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Dignity therapy as an aid to coping for COPD patients at their end-of-life stage

Abstract

Introduction: Observations indicate that struggling with a burden of an incurable disease such as advanced chronic obstructive pulmonary disease (COPD) may result in the weakening of an individual sense of dignity, and be a source of spiritual suffering. Clinicians providing respiratory care to patients should be open to their spiritual needs, in the belief it may improve coping with the end-of-life COPD.

The study aimed to assess overall feasibility and potential benefits of Dignity Therapy (DT) in patients with advanced COPD.

Material and methods: Patients with severe COPD, in whom a DT intervention was implemented according to the protocol established by Chochinov *et al.* were included into the study. An self-designed questionnaire was applied to assess the patients' satisfaction after intervention. Subsequently, the patients' statements were allocated to specific problem categories, corresponding to the spiritual suffering concerns, as structured by Groves and Klauser.

Results: DT was completed in 10 patients, with no unexpected side effects. Satisfaction Questionnaire showed a positive effect of DT on the patient' well-being (3.9 on a 5-point Likert scale). The analyses of the patients' original statements enabled an effective identification of the spiritual suffering and spiritual resources and faced by COPD patients.

Conclusion: DT is an intervention well received by COPD patients, which may help them in recognising and fulfilling their spiritual needs in the last phase of their life. Information acquired on the patients' resources and spiritual challenges may help clinicians improve their care, especially with regard to supporting their patients at the end-of-life stage.

Key words: COPD, Dignity Therapy, end of life, spiritual suffering

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Introduction

Burden of an incurable, chronic disease may be associated with a weakened sense of dignity and spiritual suffering, along with low overall quality of life [1–5]. Unsatisfactory relief of breathlessness or other symptoms, uncertain prognosis, a sense of social and professional exclusion, combined with limited access to palliative care, may adversely affect an individual sense of dignity in COPD patients who also experience spiritual suffering in various dimensions [6, 7]. Cicely Sanders was the first one to propose that total pain of a dying person is comprised not only within the physical, mental and social dimensions, but also spiritually [8]. In response, Groves and Klauser proposed four categories of human spiritual experiences, i.e. a sense of meaning, forgiveness, relatedness, and hope [9].

Healthcare professionals are encouraged to pay much closer attention to the patients' spirituality and routinely identify their spiritual

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needs wherever possible [10, 11]. Various specific approaches offering spiritual support have been developed recently, such as Dignity Therapy (DT) proposed by Chochinov *et al*. [12–14]. DT is a form of short-term psychotherapy which may be offered by a doctor, a nurse, a psychologist, or another specifically-trained person. An intimate dialogue-based on a set of open questions developed for the purpose of this therapy — addresses the patient's life story. The patient's statements are recorded and subsequently converted into a written record, i.e. his spiritual legacy, as it were. This document, with the patient's agreement, may later be handed over to another person named by him [12].

The present study aimed to assess overall feasibility and potential benefits of DT in patients with advanced COPD, since no such studies having been published to date. Furthermore, efforts were made to determine whether and in which specific way this therapy might help clinicians offer a higher standard of care to COPD patients at the end-of-life stage by way of gaining some insights into their spiritual needs, especially with regard to support the patients in facing up to their imminent death.

Material and methods

The study protocol was approved by a local Bioethics Review Committee, Nicolaus Copernicus University of Toruń, *Collegium Medicum* in Bydgoszcz (KB 348/2017). Eligibility for the study included at least two indicators from the so-called Curtis criteria, determining the likelihood that a patient was in a terminal phase of COPD [15]. These comprised very severe obstruction (FEV_1 < 30% at n.n.), dependence on oxygen therapy, at least one hospitalisation within the previous year due to COPD exacerbation, intensification of symptoms of any concomitant diseases, especially heart failure, progressive weight loss, or visible signs of cachexia, deterioration of overall functional status, or increasing dependence on other people for care, and age over 70 years. Eligibility criteria included also patients' written informed consent, and general health condition enabling participation in an approximately two-week series of meetings. All eligible patients were recruited during hospitalisation at the Department of Pneumonology, due to exacerbation of COPD, although DT was applied within the stable period of the disease. The interviews were conducted by a pulmonologist. The interviewer had not met the selected patients before, nor had been put in charge of their treatment management in the ward. In getting ready for the application of DT, the investigator had appraised himself of the available publications on the subject, and took advantage of the practical DT training pursued alongside experienced professionals from the Department of Palliative Care.

The interview itself, being of a narrative character offered the patients an opportunity to tell their life story without any interruptions, avoiding unnecessary questions, or extra prompts. The patient remained throughout in full control of his personal narrative, occasionally only being directed to address specific issues by the interviewing investigator [16, 17]. At the first meeting, the patients were informed about the key principles and purpose of the therapy, and received a set of questions, so that they might prepare the answers in advance (Table 1). After signing the

Table 1. The Patient Dignity Therapy Questions (in line with the protocol proposed by Chochinov *et al.* [10])

1. Tell me a little about your life history, particularly the parts that you either remember most, or think are the most important. When did you feel most alive?
2. Are there specific things that you would want your family to know about you, and are there particular things you would want them to remember?
3. What are the most important roles you have played in life (family roles, vocational roles, community service roles, etc.)? Why were they so important to you, and what do you think you accomplished in those roles?"
4. What are your most important accomplishments, and what do you feel most proud of?
5. Are there particular things that you feel still need to be said to your loved ones, or things that you would want to take the time to say once again?"
6. What are your hopes and dreams for your loved ones?
7. What have you learned about life that you would want to pass along to others? What advice or words of guidance would you wish to pass along to your (son, daughter, husband, wife, parents, others)?"
8. Are there words or perhaps even instructions you would like to offer your family to help prepare them for the future?"
9. In creating this permanent record, are there other things that you would like included?"

Table 2. Dignity Therapy Adherence Form [20]

1. Did the therapist ask questions as per the Dignity Therapy protocol?	yes	no
2. Was the therapist flexible to include content areas as directed by the patient?	yes	no
3. Was the therapist respectful to the patient's direction about content areas they wished not to have included in the generativity document?	yes	no
4. Was the tone of the intervention respectful, and the therapist non-judgmental in attitude?	yes	no
5. Did the therapist use elaborative techniques (as defined in the Dignity Therapy Manual) to elicit further detail when needed?	yes	no
6. Was the sequence of contacts as per the Dignity Therapy protocol?	yes	no
7. Was the participant prompted to designate at least one recipient of the Dignity Therapy generativity document?	yes	no
8. Was the editing process carried out in accordance with the Dignity Therapy protocol?	yes	no
9. Was the participant given ample opportunity to make changes to the generativity document?	yes	no
10. Was the generativity document read to the patient in its entirety?	yes	no
Total score:		
		(out of 10)

informed consent form, patients were first asked to complete the Hospital Anxiety and Depression Scale (HADS) and Edmonton Symptom Assessment System (ESAS) questionnaires assessing their psycho-physical status, and The Spiritual Needs Questionnaire (SpNQ) [18]. The latter is an established measure of spiritual needs, differentiating Religious Needs, Existential Needs, Giving/ /Generativity Needs, and Inner Peace Needs. All these tools were used by the investigators as a help to perform the holistic evaluation of the patient's needs. A session lasting 30–60 minutes then commenced. The interviewer read out the questions to be addressed by the patient. At the patient's request, a particular question could have been omitted or treated superficially, at the expense of another question which the patient thought merited more attention. All statements were recorded. If necessary, the patient could ask for a break. If the patient's physical condition indicated fatigue with a longer output, the investigator suggested cutting the session short, to be continued the following day. The questions were read out one by one, with enough time in between allowing the patient to address them freely. The investigator's most essential role was to extract from the patient's memory those recollections which might potentially give rise to a particular sense of satisfaction, a sense of pride, and consequently enhance his sense of self-esteem (a sense of personal dignity). After completing the interview, the material was transcribed, and subsequently the final document was drafted. Colloquialisms, repetitions, and any inclusions not directly pertinent to the actual course of the interview were edited out. In some cases, the syntactical order was adjusted, so as to ensure that the text as a whole would have the character of a coherent document, without losing its original emotional colouring and the intention of the speaker. At the third session, the document was read out to the patient. The patient could assess its content, make additional corrections or supplementations. At this stage, the patient was asked about the final decision to whom a copy of the document was to be handed over. After any necessary amendments, at the fourth session, the final version of the document was handed over to the patient, who might give it personally to the beloved one, or it was sent by post to the indicated person, with a comprehensive information regarding the study protocol itself. At the end of the session, the patients were requested to complete a Satisfaction Questionnaire, which was specifically developed for the purpose of the study [19]. The questionnaire comprised 10 statements, with answers based on the 5-point Likert scale, where 1 stands for "Strongly disagree", 2 — for "Disagree", 3 — for "Neither agree nor disagree", 4 — for "Agree", 5 — for "Strongly agree". In the last open question, the patients could express their opinions about the therapy itself, and specify in which way this intervention proved most helpful. Finally, overall compliance of DT was assessed in each individual by the compliance benchmark form filled-in by the attending investigator, originally developed by the authors of DT [20], and enclosed with the test protocol (Table 2).

The second stage of the study comprised a qualitative analysis of the patients' statements, as evidenced in the final documents. The com-

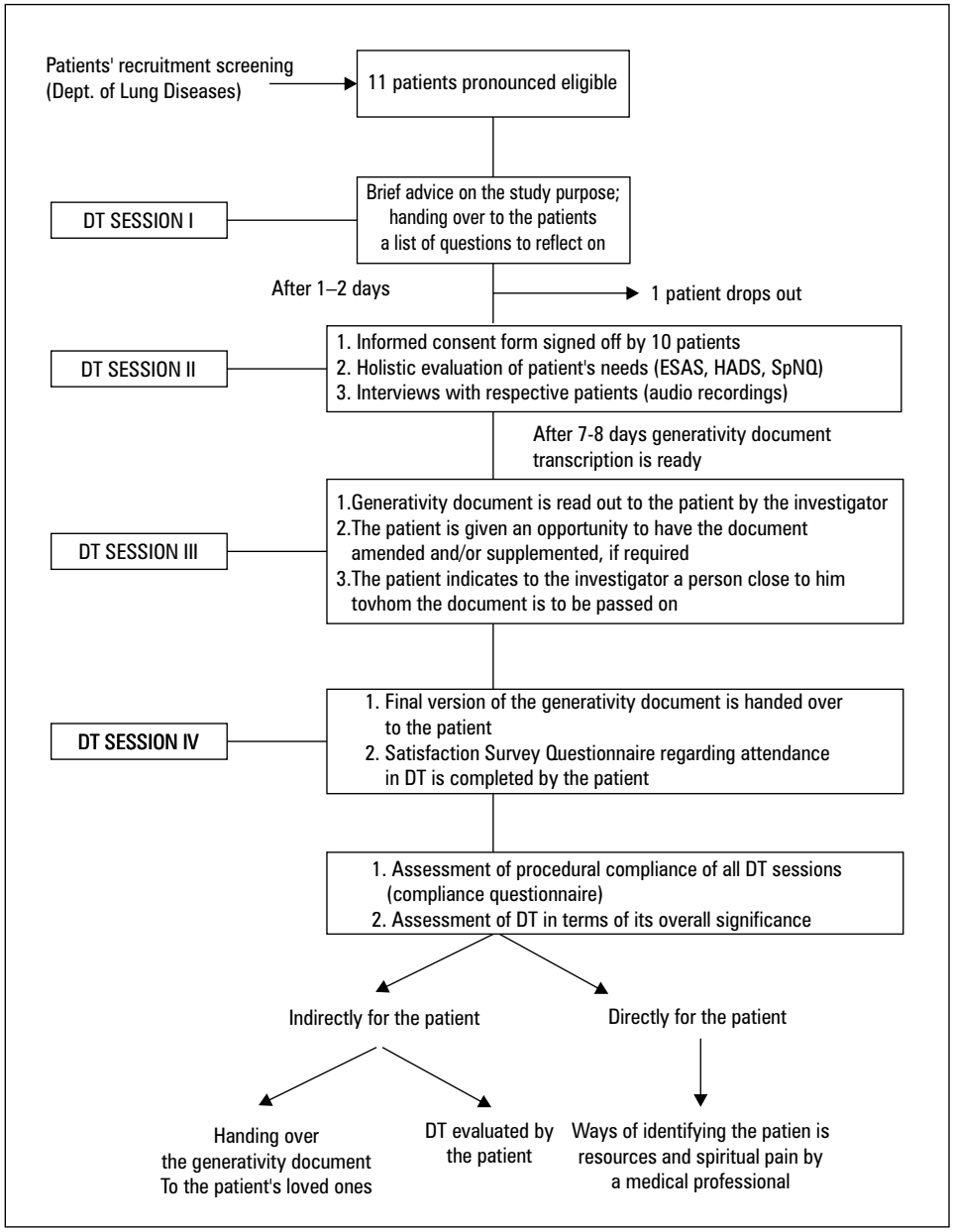

Figure 1. Dignity Therapy study protocol flowchart

petent judges method was applied. The multidisciplinary team (i.e. two doctors and two psychologists) discussed to what extent the patients' statements might be of appreciable assistance to the medical caregivers, in terms of facilitating better understanding of the patients' overall needs, in learning about their resources, especially in the spiritual dimension, but also about the potential sources of spiritual pain. Four thematic categories were ultimately generated, based on the previously referenced concept of recognition of spiritual suffering construed by Groves and Klauser [9]. When assessing the documents in some detail, individual excerpts from the patients' statements were coded in terms of having them effectively assigned to the pre-defined categories. It was also established whether the patient's statement was associated with his resource, which potentially might become a source of inner strength for him, or a difficulty which might ultimately cause him some spiritual suffering.

Results

Characteristics of patients covered by the study

Eleven patients with severe of COPD were enrolled into the study (Figure 1). One withdrew her consent arguing that she was reluctant to talk about herself. Ultimately, 10 patients in the

terminal stage of COPD (8 men, 2 women), aged 60–87 years (mean age 73 years) completed the study. Two patients fulfilled four, whereas those remaining, five or more of the Curtis criteria. The study lasted 12 months, i.e. between May 2017–May 2018. Most of the patients presented breathlessness at rest, whilst all of them a significantly reduced effort tolerance (3 or 4 points on the mMRC scale) (Table 3). All patients suffered from at least 4 moderate to severe symptoms including breathlessness, tiredness, depression, drowsiness, or a lack of appetite. Even if they complained about a number of different symptoms, still expressed a willingness to participate in the study. The HADS did not reveal any definite cases of depression or anxiety, although the psychological distress score remained within the range indicating abnormal borderline anxiety (3 patients), or depression (3 patients). There was also a great diversity and a wide range of intensity of spirituals needs in the patients, as evidenced in the SpNQ questionnaires (Table 3).

DT intervention

DT was applied in all 10 patients. The majority of patients were interviewed during their stay in the hospital ward, following stabilisation of their condition. In the case of two patients, the interviews were conducted at home, following their discharge from the hospital, upon their explicit request. In none of the cases was any exacerbation in breathlessness observed. Occasional breaks were included. Since the patients were usually well prepared to attend the interview, the investigator's role was often reduced to attentive listening and clarifying some details. All individual tests having been completed in full compliance with the rules for DT and obtained a the maximum score of 10 points, in line with Dignity Therapy Adherence Form (Table 2).

Evaluation of DT by the patients

Eight patients assessed the therapy as favourably affecting their mental well-being (Table 4). In the 5-point Likert scale, the average for this statement was 3.9. Two patients who rated the therapy as of "low" value in this category expressed their unequivocal acceptance and satisfaction with the participation in the study, so their rating, as indicated in the questionnaire, remains somehow in contradiction with their genuine interest in the therapy at large.

In the 5-point Likert scale, the average values for each statement in the whole study population were higher than 3. The patients especially valued the method and form of communication which made it easier to go through their feelings, along with naming properly all the things that truly mattered to them (average ≥ 4.2). Whilst addressing an open question in the Satisfaction Questionnaire (i.e. on when the therapy actually proved most helpful to them), the patients indicated various aspects (Table 4). For one, the most important thing was that he could "convey his precious memories and feelings", for another "telling the truth" was most essential. Another patient expressed her satisfaction that she was thus able to inspire some interest in her loved ones in the "grandmother's life story". Majority of the patients decided to designate at least one recipient of the DT generativity document while three study participants preferred to keep it for themselves only.

Qualitative analysis of patients' statements as an aid to clinicians in providing better end-of-life care

The most frequent potential spiritual resource for the patient was the sense of meaning (9 respondents) and the relations with others (8 respondents), the least frequent — the area of forgiveness (2 respondents). Most often, potential problems or potential causes of spiritual suffering were buried in the area of relatedness (7 respondents) and hope (5 respondents), least frequently — forgiveness (1 respondent) (Table 5).

Discussion

Observations acquired throughout the present study give grounds to believe that DT is positively received by patients with advanced COPD who are willing to undertake this, despite concomitant symptoms, e.g. chronic breathlessness. The patient's story about himself and his life presented through this type of intervention may help clinicians to gain some valuable insights into the patient's spiritual dimension, i.e. both the spiritual resources that can be tapped as the source of the patient's strength, and also his problems, and potential causes of spiritual suffering. This would in turn enable medical professionals to offer better whole-person-care to all patients with advanced COPD, more effectively helping them in facing up to imminent death.

Patients usually accepted the offer to attend the study with genuine interest and openness. Out of eleven persons invited to the study, only one refused to attend. Despite their exacerbated medical conditions (majority of patients experienced breathlessness at rest, and a significantly reduced

Table 3. Characteristics of the patients

Patient	Age	Gender	Marital status	Curtis criteria	ESAS	HADS		SpNQ: Spiritual needs category			
						A	D	R (religious)	E (existential)	G (giving/ /gener ativity needs)	P (inner peace)
P1	60	M	married	— hospitalization due to COPD exacerbation — severe heart failure symptoms — cachexia/progressive weight loss (BMI<19) — decreased functional status (MRC 3)	Pain 1, activity 7, nausea 1, depression 0, anxiety 0, drowsiness 7, appetite 5, wellbeing 1, dyspnoea 5 **Total 27**	5	2	0	1	4	3
P2	68	M	married	— oxygen dependence — hospitalization due to COPD exacerbation — severe heart failure symptoms — cachexia/ progressive weight loss (BMI<19) — decreased functional status (MRC 4) — increasing dependence on others for care	Pain 0, activity 8, nausea 0, depression 9, anxiety 0, drowsiness 2, appetite 9, wellbeing 5, dyspnoea 8 **Total 41**	8	3	1	8	7	4
P3	74	M	married	— FEV1<30% predicted — oxygen dependence — hospitalization due to COPD exacerbation — cachexia/progressive weight loss (BMI <19) — decreased functional status (MRC 4) — increasing dependence on others for care — age >70 years	Pain 1, activity 10, nausea 3, depression 7, anxiety 4, drowsiness 6, appetite 5, wellbeing 3, dyspnoea 6, **Total 48**	8	6	3	3	6	5
P4	69	M	widower	— hospitalization due to COPD exacerbation — severe heart failure symptoms or other concomitant diseases — cachexia/progressive weight loss (BMI <19) — decreased functional status (MRC 3)	Pain 5, activity 3, nausea 0, depression 3, anxiety 1, drowsiness 4, appetite 3, wellbeing 5, dyspnoea 7 **Total 31**	6	6	0	0	4	1
P5	81	M	married	— oxygen dependence — hospitalization due to COPD exacerbation — severe heart failure symptoms or other concomitant diseases — cachexia/ progressive weight loss (BMI<19) — decreased functional status (MRC 4) — increasing dependence on others for care — age >70 years	Pain 6, activity 9, nausea 0, depression 5, anxiety 2, drowsiness 5, appetite 5, wellbeing 8, dyspnoea 9 **Total 49**	7	9	0	3	5	6

Table 3 cont. Characteristics of the patients

P6	69	F	widow	— FEV1<30% — hospitalization due to COPD exacerbation — cachexia/progressive weight loss — decreased functional status (MRC 3) — increasing dependence on others for care	Pain 6, activity 8, nausea 0, depression 6, anxiety 7, drowsiness 8, appetite 9, well-being 8, dyspnoea 8 **Total 60**	6	7	8	9	7	7
P7	87	M	widower	— hospitalization due to COPD exacerbation — severe heart failure symptoms or other concomitant diseases — cachexia/ progressive weight loss (BMI<19) — decreased functional status (MRC 4) — increasing dependence on others for care — age > 70 years	Pain 0, activity 9, nausea 0, depression 10, anxiety 10, drowsiness 7, appetite 8, wellbeing 2, dyspnoea 8 **Total 54**	6	8	18	17	12	9
P8	82	M	married	— oxygen dependence — hospitalization due to COPD exacerbation — severe heart failure symptoms or other concomitant diseases — decreased functional status (MRC 4) — increasing dependence on others for care — age > 70 years	Pain 5, activity 5, nausea 0, depression 5, anxiety 0, drowsiness 0, appetite 0, wellbeing 5, dyspnoea 10 **Total 30**	3	5	8	13	8	8
P9	72	M	widower	— hospitalization due to COPD exacerbation — decreased functional status (MRC 3) — increasing dependence on others for care — age > 70 years	Pain 0, activity 3, nausea 0, depression 7, anxiety 1, drowsiness 7, appetite 6, wellbeing 6, dyspnoea 8 **Total 38**	4	6	14	10	12	9
P10	72	F	widow	— FEV1<30% — oxygen dependence — hospitalization due to COPD exacerbation — decreased functional status (MRC 4) — increasing dependence on others for care — age > 70	Pain 2, activity 10, nausea 5, depression 7, anxiety 4, drowsiness 6, appetite 5, wellbeing 3, dyspnoea 6 **Total 48**	9	10	10	6	7	6

ESAS (The Edmonton Symptom Assessment System): pain: 0 — no pain, 10 — worst possible pain; activity: 0 — not tired, 10 — worst possible tiredness; nausea: 0 — not nauseated, 10 — worst possible nausea; depression: 0 — not depressed, 10 — worst possible depression; anxiety: 0 — not anxious, 10 — worst possible anxiety; drowsy — 0 not drowsy, 10 — worst possible drowsiness; apetite: 0 — best appetite, 10 — worst possible appetite; wellbeing: 0 — best feeling of wellbeing, 10 — worst possible feeling of wellbeing; shortness of breath: 0 — no shortness of breath, 10 — worst possible shortness of breath.
Cut points of ESAS: 0 (none); 1–3 (mild); 4–6 (moderate); 7–10 (severe)
HADS (Hospital Anxiety and Depression Scale): A — anxiety, D — Depression, 0–7 points — normal, 8–10 points — borderline abnormal (borderline case), over 10 points — abnormal.
SpNQ (Spiritual Needs Questionnaire): R — religious needs (0–18); E — existential needs (0–21); G — giving/generativity needs (0–12); P — inner peace needs (0–9);
COPD — chronic obstructive pulmonary disease
mMRC — Modified Medical Research Council Dyspnoea Severity Scale
BMI — Body Mass Index
FEV1 — forced expiratory volume in one second

Table 4. Patients' evaluation of Dignity Therapy by means of Dignity Therapy Satisfaction Questionnaire [19]

Assessed issues	Respective patients' responses										
	1	2	3	4	5	6	7	8	9	10	Average
1.Following the therapy, my mental well-being improved	4	5	4	1	4	5	3	4	4	5	3.9
2.I hope my family will feel better when they see the recording	1	5	4	3	3	5	3	2	4	5	3.5
3.I believe that thanks to this message, my loved ones will see me in a different light, and so our relationship will improve	2	5	3	4	3	4	5	2	2	4	3.4
4. I feel more at peace now	3	5	3	1	3	4	5	3	4	5	3.6
5. I have a sense that some things that truly matter to me have now been spelt out and named properly	4	5	3	4	4	5	5	4	4	4	4.2
6.I believe this particular form of communication made it easier for me to get across some truly important matters, as well as helped me reveal my feelings to my loved ones	4	5	4	3	4	5	5	3	4	5	4.2
7. I feel that thanks to this document, I have now left an important message for my family	4	5	3	4	3	5	5	2	3	5	3.9
8. This method of communication was much easier for me than speaking face to face with my loved ones	4	5	5	3	4	5	5	3	5	5	4.4
9. I have a sense that I have now done something important both for myself and others	4	5	3	3	3	5	5	2	4	5	3.9
10. I believe that thanks to this recording, various difficult matters might well be smoothed out now	4	5	3	2	2	3	5	2	3	4	3.3

Open question	
Patient	**In what way did this intervention prove most helpful?**
P1	—
P2	I am very satisfied with the survey
P3	Passing on my memories and feelings
P4	—
P5	I am satisfied with the chat, to me every single contact is of great value, especially when someone is not judgemental.
P6	Family interest in the grandmother's life story
P7	I had an opportunity to say what I actually felt, and then pass it on to others
P8	To speak out the truth
P9	Eventually someone took some interest in myself
P10	I very much appreciate this opportunity, I feel a sense of calm now

The answers were based on the 5-point Likert scale, where 1 stands for „Strongly disagree", 2 — for „Disagree", 3 — for „Neither agree nor disagree", 4 — for „Agree", 5 — for „Strongly agree"

tolerance of physical exertion), the patients willingly took part in the therapeutic sessions, and often quite enthusiastically addressed the questions comprised in the study protocol. For some of them, deeply fatigued with continuing exacerbations of their medical conditions, and burdened with unfavourable prognosis, an opportunity to revisit the moments in their lives that could fill them again with expressions of emotion and pride, was genuinely welcomed as comforting. Patients gratefully accepted that the investigator was primarily seeking facts and episodes in their life story for which they could still be rightfully proud after so many years.

Following assessment of the transcribed interviews, in line with Groves and Klauser's spiritual health assessment tool, four problem categories were enumerated, i.e. sense of meaning, forgiveness, relatedness, and hope. Within each category, excerpts of the patients' original state-

Table 5. Assigning a disclosed resource/problem, originating in the patient's statements, to a specific problem category

Category	Potential resource or problem	Patients who's statements referred to the category	Total number of patients who's statements referred to the category	Examples of patients' statements
Meaning	Resource	1, 2, 3, 5, 6, 7, 8, 9, 10	9/10	Patients indicated persons or circumstances that made their life have a purpose, and be meaningful, be that in the past or now. They made references to persons or situations that were the mental resources for this category that motivated them to carry on with their lives. Patient 1: „I felt most alive when I had to do something for someone else". Patient 5: „The most important thing in my life was probably that I was an artist, and the first one in my family". Patient 6: „Housework, and doing the gardening. It gave me particular joy, as I liked to watch all plants grow ever so nicely".
	Problem	3,8	2/10	A sort of a challenge or a difficulty in this category were the events that made the sick person lose his sense of meaning and motivation in life: Patient 8: „Then my daughter fell ill and died. And I lost a sense of direction in my life for a quite a long time". Patient 3: „Maybe more may have been done about it, but then comes the end and that's it".
Forgive-ness	Resource	9, 10	2/10	If the patient has afforded to make a gesture of reconciliation or forgiveness in the past, this episode was classified as a spiritual resource: Patient 9: „Before reporting for a surgical procedure (....) I called my ex-wife, I made a sort of brief examination of my conscience over the phone, and offered my apologies for all my transgressions against her". Patient 10: „Even if I was hurt myself in some way, I forgive".
	Problem	10	1/10	Sometimes there appeared some recollections attesting to a sense of lacking forgiveness, be that for oneself, or for others, classified as a difficulty for this category: Patient 10: „If I could go back in time, I would have acted differently then (...) I remember the way she looked at me".
Relation-ships	Resource	1, 2, 4, 5, 6, 7, 8, 9	8/10	The patients often pointed to interpersonal relationships that used to be helpful in life, and therefore were classified as the resources for this category: Patient 1: „We have wonderful children". Patient 4: „I go along very well with my neighbours, they call me all the time and pay me visits". Patient 8: „I love my wife very much (...) she has always been a very tactile person and this is still very much the case".
	Problem	1, 4, 5, 6, 8, 9, 10	7/10	Difficult relationships or lack of good relationships with the patient's loved ones were classified as the difficulties. Patient 1: „I would love us to live close to each other in the future. This is my dream (...) as I am not going to move to England". Patient 9: „My father was a terrible tyrant".
Hope	Resource	1, 2, 5, 7, 9, 10	6/10	The patient's statements indicating the circumstances that filled him with hope and made him look forward to the future with some confidence were classified as the resource. Patient 2: „so that everyone would have it as best as can be (...) just as it used to be in our family. Let it be like this." Patient 5: „I have always taught them this, and today I would also like to teach them the same. Respect for the elderly and for both parents is the most important thing in life." Patient 10: „I know that God will help me one day, and I will still manage to make friends with my own daughter".
	Problem	4, 6, 8, 9, 10	5/10	The difficulties in this category were the facts from the patient's own life which made him experience depression or even a sense of being stripped of all hope: Patient 6: „My younger son manages all right, but he could fare better still. He has got an apartment of his own, but he is out of work." Patient 8: „I would like my wife to be cared for right up to the end, and that I would be her caregiver. But it seems rather unlikely".

ments were quoted, indicating specific spiritual resource or difficulty. The difficulties identified may well point to the direction worth following, with a view to effectively reducing the patients' suffering at the end-of-life stage. On the other hand resources may be tapped into, so as to mobilize the patients in overcoming the difficulties encountered along the way, or may be summoned to aid the patient in going through any particularly difficult patches in the disease.

DT applied in the present study revealed that a sense of meaning offered a tangible mental resource to almost all subjects. This is an inspiring observation, especially that any terminally ill patient upon entering the last phase of his life often experiences an appreciable erosion in his sense of meaning. Then spiritual suffering envelopes him like a shroud; this also intensified by deep anxiety about the future fate of his loved ones. The proposed therapy, through enhancing one's dignity, also offers an appreciable boost to one's sense of meaning in life, and, by becoming a message to others, offers the patient the hope of leaving behind a part of himself to them. Since the source of patient's suffering consists not only in somatic ailments, anguish, but also in spiritual suffering, palliative care also aims to help the patient navigate within this dimension. This is all the more essential as the patient's spiritual well-being may also be associated with going through appreciably less anxiety and depression [21], and possibly even through less exacerbated breathlessness in the COPD patients [22].

For the vast majority of patients, relationships with other people were a strong spiritual resource, but also a problem. Therefore, many patients expressed their satisfaction that the reflections they shared during DT sessions would subsequently be passed on to someone close to them. This usually felt much easier for them than a face-to-face confrontation. For some, the study was associated with the hope of having the relations within the family fold improved. Interestingly enough, even a failure to fulfil this particular hope did not cause any bitterness to the patient. Patient no.10, hoping that her daughter would re-establish the relationship with her after receiving the generativity document, which originated during the DT session, said on the study outcome: "My daughter never spoke to me, after all, but when I am very ill and beaten, I read through this document again, and this sort of calms me down, as I feel that I have really done everything in my power".

Much like the present study, the randomized trials pursued to date have corroborated the high level of satisfaction in the patients attending DT, as well as appreciable benefits for the patients themselves, and their loved ones [23–25]. The intervention has been pursued in many countries, mainly in the cancer patients [25], but also in the ones with motor neuron disease [27], in the elderly [28], in the persons suffering from cognitive disorders [29], and those in the early stage of dementia [30]. As no publications addressing this type of therapy specifically in patients with pulmonary diseases have been found to date, it would appear the present study is the first attempt ever undertaken to apply DT specifically in the patients at an advanced stage of COPD.

Conclusions

Dignity Therapy seems to hold significant therapeutic potential, also for the people with advanced COPD. The fact that the patients attending the sessions received the procedure well, in conjunction with its uncomplicated protocol and was easy to manage by the investigator himself, give the authors sufficient grounds to believe that it should be incorporated into the scope of interventions specifically aimed at enhancing overall standard of medical care offered to COPD patients at the end stage of their lives.

Conflict of interest

The authors declare no conflict of interest.

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