

A new measure of home care patients' dignity at the end of life: The Palliative Patients' Dignity Scale (PPDS)

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ABSTRACT

Objective: This study aimed to develop a new and brief instrument to be employed in dignity measurement, one based on the perceptions of patients, relatives, and professionals about dignity.

Method: Surveys of patients receiving palliative care, family caregivers, and palliative care professionals were first carried out (sample 1). In the second step, palliative care patients were surveyed with a pilot questionnaire (sample 2). Finally, a survey design was used to assess patients admitted into a home care unit (sample 3). Sample 1 included 78 subjects, including patients, family caregivers, and professionals. Some 20 additional palliative patients participated in sample 2. Finally, 70 more patients admitted to a home care unit participated were surveyed (sample 3). Together with the Palliative Patients' Dignity Scale (PPDS), our survey included other measures of dignity, anxiety, depression, resilient coping, quality of life, spirituality, and social support.

Results: After analyzing data from steps 1 and 2, an eight-item questionnaire was presented for validation. The new scale showed appropriate factorial validity ($\chi^2(19) = 21.43, p = 0.31$, CFI = 0.99, GFI = 0.92, SRMR = 0.07, and RMSEA = 0.04), reliability (internal consistency estimations of 0.75 and higher), criterial validity (significant correlations with the hypothesized related variables), and a cutoff criteria of 50 on the overall scale.

Significance of Results: The new PPDS has appropriate psychometric properties that, together with its brevity, encourages its applicability for dignity assessment at the end of life.

KEYWORDS: Dignity, Palliative care, Cuestionario de Dignidad en Cuidados Paliativos (CED-PAL), Confirmatory factor analysis

INTRODUCTION

Dignity at death has been studied in several areas, and although the concepts of dignity and dignity in dying may vary depending on an individual's context and beliefs, it is important to make clear what we mean when we refer to death with dignity in palliative care.

Traditionally, dignity in palliative care has been defined using two distinct but not opposite approaches. On the one hand, death with dignity refers to the right to die how when, and where an individual decides (Chochinov, 2002). This definition is still the subject for debate and is related to such legal aspects as euthanasia. On the other hand, dignity in dying has been defined as death without suffering (Chochinov, 2002). The study of the concept carried out by Whittemore and Knafel (2005), for example, found 28 works on death with dignity. These authors sorted the studies on dignity into several groups, which followed the following topics: human rights, autonomy

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and dependence, symptom control, respect, human and personal feelings, significant social relationships, dignified treatment and care, existential and spiritual satisfaction, privacy and intimacy, and security and calm. More recently, Guo and Jacelon (2014) reviewed the concept of dignity at the end of life and found similar topics to those of Whittemore and Knafelz (2005). In total, nine different but complementary matters were related to the meaning of dignity in dying: human rights, autonomy and independence, relieved symptom distress, respect, being human and being oneself, meaningful relationships, dignified treatment and care, existential/spiritual satisfaction, and privacy.

Within the literature, several models have underpinned dignity in the context of end-of-life care. Among them, four models stand out in scholarly circles: the conceptual model of dignity (Pleschberger, 2007), the preservation model of dignity (Periyakoil et al., 2010), the decision-taking model of dignity (Vladeck & Westphal, 2012), and the Chochinov model of dignity (Chochinov et al., 2002a). Among these, Chochinov's model (Chochinov et al., 2002a; 2006; Hall et al., 2009) is the most used to evaluate and measure dignity, as well as in interventions (Chochinov et al., 2002b; Chochinov et al., 2008; Doorenbos et al., 2006). Chochinov (2002) and Chochinov et al. (2002a) developed a dignity model for the terminally ill that incorporates a broad range of physical, psychological, social, and existential concerns affecting an individual's perception of dignity. The three major categories of resources that affect a patient's sense of dignity are: illness-related issues, a dignity-conserving repertoire, and a social dignity inventory (Chochinov et al., 2006; Chochinov, 2006). Another recurrent model in the scientific literature is the theoretical model of preservation of dignity developed by Periyakoil and colleagues (2010). These authors distinguished between intrinsic and extrinsic dignity. Whereas intrinsic dignity belongs to the individual, extrinsic dignity depends on others.

These models have led to several dignity measurement instruments, including the Patient Dignity Inventory (PDI; Chochinov et al., 2002b), based on Chochinov and colleagues' model of dignity; the Dignity Card-Sort Tool (DCT) and the Preservation of Dignity Card-Sort Tool (p-DCT), developed within the framework of the theoretical model of preservation of dignity (Periyakoil et al., 2009; 2010); and the Instrument to Measure Factors Related to Self-Perceived Dignity, measuring factors that affect patients' dignity in end-of-life care (Vlug et al., 2011).

These instruments can assist in drawing a map of the relations among dignity in end-of-life care and the related variables. In almost every study carried

out in palliative care, emotional distress is present, being reported by up to 49% of patients (Van't Spijker et al., 1997). Emotional distress, many times defined as high levels of anxiety and depression, has been related to a lack of dignity as measured by the Patient Dignity Inventory (Chochinov et al., 2008). Resilience is a construct that has gained attention during the last few years in the palliative context (Vanistendael, 2007), becoming a protective factor when it comes to emotional well-being (Barreto et al., 2013). Finally, spirituality, social support, and quality of life have also been positively related to patient dignity and well-being. Patient spirituality, for example, has been found to be a negative predictor of anguish symptoms (Chochinov et al., 2009). Social support, in turn, has shown up to benefit palliative care patients (Edmondson et al., 2008; Peterman et al., 2002). Finally, quality of life has been defined as the last bastion of dignity, and has been incorporated into the NCCN guidelines for oncology and palliative care (NCCN, 2013).

The aim of our research was to develop a new and brief instrument for measurement of dignity that has sound psychometric properties and is based on the perceptions of patients, relatives, and professional with respect to dignity.

METHODS

Step 1. Development of the Palliative Patients' Dignity Scale (PPDS)

Taking as a framework Chochinov and colleagues' model (Chochinov, 2002; Chochinov et al., 2002a), and with the aim of detecting preservation of and threats to dignity at the end of life, we developed the Palliative Patients' Dignity Scale (PPDS). In order to achieve this, we conducted several surveys with key informants on home care: patients receiving palliative care, family caregivers, and palliative care professionals.

From a total of 37 professionals consulted, 32 agreed to participate. Some 19 of 27 patients and families also did. The total number of participants was 78, including patients, family caregivers, and professionals, from three different units: a home care unit, a continued care unit, and a long-stay hospital. Participant characteristics are presented in Table 1.

The items were created taking into account participants' answers to the following questions:

1. What does dignity represent for you?
2. Mention three words related to dignity at the end of life.

Table 1. Participants in step 1

Participants	<i>n</i>	%
Professionals		
Physicians	11	14.10
Nurses	16	20.51
Psychologists	3	3.85
Nursing assistants	1	1.28
Social workers	1	1.28
Patients		
Oncological	24	30.77
Non-oncological	3	3.85
Relatives	19	24.36
Total	78	100.00

3. Give an example of a dignified attitude at the end of life.
4. Which are the conveniences or benefits of dignity? Why?
5. Which are the inconveniences or weak points of dignity? Why?

Once categorization of patients, family, and professionals' answers was accomplished, the frequencies for each category were calculated (see Table 2).

As can be seen in Table 2, dignity was defined in the context of four basic categories:

- As an *attitude*, that is to say, as a stance or intention with several orientations. In some cases, it was seen as an attitude oriented toward the individual; in others, toward the society; and in others, toward the values of life.
- As a *quality*—a virtue intrinsic to the person.
- As a *right*, as a human being and being related to others. Dignity was defined as a right to freedom and security. Negative expressions related to insecurity and difficulties in decision making were also mentioned.
- As *well-being* or *hedonism*—as a claim to pleasure or happiness as ultimate goals.

The categories that encompass the opinions of the participants were integrated in order to fulfill the individual's sense of identification. Our model was thus based on the verbalizations of patients, families, and professionals, expressed in both positive and negative ways: dignity was expressed as preserved or lost, respected or threatened. Within this approach, any personal expression related to the values, beliefs, attitudes, experiences, and circumstances of the individual can be expressed.

Table 2. Categorization of answers to open questions on dignity concept

Questions and answers	<i>n</i>
What is dignity for me?	
Respect of opinions	19
Respect of decisions	20
Respect of feelings	12
Respect toward others	22
Respect toward oneself	18
Three words related to dignity at the end of life	
Respect	25
Autonomy	7
Right	11
Support	11
Freedom	9
Quietness	7
Examples of undignified attitude at the end of life	
Pain	20
Others symptoms	14
Do not respect patients' rights	12
To be alone	10
Dependency	7
Others	10
Advantages of dignity	
Respect last wishes	15
Feeling good with oneself	19
Feeling respected	12
Others	11
Disadvantages of dignity	
The concept does not match	13
It changes with illness	3
Do not have disadvantages	21
Does not provide for alternative	1
Prejudices	3

Step 2. Pilot Project

Based on our results, and following Chochinov and colleagues' model (Chochinov, 2002; Chochinov et al., 2002a), we developed a measurement instrument assessing dignity preservation and threat at the end of life. We took into account the following premises:

- It had to be brief, and it had to examine patients' comfort and try to avoid burden with test administration.
- Its goals had to be easy to follow.
- Its items and response options were to be easy to understand, so that people with different cultural backgrounds could have access to them.
- It had to serve health professionals with different disciplinary affiliations.

As regards its length, a maximum of 10 items were proposed: 3 for the attitude approach; 3 for quality; 2 for rights; and 2 for well-being. The distribution

was made taking into account the proportion of expressions gathered. Both positive and negative expressions were included, covering the two main approaches to dignity that arose in step 1: its preservation and its threat. The items were drafted following the structure of the statements that patients, families, and professionals had expressed in the exploratory study.

Some 20 palliative care patients were surveyed with this pilot questionnaire. The mean age was 65.25 years old; 55% were women and 85% oncological patients. As patients expressed comprehension difficulties with 2 of the 10 items, they were removed.

Step 3. Testing of the Psychometric Properties

Design, Procedure and Sample

This step was conducted with palliative care patients admitted to a home care unit. After obtaining permission from the Research and Ethical Committee of the Hospital General Universitario de Valencia Foundation and the Ethics Committee on Human Research of the University of Valencia, a survey design was adopted. The survey had two parts. In the first, information on diagnosis and prognosis was included, so as to check the inclusion and exclusion criteria (see Table 3). The second, which was formed using the new questionnaire together with other scales related to dignity and quality of life at the end of life.

From a total of 80 patients, 70 met the inclusion criteria and made up the final sample. The mean age was 70.21 ($SD = 12.55$); 60% of the sample were men; 78.6% were married, 12.9% widowed, and 8.6% single; 78.60% were oncological patients.

Table 3. *Inclusion and exclusion criteria*

Inclusion criteria

1. Patients admitted in the home care unit of the Hospital General Universitario de Valencia, for palliative treatment.
2. Adult patients (18 years old or older).
3. Presence of advanced-terminal illness, following WHO criteria.
4. Patients who know their diagnosis and prognosis.
5. Acceptance of participation by the patients' relatives.

Exclusion criteria

1. Less than two weeks of expected survival.
 2. Conspiracy of silence (patients do not know their diagnosis nor their prognosis).
 3. Cognitive impairment (comprehension/expression problems measured by a brief neuropsychological evaluation).
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Instruments

Together with sociodemographic data, information on the following scales was gathered:

1. Palliative Patients' Dignity Scale (PPDS; Cuestionario de Dignidad en Cuidados Paliativos, CED-PAL). As explained, the final version of the instrument was composed of eight items, measuring two factors: the perception of dignity preservation, understood as feeling respected by others, respecting oneself, quality in a sense of intrinsic virtue to the "personhood" right to security and peace; and dignity threat or loss, seen as feelings of insecurity and values violation, lack of support, or depletion of feeling "as a person." Answers scored on a Likert-type scale ranged from 0 (nothing) to 9 (a lot). The psychometric properties of the instrument are reported within the manuscript. The scale can be consulted in Appendix 1.
2. The Patient Dignity Inventory (PDI; Chochinov et al., 2008). This instrument was designed to identify several sources of distress in patients at the end of life. We used the Spanish version (Martínez-García et al., 2013). The scale is composed of 25 items, assessing 5 dimensions: symptom distress, existential distress, dependency, peace of mind, and social support. The individual indicates his/her degree of concern on a 5-point Likert-type scale, from 1 (not a problem) to 5 (an overwhelming problem). The values of Cronbach's alpha were 0.89, 0.84, 0.71, 0.63, and 0.70, respectively.
3. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). This scale was designed to measure anxiety and depression in patients with comorbid physical illness. It is composed of 14 items, 7 for each dimension. Responses range from 0 (never) to 3 (almost all day). We utilized the Spanish version (Quintana et al., 2003). The values of alpha were 0.73 for the anxiety subscale and 0.45 for the depression subscale. Because of the lower reliability obtained for the depression factor, this subscale was not included in the analyses.
4. The Brief Resilient Coping Scale (BRCS; Sinclair & Wallston, 2004). This scale measures resilience with four items. It has been validated in Spain (Tomás et al., 2012) and previously used in palliative care studies (Benito et al., 2014). Items were rated on a 5-point Likert-type scale, from 1 (totally agree) to 5 (totally disagree), with higher scores reflecting greater resilience. Its internal consistency was 0.92.

5. Two items of the EORTC Quality of Life C-30 (EORTC-QLQ-C30; Bjordal et al., 2000). Only two items of the Global Health Subscale were used: "How would you rate your overall health during the past week?" and "How would you rate your overall quality of life during the past week?" As palliative care patients undergo inevitable physical deterioration, the other dimensions related to increased or decreased symptoms have been proved to be always negative and are thus not a good indicator of a patient's quality of life (Chochinov et al., 2008). These two items are score on a 7-point Likert-type scale, ranging from 0 (very poor) to 7 (excellent). Its value for Cronbach's alpha was 0.85.
6. The GES Questionnaire (Benito et al., 2014). Originally developed in Spanish, this scale includes six open questions, followed by eight items that assess a general dimension of spirituality, as well as three subscales: intrapersonal, interpersonal, and transpersonal spirituality. The scores for these eight items ranged from 0 (nothing) to 4 (a lot). The value of Cronbach's alpha for this was 0.85.
7. The Duke-UNC-11 Functional Social Support Questionnaire (Broadhead et al., 1988). This instrument assesses two dimensions of social support: confidential support (received from people to whom the patient can communicate intimate feelings) and affective support (received from those who express positive empathy to patients). Each item scored was on a 5-point Likert-type scale, from 1 (much less than I would like) to 5 (as much as I would like). Its internal consistency was 0.93 for the confidential support dimension and 0.80 for the affective dimension.

Statistical Analyses

Descriptive statistics were calculated. Moreover, several reliability estimations were offered: Cronbach's alpha, the rho coefficient, and the greatest lower bound (*GLB*). Although alpha is the internal consistency coefficient used most often (considered moderate with values between 0.70 and 0.79, and high with values of 0.80 or above; Cicchetti, 1994; Clark & Watson, 1995), other indices like rho and *GLB* are recommended for scales with a limited number of indicators. Test-retest reliability was also calculated, within a temporal break of 3 to 4 weeks. The behavior of the items was also studied.

In order to assess the factorial structure of the scale, a structural model was estimated and tested. Specifically, a confirmatory factor analysis, based on

the two dimensions previously obtained in the pilot project, was estimated. The estimation method used was maximum likelihood (ML), the standard method employed with data meeting the multivariate normality criteria (Mardia < 1.75). In order to assess the model's fit, several criteria were used (Hu & Bentler, 1995; Tanaka, 1993): (1) a chi-square statistic, with a nonstatistically significant value indicating a good fit (Kline, 2011); (2) the Comparative Fit Index (CFI), indicating an adequate fit with values above 0.90 (and ideally greater than 0.95) (Hu & Bentler, 1995); (3) the Goodness-of-Fit Index (GFI), also with values above 0.90 for a good fit (Tanaka, 1993); (4) the standardized root-mean-square residual (*SRMR*), with values lower than 0.08 considered indicators of goodness of fit (Hu & Bentler, 1995); and (5) the root-mean-square error of approximation (*RMSEA*), with values of 0.05 or less indicating good fit (Bentler, 1990). To this global fit, the significance of each of the relations proposed in the model was tested, offering information on what is known as analytical fit.

Convergent validity was studied through correlations among the dimensions of the Palliative Patients' Dignity Scale and the Patient Dignity Inventory, and external or nomological validity as well, through correlations among the scale and other constructs theoretically related to dignity at the end of life. Finally, to propose a cutoff point in PPDS scores for screening purposes, contingency tables were calculated. Dichotomous clinical anxiety and quality-of-life variables were employed as scores to explore the capabilities of the PPDS. Taking into account that HADS questionnaire scores in anxiety over 7 are considered indicative of psychopathology (Zigmond & Snaith, 1983), this was the cutoff criteria chosen for anxiety. In terms of quality of life, a score of 4 is in the medium range of the scale, and so it was used as a cutoff criterion. A score of 3 or lower in quality of life, then, was indicative of a negative perception of quality of life. This score was used to suggest which patients might have dignity issues with which to work.

RESULTS

The estimations related to the internal consistency of the scale were appropriate for both dimensions: preservation of dignity obtained a Cronbach's alpha of 0.89, a value of rho of 0.89, and a *GLB* score of 0.94; and threats to dignity an α of 0.75, a rho of 0.75, and a *GLB* of 0.75. The test-retest reliability values were 0.52 and 0.32 for the dignity preservation and the dignity threat dimensions, respectively. It is worth noting that this scale also aims to monitor intervention effects on dignity. These test-retest

Table 4. Means, standard deviations, inter-total correlations, and values of alpha if item deleted for the CED-PAL items

Factor	Item	M	DT	Item–Total Correlations	Alpha if Item Deleted
Dignity preservation	I1	7.06	1.79	0.71	0.87
	I2	6.91	1.67	0.78	0.85
	I4	6.04	1.91	0.63	0.89
	I5	7.60	1.61	0.71	0.87
	I8	7.44	1.55	0.84	0.84
Dignity threats	I3	6.49	2.60	0.58	0.65
	I6	5.61	2.40	0.59	0.65
	I7	6.36	2.70	0.55	0.69

results should be interpreted in the context of an intervention, as a sensitive trait of the measure. Table 4 presents the means and standard deviations for the items, item–total correlations, and values of alpha when an item is removed for the two dimensions of the scale. The results were adequate, with no items showing any anomalous behavior.

Confirmatory factor analysis results also showed an appropriate fit for the model: $\chi^2(19) = 21.43, p = 0.31, CFI = 0.99, GFI = 0.92, SRMR = 0.07,$ and $RMSEA = 0.04$ —all of the criteria with values in accord with the literature. The analytical fit was also good, with all factorial loadings being statistically significant (see Figure 1).

The correlations between the two dimensions of the new questionnaire and the dimensions of the PDI and the rest of the scales included in our study were in the expected direction, as is shown in Table 5.

Additionally, chi-square tests revealed a cutoff criteria of 50 on the overall scale (calculated with the sum of the scores for the preservation dignity items

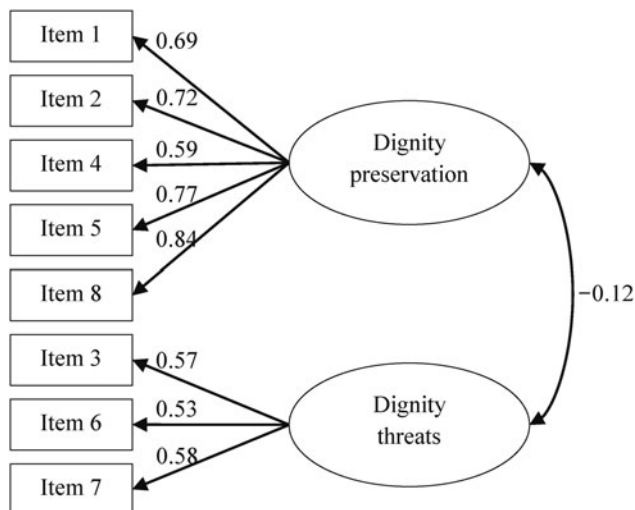


Fig. 1. Analytical fit of the confirmatory factor analysis. Note that all the factor loadings were statistically significant, but not the correlation between latent factors.

and the scores for dignity threats, after being reversed). This score represented the 65th percentile. Our results showed a significant association between groups with low versus high dignity and low versus high anxiety ($\chi^2(1) = 20.49, p < 0.001, \phi = 0.541$) (Table 6). In the case of quality of life, the association was also significant ($\chi^2(1) = 24.65, p < 0.001, \phi = 0.593$) (Table 7). It appears that patients scoring under 50 on the PPDS were those more likely to suffer anxiety or poor perception of quality of life.

DISCUSSION

In the context of palliative home care, our new measure, the Palliative Patients’ Dignity Scale (PPDS) (Cuestionario de Dignidad en Cuidados Paliativos, or CED-PAL in Spanish), has been developed, taking as a starting point analyses of dignity conceptions expressed by palliative care patients, these patients’ relatives, and professionals (physicians, nurses, and psychologists). From these expressions, ideas of preservation and threat to or loss of dignity emerged in many aspects. These ideas supported previous

Table 5. Correlations among dignity dimensions and other related variables

	Dignity preservation	Dignity threat
Symptom distress	–0.349**	0.335**
Existential distress	–0.233*	0.442**
Dependency	–0.428**	0.390**
Peace of mind	–0.146	0.413**
Social support	–0.607**	0.290*
Anxiety	–0.427**	0.649**
Resilience	0.370**	–0.114
Quality of life	0.564**	–0.453**
Spirituality	0.633**	–0.355**
Confidential support	0.664**	–0.342**
Affective support	0.693**	–0.160

Note. * $p < 0.05,$ ** $p < 0.01.$

Table 6. Contingency table: Total dignity on the CED-PAL vs. anxiety

	Clinical anxiety		Total
	>7 HADS	<7 HADS	
Global dignity			
<49	3	40	43
≥50	15	12	27
Total	18	52	70

research, mainly based on palliative care professionals (Periyakoil et al., 2010; Turner et al., 1996). Although palliative patients' self-perceptions of dignity at the end of life have been examined in the literature (Lynn, 1997; Singer et al., 1999; Stewart et al., 1999), it was Chochinov's (2012) dignity therapy that built an integrative model of patients' needs in the context of palliative care.

Our model was developed in the context of the PDI measure (25 items). Taking this measure as a starting point, we tried to go further, attending to such issues as brevity, use of confirmatory procedures, and adaptation to a different psychosocial context. A new measure of perception of dignity preservation and threat in palliative care patients has thus been developed and validated in the home care context. The PPDS (CED-PAL) is formed from eight 8 items that are scored on a Likert-type scale, measuring two dimensions: preservation and dignity. Within this manuscript, evidence on its appropriate internal consistency, test-retest reliability, and factorial structure has been offered. The self-evident two-dimensional structure was thus supported.

As regards the comparability of our results, the sample matches for age, marital status, and study level of populations the other studies based on psychological and dignity intervention in palliative care patients (Chochinov et al., 2008; Chochinov, 2012). This fact, together with the good reliability of the measure, does not make the sample size a limitation, because, as Iacobucci (2010) has pointed out, if the variables are reliable, the effects are strong,

Table 7. Contingency table: Total dignity on the CED-PAL vs. quality of life

	Quality of life		Total
	<3 QoL	>4 QoL	
Global dignity			
<49	34	9	43
≥50	5	22	27
Total	39	31	70

and the model is not overly complex, so that smaller samples will suffice (Bearden et al., 1982; Bollen, 1989).

Evidence regarding convergent and criterion validity was also appropriate. Whereas the dimension of dignity preservation was positively related to the five factors of the PDI (and statistically significant for all, except the peace-of-mind dimension), the threats-to-dignity dimension was positively and statistically related to symptom and existential distress, dependency, and absence of peace of mind and social support. Along the same lines, high levels of dignity preservation with the PPDS were related to high resilience, good quality of life, spirituality, and confidential and affective support, and to lower levels of anxiety, in accord with the previous literature (Barreto et al 2013; Chochinov et al., 2009; Edmondson et al., 2008; NCCN, 2013; Peterman et al., 2002). Finally, the suggested cutoff point, which could be used to detect patients with dignity needs, is one of the advantages of this new dignity measure.

In conclusion, our results point to the appropriate properties of the PPDS when used to assess dignity in home care patients. Potential uses of this new measure will include monitoring psychotherapeutic dignity interventions. Previous research supports the effectiveness of intervention-based therapy in counseling for dignity, and suggests that our new measure may be useful in diagnosis and intervention (Arranz & Bayés, 2000; Arranz & Cancio, 2000; Barreto et al., 2010; Chochinov, 2006; Chochinov et al., 2002a; 2005; 2006). In our context, there is already evidence of the sensitivity of the PPDS in quantifying reduction of anxiety and distress, a better quality of life, and a better perception of social support (Rudilla et al., 2015).

However, our study does have some limitations. Searching for practical or clinical context application, we developed a brief measure that perhaps would not fulfill some research requirements that could be addressed in longer-term research and with more well-established measures, especially when working with the complex and diverse construct of dignity at the end of life.

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APPENDIX 1. PPDS (CED–PAL) items in English and Spanish

Item	Dimension	Item Content	Scores									
			Nothing			A lot						
1	P	To what extent I am respected in my opinions and decisions. <i>En qué medida soy respetado en mis opiniones y decisiones.</i>	0	1	2	3	4	5	6	7	8	9
2	P	To what extent people value what I think. <i>En qué medida se valora lo que pienso.</i>	0	1	2	3	4	5	6	7	8	9
3	T	To what extent I am not able to do things for myself. <i>En qué medida no puedo hacer cosas por mí mismo.</i>	0	1	2	3	4	5	6	7	8	9
4	P	To what extent I am at peace with myself and with others. <i>En qué medida tengo paz conmigo mismo y con los demás.</i>	0	1	2	3	4	5	6	7	8	9
5	T	To what extent I receive good care. <i>En qué medida me proporcionan unos buenos cuidados.</i>	0	1	2	3	4	5	6	7	8	9
6	T	To what extent I feel distressed. <i>En qué medida estoy angustiado.</i>	0	1	2	3	4	5	6	7	8	9
7	P	To what extent I feel as a burden for the others. <i>En qué medida soy una carga para los demás.</i>	0	1	2	3	4	5	6	7	8	9
8	T	To what extent I am treated with respect and understanding. <i>En qué medida soy tratado con respeto y comprensión.</i>	0	1	2	3	4	5	6	7	8	9

Notes. P = dignity preservation; T = dignity threat. For a total score on dignity, items 3, 6, and 7 have to be reversed before the sum.