LAST HOUR EXPERIENCE
WHAT MATTERS REMAINS

SCIENTIFIC BASIS

Dignity Therapy

Background note on the research that informs the Last Hour Experience.

What dignity therapy is

Dignity therapy is a brief, individualised psychotherapeutic intervention developed by the Canadian psychiatrist Harvey Max Chochinov and colleagues for people who are terminally ill or approaching the end of life. It is grounded in a model of dignity in the terminally ill, and draws on the concepts of generativity, legacy and meaning-making.

In a typical session, a trained interviewer guides the patient through a semi-structured conversation about the things that matter most to them, for example:

- Important moments and accomplishments in their life
- The roles that have been most meaningful to them
- Things they want their loved ones to know or remember
- Hopes, wishes and words they want to leave behind

The conversation is audio-recorded, transcribed and edited into a written "generativity document". With the patient's consent, this document is given to them to share with family or friends, leaving a tangible legacy.

The question protocol

Dignity therapy follows a published, semi-structured question framework (Chochinov et al., 2005; Chochinov, 2012). The interviewer works through prompts such as:

- Tell me about your life, particularly the parts you remember most or think are most important.
- When did you feel most alive?
- Are there things you want your family to know or remember about you?
- What were the most important roles you played in life (family, work, community), and why did they matter to you?

- What are your most important accomplishments, and what are you most proud of?
- Are there things you still want to say to your loved ones, or say once more?
- What are your hopes and dreams for them?
- What have you learned about life that you would want to pass on?
- What advice or words of wisdom would you give to those important to you?
- Are there words or instructions you would like to leave your family to prepare them for the future?
- Are there other things you would like included in this lasting document?

What the evidence shows

Dignity therapy has been studied in feasibility studies, randomised controlled trials, and systematic reviews, including a multicentre randomised controlled trial across Canada, the United States and Australia (Chochinov et al., 2011).

The findings should be read carefully:

- In that randomised trial, dignity therapy did **not** produce a statistically significant reduction in psychological distress, the primary outcomes, compared with its two comparison groups: standard palliative care and client-centred care.
- It did, however, score significantly higher on **patient-reported** secondary outcomes. Patients found it more helpful, and more often reported that it improved their quality of life, their sense of dignity, and their relationship with family (Chochinov et al., 2011).
- An earlier feasibility study reported high satisfaction and self-reported gains in sense of dignity, purpose and meaning, though it had no control group (Chochinov et al., 2005).
- A systematic review concluded that dignity therapy is feasible and well-received, while noting that evidence for effects on hard psychological outcomes remains mixed (Martínez et al., 2017).
- A more recent randomised controlled study (n=68) again found **no** statistically significant effect on its primary outcome (psychological distress, measured as anxiety and depression) when the two dignity-therapy arms were each compared individually to standard care. Only when those two arms were pooled did a secondary analysis show a protective effect on anxiety and depression, alongside improvements in quality of life and reduced suffering on secondary measures (Seiler et al., 2024).
- A 2025 scoping review of 82 studies confirmed dignity therapy is an actively researched field with reported benefits for patients, while explicitly noting that some effectiveness findings remain inconclusive and that it should be delivered as a culturally sensitive intervention (Velasco Yáñez et al., 2025).

In short: dignity therapy is a well-described, acceptable and patient-valued intervention with a real and growing research base, but it is not a proven treatment for depression or anxiety, and the strongest evidence is for how meaningful patients find it rather than for measurable symptom reduction.

Why this matters for the Last Hour Experience

The Last Hour Experience is **not** dignity therapy and is not a clinical or therapeutic intervention. The two differ on every practical dimension:

- **Audience.** Dignity therapy is for people who are terminally ill or in their final phase of life. The Last Hour Experience is for healthy adults who want to reflect now, long before the end.
- **Setting.** Dignity therapy is delivered by a trained clinician (nurse, psychologist or chaplain) within palliative care. The Last Hour Experience is a self-guided audio experience with no therapist in the loop.
- **Format and output.** Dignity therapy is a recorded interview that becomes an edited legacy document handed to the patient and family. The Last Hour Experience is a guided personal reflection, not a clinical transcript or care record.

The connection is purely conceptual: both work with the idea that consciously engaging with the end of life, reflecting on what mattered, and giving it shape and words can produce a felt sense of meaning, perspective and a "well-rounded" close. Dignity therapy is one of the bodies of clinical work that makes this idea credible. A separate strand of research on the psychology of endings points in the same direction (Schwörer, Krott & Oettingen, 2020): people who experience an ending as well-rounded report more positive emotion, less regret, and an easier transition into the next phase of life.

The Last Hour Experience translates this insight into a guided, non-clinical audio experience for a general audience.

References

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