Cinematherapy and quality of life of a patient on dialysis: case study

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ABSTRACT
This article reports the case study of a patient with chronic kidney disease on dialysis, who participated in cinema therapy sessions in a specialized clinic. The objective was to evaluate the possible effects of cinema sessions on the patient, as a complementary therapy during dialysis, to improve well-being and quality of life (QOL). Eight sessions were held, once a week, using the Kidney Disease Quality of Life questionnaire – Short Form 1.3, before and after the sessions. Scores were established and comparisons were made with data from the literature to assess the patient's well-being and QOL. Increases in scores were observed in most dimensions of the questionnaire after the sessions, suggesting that cinema therapy was significant in the patient's perception of QOL. In conclusion, more studies in the area are important to strengthen the perspective of using cinematherapy, as a complementary therapeutic strategy, in dialysis clinics.

Keywords: cinematherapy, chronic kidney disease, quality of life.

RESUMO
Este artigo relata o estudo de caso de um paciente com doença renal crônica em diálise, que participou de sessões de cinoterapia em uma clínica especializada. O objetivo foi avaliar os possíveis efeitos das sessões de cinema no paciente, como uma terapia complementar durante a diálise, para melhorar o bem-estar e a qualidade de vida (QV). Foram realizadas oito sessões, uma vez por semana, utilizando o questionário Kidney Disease Quality of Life - Short Form 1.3, antes e depois das sessões. As pontuações foram estabelecidas e foram feitas comparações com dados da literatura para avaliar o bem-estar e a QV do paciente. Foram observados aumentos nos escores na maioria das dimensões do questionário após as sessões, sugerindo que a cinoterapia foi significativa na percepção de QV do paciente. Em conclusão, mais estudos na área são importantes para fortalecer a perspectiva do uso da cinematerapia, como estratégia terapêutica complementar, em clínicas de diálise.

Palavras-chave: cinematerapia, doença renal crônica, qualidade de vida.

1 INTRODUCTION
Chronic kidney disease (CKD), in its most advanced phase, when the kidneys are unable to maintain the normality of the internal environment, makes the patient dependent on treatments
that replace kidney function, such as dialysis. The objective is to reduce symptoms and increase survival, but it does not cure the patient. And, as it is a long-term process, with progressive losses and complications, it makes it difficult for the patient to adapt and adhere, reducing their quality of life (QOL) throughout the treatment.

QOL is considered as a degree of satisfaction of human life needs. Among them, work, education, health, leisure, material elements, access to housing, food and drinking water. The term QOL also refers to subjective notions of comfort, well-being and individual and collective fulfillment. Furthermore, it adds up to the individual's perception of their position in life in the context of culture, as well as in a system of values in which they are inserted, in contrast to their objectives, expectations, standards and concerns. It is also possible to differentiate the psychological approach, which emphasizes the individual's reactions to their experiences, from medical theories, which focus on the healing and survival of individuals.

Thinking about the broader concept of QOL, as well as the importance of measures that provide greater QOL for dialysis patients, there is cinema, normally with films produced with the main objective of entertaining people, but which have also been presented with other purposes, as it is a method of motivation. The influence of cinema on people's thoughts, attitudes and lifestyle supports the use of films in the therapeutic context. In this sense, cinematherapy aims to project films during an invasive treatment, such as dialysis, to minimize its impact on the patient's well-being.

This work aimed to provide beneficial changes during dialysis, through the use of films, providing participants with three conditions: entertainment, which creates a comfortable atmosphere in relation to the treatment environment; education, which expands information on a given topic; and decentralization of power, which motivates patients in relation to their therapy. As part of the work carried out, the case study analyzed well-being data and the likely benefits of QoL in a dialysis patient who participated in cinema therapy.

2 METHOD

The project approved under number CAAE 39845520.3.0000.0102 was presented to patients at a specialized dialysis clinic and those who agreed to participate signed the free and informed consent form. Participating patients watched eight movie sessions, once a week, during the second and third hour of dialysis. Patients responded to the validated Kidney Disease Quality
of Life – Short Form 1.3 (KDQOL-SF™1.3) well-being questionnaire before and after the eight cinema sessions. According to the assessment protocol of the self-report instrument, the closer to 100, the better score, that is, better QOL. In addition to the validated questionnaire, three questions were added at the end of the cycle to assess the patient's interest and enjoyment of the cinema sessions.

The cinematherapy procedure consisted of showing films in the room where the patients were undergoing dialysis. The selection of films was guided according to the authors' perception regarding motivation and improvement in patients' well-being, in order: “Inside Out” (animation – understanding emotions), “50 First Dates” (comedy – giving new meaning to illness every day), “Suddenly 30” (comedy – addressing choices), “Luca” (animation – freedom and friendship), “The Pursuit of Happyness” (drama – facing problems), “The Lion King” (animation – dealing with pain and adapting to loss), “Extraordinary” (children’s drama – adaptations) and “LION - The Journey Home” (drama and biography – concept of home and belonging).

In line with the case study definition of Del-Masso et al. (2014), the participating patient J.P. met the criteria established by the authors and was considered representative of the group. In other words, the patient showed 100% engagement, participated in all sessions, had no complications and responded to both applications of the questionnaire, before and after the cycle. Finally, the scores obtained in the two applications of the questionnaire were compared with each other, and compared with a sample validated by Duarte et al. (2004), to evaluate the patient's QoL and well-being.

3 CASE DATA

Patient codenamed J.P., male, white, 66 years old and on dialysis for three years. At the beginning of treatment, the patient reported being married, working and receiving care at the clinic through the SUS. During the period of cinematherapy sessions, there were no absences. The patient lived in a neighborhood described as having a literate population of around 97%, an average household income of R$ 2,837.00, with social vulnerability in around 10% of homes, and adequate housing around 20% (Institute of Research and Urban Planning of Curitiba, 2021).

When starting hemodialysis treatment at the unit, the patient was diagnosed with diabetes mellitus (DM), having been insulin dependent for three years and with systemic arterial hypertension (SAH) for 12 years. At the beginning of treatment, he complained of weakness,
dyspnea with little exertion and prostration, but declared he had a good appetite and no nausea, vomiting or headache. However, throughout the treatment, the patient was monitored and treated for decreased appetite, urinary and access tract infections, intestinal constipation and Covid-19, which showed improvements. Additionally, J.P. was placed on the transplant list.

Regarding anthropometric data and laboratory tests performed routinely, data were collected before, during and after the film cycle. The average values of the data collected were: body mass index (BMI) (30.9 ± 0.4), hemoglobin (12.4 g/dl ± 0.5 g/dl), systolic blood pressure (SBP) pre-hemodialysis (129 mmHg ± 5.5 mmHg), post-hemodialysis SBP (131 mmHg ± 21.8 mmHg), pre-hemodialysis diastolic blood pressure (DBP) (59 mmHg ± 8.8 mmHg) and post-hemodialysis DBP (70 mmHg ± 7.1 mmHg), the calcium x phosphorus product (43.2 ± 2.32). Creatinine and creatinine clearance values were obtained before the start of the sessions, being 4 mg/dl and 24.9 ml/min, respectively. The data showed that there were no significant clinical changes during the cinematherapy sessions.

4 QUALITY OF LIFE ASPECTS OF THE CASE

By applying the questionnaire before and after the eight cinematherapy sessions, scores were obtained relating to the specific and generic dimensions of the questionnaire (KDQOL-SF™1.3). To compare scores between the first and second questionnaire, significant improvements were considered to be dimensions with an increase equal to or greater than 30 points in their scores; intermediate improvements with an increase of up to 30 points; and situations in which there was a reduction in the score were considered as worsening of the condition. Considering data from the literature, the scores were compared with the Brazilian average according to Duarte et al. (2004).

The results showed significant improvements in the dimensions “List of symptoms and problems”, “Effects of kidney disease”, “Kidney disease burden”, “Work situation”, “Cognitive function”, “Sleep”, “Social support”, “Physical functioning”, “Pain”, “Emotional function” and “Energy and fatigue”, as shown in Table 1.

The dimensions “Quality of social interaction”, “Global health”, “Patient satisfaction”, “General health”, “Emotional well-being”, “Social function”, in addition to the scores for the indicators “SF12 as a Physical Component” and “Mental component”, showed an intermediate improvement. And, in the score referring to “Encouragement of the dialysis team” and “Physical
function”, there was a worsening between the first and second questionnaire. In relation to sexual function, the patient chose not to respond and in relation to global health, as well as the physical and emotional SF-12 components, data were not found in the Brazilian average for comparison purposes.

In the second questionnaire, in relation to the three questions added by the authors to evaluate the project from the patient’s perspective, the following results were obtained: In the first question “Did you watch the films?”, containing the options “yes” and “no”, J.P. replied yes. In the second “Were the films presented of interest to you?”, with the same options, the patient also answered “yes”. In the third question, “On a scale of 0 to 10, did your participation in cinema therapy bring you a feeling of well-being?”, J.P. rated it at 9.

Table 1: Comparison between the two applications of the KDQOL-SF1.3 questionnaire and the average obtained in Brazilian validation 1

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Score - Questionnaire 1</th>
<th>Score - Questionnaire 2</th>
<th>Brazilian Validation Average</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of symptoms and problems</td>
<td>52.08</td>
<td>91.67</td>
<td>81.25</td>
<td></td>
</tr>
<tr>
<td>Effects of kidney disease</td>
<td>31.25</td>
<td>65.63</td>
<td>73.37</td>
<td></td>
</tr>
<tr>
<td>Burden of kidney disease</td>
<td>12.50</td>
<td>43.75</td>
<td>46.68</td>
<td></td>
</tr>
<tr>
<td>Work situation</td>
<td>0.00</td>
<td>50.00</td>
<td>22.34</td>
<td></td>
</tr>
<tr>
<td>Cognitive function</td>
<td>60.00</td>
<td>93.33</td>
<td>78.44</td>
<td></td>
</tr>
<tr>
<td>Quality of social interaction</td>
<td>46.67</td>
<td>66.67</td>
<td>80.92</td>
<td></td>
</tr>
<tr>
<td>Sexual function</td>
<td>-</td>
<td>-</td>
<td>35.64</td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td>22.50</td>
<td>77.50</td>
<td>75.56</td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>50.00</td>
<td>83.33</td>
<td>86.70</td>
<td></td>
</tr>
<tr>
<td>Encouragement of the dialysis team</td>
<td>100.00</td>
<td>87.50</td>
<td>90.82</td>
<td></td>
</tr>
<tr>
<td>Global Health</td>
<td>40.00</td>
<td>50.00</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>66.67</td>
<td>83.33</td>
<td>72.69</td>
<td></td>
</tr>
<tr>
<td>Physical functioning</td>
<td>22.22</td>
<td>55.56</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Physical function</td>
<td>25.00</td>
<td>0.00</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>12.50</td>
<td>90.00</td>
<td>67.45</td>
<td></td>
</tr>
<tr>
<td>General health</td>
<td>10.00</td>
<td>30.00</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Emotional well-being</td>
<td>40.00</td>
<td>52.00</td>
<td>66.18</td>
<td></td>
</tr>
<tr>
<td>Emotional function</td>
<td>0.00</td>
<td>100.00</td>
<td>71.28</td>
<td></td>
</tr>
<tr>
<td>Social role</td>
<td>37.50</td>
<td>62.50</td>
<td>76.65</td>
<td></td>
</tr>
<tr>
<td>Energy and fatigue</td>
<td>30.00</td>
<td>60.00</td>
<td>60.64</td>
<td></td>
</tr>
<tr>
<td>SF12 - Physical component</td>
<td>28.19</td>
<td>37.25</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>SF12 - Mental component</td>
<td>33.88</td>
<td>50.69</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Source: Authors.

1 The data which were not possible to be obtained, both in the collection carried out by the authors and those not found in the Brazilian validation of the KDQOL-SF1.3, were indicated with the hyphen.

2 DUARTE et al. (2004)
THEORETICAL ARTICULATION

DCR is a pathology that causes a reduction in renal function, defined by a glomerular filtration rate (GFR) lower than 60 mL/min/1.73m², for at least 3 months, regardless of the etiology. In its most advanced phase, the kidneys are unable to maintain the normality of the internal environment (GFR less than 15 mL/min), making the patient dependent on treatments that replace kidney function, such as hemodialysis or peritoneal dialysis. Treatments aim to reduce symptoms and increase the patient's lifespan, but are not curative (Gonçalves et al., 2015; Webster et al., 2017; Leimig et al., 2018; Zanini et al., 2012). As it is a progressive and irreversible disease, over time it is associated with the terminal stage, cardiovascular morbidity and premature mortality, standing out as one of the main causes of morbidity and mortality and disabilities worldwide, and among the characteristics of the population affected by cardiovascular diseases, it is identified as an independent risk factor (Hill et al., 2016). Several authors report the presence of comorbidities such as DM and SAH, in addition to the presence of complications resulting from the loss of renal function, such as chronic anemia, calcium metabolism disorders, seizures, headache, nausea, vomiting, malaise, muscle cramps, embolism gas, phlebitis, itching, tiredness, inability to have children and sleep disorders (Hill et al., 2016; Jesus et al., 2018; Kdigo, 2023; Lira et al., 2015; Terra et al., 2010).

Within the context of progressive loss of kidney function and dialysis treatment, in addition to the negative effects on the patient's physical state, CKD also causes harm to the subject's biopsychosocial state (Hill et al., 2016). Parallel complications resulting from treatment such as pain, cramps, among others mentioned above, lead the patient to use several medications, which has an impact on the perception of the therapy. The factors added to the restrictions that the treatment imposes, such as reduced mobility, social isolation, loss of employment and autonomy, affect patient adherence and, consequently, the beneficial potential of dialysis (Terra et al., 2010; Zanini et al., 2012). Therefore, it is notable how the course of CKD and its effects, added to dialysis treatment, represent losses or decreased QOL.

In this sense, the definition of QOL as the degree of satisfaction of human life needs (WHO, 2023) can be complemented by concepts from Pereira et al. (2012), who associate the individual's perception of their position in life in the context of culture, as well as in a system of values in which they are inserted, in contrast to their objectives, expectations, standards and concerns. These authors also differentiate between the psychological and medical approaches.
with the psychological approach emphasizing the individual's subjective reactions to their experiences and pointing out an alternative that considers current life in comparison to a standard: what one has and what one wants to have, what is considered ideal life, the relationship that is perceived between the circumstances in the present and what is expected to be, and finally, a comparison between the current QoL and that experienced in the past. While medical theories maintain a focus on the cure and survival of individuals (Pereira et al., 2012). Furthermore, taking into account the definition of health-related quality of life (HRQOL), such as general physical, mental and social well-being (Hussien et al., 2020), end-stage CKD produces significant damage, since which, added to the changes brought about by dialysis treatment, require adaptations to lifestyle habits, including continuous use of medications, water and nutritional restrictions, physical limitations, restrictions on social and family life, in addition to constant outpatient clinical monitoring. Patients may also be exposed to changes in family structure, financial problems, difficulties with transportation to the dialysis unit, and a decline in bodily functions, which can cause stress. Regarding possible psychosocial consequences, confronting a patient with a chronic illness with the prospect of dependence on invasive therapy can generate conflicts and coping difficulties (Chuasuwon et al., 2020; Jesus et al., 2018; Lira et al., 2017; Pereira et al., 2017). Therefore, research into complementary therapeutic alternatives is fundamental, seeking not only to extend lifespan, but to improve HRQoL and QoL and well-being in the patient's general context.

Based on this, there are the first psychotherapeutic experiences through films, which began in 1920 (Powell, 2008) and which began to be more widely used in recent decades (Vallarelli et al., 2010), helping the patient to transform their attitude and narrate their life stories through film processing (Schulenberg, 2003). It is understood that visual media, among several possible effects, can impact people by presenting another perspective on problems, providing models and helping individuals prioritize their values. Although films are produced with the main objective of entertaining people, recently they have been used for other purposes, such as education or therapeutic techniques, which involve the selection of films for the patient to watch alone or in a group (Cape, 2009; Kalra, 2011; Berg-Cross, 1990; Joseph, 2015). In this sense, the neuroscientific perspective can be valuable for understanding how films work in therapy, showing that the brain is influenced by watching films, and responds to them in different ways (Hasson, et al., 2008). This response to the film is determined by several aspects, such as
emotional, cognitive, intellectual experience and personal characteristics (Zacks, et al., 2010). Hasson and colleagues (2008) measured brain activity during film viewing using functional magnetic resonance imaging and demonstrated that brain activity was similar in viewers. This implies that despite individual experience, a specific selection of films can similarly influence viewers' neural responses, including perceptions, emotions and thoughts. In exploring the therapeutic use of films, it is important to highlight that most of the literature on film therapy is in the context of counseling (Henston and Kottman, 1997; Tyson, et al., 2000), where the focus is more likely to be on specific problems, life changes and adjustments to promote the patient's well-being.

From the data collected in relation to patient J.P., some elements were observed, such as the treatment marked by the pandemic and the diagnosis of Covid-19, considered as less prominent occurrences for the case study. Other elements involved in the general course of patients with CKD ended up being reproduced in J.P., such as previous diagnoses of DM and SAH, or even in the results obtained in the application of the first questionnaire, before the cinematherapy sessions, with emphasis on the dimensions “disease burden renal”, “general health” and “pain” with scores below 20, pointing to the impact that these dimensions covered by KDQOL-SFTM1.3 had on the patient's QoL. After the cinema sessions, it was possible to observe a significant improvement in the scores of the dimensions “list of symptoms and problems”, “sleep” and “energy and fatigue”, indicating a possible benefit of cinema therapy. According to Hussien et al. (2020), many dialysis patients had some degree of cognitive impairment, which may be related to low education, aging and CKD itself, as this population is classified as high risk for cognitive decline, due to the use of polypharmacy and the presence of comorbidities. Regarding the “cognitive function” dimension and considering the Brazilian average (78.44), J.P. presented below average results in the first questionnaire (60.00), and higher in the second (93.33). Such scores may indicate that the patient is considered to have a good functional level when dealing with daily activities, given that the score in the first application is close to the Brazilian average and that after the cinema sessions, there was an improvement. These data may have been corroborated by better scores in “pain” and “emotional function”, as these dimensions are intertwined with regard to the patient’s experiences and perceptions.

Other losses of dialysis over time, reported by some authors, are sexual decline, conflicts linked to existence, spirituality and uncertainty about the future, which have the power to
interfere with physical and emotional symptoms. Psychological problems such as depression, low self-esteem and anxiety have also been described, which may be linked to the fact that the patient is connected to the dialyzer machine for hours, the installation of the dialysis access route and the concern about the care required (Hussien et al., 2020; Pereira et al., 2017; Jesus et al., 2018). The questionnaire takes these situations into account in the scores for the dimensions “burden of kidney disease”, “emotional well-being” and “emotional function”. It is interesting to note that, in the “burden of kidney disease” dimension, in addition to J.P. obtaining results lower than the average in both applications, the Brazilian average itself maintains a score below 50.00. These values highlight how dealing with the implications of CKD represents an important vulnerability.

Regarding the dimensions “emotional well-being” and “emotional function”, both presented better scores after the cinema sessions. It is noteworthy that in “emotional well-being”, there was an intermediate improvement, despite being below the Brazilian average, and in “emotional function”, there was a significant improvement, going from zero to 100. Despite the similarity in the nomenclature of the two dimensions, the issues involved are different. The term “well-being” refers to the emotional state, with questions involving the self-report of feelings such as calm, irritability, sadness, discouragement and happiness in the four weeks prior to the moment of application. The emotional function concerns how this emotional state affects or does not affect daily activities, and the issues covered involve the time and attention spent on work or daily activities, as well as the number of activities performed. Patient J.P. seems to have shown greater emotional well-being since the first questionnaire, and perceived his daily life to be less affected by emotional problems, with a score for this dimension going from zero to the maximum score in the second questionnaire, after the sessions, a fact perhaps explained by the context of welcome, relaxation and entertainment provided by the use of films.

According to Lira et al., patients develop particular coping strategies, such as religious or spiritual strategies, seeking support in the marital relationship, family characteristics, social networks, functional or practical resources and economic circumstances (LIRA et al., 2015). Issues such as the number of people in the residence appeared to help in the physical domain, allowing consideration of the influence of family and social support, such as patient care or assistance in daily activities (JESUS et al., 2018). Further reinforcing the importance of work and socialization for QOL, Pereira et al. (2017) presented a correlation between the number of
complications and QOL, where it was possible to observe as positive influences, both the level of education, higher income or the presence of a partner (JESUS et al., 2018; Duarte et al., 2004). These aspects mentioned are reflected in the dimensions “social function” and “social support”. Despite increasing significantly from the first to the second application, these values did not exceed the Brazilian averages. The patient responded to both applications that he had not received money to work in the month prior to the application, converging with the profile described in the literature, which states that the changes resulting from dialysis affect the way the subject perceives himself, his capabilities and his environment, such as employment relationships, made difficult by the time dedicated to treatment, the routine it imposes and reduced physical performance. It was pointed out that the impact of work limitations becomes smaller as age increases, considering that the impact on this type of activity may be reduced for retired people (Pereira et al., 2017; Jesus et al., 2018). In this sense, the patient stated in the first application that his health had made paid work impossible, while in the second, he responded negatively to this question. This discrepancy could be explained by a change in the perception of how the CKD condition affects the possibility of obtaining a job, such as in cases of retirement.

J.P.'s scores regarding the dimensions “quality of social interaction”, “social support” and “social function” showed increases from the first to the second application. Even below the Brazilian average, the data allowed considerations about coping strategies and the patient's support network, linked to possible changes in relationships and activities carried out or a change in their perception. Although “Physical function” showed a decrease in score, the patient showed significant improvement in the dimensions “List of Symptoms and Problems” (from 52.08 to 91.67), “Sleep” (from 22.50 to 77.50) and “Energy and Fatigue” (from 30 to 60). Such data point to a possible benefit of cinema therapy. Some authors point out that the prolonged duration of hemodialysis sessions can present a positive point when related to physical issues, social relationships and the environment in which one lives (JESUS et al., 2018). Based on this information, it can be suggested that despite the limitations during the time on dialysis, on the other hand, it can be an opportunity to meet other people in the same situation to exchange experiences. Continuing with regard to social relationships in the environment, the dimension “Encouragement of the dialysis team” showed a decrease, which may indicate changes in the bonds established, or in the perception about them. Despite this, the second result remained very close to the average used for comparison. Furthermore, the other results presented that refer to
J.P's social ties showed improvement, which allows us to consider a more positive perception about the social support network, understood as a "set of systems and significant people, which make up the relationship links received and perceived by the individual" (Brito and Koller, 1999), and socialization, in general.

It is noteworthy that the treatment of people with CKD involves not just one person, but a multidisciplinary team, and in this sense, the primary care professional has a fundamental role in identifying the decline in GFR, in addition to comorbidities and factors that can be modifiable, such as hypertension, hyperglycemia, dyslipidemia, smoking, obesity and nephrological agents as contrast agents. The identification and differentiation between unchangeable and modifiable factors are relevant for adequate intervention, slowing the progression of the disease and treating its complications (Charles & Ferris, 2020; AMMIRATI, 2020; Hussien et al., 2020; JESUS et al., 2018). Therefore, the identification and analysis of possible impediments to early diagnosis and adequate treatment are relevant for the planning and development of social and institutional strategies. These factors are related to the outcomes of CKD and possible patient survival. With this in mind, the routine assessment of QOL, through validated questionnaires, becomes extremely important. It is also suggested that the patient be treated individually, also addressing psychosocial aspects, and within this context, cinema therapy can be a complementary therapy option focused on improving the patient's well-being and QOL.

6 FINAL CONSIDERATIONS

Based on the data analyzed, it was possible to observe a significant improvement in the patient's QOL and well-being after using cinematherapy. The authors believe that when dialysis is necessary, it is important to evaluate the patient's psychosocial aspects, considering the principle that the benefits of treatment must be greater than the suffering involved in the process. In conclusion, it is important to highlight that this is a case study, and the production of knowledge of a broader scope is not the immediate objective of the work, but rather an essay that points out possibilities with regard to the patient's QOL and well-being on dialysis.
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