative care. This is a case study of a 41-year-old Brazilian married woman with chronic kidney disease in palliative care. The study was developed over five meetings, in which the Hospital Anxiety and Depression Scale (HADS) and the Patient Dignity Inventory (PDI-Br) instruments were administered before and after the intervention to assess anxiety, depression and dignity. The data analysis was qualitative, through thematic categorization and the results obtained through the instruments. The results indicated that, although there was a temporary increase in the levels of anxiety and depression, through the HADS, the Dignity Therapy contributed to the reduction of existential and psychological suffering, evidenced by the PDI-Br, revealing a decrease in the suffering related to dignity, suggesting that the DT provided positive effects on the patient's emotional well-being. The intervention provided the patient with a space to reflect on her life and legacy, preserving her dignity and strengthening the meaning of life.

Keywords: Brief therapy. Terminality. End-of-life care.

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INTRODUCTION

Palliative Care (PC) emerged as a distinct practice in the health field in the 1960s in the United Kingdom under the leadership of physician, nurse, and social worker Cicely Saunders. Combining care, teaching, and research, this pioneering movement introduced a transformative approach to the care of patients with life-threatening illnesses, seeking a structured and humanized practice aimed at alleviating suffering and promoting dignity (Du Boulay, 2007). In the 1970s, Elisabeth Kübler-Ross took this approach to North America, founding a Hospice in Connecticut in 1974, marking the beginning of the global expansion of PC and its integration into the care of patients with no possibility of cure (Matsumoto, 2012).

Recognizing the relevance of this approach, in 1990, the World Health Organization (WHO) established the principles of PC, initially aimed at cancer patients, recommending their inclusion as an essential part of comprehensive care, along with prevention, diagnosis and treatment. Over the years, the definition has been expanded, adapting to different realities, resources, and epidemiological needs. Currently, PC is described as an approach that aims to improve the quality of life of patients and families, focusing on the prevention and relief of suffering through early assessment and comprehensive management of physical, emotional, social and spiritual symptoms (WHO, 2007).

With the increase in the scenario of population aging, there is also an increase in subjects with complex, chronic or terminal health conditions (Bettinelli; Portella, 2004). In this scenario, PC comes into evidence, considering that every individual affected by a life-threatening disease, whether acute or chronic, becomes eligible to receive PC. Integration of this approach into disease-modifying treatment is recommended from diagnosis to manage symptoms and meet the specific needs of the patient. As the disease progresses, the palliative approach intensifies, with a gradual and personalized transition between curative and palliative care. This process aims to ensure quality of life, comfort and dignity, respecting the singularities of each trajectory (Gamondi; Larkin; Payne, 2013; INCA, 2022).

PC patients face progressive losses that affect not only their physical health, but also emotional, social, financial, and family dimensions. Feelings such as anger, frustration, fear and sadness intensify existential suffering, weaken bonds and generate a rupture in the continuity of life. Given this, PC assume a central and holistic role, seeking to alleviate suffering in all its dimensions and promote the integral well-being of the patient and his family (INCA, 2022).

Given the complexity of the suffering experienced by PC patients, which transcends the physical sphere and involves emotional, social, and spiritual dimensions, Dignity Therapy (DT) emerges as an innovative approach. Created by Chochinov et al. (2005), it aims to address issues that generate psychosocial and existential anguish in a brief and personalized way, enabling reflection on topics that are significant to the individual. DT emerged based on the conceptual model of dignity, arranged in three fundamental categories: concerns associated with the disease (such as physical and psychological symptoms), internal resources of dignity (psychological and spiritual factors that shape the sense of dignity) and social resources of dignity (covering the social context, including positive aspects, adversities and sources of suffering) (Chochinov et al., 2002b; Chochinov, 2002).

When their dignity is threatened, patients have a worsening of their quality of life and lower satisfaction, associated with symptoms of hopelessness, anxiety, depression, and the desire to hasten death (Chochinov et al., 2002a). In this way, DT seeks to reduce psycho-emotional suffering and promote the strengthening of the individual's identity, self-esteem, and self-worth (Nunziante et al., 2021). It can also assist in conflict resolution and promote a dignified end of life (Barbosa et al., 2016; Chochinov et al., 2005; Chochinov, 2024).

The systematic review by Guerra, Scortegagna and Fanton (2024) points to the potential of DT to improve the quality of life of PC patients, evidencing its usefulness and feasibility in various cultures around the world. Although research in the area is still incipient, the results obtained so far suggest that DT has proven to be useful and viable and has contributed to the growth of quality of life, through a review of life and elaboration of disease and death. From this perspective, the present study aimed to evaluate the effects of DT intervention to alleviate suffering and preserve the dignity of a PC patient.

METHOD

DESIGN

This study was based on the methodological approach of case study, as proposed by Yin (2018). The case study is a research strategy that aims to investigate a phenomenon within its real context of life, allowing the analysis of complex social situations and the formulation of hypotheses that explain the observed phenomena.

The case presented in this article is part of a master's thesis and is part of a multiple case study research. The study involves the application of DT in patients in PC, hospitalized or in outpatient follow-up at a medium-complexity general hospital, located in the Metropolitan Region of Vale do Itajaí, Santa Catarina. This institution has a multidisciplinary team specialized in PC, dedicated beds for the hospitalization of these patients and a multidisciplinary outpatient clinic for longitudinal follow-up.

The inclusion criteria for the study were defined as: patients of both sexes, between 18 and 80 years old, who are in PC, with various pathologies, hospitalized in a hospital institution or outpatient care, and who are aware of their health prognosis. Patients who did not fit the indicated age group, who had cognitive, neurological or verbal communication limitations, or who were sedated or unconscious were unable to participate.

PARTICIPANT

Flor (not her real name), a 41-year-old woman, lives in a stable union with Adão (not her real name). Her support network also includes her adoptive parents, she has no children. During the period in which she participated in the study, she was away from work, although she had previously dedicated herself to the trade of seamstress. Consistent with his age group, he has a medical diagnosis of terminal Chronic Kidney Disease (CKD), in Renal Replacement Therapy (RRT) through hemodialysis (HD) and in exclusive PC due to his vascular access failure.

INSTRUMENTS

The following instruments and techniques were used to carry out the intervention:

Dignity Therapy (DT) Protocol

This is the therapeutic approach described in this study, consisting of a 10-question protocol created to help individuals express significant aspects of their lives. The process begins with a careful orientation to the patient, clarifying the objectives of the intervention, the methods used and the subsequent steps, while at the same time being given a protocol containing the 10 fundamental questions, allowing him to understand in advance the topics to be addressed. This set of questions was elaborated to facilitate the patient's expression about significant aspects of his life, covering both present and future concerns that may generate suffering. The patients' answers to these questions are recorded, transcribed and elaborated in a final legacy document, which is given to the patient so that, if desired, it can be shared with their loved ones (Barbosa et al., 2016; Chochinov et al. 2005; Chochinov et al., 2011; Chochinov, 2024).

The process follows the dignity model, which emphasizes elements such as generativity, continuity of identity, preservation of roles, permanent care, pride and hope (Chochinov et al., 2005; Chochinov, 2024).

Hospital Anxiety and Depression Scale (HADS)

The HADS Scale aims to measure symptoms of anxiety and depression in non-psychiatric settings. It is a self-report instrument that has 14 multiple-choice items, divided into two subscales: HADS-Anxiety (HADS-A) and HADS-Depression (HADS-D), each with 7 items. Each question has answer options ranging from 0 to 3, and the higher the score, the greater the perception of the symptom. The maximum score is 21 points per subscale, and the cutoff points are ≥9 points for each, as follows: from 0 to 8 without symptoms; 8 to 10 mild symptoms; from 11 to 14 moderate symptoms and from 15 to 21 severe symptoms. The scale was developed by Zigmond and Snaith (1983) and validated in Brazil by Botega et al. (1995). It is widely used and considered easy to understand by patients. Regarding reliability, its Cronbach's alpha coefficient was evaluated at 0.94, which is considered a high index (Pereira; Figueiredo, 2008).

Patient Dignity Inventory (PDI-Br)

The PDI-Br was developed by Chochinov et al. (2008) and aims to understand the factors that affect the perception of dignity in patients with critical health conditions, helping to identify the causes of existential, emotional and social suffering in these individuals. The self-assessment inventory consists of 25 statements, rated on a five-point Likert scale: 1 ("no problem"), 2 ("a small problem"), 3 ("a problem"), 4 ("a big problem"), and 5 ("a huge problem"). According to Chochinov et al. (2011), a response equal to or greater than 3 reflects a high level of distress related to the sense of dignity. The 25 items are organized into five subscales related to dignity in the context of palliative care: presence of physical symptoms that affect dignity, such as pain or fatigue; existential suffering; dependency; peace of mind and quality of interpersonal relationships and social support. The inventory was adapted to a Portuguese version by Gonçalves (2012) and in studies in Brazil, it presented a Cronbach's alpha coefficient of 0.90, a high and satisfactory index, proving to be reliable (Donato et al., 2021).

DATA COLLECTION PROCEDURE

For data collection, patients who met the inclusion criteria were selected through an active search in the institution's data system. Patient Flor's case was identified and discussed with her attending palliative care physician, ensuring the patient's knowledge of her disease, treatment and prognosis.

After confirming that she met the inclusion criteria for the study, Flor was approached individually during one of her HD sessions at the hospital. During the meeting, the objectives of the research were explained, the commitment to the confidentiality of their identity and their freedom to withdraw from participation at any time. With the patient's agreement, the Informed Consent Form (ICF) was completed.

Also on the same date, the patient's dignity, depression and anxiety scores were collected using the PDI-Br and HADS instruments. In line with the guidelines of Chochinov (2024), author of the DT, the patient received the protocol containing the 10 guiding questions, which allowed her to understand the themes to be worked on. The next meeting was then scheduled by mutual agreement for two days later.

Thus, DT was applied to the patient in three subsequent meetings, with a frequency of two and four days between each session, respectively, coinciding with her visits to the hospital for HD sessions, respecting her preference and convenience. Each meeting lasted approximately 45 minutes. During these moments, the patient's accounts were recorded, transcribed, and carefully edited into a final legacy document. This document was read, reviewed and delivered to the patient in a fifth and final meeting, four days after the end of the DT application. On the same date, the scores of dignity, depression and anxiety were collected again using the PDI-Br and HADS instruments, concluding their participation in the study.

Age, gender and health diagnoses were used from her clinical records, opting for a fictitious name that would preserve the patient's identity. The other data regarding their previous and current history were brought spontaneously during the application of the DT.

DATA ANALYSIS PROCEDURE

The results obtained through the HADS and PDI-Br instruments were analyzed descriptively, without the application of statistical methods. The reports of the DT sessions were fully transcribed, and some excerpts were selected for illustrative purposes, taking care to preserve the authenticity of the patient's expression in her own words.

The transcriptions were analyzed through Bardin's (2016) content analysis, which made it possible to organize the data into thematic categories and build a consistent analytical structure. The process followed three stages. In the pre-analysis, an exploratory and fluctuating reading of the material was carried out, allowing an initial understanding of the content and preparation for the identification of the registration units. In the material exploration stage, the registration units were defined based on the detailing of the interviewees' statements, being coded and linked to context units. Finally, in the inference stage, the categorization of ideas into themes was carried out, synthesizing the meanings present in the content in a structured way.

ETHICAL PROCEDURES

About ethical issues, this research was conducted by the procedures established by Resolution 466/2012 of the National Health Council. The study was approved by the Research Ethics Committee of the University of Passo Fundo (UPF), under CAAE 81480024.4.0000.5342.

RESULTS AND DISCUSSIONS

The present case study aimed to evaluate the effects of the DT intervention on the relief of suffering and the preservation of the dignity of a patient on PC. The results found are divided into: previous history; current history; scores of the psychometric instruments and analysis of the thematic categories will be presented below.

EARLY HISTORY

Flor was diagnosed with CKD in 2013, after an episode of sudden malaise at home. From then on, she started RRT with regular HD sessions. In 2015, she underwent a kidney transplant, which provided her with autonomy and quality of life until December 2022. During this period, during routine exams, the loss of the renal graft was found, which led her to resume HD sessions.

At the beginning of her journey with the disease, Flor was married to her second husband, but the relationship came to an end after he became aware of her health condition. At the age of 16, during her first marriage, she faced a stillbirth pregnancy and currently has no children. In this way, after the end of the second marriage, she found support in her adoptive parents, returning to her adoptive mother's house. At the time, in an attempt to make her transplant feasible and faced with the need for a biological link for donation, Flor decided to look for her biological family. This search resulted not only in the reunion with his blood mother, but also in the discovery of siblings he did not know. However, despite compatibility tests with family members, the transplant was performed with an organ from a deceased donor.

About four years ago, Flor found her third partner and built a relationship with Adão, with whom she currently lives in a home close to her adoptive parents, who, despite being divorced, remain part of her support network along with her stepmother. She also keeps in touch with her biological family, which lives in another city not very close to hers.

CURRENT HISTORY

In September 2024, after episodes of intense pain, Flor was admitted to an Intensive Care Unit (ICU), where she was diagnosed with an infected ruptured ovarian cyst. It was during this hospitalization that exclusive PC was established, given the impossibility of surgical intervention to treat his condition. In addition, Flor already had a delicate history, marked by multiple infections related to vascular accesses and the failure of new possible accesses for HD. After hospital discharge, Flor continued to perform HD sessions three times a week, using her last and only available access. A new kidney transplant was contraindicated, and the progressive failure of her vascular network reflected the terminality of her CKD. The patient died about three months after the PC was started and one month after the delivery of her final legacy document.

SCORES OF PSYCHOMETRIC INSTRUMENTS

The results obtained in the first application of the HADS and PDI-Br scales are described in Table 1.

Table 1. Description of the results obtained in the application of psychometric instruments.

	HADS Scale			PDI-Br
	HADS-A	**HADS-D**	**Total**	
Two days before the Intervention	3 points	2 points	5 points No Symptoms	71 points

Four days after the intervention	6 points	4 points	10 points No Symptoms	57 points

Source: prepared by the authors.

Analyzing the results, it is possible to notice the absence of symptoms of anxiety and depression, with scores of 3 points for HADS-A and 2 points for HADS-D. In the reapplication, performed in the last meeting, the patient maintained the absence of symptoms, but her score doubled, with 6 points in SAH-A and 4 points in HADS-D. These results are related to the applied technique, which stimulates deep reflection and the revision of values and attitudes throughout life. This process can cause the subject to face painful memories and their finitude, factors that can intensify levels of anxiety and depression. The study by Rudilla et al. (2015) found similar conclusions. This is a randomized clinical trial that compared the efficacy of DT and Counseling Therapy. As a result, it indicated an increase in anxiety and depression levels in patients undergoing TD. Despite the increase in symptoms such as anxiety and depression, DT is effective in resolving conflicts and increasing levels of resilience. In the case study by Espíndola et al. (2017), which addressed the application of DT with an oncology patient, there was an increase in anxiety levels, which was associated with the confrontation with the end of life provided by the technique.

Regarding the PDI-Br instrument, its application with the patient initially resulted in a score of 71 points, with a higher score (classification 4 and 5) in the subscales corresponding to the presence of symptoms (21 points) and existential suffering (22 points). After the application of the TD, the patient presented a decrease in her final score, totaling 57 points. The subscales of presence of symptoms (16 points) and existential distress (15 points) also improved. Corroborating what was found, in a study by Chochinov et al. (2016), which compared the suffering related to dignity in patients with non-cancer diagnoses, it was found that patients with CKD did not obtain a high score in PDI items, but reported a higher number of comorbidities and symptom burden about other groups of diseases. The authors also consider that the suffering presented by chronic kidney patients is directly linked to physical symptoms, rather than psychological ones. Studies carried out on the application of DT have validated its efficacy in physical symptoms, such as fatigue and well-being (Weru; Gatehi; Musibi, 2020; Zaki-Nejad et al., 2020), thus being able to justify the scores presented in this study.

ANALYSIS OF THE THEMATIC CATEGORIES

According to Chochinov (2024), the way each person experiences a disease is unique and determined by a combination of factors, such as their life history, beliefs, values, and personal resources, in addition to the specific characteristics of the disease. The author developed a repertoire for the preservation of dignity (Chochinov et al., 2002a, Chochinov et al., 2002b), which provides a framework for understanding the way each copes with their reality and disease. The thematic categories of this study are based on this theoretical framework associated with the patient's discourse and themes that stood out the most during the application of DT. They are: acceptance and hope; spirituality; social support; resilience; generativity and legacy; regrets and achievements and thanks, which will be discussed below.

ACCEPTANCE AND HOPE

In Flor's discourse, the process of acceptance she had during the discovery and living with her disease can be perceived. When reporting on the fluctuations in her illness process, the patient mentions:

> "When I found out I had to do hemodialysis again, of course I was like... revolted, upset, I said: my God! all over again [...] when I'm like this, something happens to me, so I think: I'm not going to get down, I'm not going to let it destroy me."

Acceptance refers to the ability to gradually adjust to reality and the changes brought about by the disease, preferably at a pace that can be tolerated, thus appearing in small gradations (Chochinov, 2024). For a patient on HD, planning new living conditions is a challenging task that must be conducted by him/herself, as it is the patient who experiences the rigid changes that begin in the biological sphere and extend to the psychological and social field (Chan et al., 2011; Araújo et al., 2009). When she discovered the malfunction of her transplant, the patient had to disconnect from work and start going to the hospital three times a week for HD sessions, thus completely changing her routine and consequently her life.

Still on acceptance, according to Chochinov (2024), denial can offer the patient the necessary psychological space so that he can assimilate the reality of the decline in his health gradually and in more manageable stages. This concept is directly related to hope. As the disease imposes itself, hope must align with the demands of the condition and with what time may yet bring (Buckley; Herth, 2004; Chochinov, 2024). About this, Flor mentions:

> "And the doctor even disillusioned me, even said that I was supposed to take it and... do everything I wanted to do, enjoy the family and everything, right? That he said that I was supposed to get ready, that I had nothing else to do [...] Then I let him talk, right? Because doctor, right? I let him speak, then I simply looked at him and said to him: doctor, for God nothing is impossible."
> "I believe in God because... Look at everything I've been through... The doctors have disillusioned me and I'm here, firm and strong."

It is perceived, at various times, that, in the patient's discourse, denial acts as a protection mechanism, allowing her to maintain hope in the face of a difficult prognosis. Although the medical reality points to limited options, the patient finds support in her personal beliefs to face the emotional impact. This space of denial and hope allows her to assimilate the situation in her own time, balancing coping with the decline in her health with preserving her psychological balance.

The findings of this study, regarding acceptance and hope, converge with those of Silva and Motta (2012). When investigating the process of illness in kidney patients on HD, these authors showed that the discovery of CKD triggers a complex journey, marked by initial denial, which gradually evolves into a process of acceptance. This trajectory, corroborated by Fontoura et al. (2020), reveals denial as a common reaction and acceptance as an adaptive strategy in the face of the imposition of the disease.

SPIRITUALITY

Spirituality, in this scenario, presents itself as an intrinsic resource, capable of offering consolation and guidance in the face of finitude (Puchalski et al. 2009). It is not limited to religion, but encompasses broader existential issues, such as the search for meaning and connection (Chochinov, 2024). Spirituality appears to the study patient during the application of her DT:

> "It (faith) is important because... For everything I've been through, you know? So I say like this, that we have to put God first in everything [...] I believe in God because... Look at everything I've been through and I'm here."
> "When we are close to God, we feel a thousand times better. Your life changes, your way of speaking, your way of thinking... changes completely."

Spirituality emerged as a fundamental resource for Flor in her coping with chronic kidney disease. The patient, an evangelical, expressed the belief that her faith, in addition to providing a deeper meaning to life, facilitated the adaptation to the new reality imposed by the disease. This individual experience is supported by studies such as that of Leimig et al. (2018), who identified spirituality as a positive coping strategy in patients with CKD. By providing meaning and purpose, spirituality contributes to emotional well-being, as Benito, Dones, and Babero (2016) point out in their research with PC patients.

SOCIAL SUPPORT

By elucidating her story, Flor demonstrates the support of her family members as a source of help in her relationship with the disease and life:

> "My parents, my father's wife and my husband are the most important people in my life, because they are always there by my side helping me, right? If I need anything, they're there."

The presence of social support in PC is so important that the patient and family are identified as a unit of care (Chochinov, 2024). Martire and Schulz (2007) show us that few circumstances become as difficult as the diagnosis of a chronic disease and the family plays a fundamental role in psychological adjustment and in helping to adapt and manage the symptoms of these conditions. Close social relationships have a positive impact on biological systems, health behaviors, and the psychological well-being of individuals. Bertolin et al. (2011), who sought to study the association between coping modes and sociodemographic variables of people on HD, directly associated the presence of social support with increased life satisfaction and decreased depression.

Still, patients with life-threatening or life-limiting illnesses often fear abandonment. Social support provides the security that they will not be left behind, ensuring that they are worthy of attention and care (Chochinov, 2024). In Flor's case, her experience illustrates this dynamic clearly. When she was diagnosed with the disease, she was in her second marriage, which ended soon after:

"Then when my husband found out that I had this problem, like, instead of him supporting me, he abandoned me."

This statement highlights the pain of abandonment in a fragile moment of life. However, she also shares an experience of reuniting with the shelter:

> "I met a wonderful person in the meantime, we've been together for four years, and I thought: oh, it's going to be another one who will abandon me, right? But no, he's been with me since the beginning and helps me with everything."
> "Now that I see myself more alive, more complete, like this, that I'm living life is after I met my husband [...] He was the one who gave me, like, he who gave me strength, he who showed me that he's not one of those guys that the person is sick and gets it and leaves."
> "What I went through back then was a learning experience and my two marriages were a failure, but now I saw that God put a wonderful person in my life to help me."

These words reflect the positive impact of solid social support, which not only provides emotional security, but also helps in adapting to suffering, as highlighted by Chochinov (2024). Flor's new partner represents part of her support network, strengthening her and showing that the constancy of meaningful relationships is fundamental to coping with the disease.

RESILIENCE

It is perceived that chronic diseases impose significant losses, such as autonomy and health, generating stress and suffering. In this context, resilience emerges as a crucial factor for subjective well-being, helping individuals to cope with adversity and find meaning in life (Limonero et al., 2012; Arrebola-Moreno et al., 2014). Resilience translates courage to face situations. When reflecting on her history with CKD, Flor reports:

> "This health problem I had, I learned a lot, I changed a lot, you know? I was a person like that... Nervous, angry, any little thing was already fighting and, after I started having to do hemodialysis, these things, I started to change [...] now I'm a more responsible person, I'm a person who if I need to help others I help."

In Flor's explanation, it is observed how the experience with the disease triggered significant transformations in her way of being and relating to the world. Through her trajectory, the patient suggests transforming her suffering into personal growth, reinforcing the meaning of her existence.

Corroborating the discourse of Flor, Santos and Costa (2016), who sought to assess the levels of resilience in chronic kidney patients on RRT, showed that the tendency to resilience was present in most patients on dialysis. Still, for these authors and Chochinov (2024), resilience is shaped through the course of the disease, beliefs, support network, and the ability to attribute meaning to one's own existence. It is noticed, so far, that Flor has a significant relationship with her spirituality, present social support and an effective acceptance process, factors that can contribute to the development of her resilience.

GENERATIVITY AND LEGACY

Flor, when asked about special moments that she would like her family to remember, highlighted:

> "Like my father, every year we always celebrate my birthday, it's always a surprise [...], in addition to the trips we make [...] These are moments that I try to record and keep in my head and in my heart."

In addition, when talking about important roles she played, she stated:

"What has been important to me, throughout my life, is that I have taken care of Joana (not her real name), who is my stepdaughter."

Also, according to some of the questions suggested by the DT protocol, the patient's statements were directed to guidance to her relatives:

> "To my mother, I wish her to have a good retirement, that she stops working and rests and goes enjoy life more, you know? [...] It's something I want him (his father) to do too, like, stop and start enjoying his life more, staying at home more, enjoying with his grandchildren."
> "My husband, right? Also, that he likes to travel, he says he can't wait to retire too, to be able to travel, to be able to do his own things, right? That he likes to travel and see his family, see his friends and what kind of he can make his dreams come true, right?"

Flor's speeches reveal the desire to leave a lasting legacy in her family. By sharing memories of family celebrations and highlighting the care she has dedicated to her stepdaughter, Flor demonstrates the importance she places on building meaningful relationships and passing on her values.

For Erikson (1971), a developmental psychologist, the human personality develops through predetermined stages, based on the individual's willingness to grow, become aware of and interact with increasingly wider social circles. In middle age, according to Erikson, people enter a developmental phase called "generativity versus stagnation," where generativity refers to the ability to provide guidance to the next generation and expand influence beyond life itself. For Chochinov (2024), this concept of generativity, or legacy, is central to DT, as patients are encouraged to reflect on important aspects of their lives, sharing thoughts, memories, and advice to and with those they love.

In this way, the patient's orientations and memories to her family members represent a transmitted legacy, functioning as an extension of her in the future (Chochinov et al., 2002b; Chochinov, 2024). In addition, Baker et al. (2015) found in their research that indicating how and what should be done provides the patient with a sense of autonomy and a resumption of control over their own life. This allows the terminally ill person to have a voice and recognition, especially after having lost, due to the disease, many of their social roles and abilities (Baker et al., 2015; Chochinov et al., 2002b; Timóteo et al. 2024; Vuksanovic et al., 2017).

REGRETS

DT also aims to provide the patient with the expression of regrets during the life review. About this item, Flor shows regrets when reporting on her relationship with the disease:

> "Then I took it and did the transplant and everything. Normal life, right? Normal life. So, I took care of everything, but I relaxed a little too, right? I ate things that I wasn't supposed to eat [...] some parts I think like: what did I fail at?"

In addition, when describing her relationship with her adoptive mother, Flor mentions:

> "I want to come a time and ask her forgiveness for not ... kind... not being able to like her as a mother. I like it that way as a mother, but not like my mother who raised me, you know? I like it as a mother, but it's not that love from mother to child. I still have to learn to like her like her being my mother, you know? [...] I'll have to come at some point and sit down and talk to her and tell her this, which is something that bothers me, right?"

The life review, as evidenced by Flor's experience, reveals the presence of regrets and the desire to repair past situations. The patient expresses both regret for choices related to her treatment and the desire to ask her adoptive mother for forgiveness. These feelings, common in patients with advanced chronic diseases, can be deeply distressing. DT, in this context, by providing a safe environment for the narrative, can enable the elaboration of past experiences and the construction of new meanings (Keall, Clayton, Butow, 2015; Nunziante et al., 2021; Chochinov et al., 2011). For Bluck et al. (2021), this construction of meaning, which involves processes such as insights and integration of events, is fundamental for psychological well-being. Dose and Rhudy (2017) corroborate this idea, showing that they found in their research that the construction of meaning is a common phenomenon in DT, especially in relation to events that caused suffering. Zaki-

Nejad et al. (2020) found, in their study, that the construction of meaning perceived during DT offered an improvement in the quality of life of patients.

ACHIEVEMENTS AND ACKNOWLEDGMENTS

In this item, Flor's statements reveal important achievements and thanks that reflect the appreciation of significant moments and relationships in her life:

"I say that what I achieved was my transplant [...] because like this... new life, right?"

Kidney transplantation, for Flor, is not limited to a physical achievement, but symbolizes overcoming challenges and valuing life. This experience aligns with the findings of Silva et al. (2013), who investigated the significance of kidney transplantation for patients who had it. According to the authors, transplantation is often seen as a miracle, capable of restoring hope and quality of life. Mattos and Maruyama (2009) corroborate this perspective, highlighting that transplantation represents a symbol of hope and faith, freeing patients from HD dependence and allowing them to regain their autonomy and independence.

In addition, the patient expresses deep gratitude to her adoptive family, emphasizing the importance of education and the values received.

> "She's my mother, she raised me, she gave me education, she taught me right and wrong, right? So to tell her, thank her for adopting me, for teaching me the things I learned, that I learned to sew was with her [..] like my father, the same thing."

Dose and Rhudy (2018) conducted research in a PC center in the United States, applying DT to a group of 20 patients. The results showed that the intervention provided the participants with the opportunity to reflect on their family roles, evidencing a more significant impact in this sphere compared to the professional one. These findings corroborate previous studies by Montross, Winters, and Irwin (2011) and Hack et al. (2010), who identified family, a sense of accomplishment, and friendships as core values for PC patients. By having access to DT, participants sought to strengthen their family bonds, expressing affection and sharing meaningful stories. The authors suggest that the opposite, that is, the valorization of material goals may be inversely related to the feeling of life purpose.

Thus, it is understood that, in PC, the life review promoted by DT facilitates the reflection of relationships and the expression of important feelings, offering patients the opportunity to revisit their experiences, allowing them to recognize achievements and express thanks, which facilitates the validation of relationships, contributing to the patient's life legacy (Kemp, 2006).

FINAL CONSIDERATIONS

The present case study, centered on Flor's experience, aimed to investigate the effects of DT on relieving suffering and preserving the dignity of a patient on PC.

The results of the psychometric instruments, HADS and PDI-Br, indicated that, although there was an increase in the levels of anxiety and depression after the application of DT, this effect can be attributed to the therapeutic process, which provokes reflection on the finiteness and life history of the patient. The HADS scale presented higher scores in the second application, reflecting the intensification of feelings related to coping with the disease and the patient's health condition. On the other hand, the PDI-Br showed a reduction in existential distress and psychological symptoms, suggesting that, despite the temporary increase in anxiety and depression, TD contributed to the strengthening of the patient's emotional well-being and the decrease in psychological distress.

From the thematic categories, it is perceived that DT brought benefits by providing the patient with a space for reflection on significant aspects of her life, allowing her to review and elaborate her history through the construction of meaning, express emerging feelings and formulate wishes for her loved ones, contributing to the preservation of her dignity and the strengthening of the meaning of life and legacy.

Thus, this study suggests that DT as an intervention can be useful to other patients in the context of PC, considering that it offers the opportunity to revisit life stories and attribute meaning to them, which can help strengthen the ability to face finitude with dignity. It is recommended that further research be conducted in order to continue evaluating the applicability and effects of DT.

REFERENCES

1. ARAÚJO, E.S. et al. Autonomy of patients with chronic kidney disease undergoing hemodialysis: Acceptance as a decision-making factor. Acta Paulista de Enfermagem, v. 22, n. 1, p. 509-514, 2009. Available at: <https://www.scielo.br/j/ape/a/3hfjLB7yqz7dpWRthXf9qhc/?format=pdf&lang=pt>. Accessed on 15 Dec. 2024.

2. ARREBOLA-MORENO, A. L. et al. On the protective effect of resilience in patients with acute coronary syndrome. Journal of Clinical and Health Psychology, v. 14, n.2, p. 111-119, 2014. Available at: <https://digibug.ugr.es/handle/10481/35276>. Accessed on: 11 Dec. 2024.

3. BAKER, N. et al. The legacy of cancer: Why a health promoting approach is so important in palliative care. BMJ Supportive and Palliative Care, v. 5, n. 1, 2015. Available at: <https://pubmed.ncbi.nlm.nih.gov/25960500/>. Accessed on: 16 Dec. 2024.

4. BARBOSA, A. et al. Manual and Palliative Care. 3rd edition, Lisbon: Faculty of Medicine of the University of Lisbon, 2016. Available at: <https://www.researchgate.net/profile/Miguel-Juliao/publication/308902043_Terapia_da_Dignidade/links/57f6498e08ae280dd0bb2242/Terapia-da-Dignidade.pdf>. Accessed on: 24 nov. 2024.

5. BARDIN, L. Análise de conteúdo. São Paulo: Edições 70, 2016.

6. BENITO, E; DONES, M.; BABERO, J. El acompañamiento espiritual en cuidados paliativos. Psychooncology. v. 13, n 2, p. 367-384, 2016. Available at: <https://www.academia.edu/30469791/EL_ACOMPA%C3%91AMIENTO_ESPIRITUAL_EN_CUIDADOS_PALIATIVOS>. Accessed on: 11 Dec. 2024.

7. BERTOLIN, D. C. et al.. Association between coping modes and sociodemographic variables of people on chronic hemodialysis. Journal of the School of Nursing of the University of São Paulo, v. 45, n. 5, p. 1070-1076, 2011. Available at: <https://www.scielo.br/j/reeusp/a/mP6JrcmNf4dBbxPZ74y4bjw/?lang=pt>. Accessed on: 15 Jan. 2025.

8. BLUCK, S., et al. Quality of Life for Older Cancer Patients: Relation of Psychospiritual Distress to Meaning-Making During Dignity Therapy. American Journal of Hospice and Palliative Medicine, v. 39, n. 1, p. 54-61, 2022. Available at: <https://journals-sagepub-com.ez116.periodicos.capes.gov.br/doi/10.1177/10499091211011712#bibr49-10499091211011712>. Accessed on: 18 jan. 2025.

9. BOTEGA, N. J., et al. Mood disorders in a medical clinic ward and validation of the anxiety and depression measurement scale (HAD). Revista de Saúde Pública, v. 29, p. 355-363, 1995. Available at: <https://www.scielo.br/j/rsp/a/dY4tVF5tWXkrfkyjz5Sp4rM/?lang=pt#>. Accessed on: 10 nov. 2024.

10. BUCKLEY, J.; HERTH, K. Fostering hope in terminally ill patients. Nurs Stand, v. 19, n. 10, 0. 33-41, 2004. Available at: <https://pubmed.ncbi.nlm.nih.gov/15612429/>. Accessed on: 15 Dec. 2024.

11. CHAN, R. et al. Studying psychosocial adaptation to end-stage renal disease: The proximal-distal model of health-related outcomes as a base model. Journal of Psychosomatic Research, v. 70, n. 5, p. 455-464, 2011. Available at: <https://www.sciencedirect.com/science/article/abs/pii/S0022399910004393>. Accessed on: 15 Dec. 2024.

12. CHOCHINOV, H. M. et al. Dignity in the terminally ill: a cross-sectional, cohort study. Lancet, v. 360, 2002a. Available at: <https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)12022-8/abstract>. Accessed on: 24 nov. 2024.

13. CHOCHINOV, H. M. et al. Dignity in the terminally ill: a developing empirical model. SocSci Med. v. 54, n. 3, p. 433-443, 2002b. Available at: <https://www.sciencedirect.com/science/article/abs/pii/S0277953601000843?via%3Dihub>. Accessed on: 24 nov. 2024.

14. CHOCHINOV, H. M. Dignity-conserving care--a new model for palliative care: helping the patient feel valued. JAMA. v. 287, n. 17, p. 2253-2260, 2002. Available at: <https://jamanetwork.com/journals/jama/article-abstract/194871>. Accessed on: 24 nov. 2024.

15. CHOCHINOV, H. M. et al. Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. Journal of Clin Oncol, v. 23, n. 24, p. 5520- 5525, 2005. Available at: <https://ascopubs.org/doi/10.1200/JCO.2005.08.391?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed>. Accessed on: 24 nov. 2024.

16. CHOCHINOV, H. M., et al. The patient dignity inventory: A novel way of measuring dignity-related distress in palliative care. Journal of Pain and Symptom Management, v. 36, n. 6, p. 559-71, 2008. Available at: <https://www.jpsmjournal.com/article/S0885-3924(08)00250-9/fulltext>. Accessed on: 23 nov. 2024.

17. CHOCHINOV, H. M., et al. Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: a randomized controlled trial. Lancet Oncol, v. 12, n. 7, p. 753-762, 2011. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC3185066/>. Accessed on: 23 nov. 2024.

18. CHOCHINOV, H. M. et al. Dignity and Distress towards the End of Life across Four Non-Cancer Populations. PLOS ONE. Vol. 11, No. 1, 2016. Available at: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0147607>. Accessed on: 10 Dec. 2024.

19. CHOCHINOV, H. M. Terapia da Dignidade: finitude, legado e dignidad nos cuidados paliativos. Translation: Idalina Lope. 1. ed. São Paulo: Manole, 2024.

20. DONATO, S. C. T. et al.. Validity and reliability of the Brazilian version of the Patient Dignity Inventory (PDI – Br). Latin American Journal of Nursing, v. 29, p. 3371, 2021. Available at: <https://www.scielo.br/j/rlae/a/49J5LVJg9JwdGmcnyXwhVXw/?lang=pt#>. Accessed on: 23 nov. 2024.

21. DOSE, A. M.; RHUDY, L.M. Perspectives of newly diagnosed advanced cancer patients receiving dignity therapy during cancer treatment. Support Care Cancer, vol. 26, pp. 187–195 (2018). Available at: <https://link-springer-com.ez116.periodicos.capes.gov.br/article/10.1007/s00520-017-3833-2>. Accessed on: 18 jan. 2025.

22. DU BOULAY, S. Changing the face of death The story of Cicely Saunders. 2nd ed. Great Britain: Brightsea Press, 2007.

23. ESPINDOLA, A. V. et al . Dignity therapy for adults with cancer in palliative care: a case report. Temas psicol., Ribeirão Preto, v. 25, n. 2, p. 733-747, 2017. Available at: <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-389X2017000200017&lng=pt&nrm=iso>. Accessed on: 10 Dec. 2024.

24. ERIKSON, E. H. Childhood and Society. Rio de Janeiro, Zahar, 1971.

25. FONTOURA, E. G. et al. Surviving with hemodialysis: perception of the person in the light of Merleau-Ponty's phenomenology. Braz. Ap. Sci. Rev, Curitiba, v. 4, n. 3, p. 2068-2078, 2020. Available at: <https://ojs.brazilianjournals.com.br/ojs/index.php/BASR/article/view/12323/10616>. Accessed on: 15 Jan. 2025.

26. GAMONDI, C.; LARKIN, P.; PAYNE, S. Core competencies in palliative care: an EAPC white paper on palliative care education - part 2. European Journal of Palliative Care, Toronto, v. 20, n. 3, p. 140-145, 2013. Available at: <https://www.sicp.it/wp-content/uploads/2018/12/6_EJPC203Gamondi_part2_0.PDF>. Accessed on: 24 nov. 2024.

27. GONÇALVES, A. L. Linguistic Adaptation to Portuguese of the Patient's Dignity Scale. In: BARBOSA, A. (org.) Qualitative Research in Palliative Care. Lisbon: Faculty of Medicine of the University of Lisbon, 2012, p. 63-73.

28. HACK, T. F., et al. Learning from dying patients during their final days: life reflections gleaned from dignity therapy. Palliative Medicine. v. 24, n. 7, p. 715-723, 2010. Available at: <https://journals.sagepub.com/doi/10.1177/0269216310373164>. Accessed on: 18 jan. 2025.

29. NATIONAL CANCER INSTITUTE (BRAZIL). The evaluation of the patient in palliative care / National Cancer Institute – Rio de Janeiro : INCA, 2022. Available at: <https://www.inca.gov.br/sites/ufu.sti.inca.local/files/media/document/completo_serie_cuidados_paliativos_volume_1.pdf>. Accessed on: 24 nov. 2024.

30. KEALL, R. M.; CLAYTON, J. M.; BUTOW, P. N. Therapeutic Life Review in Palliative Care: A Systematic Review of Quantitative Evaluations. J Pain Symptom Manag, v. 49, n. 4, p. 747–761, 2015. Available at: <https://www-sciencedirect-com.ez116.periodicos.capes.gov.br/science/article/pii/S0885392414004709?via%3Dihub>. Accessed on: 18 jan. 2025.

31. KEMP, C. Spiritual care interventions. In FERREL, B.R.; COYLE, N. Textbook of Palliative
Nursing, New York: Oxford, p. 595-604, 2006.

32. LEIMIG, M. B. C. et al. Quality of life, spirituality, religiosity and hope in people with chronic kidney disease on hemodialysis. Rev Soc Bras Clin Med. v. 16, n. 1, p. 30-36, 2018. Available at: <http://www.sbcm.org.br/ojs3/index.php/rsbcm/article/view/322/293>. Accessed on: 15 Jan. 2025.

33. LIMONERO, J. T. et al. Resilient coping strategies and emotional regulation: predictors of life satisfaction. Psicología conductual, v. 20, n.1, 2012. Available at: <https://www.behavioralpsycho.com/producto/estrategias-de-afrontamiento-resilientes-y-regulacion-emocional-predictores-de-satisfaccion-con-la-vida/>. Accessed on: 11 Dec. 2024.

34. MATTOS, M. MARUYAMA, S. A. T. The family experience of a person with diabetes mellitus and undergoing hemodialysis treatment. Rev Eletr Enf., v. 11, n. 4. p. 971-981, 2009. Available at: <https://revistas.ufg.br/fen/article/download/33253/17589/140028>. Accessed on: 18 jan. 2025.

35. MATSUMOTO, D. Y. Palliative Care: concept, fundamentals and principles. In: CARVALHO, R. T.; PARSONS, H. A. (Org.) Manual de Cuidados Paliativos São Paulo: Academia Nacional de Cuidados Paliativos (ANCP), p.23-30, 2012.

36. MARTIRE, M. L.; SCHULZ, R. Involving family in psychosocial interventions for chronic illness. Current Directions in Psychological Science, v. 16, p. 90-94, 2007. Available at: <https://pure.psu.edu/en/publications/involving-family-in-psychosocial-interventions-for-chronic-illnes>. Accessed on: 15 Dec. 2024.

37. MONTROSS, L.; WINTERS, K. D.; IRWIN, S. A. Dignity therapy implementation in a community-based hospice setting. J Palliat Med. v. 14, n. 6, p. 729-734, 2011. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC3120093/>. Accessed on: 18 jan. 2025.

38. NUNZIANTE, F. et al. Providing dignity therapy to patients with advanced cancer: a feasibility study within the setting of a hospital palliative care unit. BMC Palliat Care, Vol. 20, 2021. Available at: <https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-021-00821-3>. Accessed on: 24 nov. 2024.

39. PEREIRA, M. G.; FIGUEIREDO, A. P. Depression, anxiety and post-traumatic stress in patients with colorectal cancer: validation of the Hospital Anxiety and Depression Scale (HADS) and Impact of Events Scale (IES) in a sample of cancer patients. Onco-

News, v.2 n. 5, 2008. Available at: <https://repositorium.sdum.uminho.pt/bitstream/1822/16463/1/Cancro%20colo-rectal.PDF>. Accessed on: 23 nov. 2024.

40. PUCHALSKI, C. et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. Journal of palliative medicine, v. 12, n. 10, p. 885-904, 2009. Available at: <https://www.liebertpub.com/doi/10.1089/jpm.2009.0142?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed>. Accessed on: 11 Dec. 2024.

41. RUDILLA, D. et al. Comparing counseling and dignity therapies in home care patients: A pilot study. Palliative and Supportive Care, v. 1, n. 9, 2015. Available from: <https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/abs/comparing-counseling-and-dignity-therapies-in-home-care-patients-a-pilot-study/8B03E7B017060C73493560C9BFE8909A>. Accessed on: 10 Dec. 2024.

42. TIMÓTEO, C. et al. Legacy in End-of-Life Care: A Concept Analysis. Nurs Rep. v. 14, n. 3, p. 2385-2397, 2024. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11417748/>. Accessed on: 16 Dec. 2024.

43. SANTOS, R. I.; COSTA, O. R. S. Evaluation of Resilience in Patients with Chronic Renal Failure Undergoing Hemodialysis. Journal of Health Sciences, v. 6, n. 1, 2016. Available at: <https://portalrcs.hcitajuba.org.br/index.php/rcsfmit_zero/article/view/461/298>. Accessed on: 15 Jan. 2025.

44. SILVA, L. C. et al. Kidney transplantation from the perspective of the transplanted person. Ciênc. care. Saúde, v 12, n 2, 2013. Available at: <https://www.revenf.bvs.br/scielo.php?script=sci_arttext&pid=S1677-38612013000200020>. Accessed on: 18 jan. 2025.

45. SILVA, R. M.; MOTTA, R. F. Psychology and the disease process in chronic kidney patients. Disciplinarum Scientia Ciências Humanas, v. 13, n. 2, p. 137–150. Available at: <https://periodicos.ufn.edu.br/index.php/disciplinarumCH/article/view/1734/1638>. Accessed on: 15 Jan. 2024.

46. VUKSANOVIC, D. et al. Dignity Therapy and Life Review for Palliative Care Patients: A Qualitative Study. Journal of Pain and Symptom Management, v. 54, n. 4, p. 530 - 537, 2017. Available at: <https://www.jpsmjournal.com/article/S0885-3924(17)30279-8/fulltext>. Accessed on: 16 Dec. 2024.

47. WERU, J.; GATEHI, M.; MUSIBI, A. Randomized control trial of advanced cancer patients at a private hospital in Kenya and the impact of dignity therapy on quality of life. BMC Palliative Care, v. 19, 2020. Available at: <https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-020-00614-0#:~:text=This%20single%20center%20randomized%20controlled,compared%20to%20routine%20care%20only>. Accessed on: 10 Dec. 2024.

48. WORLD HEALTH ORGANIZATION (WHO). Palliative Care Cancer control: knowledge into action: WHO guide for effective programs. Module 05. Genève, 2007. Available at: https://www.ncbi.nlm.nih.gov/books/NBK195408/>. Accessed on: 23 nov. 2024.

49. YIN, R. K. Case Study: Planning and Methods. 6 ed. Porto Alegre: Bookman, 2018.

50. ZAQUI-NEJAD, M. et al. The Effect of Dignity Therapy on the Quality of Life of Patients with Cancer Receiving Palliative Care. Iranian Journal of Nursing and Midwifery Research, v. 25, 2020. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7494160/>. Accessed on: 10 Dec. 2024.

51. ZIGMOND, A. S.; SNAITH, R. P. The Hospital Anxiety and Depression Scale. Acta Psychiatrica Scandinavica, 67, 361-370, 1983. Available at: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1600-0447.1983.tb09716.x?sid=nlm%3Apubmed>. Accessed on: 10 nov. 2024.