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Dignity therapy during active chemotherapy: Promising findings, but methodological questions remain

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Letter to the Editor

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To the Editor,

We read with interest the article by Andreis et al., "Fostering human dignity during chemotherapy: An explorative study on Dignity Therapy in advanced gastric and pancreatic cancer" (Andreis et al. 2026). The authors deserve praise for introducing Dignity Therapy (DT) to patients with advanced pancreatic and stomach cancer receiving aggressive chemotherapy, moving beyond its customary end-of-life use. The study tackles a crucial aspect of supportive oncology because of the significant psychological and existential burden connected to these cancers. However, when evaluating its encouraging results, a number of issues should be taken into account.

First, it is remarkable that emotional and dignity-related suffering has significantly decreased. Patient Dignity Inventory ratings dropped from 37.1 to 27.9 following DT, while emotional discomfort fell from 6.67 at baseline to 3.13 (Andreis et al. 2026). These results are in line with research that suggests DT has psychological advantages for cancer patients (Zhang et al. 2022). However, these benefits cannot be directly attributed to DT due to the single-group architecture. The observed alterations may potentially have been caused by enhanced therapeutic focus, concomitant supportive care, psychological adaptation, chemotherapeutic response, and symptom stabilization.

Second, arguments about viability should take the 43% attrition rate into account. Only 30 of the 53 patients who were recruited finished all 3 evaluation points; noncompletion was caused by withdrawal, clinical worsening, or death (Andreis et al. 2026). While earlier studies have demonstrated the viability of DT during active chemotherapy (Vergo et al. 2014), in advanced cancer, viability should take into account patients' ability to finish the intervention in spite of their worsening condition as well as acceptability among completers. As a result, the results might mostly reflect patients who continued to be clinically stable enough to take part.

Third, care must be taken when interpreting the given effect sizes. Cohen's d was calculated using pooled standard deviations since individual-level change scores were not provided (Andreis et al. 2026). Therefore, it is not appropriate to interpret the extraordinarily large effect for dignity-related distress ($d = 3.77$) as a typical within-subject effect. Mixed-effects or repeated-measures analyses and participant-level longitudinal data might be useful for future research.

It is also instructive to note that quality of life (QoL) has remained stable despite improvements in emotional and dignity-related suffering. Research indicates that hope and psychological or existential outcomes may be more directly impacted by DT than overall QoL (Zhang et al. 2022). Furthermore, cultural and relational factors have an impact on dignity. While qualitative research highlights identity, emotional expression, connections, and meaning-making (Buonaccorso et al. 2021), family-oriented DT has shown benefits for dignity, depression, and spiritual well-being (Xiao et al. 2022). When DT is used earlier in cancer treatment, these factors encourage culturally and relationally sensitive adjustments.

One could contend that an exploratory study's significance should not be diminished by the lack of randomization. We concur. DT's acceptability during chemotherapy is supported by prior research, and feasibility studies should suitably come before definitive trials (Vergo et al. 2014). While showing that results are not consistently improved, randomized data (Chochinov et al. 2011) and systematic review findings (Martínez et al. 2017) further indicate its potential.

All things considered, Andreis et al. (2026) offer important initial evidence for including dignity-oriented treatment at an earlier stage of the cancer trajectory. To ascertain which patients benefit most, when DT should be introduced, and whether its effects are sustained over

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time, larger multicenter controlled studies with longer follow-up, intention-to-treat analyses, standardized feasibility assessments, and culturally appropriate techniques are necessary.

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