In the name of the Almighty,
creator of life and wisdom

Death Distress in Nurses:
Psychoeducational Interventions

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Preface

Death is a normal expected reality in the process of life. Death is an inevitable part of life. When death occurs, every individual is affected physically, psychologically, socially, and spiritually.

Death anxiety is an attitude towards death and it is a negative and apprehensive feeling that one has when thinking about death and dying. Death anxiety is used interchangeably with concern about death or fear of death. Death fear is defined as a morbid, abnormal or persistent anxiety of one's own death or the process of his/her dying. Fear of death is a feeling of dread, apprehension or solicitude (anxiety) when one thinks of the process of dying, or ceasing to 'be'.

Death obsession is preoccupations thoughts, ruminations or persistent and intrusive beliefs that are focused on the death of the self and other significant people.

Death depression is a worldwide phenomenon. It is an emotional, attitude, and cognitive concept and the second element of death. Death depression includes feelings of despair, loneliness, dread and a type of sadness that reflects with the death of a close person, the death of others and generally the concept of death.

Nurses, as healthcare professionals, are exposed to dying patients and their beliefs about death phenomenon can impact on their general health. Nurses are exposed to dying patients in the course of their clinical work, and the personal attitudes of nurses about death and dying will probably affect the quality of care that they provide during the terminal stages of a patient's life. There are different reasons for fear of death. Nurses often have to work with dying patients, and their death distress (concerns/fears/anxieties, obsessions, and depressions regard to the death and dying) can have an impact on their mental, physical, general health aspects, and the quality of care that they provide during the terminal stages of a patient's life. Attention to death education program for health care professionals particularly nurses has been revealed in the literature.

There are various psychoeducational interventions for death distress such as death education programs. Death education refers to some of the activities and learning experiences associated with death and as original as meanings and attitudes towards death, dying and bereavement process and care of people have been affected by the death. There are different approaches to death education program include didactic, experimental, and recently developed 8A model (Alienation, Avoidance, Access, Acknowledgment, Action, Acceptance, Appreciation, and Actualization). We will discuss about all of topics in the present book.

This book is based on a doctoral dissertation in clinical psychology. As every author to write a book has surely noted, no work is created unilaterally. This work is no exception. We are happy and grateful to have so many wonderful people to thank. We have been extremely fortunate to have had to us advice and encouragement all along the way. We are so grateful for thoughtfulness, friendship, and priceless guidance of Prof. Ahmed M. Abdel-Khalek of the Alexandria University in Egypt. Along the lines of helpful advice, we are also indebted to Prof. Wallace Chi Ho Chan of the Chinese University of Hong Kong, and Agnes T. Fong, MSW Centre on Behavioral Health University of Hong Kong, both of whom selflessly gave of their valuable time to share their experiences with us and to give us helpful tips. Our sincere thank to Dr. Hadi Kazemi, director of Shefa Neuroscience Research Center, and to Dr. Pir Hossien Kolivand, manager of Shefa Neuroscience Research, for assisting the publication of this book. We are grateful for the dedication, and kindness of four marvelous men: Drs. Mohammad Sadegh Ghasemi, and Mohammad Bagher Shiran of International Campus, Iran University of Medical Sciences, Prof. Jafar Bolhari, Dean and Dr. Seyed Kazem Malakouti, director of research and international affairs, the School of Behavioral Sciences and Mental Health-Tehran Istitute of Psychiatry, Iran University of Medical Sciences. We are sure we have missed some important and superb friends and colleagues. Thank you, one and all.

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Contents

Introduction

Death is an unavoidable event in human life. Although death and life concepts seem so different from one another, some believe that death should be accepted as the goal of life and that death completes life (Karakus, Ozturk, & Tamam, 2012). Death and dying are a process that every human being must experience (Jung, 2012). Death is a natural process that occurs each day (Abu-El-Noor, & Abu-El-Noor, 2015). Life and death may outwardly appear to be conflicting concepts, yet they cannot be separated. As they become more self-consciousness of death, people often begin to reflect on the meaning of life and to ponder their life goals (Jung, 2013).

In different cultures, societies and disciplines, there have been many definitions of death which change according to the personality, age, religion and cultural status of the individual. Attitudes towards death vary dramatically among individuals (Karakus, et al., 2012). Thoughts related to the death can also be conscious and unconscious (Lester, Templer, & Abdel-Khalek, 2007).

There are four major concerns in human existence including freedom, loneliness, meaninglessness and death (Yalom, 1980). Death has three elements: Death anxiety, death depression and death obsession (Limonero, 1996). Death anxiety, death depression and death obsession were labeled as death distress by Abdel-Khalek (2011-2012).

Thanatology is the scientific study of death and the practices associated with it, including the study of the needs of the terminally ill patients and their families. Death concern is a universal issue in thanatology. Waskel (1991) defined death concern as the conscious contemplation of the reality of death and a negative evaluation of that reality. Concern with death is related to the fear of death (Aiken, 2001).

Death fear is defined as a morbid, abnormal or persistent anxiety of one's own death or the process of his/her dying (Lester, 2013). There are different reasons for fearing of death (Abdel-Khalek, 2002) and when people are faced with death, they show different reactions to it (Arndt, Routledge, & Goldenberg, 2006).

Death anxiety is a multidimensional construct with two main components, unknown/existential death anxiety (i.e., the fear of annihilation) and known/tangible death anxiety (i.e., the fate of the body, anxiety about the body as it is dying (Benton, Christopher, & Walter, 2007; Cicirelli, 2002). Death anxiety or thanatophobia, is a state in which people experience negative emotional reactions in recognition of their own mortality (Brady, 2015; Lopez, 2015).

Death anxiety includes thoughts, fears and emotions associated with the end of life (Belsky, 1999; Yalom, 2008). Death anxiety is a feeling which can start soon, is the underlying basis of all fears, has an impact on character development, and it is formed after realization that the person will no longer exist, and that life is meaningless (Karakus, et al., 2012)**.** Death anxiety is a feeling of dread, apprehension or (anxiety) when one thinks of the process of dying, or ceasing to 'be' (Farley, 2010; cited in Peters, Cant, Payne, O'Connor, et al., 2013).

Death obsession is preoccupations thoughts, ruminations or persistent and intrusive beliefs that are focused on the death of the self and other significant people (Abdel-Khalek, 1998).

Depression is one of the most important features in distress death (Abdel-Khalek, 2011-2012). Death depression is a sadness that is connected with the death of others and the issue of death in generally (Templer, Harville, Hutton, Underwood, et al., 2001-2002). Depression associated with death, is the fourth stage in the Kübler-Ross' dying process (Kübler-Ross, 1969).

Many individuals do not like to think or discuss about death and dying. Actually, hatred and denial are the usual feelings when they encounter death and dying. Dying is more than a biological occurrence. It is a human, social, and spiritual event, but the spiritual dimension of patients is too often neglected. Whether death is viewed as a "wall" or as a "door" can have significantly important consequences for how people live their lives. Near death experience is one of the excellent evidences to prove that there should be spiritual component being separated from the human physical body when people experience death. They have called it soul, spirit, or nonlocal consciousness (Jung, 2012).

Death education refers to some of the activities and learning experiences associated with death and as original as meanings and attitudes towards death, dying and bereavement process and care of people have been affected by the death of the covers. There are different approaches to death education program, and various methods have been used in each of them. Death education approaches are including didactic, experimental (Peters, et al., 2013; Kraje-Kulak, et al., 2013; Cavaye, & Watts, 2014; Dadfar, & Lester, 2014; The National Center for Death Education (NCDE), 2015); and recently developed 8A model by a community-wide death education project called Empowerment Network of Adjustment to Bereavement and Loss in End-of-life (ENABLE) in Hong Kong. The 8A model (Alienation, Avoidance, Access, Acknowledgment, Action, Acceptance, Appreciation, and Actualization) adapted the Transtheoretical model (TTM) for understanding the needs of clients in different phases of behavior change proposed by Prochaska and Velicer in 1997 (Chan, Tin, Chan, Chan, & Tang, 2010).

Preparation for death is one of the most crucial tasks in end of-life care. Preparation for death may enhance the sense of control in patients and ensure that their preferences for end-of-life care are respected (Pinquart, & Sörensen, 2002). Reminiscing when preparing for death preparation was also found to be associated with higher life satisfaction (Cappeliez, O'Rourke, & Chadhury, 2005). In Hong Kong, a survey reported that people who had thought of preparing for their own deaths but had not yet done anything (contemplators) experienced a higher level of anxiety than did non-contemplators (Chan, Chan, Tin, Chow, & Chan, 2006). Another survey in Hong Kong showed that different physical and psycho social spiritual issues (e.g., no physical suffering, financial security for bereaved family members, tying up family obligations, reconciliation with family members, etc.) are important components of a good death (Chan, Tse, & Chan, 2006). All these findings reflect the paramount need to address the topic of death in the different communities, if better well-being is expected for the people in end-of-life care (Chan, et al., 2010).

To promoting planning for end-of-life care among Chinese people, a team launched a community-wide death education project called the ENABLE in Hong Kong. Their key

objectives were to promote among the public positive attitudes towards death and dying, as well as planning for end-of-life care. They believed that such objectives cannot be reached unless the general public is able to address the issue of death openly (Chan, et al., 2010). Caregivers need to recognize and acknowledge the spiritual component of patient care. Learning about death and dying helps they encounter death in ways that are meaningful for their own lives **(**Jung, 2012).

Health care professionals including physicians, counselors, psychologists, psychiatrists, social workers, nurses, serve a wide range of clients in the community. Thus, they espoused a train-the-trainer mode and aim at empowering these professionals to promote death education and end-of-life care planning. In order to accomplish this, a team developed the 8A model (Chan, et al., 2010).

Nursing is an art care of the dying and is a fine art. Emergency nurses are constantly reminded of death and therefore of their own mortality, and this makes them susceptible to death anxiety (Brady, 2015; Lopez, 2015). Little research has been conducted with Iranian nurses and their emotional needs about death issues. There were studies of death anxiety in Iranian nurses (for example Masoudzadeh, Setareh, Mohammadpour Tahamtan, & Modanloo Kordi, 2008; Aghajani, Valiee, and Tol, 2010; Naderi, Bakhtiar pour, & Shokohi, 2010; Bagherian, Iranmanesh, Dargahi, & Abbaszadeh, 2010).

Aghajani, et al (2010) found that death anxiety was higher in critical care nurses, and these nurses cared for more dying patients than nurses in the general wards. A negative correlation has been reported between humor and death anxiety, and between social maturity and death anxiety among nurses by Naderi, and Shokohi (2010).

Naderi, et al (2010) found significant differences in death anxiety among female nurses working in emergency departments, intensive care units, renal, surgical and psychiatric wards, operating rooms, and children's units. Female nurses working in emergency departments reported less death anxiety than female nurses who working in operating rooms.

However, greater work experience in nurses resulted in more positive attitudes toward death and caring for dying patients (Lange, Thom & Kline, 2008). Ayyad (2013) found that nurses dealing with critical cases and working in higher stress wards, such as intensive care units, obtained higher mean scores on the Reasons for Death Fear Scale (RDFS) than nurses who working in lower stress wards such as internal medicine. There are also cultural differences. For example, Turkish nurses are found to have more negative attitudes toward death and the caring of dying patients than nurses in other cultures (Cevik, & Kav, 2013).

Kang and Han (2013) investigated four categories of the meaning of death, death anxiety, death concern and respect for life among nurses. Findings revealed that positive meaning of death was negatively correlated with death anxiety and death concern and positively with respect for life; death anxiety was positively correlated with death concern and negatively with respect for life; death concern was negatively correlated with respect for life. Compared with nurses who served at ICU for a long time, nurses with less ICU experienced scored lower on the meaning of death and respect for life, while they presented high anxiety and concern about death.

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Nurses are exposed to dying patients in the course of their clinical work, and the personal attitudes of nurses about death and dying will probably affect the quality of care that they provide during the terminal stages of a patient's life. Nurses face with the dying patients and death in their patients every day, and the care of dying patients, giving comfort and solace to the patients' family, whether in the case of sudden death or during a long incurable illness, are difficult experiences for nurses (Fernandez-Donaire, et al., 2014; Edo-Gual, Monforte-Rovo, & Tomas-Sabado, 2014; Edo-Gual, Tomás-Sábado, Bardallo-Porras, Aradilla, et al., 2014; Edo-Gual, Tomás-Sábado, Bardallo-Porras, & Monforte-Rovo, 2014). Nurses who have clinical variables related to death and dying such as death concern, death fear, death anxiety, death obsession, and death depression may be less comfortable providing nursing care for dying patients. These variables can be major issues for nurses, as healthcare professionals. Nurses often have to work with dying patients, and their concerns, fears, anxieties, obsessions, and depressions regard to the death and dying can have an impact on their mental and physical aspects. Nurses are exposed to dying patients and their beliefs about death phenomenon can impact on their general health. The fear of death can influence their communication with and quality of care delivery for dying patients and can also affect their own mental health. The death of their patients has an impact on nurses. This can affect them both in their work environment and outside of work (Masoudzadeh, et al., 2008; Bagherian, et al., 2010; Wilson, & Kirshbaum, 2011).

Dadfar, Lester, Asgharnejad Farid, Atef Vahid, and Birashk (2014a) showed that on the RDFS, the nurses had significantly higher scores than the control group on only two items: grieving over what they would leave behind (wealth, valuables, etc.) and over the loss of self or identity. Since nurses experience emotional issues related to death, they need skills to manage their fear of death, and death education program in the workplace might reduce their fear of death.

Dadfar, Asgharnejad Farid, Atef Vahid, Lester, and Birashk (2014b) indicated that on the Death Depression Scale (DDS), nurses had significantly higher scores on the 10 items and 3 elements of death despair, death loneliness, and death finality/end than the controls. Nurses should be aware of state of mind of themselves, and they should be proactive and educated about death. This research may expand the knowledge base about death depression in Iran that might lead to intervention that would help to improve nurses' attitude and their quality of life.

Dadfar, and Lester (2014c) reported that on the Collett-Lester Fear of Death Scale (CLFDS), the nurses had higher scores in the total and subscales of your own death, your own dying, the death of others and the dying of others than the control group but these differences were not significant. Nurses have negative emotions about death and dying. They have to monitor their fear of death. The research opens rooms for a dialogue on the use of death education program on the nurse's workplace.

Dadfar, and Lester (2015) reported that on the Death Concern Scale (DCS) and the Death Obsession Scale (DOS), female Iranian nurses and hospital staff members did not differ significantly in their scores on either scale. They recommended that death education programs in hospitals be given to all staff, nursing and non-nursing.

Finding done studies about death and dying have revealed attention to death education program for health care professionals particularly nurses (Peters, et al., 2013; Kraje-Kulak, et al., 2013; Cavaye, & Watts, 2014; Dadfar, & Lester, 2014d; Jeffers, & Ferry, 2014). To provide any psychoeducational interventions, the focus should be placed on a community-based approach (Chan, et al., 2010; Dadfar, Atef Vahid, Asgharnejad Farid, & Kolivand, 2014).

Problem statement about death distress

Death is a normal expected reality in the process of life (Roshdieh, 1996). Death is the only certainty in the life. All living organisms die; there is no exception (Wong, 2008). Death is referred as the cessation of all vital functions of the body including the heartbeat, brain activity (including the brain stem), and breathing. Death can arrive unannounced at any time and is not the special province of the very aged. Fear and anxiety are among the words most often used to describe feelings toward death. Most of people have images of death that are negative and disturbing, and that evoke feelings of fear and anxiety. Many people fear dying more than death itself. According to Government statistics, there are about 6000 common ways of dying, such as heart failure, stroke, cancer, accident, lightning, natural disasters and infectious diseases, etc. But in fact, there are just as many unique ways of dying as distinct ways of living, because the former is influenced by the latter. Most people are afraid of dying a violent or painful death. They prefer to die in their sleep-without pain and without awareness (Wong, 2008).

Death is something that occurs along path of life. It is the last thing that occurs, yet it is still an occurrence. Many have come to fear death; it is a rather strange reaction to a normal occurrence (Ruffin, 2011). The inevitability, irreversibility, and permanence of death create anxiety in all individuals at some time in life. To some degree such anxiety is normal. However, in excess, it can be functionally debilitating and inhibiting of personal growth (Niemiec, & Schulenberg, 2011). Awareness of human mortality arose through some 150,000 years ago. In that extremely short span of evolutionary time, humans have fashioned but a single basic mechanism with which they deal with the existential death anxieties, this awareness has evoked denial in its many forms. Thus denial is basic to such diverse actions as breaking rules and violating frames and boundaries, manic celebrations, violence directed against others, attempts to gain extraordinary wealth and/or power and more. These pursuits often are activated by a death-related trauma and while they may lead to constructive actions, more often than not, they lead to actions that are, in the short and long run, damaging to self and others (Roshdieh, 1996). Archbishop Desmond Tutu, who won the 1984 Nobel Prize for his role in the antiapartheid movement in South Africa, has said “When you have a potentially terminal disease, it concentrates the mind wonderfully. It gives a new intensity to life. People discover how many things they have taken for granted such as the love of their spouse, the Beethoven symphony, the dew on the rose, the laughter on the face of their grandchild” (Kuhl, 2002).

Unconscious death anxiety may be threatening for health of individuals. They believe when concerns related to death operate below the threshold of consciousness, basic defensive behavior will affect to high self-confidence these persons and regardless of health status, they will not involve themselves to health promoting behaviors (Routledge, Arndt, & Goldenberg, 2004).

According to dual process model (Pyszczynski, Greenberg, & Solomon, 1999), for dealing with simple conscious and unconscious thoughts related to the death, people use different defense mechanisms. When thoughts related to the death are conscious, they use simple defense mechanisms that include active suppression such thoughts or they distort thoughts related to the death as death will happen for them in many years away. When thoughts related to the death are unconscious, they use complex defense mechanisms that enable them to be a valuable contribution to the significant world. Therefore health promoting behaviors can be considered as a surface defense that they are used to get rid of conscious thoughts related to the death.

Death anxiety is thoughts, fears and emotions related to the final event of life and it is beyond normal life. Death anxiety is a conscious and unconscious fear of death or dying. Death anxiety is a complex concept that cannot be explained simply and generally include own death and other death. In other words, death anxiety includes prediction of own death and fear of death and dying process about significant persons in life (Bodner, Shrira, Bergman, et al., 2015). Death anxiety is a negative emotional reaction provoked by the anticipation of a state in which the self does not exist (Tomer, 1996; cited in Peters, et al., 2013). Generally death anxiety, as a feeling of discomfort associated with fear, is directed to death of self or death of others. Death anxiety is defined as feeling evocated of end of life or visualization of funeral/burial and body/cadaver (Firestone, & Catlett, 2009).

Death anxiety generally refers to the anxiety about personal death that is experienced in ‘‘daily life’’ (Beydag, 2012). This type of anxiety can range from a low level of awareness to intense neurotic fears of loss of the self and parallel perceptions of helplessness and depression (Singh, 2013). Death anxiety is a normal human experience, yet it can engender paralyzing fear. It is considered to be a basic fear underlying the development and maintenance of numerous psychological conditions. Death anxiety appears to be a basic fear at the core of a range of mental disorders, including hypochondriasis, panic disorder, anxiety and depressive disorders. It is a transdiagnostic construct involved in numerous disorders (Iverach, Menzies, & Menzies, 2014).

Nurses have negative emotions about death and dying. Research indicates that nursing students feel unprepared and unable to care for the dying patients at the end of their training. Studies on attitudes of nursing to caring for dying patients can play a main role in education of nursing (Leombruni, et al., 2014). They have to monitor their fear of death. Nurses should be attained a balance in caring for patients who are dying. It is a major challenge both in interactions of nurses with patients, families of them, and perceptions of nurses of themselves and their efforts in end-of-life care for patients (Zargham Boroujeni, Mohammadi, Haghdoost Oskouie, & Sandberg, 2009). When nurses want to cope with the death of a patient, they use

from such resources: communication with patients, their families and coworkers (Peterson, Johnson, Halvorsen, Apmann, et al , 2010).

Research on how death anxiety and the attitudes of nurses affect the nursing care of dying patients, has identified three key issues: (1) The level of death anxiety of nurses, (2) Attitudes toward the care of dying patients, and (3) The role of death education for nurses (Peters, et al., 2013).

Naderi, et al (2010) reported that nurses had different significantly in death anxiety depending on the type of ward in which they worked. Peters, et al (2013) showed that younger nurses reported more fear of death and more negative attitudes to end-of-life patient care. Chen, Del Ben, Fortson, et al (2006) indicated that nursing students who had experienced the death of other people, reported significantly more fear of the dying process than nursing students who had not. Both experienced and inexperienced nursing students had more fear of the unknown than controls.

Valiee, Negarandeh, and Dehghan Nayeri (2012) revealed the need for providing the nurses with psychological support, accommodating the possibility for offering a complete care, attending to and managing the conditions of the patient and their families and engaging nurses in decision making about end of life patients. They suggested that managers should provide specialized units for providing care to end of life patients by attending to these dimensions and supporting the nurses at the same time.

Nurses need to be supported by their families consistently. Ignoring the needs of nurses can have adverse effects on the patients and their community (Karimi Moneghy, Zubin, Yavari, Noghredani, et al., 2013).

Existential social psychology studies showed that awareness of one's eventual death profoundly influences human cognition and behavior by inducing defensive reactions against end-of-life related anxiety. Personality and demographics modulated psychophysical and neural changes related to mortality salience (MS) (Valentini, Koch, & Aglioti, 2014).

Death depression is a worldwide phenomenon. It is an emotional, attitude, and cognitive concept and the second element of death. Death depression is a psychological and conceptual phenomenon related to death (Templer, Lavoie, Chalgujian, & Thomas-Dobson, 1990). Anxiety level and death distress are related to depression (Chibnall, Videen, Duckro, & Miller, 2002). Almostadi (2012) indicated that there was a significant correlation between death anxiety and death depression.

Death obsession includes ruminations, repetitive, intrusive thoughts or images about death (Abdel-Khalek, 1998). There was a significant positive relationship between death rumination, death dominance and death idea (Shiekhy, Issazadegan, Basharpour, & Maroei Millan, 2013; Ashouri, Hosseini, Ghariblo, Kalhor, et al., 2013).

Some studies have been done by using the DOS in nursing college students. Shiekhy, et al (2013) revealed that there was a significant positive relationship between death anxiety with death rumination, death dominance and death idea repetition in nursing college students.

Students' personal anxieties and fear of death may lessen and their empathic interpersonal skills increase with formal academic preparation (Reed, 1996). Jo and Lee (2008) showed that death attitude and life satisfaction of nursing college students were significantly different according to frequency of death ideation. Death attitude correlated with self-efficacy, depression, and life satisfaction. The most significant predictor of death attitude was life satisfaction. As death attitude was influenced by self-efficacy, depression, and life satisfaction, they suggested that a death education program to improve life satisfaction and to give a positive attitude toward death is needed for nursing college students.

In study of Iranmanesh, Savenstedt, and Abbaszadeh (2008) Bam city nursing students who had more experience of death of others, were found to be less afraid of death and also less likely to give care to people at the end of life compared to Kerman city nursing students. In another study Iranian nursing students were more afraid of death and less likely to give care to dying persons than the Swedish nursing students (Iranmanesh, Axelsson, Haggstrom, et al., 2010).

Lehto and Stien (2009) identified defining attributes, antecedents, and consequences of the concept of fear of death in nurses. Defining attributes were emotional, cognitive, experiential, developmental, cultural variables and source of motivation. Antecedents included stressful environments, the experience of unpredictable circumstances, the diagnosis of a life-threatening illness or the experience of a life-threatening event, and experiences with dying patients. Consequences were adaptive and maladaptive reactions. Hinderer (2012) explored critical care experiences of nurses with death of patient are in four themes of coping, personal distress, emotional disconnect, and inevitable death. Valiee, et al (2012) used a qualitative design by conventional content analysis method, depth interviews with a purposive sample of 10 nurses who working at intensive care units in Sanandaj city of Iran. They reported that three main themes emerged: psychological harm, lack of feeling indebted by the nurses to patients, and sticking to the inner voice for the nurses. Karimi Moneghy, et al (2013) used a phenomenological approach. They individually interviewed with twelve nurses from high mortality wards in one of hospitals of Iran and explored five themes in nurses' experience of dealing with dying patients: mental erosion, maladaptive interpersonal interactions, stress from caring for the patients, feelings of sadness and normalization that portrayed the experiences of nurses concerning the patient deaths. Nurses were experiencing serious problems.

Nurses have many roles in dealing with patients: clinical care, treatment, education, research, administrative work, making and applying policies, and decision making (Carpenito-Moyet, 2008). Culture is closely related and intertwined with health and nursing (Donnelly, 2000; Cowan, & Norman, 2006). Death concern, death fear/anxiety, death obsession, and death depression in the nursing profession can occur on a daily basis, and communication with dying patients can be stressful for nurses. Nurses with such emotions need to death education program.

Death education occurs in a variety of formats (Corr, Nabe, & Corr, 2009). There have been two principle educational approaches to death education, namely the didactic and the

experiential approaches (Foyle, & Hostad, 2004). In other words, two distinct methodological approaches to structured death education are the didactic and the experiential. Most educators use a combination of the two approaches (Meagher, & Balk, 2013). There is considerable overlap between the content and strategies for delivery between the two approaches. In this case it may also helpful to view this as a didactic- experiential continuum, rather than viewing these approaches as completely dichotomous and discrete entities (Foyle, & Hostad, 2004). Technically speaking, because there is an overlap in the process and content of didactic and experiential programs, the important distinction is between programs that emphasize experiential elements and those that do not. For convenience's sake, however, the terms didactic and experiential are customarily used to make this distinction (Neimeyer, 1994). The primary differences between didactic and experiential death education programs have illustrated in the study of Bell (1975) described a university-based, semester-long didactic death education course, and study of Irwin and Melbing-Herbert (1992) described a semester-long university course on dying and bereavement that contained several experiential elements (Neimeyer, 1994).

Lack of attention to their death concerns can be lead to unintended and undesirable consequences for nurses (such as job dissatisfaction and psychological distress), and patients may be denied proper care (Fernandez-Donaire, et al., 2014). Some studies concluded that death education program in healthcare professionals, is necessary (Peters, et al., 2013; Kraje-Kulak, et al., 2013; Cavaye, & Watts, 2014; Dadfar, & Lester, 2014; Jeffers, & Ferry, 2014).

Significance and necessity the study on the death distress

Death is a common and an inevitable phenomenon. Death is perhaps the most paramount loss an individual can experience (Dorney, 2014). Death is very important to determine how to accommodate and treat death, and it has more important for medical professionals to consider how to accommodate and treat death as they are always facing with death. The debate on death from the biomedical perspective emerged as a general and objective concept from the end of the 18th century and this tendency brought about the clinical and pragmatic judgment criteria for death. Also, it became inevitable to identify medically the phenomenon related to death (Kim, Kim, Ahn, et al., 2014).

Most studies on burnout suggested that one of the most stressful situations that health care providers experience on the job is death (Papadatou, 2009). Walter and McCoyd (2009) stated that examination of the issues of loss and death experiences, with a biopsychosocial perspective, across the lifespan is a need. Awareness that life will end helps people ask questions about values, preferences, choices, and motivations at all age (Qualls, & Kasel-Godley, 2011).

Fear of death is an emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation or anticipation of any of the several facts related to death. Fiefel (1995) opined that all human behavior is a response of death. It is for reason that philosophers, theologies and social scientists are attracted the study for death anxiety. Death is not only the greatest source of anxiety for man but also it is the primary crisis event

which calls forth religious behavior. Death is considered a universal reaction. It has been emphasized that individuals must take into account the "Meaning of death for an individual'' in order to expend their understanding of human behavior (Kaur, & Yadav, 2009).

Death anxiety is a complicated factor that is experienced with variable severity during one's life. Death anxiety is an attitude that an individual holds towards death. It is defined as a negative and apprehensive feeling that one has when thinking about death and dying and is used interchangeably with fear of death (Sridevi, 2014a; Sridevi, & Swathi, 2014; Sridevi, 2014b). Death anxiety is a type of bound anxiety in which the source of anxiety is the fear of death (Kaur, & Yadav, 2009).

Obsession is an important aspect of death. Death obsession is persistent and bothersome thoughts or ruminative or images which are centered around own death or other important persons death (Abdel-Khalek, 1998). Death obsession is the third element of death and a psychological phenomenon. Death obsession includes repetitive, intrusive thoughts, ruminations, or intrusive images around the death of self or loved ones. Literature suggests that health care professionals including nurses have inner struggles with the notion of death, therefore they choose the field. Nurses who anxious/fearful about death may be depressed or obsessive about it. Abdel-Khalek, and Maltby (2008) reported that death obsession was related to pessimism. Death obsession is a central feature of health anxiety and can play a significant role in development of other anxiety disorders (Furer, & Walker, 2008). Overall, death obsession and death anxiety are neurotic conditions and there is a mutual and overlap relationship between death obsession and death anxiety. Nurses, who experienced death obsession, may experience death anxiety and death depression too. It is necessary nurses promote their information and knowledge about death and guidelines of adjustment and adaptation to issues related death and dying. Death education program will be useful in order to reduce of death obsession and mental health promotion in the nurses.

Clinicians, in accordance with their clinical impressions, have reported that there is a stage with a strong depression in the process of dying (Templer, et al., 1990; Abdel-Khalek, & Lester, 2006). When a person thinks about death issues, he/she may experience depressive symptoms such as despair, hopelessness, loneliness, and sadness and also denial of thoughts related to death can decrease energy that is considered as a symptom of depression (Ramchandani, 2010). Because nurses are usually the first to approach and discuss the feelings of depression of death with the patients**,** they should be awared of state of mind of themselves. Providing of information and education to nurses is very important for reason they can have fear of dying and/or depression that may affect their care of patients. Nurses should be proactive and educate educated. If education about depression of death is discussed early in curriculum of nursing, more nurses may become more comfortable with these issues, and the entire they may be able to be more supportive during care of their patients and also family of patients (Dadfar, & Lester, 2014; Fernandez-Donaire, at al, 2014).

As a supporting role of the nurses, understanding the notion of death, they can better provide care for their sick patient and their family. Nurses are not familiar with all aspects of death, they cannot be able to make right decisions about the care of a really sick and dying

patient. However, normalization of the patient's death may have beneficial effects for the nurses, but the reactions of patients and their families should be taken into consideration (Karimi Moneghy, et al., 2013). Naderi and Shokohi (2010) stated that enough understanding and maturity and positive attitude toward death could result in decreasing the death anxiety in nurses.

In order to design appropriate care and support systems for dying patients and their families, it is necessary to examine nurses' attitudes and beliefs, since the attitude of nurses to death can affect how they care for dying patients and their families. If healthcare workers believe that death is an ominous and frightening event, they will not be able to assist patients in dying peacefully. Identifying the daily experiences of nurses with dying patients would be useful for setting and monitoring adequate standards of care (Heidari, Anoosheh, Azad Armaki, & Mohammadi, 2011; Zargham Brojeni, Mohammadi, & Haghdoost Oskuei, 2007).

Nurses have negative emotions about death and dying. They have to monitor their fear of death. They should receive education about death and dying in their work setting in order to improve the quality of their care for very ill and dying patients (Cavaye, & Watts, 2014; Fernandez-Donaire, et al., 2014).

Grief education and support of others are useful for nursing staff. These actions can help to develop of strategies in nursing staff as they able to cope with death and dying of patients (Wilson, & Kirshbaum, 2011). Critical care reactions of nurses to patient death and dying should be understood. This understanding can help to promote both care provided to critically ill dying patients, families of them and to consider of needs of nurses (Hinderer, 2012; Chan, 2014; Fernandez-Donaire, at al, 2014).

Some nursing students may encounter the experience of taking care of a dying patient. Therefore, their attitude toward death and caring for dying patients may vary (Abu-El-Noor, & Abu-El-Noor, 2015). Mutto, Cantoni, Rabhansl, et al (2012) reported that undergraduate nursing students had a highly positive attitude toward dying patients. Shim (2012) investigated the subjectivity of undergraduate nursing students about well-dying by Q-methodology, which is effective in scientifically measuring individual subjectivity. Four cognitive types of subjectivity about well-dying were identified and labeled as follows: type 1) Oriental and family-centered type; type 2) Individual and fate-adapted type; type 3) Altruistic and afterlife-centered type; and type 4) Self-leading and secularistic type. Undergraduate students had a well-dying concept which tends to be self-centered and secularistic. At the same times, they also had a well-dying concept which has a basically oriental view, that is, family-centered and fate-adapted views. Nursing students' and nurses' attitudes toward caring for the dying need to be explored (Henoch, Browall, Melin-Johansson, et al., 2014; Wang, Li, Yan, et al., 2015). It will be helpful that nursing students should be trained about the care for dying patients during their formal education (Arslan, Akca, Simsek, et al., 2014). Education can improve knowledge and attitudes toward end-of-life care (Mastroianni, Piredda, Taboga, et al., 2015).

Awareness of death increases a sense of responsibility towards life. Also information and awareness of death increases motivation in the facing with high risk activities. Death

education has cognitive and effective components (Meagher, & Balk, 2013). Death education can influence death anxieties, but it depends on the type of program. The experiential groups generally produced a modest decrease in death fears and anxieties, whereas the didactic groups tended to show an increase in discomfort with death. Death education has many outcomes such as affective, cognitive, personality, and behavioral change. Cognitive and behavioral changes were moderately large across types of educational intervention, whereas the effective impact of interventions varied as a function of program type (Durlak, & Reisenberg, 1991; Wass, & Neimeyer, 1995). Death education in its both forms is essential for the training of practitioners, for the advancement of knowledge about dying, death, and loss through the work of scholars and researchers, and for the consumers of death-related information (Sofka, Cupit, & Gilbert, 2012). Death education program has several basic goals. Efficacy of death education program has been shown in some of studies (İnci, & Öz, 2009; Kim, & Lee, 2009; Dadfar, & Lester, 2014; Cavaye, & Watts, 2014). Health personnel of hospitals have the most important role in providing health of the patients and also they face with death the most thus regarding the fact that fear of death and attitude toward death has an important role in maintaining the mental health and level of concern of the health personnel.

Theoretical definitions of terms

Death concern

In view of psychologists concern/worry is a general feeling of unpleasant irritation, expectation of danger and fear due to a danger that someone is waiting for it and he/she does not know where it comes from. Although some researchers know concern/worry a strategy or coping mechanism emotion-oriented (no problem-oriented) toward threatening issues and events. Borkovec (1985; cited in Davby, Hamptons, Farrelli, & Davidson, 1992) argued that worry linked to definition of the problem or cognitive avoidance of expected event. In other words, he knew concern as a kind of avoidant cognitive mechanism. Borkovec, Robinson, Pruzinsky, and Dupree (1987; citted in Davby, Hamptons, Farrelli, & Davidson, 1992) knew worries as a series of negative and relatively uncontrollable thoughts and ideas involved in psychological issues or topics that they include the possibility of one or more negative results. Therefore, concern/worry has intimately relationship with fear processing. Death concern is a worry related to the death particular situation (Dickstein, 1972, 1975).

Death fear

Fear of death or thanatophobia is a specific fear from death and dying. Death fear is neither a psychological phenomenon of death anxiety, nor related to it, but it is associated with a feeling of worry and an «existential» philosophical horror. Death fear refers to verbal response of existing level of death anxiety or death related feelings of individuals. Death anxiety and a feeling of worry and an “existential” philosophical horror are not a phobic. People who suffer from the death fear have a lot of preoccupations with death dying, and this issue can affect on their daily lives. Death fear may lead to psychiatric disorders such as obsessive-compulsive disorder and hypochondriac disorder (Rice, 2009; Fritscher, 2010).

Death anxiety

Death anxiety (Tanatophobia) is defined as the dread of death, the horror of physical and mental deterioration, the essential feeling of aloneness, the ultimate feeling of aloneness, the ultimate feeling of separation anxiety, sadness about the eventual loss of self and extremes of anger and despair about a situation over which people have no control (Firestone, Firestone, & Catlett, 2009).

Death anxiety is fear, dread, fright and concern of death, or whatever may be caused it. According to another definition death anxiety means a set of negative emotional reactions with variable severity due to thoughts indicating the loss of one's existence. In this definition, addition to the emotions, emphasis is on the cognitive view (Urien, 2007; Urien, & kilbourne, 2008). Death anxiety defined as an eccentric and a great fear of death associated with feelings of dread of death or apprehension when thinking about dying process or the things that happen after death (Rice, 2009).

Death anxiety is the morbid, abnormal or persistent fear of death or dying. Death anxiety as the thoughts, fears, and emotions about that final event of living that ones experience under more normal conditions of life. The British National Health Service (BNHS) defines death anxiety as a feeling of dread, apprehension or solicitude (anxiety) when one thinks of the process of dying, or ceasing to be or what happens after death. It is also referred to as thanatophobia (fear of death) and necrophobia (fear of death or the dead) (Peters, et al., 2013).

In handbook of nursing diagnosi**s,** Carpenito-Moyet (2008) defined death anxiety as "A condition in which a person experiences horror, dread, apprehension, concern or fear related to death and dying (p 39)". In guide of nursing outcomes classification (NOC), Moorhead, Johnson, Maas, and Swanson (2008) defined death anxiety as "a vague feeling of anxiety or fear and dread caused by a real or imagined threat to ones' life and existence".

Death anxiety is a complicated factor that is experienced with variable severity during one's life, and is also influenced by a variety of factors such as environmental events, age, and sex. Death anxiety is an attitude that an individual holds towards death. It is defined as a negative and apprehensive feeling that one has when thinking about death and dying and is used interchangeably with fear of death (Sridevi, & Swathi, 2014).

The Association for Death Education and Counseling (ADEC)-The Thantology Association (2015) stated that anxiety is the preeminent emotion in acute grief and can manifest in a number of ways. It can be a leading indicator of complicated mourning; yet often, grief professionals focus their attention and interventions on other emotions. This is unfortunate, since anxiety after a loved one's loss is often a significant concern and can create many problematic reactions.

Death obsession

Abdel-Khalek (1998) was introduced concept of death obsession. His underlying rationale for the design of this concept was presence a mutual and overlap relationship between death and obsession, that is, component of death in obsession, and death is a possible issue in death obsession.

Death depression

There is an important component of depression in the process of dying. Depression is one of the important features in distress of death. The concept of death depression, as a conceptual and psychological level of death, was introduced by Templer, et al (1990). Their rationale to introduce this concept was implication of depression in connection with the death. They defined death depression as feelings of despair, loneliness, dread and a type of sadness that reflects with the death of a close person, the death of others and generally the concept of death (Templer, et al., 1990).

Death education program

The term of death education refers to the variety of the activities and educational experiences associated with the death and original topics such as meanings and attitudes towards death, dying and bereavement process and care of people who have been affected by the death. Death education is called as well as education about death, dying and bereavement, is based on the belief that the attitudes and actions of death denial, fight to the death and death avoidance in American culture can be changed, and death education assumes that individuals and institutions as a result of the educational efforts, they will be better able to engage in acts related to death. There are structured approaches in death education program. Didactic approach (for example, consists of lectures and audiovisual presentations) is used to enhancement of knowledge and awareness. Experimental approach is used to actively engage of participants through the call for feelings, and thereby attitudes are associated with death can be used to change. This approach includes the co-ownership of personal experiences in group discussions, role playing, and a variety of other simulative exercises or similar exercises and it needs to a mutual trust atmosphere (Kraje-Kulak, et al., 2013; Cavaye & Watts, 2014; Dadfar, & Lester, 2014; The National Center for Death Education (NCDE), 2015). The 8A model seeks to help people to understand their thoughts and experiences in different stages of change of awareness/knowledge, attitude and practices. The 8A model also provides a road map that permits to intervene in accordance with the potential stage to maximize the individuals feeling of independence, to address to issues related to the death. The 8A model acts as a guide framework to the overall social organizing proceedings of ENABLE and also two major death education programs (Chan et al., 2010).

Nurses

Nurses are who with academic degree of bachelor, master and doctoral degrees in nursing professional course, and in any situation, and environment, faced with the clients, are able to play the following six roles: 1) Care role of care: Nurses help to the patients for doing activities that when they were healthy, did them alone, but for the reasons they are not able to carry them now for example eating, 2) Treatment role: Although the treatment is related to physician and practitioners, but nurses with careful observations of the patients conditions and having skills and spending much time for them, and impact of treatments, and patient response to therapy, play an important role in helping to planning or modifying of the treatment program,

3) Protective role: They help to patients to protect them from environmental factors such as infections, fires, falls, etc., 4) Educational role: Training and coaching of the patients are one of the most important responsibilities of the nurse as education about and necessary health care at home or health proceedings, 5) Coordination role: Coordination of the work of nurses team in relation to the planning of agenda for healthcare workers and other service personnel, and coordination with other groups in relation to health care team in different parts such as nutrition social worker, laboratory, physiotherapy, radiology, etc., 6) Supportive role: Nurses who more than others associated with patients and clearly understand patient's wanted and therefore they can defend and protect them and they are considered as effective mediators for patients with various medical institutions as the center of the fight against Tuberculosis (TB). Generally, the domain of nursing services not only is in hospitals, but also is into the community and nurses can serve in the following locations: Hospitals, clinics, schools, health organizations, factories, homes, offices, on ships, planes and trains, child care as an educator, nursing homes and consulting care centers (Carpenito-Moyet, 2008; Moorhead, et al., 2008; Iranian Nursing Organization, 2015).

Theoretical foundations

In this section, the first, theories about concepts and terms death concern, death fear, death anxiety, death depression, death obsession, and death education programs will be represented. Then, literature, previous studies and research about them will be reviewed.

Because concepts and terms of death concern, death fear, and death anxiety are similar and overlap with together, theories about them are the same. Therefore, in this section, these theories will be emphasized on a title and one part.

Theories of Death concern/ Death fear/ Death anxiety

There are many theories about concepts and terms of death, and dying concern/fear/ anxiety. Everyone reacts and copes in his/her own way. Three of the leading theories about death and death fear/anxiety were developed by Sigmund Freud, Ernest Becker, and Mohammad Samir Hossain. Theories about these concepts include Thanatophobia; Theory of Ernest Becker; Edge theory; Wisdom: Ego integrity vs. despair; Terror Management Theory (TMT); Separation Theory; Death and Adjustment Hypotheses (DAH); Being, time, and Dasein; Meaning management theory; the existential approach; the regret theory; Personal meanings of death and so on (Kraje-Kulak, et al., 2013). Two influential theories dominated thinking about death anxiety and fear until the late twentieth century. Other approaches to understanding death anxiety and fear were introduced in the late twentieth century.

- Thanatophobia

Sigmund Freud, founder of psychoanalysis (1856–1939) had the first say and he hypothesized that people sometimes express a fear of death, called Thanatophobia. The name of Thanatophobia is made from the Greek figure of death known as Thanatos (Freud, 1953). He saw this as a disguise for a deeper source of concern. It was not actually death that people

feared, because: *Our own death is indeed quite unimaginable, and whenever we make the attempt to imagine it we . . . really survive as spectators. . . . At bottom nobody believes in his/her own death, or to put the same thing in a different way, in the unconscious every one of us is convinced of his own immortality* (Freud 1953). In Freud's view nobody believes in his/ her own death. The unconscious does not deal with the passage of time or with negations, which does not calculate amount of time left in one's life. That one's life could and would end just does not compute. Furthermore, that which one does fear cannot be death itself, because one has never died. People, who express death-related fears, then, actually are trying to deal with unresolved childhood conflicts that they cannot come to terms with or express emotion towards death or bring themselves to acknowledge and discuss openly (Freud, 1953; Langs, 2004; Meyers, Golden, & Peterson, 2009).

In other words, Freud stated that most people have a fear of death. However, he believed that it is not actually death that people fear because nobody believes in the reality of their own death. Freud felt that people who express death-related fears are really trying to deal with unresolved childhood conflicts that they cannot openly admit and discuss. People do not have to rely upon the untested and perhaps untestable opposing views of them. That they are either incapable of experiencing death anxiety, or that death anxiety is the source of all fears. It is more useful to observe how their fears as well as their joys and enthusiasms are influenced by the interaction between cognitive development and social learning experiences. In this way people will be in a better position to help the next generation learn to identify actual threats to their lives while not overreacting to all possible alarms all the time (Freud, 1953).

- Theory of Ernest Becker

Freud's reduction of death concern to a neurotic cover-up did not receive a strong challenge until Ernest Becker's 1973 book, *The Denial of death.* He presented a different death anxiety theory. Becker's existential view turned death anxiety theory on its head. Not only is death anxiety very real, but it is people's most profound and deepest source of concern. This anxiety is so intense that it can result and generate many if not all of the specific fears and phobias people experience in everyday life. He stated that the fears of being alone or in a confined space, for example, are fears whose connections with death anxiety are relatively easy to trace, but so are the needs for bright lights and noise. It is more comfortable, more in keeping with one's self-image, to transform the underlying anxiety into a variety of smaller aversions. According to the Becker, many of people's daily behaviors consist of attempts to ward off death or deny the reality of death and thereby keep their basic anxiety under control and strict regulation. People would have a difficult time controlling their anxiety, though, if alarming realities continued to intrude and if they were exposed to brutal reminders of their vulnerability. Becker also suggested that this is where society plays its role. No function of society is more crucial than its strengthening of individual defenses against death anxiety. Becker's analysis of society convinced him that many beliefs and practices are in the service of death denial, that is, reducing the experience of anxiety. Funeral homes with their flowers and homilies, and the medical system with its evasions, are only among the more obvious

societal elements that join with individuals to maintain the fiction that there is nothing to fear. Ritualistic behavior on the part of both individuals and social institutions generally has the underlying purpose of channeling and finding employment for what otherwise would surface as disorganizing death anxiety. Schizophrenics suffer as they do because their fragile defenses fail to protect them against the terror of annihilation. "Normal" people in a "normal" society function more competently in everyday life because they have succeeded at least temporarily in denying death (Becker, 1973).

Theory of Becker was based on existential view which turned death anxiety theories towards a new dimension (Roshdieh, 1996; Langs, 2004; Meyers, et al., 2009). As an individual becomes more aware of the inevitability of death, they will instinctively try to suppress it out of fear. The method of suppression usually leads to mainstreaming towards cultural beliefs, leaning for external support rather than treading alone. This behavior may range from simply thinking about death to severe phobias and desperate actions (Castano, Leidner, Bonacossa, et al., 2011; Kraje-Kulak, et al., 2013).

- Edge theory

Robert Kastenbaum suggested that people might not need a special theory for death anxiety and fear. Instead, they can make use of mainstream research in the field of life span development. Anxiety may have roots in people's physical being, but it is through personal experiences and social encounters that they learn what might harm them and, therefore, what they should fear. These fears also bear the marks of sociohistorical circumstances. For example, fear of the dead was salient in many preliterate societies throughout the world, while fear of being buried alive became widespread in nineteenth-century Europe and America. In modern times many people express the somewhat related fear of being sustained in a persistent vegetative state between life and death. Death-related fears, then, develop within particular social contexts and particular individual experiences. People do not have to rely upon the untested and perhaps untestable opposing views of Freud and Becker—that they are either incapable of experiencing death anxiety, or that death anxiety is the source of all fears. It is more useful to observe how their fears as well as their joys and enthusiasms are influenced by the interaction between cognitive development and social learning experiences. In this way people will be in a better position to help the next generation learn to identify actual threats to their lives while not overreacting to all possible alarms all the time (Kastenbaum, 1987, 2000). Trait anxiety is a general apprehension and restlessness. There is a situational death anxiety. Situations that often increase death anxiety include transitional situations such as divorce, exposure to death such as a neighbor or parent, and life-threatening illness (Kastenbaum, 2007).

- Wisdom: Ego integrity vs. despair

Developmental psychologist, Erik Erikson, formulated the psychosocial theory that explained people progress through a series of crises as they grow older. The theory also enveloped the concept that once individuals reach the latest stages of life, they reach the level

he titled as «ego integrity». Ego integrity is when one comes to terms with his or her life and accepts it. It was also suggested that when a person reaches the stage of late adulthood, he or she becomes involved in a thorough overview of his or her life to date. When one can find meaning or purpose in his or her life, he or she has reached the integrity stage. In opposition, when an individual views his or her life as a series of failed and missed opportunities, then he or she does not reach the ego integrity stage. Elders that have attained this stage of ego integrity are believed to exhibit less of an influence from death anxiety (Roshdieh, 1996; Langs, 2004).

In the eighth and final stage of Erikson's theory of psychosocial development, psychosocial conflict is integrity versus despair, major question is "Did I live a meaningful life?" Basic virtue is wisdom and important event is reflecting back on life. Dealing with task related to the eighth stage of life is as a part of critical developmental period. During this period of time, elders who feel proud of their accomplishments will feel an integrity sense, look back with few regrets and feel satisfaction. These elders will attain wisdom, even when they confront with death. Wisdom enables a person to look back on their life with a sense of closure and completeness, and also accept death without fear. Elders who are unsuccessful during this stage feel their life has been wasted, experience many regrets, do not confront with death, avoidant from death and exhibit more fear to death (Erikson, 1968; Bahrami, Dadfar, Lester, & Abdel-Khalek, 2014).

- Terror Management Theory (TMT)

One of the more recent theories on death, which developed in the late 20th century, is called the Terror Management Theory (TMT). This theory was proposed in 1986 by three social psychologists: Jeff Greenberg, Tom Pyszczynski, and Sheldon Solomon. According to Arndt and Vess (2008), the TMT is a "social psychological theory that draws from existential, psychodynamic, and evolutionary perspectives to understand the often potent influence that deeply rooted concerns about mortality can have on our sense of self and social behaviour". The theory is based upon the work of Ernest Becker, a cultural anthropologist, and it was inspired by the writings of him. Becker's (1973) existential view of death proposes that the human motivation to stay alive, coupled with the awareness that death can occur at any time, has the power to engender paralyzing fear of death. The TMT was initiated by two relatively simple questions: Why do people have such a great need to feel good about themselves?; and why do people have so much trouble getting along with those different from themselves? The TTM stated that people who feel better about themselves have less death-related anxiety. The TTM assumed that humans spend a great deal of psychological energy in their attempts to manage or deny their subconscious terror. The TTM may lead to cognitive construction of immortality through attaching ourselves psychologically to institutions, traditions, or symbols. When these constructs are threatened, people resort to anger and violence to bolster their sense of security and protect their illusion of immortality. According to the TMT, human possess a dual process system that helps to prevent death-thoughts from turning into death fears. Specifically, the dual process model of the TMT proposes that when thoughts

about death are brought into focal attention, people immediately engage in efforts to remove these thoughts from focal attention. These initial efforts to counter a conscious awareness of mortality are referred to as proximal defenses and include strategies such as death-thought suppression and denial of vulnerability to mortality (Greenberg, et al., 1986, 2000; Pyszczynski et al., 1999). For example, when death cognitions are highly accessible people may rely upon health-relevant strategies that deny their vulnerability to death. These health-relevant denial strategies include both adaptive (e.g., increased health intentions; Arndt et al., 2003) and maladaptive (e.g., denial of vulnerability to health risk; Greenberg et al., 2000), and methods of coping that are often determined by individual differences (e.g., coping style, health optimism; Arndt et al., 2006). Importantly, regardless of how these distinct defenses impact physical health, they serve the psychological function of combating death cognition by removing death-thoughts from focal attention (Pyszczynski, et al., 1999; Abeyta, Juhl, & Routledge, 2014).

According to the TMT, cultural worldviews and self-esteem are thought to serve an important anxiety-buffering function in order to manage (or 'tranquilise') existential fear of death (Greenberg et al., 1992; Pyszczynski et al., 1999; Strachan et al., 2007; Hayes et al., 2010; Davis, Juhl, & Routledge, 2011; Routledge, 2012; Vail, Juhl, Arndt, et al., 2012). Cultural worldviews refer to shared symbolic conceptions of reality which are thought to provide a sense of permanence, order and meaning, such as believing in an afterlife or identifying with personal achievements and family (Greenberg, 2012; Strachan et al., 2007). On the other hand, self-esteem is garnered through the belief that one is meeting the standards and values of the cultural worldview. Research suggests that high or temporarily raised self-esteem, coupled with increased faith in one's worldview, allows an individual to function with minimal anxiety and defensiveness in response to threats (Greenberg, 2012; Greenberg et al., 1992). According to the TMT, people deal with the potential for anxiety that results from their knowledge of the inevitability of death by holding on to sources of value that exist within their cultural worldview (Zaleskiewicz, Gasiorowska, Kesebir, Luszczynska, & Pyszczynski, 2013). Mohammadi, Noori Moghadam, Shahsavarani, et al (2013) showed that there was a significant negative relationship between death anxiety and self-esteem, while there was no significant correlation between death anxiety and mental health, and the power of self-esteem in the prediction of death anxiety was more than mental health. Therefore, consistent with previous findings of the TTM, self-esteem is a strong correlated of death anxiety. According to the TMT, culture and personal self-esteem both serve as buffers against death anxiety (Vance, 2014: Dunn, Gallagher, & Mattews, 2015).

The TMT is based on studies finding that people who felt better about themselves also reported having less death-related anxiety. These data immediately suggested possibilities for preventing or reducing disturbingly high levels of death anxiety: Help people to develop strong self-esteem and they are less likely to be disabled by death anxiety. If self-esteem serves as a buffer against anxiety, might not society also be serving this function just as Becker had suggested? People seem to derive protection against death anxiety from worldview faith as well as from their own self-esteem. "Worldview faith" can be understood as religious

belief or some other conviction that human life is meaningful, as well as general confidence that society is just and caring (Pyszczynski, Greenberg, & Solomon, 2002; cited in Tomer, Eliason, & Wong, 2008).

In view of Bassett (2007), the TMT highlights the motivational impact of thoughts of death in various aspects of everyday life. The TMT emphasizes on defense against death anxiety as a key human motive. The TMT focuses extensively on self-esteem and cultural worldview. The TMT offers a strong base of experimentally validated ideas and the experimental paradigms to test the broad array of defenses enumerated in Firestone's Separation Theory (Bassett, 2007). The TMT hypothesized human beings unconsciously defend themselves in two ways: (a) Faith in an internalized cultural worldview, and (b) Self-esteem, which is attained by living up to the standards of value prescribed by one's worldview. The TMT emphasized on unconscious defense mechanisms against the terror of death, cultural worldview defense mechanism, self-esteem defense mechanism, no longer adequate in the face of impending death, need to accept our personal mortality, need to connect with the continuity of life, and need for symbolic immortality. Existential anxiety is an existential given, but the TMT is based on unconscious defense mechanisms against this anxiety rather than a rational decision to work towards death acceptance (Tomer, Eliason, & Wong, 2008).

Awareness of mortality and fear of death has been part of the human condition throughout recorded history (Eshbaugh, & Henninger, 2013; Furer, & Walker, 2008; Yalom, 2008). Themes of death and the wound of mortality have featured heavily in both ancient and modern art, literature, theater, philosophy, and psychology (Yalom, 2008; Menzies, 2012; Iverach, Menzies, & Menzies, 2014). The awareness of one's eventual death, also known as mortality salience or heightened death-thought accessibility, play an integral role in the TMT (Burke et al., 2010; Greenberg, 2012). In particular, efforts to cope with one's impermanence are considered to be at the root of human social behavior, and can precipitate the development of symbolic language, creation of art and music, attempts to transcend the human body, as well as strong defense and aggression against those with alternative worldviews (Shaver, & Mikulincer, 2012). Because humans typically rely on other people for social validation of their worldviews and self-esteem in order to obtain protection against anxiety, reminders of mortality can lead to favorable responding toward others who support one's worldview and self-esteem, and negative or even aggressive responding against those with opposing worldviews or who challenge the components of the anxiety-buffering system (Greenberg et al., 1997; McGregor et al., 1998). When an individual's view of his/her self and the world is threatened, he/she is likely to experience anxiety and defend against such threats in an attempt to regain psychological structure, maintain self-esteem, and uphold faith in their cultural worldview (Greenberg, 2012; Hayes et al., 2010).

The TMT provided a valuable framework for examining proximal and distal defenses against death anxiety (Abeyta et al., 2014; Burke et al., 2010; Hayes et al., 2010; Pyszczynski et al., 1999). In particular, a dual process model has been proposed whereby proximal and distal defenses are used to prevent death-related thoughts from becoming death fears. According to this dual process model, when death-related thoughts come into conscious

awareness, proximal (conscious, threat-focused) defenses are triggered in order to remove these thoughts from focal attention. These proximal defenses can include death-thought suppression and denial of vulnerability to mortality, and may include such strategies as maintaining optimum physical health for self or loved ones. However, when fear of death moves out of conscious awareness, the second part of the dual process model is activated, triggering distal (unconscious, and symbolic) defenses. These distal defenses typically include strategies to protect the symbolic self and to reduce the accessibility of death-related thoughts, such as upholding cultural worldviews, shared identities, and relationships that enhance self-worth, promote personal significance, and increase self-assurance that one will be remembered after death (Pyszczynski et al., 1999). This dual process model has been the focus of a substantial number of experimental studies, with evidence confirming the tendency for death-related thoughts to trigger defensive responding in order to reduce death fears (Abeyta et al., 2014; Burke et al., 2010; Greenberg, 2012; McGregor et al., 1998).

Conservatism stems from epistemic and existential needs of the individual, and notably the fear of death. The TMT proposed a view of conservatism and its contrary, liberalism, as equivalent cultural worldviews, equally fit to fulfill such needs (Castano, Leidner, Bonacossa, et al., 2011). The TMT is the leading, and most influential, theoretical approach to death anxiety (for a comprehensive overview) (Greenberg, 2012). The TMT has generated extensive research into death anxiety (Iverach, Menzies, & Menzies, 2014).

- Separation Theory

Robert. W. Firestone (1984, 1987, 1993) developed Separation Theory that aims to make sense of death anxiety and its impact on the human condition. Bassett (2007) proposed that an integration of the TMT and Firestone's Separation Theory would be beneficial to a fuller understanding of psychological defenses against death anxiety. Both theories emphasized on defense against death anxiety as a key human motive. Whereas the TMT focused extensively on self-esteem and cultural worldview, firestone posited additional defenses such as gene survival, self-nourishing behaviors, addictive couple bonds, and adopting an anti-sexual approach to life. The TMT offered a strong base of experimentally validated ideas and the experimental paradigms to test the broad array of defenses enumerated in Firestone's Separation Theory. Both theories explained the interplay between death thoughts, death terror, and the modes by which such fears are mitigated. In particular, these theories offered evidence for the relationship between death and close relationships (Bassett, 2007). Two studies demonstrated that attachment serves as the primary psychological mitigation of death concerns. When our most valuable relationships are threatened, thoughts of our own death increase. In an effort to deny the onslaught of mortality concerns, people rush to defend and maintain the threatened relationship or use a past object relationship (transference) in order to repress death anxiety. This fantasized relationship from the past, used during *mortality salient situation,* a situation which increases awareness of our mortality, is called the fantasy bond (Mikulincer, Florian, Birnbaum, & Malishkevich, 2002; Mikulincer, Florian, & Hirschberger, 2003).

- Death and Adjustment Hypotheses (DAH)

Death and Adjustment Hypotheses (DAH), has postulated by Mohammad Samir Hossain**,** faculty at Bangabandhu Sheikh Mujib Medical University and Medical College for Women and Hospital (Hossain, & Gilbert, 2010; Castano, et al., 2011). Hossain is a mental health researcher and physician who developed a death and adjustment hypothesis. He believed that death is not the end of existence and that we should abandon the focus of death as an endpoint, and instead think of death as a part of an ongoing process. With the declaration of the hypotheses, two things were postulated: 1) The first part of the hypotheses theorizes that death should not be considered the end of existence, 2) The next segment states the belief that the immortal pattern of human existence can only be adopted in a morally rich life with the attitude towards morality and materialism balanced mutually (Roshdieh, 1996; Langs, 2004; Siddique, 2009). The DAH hypothesized the following for optimum attitude towards death as well as to harmonize the adjustment problems in relation to the phenomenon: 1) In the absence of empirical evidence from science, to regard death to be not our absolute end seems natural and is an epistemologically sound point of view. Therefore, it is also more useful practically and for our adjustment to the phenomenon, 2) Changing our materialistic view to a moral one on life can help eradicate the social denial of death through the establishment of a sound concept of the phenomenon at personal and societal level, which should also potentate our adjustment to the phenomenon (Hossain, 2010). Although death is the inevitable end of life, human beings struggle to integrate death as a personal reality. A fuller understanding of death as a phenomenon could mitigate the pervasive contemporary tendency toward its denial, and promote better adjustment to this ultimate reality, on both personal and societal levels (Hossain, & Gilbert, 2010).

- Being, time, and Dasein

Martin Heidegger, the German philosopher, on the one hand showed death as something conclusively determined, in the sense that it is inevitable for every human being, while on the other hand, it unmasks its indeterminate nature via the truth that one never knows when or how death is going to come. Understanding Heidegger's philosophy of death hinges upon understanding the following key terms, phrases and distinctions: (1) Being at-an-end/ Being-towards-the-end; (2) Ownmost, non-relational, and not to be outstripped; (3) They-self/ authentic self, falling/fleeing in the face of death, anxiety/fear, potentiality-for-Being: authentic/inauthentic; (4) Inauthentic -Being-towards-death/authentic-Being-towards death; and (5) Freedom towards' death. For Heidegger death is a phenomenon of life that reveals the way in which a human being exists and what it means to be. He interprets death as a meaningful possibility by showing that death is an existential awareness of possible not-being (Magrini, 2006). Heidegger did not engage in speculation about whether being after death is possible. He argued that all human existence is embedded in time: Past, present, future, and when considering the future, we encounter the notion of death. This then creates angst. Angst can create a clear understanding in one that death is a possible mode of existence, which Heidegger described as "clearing". Thus, angst can lead to a freedom about existence, but

only if we can stop denying our mortality (as expressed in Heidegger's terminology as "stop denying being-for-death") (Hossain, & Gilbert, 2010).

- Meaning Management Theory (MMT)

Paul T. P. Wong's work on the Meaning Management Theory (MMT) indicated that human reactions to death are complex, multifaceted and dynamic (Hossain, & Gilbert, 2010). His "Death Attitude Profile" identified three types of death acceptances as Neutral, Approach and Escape acceptances. Neutral acceptance is facing with death rationally as an inevitable end of every life. It is a rational and scientific approach to accepting death as part of the biological process. There is no afterlife, but there is a symbolic immortality. Creative and significant contributions make life worth living. Meaningful relationships reduce death anxiety. Approach acceptance is accepting death as a gateway to a better afterlife; beliefe in the God and an afterlife; the Heaven is a better place than this world; readiness to let go things of this world and recognition of the spiritual connection with a transcendental reality. Hope is in sharing spiritual life with loved ones for all eternity. Escape acceptance is choosing death as a better alternative to a painful existence. Life is unbearable; death is a better alternative. Death sets us free from pain and suffering. Death seems to be the only way out of a terrible mess. No more quality of life, no meaning for continued existence (Gesser, et al., 1988; Wong, Reker, & Gesser, 1994). Wong (2008) emphasized on the two fundamental, interconnected psychological tasks of living well and dying well as managing death anxiety (i.e., protecting against the terrors of loss and death) and managing death acceptance (i.e., pursuing a life of meaning). Death attitudes are important variables to consider in research and in patient care when facilitating communication about end-of-life care preferences. Past research has focused on death anxiety, fear, avoidance and acceptance (Wong, & Tomer, 2011).

Apart from acceptances, Wong's work also represented different aspects of the meaning of death fear that are rooted in the bases of death anxiety. The ten meanings he proposed are finality, uncertainty, annihilation, ultimate loss, life flow disruption, leaving the loved ones, pain and loneliness, prematurity and violence of death, failure of life work completion, and judgment and retribution centered. Ten pathways to death acceptance through meaning management: 1) Attitudinal: Maintain a courageous and hopeful stance, 2) Experience: Receive and appreciate beauty and love, 3) Creative: Give ourselves to creative work, 4) Generative: Give ourselves to future generations, 5) Relational: Maintain connections and repair relationships, 6) Narrative: Construct meaning through stories and narratives, 7) Symbolic: Enrich life with rituals, images, and poetry, 8) Spiritual: Practice and internalize religion/spirituality, 9) Nature: Become attuned to the rhythms of nature, and 10) Internal: Develop an inner sanctuary.

The MMT is a psychological model that deals with the important issue of specifying mechanisms that may allow individuals to accept death by infusing meaning into their life (Tomer, Eliason, & Wong, 2008). Meaning management refers to how we manage meaning-seeking, meaning-making, and meaning reconstruction in order to survive and flourish.

Meaning management focuses on acceptance and self-regulation of our inner life (e.g., consciousness and intentionality). Managing of meaning seeking consider as a motivation and core value. Manage of meaning-making regards to the content of one's life meaning. Managing of meaning-reconstruction is as a way of coping (re-appraisal and re-storying). There are three levels of Self-Transcendence: 1) Mindful awareness–situational meaning (Transcends defense mechanisms), 2) Setting life goals-mission or calling (Transcends egotistic desires), and 3) Choosing core values–ultimate meaning (Transcends material world). Level 1: Seeking situational meaning is to reach beyond our mental and situational constraints and connect with our spiritual values. This involves being mindful of the present moment with an attitude of openness, curiosity, and compassion. Level 2: Seeking one's calling is to reach beyond self-actualization and pursue a higher purpose for the greater good. It involves engagement and striving to achieve a concrete meaning in life. It involves a life goal of contributing something of value to others. It often has a transcendental origin. Level 3: Seeking ultimate meaning is to reach beyond our physical limitations. It is beyond our comprehension. We can only gain a glimpse of the invisible glory of the transcendental realm. Only a purpose of Self-Transcendence leads to fulfillment and reduction of death fear. Meaning needs to be based on enduring values. According to Wong (1998), there are eight sources of meaning and the good life: 1) Achievement, 2) Acceptance, 3) Transcendence, 4) Intimacy, 5) Relationship, 6) Religion, 7) Fairness, and 8) Positive emotions. Managing is a balanced meaningful life. The TMT focuses on denial, whereas MMT focuses on acceptance (Tomer, Eliason, & Wong, 2008).

Other theories on death anxiety were introduced in the late part of the twentieth century (Langs, 2003).

- The existential approach

The existential approach, with theorists such as Rollo May and Victor Frankel, views an individual's personality as being governed by the continuous choices and decisions in relation to the realities of life and death **(**Schacter, 2011).

Zaleskiewicz, Gasiorowska, and Kesebir (2013), with the main goal to show that saving behavior can similarly serve symbolic psychological functions, tested the idea that saving money can buffer death anxiety and constitute a more effective buffer than spending money in four studies. In view of these researchers, saving can relieve future-related anxiety and provide people with a sense of control over their fate, thereby rendering death thoughts less threatening. In study 1 they found that participants primed with both saving and spending reported lower death fear than controls. Saving primes were associated with significantly lower death fear than spending primes. In study 2 they demonstrated that mortality primes increase the attractiveness of more frugal behaviors in save-or-spend dilemmas. In studies 3 and 4 they showed that in two different cultures (Polish and American), that the activation of death thoughts prompts people to allocate money to saving as opposed to spending. They provided evidence that saving protects from existential anxiety, and probably more so than spending.

Existential social psychology studies showed that awareness of one's eventual death profoundly influences human cognition and behavior by inducing defensive reactions against end-of-life related anxiety. Personality and demographics modulated psychophysical and neural changes related to mortality salience (MS) (Valentini, Koch, & Aglioti, 2014).

- Regret theory

Another fresh and popular theory or approach in the late 20th century is called the regret theory. This theory was proposed and introduced in 1996 by Adrian Tomer and Grafton Eliason. The main focus of the theory is to target the way people evaluate the quality and/or worth of their lives. The prospect and possibility of death usually makes people more anxious if they feel that they have not and cannot accomplish any positive task or something good in the life that they are living. Research has tried to unveil the factors that might influence the amount of anxiety people experience in life (Langs, 2003). People might torment themselves with regrets over past failures and missed opportunities or with thoughts of future accomplishments and experiences that will not be possible. Regret theory (similar in some respects to Robert Butler's life review approach) also has implications for anxiety reduction. People can reconsider their memories and expectations, for example, and also discover how to live more fully in the present moment (Butler, 1974; Tomer, 1994; Tomer, & Eliason, 1996).

- Personal meanings of death

All human drama is, to a great extent, a story of how human beings cope with the terror of death, and how they overcome death anxiety through a great variety of conscious efforts and unconscious defense mechanisms. How persons view death and how they cope with death anxiety can profoundly affect every aspect of their lives- either positively or negatively. This proposed that meaning management is more adaptive than terror management in dealing with death anxiety. Meaning management fits under the umbrella of positive psychology which is about how to live well and die well. Such wisdom and courage can only be acquired through accepting death and understanding its meanings. Ultimately, meaning management may be the only effective psychological model that protects us against loss and death.

Humans develop meanings and associate them with objects and events in their environment, provoking certain emotions within an individual. People tend to develop personal meanings of death which could accordingly be negative or positive for the individual. If they are positive, then the consequences of those meanings can be comforting (for example, ideas of a rippling effect (Yalom, 2008) left on those still alive). If negative, they can cause emotional turmoil. Depending on the certain meaning one has associated with death, the consequences will vary accordingly whether they are negative or positive meanings (Cicirelli, 1998).

- Death Anxiety Model (DAM)

Tomer and Eliason (1996, 2000) presented an integrative, comprehensive model of death anxiety. The model postulates three immediate antecedents of death anxiety: past-related

regret, future-related regret, and meaningfulness of death. Past-related regret refers to a person's unfulfilled aspirations that should have been achieved but were not. Future-related regret refers to the anticipation that, as a result of premature death, one cannot achieve important goals in the future. Meaningfulness of death refers to one's concept of death and ability to make sense of it. These three antecedents are related to death salience in a complex way, mediated by coping mechanisms and their effects on one's beliefs about self and the world. The coping mechanisms include (but are not necessarily limited to) life review, life planning, identification with culture, and self-transcending processes. Developmental and practical applications of this comprehensive model have explored (Chan, et al., 2010).

Correlates of death anxiety

Many studies on death anxiety have focused on examining gender differences, religious and spiritual influences, and aging (Hoelterhoff, & Chung, 2013). Agras, Sylvester, and Oliveau (1969) reported that 16% of people had fear of death. Kastebbaum (2000) reviewed studies on fear of death in general population and showed that fear of death is common in general population, women had higher fear of death than men, in cross sectional studies elders had no higher fear of death than youths, higher educational economic social levels were associated with lower fear of death, high level of religious beliefs and participation in religious activities were not associated with low level of fear of death. Pierce, Cohen, Chamber, and Meader (2007) reported that women high school and college students had higher fear of death than men. Duff and Hong (1995) revealed that persons with motivation of internal religious had lower death anxiety, and stronger belief to afterlife live was associated with lower death anxiety. Caring for the dying may trigger negative emotions such as unstable emotional equilibrium, emotional distress, grief and anguish, stress and anxiety. Death anxiety influencing factors include: demographic variables, such as age and gender, religiosity/spirituality, psychological factors, culture, environmental events, personal and professional experience, attitudes towards caring for the dying, and education (Scalpello Hammett, 2012). Studies have shown that females typically report higher death anxiety than males; higher education and socioeconomic status are moderately associated with lower death anxiety; older people do not typically report higher death anxiety than younger people; higher religious beliefs and practices are not necessarily associated with lower death anxiety; good physical health is associated with lower death anxiety; and more psychological problems are associated with higher levels of death anxiety (Abdel-Khalek, & Lester, 2009; Eshbaugh, Henninger, 2013; Iverach, Menzies, & Menzies, 2014). Although there are exceptions, it is possible to summarize the association between death anxiety and several demographic and experiential factors (Cartwright, 1991; Rasmussen, & Christiane, 1996; Madnawat, & Kachhawa, 2007; Harrawood, White, & Benshoff, 2008). Nienaber, and Goedereis (2015) investigated the association between level of education and self-reported levels of anxiety regarding death of self and others among college students. On the Multidimensional Fear of Death Scale (MFODS) and the Revised Death Anxiety Scale (RDAS), results showed that undergraduate students and graduate students did not differ on Fear of Being Destroyed,

but graduate students reported lower levels of death anxiety on all remaining measures. The thought of death causes a different degree of anxiety for different individuals, depending on many factors including education, religion, health, gender, age, culture, and psychosocial variables. Mortality salience increases death anxiety for individuals who lack meaning in life (Routledge, & Juhl, 2010), and for individuals low in personal need for structure (Routledge, Juhl, & Vess, 2012). Failure causes fear and self-esteem threat effects on death-anxiety (Routledge, Arndt, & Goldenberg, 2004; Routledge, Ostafin, Juhl, et al., 2010; Routledge. 2012). Abeyta, Juhl, and Routledge (2014) explored the effects of self-esteem and mortality salience on proximal and distally-measured death anxiety. Juhl and Routledge (2014) showed effects of trait self-esteem and death cognitions on worldview defence and search for meaning. McLennan, Bates, Johnson, et al (1993), and McLennan, Stewart, Pollars, et al (1997) used metaphors to assess anticipatory perceptions of personal death.

- Religiosity/spirituality

The relationship between death anxiety and religious belief seems to be too complex to provide a simple pattern of findings. Chaggaris, and Lester (1989) reported that scores on the four fear subscales of the CLFDS were not related to belief in God, an afterlife, or the subject would go to heaven, to church attendance, or whether the subject considered himself to be a religious person. Fear of one's own of death was related to a fear of hell. There was no evidence for a strong association between fears of death and religious belief. Roshdieh, Templer, Cannon, et al (1998-1999) showed a relationship of death anxiety and death depression with religion and civilian war-related experiences in Iranians. Alvarado, Templer, Bresler, et al (1992, 1995) found that religious variables related to death depression and death anxiety. Death-related teachings differ, and believers may take different messages from the same basic doctrine. Historical studies also suggest that religious faith and practices seem to have sometimes reduced and sometimes increased death anxiety in death education (Becker, 2004). Kastenbaum (2007) reported that there are difficulties in interpreting death anxiety scales: it cannot interpret death anxiety out of context of religious, cultural, and personal beliefs, low scores do not mean low death anxiety or denial, no a normal score for death anxiety, level of death anxiety which is most adaptive and productive, participants' responses do not reflect the general population, a one-time sample of an individual's thoughts do not give an adequate indication of death anxiety, and researchers assume that individuals would behave in a way that is consistent with their attitudes towards death anxiety. On the Arabic Scale of Death Anxiety (ASDA), Lester, and Abdel-Khalek (2008) found that religiosity in a Muslim context and death anxiety were not associated. Abdel-Khalek, and Lester (2009) reported that there were not significantly correlated between death anxiety and intrinsic religious motivation, or religiosity and strength of religious belief. Religion was the predominant predictor in the understanding of death acceptance or attitude, but the influence of racial socialization and world view were also significant contributors. World view and religion were dominant predictors in the understanding of death anxiety and racial socialization was a significant contributor (Menyweather-Woods, 2008). The studies on

death have been performed based on the metaphysical and psychological meaning from the philosophical, cultural and religious aspects. It was also true that they were treated independently in each area with the direction of analyzing the meaning of death from the medical and social aspects (Kim, & Lee, 2009; Castano, Leidner, Bonacossa, et al., 2011). Dennis Yoshikawa, a Shin Buddhist, explained that according to Shin Buddhist teaching, "to solve the problem of death, one must first solve the problem of life, living life. If one is able to do that, to live a truly human life, then there's nothing to be feared by the experience of death, because the experience of death is a natural part of life (Moatamedi, 1988; Palmer, 1993). It has been shown through results of various studies that a strong sense of religion in a person's life can be related to a lower sense of anxiety towards the death. Although there has been no association discovered between religiosity and death anxiety, it has also been shown that death anxiety tends to be lower in individuals who regularly attend religious meetings or gatherings (Wen, 2010). On a recent study, one hundred and sixty-five church participants have been asked to fill out the "Intrinsic Religious Motivation Scale, the Revised Death Anxiety Scale" and the results were analyzed using factor analyses, Pearson correlation, and linear and quadratic regression. All found an inverse relationship between intrinsic religious motivation and death anxiety. In short, the more religious you are, the less anxious you are about death because you may associate death with another beginning that is promised through many religions. The study also found that gender did not have an effect on religiosity and total death anxiety (Wen, 2010). Religiosity/spirituality is one of the dimensions of human health (Chi, 2004).

There are mechanisms that indicate religiosity and spirituality effect on mental health. Relationship between religious spiritual well-being and mental health was been shown in some studies (Ryu, 2007; Abdel-Khalek, & Lester, 2009; 2013, 2015; Abdel-Khalek, 2010, 2014; Song, 2010; Park, 2011; Bahrami, Dadfar, Unterrainer, et al., 2015). Lester (2000) showed that cultural and religious context impacted on the effectiveness of learning about suicide risk. Lester (2012) reported that religiosity and spirituality were positively associated with depression, mania, and past suicidal ideation. Spirituality and religiosity are predictors of depression and suicidal ideation (Colucci, & Lester, 2013). Kassa, Murugan, Zewdu, et al (2014) indicated that spiritual and medical conditions were highly taken into consideration while dealing with terminally ill patients. Some of studies have reported that religious attitudes toward death can be considered as a threat to mental health (Fritscher, 2010). Ellis, Wahab, and Ratnasingan (2013) found that religiosity is positively correlated with increase of death fear and meaning and more religious persons showed more fear from the death in the US, Turkey, and Malaysia. Démuthová (2013) showed that religiosity was not connected with the levels of fear of death. It seems that age is more important factor than religiosity. The thought of death causes a different degree of anxiety for different individuals, depending on many factors for example religion (Harding, Flannelly, Weaver, et al., 2005; Olianasab, 2010; Ellis, & Wahab, 2013). Religious attitudes are a preventive agent to reduce of problems related to death and dying issues. Religion is one of the spiritual intelligence domains that can reduce death anxiety in elders (Roshani, & Naderi, 2011). Findings have

shown that faith and believe to life after death is related to less fear of death. Persons, who were more religious, reported more less fear of death. In fact religious attitudes make persons overcome to their fear, feel more comfortable in their life and more cope with fact of death fear (Koenig, 2010; Zeng, Gu, & George, 2011; Hasan Zehi, 2012; Ellis, & Wahab, 2013). There is a relationship between religious orientation and issues related to death. Wen (2010) reported that there was a positive relationship between intrinsic religious motivation and frequency of religious service attendance and strength of belief. There was a linear and a quadratic relationship between death anxiety and intrinsic religious motivation. Ali Akbari Dehkordi, Oraki, and BarghiIrani (2011) reported that there was a negative correlation between internal religious orientations and death anxiety, and a significant positive solidarity between external religious orientations and death anxiety. There was a relationship between existential and religious variables to death depression (Harville, Stokes, Templer, et al., 2003-2004), and between religious orientation and death obsession (Maltby, & Day, 2000b). A negative association between having a Taoist orientation to life and death anxiety was found for American students but not in a Turkish students (Zeyrek, Lester, & Alpan, 2006). Ben Park, Zeyrek, and Lester (2007) showed associations for a measure of having a Taoist orientation to life with death anxiety and the perception that one's self is unified (versus fragmented) in Korean high school and Korean university students. Zeyrek, and Lester (2009) found Taoist orientation was not consistently associated with fear of death and dying. Beshai (2012) reviewed a book review of Abdel-Khalek's (2005) Arabic Handbook on "Death and Dying." This review extrapolated the Islamic ontology presented in 492 pages covering 56 empirical and 304 empirical studies published by a host of Arab, American and European psychologists and psychiatrists. The handbook presented an Islamic ontology on death anxiety for the first time to English readers. Freud's Judeo-Christian view of death anxiety was already familiar to readers of *Omega:Journal of Death and Dying.* But the Islamic ontology of death was relatively unknown even though it was relevant. This reviewer found the Islamic ontology of death to be similar to the Judeo-Christian one. Islam provided believers with assurance of God's mercy regardless of human vulnerability to evil. Death anxiety could be relieved by exercising moderation in relations with others. Quoting from the Qur'an, Abdel-Khalek (2005) made the claim that there was a judicious path to follow between daily distress and achieving social goals. The Arabic term to describe this path is *Surat-Mustakeem.* It came close to Aristotle's *Eudaimona* or happiness. Death Anxiety was neither negative nor positive in connotation. It was the ethical pursuit of a dialectic of truth and virtue. Death anxiety research showed a convergence between ontology and empirical research.

Some studies focused on relationship between religiosity and death anxiety for example (Lester, & Abdel-Khalek, 2008; Harrawood, 2009; Beshai, & Lester, 2013). Naderi and Roushani (2010) indicated that on the CLFDS, there was a significant correlation between spiritual intelligence and death anxiety. Spiritual intelligence was the only predicting variable for death anxiety. Mahboubi, Ghahramani, Shamohammadi, and Parazdeh (2014) reported that on the CLFDS, significant relationship between fear of death and spirituality

in hemodialysis patients. There was no significant correlation between fear of death and spiritual needs.

Ali Akbari Dehkordi, Oraki, Barghi Irani, and Kimia Kiarad (2011) reported that there was a negative correlation between the internal religious orientation and death anxiety and a positive and significant correlation between the external religious orientation and death anxiety. Mansurnejad, and Kajbaf (2012) showed that main effects of religious orientation on death anxiety were significant. The individuals with intrinsic religious orientation significantly reported lower levels of death anxiety than individuals with extrinsic religious orientation. Internal religious orientation seems to decrease death anxiety and is an important factor in mental health. In study of Campbell (2013), one of reason for fearing death was a non-existent or a terrible afterlife. Religious individuals may fear death more because they are afraid of the afterlife and the judgment that will be made about the way they lived their life. Beshai and Lester (2013) found that scores on a scale to measure the belief in a Day of Judgment were associated with scores on a traditional religiosity scale, but not with fears of death and dying. On the RDFS, Aflakseir (2014) reported that there was positive relationship between religiosity with reasons for death fear (Fear of Pain and Punishment, and Religious Transgression and Failures) in Iranian college students.

Azaiza, Ron, Shoham, and Tinsky-Roimi (2011) reported that religiosity was not related to death and dying anxiety. Ziapour, Dusti, and Abbasi Asfajir (2014) showed that there was no significant correlation between religious orientation and death anxiety in health personnel of Zare hospital staff in Iran.

- Health

The findings already mentioned come mostly from studies in which respondents in relatively good health reported on their own fears. Other studies and observations, though, give occasion for further reflection. There is evidence to suggest that people may be experiencing more anxiety than they are able to report. Even people who respond calmly to death-related words or images show agitation in breathing, heart rate, and reaction time, among other measures. Researchers Herman Feifel and B. Allen Branscomb therefore concluded in 1973 that everybody, in one way or another, is afraid of death. Presumably, people may have enough self-control to resist death -related anxiety on a conscious level but not necessarily to quell their underlying feelings of death anxiety (Corr, & Corr, 2013). Negative attitudes toward organ donation were associated with higher fears of the death and dying of the self and less strongly with higher fears of the death and dying of others (Lester, 2005). Wu, and Tang (2008) reported that death anxiety had negative impact on self-efficacy and willingness to donate organs.

Awareness of inevitable death and anxiety associated with death lead to different behaviors (Pyszczynski, Greenberg, & Solomon, 1997). On the one hand, they tend to increasing of health promoting behaviors and on the other hand they may adopt some behaviors that threaten their health (Arndt, Routledge, & Goldenberg, 2006). So the people affected death

anxiety, may address to health promoting behaviors or health threatening behaviors. Death anxiety is one of variables affected on the excessive and pathological applying or no applying of health promoting behaviors (Firestone, & Catlett, 2009). Ghorbanalipoor, Borjali, Sohrabi, and Falsafinejad (2010) reported that death anxiety is a determinant factor on the frequency of health promoting behaviors in young and older adults. People with high death anxiety reported more health promoting behaviors than people with low death anxiety. Lo, Hales, Zimmermann, et al (2011) revealed that dying and death-related distress was positively associated with depression and negatively associated with spiritual, emotional, physical, and functional well-being.

Some studies have focused on dead fear/anxiety in mental health problems. There is hardly a disease known to psychiatrist which does not contain the components of death anxiety. It plays an important role in depression, psychosomatic and severe other psychological mental disorder (Fiefel, 1977; Meyers, 1981). Fear of death is as being central to the psychopathology of schizophrenia (Kline, 1934; cited in Kaur, & Yadav, 2009). Recently there is a growing awareness that an individual approach to death is complex and anxiety can be expressed on different aspects of death anxiety (Kastenbaum, 1981). Some of the ambiguities in the results published so far may be because of the widely prevalent assumption of fear of death as a simple psychological phenomenon characterized by general anxiety about death. Several methods have been employed for the measurement of death anxiety, interviews, projective techniques, questionnaires and psycho physiological measure of anxiety. Research update has largely been confined to normal healthy individuals or those with physical illness and there is paucity of systematic studies on death anxiety in psychiatrically ill population. Fiefel (1995) explored death attitudes of 38 acutely distorted closed ward patients and 47 psychoneurotic patients, and found that the degree of mental disturbance per se in the patient had little affected on their overall attitude towards death. In other study manic depressive patients had higher score on Thakur and thakur's (1985) death anxiety scale than control group (Kaur, & Yadav, 2009). Krause, Rydall, Hales, et al (2015) reported that death anxiety was associated with less preparation for end of life, more generalized anxiety, and more depressive symptom severity. Individuals with major depression had greater death anxiety than the nondepressed as did individuals with minor depression.

Death anxiety has reported in mental disorders. Identify of fear of death among mental disorders provides a background for recognition and understanding of relationships between them and for development of more effective treatment planning for these disorders. Fear of death is a common anxiety disorder. Furer and Walker (2007) reported that patients with panic disorder experienced severe fear of dying as a consequence of panic attack. Furer and Walker (2008) reported that patients with hypochondriasis disorder had higher scores on the DAS than other groups on the subscales of Attitude to Death Scale including subscale of fear of death. Fear of death was very common in patients with anxiety disorders. There was high correlation between fear of death and hypochondriasis disorder, somatization disorder, and health anxiety. Patients with hypochondriasis disorder had higher scores on the DAS than other patients (Noyes, Stuart, Langbehn, et al., 2002; cited in Solaymannejad, 2010).

Starcevic (2005) reported that death was on the basis of an anxious anticipation about death in an unknown future in hypochondriasis disorder, and comorbidity of hypochondriasis disorder with fear of death was high. Fear of death in this disorder was very common. Death causes to loss of vital functions of body, so patients with hypochondriasis experienced fear from their inner and body. Major part of hypochondriasis was due to fear of death. Solaymannejad (2010) studied 121 Iranian patients with hypochondriasis and anxiety disorders out of patients referring to health care centers. Results indicated that patients with panic disorder, generalized anxiety disorder (GAD) and post traumatic stress disorder (PTSD) experienced fear of death but these symptoms are markedly less common than those with hypochondriasis on the DAS. Findings of the study will be helpful in terms of the conceptualization and treatment of hypochondriasis and anxiety disorders. Patients with panic disorder had higher scores on the DAS than patients with social phobia disorder and control group. Patients, who had comorbid panic disorder and hypochondriasis disorder, had higher scores on the DAS than other patients and control group (Furer, Walker, Chartier, and Stein, 1997; cited by Solaymannejad, 2010). Concern about death of self or death of others was a part of wide pattern in GAD. Patients, who had comorbidiity of GAD and hypochondriasis disorder, had higher scores on the DAS than others (Starcevic, Fallon, Uhlenhuth, et al., 1994; cited in Solaymannejad, 2010). There was a significant correlation between PTSD and death anxiety on the DAS (Chung, Chung, & Easthope, 2000; cited in Solaymannejad, 2010). Unresolved death-related fears may underlie neuroses and contribute to diminished psychological adaptation, although managing the reality of death and related concerns are also associated with heightened life meaning and authentic purposeful lives (Langs, 2003; Lehto & Therrien, 2010). A critical review of the literature revealed some interesting patterns such as most people report that they had a low to moderate level of death-related anxiety; people with mental and emotional disorders tend to have a higher level of death anxiety than the general population, and death anxiety can spike temporarily to a higher level for people who have been exposed to traumatic situations. Fear of death results from terrorizing life experiences such as the sudden death of a loved one or a bad automobile accident; anything that terrifies people and heightens their awareness death (Christin, 2011; cited in Scalpello Hammett, 2012). Increased death anxiety has been associated with increased depression among patients with depressive disorder (Ongider, & Eyuboglu, 2013), and similar findings have been reported among patients with advanced cancer or AIDS and their family caregivers (Sherman, Norman, & McSherrv, 2010), and people with HIV/AIDS (Miller, Lee, & Henderson, 2013). Otoom, Al-jishi, Montgomery, et al (2007) showed that the mean death anxiety score was moderate, with 26.09% of epileptic patients reporting high levels of death anxiety. Period of illness and educational level were significant predictors of death anxiety. Female patients, generalized type of epilepsy, the short duration of the illness and low level of education were associated with higher death anxiety. Santos, Figueiredo, Gomes, et al (2010) indicated a relationship between death anxiety and symbolic immortality in relatives at risk for familial amyloid polyneuropathy type I (FAP I, ATTR V30M). Ziapour, et al (2014) showed that there was a significant correlation between hospital personnel's happiness and death anxiety.

- Gender

Lester (1971c) reported that male students were more likely to think about death than were femals, but had less negative effective reaction to death. A widely cited early review by Polack (1980) concluded that most previous studies reported gender differences, with women consistently reporting greater death anxiety than men. Lester (1985) indicated that sex and masculinity/femininity scores had little relationship with attitudes toward death. Also sex did not account for the relationship between masculinity/femininity scores and attitudes toward death. In his commentary on death concern, Kastenbaum (2000) found the gender effect so consistent that, ''In lieu of impressive data to the contrary, it seems reasonable to conclude that the higher self reported death anxiety for women is a robust finding''. Results from Irish and Canadian students suggested that the effect generalizes beyond American culture (Lonetto Mercer, Fleming, et al., 1980). The gender differences require a second look. Both genders are often related to death anxiety. Females tend to report higher death anxiety than males. Although women tend to report higher levels of death-related anxiety, it is also women who provide most of the professional and volunteer services to terminally ill people and their families, and, again, it is mostly women who enroll in death education courses. Women are more open to death-related thoughts and feelings, and men are somewhat more concerned about keeping these thoughts and feelings in check. The relatively higher level of reported death anxiety among women perhaps contributes to empathy with dying and grieving people and the desire to help them cope with their ordeals (Peters, et al., 2013).

The greater concern about death reported by women may stem from the fact that they are most often the primary caretakers for the dying. Another explanation for gender differences in death anxiety invokes the concept of locus of control. In study of Sadowski, Davis, and Loftus-Vergari (1979) women were both more concerned about death and more externally controlled.

Findings of Suhail and Akram (2002), Abdel-Khalek (2005), Lester, Templer, and Abdel-Khalek (2007) indicated that women showed more death anxiety than men. In study of Abdel-Khalek (2005) there were statistically significant gender differences on the ASDA in which females attained higher mean scores than their male counterparts in the three categories: Egyptian normal participants (non-clinical), anxiety disorder patients, and patients suffering from schizophrenia-as well as the total group of males versus females. Abdel-Khalek (2007) declared that relation between love of life and death distress scales were not significant, except death depression and one pertaining to love of life that was negative in women. Chuin and Choo (2010) reported that women subjects had lower death anxiety. Women tended to report somewhat higher levels of death-related anxiety (Christin, 2011; cited in Scalpello Hammett, 2012). Women possessed higher levels of death anxiety. Social desirability related to gender may influence death anxiety. Females are considered more emotional and empathic (Scalpello Hammett, 2012).

Ali Akbari Dehkordi, et al (2011) found that the internal religious orientation negatively and the external religious orientation positively has been predicted death anxiety in males

and females. Azaiza, et al (2011) showed that bereaved elderly Israeli mothers had higher death anxiety than bereaved elderly Israeli fathers, and religiosity was not related to death and dying anxiety. Mansurnejad, and Kajbaf (2012) reported that there was a significant relationship between gender and death anxiety and death anxiety in the females was higher than in the males. Thabet, Tawahina, Sarraj, and Vostanis (2013) indicated that on the ASDA, mean death anxiety in Palestinians female victims of war on Gaza was statistically significant higher compared to male. Mahboubi, et al (2014) reported that on the CLFDS, there was no difference between men and women about fear of death. On the RDFS, Aflakseir (2014) found that there was no difference in four components of the scale (Fear of Pain and Punishment, Religious Transgression, Fear of Losing Worldly Involvements, and Parting from Loved Ones) between male and female college students. This result is similar to finding of Abdel-Khalek (2002), reported that no gender-differences were detected with Arabic and Muslim college students. In study of Bahrami, et al (2014), on the DAS, DDS, and DOS, Iranian women older adults showed higher death distress than men older adults but the difference was no statistically significant. Ziapour, et al (2014) reported that on the DAS, there was a difference between the death anxiety in males and females, and female staff of hospital had more death anxiety than the male staff.

- Age

One of the undeniable facts in aging is coming to true of death (Démuthová, 2014). Bahrami, et al (2014) stated that one of the important domains of elderly health is psychological dimension which requires to special attention. In aging, the source of anxiety and stress is different from other life stages. The origin of these psychological factors is focused on the anxiety of lack of change and compensation in the life and death distress. Elders reviewing of their life experiences and memories conclude that there is no chance to compensate of their mistakes. Therefore, distress of death can concern them and also it can interfere in health care of elders. The relationship between age and death anxiety is also rather complex (Depaola, Griffin, Young, & Neimeyer, 2003). A negative relationship is often seen between age and death anxiety such as younger populations (primarily high school and college). Adolescents may at the same time harbor a sense of immortality and experience a sense of vulnerability and incipient terror, but also enjoy transforming death-related anxiety into risky death-defying activities. What people fear most about death often changes with age? Young adults are often mostly concerned about dying too soon-before they have had the chance to do and experience all they have hoped for in life. Adult parents are often more likely to worry about the effect of their possible deaths upon other family members. Elderly adults often express concern about living “too long” and therefore becoming a burden on others and useless to themselves. Furthermore, the fear of dying alone or among strangers is often more intense than the fear of life coming to an end. Knowing a person’s general level of anxiety, then, does not necessarily identify what it is that most disturbs a person about the prospect of death (Bahrami, et al., 2014).

There was a relationship between religious, death concern, and attitudes toward death (Otto, 1963). Elderly with sound emotional health, married and with more number of children received lower death anxiety scores. Elders who perceived time as slow and those who lived in institutions tends to feel more anxious about death. Elderly with satisfactory family-ties and more life satisfaction received less death anxiety scores (Baum, & Boxely, 1984). After going through all the ways also accepting death gives great anxiety and fear to the elderly people. Each individual varies from one another. People afflicted with death anxiety may spend a large amount of time obsessing over death or trying to avoid talking about death. Death anxiety becomes a problem when it stands in the way of experiencing life. How people live foreshadows how they die. When people live a meaningful life, they will leave a meaningful life. If they can answer these questions affirmatively, then they know how to live and die well. Have they lived the life they have always wanted to live? Have they lived a life that is worth living? Do they have the faith to embrace death with joy and hope? (Berk, 2007). Sarvandian and Hassanpor (2003) found a relation between loneliness and fear of death among aged residents of care facility residency. Paimanfar, Ali Akbari Dehkordi, and Mohammadi (2013) found that elderly who had stronger faith and religious attitude, reported a more sense of meaning in life, also less feel of lonely compare to other older adults.

Daniel Levinson has said that the developmental task for the stage of late adulthood is to come to terms with life's end. Erik Erikson stated that in this stage some people may become depressed or preoccupied with death. Lower ego integrity, more physical problems, and more psychological problems are predictive of higher levels of death anxiety in elderly people (Fortner, & Neimeyer, 1999). An American surgeon has made the point that death in old age is often a protracted affair, rather than a clear-cut process that can allow patients and those bereaved to go through the classic stages (Nuland, 1994).

Tang, Wu, and Yan (2002) reported that younger Chinese college students as compared with older participants and women as compared with men tended to be more death anxious. Those with low levels of self-efficacy and external health control orientations were more likely to report a high level of death anxiety. Suh (1987) reported that there was a relationship between death anxiety and life satisfaction, locus of control, in Korean and American older adults. Kim, and Min (2005) showed that gender and personality influence on fear of death and death acceptance among young adults. Maxfield, Pyszczynski, Kluck, Cox, et al (2007) indicated that elders used lower defense mechanisms to death compare to young.

There is no consistent increase in death anxiety with advancing adult age. If anything, older people in general seem to have less death anxiety (Christin, 2011; cited in Scalpello Hammett, 2012). Azaiza, et al (2011) reported bereaved elderly Israeli parents had significantly higher dying anxiety scores than nonbereaved parents, but there were no significant differences between the 2 groups in death anxiety. Death anxiety and age are negatively correlated, however, it is sustained that the influencing factor is psychosocial maturity rather than age (Scalpello Hammett, 2012). Ghorbanalipoor, et al (2010) indicated that young adults with death anxiety compared to older adults with death anxiety showed high rate of health promoting behaviors. Naderi and Roushani (2010) found that on the

CLFDS, there was no significant correlation between social intelligence and death anxiety in elder women. Rasquinha, and Acharya (2013) reported that there was a relationship between depression and death anxiety among elderly. Lyke (2013) reported that search for meaning in life was significantly associated with fear of dying and death in young adults. Sridevi and Swathi (2014) showed that 47.5% elders had mild death anxiety and 52.5% had moderate level of death anxiety in both institutionalized and non-institutionalized elders. The institutionalized elders had significant death depression than non-institutionalized elders but there was no significant difference in death anxiety among institutionalized and non-institutionalized elders. There was no significant difference in death anxiety and death depression among institutionalized elders based on gender but non-institutionalized male elders had significant death anxiety than female elders. The single elders had significant death depression than coupled elders. There was no significant difference between death anxiety and death depression based on age, SES, educational background of the elders and rural elders are showed significant death depression than urban elders. There was correlation between death anxiety, death depression and geriatric depression.

Bahrami, et al (2014) reported that Iranian older adults showed death distress on the DAS, DDS, and DOS. There was correlation between death anxiety, death depression and geriatric depression; and no significant difference between death anxiety, death depression, geriatric depression and suicidal ideation based on age of the elders (Sridevi, 2014a; Sridevi, 2014b; Sridevi, 2014c; Sridevi, & Swathi, 2014). The study of Nouhi, Karimi, & Iranmanesh (2014) showed that fear of death in the elderly group settled in city houses was higher than elderly settled in the elderly's home. Death anxiety is related to the threat of non-existence and to fears from an unknown afterlife, and this anxiety can lead to ageism, a prejudice or discrimination on the basis of a person's age (Bodner, Shrira, Bergman, et al., 2015). Garbay, Gay, and Claxton-Oldfield (2015) found that there were no significant differences in levels of death anxiety or empathy between France hospice volunteers, non-hospice volunteers and non-volunteers.

Çelik, Ünsal and Çağan (2014) reported that school of health students who were under the age of 20 had higher levels of death anxiety on the DAS. Students who had experience in dealing with the dying patients and their relatives as to be afraid to see a dying patient, cannot say the right things to relieved the patients' relatives, not want to care to the dying patient, not to see while preparing for the discharge died, afraid of dead body had higher levels of death anxiety. On the CLFDS, fear of death average scores differences were not significant in age groups of college students (Mahboubi, et al., 2014).

- Culture

Death anxiety is culturally shaped, since culture establishes a composite of different meanings and beliefs towards death. Lester, Templer, and Abdel-Khalek (2007), in a cross-cultural comparison of death anxiety, reported that there were strong sex differences in death anxiety and an association between the DAS scores of men and women. Death anxiety is subjective to the respective cultures (Scalpello Hammett, 2012). Braun (2010) using

Frommelt Attitude Toward Care of the Dying Scale (FATCOD), and Death Attitude Profile-Revised (DAP-R) revealed that culture and religion may be key to attitudes toward death.

There are cultural differences about attitudes toward death and dying among nurses. For example, Turkish nurses are found to have more negative attitudes toward death and the caring of dying patients than nurses in other cultures (Cevik, & Kav, 2013). Several studies have shown that when death awareness and its associated anxiety are increased, individuals respond by defending and/or intensifying their cultural beliefs (Sridevi, 2014a; Sridevi, & Swathi, 2014; Sridevi, 2014b).

Anxiety levels

The fact that most people report themselves as having a low to moderate level of death anxiety did not offer support for either Freud's psychoanalytic or Becker's existential theory. Respondents do not seem to be in the grips of intense anxiety, but neither do they deny having any death related fears. Kastenbaum's Edge theory offered a different way of looking at this finding. According to the theory, most people do not have a need to go through life either denying the reality of death or in a high state of alarm. Either of these extremes would actually interfere with one's ability both to enjoy life and cope with the possibility of danger. The everyday baseline of low to moderate anxiety keeps people alert enough to scan for potential threats to their own lives or the lives of other people. At the perceived moment of danger, people feel themselves to be on the edge between life and death, an instant away from catastrophe. The anxiety surge is part of a person's emergency response and takes priority over whatever else the person may have been doing. People are therefore not "in denial" when, in safe circumstances, they report themselves to have a low level of death anxiety. The anxiety switches on when their vigilance tells them that a life is on the edge of annihilation.

Types of death anxiety

Langs (2004) distinguished three types of death anxiety: 1) Predatory death anxiety, 2) Predation or predator death anxiety, and 3) Existential death anxiety.

- Predatory death anxiety

Predatory death anxiety arises from the fear of being harmed (Langs, 2004). It is the most basic and oldest form of death anxiety, with its origins stemming from the first unicellular organisms' set of adaptive resources. Unicellular organisms have receptors that have evolved to react to external dangers and they also have self-protective, responsive mechanisms made to guarantee survival in the face of chemical and physical forms of attack or danger. In humans, this form of death anxiety is evoked by a variety of danger situations that put the recipient at risk or threatens his or her survival. These traumas may be psychological and/or physical. Predatory death anxieties mobilize an individual's adaptive resources and lead to fight or flight, active efforts to combat the danger or attempts to escape the threatening situation (Bonacossa, & Humphrey, 2011).

- Predation or predator death anxiety

Predation or predator death anxiety is a form of death anxiety that arises from an individual physically and/or mentally harming another. This form of death anxiety is often accompanied by unconscious guilt (Langs, 1997). This guilt, in turn, motivates and encourages a variety of self made decisions and actions by the perpetrator of harm to others (Hilgendorf, 1996).

- Existential death anxiety

Existential death anxiety is the basic knowledge and awareness that natural life must end. It is said that existential death anxiety directly correlates to language; that is, language has created the basis for this type of death anxiety through communicative and behavioral changes (Langs, 1997). Existential death anxiety is known to be the most powerful form. There is an awareness of the distinction between self and others, a full sense of personal identity, and the ability to anticipate the future. Humans defend against this type of death anxiety through denial, which is effected through a wide range of mental mechanisms and physical actions many of which also go unrecognized. While limited use of denial tends to be adaptive, its use is usually excessive and proves to be costly emotionally (Sterling, 1985). Human beings alone are burdened with the cognitive capacity to be aware of their own inevitable mortality and to fear what may come afterwards. Furthermore, their capacity of human to reflect on the meaning of life and death creates additional existential anxiety (Wong, 2008). The existential fear of death, the fear of not existing, is the hardest to conquer. Most defensive structures, such as the denial of reality, rationalization, insulation erected to ward off religiously conditioned separation-abandonment fears, do not lend themselves readily as protective barriers against the existential fear of death, There is no reversal, no remedy, no more tomorrow. Therefore, death signifies the cessation of all hope with respect to this world. Socrates has made the case since people really don't know what will happen, they should not fear. But uncertainty coupled with finality can create a potential for terror. When death occurs, people are forced to lose everything they have ever valued. Those with the strongest attachments towards things of this word are likely to fear death most. Loss of control over affairs in the world and loss of the ability to care for dependents also contribute to death anxiety. Interviews with eminent artists and scientists, many people are more afraid of a meaningless existence than death itself; their fear of death stems from fear of not being able to complete their mission or calling in life (Goodman, 1981).

Anxiety and comfort Near the End of Life

What of anxiety when people are nearing the end of their lives, when death is no longer a distant prospect? The emergence of hospice programs and the palliative care movement is stimulating increased attention to the emotional, social, and spiritual needs of dying people. Signs of anxiety are more likely to be recognized and measures taken to help the patient feel at ease. These signs include trembling, restlessness, sweating, rapid heartbeat, difficulty sleeping, and irritability. Health care professionals can reduce the anxiety of terminally ill people by providing accurate and reassuring information using relaxation techniques, and

making use of anxiolytics or antidepressants. Reducing the anxiety of terminally ill people requires more than technical expertise on the part of physicians and nurses. They must also face the challenge of coping with their own anxieties so that their interactions with patients and family provide comfort rather than another source of stress. Family and friends can help to relieve anxiety (including their own) by communicating well with the terminally ill person. Near-death experiences (NDEs) are situations in which individuals feel their death is imminent as a result of an accident, a near-accident, a medical condition, or some other events. Near-death experiences often have a salutary effect by reducing negative feelings and increasing positive feelings about death (Lang, Greyson, & Houran, 2004). NDEs are multi-dimensional (Lester, 2000; Sabom, 1982) and there were four independent clusters of elements to the experience and personal and circumstance-related variables necessarily influence major elements of the NDEs, such as transcendental environment, life review, subjective sense of death and sense of bodily separation (Lester, 2000).

Theory of death obsession

Abdel-Khalek (1998) was introduced concept of death obsession. His underlying rationale for the design of this concept was presence a mutual and overlap relationship between death and obsession, that is, component of death in obsession, and death is a possible issue in death obsession. Abdel-Khalek (2011-2012) stated that death distress included death anxiety, death depression, and death obsession.

Many obsessive compulsive tendencies are semantically linked with death-related concerns about self or loved ones for example germs, disease, and danger (Strachan et al., 2007). In line with this, Strachan et al (2007) have provided strong evidence that reminders of death are capable of intensifying compulsive behaviors. In their experimental study, patients who scored high on compulsive hand washing were found to spend more time washing their hands, and used more paper towel to dry their hands, following mortality salience induction, than patients scoring low on compulsive hand washing. This suggests that mortality salience may be a general factor in the experience of obsessive compulsive disorder (OCD), and may in some way explain the exaggerated focus that individuals with OCD place on the elimination of germs, disease, and danger (Strachan, et al., 2007).

Theory of death depression

Erikson believed that in the last stage of life, persons who are lack a coherent sense of self, they consider themselves as failed and despaired (Berk, 2007). Kobler-Ross (1969) identified five stages in reaction toward death: Shock and denial, anger, bargaining, depression and acceptance. Depression is associated with death, and is the fourth stage in the process of dying (Kobler–Ross, 1969).

Depressive disorders may be associated with, or exacerbated by, existential despair and lack of meaning (Ghaemi, 2007; Havens, & Ghaemi, 2005; Simon, et al., 1998). Depressed individuals may respond to reminders of death with more worldview defense than non-depressed individuals, confirming that depression may be associated with less buffering

against mortality concerns (Simon, Greenberg, Harmon-Jones, et al., 1996). Experimental research has shown that mildly depressed individuals demonstrated greater worldview defense in response to reminders of death, when compared to non-depressed individuals (Simon, et al., 1996).

Death education

- Psychology and death education

When the people are experiencing a need to find independence, as well as to find relation intimacy, they will be shocked by an encounter with the finality of death, and not only have nowhere to turn, but also have no background on which they might ground their feelings and find the help they need in order to cope. Science and technology have greatly changed the way death-related issues are perceived in the world. The people are searching for answers – trying to find one's way in life, which includes death. It is really about making meaning for life which includes death. Making meaning in the life of the people is critically important. Some people will determine that their meaning does not lie in any religious idea. Some will look for meaning in the "facts" of science, but others will say that meaning lies elsewhere. For instance, Godsey (2005) believed that "our sense of the meaning of life we must gain from our own choices". By this, he referred to the way human beings treat one another. Meaning, then, is built through relationship. This idea is not uncommon. Both Moller (2000) and Elias (2001) shared a similar view of life's meaning; only the understanding of how this meaning is constituted for them varies. Meaning of life means for people a life continuous or a life that ceases entirely once it ceases biologically. It is about living. This is why people are so insistent that death is a part of life. Meaning is to be found in the entire life-cycle. It may be that life's meaning will be found in relationship to others, whether one is religious or atheistic. It may be that life's meaning will be found in one's work, or in education, or in one's daily play. For some, life may only have meaning if it is seen from an existentially significant position. The entire point is to help the people reflect upon the possibilities and make deep inner connections that give meaning to all facets of their life (Ruffin, 2011).

Edgar and Howard-Hamilton (1994**)** suggested that the adolescent has, by age ten or eleven, "completed the cognitive developmental stages necessary to accept the elements of a mature definition of death." This rather broad statement, encompassing both intellect and emotion, is based on the idea that the ability to think abstractly makes one ready to deal with death. All people are capable of handling death on a psychological level, as long as it is communicated in an age-appropriate and supportive manner. It is suggested a need for death and dying communication if people are to "accept" the definition of death, and a need to help people get information and understand as much as is possible what happens to them and their loved ones at the time of dying and death. For example, while individuals are capable of abstract and logical thought, they are also prone to emotional misunderstandings and a lack of self-control. This makes it all the more necessary to give people the tools they need to cope with loss. Elias (2001) contended that a tendency toward self-isolating behavior is socially

born and applies to all people, whether dying or mourning. The emotionally immature brain of the adolescent, then, adds to the discomfort of the teen's experience as compared to the child or the adult. The child is also emotionally immature, but the child is also not yet capable of the abstract and deeply reflective thought that might contribute to the serious nature of the death experience. Conversely, the adult has both the cognitive and the emotional maturity with which to cope with the experience of death, or so it is hoped (Ruffin, 2011).

- History of death education

Death education is at the heart of thanatology (Sofka, et al., 2012). It is an interdisciplinary and multidisciplinary approach (Meagher, & Balk, 2013). In 1950s Herman Feifel presented a paper on "*Death and Behavior*" for the 1956 Annual Meeting of the American Psychological Association (Wass, 2004). In 1959, Feifel published *The Meaning of Death*, in which he basically suggested that in broad terms the conversations surrounding death and dying (what would come to be called the "death awareness movement") had an educational tone. Feifel suggested that death education is for everyone. Death education arose along an academic interest in death in the mid-1950s, specifically with Herman Feifel's 1959 book, *The Meaning of Death*. Cicely Saunders (1967) encouraged behavioral scientists, clinicians, and humanists to pay attention and to study death-related topics. V. R. Pine (1977) identified three periods in the history of death education: exploration (1928-1957), development (1958-1967), and popularity (1967-1977). It is probably reasonable to assume that death education is still in the popularity period. Pine said that the three periods can be future divided into pure and applied approaches. Applied death education refers to an interest in the management of dying or adjustment following bereavement. The work of Elizabeth Kubler-Ross exemplifies the applied interest approach, By contrast, the pure approach involves educating people about attitudes toward death, understanding grief and mourning, euthanasia and suicide, the effect of parental death on children, and the meaning of one's own death. Thirty years ago, in the scope of death education (1977), Daniel Leviton identified the goals of death education and defined death education as a developmental process in which death-related knowledge and the implications resulting from that knowledge are transmitted. He identified the following goals of death education: primary prevention (preparing individuals for eventual death events), intervention (helping people face personal aspects of death), and rehabilitation (understanding and learning from death-related crises). More specific goals included promoting comfortable interactions with dying, removing taboos, and reducing anxiety. In his article, "death education: an outline and some critical observations", Wiliam Warren (1981) suggested, from having read syllabi and course aids used in death education courses, that the expressed goals of the courses were incorporated to defuse death of the "socially disruptive consequences that might flow from the acceptance of personal mortality". Sometimes, though, according to Simone de Beauvoir (1964), the goal of death education is to create anxiety rather than to reduce it (Dennis, 2008).

Durlak (1994) stated that the first formal death education programs started in the USA in the 1950s and were influenced by the work of several noted thantalogists (Richard Kalish,

Robert Kastenbaum, Elizabeth Kubler-Ross, Herman Feifel, Earl Grollman, and Edwin Shneidman). Death education practices proliferated in the 1960s (Neimeyer, 1994). As above mentioned, in the 1960s, death education led to more scientific studies, after one of the first multidisciplinary texts on thanatology, and one of the best-known books in the field, *The Meaning of Death*, was published by Herman Feifel in 1959. He broke the prevailing taboo on doing a scientific study of death and dying, and his work aroused public attention and transformed people's perceptions of death and dying. Feifel pioneered the scientific study of attitudes toward death and pointed to the multidisciplinary nature of the field. According to the Kalish, even though there were a few sociologists and psychologists writing about the need to discuss death as early as the 1920s and 30s, it was not until Herman Feifel wrote a series of articles about death's meaning in the late 1950s, and Elisabeth Kübler-Ross discussed her stages of dying in the late 1960s, that the "death-awareness movement" gained momentum (Kalish, 1985). He argued that the only reason this occurred was that young activists were looking for a cause and that death and dying lost their taboo status in the late 1970s.

This situation has solidified on the heels of the death awareness movement that followed the work of Kübler-Ross, and the explosion of interest her work apparently produced in the 1970s. By the 1980s, Gatliffe indicated that death education courses were appearing in great numbers (Gatliffe, 1988). It is certainly true that college death and dying courses are not uncommon to this day. Wass (2004) has also noted how the shorter death education courses were not always helpful, the shorter courses can even be harmful. In harmony with Moller (2000), Wass (2004) noted that death education will become more and more important as technology becomes more and more sophisticated and prevalent. He suggested that death education include three parts: 1) Some form of culture-based death education, 2) The intentional objective of preventing suicide and violence of other sorts, and 3) The use of death education to inform children of the facts in order to avoid as much unreasonable fear as possible.

Since then publication of *The Meaning of Death*, death-related research has developed extensively, and different interpretations and definitions of death education have been found, and death education has developed in a number of countries, such as Israel, Canada, and Australia. There were a number of reasons why a demand to discus death developed within education at that time in the USA. First fewer people were dying at home than previously and so children and young people in particular were becoming distanced from such events. Second, a more humanitarian perspective was being applied by society to disability, illness and infirmity and ways of caring for people were changing. Third the national and state laws, prevented religion (which is often linked with death), from being discussed in education (Howarth, & Leaman, 2001). Death education for healthcare professionals and grief counselors has been gradually developing in the West (Wass, 2004). Reflecting the broad-based academic beginnings, courses on death and dying were developed by Robert Kastenbaum, at the Clark University, Robert Fulton at the University of Minnesota, Dan Leviton at the University of Maryland, and James Carse at the Yale University, among

others. In 1969 Fulton established the Center for Death Education (now the Center for Death Education and Bioethics at the University of Wisconsin, La Crosse) (Wass, 2004).

There are a dozen or so journals that deal with the topic of death education. The dissertations researchers have been able to locate, other than those listed, are generally only obliquely related to death education, usually having to do with professional medical and/or psychological personnel. There are a number of organizations dedicated to death education. Not listed are courses offered in public institutions, mostly at the university level. For example, Marian College in Fond du Lac, Wisconsin has offered a Thanatology Program which consisted of a series of seminars held in 2001/2002. In 1974 the Duke University Religion Department offered "Aspects of Death and Dying." In 2000 Duke U. also founded Duke Institute on Care at the End of Life, dedicated to improving care for the suffering and dying. In New Zealand, the University of Canterbury offers a special topic "On Death & Dying" through the sociology department. Tampere University in Finland offers death education for nurses. Around the US, there are numbers of death education courses offered on the university level, generally offered by medicine, sociology, and religion departments. One representative offer of a death and dying course comes from Aurora University in Illinois (Warren, 2014).

Death education programs probably peaked in popularity during the 1970s (Neimeyer, 1994). In 1970 Robert Kastenbaum founded *Omega: The Journal of Death and Dying,* the first professional journal in the field. In the same year the first conference on death education was held at Hamline University in St. Paul, Minnesota. In 1977 Hannelore Wass founded the journal *Death Education* (later renamed *Death Studies)* (Wass, 2004). Pine (1977) has provided a helpful historical perspective on death education. At one point, there were more than 1000 death education programs of some sort being offered each year in USA. By 1978, at least 938 and universities were offering death education courses (Neimeyer, 1994). The popularity of death education has diminished over the past few years on college campuses, but not necessarily in other settings. It has estimated that approximately 11% of all elementary and secondary public schools offer a course or some instructional units on death education in general, 17% offer a grief intervention or support program, and 25% conduct suicide prevention and educational programs (Wass, Miler, & Thornton, 1990; cited in Wass, 2004). Among schools of medicine, nursing, pharmacy, dentistry, and social work, 13-40% offered a full course on death education and 43-83% integrated such instruction into other courses (Dickinson, Sumner, & Frederick, 1992; cited in Neimeyer, 1994). Dawne-Wamboldt and Tamlyn (1997) suggested that death education begun to appear as a topic for discussion, research and education in the late of 1960s, and remains an educational challenge four decades later. They also stated that although a range of programs originated in the USA, there was significantly less information about similar programs that were developed in the UK and Canada (Foyle, & Hostad, 2004). The field of death education has grown in other ways as well. Like *Omega: The Journal of Death and Dying,* and *Death Studies,* Journals of

Mortality; *The Forum: Newsletter of the ADES* also provided recent theoretical and empirical work in thanatology. The professional organizations such as International Work Group on Death, Dying, and Bereavement, the Association for Death Education and Counseling (ADEC), is an international, multidisciplinary organization devoted to improving the quality of death education (Neimeyer, 1994), and the Hospice Foundation of America (HFA) were formed during the 1970s and 1980s (Meagher, & Balk, 2013). The ADEC has held 37 annual conferences in the 1970s to the present. The National Center for Death Education (NCDE) at Mount Ida College is dedicated to offering you and fellow care giving professionals in thanatology (Corr, & Cor, 2013).

In Iran, Gholam Reza Moatamedi (1988) wrote a book about death: *Human and death*. In 2014, Mahboubeh Dadfar and David Lester published the first book: *Death Education Programs: An Applied Guide for Health Care Professionals,* in which they basically suggested that death education program in healthcare professionals, is necessary, and using of various death education approaches can be useful for them. Mohboubeh Dadfar (2015) wrote the first doctoral dissertation in clinical psychology about effectiveness of death education program.

- Goals of death education program

Thanatology has many goals. In most cases, thanatology is not directly related to palliative care, which aims to provide treatment for dying individuals and their families. According to the World Health Organization (WHO), «palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, involving the «treatment of pain and other problems, physical, psychosocial and spiritual». Thanatology does not directly explore the meaning of life and of death. Such questions are irrelevant to those studying the medical aspects. However, the question is very relevant to the psychological health of those involved in the dying process: individuals, families, communities, and cultures (Association for Death Education and Counseling (ADEC) The Thanatalogy Association, 2015).

Death is no enemy of life; it restores our sense of the value of living. Illness restores the sense of proportion that is lost when people take life for granted. To learn about value and proportion people need to honor illness, and ultimately to honor death. Death education honors death by educating about death, dying, and bereavement to enrich personal lives, inform and guide individuals in their transactions with society, prepare individuals for their public roles as citizens, help prepare and support individuals in their professional and vocational roles, and lastly to enhance the ability of individuals to communicate effectively about death-related matters. There are two major reasons for providing death education. First, death education is critical for preparing professionals to advance the field and accomplish its purposes. Second, it provides the general public with basic knowledge and wisdom developed in the field. The overarching aims of death education are to promote the quality of life and living for oneself and others, and to assist in creating and maintaining the conditions to bring this about. This

is accomplished through new or expanded knowledge and changes in attitudes and behavior (Encyclopedia of Death and Dying, 2015).

Death education refers to the experiences and activities of death that one deals with. Death education also deals with being able to grasp the different processes of dying, talk about the main topics of attitudes and meanings toward death, and the after effects on how to learn to care for people that are affected by the death. The main focus in death education is teaching people how to cope with grief. Death education refers to planned educational experiences that pertain to issue invoking understanding the meaning of death, dying, and factors involved in grief and bereavement. Many people feel death education is a taboo and instead of talking about death and grieving, they hide it away and never bring it up to others. With the right education of death, the less of a taboo it will be (Kalish, 1989; cited in Sofka, et al., 2012).

Kurlycheck (2006) stated that in death education some considerations of purpose and rationale should be examined, which include issues of importance to death educators and program administrators, the potential benefits of examining the issues surrounding death and dying, the readiness of people to explore this subject, ethical concerns for death educators, and the status of outcome research evaluating the effects and effectiveness of death education programs.

Some of the goals of death education are to promote discourse about death; integrate the dying with the living; explain the developmental processes of death understanding and grief; heighten sensitivity about cultural variations in dying, death and grief; and appreciate the universal and individual course of the grief experience (Fiefel, 1959; Kalish, 1989; Corr, Nabe, & Corr, 2009). Catholic priest and Professor Deeken classified death preparation education into the four steps. The first step was to delivery death information and the second step was to approach emotionally and the third step was to emphasize the value of life and death. The last was to the teach method step. It was to teach the education method in relation to death preparation education (Oh, & Kim, 2009).

In 1992 International Work Group on Death, Dying, and Bereavement, which first convened in 1974, advocated education about death for all segments of the worldwide population in order to:

1. Optimize the potential for human development through the lifespan
2. Understand the impact of technology on human life
3. Achieve equitable allocation of scarce socioeconomic resources
4. Cope with social systems and social change
5. Cope with cross-cultural movements and interaction
6. Cope with global issues (e.g., terrorism, world hanger, population growth, and nuclear processes and dangers.

Corry and Corr (2003) stated that there are several basic goals for death education including:

1- A first goal of death education is seek to enrich the personal lives of those to whom it is directed. “The really important thing is not to live, but to live well”. Help to individuals to understand themselves more fully, and to appreciate both their strengths and their limitations as finite human beings.

2- A second goal is to inform and guide individuals in their personal transactions with society. It does this by making them aware of services that are available to them and options that they might or might not select in such matters as end-of-life care, funeral practices, and memorial rituals.

3- A third goal of death education is to prepare individuals for their public roles as citizens. It does this by clarifying some important social issues that face society and its representatives, such as advance directives in health care, assisted suicide, euthanasia, and organ and tissue donation.

4- A fourth goal of death education is to support individuals in their professional and vocational roles. Those whose work in involving teaching young people about death, caring for the dying, or counseling the bereaved can benefit from the perspectives offered by a well-grounded death education.

5- A fifth goal of death education is to enhance the ability of individuals to communicate effectively about death-related matters. Effective communication is essential when one is addressing death-related topics, which may be challenging for many people (Strickland, & DeSpelder, 1995). Principles that can guide effective communication are at the heart of education about dying, death, and bereavement.

6- A sixth goal of death education is to assist individuals in appreciating how development across the human life course interacts with death-related issues. Children and adolescents, as well as young, middle-aged, and older adults, face with issues that are dissimilar in many ways, and they are likely to differ in the ways in which they confront and cope with dying, death, and bereavement (Corry, & Corr, 2003).

Death education is one type of nursing education. Nurses spend far more time with critically ill patients and their families than do other caregivers. They have been better prepared for this aspect of their profession than physicians in that many nursing schools have been offering courses or modules at the undergraduate and graduate levels. Still, a 1999 study by Betty Ferrell suggested that end-of-life education in nursing schools is inconsistent. In response, the American Association of Colleges of Nursing (AACN) developed “Peaceful Death: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care.” Reflecting these guidelines, the AACN in 2001 developed the End of Life Nursing Education Curriculum (ELNEC). The ELNEC is a comprehensive curriculum of nine modules to prepare bachelor’s and associate degree nursing faculty who will integrate end-of-life care in basic nursing curricula for practicing nurses, and to provide continuing education in colleges and universities and specialty nursing organizations across the country. Among other efforts to improve nursing education in end-of-life care is the Tool-Kit for Nursing Excellence at End of Life Transition (TNEEL), a four-year project developed by six prominent

nursing educators and researchers. The TNEEL is an innovative package of electronic tools distributed to nurse educators in academic and clinical settings and eventually will be offered as a web-based self-study course (American Association of Colleges of Nursing (AACN), 2015).

- Basic competencies of an effective death educator

Wass (2004) stated basic competencies of an effective death educator followings:

- Confrontation of personal mortality and comfort with the topic of death
- Knowledge of the subject matter and commitment to keep up with new developments
- Ability to develop objectives consistent with the needs, interests, and educational levels of learners
- Familiarity with basic principles of learning and instruction
- Knowledge of group dynamics
- Skills in interpersonal communication and, when necessary, in identifying students' needs for support and counseling (Wass, 2004).

The ADEC is currently developing standards for training death educators based on teacher competencies.

- Contents of death education program

The National Center for Death Education (NCDE) (2015) stated that following outlines are courses about human experience of death and dying: 1) Introduction: valuable classification, 2) Physical death, 3) Dying process, 4) Arts and death, 5) American funeral, 6) Grief, mourning and consulting: the psychology of death, 7) Cross cultural comparative views of death, 8) Euthanasia and suicide, 9) Will and insurance, 10) Donation, 11) Life after death phenomenon and 12) Course summary.

The Association for Death Education and Counseling (ADEC) The Thanatalogy Association (2015) indicated that a thanatology course is for accountability to needs of the individual, in the training on the realities of the individual about death and dying, a course should include the following components: 1) A sympathetic, awere, and supportive educatore with experience in grief counseling; 2) Appropriate educational resources such as publications, books, movies, music and expert speakers; 3) Discussion and research about the attitudes about death, cause of death and dying 4) A discussion which leads to understand of that death is a inevitable and natural process and how death acceptance leads to ability for a richer life and a peaceful dying; 5) Discussion and research about the physical, cognitive, emotional, and spiritual processes associated with death and dying; 6) Discussion and research about the cultural and religious differences about death, dying, and death afterlife; 7) Discussion and research about the opportunities for organ donation; and 8) Discussion and research about reported near-death experiences and relational experience after death (Association for Death Education and Counseling (ADEC) The Thanatalogy Association, 2015; The National Center for Death Education (NCDE) (2015).

Term of death education is to teach about issues and topics related to death. These issues include the following: the encounter of death; attitudes toward death; the actions associated with death, dying, bereavement; practices and rituals associated with death; experiences with death among different developmental or cultural groups; deal with HIV/AIDS, suicide, assisted suicide and euthanasia; legal issues; religious, philosophical or spiritual views; and near-death experiences. For example, thematic domain of the encounter of death includes the number of deaths in a given population, the rate of mortality, causes of death, the average of life expectancy, places of death and experience with certain types of death, like the death of long-term degenerative diseases (heart disease, cancers, neuromuscular diseases such as amyotrophic lateral sclerosis which was known as Lou Gehrig's disease, and dementia diseases as Alzheimer dementia disease) and their differences from deaths due to communicable diseases. Domain of attitudes toward death, includes death anxiety, as well as attitudes of individuals about their death or dying, about the death dying of another person, or about what happens after death. Subject domain of acts related to death covers death within a certain death system (i.e. contemporary American acts, or practices of) such as to talk about death, media relationship with death, and forms of death imposed human acts (such as accidents, murder and other homicide). Dying domain include ways in which people die, as well as the ways in which people deal with death, and help to those who are dealing with death. It also includes social programs that pay attention to dying care end of life care. Issues and domains of bereavement, practices and rituals associated with death, death experiences among various developmental or cultural groups, combating HIV/AIDS, suicide, assisted suicide and euthanasia, legal issues, religious, philosophical or spiritual and near-death experiences, include various and diverse programs (The National Center for Death Education (NCDE), 2015).

Learners of a death education course need to clearly understand the complex knowledge of the subject, learn the five key areas of knowledge, and to learn the physical, psycho social, behavioral, and cognitive aspects of death. The five key areas are: understanding the dying process, decision making for end of life, loss, grief, and bereavement, assessment and intervention, and traumatic death. Death education should be taught in perspective and one's emotional response should be proportionated to the occasion (Association for Death Education and Counseling (ADEC) The Thanatalogy Association, 2015).

Some contents of death education program include special cultural' understanding about death; modern people's understanding about death; meaning and awareness of death and value of life; fear of death, reduction of fear and method to overcome fear; think more frequently about death; overcoming loss and grief due to death; value of time and meaningful future life; death and next life (religious understanding about spirit and body); removing taboos about death and accepting death positively; ethical issues about death and death process; identifying issues from forensic science; creating will and legal effect, heritage handling; planning one's funeral in advance; reflection and organizing the past life; things one want to leave to the world (sharing and social contribution); suicide and suicide prevention; hospice

education, caring cancer patients, telling truth about disease; aged society, aging and change and characteristics at old age; medical tips and prevention for sudden death; actual cases and method of death preparation; and reconciliation and forgiveness (The National Center for Death Education (NCDE), 2015); Encyclopedia of Death and Dying, 2015). Chang (2012) identified the content of the death education program (Table 1).

Table 1- The content of the death education program

Sessions	Topics	Contents and learning activity	Methods
1st (150min)	Finding myself	- Understanding Kübler-Ross's meaning of death - Introducing self and making a nickname - Finding the happiest moment in my life so far, and the most enduring painful memory relating to death -Word list and colors related to death	Lecture, Discussion
2nd (100min)	Finding myself	- Drawing a the life graph: contemplating life's journey from birth to one's future death and expressing all the separate moments using fitting colors	Activity, Presentation
3rd (150min)	Thinking about death	- Sharing thoughts on death, and life after death in each religion - Understanding suicide and cognitive therapies associated with suicide prevention	Lecture, Presentation, Discussion
4th (150min)	Thinking about death	- Watching a video DVD related to the dying process - If you were the heroine in the video DVD? - Writing one's own obituary (suicide versus a death by desired means)	Animation, Lecture, Discussion
5th (120min)	Preparing for death and finding the meaning of life	- If you have only one month to live, how would you spend your time until death? - List the most precious and most regrettable moments in your life	Presentation
6th (150min)	Preparing for death and finding the meaning of life	- Planning my funeral: pairing with a partner and expressing the process of life and death through body movement	background music, Active participation
7th (120min)	Setting goals and values for life	- Establishing life goals and expressing them - Word list and colors related to death - Presenting your feeling and thought on death after the completion of the education program	Presentation

Adapted from Chang (2012)

- Instructional methods in death education program

There are many instructional methods can be used in death education program. Table 2 shows instructional methods used in the death education program.

Table 2 - Instructional methods for using in death education program

Presentation techniques	Visual aids used in the Death education Program
Lecture	Computer-generated graphics
Readings	Slides
Slides/Computer/Overheads	Videotapes
Video/Audio tapes	Audiotapes
Movies/Films	Overheads
Debates	Flipcharts/chalkboards
Testimonials	Workbooks
Victim impact panels	Handouts

Audience participation techniques	Simulations
Question-and-answer period	Small-group discussions
Reaction panel	Role -playing exercises
Audience role-playing	Skill-practice exercises
Professional sharing	Coaching
Guided discussion	
Case discussion	

Adapted from Maglio, and Robinson (1993)

- Approaches of death education program

Death education varies in specific goals, formats, duration, intensity, and characteristics of participants. It can be formal or informal. Formal death education can involve highly structured academic programs of study and clinical experience. It can be organized into courses, modules, or units taught independently or incorporated into larger curricular entities. It can be offered at the elementary, middle, and high school levels, in postsecondary education, as professional preparation, and as short-term seminars or workshops for continuing professional and public education. Informal death education occurs when occasions arising in the home, at school, and in other social settings are recognized and used as «teachable moments.» In the home, the birth of a sibling or the death of a pet may naturally lead to interactions that answer a child's questions about death. At school, a student's sudden death may trigger educational follow-up, in addition to crisis counseling. So death education can be taught formally or informally. Formally planned death education is associated with learning in organized educational settings including: schools, colleges, graduate education, professional workshops, and volunteer training programs. Two distinct methodological approaches to structured death education are the didactic and the experiential (Association for Death Education and Counseling (ADEC) The Thanatalogy Association, 2015).

- Didactic death education

Didactic death education is primarily educational in nature and tends to include lectures and readings, but little or no exploration and disclosure of personal feelings (Neimeyer, 1994; Wass, 2004). Typical didactic programs were primarily based on reading and lectures and used audiovisual aids as a part of a classroom activity (Durlak, & Reisenberg, 1991; Wass, & Neimeyer, 1995). Durlak (1994) suggested that the didactic programs highlight knowledge and information about the study of death (Foyle, & Hostad, 2004).

The didactic approach (involving, for example, lectures and audiovisual presentations) is meant to improve knowledge. Didactic death education emphasized knowledge and information (Sofka, et al., 2012). Didactic death education involved the dissemination of knowledge, emphasized lecture, reading, discussion of content-driven material promotes increased cognitive awareness (Meagher, & Balk, 2013).

- Experiential death education

In experiential death education, exploration and sharing of personal feelings and experiences are encouraged through the use of personal exercises, role playing, fantasy, media presentation, and simulations (Neimeyer, 1994). Durlak (1994) suggested that the experiential programs might share some of techniques, but emphasize and encourage the examination of feelings and issues related to death (Foyle, & Hostad, 2004). Experiential programs involved visiting cemeteries or mortuaries, witnessing interviews with the terminally ill, and engaging in role play or other personal awareness exercises (Durlak, & Reisenberg, 1991; Wass, & Neimeyer, 1995). The experiential approach is used to actively involve participants by evoking feelings and thereby permitting death-related attitudes to be modified. This approach includes personal sharing of experiences in group discussion, role-playing, and a variety of other simulation exercises, and requires an atmosphere of mutual trust. In experiential approach learners are encouraged to relate their own personal experiences and feeling about death to the material (Durlak, 1994; Sofka, et al., 2012). This method provides a focus on affective factors (Meagher, & Balk, 2013).

Experiential death education refers to classes or workshops that help participants examine and discuss their personal views and feelings about death. This is usually achieved through a combination of readings, movies, videos, experiential exercises, and frank discussions. Whereas experiential death education significantly reduces death anxiety, didactic programs have no significant impact.

Warren (2014) stated that in the case of encounter or growth group, shared reactions to arousing visual stimuli, or role play. Personal relationship factors and an ability to work with group dynamics under conditions of high emotional arousal will be important. Experiential approach to death education can itself have two thrusts. The first is directly emotionally arousing one in which a personal encounter with one's own mortality is engineered. This may involve films, visits, imagery, and a whole host of devices for unlocking feelings. The method is relatively aggressive and short-term (a weekend perhaps), and the outcome unpredictable. The second type of experiential thrust is less aggressive and intends to provide

the opportunity for talking over one's own fears and uncertainties about death and dying. A study group approach might focus on some of the literature in the field or on a specific book. Pros and cons of death preparation (wills, insurance, and purchase of grave plot) might be discussed in terms of group members' various attitudes to these preparations. Feeling about loss of parents and significant others might be discussed, and expectations about one's own future life and the time and the nature of one's own death speculated upon. In general terms this second approach within the experiential focus would seem to be something along the lines of Units I and II in Corr (1978). The first, more aggressive and arousing approach, is more appropriate for helping professionals, and would require a great deal of thought before its application with children, young people, or the aged (Warren, 2014).

- 8A model

Empowerment Network of Adjustment to Bereavement and Loss in End-of-life (ENABLE) had two enabling programs. The Primary Enabling Program (PEP) was launched following workshops and symposiums. It was a standard teaching protocol, a trainer manual, and various death education workbooks to roll out death education. Support by resources of updates on related service developments, research findings on death and dying, continuous training and consultation support, online audiovisual resources, and use of a death education library. A self- help workbook, *in celebration of life: a self- help journey on preparing a good death and living with loss and bereavement* was published in English and Chinese and widely distributed in the community. The Secondary Enabling Program (SEP) involved specialized and comprehensive training to target professionals in palliative and bereavement care services. It aimed at increasing three levels of professional competence including emotional competence, which strived to help trainees to overcome their own sense of death anxiety and related distresses to enhance their work with death and dying; knowledge competence, which included the transfer of state- of- the- art theories in field of palliative and bereavement care; and practical competence, which involved developing and enhancing the clinical sets of trainees for working with dying patients and bereaved families. The ENABLE website, the interactive ENABLE *journey*, was launched in 2009 to enhance and facilitate public awareness, participation and involvement. Website consistes death education contents, stories from professionals and individuals of their own experiences of death and loss, Also Memorial Garden, literatures and illustrations on life and death, and electronic sympathy cards, was used in online learning experience (Centre Behavioral Health (CBH), 2009).

An expert panel, which includes an experienced death educator, a thanatologist, a social worker, and a health psychologist, was set up by the ENABLE project team to develop 8A model. Based on the literature review and discussion among panel members, a preliminary 8A death education model was developed. Subsequently, it was tested and modified after a pilot death education training session for frontline social workers who work with elderly people. The final model was then developed for future death education training. An 8A model (Alienation, Avoidance, Access, Acknowledgment, Action, Acceptance, Appreciation, and Actualization) was developed as a framework for providing death education to the

professionals. The 8A model adapted the Transtheoretical model (TTM) for understanding the needs of clients in different phases of behavior change. The 8A framework is designed as a preliminary attempt in death education that adopts TTM in understanding positive death preparation behaviors (Chan, et al., 2010).

- Adapting the Transtheoretical model (TTM) for positive death preparation

Chan and his colleagues (2010) indicated that experience in the field tells that different people may show different readiness in death preparation. Whereas some may perceive death as a taboo topic and avoid talking about it, others may be more ready to think of death and dying but may not know how to turn preliminary thoughts into action. Keeping in mind such concerns in developing this model, they were inspired by the concepts in health promotion, and they were aware that there may be similarities in death preparation and health promotion. Their idea was to match death preparation with a health behavior to be promoted. Thus, the Transtheoretical model (TTM) proposed by Prochaska and Velicer (1997), originally developed to understand health behavior change, was adopted to provide insights into developing a model on death preparation. This model was developed after Prochaska and his colleagues analyzed different theories of psychotherapy, and it is thus named as "transtheoretical" (Prochaska, 1979).

The TTM describes five formal progressive stages of behavioral change: precontemplation, contemplation, preparation, action, maintenance, and possibly occasional relapse in some conditions. The model assumes that the process of behavioral changes may not occur linearly but in a spiral manner, in which overlapping, concurrent, and recurrent stages are possible. The TTM has been commonly adopted in such health-related practices as smoking behavior (Fava, Velicer, & Prochaska, 1995; Velicer, Prochaska, Fava, Norman, & Redding, 1998), exercise behavior (Marcus & Simkin, 1994; Nigg, & Courneya, 1998), substance abuse (Sutton, 2001), pain management (Jensen, Nielson, Romano, Hill, & Turnet, 2000), eating behavior (Horwath, 1999), HIV prevention (Prochaska, Redding, Harlow, Rossi, & Velicer, 1994), and suicidal behavior (Coombs, Fish, Grimley, Chess, Ryan, Leeper, et al., 2001). Similarly, Chan, et al (2010) believed that such a model may also enrich their understanding of people's needs in preparing for death and may enhance their intervention, by considering it a process of change in behavior. In fact, cumulative evidence also suggested that tailoring treatment intervention to the stage of change could improve the outcome of the change (Prochaska, & Norcross, 2001).

- Developing the 8A model for positive death preparation

The existing 8A model expanded the five TTM stages to eight (Alienation, Avoidance, Access, Acknowledgment, Action, Acceptance, Appreciation, and Actualization), manifesting different degrees of death preparation in knowledge, attitudes, and practice of life experience. It also developed the internal process that may occur in the changing stages from more initial cognition to behavioral outcomes. By adopting references from the TTM, the 8A model also implied a continuum on which people may go back and forth through their changes in

behavior in death preparation. A summary of the model is illustrated in Table 3. Permission for use of the 8A model has been obtained from Agnes T. Fong, MSW Centre on Behavioral Health University of Hong Kong, who sent her published paper available for the use of us.

Table 3- The 8A model for positive death preparation

TTM stages	Process in 8As	State of death preparedness (Knowledge, attitude, and practice)	Possible themes and interventions in life and death education
Precontemplation	Alienation	People feel indifferent to death because it is too distant.	Introduce positive terms and concepts in talking about death.
	Avoidance	People try to avoid death because it brings bad luck.	Nurture positive atmosphere to break taboo.
Contemplation	Access	People do not have access or information about death preparedness.	Provide relevant information
Preparation	Acknowledgment	Triggering of emotions during death preparation makes people feel uncomfortable.	Provide psycho-education and promote expression and acceptance of feelings.
Action	Acceptance	People treat death as a natural part of life.	Facilitate personal life review and promote sense of integrity in one's life.
	Action	People are actively involved in related life planning.	Support implementation of an action plan.
Maintenance and Transformation	Appreciation	People can appreciate life and the search for life meaning.	Promote personal reflections and discussion of existential and meaning of life.
	Actualization	People can readjust life priorities, live in the preset moment, and integrate the meaning of life in future goals.	

Adapted from Chan, et al (2010)

- The Alienation and the Avoidance phases

According to TTM, overt behaviors are often absent in the initial stages of change, before the preparation stage, during which time there is a dominance of the mental incubation process happening within. The pre-contemplation stage involves the alienation phase and the avoidance phase. The alienation phase is mainly manifested by the common belief that death is distant. This belief is frequently observed in younger adults, who may think that death is remote and hence are indifferent to thinking or talking about death. People in this phase

generally lack interest in knowing about and discussing death-related issues. In addition to the social norm of alienation, Chow and Chan (2006b) also suggested that there is a general denial of death among the Chinese population. It is believed that talking about death brings bad luck, so people avoid the topic by using metaphors or covering up the fact of death by a representation of life (Koo, Tin, Koo, & Lee, 2006).

Having a stage-based framework of death preparedness behaviors, potential phase-matching interventions can then be designed to maximize people's receptiveness in knowledge, attitudes, and behaviors in preparation for death. In the pre-contemplation stage, the key objective of intervention is to nurture an atmosphere of positive discussion in breaking the taboo of death, enhancing sensitivity toward death-related issues, and introducing a positive conceptualization of the issue. Multimedia forms of information, mass media campaigns, and public education, like seminars, lectures, and psycho-educational talks, may be used to enhance general understanding and interest from the public. Case studies and daily news items related to death issues may also be used to raise awareness of death and construct positive elements or new language in discussing the topic.

- The Access and the Acknowledgment phases

The contemplation stage is marked by the access phase, during which people have more awareness of an interest in knowing about the topic. But because death is still a taboo subject for Chinese people, they often do not have access to information or they do not know where to begin. They are generally more open to information and may be curious about knowing about the experience of death. When individuals are open to knowledge about death, they may then feel uncomfortable in dealing with the potential negative feelings that may be triggered in the process. During this phase of acknowledgment, people may experience common emotions like death anxiety and grief reactions to prior losses.

In order to provide the necessary information, various means can be used. Talks, web-based information, pamphlets, or booklets can offer more detailed information on death-related procedures like planning a funeral, advance care planning, and making a will. In the acknowledgment phase of the preparation stage, emphasis may be placed on psycho education of common death-related emotions and coping, as well as promoting the expression and acceptance of these emotions. On some occasions, practitioners may need to be prepared for follow-up when individuals need additional support in dealing with their emotions in order to move on with the process. Durlak (1994) suggested that life and death education programs are in general fairly successful in modifying participants' death-related cognitions and behaviors, whereas experiential programs are more effective in facilitating positive changes in feelings. Tomer and Eliason (2000) proposed the Death Anxiety Model, in which death anxiety is determined by meaningfulness of death, past-related regret, and future-related regret. Therapeutic interventions including existential discussions, life review, and life planning can then be applied experientially to facilitate this attitude change (Eliason, 2000). Various practitioners and scholars have also proposed different therapeutic approaches and intervention proceedings in dealing with people's grief (McKissock, McKissock,

& Bereavement C.A.R.E. Centre, 1998; Neimeyer, 2001; Rando, 1993; Worden, 2002). Practitioners may find appropriate therapeutic and experiential means to support individual participants in working with specific emotional distress related to death, so that they can continue to develop positive coping and preparation for death.

- The Acceptance and the Action phases

The action stage of positive death preparation involves the acceptance and action phases. According to Wong, Reker, and Gesser (1994), there are three types of death acceptance: approach, neutral, and escape acceptance. Approach acceptance is often related to religious belief and refers to the anticipation of a rewarding afterlife. Neutral acceptance refers to the acknowledgment that death is a natural part of the life cycle. Escape acceptance, in contrast, is based on the relatively negative belief that death is acceptable only because of the unbearable nature of life. Practitioners should try to promote neutral acceptance or approach acceptance, which are more helpful in motivating individuals to put their thoughts into overt behaviors and concrete action. When people are ready for the action phase, they can make detailed planning related to preparation for death. They may make choices and concrete plans in advance care planning, funeral arrangements, and a will. The action phase may also include actively communicating with family members so as to express decisions and concerns. The realization of mortality may also promote sharing of emotions, feelings, and appreciation among family members. Keeley (2007) found that five types of messages during final conversations between dying patients and their families have important functions in their close relationships: love, identity, religion or spirituality, routine or everyday matters, and difficult relationship issues. These messages may shed insight into how people can make use of the present moment to communicate positively to improve the quality of relationships, facilitate reconciliation, and reduce possible regrets for the family after the death of the family member.

Life review, proposed by Bulter (2002), has been commonly used to promote ego integrity at the end stage of life (Erikson, 1963). It is believed that an integration of life can promote acceptance and appreciation of life, important prerequisites for the acceptance of death. It is therefore suggested that experiential programs and small groups for participants to work on a life review may be used in reviewing life stories and affirming the worthiness of the past of the participants, so that individuals can have the courage to face the uncertainty of death. Discussion and exploration of spiritual and existential issues are also crucial in facilitating acceptance of death. When participants are ready to actualize their plans, they can be helped to implement the plans through various types of tangible support if necessary. Family participation is also important during the action phase. Death affects the whole family. The purpose of planning death-related issues like advance care planning and funeral arrangements not only serves to implement personal will but also facilitates the family's acceptance and coping with grief after the occurrence of death. Practitioners may therefore offer assistance in promoting family communication and understanding through this process.

- The Appreciation and the Actualization phases

As the changing behaviors are sustained and the actions are integrated into the individual's life, one approaches the maintenance stage of the TTM. An additional element of transformation is added to the maintenance stage, because more and more evidence demonstrates that the experience of death may lead to further personal growth and transformation (Calhoun, & Tedeschi, 2001). Yalom (1980) also suggested that the realization of death led to the confrontation of a "boundary situation" during which people are forced to reflect on their lives and make changes in lifestyles. The maintenance and transformation stage of death preparation is further divided into appreciation and actualization phases. The appreciation phase is characterized by the awareness of the limited nature of life, the ability to appraise the preciousness of life, and the search for meaning in life. These existential realizations may lead to practical actualization in everyday life. People are then able to readjust their priorities, live in the present moment, treasure family relationships, and establish future goals and new meaning in life.

Wong (2000) suggested that a positive type of neutral acceptance is related to self-actualization, because people are reminded to make good use of their time and accomplish something worthwhile when they realize the brevity of life. The acceptance of death during the previous phase serves as an important step for further appreciation and actualization of life. Practitioners may take an existential approach in helping participants to search for life meaning and existential answers. Various schools as developed by different scholars, such as logotherapy by Viktor Frankl (1984), existential psychotherapy by Irvin Yalom (1980), and the meaning-centered counseling approach by Paul Wong (2008), may provide some useful references. As Frankl (1984) stated "Ultimately, man should not ask what the meaning of his life is, but rather must recognize that it is he who is asked. In a word, each man is questioned by life, and each can only answer to life by answering for his own life, to life he can only respond by being responsible".

Quint's adaptation of symbolic interaction theory

Quint's (1967) theoretical model suggested that nursing students exposed to dying patients, but lacking education in how to care for the dying, led to death anxiety and negative attitudes toward care of the dying and eventual withdrawal from care of the dying. Her theory proposed that if students were exposed to care of the dying without accompanying educational support, they would adopt the behavior of the other professionals around them and limit their involvement in death-related issues. Quint also theorized that if nursing students were to receive systematic death education with planned assignments, they would develop positive attitudes toward the dying and be less likely to withdraw from care of the dying.

Transformative learning theory

Transformative Learning Theory (TLT) involves the transformation of an individual's beliefs, ideas and views. Educators can create an atmosphere in which learners are encouraged to evaluate their beliefs and views using self-reflection. Change occurs as learners incorporate

their new learning into their belief system and transform or reject their old beliefs. Educators can facilitate transformative learning in a number of education arenas. Palliative care provides an excellent example of an issue that lends itself readily to the TLT. Transformative learning is a gain in knowledge that brings about change within persons that is significant to their beliefs and thought processes. Habermas (1971) discussed three domains of knowledge: technical knowledge is knowledge related to cause and effect, practical knowledge pertains to understanding what others mean, and emancipatory knowledge involves critical self-reflection. Cranton (1994) noted that emancipatory knowledge is a process of removing constraints and being free of forces that limit options and control lives. Transformative learning is primarily emancipatory knowledge. Transformative learning is gained through critical self reflection, as distinct from the knowledge gained from our technical interest in the objective world or our practical interest in social relationships (Mezirow, 1991). Cranton (1994) expressed the importance of an emancipatory knowledge when she stated, if people view education as the means by which individuals and societies are shaped and changed, fostering emancipatory learning is the central goal of adult education. As learners experience emancipatory learning, they not only experience a change in their thinking and beliefs, but they also experience a change in who they are. They are freed from a previous way of thinking and believing, but now must incorporate their new beliefs, understandings, and knowledge into their lives. Emancipatory learning can be difficult and at times painful to the learner (Cranton, 1994).

Critical self-reflection, a foundational element of transformative learning, is the ability of learners to remove themselves from their own views and thoughts, then step back and view themselves from an ethic perspective. The ability to disengage from one's closely held beliefs and to look at something from another point of view provides for exciting learning opportunities combined with a sense of risk and adventure. Mezirow (1991) stated that goal of adult education is to help adult learners become more critically reflective, participate more fully and freely in rational discourse and action, and advance developmentally by moving toward meaning perspectives that are more inclusive, discriminating, permeable, and integrative of experience. Cranton (1994) discussed how adults have acquired a way of seeing the world through their experiences and values. As adults learn new things, they must incorporate them into their previous knowledge. When this incorporation does not occur easily or there is a contradiction, the learner must reject the new information, or upon reflection, experience transformative learning.

Educators seeking to facilitate transformative learning must first be aware of their own biases and be willing to have those views challenged. The ethical educator will inform learners that their views, thoughts, and beliefs may be challenged and that through critical reflection, transformative learning may occur (Mezirow, 1991). The educator starts by creating an environment that is conducive to learning. The classroom must be warm and inviting, a place where it feels safe to risk self-disclosure and experience open communication. Small class size or small groups within a larger class are important so that learners learn from each other and help each other in problem-solving (Cranton, 1997). In this environment, the educator

begins by presenting the learners with real-life experiences that challenge their thinking and facilitating small group discussion to assess reasons, examine evidence, and arrive at a reflective judgment (Cranton, 1997). The educator also uses case studies that present ideas and challenges to the learners and forces their participation in helping address the problems presented in the case studies.

Group projects allow the learners to work together, using skills of communication, cooperation, negotiation and consensus. Learners create a project that is meaningful to each individual and representative of the group as a whole. During the group process each member of the group must participate in critical self-reflection, addressing self-beliefs, comparing their beliefs to the others in the group, and choosing how to come to a consensus without compromising what is uncompromisable.

Role-play, acting out a scenario in the safety of a classroom, allows the learners to challenge their beliefs in an active way. Rather than reading or talking about a given situation, students are placed in the situation and encouraged to respond in a way that would support their beliefs. As the role is played out, the learners may upon self-reflection see their views differently or feel a change is needed. Through repeated role-play the learners may find a new or different meaning, and their beliefs on a topic may be changed or confirmed. Cranton (1994) stated that adults will resist contradiction to their beliefs and will deny discrepancies between new learning and previous knowledge. By using several different strategies of adult learning the educator provides opportunities for the learners to challenge their beliefs, and change if desired. Even when learners are able to overcome their resistance to examining their own beliefs, emancipatory learning is still a great challenge (Cranton, 1997).

Adult learners, during their educational courses, should not only learn new information, but should, when appropriate, be challenged to reflect upon their current views on a given subject. By 2013 Palliative Care will become a mandatory examination subject in the medical curriculum in Germany. There is a pressing need for effective and well-designed curricula and assessment methods. Debates are ongoing as how Undergraduate Palliative Care Education (UPCE) should be taught and how knowledge and skills should be assessed (Schulz, Moiiler, Seidler, & Schnell, 2013). Palliative care at the end of life is an example of a subject through which an adult learner could have a transformative learning experience. As the educator and the learner explore palliative care issues for end-of-life care, views that are held strongly may be reaffirmed or challenged. New information is learned, and after reflection, previously held beliefs maybe challenged or changed. The educational component will use role-play, group process, and patient interaction to facilitate transformative learning. Students will be educated in the seven nursing behaviors deemed to be critical in the care of the dying (Degner, Gow, & Thompson, 1991).

The TLT can play a significant role in changing attitudes toward care of the dying. By examining both Quints adaptation theory and the TLT, the literature review has established the importance of education, particularly experiential education in changing nursing students attitudes toward care of the dying. The theoretical and historical framework of the proposed study points to the significance of the topic and the importance of future research.

Because death has meanings beyond just the cessation of vital signs, students develop attitudes about death that come from their culture, religion or previous experience. Discomfort with End-Of-Life (EOL) comes from these attitudes as well as feeling unprepared to care for the dying patient. In order to provide competent the EOL care, students need factual knowledge but they also need the opportunity to explore and evaluate attitudes that may help or hinder their nursing practice. The TLT provides a framework for teaching the EOL care. The TLT is an adult learning theory that focuses on attitudes as an important part of the learning process. By participating in learning environments that challenge attitudes as well as teach skills, students have the opportunity to identify, reflect on and discuss their attitude with others and hear others' perspectives. This process may change their attitude and ultimately modify their behavior the next time they encounter a similar situation. In order to provide competent the EOL care, students need opportunities to explore their attitudes about death and dying (Gilliland, 2011). Research has demonstrated that many nursing students have negative attitudes toward care of the dying. Through an educational process incorporating transformative learning, attitudes toward care of the dying can be changed from negative to positive.

Offered Modules by University of California, Davis, West Coast Center for Palliative Education (WCCPE)

Three modules were offered by the University of California, Davis, West Coast Center for Palliative Education (WCCPE):

Module 1: Offered on-site, blends didactic and field learning using lectures, case studies, patient contact, and role modeling.

Module 2: Programs, held off-site, are customized in collaboration with the sponsor to address local needs and concerns. This module emphasizes group discussion and problem solving.

Module 3: Trains health care and custody staff and volunteer inmates at correctional facilities. Inmate training focuses on developing communication skills and a capacity to empathize through experiential exercises, dialog, and role-playing (Linder, Blais, Enders, et al., 1999).

Theory of Planned Behavior (TPB)

The Theory of Planned Behavior (TPB) (Ajzen, 1985), was used to predict participant's death related behavioral intentions, attitudes, subjective norms, and perceived behavioral control towards a behavior. When Ajzen developed the TPB, it was stated that the TPB is, in principle, open to inclusion of additional predictors as long as they increase the explained variance in behavioral intentions (Ajzen, 1985, 1988, 1999; Ajzen, & Fishbein, 1980; Ajzen, & Madden, 1986; Ajzen, & Driver, 1992; Armitage, & Conner, 2001; Karimy, Niknami, Hidarnia, & Hajizadeh, 2012). The TPB allows for the prediction of behavior based on changes in attitudes, social norms, perceived behavioral control, and behavioral intent. The evaluation of EDECTsm program and the 2 hour CME session requires a theory that measured

behavior and the influences of personal evaluations, attitudes, perceived social pressure, and self-efficacy, on that behavior. The TPB encompasses all of these areas (Ajzen, 1985); and therefore, seemed an ideal selection. The TPB is one of the more widely used models to predict human behavior and one of the few to examine behavioral intent (Madden, Ellen, & Ajzen, 1992). The TPB examines the motivating factors that lead to a behavior. According to the TPB, personal evaluations, perceived behavioral control, and perceived social pressure precede behavioral intent, and behavioral intent precedes the behavior. Additionally, it performs well in health behavior research and in different samples (Ingram, Cope, Harju, Wuensch, 2000). The TPB assumes that the best predictor of a behavior is behavioral intention; intention, in turn, has three determinants. The first is the person's attitude towards performing the behavior, which reflects an overall positive or negative evaluation of the behavior (Hukkelberg, Hagtvet, & Kovac, 2014). Attitude is determined by the individual's beliefs about outcomes or attributes of performing the behavior (behavioral beliefs), and weighted by evaluations of those outcomes or attributes. Secondly, an individual's subjective norm is determined by his/her normative beliefs, that is whether the important referent individuals approve or disapprove of performing that behavior, weighted by his or her motivation to comply with those referents (Karimy, et al., 2012). And thirdly, the perceived behavioral control (PBC) refers to the person's perception of the amount of control he or she has over performing the behavior, which is seen to cover the influence of both internal (e.g. refusal skills) and external (e.g. constraints) control factors (Hukkelberg, et al., 2014; Travlos, Kalokairinou, Sachlas, et al., 2014). Smith-Cumberland (2006) reported that the majority of Emergency Medical Technicians (EMTs) intended to change their behavior at the scene of a death compared to the control group. A three-month follow-up study indicated that the majority of EMTs who received the intervention (and made a death notification) changed their behavior. They included death education programs were effective in changing the behavioral intentions of EMTs.

Literature review

Many studies have focused on the various aspects, components, clinical correlates, issues related to death and dying, and developed instruments for measuring of attitudes toward death in Western and Eastern countries, for example antecedents of the fear of the dead (Lester, 1966), fear of death and nightmare experiences (Lester, 1966), fear of death of suicidal persons (Lester, 1967), fear of death and the fear of dying (Collett, & Lester, 1969), threshold differences for the perception of death words and neutral words (Lester, & Lester, 1969-70), the need to achieve and the fear of death (Lester, 1970), attitudes toward death and suicide in a non-disturbed population (Lester, 1971a), attitudes toward death held by staff of a suicide prevention center (Lester, 1971b; Lester, 2004), fear of death of those in a high stress occupation (Ford, Alexander, & Lester, 1971), studies in death attitudes (Lester, 1972), attitudes of nursing students and faculty toward death scale (Lester, Getty, & Kneisl, 1974), fear of death and self-actualization (Lester, & Colvin, 1977), preference for method of suicide and attitudes toward death in normal people (Lester, 1979), fear of death, locus

of control and occupation (Hunt, Lester, & Ashton, 1983), depression and fear of death in a normal population (Lester, 1985), ontological insecurity and fears of death (Lester, 1992), funeral cost for suicides (Lester, & Ferguson, 1992), attitudes toward death related choices (Grain, & Lester, 2000), major dimensions of near-death experience (Lester, 2000), attitudes toward physician-assisted suicide and death anxiety (Schaller, Lester, & Abdel-Khalek, 2003; Abdel-khalek, Lester, & Schaller, 2005), organ donation and the fear of death (Lester, 2004), attitudes toward funerals (Lester, & Blustien, 1980), death concern (Abdel Khalek, & Saleh, 1999), death depression (Abdel-Khalek, 2000, 2004; Abdel-khalek, & Lester, 2006), death anxiety, death depression and death obsession (Lester, 2003; Abdel-Khalek, 2004), death obsession (Abdel-Khalek 1998, 2002b; Abdel-Khalek, & Lester, 2003; Abdel-Khalek, 2005; Abdel-Khalek, Al- Arja, & Abdalla, 2006; Abdel-Khalek, & Maltby, 2008), and death distress (Abdel-Khalek, 2004, 2005, 2007; Abdel-Khalek, & El-Yahfoufi, 2004; Abdel-Khalek, & Al-Sabwah, 2005; Abdel-Khalek, 2011-2012; Bahrami, et al., 2014).

Some studies developed, and validated different instruments for measuring of concerns/ fears/anxieties and attitudes toward death and dying, for example The Death Concern Scale **(**Dickstein, 1972**),** the Collett–Lester fear of death scale (Collett, & Lester, 1969; Lester, 1990, 1994, 2002, 2004; Lester, & Abdel-Khalek, 2003; Abdel-Khalek, & Lester, 2004; Zeyrek, & Lester, 2008), the Templer Death Anxiety Scale (Templer, 1967, 1969, 1970; Lester, 2002, 2007; Lester & Templer, 1992-93; Abdel-khalek, Lester, Maltby, & Tomás-Sábado, 2009), the Reasons for Death Fear Scale (Abdel-Khalek, 2002), the Arabic Death Anxiety Scale (Abdel-Khalek, 2004), the Death Depression Scale (Templer, et al., 1990; Templer, Harville, Hutton, et al., 2001-2002), the Death Obsession Scale (Abdel-Khalek, 1998), the Wish to be Dead Scale (Lester, 2013; Dadfar, Lester, Atef Vahid, & Abdel-Khalek, in press) and so on.

Many research studied nurses' attitude toward death (Cha, 2006; Lai, Chan, Yin, & Chow, 2006**;** Kim, 2007; Jeon, 2008), nurses' recognition of attitude towards good death (Gustafson, 2007; Jeong, 2010), nurses' perception of death and terminal care attitude (Cho, 2011), nurse's death anxiety and attitude concerning hospice care (Eo, 2010), nurses' experience of caring for dying patients (Ham, 2008; Han, 2010), nurses' death perception and terminal care performance (Noh, 2010; Kim, 2011), clinical nurses' perception of death and end of life care stress (Yoon, 2012), nurses' death anxiety, terminal care stress and terminal care performance (Woo, 2012).

Overall, findings of the studies about death and dying using various tools have indicated a need for attention to health care interventions and death education for different population especially health care professionals including nurses (Peters, et al., 2013; Kraje-Kulak, et al., 2013; Cavaye, & Watts, 2014; Dadfar, & Lester, 2014; Jeffers, & Ferry, 2014; Fernandez-Donaire, et al., 2014).

- Death concern/ Death fear/Death anxiety

Death anxiety became a topic of psychological interest in the late 1950's. From its inception «thanatology» has been a multidisciplinary field including contributions from

all disciplines. The definition of death anxiety has been the most perplexing task for a researcher till today. Pettigrew and Dawson (1979) reported that death anxiety may be a "trait" as opposed to a "state" phenomenon. Research within the field of death and dying has acknowledged that the difficulties met by the terminally ill patient may be exacerbated by the failure of physicians and other health care workers to deal with their own personal reactions relative to death anxiety or fear of death (Glaser & Strauss, 1966; Kastenbaum & Aisenberg, 1972; Knight, 1983; LeShan & LeShan, 1961). Studies have demonstrated that the avoidance behaviors, detachment, and emotional withdrawal of physicians are common coping strategies associated with death anxiety (Lonetto & Templer, 1986; Neimeyer, 1988). Such defense mechanisms may mediate the enormous burden of death anxiety but at the same time, serve to block empathic communication with the dying patient. In a descriptive British study of final-year medical students' self-reported attitudes and behaviors toward dying patients, Field and Howells (1988) found that medical students with a high personal fear of death were significantly more likely to describe difficulty in discussing the prognosis with a dying patient and reported more personal psychological problems in dealing with dying patients. Neimeyer, Behnke, and Reiss (1982) reported that medical residents high in death threat were more likely to use denial and avoidance when faced with dying patients. As many dying patients desire to discuss their feelings about death (Kubler-Ross, 1969; Wass, 1979), medical students need assistance in facilitating supportive interactions and in understanding their own personal responses to loss and anxieties about death and dying. Self-awareness is considered by many thanatologists to be an essential prerequisite to intelligent, compassionate interaction with dying or bereaved individuals (Corr, 1979; Grady, & Strober, 1980; Pike, 1990). Corazzini (1980) contends that before individuals can help another person with grief work, they must have accepted their own mortality, as well as that of others, must have acknowledged their own losses, and must have successfully resolved their own grief. Cassidy (1986) suggested that the distress caused by dealing with intense emotions associated with terminal i1lness (e.g., fear, grief, and anger) is due to the fact that caregivers are reminded of their own mortality. The anxiety surrounding thoughts of one's own death has been referred to as death anxiety within the field of death education (Lonetto, & Templer, 1986). Tomer (1992) suggested that the etiology of death anxiety might be understood in light of Rogers' concept of defense. If an individual's perceived self or self-concept depends on the conditions of good health and '"being alive," awareness of approaching death might be construed as a threat. Denial or distortion of the awareness of one's mortality would then be necessary in order to prevent the discrepant experience from entering consciousness and causing feelings of fear and apprehension which Schulz (1979) mentioned as overt manifestations of death anxiety. Individuals who distort or deny their own experience of mortality will be unable to empathically help others gain understanding and acceptance of the dying process. From the Rogerian perspective, medical students who have not confronted their own inevitable mortality along with the fearful thoughts and anxieties about the many unknowns associated with death may become highly apprehensive when exposed to the care of terminally ill patients and react with avoidance behaviors and poor

empathic communication. The measurement of death anxiety or death attitudes has often proceeded in the absence of any theoretical or formal definition of the construct. Schulz (1979) has provided a clear definition of death anxiety: the terms fear and anxiety have been used here interchangeably. A distinction often made by psychoanalysts is that fear is experienced in reference to specific environmental events or objects while anxiety is a negative emotional state that lacks a specific object. The apprehension evoked by thoughts of death and dying has properties of both fear and anxiety. There are specific things one can fear, such as the pain and associated psychological suffering. In addition, thinking about death may arouse amorphous and unspecified anxieties about the many unknowns associated with death: people do not know when or how they will die, or if there is an afterlife. The idea of not being is for some persons incomprehensible and unsettling.

In the opinion of earlier reviewers, much confusion in the literature on death attitudes can be traced to the "careless interchange of 'fear' and 'anxiety,' each of which implies different approaches", for e.g., if fear represents a more realistic reaction to a specific danger, anxiety refers to a more neurotic response that is out of proportion to any actual external hazard concluded that the study of death and dying "is severely limited in terms of both methodology and on theory (Kastenbaum, & Costa, 1977). In view of Kastenbaum (2007) anxiety, denial, and acceptance were include these premise: most of people use both acceptance and denial-type strategies; total acceptance and total denial-type strategies occur only in extreme situations; much of what is called denial is adaptive, selective responses; interpersonal context must be considered; and we must understand what the person is trying to accomplish. Death anxiety, denial, and acceptance are three core concepts. Death anxiety is an emotional distress, insecurity, tension, and apprehensiveness concepts. Denial is a response that rejects certain key features of reality in an attempt to avoid or reduce anxiety. Acceptance is coming to terms with death and easing anxiety, different from resignation or depression (Kastenbaum, 2007). Types and contexts of acceptance and denial are selective attention (redirecting attention to whatever seems most salient in the immediate situation), selective response (the individual feels this is not the time or place to discuss death, or the person may be working very hard at completing tasks in full awareness that time is running out), compartmentalizing (much of the dying and death reality is acknowledged, but the person stops just short of realizing the situation by putting all the information together), deception (deliberately giving false information to others is deception, for whatever reason), resistance (the individual comprehends the reality of the situation but chooses to fight for life as long as possible), and denial (a primitive defense mechanism that totally rejects the existence of threat or death-laden reality) (Kastenbaum, 2007).

Attitude toward death in an individual varies depending on time, academic background, the manner of death, relationship with the deceased, culture, and religion, as well as factors such as gender, educational level, health, socioeconomic status, life satisfaction, support system, psychological health, and values (Jung, 2013). Research has reported positive and negative consequences of attitude toward death and dying. Nurse educators have identified that historically nurses have not been prepared to care for dying patients, also research has

identified that nursing students have anxieties about death, dying, and caring for dying patients. Several factors have been identified as affecting nurses' and nursing students' attitudes toward care of the dying (Mallory, 2003). Nurses, who spend more time with dying patients, reported more positive attitudes toward death (Dunn, Otten, & Stephens, 2005), and work experience is also associated with more positive attitudes of nurses to the subject of death and dying (Lang, Thom, & Kline, 2008). In study of Shorter, and Stayt (2010), critical care nurses reported feelings of grief for patients, they had cared for, the death of a patient was reported as being less traumatic if they had perceived the death to be a 'good death', incorporating expectedness and good nursing care. Nurses described how a patient's death was more significant if it 'struck a chord', or if they had developed 'meaningful engagement' with the patient and relatives. Nurses denied accessing formal support: however, informal conversations with colleagues were described as a means of coping. Nurses exhibited signs of normalizing death and described how they disassociated themselves emotionally from dying patients. A study on the Gilan University of Medical Sciences senior nursing students found that they had a positive attitude toward caring for dying patients and toward helping the families of deceased patients (Raoufi, 1995; Heidari et al., 2011). Negative emotions and fear of death have negative influences on an individual's entire life, and may have negative influences on an individual's identity (Han, & Kim, 2008). Research on attitude toward death has been almost entirely focused on healthcare providers and medical personnel taking care of terminally ill patients (Kim, & Lee, 2009; Matsui, & Braun, 2010). Braun, Gordon, and Uziely (2010) reported that oncology nurses demonstrated positive attitudes toward care of dying patients. The attitudes were significantly negatively correlated with death avoidance, fear of death, and approach acceptance of death. A mediating role of death avoidance was found between fear of death and attitudes toward caring for dying patients. Nurses' personal attitudes toward death were associated with their attitudes toward the care of dying patients. They concluded that mediating model suggests that some nurses may use avoidance to cope with their own personal fears of death. Culture and religion might play important roles in the development of acceptance of death and attitudes toward care for dying patients. They suggested that training and support programs for oncology nurses should take into consideration nurses' personal attitudes toward death as well as their religious and cultural backgrounds. Kim and Kim (2011) reported that the level of attitude to death of nursing students averaged 2.60; the item receiving the lowest score was 'I am not afraid of a long, slow death'. Approximately 62.0% of them had no death-related education experience and 89.8% of them answered that death-related education was necessary. For attitude to death followed by general characteristics, death-related education experience and educational needs, there were significant differences in attitude to death according to gender, religion, perceived health status, worrying about problems, motivation of nursing, and an experience with death. They concluded that as nursing students' had a high educational need university curriculum development and educational programs addressing death should be developed and applied to nursing students. Scalpello Hammett (2012) reported that quality of care is influenced by the nurses' attitudes. Nurses and nursing students have positive attitudes towards caring

for the dying. There were contrasting viewpoints between the correlation of death anxiety and attitudes towards caring for the dying. Death anxiety may influence the nurses' health, since nurses may suffer from stress, burnout, and compassion fatigue. There were divergent findings regards the correlation between death anxiety and experience. Death anxiety depends on the personal experience of illness and death rather than the clinical experience. Death anxiety may affect the quality of care: adhering to the western curing model, focusing on the physical needs, adopting detachment coping mechanisms, communication with the dying and their families, and psychological and negative emotional status (Scalpello Hammett, 2012).

Attitude toward death is one of factors related to meaning in life. Understanding the relevance between attitude toward death and meaning in life in individuals gives nurses an indirect index to understanding patients, helping nurses to figure out their meaning in life, existence, goals, and psychological health, and forming a basis for an in depth understanding of patients (Jung, 2013). Kim, Choi, Lee, and Shin (2005) reported that there were correlations among meaning of death (positive meanings of death, negative meanings of death), death anxiety, death concern and life respect will in university students. The study of Cho, and Kim (2005) based on the literatures related to death education reflected on the positive attitude toward life and the meaning of life as a university student and proposed the need for development of education program for death preparation. The content thereof was consisted of search for death, acceptance of death and opening for death. As for the thought on death, those with a positive attitude for death understood the meaning of death and had a proper mindset to prepare death well so that they could provide true help to those in need (Lin, Pong, & Lin, 2006). Hyun (2014) was developed death education program and practiced for 8 sessions in college students. Results showed that death education program reduced the negative attitude toward death, increased the meaning in life significantly in the experimental group; and suicidal ideation was decreased but no statistically significant. Shin (2011) examined the effects of death education program on meaning in life, death anxiety and attitude toward nursing care of the dying patients among nursing students. Results showed that meaning in life and attitude toward nursing care of the dying patients levels significantly increased, death anxiety levels significantly decreased. The death education program will be helpful for recognizing the values of themselves and their current lives and improving their nursing intervention care of the dying patients. Jung (2013) showed that life stress was negatively correlated with attitude toward death and meaning in life; attitude toward death was positively correlated with meaning in life. Factors influencing meaning in life were life stress, volunteer activity, religion, economic status and attitude toward death, which explained about 36.9% of the total variance. Thoughts about one's death can not only induce death distress for example death anxiety but also activate death-related semantic concepts. These concepts have different implications for judgments and behavior. The effect of inducing death anxiety, which is driven by a desire for stability, may override the effect of semantic concept activation when people think about their own death (Huang, & Wyer JR, 2015). People bolster their worldviews and enhance their self-esteem in order to cope with the death anxiety (Burke, Martens, & Faucher, 2010). Alper, and Özkan (2015) stated that answer to

the question of whether internals do speed less and externals speed more to cope with the death anxiety seems to depend on the kind of control orientation. If a general desirability of control over one's life is meant, than internals do speed less to cope with the death anxiety. Helping nurses, who face death of others or are about to die, prepare for death would have a significant impact on the life of nurses who provide care (Noh, 2014).

There were 509090 deaths recorded in England and Wales for 2008 (Office for National Statistics, 2010); of these, over 56% (260000) occurred in National Health Service (NHS) hospitals. The death of a patient is an event that most, if not all, nursing staff will encounter during their work. This experience can elicit physical, cognitive, behavioural, spiritual and emotional responses (Parkes, 1998; cited in Wilson, & Kirshbaum, 2011). In a study, high levels of distress in nursing staff was correlated with a younger age, low levels of self-efficacy, low satisfaction with social support, increased work pressure and low levels of supervisor support (Kennedy, & Grey, 1997). The literature indicated an abundance of empirical evidence relating to nurses' communications with and care of the dying patient and his family. Evidence was scant however pertaining to the concept of death anxiety, how nurses cope with death, and ultimately the impact nurses' levels of death anxiety may have on their ability to prescribe and deliver palliative nursing care (Boyle, & Carter, 1998).

Poghosyan, Clarke, Finlayson, et al (2010) on the collected data for the International Hospital Outcomes Study (IHOS); the National Institute for Nursing Research (R01NR04513 and P30NR05043; the Commonwealth Fund; the Agency for Healthcare Research and Quality; the Alberta Heritage Foundation for Medical Research; the British Columbia Health Research Foundation; the Federal Ministry of Education and Research (Germany); the Nuffield Provincial Hospitals Trust, London; the Baxter Foundation; the Health Research Council of New Zealand; the International Research Grant by Pfizer Health Research Foundation; and the Japan Society of Promotion of Science in six countries in nurses, reported that higher levels of burnout were associated with lower ratings of the quality of care independent of nurses' ratings of practice environments.

The goal of patients entering critical care is survival and recovery. However, despite application of advanced technologies and intensive nursing care, many patients do not survive their critical illness. Nurses experience death in their everyday work, exposing them to the emotional and physical repercussions of grief. There are many predisposing factors and circumstantial occurrences that shape both the nature of care of the dying and subsequent grief among nurses. Repeated exposure of nurses to death and grief may lead to occupational stress, and ultimately burn out. Emotional disengagement from caring for the dying may have an impact on the quality of care for both the dying patient and their family (Shorter, & Stayt, 2010).

Wilson, and Kirshbaum (2011) explored how the death of patients in a hospital setting impact on nursing staff by review of the literature using the online databases CINAHL, Medline and PsychInfo, the search was limited to articles in the English language and those from peer-reviewed journals. Results showed that the death of patients had an impact on nurses, both in their work environment and outside of work.

The working environment for nurses is important in retaining nurses working at hospitals (Ogata, Nagano, Fukuda, & Hashimoto, 2011). Although nurses may be well aware of the daily stress of the job and potential for burnout, many emergency nurses and paramedics may be unaware of death anxiety, even though they're exposed to it every day. Nursing has been found to be one of the most stressful occupations. Nurses' stress to be linked to decreased well-being and poorer job performance, with work stressors eroding the quality and outcomes of care. Nurses' stress can include experiences of burnout and of psychological distress, such as anxiety and depression (McVicar, 2003). The Department of Health's Boorman Review (DOH, 2009) demonstrated that a quarter of the absence from work in the National Health Service (NHS) employees was due to stress, anxiety and depression. 80% of the NHS staff felt that their health and well-being impacts on the care they provide patients. Common mental health disorders in nurses and other health professionals linked to general errors, medication errors and patient safety (Gärtner, Nieuwenhuijsen, van Dijk, et al., 2010). In a sample of nurses in the UK, 26.3% presented with clinical anxiety scores and 5.9% with clinical depression scores and their coping strategies were important in predicting levels of anxiety and depression (Mark, & Smith 2012).

Nurses working in emergency rooms (ER) are being exposed to a particular kind of stress due to their environment- death anxiety. Nurses already deal with high stress from their jobs, but emergency department nurses might be at additional risk of suffering from death anxiety. Nurses are at high risk for job-related stress, which often leads to physical and mental conditions like fatigue or depression. As a result of their job burnout, they often become disengaged from their work, which can then lead to mistakes or patient safety issues. Brady (2015) warned for *Emergency Nurse*, being surrounded by life-and-death situations could take a serious toll on ER nurses' mental well-being. The thanatophobia or death anxiety made nurses hyperaware of their own mortality, causing their stress levels to skyrocket, and making them more susceptible to stress-related side effects and conditions. Regular exposure to death and trauma causes death anxiety in emergency nurses. While many emergency nurses and paramedics may be unaware of death anxiety, they are exposed to it in their everyday practice. Emergency nurses are highly susceptible to death anxiety and employers must recognize this and put support in place to improve the health of their staff and patient care. Brady (2015) stated that nurses working in emergency settings should be made aware of the risks of death anxiety or thanatophobia, and given access to interventions to prevent it from affecting their physical and mental health. The nature of their work and everyday exposure to death and other mortality cues put them at greater risk of developing this debilitating psychopathology.

Nurses more likely experience death anxiety. Emergency nurses are exposed to bereavement, patient suffering and death, making them highly susceptible to death anxiety (University Herald, 2015). The ER nurses often suffer from death anxiety (Van Wyk, & Pillay-Van Wyk, 2010). Hospitals should be provided support for healthcare workers who face trauma cases every day (Van Wyk, & Pillay-Van Wyk, 2010; MacDonald, 2015). Death anxiety touched on a common issue: nurses are often affected by their work environment, especially nurses who are required to consistently show empathy and compassion to patients. University of

Bedfordshire (2015; cited in Brady, 2015) has surveyed 351 nurses, and has shown that the pressure to appear compassionate around the clock can be emotionally exhausting, and make nurses more likely to be affected by work-related stress. Nurses who had to routinely show compassion each day were at a higher risk of suffering from fatigue and burnout.

Wilson (2014) explored how ward staff, including nurses and healthcare support workers, experience patient death in an acute medical setting. Findings showed that three main themes were identified: responses, influences and support. These themes were further subdivided into preliminary themes that reflected the social psychology literature. Ward staff often experienced grief following the death of a patient and the effects on staff were not always recognized or acknowledged by managers.

There appear to be significant differences between experienced and inexperienced nurses and also between nurses and non-nurses (Chen, Del Ben, Fortson, et al., 2006). Naderi, et al (2010) found significant differences in death anxiety among female nurses who working in emergency departments, intensive care units, renal, surgical and psychiatric wards, operating rooms, and children's units. Female nurses who working in emergency departments reported less death anxiety than female nurses who working in operating rooms.

Death fear is **s**pecific and conscious thoughts against death (Wong, et al., 1994). Death fear is defined as a morbid, abnormal or persistent anxiety of one's own death or the process of his/her dying. Fear of death is a feeling of dread, apprehension or solicitude (anxiety) when one thinks of the process of dying, or ceasing to 'be'. Fear of death is thoughts, fears and emotions related to end of life (Belskey, 1999). Fear of death is a multidimensional concept. Hoelter (1979) proposed eight dimensions of death fear: fear of the dying process, fear of the dead, fear of being destroyed, fear for significant others, fear of the unknown, fear of conscious death, fear for body after death, and fear of premature death. Hoelter and Hoelter (1987; cited in Furer & Walker, 2007) indicated eight dimensions for fear of death including: 1) Fear of dying process, 2) Fear of early death, 3) Fear of death of loved persons, 4) Pathological fear from death, 5) Fear of deterioration, 6) Fear of body after death, 7) Fear of being unknown of death, and 8) Fear of dead. Florian and Mikulincer (1993; cited in Furer & Walker, 2007) considered three dimensions for this concept including: 1) Intrapersonal dimension that it is due to effect death on the mind and body, and it is characterized by fear of lack of access to personal goals, fear of lack of access to pleasures and deterioration of body, 2) Interpersonal dimension that it is characterized by effect death on the interpersonal relationships, and 3) Para personal dimension that is mixture of fear about world of after death and punishment of after death. In a study, nine components was articulated to death anxiety including: fear of physical suffering, fear of isolation and loneliness, fear of non-being, fear of cowardice and humiliation, fear of failing to achieve important goals, fear of impact on survivors, fear of punishment or of the unknown, fear of death of others and fear of the act of dying, e.g. pain; loss of control; rejection because of illness (Faull, Carter, & Woof, 1998; cited in Schulz, et al., 2013). Hinderer (2012) explored critical care experiences of nurses with death of patient are in four themes of coping, personal distress, emotional disconnect, and inevitable death. In a qualitative descriptive and hermeneutic study to explore

nursing students' experiences of death and dying in clinical practice, Edo-Gual, et al (2014) explored five themes including impact, training in end-of-life care, ethical issues, coping and learning/growth/healing connections. They derived an explanatory model on the basis of relation among these five themes. Sharif Nia, Ebadi, Lehto, and Peyrovi (2015) identified four major themes related to death anxiety experiences included afterlife fears; alienated farewell; ambiguous separation; and physical dissolution. Patients who have been exposed to death trauma in the battlefield may carry added burden from unique cognitions and fears related to personal death.

Death distress, or a negative attitude toward death, is associated with different emotional states, mainly anxiety and fear. The academic research literature on death-related topics is dominated by studies purporting to investigate death anxiety (Kastenbaum, 1987; Koenig, & Al Shohaib, 2014). Among Kuwaiti college students, a general high-loaded factor of death distress included death anxiety, death depression, and death obsession (Abdel-Khalek, 2004).

Naderi and Shokohi (2010) reported that on the CLFDS, there is no significant correlation between optimism and death anxiety but there is a negative correlation between humor and death anxiety, and between social maturity and death anxiety in nurses. Humor was the only predicting variable for death anxiety.

There are reasons for fearing of death. Money is one such source capable of soothing existential anxiety. Individuals reminded of their mortality overestimated the size of coins and monetary notes. Participants induced to think about their mortality used higher monetary standards to define a person or family as rich than those in the control condition. People reminded of death desired higher compensation for waiving the immediate payment of money. Priming participants with the concept of money reduced self-reported fear of death. Money possessed a strong psychological meaning that helped to buffer existential anxiety (Zaleskiewicz, Gasiorowska, Kesebir, Luszczynska, & Pyszczynski, 2013). Han (2001) reported that there was a relationship between coping style, locus of control and self-esteem and death anxiety. Bath (2010) indicated that regardless of the degree to which individuals fear their own death, most individuals fear the death and dying of others. Specifically, the leaving, or separation/loss of loved ones is a central theme in people's fear of death.

Lewis Thomas claimed our fear of death is not justified, and thus it has no reason to be. In study of Abdel-Khalek (2002) on the RDFS, Fear of Pain and Punishment was only one factor amongst others including but not limited to Fear of Losing Worldly Involvements, Religious Transgressions and Failures, and Parting from Loved Ones. Thus, contrarily to what he claimed, even if people assume that pain is turned off at the moment of death, they are still left with seventeen more reasons to fear death. John Hollander in his article "Fear Itself" separated clearly between Fear of Pain and Fear of Death. He identified various kinds of fear which includes rear of One's Own Death, Fear of Pain and other bodily suffering as distinct types of fear among many others. Similarly to Abdel-Khalek's model, Hollander argued that fear of One's Own Death consists itself of many kinds of this fear, including Fear of Experiencing the Precise Moment of One's Own Dying; of the Consequences of Dying; of Something in an Afterlife; of there is no Afterlife (Brezini, 2014).

Peters, et al (2013) found that younger nurses reported more fear of death and more negative attitudes to end-of-life patient care. Chen, et al (2006) showed that nursing students who had experienced the death of other people reported significantly more fear of the dying process than nursing students who had not. Both experienced and inexperienced nursing students had more fear of the unknown than controls. Findings of Iranmanesh, Sävenstedt and Abbaszadeh (2008) showed that nursing students from Bam city who had more experience of the death of others were less fear of death but also less likely to provide care to people at the end of life. Iranian nursing students have been found to be more afraid of death and less likely to give care to dying persons than Swedish nursing students (Iranmanesh, Axelsson, Häggström, et al., 2010). The mean score of fear of death in people with a college education more than whom were high schools and under graduates, so that the difference was significant (Mahboubi, et al., 2014).

Aghajani, et al (2010) found that death anxiety was higher in critical care nurses, and these nurses cared for more dying patients than nurses in the general wards. Naderi, et al (2010) reported that nurses in differed significantly in death anxiety depending on the type of ward in which they worked. However, greater work experience in nurses resulted in more positive attitudes toward death and caring for dying patients (Lange, et al., 2008). Ayyad (2013) found that nurses dealing with critical cases and working in higher stress wards, such as intensive care units, obtained higher mean scores on the RDFS than nurses who working in lower stress wards such as internal medicine.

Campbell (2013) listed many reasons for fearing death including: the unknown, loneliness, anxiety about tolerating the death experience, loss of family and friends, losing self-control of bodily functions, suffering and pain, unbearable grief, a non-existent or a terrible afterlife, and a failure to achieve one's goals in life. Abdel-Khalek (2002) studied reasons for fearing death in Kuwaiti college students. Women obtained higher scores for three items of the RDFS including fear of hell and doomsday, fear of the vague and unknown issues, and the torture of the grave, but this difference was not significant.

Zargham Boroujeni, et al (2007) suggested that one of the most important ideas that will help nurses to deal with death better is a belief in life after death. Being religious helped nurses cope with their dying patients, and religion also brought relief to dying patients and their families. The nurses noted that employment in the nursing field had increased the importance of religion to them and lessened their fear of death.

On the RDFS, Aflakseir (2014) reported that the college students showed the highest score mean in the Fear of Pain and Punishment, and the lowest score mean in the Fear of Losing Worldly Involvements. Components of the RDFS explained 24% of variances of anxiety on the Spielberger State-Trait Anxiety Inventory (STAI). Only Fear of Losing Worldly Involvements predicated anxiety. Three components had positive relationships with anxiety, the highest was related to Fear of Losing Worldly Involvements, Parting from Loved Ones, respectively, and the lowest was related to Fear of Pain and Punishment.

There have been many empirical studies of death anxiety, but many questions also remain because of methodological limitations and the difficulties inherent in this subject.

Nevertheless, a critical review of the literature does reveal some interesting patterns such as most people report that they have a low to moderate level of death-related anxiety; women tend to report somewhat higher levels of death-related anxiety; there is no consistent increase in death anxiety with advancing adult age. If anything, older people in general seem to have less death anxiety; people with mental and emotional disorders tend to have a higher level of death anxiety than the general population; and death anxiety can spike temporarily to a higher level for people who have been exposed to traumatic situations. Summary of death anxiety studies and their outcomes has shown in Table 4.

Table 4- Summary of death anxiety studies and their outcomes

Author/Setting/ Nursing Discipline	Design/Sample & Instruments	Findings	Outcomes	Effect/Correlations
Hutchison and Sherman (1992) Student nurses in USA	Non-random trial of didactic or experiential death & dying training for students (N=74): pretest- posttest using Templer Death Anxiety Scale (DAS)	No differential effects of training technique were found. However, DAS post-test scores were significantly lower than the pre-test scores for both groups; also maintained at 8-week follow-up.	There was inconclusive evidence of the effect of training on students' level of death anxiety. Training positively impacted on students' levels of anxiety.	Anxiety was lower after training and at 8 weeks.
Payne et al (1998) Hospice and emergency nurses in England	Mixed methods: survey (N=60) using Death Attitude Profile-Revised Questionnaire & semi-structured interview	Hospice nurses had lower death anxiety, as shown by 8 of 32 items with significantly more positive responses than emergency nurses. Subscale differences were not reported.	Limited differences were shown between disciplines. Between groups- hospice nurses appeared to have low death anxiety despite frequent exposure to deaths.	Significant difference by demographics.
Rooda (1999) Metropolitan private hospital nurses and visiting nurses USA	Cross-sectional survey (N=403) using Frommelt Attitude Toward Care of the Dying Scale, and Death Attitude Profile-Revised (DAP-R)	DAP-R scores were related to sex, religious affiliation, and current contact with terminally ill patients. FATCOD scores (e.g., showing acceptance of death) were positively related to current contact with dying patients, negatively correlated with two DAP-R subscales (Fear of Death and Death Avoidance), and positively correlated with two other DAP-R subscales (Approach Acceptance and Neutral Acceptance)	Nurses' attitudes toward death and their current contact with terminally ill patients were predictive of their attitudes toward caring for terminally ill patients.	Significant inverse relationship: 2 subscales of DAP-R and between attitude to death and caring for dying.

Author/Setting/ Nursing Discipline	Design/Sample & Instruments	Findings	Outcomes	Effect/Correlations
Deffner (2005) Registered nurses in USA	Correlation study- Cross sectional survey (N= 190) using Death Anxiety Scale	Regression analysis showed death anxiety level was significantly inversely related to comfort level of nurse when communicating with patients/ families regarding death ($p = .000$). Age, education, years of nursing, exposure to communication education for dealing with death showed negative Gamma values or R, indicating that discomfort decreases as age, education, experience, current nursing employment, work in other areas, and exposure to communication education increase.	Comfort level of the nurse during communication with patients and families is adversely affected by an increase in the nurse's own death anxiety, and positively affected by exposure to communication education. Importantly, nurses should identify their level of death anxiety/be exposed to education on communicating with patients/ families regarding death.	Significant inverse relationship: comfort and attitude to death.
Dunn (2005) Oncology and med-surg registered nurses in USA	Cross-sectional survey (N=58) using Fromelt Attitudes Towards Care of the Dying (FATCOD) and Death Attitude Profile- Revised (DAP-R) scale	Nurses who reported spending more time with dying patients had more positive attitudes. No significant association was found between nurses,' attitude towards death and attitude to caring for dying patients.	Nurses were positive about caring for the dying; there was no effect of death anxiety on attitude towards caring for dying patients; some subscales were associated with demographic variables & scales. Education programs on death and dying are recommended.	Non-significant relationship death anxiety and caring for dying.

Author/Setting/ Nursing Discipline	Design/Sample & Instruments	Findings	Outcomes	Effect/Correlations
Santisteban (2006) Various practitioners in palliative care unit in Spain	Cross-sectional survey (N=24) using Templer's DAS and Maslach's MBI	Average death anxiety was 5.75. Nurses scored highest on depersonalization. Factors related to team relationships were most stressing. Assistant nurses hardly ever sought family or colleague support to discuss work-related topics.	Average death anxiety was 5.75, similar to other studies, but this figure varies depending on the presence of spiritual beliefs or otherwise. Differences in MBI variables were seen between professions.	Mean death anxiety 5.75.- context not reported.
Myashita et al. (2007) Hospital general nurses in Japan	Cross-sectional survey (n= 178) using FATCOD & Death Attitude Inventory (DAI). (Japanese versions) & Pankratz Nursing Questionnaire	Multivariate linear regression identified various subscales that were related to caring; Death anxiety domain, DAI (r = –.17, *P*=.02), death relief (*r*= –.19, *P*= .012), death avoidance (*r*=.33, *P*=.001), and life purpose (*r*=.38, *P*=.001) were significantly correlated with DAI (positive attitude toward caring for the dying).	Most participants had a positive attitude toward caring for the dying patient and recognized the need for patient- and family-centered care. Educational and administrative efforts to strengthen nursing autonomy are necessary	Significant inverse & positive relationships for attitude to death and caring for dying.
Inci (2007) Oncology & ICU Nurses in Turkey (not in English)	Pretest-posttest-Surveys: Effects of death education - using Death Anxiety Scale (DAS), Death Depression Scale (DDS), & Attitude Scale Euthanasia, Death and Dying Patients (EDDP).	DAS and DDS scores decreased significantly (p=<.05) after training; Non significant change in EDDP (p>0.05). No effect of death education by age, years of work, how they were affected by terminal patient nursing or the meaning attributed to death.	There was a positive effect on nurses, death anxiety after death and dying training over 7 sessions, however there was no impact of nurses' age, years working or how they reported being affected.	Anxiety was lower after training.

Author/Setting/ Nursing Discipline	Design/Sample & Instruments	Findings	Outcomes	Effect/Correlations
Black (2007) Healthcare Professionals including nurses in New York state, USA	Cross-sectional survey (N=135) (nurses, doctors social workers): who managed older patients- using Death Attitude Profile-Revised (DAP–R).	Age correlated positively with fear of death, (p= .004), avoidance of death (p= .007); negatively with neutral acceptance of death (p =.001), escape acceptance of death (p=.034). Negative correlations were found between collaborating with other professionals regarding directives and fear of death, avoidance of death, and escape acceptance of death.	Death anxiety was a predictor of professionals, communication with others about advance directives. Experts in end-of-life care recommend probing the relationship between healthcare provider communication behavior and personal death attitudes.	Significant inverse relationship between 2 attitude subscales 'Avoidance, and 'Escape, and caring for dying.
Lange, Thom and Kline (2008) Inpatient & outpatient oncology nurses in USA	Cross-sectional survey (n= 355) using FATCOD & DAP-R instruments.	Statistically significant relationships were found among age, nursing experience, previous experience with caring for the terminally ill, and scores on FATCOD and DAP-R. Nursing experience and age were the variables most likely to predict nurses' attitudes toward death and caring for dying patients.	RNs with more work experience tended to have more positive attitudes toward death and caring for dying patients. Less experienced oncology nurses will benefit from increased education, training, and exposure to providing and coping effectively with end-of-life care.	Significant inverse relationship: attitude to death and caring for dying.

Author/Setting/ Nursing Discipline	Design/Sample & Instruments	Findings	Outcomes	Effect/Correlations
Iranmanesh et al (2008) Hospital general and oncology nurses in Iran	Cross sectional survey of nurses (N=114) using translated Death Attitude Profile-Revised (DAP-R) and Frommelt,s Attitude towards Caring for Dying Patients (FATCOD)	Fear of death was negatively (r -.199) correlated with attitude toward giving care to the dying. Neutral to moderately positive attitude toward caring for dying (FATCOD mean 3.55/15). Most were likely to give care and emotional support to persons at the end of life whilst taking an authoritative approach.	Lack of education and experience, as well as cultural and professional limitations, may have contributed to the negative attitude toward some aspects of the care for people who are dying among the nurses surveyed.	Significant inverse and also positive relationships between attitude to death and caring for dying.
Braun (2010) Oncology nurses in Israel	Survey of nurses (N=147) using Frommelt Attitude Toward Care of the Dying Scale (FATCOD), Death Attitude Profile - Revised (DAP-R)	Nurses had moderate levels of fear of death (x^2=4.11), death avoidance (x^2=2.93), approach acceptance (x^2=3.53), & escape acceptance (x^2=3.6), with correlation of Fear of death with Death avoidance & Approach acceptance. Approach acceptance was correlated with Death avoidance & Escape acceptance. Mean FATCOD: 125.7.	Nurses, personal attitudes towards death were associated with their attitudes to caring for dying patients, with most demonstrating positive attitudes. A mediating role was found for death avoidance, suggesting some may use avoidance to cope with fear of death. Culture and religion may be key to attitudes (most were Jewish).	Significant positive relationship between 4 subscales.

Author/Setting/ Nursing Discipline	Design/Sample & Instruments	Findings	Outcomes	Effect/Correlations
Matsui and Braun (2010) Hospital adult and childrens' nurses caring for terminal patients in Japan	Pretest- posttest survey (N=190 RNs; 176 care workers): using Death Attitude Profile (DAP), Japanese version, and Attitude Scale about Euthanasia, Death, and Dying Patient.	After 7x 90min sessions of nurse education on death and dying- multiple regression showed better attitudes toward caring for the dying were positively associated with seminar attendance and negatively associated with fear of death. There was no difference between RNs and care workers' responses.	Attitudes (measured by FATCOD) were not correlated with job certification or work setting but with death attitudes and seminar attendance. Staff education is important for maintaining and improving standards in end of-life care in institutional setting	Significant inverse relationship: attitude to death and caring for dying.
Ho et al (2012) Renal registered nurses in Spain	Cross sectional survey (N=202) using Frommelt Attitude Toward Care of the Dying Scale-Form B.	Nurses were managing elderly patients at end of life (EOL); they held positive attitudes towards caring for the dying, 88.9% viewed EOL care as an emotionally demanding task, 95.3%% reported that addressing death issues require special skills and 92.6% reported that education on EOL care is necessary.	Further education about end of life care was recommended for Spanish renal nurses.	N/A
Zyga (2012) Renal nurses including palliative- trained-in Greece	Descriptive quantitative survey (N=49) using Death Attitude Profile-Revised (DAP-R)	Nursing experience and age predicted nurses' attitudes towards death. Nurses with specific education on palliative care had less difficulty talking about death and dying and did not have a fear of death.	Hospital-based teams (palliative care, supportive care or symptom assessment teams) had statistically significant different relationships with fear of death and neutral acceptance scores.	Significant difference by demographics

Adapted from Peters, et al (2013)

- Death obsession

Elements of death (death anxiety, death depression and death obsession) are psychological phenomena (Leombruni, Miniotti, Bovero, Zizzi, et al., 2014; Dadfar, & Lester, 2014; Fernandez-Donaire, et al., 2014).

Abdel-Khalek (2002b) reported that anxiety disorders patients had higher scores than Egyptian normals (non clinical), schizophrenic, and addicted patients on the DOS. Abdel-Khalek and Lester (2003) showed that Kuwaiti students obtained significantly higher score than American students on the DOS. Abdel-Khalek (2005) found that Egyptian, Kuwaiti, Lebanese and Syrian male and female undergraduates showed higher scores on the DOS than British, Spanish, and American undergraduates. Abdel-Khalek, Al-Arja, and Abdalla (2006) indicated that Palestinians obtained significantly lower DOS scores than subjects from Arab countries of Egypt, Kuwait, Lebanon and Syria, showed that Palestinians were adapted to strife and violence.

Abdel-Khalek and Abdulla (2006) in study of Palestinians in found that women had higher mean scores than their men counterparts in death obsession, which was congruent with previous investigations on Kuwaiti and Lebanese participants, but contradicted the non-significant gender differences on the death obsession among Egyptian (Abdel-Khalek, 2003); Syrian (Abdel-Khalek, & Salleh, 1999), American (Abdel-Khalek, & Lester, 2003) samples. Abdel-Khalek, and Maltby (2008) reported that anxiety among two samples of Kuwait and United Kingdom, pessimism among the sample of Kuwait, and (un) happiness among the sample of United Kingdom college students, provide a good theoretical and empirical context for understanding of reasons and consequences of death obsession. Ashouri, Hosseini, Ghariblo, et al (2013) indicated that there was a significant negative relationship between death anxiety and hope with death rumination, death dominance and death idea repetition on the DOS in college students.

Literature has shown relationship between religious orientation and issues related to death. Different situational variables for example the young ages may effect on the conceptual relationship between religiosity and death distress (Al-Sabwah, & Abdel-Khalek, 2006). Maltby and Day (2000b) reported that there was a relationship between death obsession and extrinsic religious orientation in English college students. Mohammadzadeh, and Najafi (2011) indicated that there was a positive relationship between death obsession with extrinsic orientation toward religion in men and women, but death obsession had a negative relation with intrinsic orientation toward religion. Also extrinsic religious orientations in women predicted death obsession with greater power. Negative relationship between intrinsic religious orientations with death obsession could be concluded that religious immaturity caused pathological attitudes toward death and role of gender differences was significant. Issazadegan, Salmanpour, and Qasimzadeh Alishahi (2012) reported that good features and death obsession was predicted and explained by the testable dimension of personality and religious orientation. Salmanpour, and Issazadegan (2012) showed that the relationship between death obsession with extrinsic orientation toward religion was positive, whereas death obsession had a negative relation with intrinsic orientation toward religion. On the

NEO personality inventory (NEO-FFI), there was a significant positive relationship between neuroticism and death obsession. Other dimensions of personality had negative relationship with death obsession. The greater negative relationship was between intrinsic orientation toward religion and conscientiousness dimension. Extrinsic orientation toward religion and neuroticism predicted 19% of variance of death obsession. On the DOS, there were significant differences between undergraduate female and male students, and women had more scores in total death obsession, and its three agents (death rumination, death dominance, and death idea repetition) than men.

Some studies have been done by using the DOS in nursing college students. For instance, Al-Sabwah, and Abdel-Khalek (2005-2006) reported a significant difference between freshmen and sophomores nursing students. Shiekhy, Issazadegan, Basharpour, et al (2013) revealed that there was a significant positive relationship between death anxiety with death rumination, death dominance and death idea repetition in nursing college students. The first step in the pathway to suicide is assessment of the wish to be dead in clients (Maruši, Roškar, Svetii, & Zorko, 2012). Lester (2013) developed the Wish to be Dead Scale (WDS) that is useful for clinical practice and research, and scores the scale showed modest correlations with a history of suicidal ideation and attempts and with scores on a scale to measure obsession with death.

- Death depression

Depressive signs including suffering, hopeless, loss, and sadness have been reported by some health professionals to work with dying patients (Tomas–Sabado, Limonero, Templer, et al., 2004-2005). In the stage of depression, in the process of grief, common signs of depression are difficulty sleeping, poor appetite, fatigue, lack of energy, crying spells, self-pity, feel lonely, isolated, empty, lost, and anxious. Tomas-Sabado, & Gomez-Benito (2005) reported death anxiety and death depression is related together but they are distinct aspects of human reactions to death phenomenon. Death distress and anxiety level are associated with depression (Chibnall, Videen, Duckro, et al., 2002). Preoccupation with death can cause anxiety and depression in some religious people. In general, religious attitudes toward death are debatable in three characteristics: death anxiety, death depression, and death obsession. Abdel-Khalek (2011-2012) believed that death distress includes death anxiety, death depression, and death obsession.

There were done studies about afterlife view and death depression. Results of a study showed that lower death depression scores were associated with more confidence in religion and stronger afterlife beliefs. Also less belief and faith to life after death were associated with the DDS lower scores (Alvarado, Templer, Bresler, et al., 1995). More certain about life after death was related to less depression and afterlife beliefs play a main role in lower the DDS scores than belief in God (Harville, Stokes, Templer, et al., 2003-2004). It is seemed that relationship between death anxiety and afterlife beliefs be more inconsistent than the literature on death depression (Ramchandani, 2010).

Ayyad (2013) reported that working in higher stress nursing departments such as ICU and Heart Department, affected death distress (the DDS, DOS, and RDFS) than their counterparts working in lower stress departments such as internal medicine. Little research has been conducted with Iranian Muslim nurses and their emotional needs about death issues. There were studies of death anxiety in Iranian nurses (for example Masoudzadeh, et al., 2008; Aghajani, et al., 2010; Naderi, et al., 2010; Bagherian, et al., 2010). There is one study about death depression in college students (Aghazadeh, Mohammadzadeh, & Rezaie, 2014), and one study about death depression in nurses (Rajabi, Begdeli, & Naderi, 2015) in Iran.

- Death education

Critically ill patient death education program (The End of Life Nursing Consortium, ELNEC) was developed in 2000 in the United States. This program allowed people to ponder over the meaning of life through the education on care, ethical issues, communication, post-death care for dying people and had a positive mindset for death so that they could form an appropriate attitude for death preparation (Kono, 2006). Education is a key factor in improving attitudes toward care of the dying. The literature indicated that educators have used a variety of methods to teach students about death and dying. The majority of studies in nursing education have looked at how death education affects death anxiety. Other researchers have also demonstrated that death anxiety can be reduced by death education (Murray, 1974; Durlak, 1978; Miles, 1980; Murphy, 1986; Warren, 2014). Nurses face with their own fear of death whenever they come to the bedside of a dying patient. This fear must be confronted and reconciled before they can help others meet death with dignity.

Nursing, an art care of the dying, is a fine art. Behaviors deemed critical to care for dying patients. include: (1) Responding during the death scene, (2) Providing comfort, (3) Responding to anger, (4) Enhancing personal growth, (5) Responding to colleagues, (6) Enhancing the quality of life during dying, and (7) Responding to the family (Degner, Gow, & Thompson, 1991). It is critical that educators take on this most important role of educating new nurses on how to care for the dying. History has shown that although researches have not completely neglected the task of educating nurses to care for the dying, they have done very little in this area. The time has come to move forward and seek the best ways to educate that will change negative attitudes toward care of the dying and improve care of the dying. Through education and change, nurses can facilitate improved care of the dying. LaGrand (1980) indicated that work-related stress is a reality that should be an open topic of concern to medical teams, hospice personnel, and all involved in death education. He proposed four possibilities for reducing stress: (a) Cognitive modification, (b) Exercise outlets, (c) Relaxation techniques, and (d) Stimulus control. Both awareness and social support among professionals are emphasized as resources to be utilized in designing individual stress-management programs. Humanistic nursing is divided into four dimensions, including empathy, status equality, holistic selves, and shared decision-making and responsibility (Kuusisto, Krause, & Kiikkala, 1991).

Research evaluating death education programs has yielded vague and misty results**.** Frommelt (1991) used the death education program, based on the hospice concept of care, included a didactic section based on Kubler-Ross' stages of death and dying, and a role-play model designed by the researcher, and using the Frommelt Attitude Toward Care of the Dying Scale (FATCOD). Nurses obtained significantly higher scores and had a more positive attitude toward caring for terminally ill persons and their family members after participation in the educational program. Previous education on death and dying related to the nurses' attitudes. Maglio, and Robinson (1993) performed a meta-analysis of various death education interventions to assess the effectiveness of death education programs in reducing death anxiety. Three questions were examined: (1) Is death education effective in reducing death anxiety? (2) What portion of the variance in death anxiety can be accounted for by the death education treatment? And (3) How many treatment effects are practically significant? An effect size for each individual study was calculated along with an overall treatment effect size for death education. Investigators calculated a total of 62 effect sizes which represented 5,327 treated individuals. Results indicated that death education led to more death anxiety. Of the two types of interventions tested, didactic interventions led to significantly higher death anxiety than did experiential interventions. For questions two and three, death education interventions accounted for practically significant portions of the variance in less than half of the cases which suggests that statistical significance does not necessarily establish practical significance.

In other studies researchers developed their own instrument or tool and did not report validity and reliability. As stated earlier, medical schools are seeing the need for improved End- Of- Life (EOL) education and have begun to conduct research to assess the courses they are implementing. Unfortunately, the ability to compare these courses to each other or to replicate in different settings is greatly hampered by the lack of uniformity of testing. As the field of nursing seeks to examine its educational process regarding attitudes toward the EOL care it is imperative that valid and reliable instruments be used to ensure quality and viability of the research. Change is occurring at a national level for nursing education regarding the EOL care. Nurse researchers at the City of Hope National Medical Center in Duarte California conducted a project funded by the Robert Wood Johnson Foundation titled: Strengthening Nursing Education to Improve End of Life Care (Ferrell, Grant, & Virani, 1999). For this project the researchers established three goals: 1) Improve the content regarding the EOL care in nursing textbooks, 2) Ensure adequacy of content in the EOL care as tested by the national nursing examination, and 3) Support the three key nursing organizations in their efforts to promote nursing education and practice in EOL care. The three nursing organizations are The National Council of State Boards of Nursing, the American Association of Colleges of Nursing and the National League for Nursing Accreditation Commission (Ferrell, et al., 1999). This project, along with individual researchers seeking the best way to educate nursing students about the EOL care, has nursing heading in the right direction to achieve what Quint (1967) set out to achieve. Dunn, Otten, and Stephens (2005), Brien, Legault, and Tremblay (2008) reported that the experience in EOL care education caused affective learning in nurse

educators and students. It is exciting that nursing education is finally changing over thirty years later. Mallory (2003) incorporated experiential learning using a model of death education and transformative learning theory. The educational experiences were geared to help students understand the skills needed to care competently and compassionately for the dying. The use of the End of Life Nursing Education Consortium (ELNEC) education package along with experiences at the hospice, the funeral home, the anatomy laboratory, and role play helped facilitate transformative learning in the nursing students. The study examined the effects of an educational experience to determine if a one-time educational experience provides sufficient, lasting effects in a 6-week format. Results indicated that education can have a positive effect on nursing students' attitudes toward care of the dying. Nursing students in the intervention group had a significant positive increase in their attitudes toward care of the dying after the intervention. The attitude change increased slightly after a 4-week period. Choi, and Park (2004) compared death orientation scores of nurses before and after a hospice training program. Finding showed that there was no significant difference in mean scores for death orientation before and after hospice training. The death orientation score before hospice training was significantly different according to the work place of nurses but after the hospice training there was no significant difference for any of the general characteristics, also there was no correlation between religiosity and death orientation scores before and after hospice training. Tracy (2006) evaluated the effectiveness of two death education programs by comparing pretest and posttest scores of behavioral intentions and (reported) behavior of Emergency Medical Technicians (EMTs) when at the scene of a death. Results showed that the majority of EMTs intended to change their behavior at the scene of a death when compared to the control group. In a three-month follow-up study, the majority of EMTs who received the intervention (and made a death notification) changed their behavior. These programs were effective in changing the behavioral intentions of EMTs. Jo, Lee, and Lee (2007) developed and applied online education on death. Adriaansen and van Achterberg (2008) reviewed relevant literature published between 1990-2005 and reported that the most successful were integrated courses with several themes and variety of didactical teaching methods. İnci, and Öz (2009) assessed the effects of death education program on death anxiety of 45 nurses who are nursing patients in terminal phase, their death depression regarding death, and their attitudes towards the dying patient. In their study each session of the training program was consisted of 7 total sessions once a week within the framework of the session and in harmony with the determined aims for duration of 90 minutes. Scales were including the DAS, the DDS, and the Attitude Scale about Euthanasia, Death, and Dying Patient (ASEDDP). Results showed that after death education program, scores on the scales of the DAS, and DDS decreased at a statistically significant level but no on the ASEDDP. Also they reported that effect of the death education program didn't vary according to the age of the nurses, years they worked, manner of being affected from terminal phase patient nursing and meaning they attributed to death. Kang (2010) evaluated meaning in life and death attitude between participants and non-participants in well-dying education program. Findings showed that the program participants showed higher scores in the death attitude

than non-participants; there were significant correlations between meaning in life and death attitude in participants. Well-dying education program was effective to prepare good death with more comprehensive vision. He suggested that this program should be served for patient with life-threatening illness by nurse and this is the expended role of oncology and hospice palliative nurses. Matsui and Braun (2010) using the Japanese version Death Attitude Profile (DAP), and the ASEDDP, indicated that staff education is important for maintaining and improving standards in end of-life care in institutional setting. Walker and Avant (2011) were chosen as a deductive method to distinguish between the defining attributes of death preparedness and its relevant attributes. This inquiry was guided by the researcher's philosophical orientation as an ethicist to deduce the definition of the transition of facilitated communication with a healthcare provider that leads to awareness and/or acceptance of EOL, as evidenced by an implementation of an EOL plan. White, and Coyne (2011) assessed the EOL care core competencies deemed most important with corresponding educational needs from oncology nurses and described the characteristics of the respondents that were associated with selection of the top-ranked core competencies. A descriptive, cross-sectional study, mailed and online surveys, 714 members of the Oncology Nursing Society from Georgia, Virginia, Washington, and Wisconsin were used. Responses to a mailed or e-mailed researcher-developed questionnaire during a six-month period were collated and analyzed. Ranking of the EOL care core competencies and perceived gaps in EOL continuing education were studied. Almost all of the nurses indicated that the EOL care was a part of their practice and that continuing education was important, but more than half of the them had fewer than two hours of continuing education regarding the EOL care in the past two years. Twenty-five percent of the nurses did not believe they are adequately prepared to effectively care for a dying patient. Symptom management was the top-rated core competency, consistent across age, education level, practice role, and practice setting. How to talk to patients and families about dying and what comprises palliative care also was selected frequently. Symptom management was the number one core competency, and the quantity and quality of EOL continuing education was inadequate. Educational gaps existed in the EOL nursing care. Assessing what nurses believed to be leading EOL core competencies was useful in improving educational curricula along with considering characteristics of nurses when planning EOL educational programs. Cui, Shen, Ma, and Zhao (2011) identified what nurses wanted to know most about death education and obtained baseline data to improve nurses' training and education. The dimension of managing issues associated with death and dying had the highest score, but issues associated with funeral planning had the lowest score. Three factors influenced the nurses' needs in death education: educational background, previous training about death education, and hospital size. Nurses had high levels of need in the content of death education, particularly regarding knowledge and skills in coping with death and dying patients (e.g., caring for patients and their families physically and psychologically). Schulz, et al (2013) reported that three constructs willingness to accompany a dying patient, self-estimation of competence in communication with dying patients and their relatives, and self-estimation of knowledge and skills in Palliative Care increased in the intervention group

before and after. Kim and Kim (2014) explored the types of the attitude on a good death of nurses in long-term care hospitals by Q-methodology, which is effective in scientifically measuring individual subjectivity. The types of attitude were categorized into three: 1) Death in supportive environment; 2) A comfortable death in real life; and 3) Dignity guaranteed death by identifying three attitude patterns toward a good death of long-term hospital nurses, this study suggested to think about ways to improve the quality of nursing in the current increasing long-term hospitals. Cavaye and Watts (2014) reported that on death education there were inconsistencies across educational provision with variations in quantity, content, and approach; and a deficit in key areas such as knowledge, skills, organization of care, and teamwork of death education in pre-registration curricula. They were used an integrative review process that is a five-stage approach proposed by Whittemore and Knafl (2005) including: 1) Problem identification, 2) Literature search, (3) Data evaluation, (4) Data analysis and (5) Presentation (results) were outlined in Table 5.

Table 5- Integrative review process

Approach stages	Characteristics
1. Problem identification	What is the nature and extent of provision of death education end-of-life care/palliative care in pre-registration curricula?
2. Literature search	Electronic databases searched: ONCL First Search, ASSIA, Psychlnfo, CINAHL, MEDLINE, EMBASE, British Nursing Index, and AMED
3. Data evaluation	Data included theoretical and empirical reports. Quality evaluation by two researchers
4. Data analysis	Qualitative analysis to develop themes and categories
5. Presentation (results)	Quantity: amount and perceived adequacy Content and teaching strategies: the interventions used in curricula design Reported outcomes: attitudes, communication, and clinical skills Limitations: stringent inclusion criteria including exclusion of papers focusing on post registration education Data quality of included papers: small numbers, incomplete data sets, and tendency towards self-reporting

Adopted from Cavaye, and Watts (2014)

Yeun, Kwon, and Lee (2015) developed a "Palliative Care Professional" education program (PCPE), consisted of 5 sessions and 16 content items for 2 weeks and evaluated its effects on the recognition of good death, palliative care, and the meaning of life for nurses. The results indicated that the PCPE program allowed the nurses to accept death as a positive experience, understand the effects of palliative care, and reflect on their own lives to find further meaning of life. Nurses felt that the PCPE program met their identified need for topic and context specific education.

Many studies used death education program in nursing students. Degner's (1985) course in palliative care decreased nursing student's death anxieties and improved attitudes toward care of the dying. Lev (1986) found that a course in hospice nursing decreased nursing student's attitudes of fear toward death and dying and avoidance behaviors toward the dying. Lockard (1989) reported that her seven-hour course in death and dying had a significant effect in reducing nursing student's death anxiety. Examining one's attitude towards death is a difficult task that needs to begin in the student years, when attitudes towards working with the dying are formed. Nurse educators recognize that brief but effective ways of promoting this kind of personal awareness need to be found. An experimental study is described that investigated the effect of death education programs and personal experience with death on the attitudes of nursing students. It was found that the death attitudes of inexperienced students who were in an experiential program were more positive than similar students who received a didactic or placebo program. Experienced students, however, were negatively affected by the experiential approach. The implications of these findings for nursing education are outlined (Hurting, & Stewin, 1990). Johansson and Lally (1990) evaluated the effectiveness of a death education program in reducing death anxiety of nursing students following the viewing of a film depicting a death experience. Findings indicated that the death education program was effective in decreasing the death anxiety of some of the seniors, but it had an opposite effect on some of the juniors. This discrepancy could result from the fact that seniors had prior supervised clinical experience with dying patients, and juniors did not have this experience. Hutchison and Sherman (1992) in a non-random trial of didactic or experiential death and dying training for nursing students reported that on the DAS, no differential effects of training technique were found. The DAS post-test scores were significantly lower than the pre-test scores for both groups. They found very little difference in change in student's death anxieties. They showed a significant change in overall death anxiety, which supported study of Lockard. They also found that the effects of the attitude change stayed and maintained eight weeks after the educational experience (follow-up). There was inconclusive evidence of the effect of training on students' level of death anxiety. Training positively impacted on students' levels of anxiety. Baek, Lee, and Kim (2001) evaluated the effectiveness a hospice care class on the death orientation in nursing students. Results showed that 14 items of the Death Orientation Scale of Thorson and Powell (1988), decreased significantly after the class as compared to before the class. On the scale there were no significant statistical differences in personal attributes (religion. the existence of religion, the experience of a death in recently). Hwang, Lin, and Chen (2005) evaluated life and death studies course on attitude toward life and death among nursing students. Kim, Choi, Lee, et al (2005) examined effects of a death education program consisted of lectures and discussions for 6 hours a day over 5 days on attitude to death and meaning in life for nursing college students .The design of the study was quasi-experimental and non-synchronized with a non-equivalent control group. The 30-hr course examined the meaning of death, modern society and death, hospice movements and desirable life and death. Results showed that attitude to death scores in the experimental group were significantly lower than in the control group and meaning in life scores in the

experimental group were significantly higher than in the control group. Death education program was effective to enhance the attitude to death and meaning in life among in nursing college students. Kono (2006) revealed that experiential death education was effective in reducing negative perspectives toward death, increasing more positive perspectives in nursing students. The experiment fell short of inducing lasting change in perspective. Also, religiousness was found to influence the amount of effect experiential death education had on the perspective toward death. Brien et al (2008) using mixed methods, revealed that death training course had positive effect on nursing students' attitudes and development of their interpersonal skills. Studies indicate that nurses spend more time with patients at the end of life than any other health care discipline. So it was imperative that nurses be educated so they could provide this high-quality end-of-life care. Wallace, Grossman, Campbell, et al (2009) provided a current state of EOL nursing education in the literature and to report on EOL knowledge and experiences of two groups of nursing students. The review of literature and student knowledge and experience assessment resulted in the development of a model of EOL curriculum integration implemented at the university and sets the stage for future program evaluation studies. In Korea, the death preparation education program was developed and included the understanding of death, death of contemporary society, people caring life, handling loss and grief, proper life and death, etc. for nursing students. As for the death teaching method used in death education study, lectures and discussions have been mainly utilized. Also, the death related experiences and information and data have been provided through Internet (Kim, Kim, & Choi, 2011). Lu, et al (2011) in a qualitative study exploring the experiences of undergraduate nursing students imagining the possibility of their own death during a workshop on life-and-death issues, reported that nursing students experienced a process of dying, death and rebirth. Students not only expressed emotional responses that included surprise, reluctance to let go and gratitude but also realized the importance of cherishing the present, committing to the nursing profession and valuing their own lives. They concluded that students can learn their fear of death and possible emotional reactions towards dying patients through self-reflection during a workshop on life-and-death issues. The foundation for facilitating students' self-awareness is a safe environment for them to gain experiential knowledge of the dying process and end-of-life care. Experiential education not only helps students grow personally but also increases their motivation to learn. Hope, et al (2011) evaluated the effectiveness of a simulation exercise in end-of-life care and role play by in nursing students. The students showed that simulation improved their humanistic and problem solving abilities and also helped to develop their psychomotor, technical skills, and overall confidence. Didactic instruction in EOL care is a critical element of nursing education and for most health professions training in general. Properly implementing this often-overlooked educational process requires providing students with opportunities to reflect on death and dying along with guidance during nursing practice in coping with emotional reactions to caring for dying patients. Students' ability to recognize and manage their own emotional reactions towards death and dying patients should be included as part of EOL education. A workshop on life-and-death issues can help students discover that they are not

alone and that they can support each other and learn how to manage their own emotions (Lu, et al., 2011). Education can change attitude toward death and caring for dying patients in nursing students (Bagherian, et al., 2010; Aradilla-Herrero, Thomas-Dobson, & Gómez-Benito, 2012). Kopp, and Hanson (2012) indicated that awareness of issues was related to terminal illness, death, and loss in undergraduate nursing students. Kim (2013) compared the differences of attitude to death and perception on hospice-palliative care (HPC) between nursing and medical students. Statistically significant differences were found course of knowing HPC; reason of inactive introduction; having to CPR in irresponsive terminal situation to you and to your family; decision-making about DNR; awareness to medical authority legal representative; awareness; and subject of AD, addiction, tolerance, taking a point, of narcotic analgesics and control of pain. These findings provided the basis for expanding practice and education to hospice-palliative care for nursing and medical students. Kim, Hur, and Kim (2014) examined understanding of the meaning of well-dying and types of such views held by medical practitioners and nursing students by Q-methodology. Findings showed that the participants had three types of meaning of well-dying; total variance explained by these types was 57.97%" where type 1 was "reality-oriented", type 2 "relationship-oriented" and type 3 "obeying-the-nature". The participants' subjective views on well-dying influenced their medical practice on patients who are facing death. They concluded that medical practitioners should have profound insights concerning life and death, to that end, a training program is needed to help medical practitioners develop a proper view on well-dying by subjectivity type. Dorney (2014) yielded a rich understanding of the grief experience of nursing students, while providing insights for policy development and supportive interventions for nursing faculty and college administrators. Jafari, Rafiei, Nassehi, et al (2015) in a quasi-experimental method with one-group pre-test/post-test design and using FATCOD, examined the nursing students' attitude toward caring for dying patients and effects of education on their attitude. Results showed that 20% of the students reported previous experience of dying patients in their clinical courses; they showed moderately negative to neutral attitudes toward caring for dying patients; and education improved students' attitude significantly and it was effective in changing nursing students' attitude toward caring for dying patients. Dadfar (2015) in an experimental study (pretest, posttest, with a control group), examined 42 nurses in four independent groups (12 didactic, 10 experiential, 10 8A model, and 10 controls). The groups were selected randomly from different wards of the Khatom-Ol-Anbia General Hospital in Tehran city, and they roughly matched with together for demographic variables. The nurses completed Death Concern Scale (DCS), CLFDS, RDFS, DAS, DOS, DDS, and the Stage of Change Scale (SCS) before and after intervention. Death education programs were held by 6-hours 6-days 6 workshops weekly. Data were analyzed through descriptive statistics, t-test, ANCOVA, ANOVA, and Scheffé test using SPSS/WIN 16.0 program. Results showed that there were significant differences between pretest and posttest for didactic approach on the scales scores of the DCS, and the DOS. There were significant differences between pretest and posttest for 8A model on the scales scores of the DDS. On the SCS, there were significant differences

between pretest and posttest for 8A model on the Alienation and the Access stages scores. There was a significant difference between posttest for 8A and control groups on the scale score of the DOS. There was a significant difference between posttest for experiential and control groups on the scale score of the DOS. Although, scores of the RFDS, the DOS, and the DDS increased in posttest for control group, but there were no significant differences between pretest and posttest for control group on the scales scores. On the DAS, the DOS and the DDS scores more increased in control group in posttest compared to experiential and didactic approaches and 8A model. But these differences were no significant statistically. The most Eta (Effect size) was on the DOS (14%), and the DDS (11%), respectively. On the Scale of Death Education Program Evaluation (SDEPE), there was a significant difference between didactic approach and 8A model. The nurses evaluated 8A model more useful compared to didactic approach. In her study self-report scales was used, sample was small, education was not trained by teamwork of death education, it was trained only by one educator and the study had no follow-up phase so there is difficulty in generalizing results. Based on the results, it was apparent that the death education programs had some affirmitive impacts on the death distress of nurses. Her study paved the way for the establishment of a similar program in the hospitals and community in the future and the use of the program was expected to improve the quality of the palliative nursing services as well as the satisfaction of the patients and their families. Overview of studies reviewed about death education in nurses and nursing students has been shown in Table 6.

Table 6- Overview of studies reviewed about death education

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Field and Kitson 1986 UK	192 institutions and schools of nursing offering undergraduate education; respondents were tutors in nursing schools; response rate for institutions was 64% and 88% for schools.	Cross-sectional survey; data collection 1984.	To gain an overview of the nature and extent of teaching about death and dying in UK nursing schools.	Time reported ranged from 2–42 hours with an average of 9.8 hours focus on palliative care.	Short questionnaire with only 8 questions so, limited amount of data was gathered and some questions remain unanswered.
Kiger 1994 UK	Convenience sample of 24 student nurses.	Grounded theory longitudinal qualitative study; questionnaire applied at start of training with participants followed up at two further points during training period.	To explore student experiences of death throughout preregistration training and to what extent theory actually supported clinical practice.	Death was a predominant feature in students' images of nursing; concern about inability to cope and lack of support to deal with patients' death.	Very small convenience sample known to researcher.
Downe-Wamboldt and Tamlyn 1997 Canada	Teaching staff in 23 nursing schools in UK and 27 in Canada. Response rates of 45% and 93%, respectively	Descriptive, mailed survey; structured questionnaire.	To identify and describe death education curricula; content amount, topics, and assessment.	Canada: 26% schools offer elective and 7% compulsory courses; average 24 hrs in classroom and 36 hrs clinical practice. UK: overall 97% programs offer death education; 17% schools offer elective and 33% compulsory course; average 44 hrs in classroom and 100 hrs clinical practice.	Small sample; results not generalizable. Possibility of curriculum changes since study reported.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Ferrell et al. 1999 USA	45,683 pages in 50 text books reviewed, 902 pages (2%) were related to end-of-life, 65 pages were devoted to death, and 94 pages to bereavement.	Content analysis and quantification of end-of-life care content in nursing textbooks.	To quantify content regarding end-of-life care in textbooks as an indication of amount of educational provision.	Found lack of and inaccurate information regarding end-of-life care. Claim that changes in curriculum and provision are essential.	Uses terms end-of-life and palliative care interchangeably. Focus only on US publications.
Ferrell et al. 2000 USA	2033 nurses responded to adverts; 300 nurses were randomly selected.	Cross-sectional survey distributed via mail, professional journal, and internet.	Description of nurses views about care of terminally ill.	62% nurses rated education on EOL care as inadequate; 71% said pain management was inadequate; 59% rated symptom management inadequate; less than 35% rated bereavement and spiritual support to patients as effective.	Self-selected sample so result may be skewed as only those with a particular interest may have responded.
Turner et al. 2000 UK	Convenience sample of 40 students and 12 carers. Response rates of 91% and 48% respectively.	Methods used: semi structured interviews, participant observation, focus groups and in-depth interviews.	To evaluate regular one day palliative care workshops held out with clinical setting where carers share their story with students.	Students gained insight, knowledge, communication, and team working skills.	Educator self report. Participants were interprofessional groups including nursing, social work, medicine, occupational therapy, and physiotherapy students but no data on percentage of each.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Wong and Lee 2000 Hong Kong	Sample of 77 nurses asked to reflect upon their experiences.	Phenomenological study with thematic analysis of the critical incidents.	To describe experiences of newly qualified nurses.	Most frequently cited critical incident while in training was "facing death nurses". felt their communicating skills were inadequate to deal with dying patients and grieving relatives.	Educator self-report. Reflexive study so issues of memory and accuracy of recall may have influence reliability of results.
Arber 2001 UK	Convenience sample of 33 third year student nurses.	Mixed methods study, Pretest and posttest questionnaire.	To evaluate an optional palliative care module comprising 50 hours of classroom teaching plus one week, hospice placement.	Significant increase in knowledge especially of pain and symptom control but also deficits identified, leading author to conclude that module should be compulsory.	Small sample but rigorous methodology.
Lloyd-Williams and Field 2002 UK	Senior tutors (=46) responsible for degree and diploma nursing courses in UK. Response rate of 40%.	Mailed survey with structured questionnaire	To explore extent of palliative care teaching to undergraduate preregistration students in UK.	During training, students received 8–12 hrs of palliative care teaching; an apparent reduction since earlier study (Field and Kitson 1986).	Overestimation of provision possible because only those with an interest in this area may have responded to questionnaire. Relatively low response rate so cannot generalize results.
Frommelt 2003 USA	115 nursing students (49 experimental, 66 control).	Pretest, posttest with control group.	To evaluate course about caring for terminally ill persons comprising 45 hours of training over 15 weeks.	Significant positive change in experimental group.	Convenience sample Educator self-report. No evidence of effect on patients.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Mallory 2003 USA	104 undergraduate nursing students (45 experimental, 59 control).	Pre and post test with control group; randomized at group level; used an un-validated tool FATCOD to measure attitudes.	To evaluate outcomes of module designed to support attitudinal change; comprising 45 hrs spread over 15 weeks in classroom using theory and role play.	Significant difference in between pre and post test scores in intervention group; no significant difference in post test scores at follow-up.	Educator self-report No evidence of effect on patients.
Walsh and Hogan 2003 USA	26 senior students.	Qualitative study with thematic analysis of student accounts undertaken by educators.	To evaluate new elective oncology classroom based course for students which uses Chaplain's personal experience and case studies.	Course had positive effect on students' knowledge, empathy and reduced fear of death and dying patients.	Educator self-report. No definition of what stage of training students were at. Non-rigorous methodology.
Pfund et al. 2004 UK	2 nursing students, 1 educator and 1 practitioner.	Case study and participant observation; used qualitative interviews and focus group.	To evaluate efficacy of teaching methods used in classroom to develop strategies to deal with child death.	Claims that reflection is effective tool for learning to deal with emotionally challenging situations.	Very small convenience sample. Educator self-report where no detailed description of methodology is provided.
McCabe 2004 Republic of Ireland	Purposive sample of 8 patients.	Phenomenological qualitative study using unstructured interviews.	To explore and describe nurses' communication with patients.	Nurses communicate well with patients when using a patient-centered approach.	Very small sample so difficulty in generalizing results.
Thompson 2005 USA	Convenience sample of 14 students of which only one was male; average of 33 years.	Exploratory descriptive design using non-validated pre and post-test attitude checklist, self-completion inventory on ability to cope.	To evaluate efficacy of elective module on death education using interactive classes, role play, field trips and online discussions.	Increase in student confidence, resourcefulness and management of own emotions when dealing with dying patients.	Educator self-report and small sample. Used non-validated tools.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Ferrell et al. 2005 USA	8 national training courses based on core curriculum implemented in 5 undergraduate curricula.	Developed core curricula and training materials to improve evidenced based care.	Overall evaluation of End-of-life Nursing Education Consortium (ELNEC) training project; comprises result of individual studies reported elsewhere.	Implementation of ELNEC curricula results in increase content in nurse education; improves effectiveness of new graduates; encourages expertise in specialist area of nursing.	Educators self-report of larger project with multiple strands of activity.
Hopkinson 2005 UK	28 newly qualified nurses working in acute medical words in two hospitals in England.	Qualitative study used in-depth interviews; set within a stress-coping paradigm.	To explore nurses experiences of death in order to develop effective support.	Nurses felt theoretical learning made little contribution to way they cared for dying patients: that experiential learning more important and that pre-registration training failed to address relevant issues.	Unable to generalize as data gathered from small sample.
O'Connor and Fitzsimmons 2005 UK	Draws on literature, course materials, personal experience.	Descriptive case study of pre-registration curriculum review in one nursing school.	To review policy and practice drivers underpinning changes to nurse education.	Argues for cancer care to be integrated into pre-registration curricula.	Educator self-review and report.
Allchin 2006 USA	Convenience sample 12 students nurses	Descriptive qualitative study; data collected via single interviews.	To explore and describe nursing students' experience of care of dying during adult clinical placement.	Care of dying patients is challenging for students; advocates death education theory and practice to be integrated in all nurse programs; that one class should focus on specific client groups; students need clinical experience of EOL care.	Very small sample so findings not generalizable; interviews very short in length 15–45 minutes.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Cunningham et al. 2006 UK	134 students at end of first year of study. Response rate 88%.	Quantitative study using self-report questionnaire and semi-structured interviews with 15 students.	To explore student perceptions of education and clinical inputs that were helpful in preparing them to care for cancer patients.	Students reported lack of classroom input and felt their communication skills inadequate; 80% said learnt most from clinical practice rather than classroom theory; 77% said didn't have enough clinical skills to care for cancer patients during clinical placement.	Much extrapolation from very few interviews.
Kurz and Hayes 2006 USA	Intervention group consisted of 26 students at pretest, 15 at T1, 11 at T2, and 12 at T3. Control group 34 at T1, 22 at T2, and 15 at T3.	Quasi-experimental longitudinal survey completed prior to and 3 times after intervention. Used Revised Death Anxiety Scale.	To evaluate educational intervention aimed at influencing death anxiety attitudes and knowledge over time.	Death anxiety decreased but effects not long lasting; levels returned to premodule levels at 12 months. Authors conclude that repeated interventions are needed to effect long-term change in attitudes.	High-attrition rate with only 12 students completing study. Data collection coincided with start of Iraqi war and increase in terrorist alerts so possible environmental bias.
Kwekkeboom et al. 2006 USA	Convenience sample of 52 students, 32 in experimental and 20 in control group.	Quasi-experimental longitudinal study. Pre and post test with control group.	To evaluate new optional companionship program, 4 hours theory, 20 hours contact with dying patient in clinical setting.	Program did not produce significant improvement in knowledge and concerns compared to control group. Intervention group describes its participation as a meaningful learning experience.	Participants reported that during the program, other experiences may have influenced their knowledge and responses.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Dickinson 2007 USA	410 nursing and 99 medical schools in US. Response rates of 70% and 81%, respectively.	Mailed survey with structured questionnaire used to collect data on curricula content, teaching methods, hours of EOL care in curricula, and number of students spending time with hospice patients.	To gain an overview of palliative care education provided by medical and nursing schools in US.	Majority of nursing schools (88%) offer something, 5 had no formal death education; 18 had full semester course; average teaching hours 14; Only 1/10 nursing schools have a complete course in palliative care.	No attempt was made to assess effectiveness of provision or students views. Overestimation of provision was possible because only those with an interest in this area may have responded to questionnaire.
Schim and Raspa 2007 USA	Sample of 14 students on each presentation of the module.	Case study design incorporates participant observation. Data collection 2001–06.	To evaluate the evolution of an interdisciplinary end-of-life elective which uses a story-telling approach, presented in classroom for 4 hrs a week for 15 weeks.	Course had significant impact on students' lives but was challenging to implement.	Lack of clarity about actual sample size; seems small but text alludes to multiple presentations of module. Report is from educator so draws on personal experience.
Schwartz and Abbott 2007 USA	5 educators and undisclosed number nursing students.	Descriptive case study includes participant observation.	To outline the development and implementation of teaching tool using various storytelling techniques.	Storytelling supports student learning and impacts upon care provided to students.	Educator reflection which lacks data on numbers participating.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Adriaansen and van Achterberg 2008 Netherlands	25 palliative care courses.	Search of literature databases for relevant literature published between 1990–2005.	To explore effects of palliative care courses with focus on expertise, skills, teaching methods, and outcomes.	Most successful are integrated courses with several themes and variety of didactical teaching methods.	Do not distinguish between outcomes for under and postgraduate students.
Barrere et al. 2008 USA	73 senior nursing students, 5 of which were male.	A quasi-experimental, longitudinal repeated measures design was used. Data collected 2005 to 06; tools included (FATCOD) and student journals.	To evaluate end-of-life content integrated into nursing curriculum and its effects on students' attitudes towards dying patients.	Education program positively influenced attitudes of students towards care of dying. Age and previous experience of terminally ill were predictors of attitude change; previous education on death was not.	Educator self report. Convenience sample from one university site decreases the generalizability of results. Attrition rate of 23%.
Brien et al. 2008 Canada	137 students plus 11 focus group participants.	Mixed methods study; used questionnaire with open questions, reflective journals, focus group and adapted version of FATCOD scale applied at end of course.	To evaluate a mandatory 4-week end-of-life course set in classroom, which used clinical case studies, lectures, seminars, and reflective activities; focus on affective domain of learning.	Course had positive effect on student attitudes and development of interpersonal skills. Revealed difficulties for educators and students when formally assessing outcomes derived from affective learning activities and their perceived usefulness.	Poor student participation in reflective activities. Educator self-report highlights lack of preparedness of teaching staff, which may have affected outcomes.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Dickinson et al. 2008 UK	66 preregistration nursing programs. Response rate 79%.	Mailed survey: structured questionnaire used to collect data on curricula.	To gain an overview of palliative care education provided by nursing schools in UK. Data collected on teaching methods, literature used, topics covered, number of hours of teaching, and percentage of students undertaking elective and/ or mandatory modules	All nursing schools had some provision: 24 had full semester course; average teaching hours was 45; 95% of students participated in palliative care education; 3/5 programs included hospices visits; pain, communication, and attitudes were covered by all curricula.	No attempt was made to assess effectiveness of provision or students views. Overestimation of provision was possible because only those with an interest in area may have responded to questionnaire.
Brajtman et al. 2009 Canada	Purposive sample of 58 fourth year students and key informant educators.	Cross-sectional survey; use of open-ended questions, PCQN and FATCOD scales.	To examine current curriculum content and learning needs of senior students related to EOL care in two university sites in Canada.	Found that one third of students did not feel adequately prepared to care for dying patients and had modest knowledge levels. Concludes that more EOL care and experiential learning should be integrated throughout curriculum.	Number of educators included in sample is not disclosed but low response rate was reported. Possibility that only students interested in EOL care completed the survey. The retrospective nature of the study relied on students' memory of their experiences over four years so inaccuracies possible.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Johnson et al. 2009 Australia	39 Deans of Nursing or equivalent invited, of which 26 participated. Response rate of 76%.	Descriptive survey which is phase one of a longitudinal mixed method study. Mailed survey self-administered by participants generated descriptive statistics.	To explore death and dying education in Australian undergraduate nursing curricula.	Death education is included in all undergraduate curricula but it is poorly designed; few attempts were made to link clinical placements to theory; few students had opportunity for experiential learning. Concludes that reform is required to enhance preparation for practice.	Nonvalidated researcher-developed survey instrument used. Descriptive study not generalizable to other contexts.
Wallace et al. 2009 USA	111 undergraduate students at one university.	Descriptive survey to determine baseline knowledge about end-of-life care.	To evaluate program where EOL content is integrated throughout the curriculum using a range of methods including clinical placements in hospices.	Identified need for improved integration of EOL care including: dedicated clinical days using real examples of dying patients, hospice experience, and bereavement classes.	Educator self report is first stage in ongoing curriculum review.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Leighton and Dubas 2009 USA	16 undergraduate nursing students from one university taking a 1 hour elective course on death, dying, and bereavement.	A self- completion questionnaire with 10 open questions administered after the simulation intervention followed by thematic analysis.	To evaluate the effectiveness of a simulated end-of-life care scenarios with a high-fidelity mannequin and teaching staff playing the role of family members.	Students reported that they lacked confidence in dealing with dying patients but that the enhanced realism of the simulation exercise improved their learning and helped them relate theory to practice and raised awareness of family matters and gaps in their knowledge.	Descriptive study that only reports on three themes identified: impact of family presence, value of realism, and self-efficacy. Data reflects subjective rather than objective experiences of students. Outcomes not measured.
Smith-Stoner 2009 USA	Undergraduate nursing students at one university. Numbers and characteristics not reported.	Descriptive case study that uses date gathered from students during debriefing sessions.	To evaluate the effectiveness of an author developed module "The Silver Hour" that represents the 30 minutes prior to and immediately after death.	Students value the inclusion of simulation focused specifically on death. They report bewilderment when caring for dying patients but quickly overcome this to address the patient's needs.	Descriptive case study in which numbers and characteristics of students are not outlined and outcomes are not measurable.
Ramjan et al. 2010 Australia	Draws on academic and policy literature to justify implementation of an integrated curriculum.	Descriptive case study.	To describe how palliative care content has been embedded throughout a three year undergraduate nursing degree program at one Australian university.	Notes the importance of educators being supported to develop the competencies required to support theoretical and experiential learning of students in relation to palliative care.	Some of the literature supporting the case for integration relates to medicine rather than nursing.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Hope et al. 2011 UK	Pre-registration nursing students (≥500) at different stages of the adult curriculum, data gathered across two years.	Mixed methods design involving evaluation and focus groups. Stage 1 was the thematic analysis of evaluative questionnaires, which then informed the construction of semi structured focus group interviews for stage 2.	To evaluate the effectiveness of a simulation exercise in end-of-life care with a high fidelity mannequin and role play by students	Students felt prepared for practice, that simulation improved their humanistic and problem solving abilities and also help develop psychomotor, technical skills, and overall confidence. Concludes that simulation encourages the integration of theory and practice in a controlled environment.	Educator self-report. Data represents the subjective students' perspective to the expense of objectivity and not focused solely on dying patients.
Fluharty et al. 2012 USA	370 undergraduate students drawn from 4 schools of nursing, 90% of which were female.	4 self-completion questionnaires administered after debriefing session on the simulation intervention. Data analyzed using PASW Statistics.	To evaluate a new learning intervention using simulated end-of-life care scenarios with a mannequin and students playing the role of family members accompanied by one traditional lecture.	Results showed significantly enhanced student end-of-life knowledge; high levels of self-confidence in caring for a dying patient; and strong self-reported communication skills in caring for patients and families at the end of life.	No data available on separate contributions of the lecture and simulation intervention. Also difficult to determine the extent to which communication skills were actually improved. Reliability and validity of tools not established prior to study.
Kopp and Hanson 2012 USA	Undergraduate nursing students at one university. Numbers and characteristics not reported.	Descriptive case study that used two questions with a 5 point Likert type scale administered to students after simulation and game play interventions.	To evaluate students responses to 3 hour end-of-life simulation with a high fidelity model and the 'Seasons of Loss' board game.	Students better understood interventions and communication techniques used in end-of-life care and death. The board game developed awareness of issues related to terminal illness, death, and loss.	Descriptive case study in which numbers and characteristics of students are not outlined and outcomes are not measurable.

Reference location	Sample response rate	Research designdata collection	Aims	Findings	Limitations
Mutto et al. 2012 Argentina	730 medical and nursing students from 7 universities of which, 289 (59%) were 1st year and 194 (40%) were final year nursing students.	Survey with structured 24 item questionnaire and open questions generated descriptive data.	To evaluate student experiences and attitudes after exposure to dying patients and whether exposure influences attitudes.	Majority (94%) of nursing students had positive attitudes to dying patients although they reported finding it arduous. High numbers of final year nursing students tried to avoid affective involvement with dying patients.	No pre-test on attitudes conducted prior to completion of questionnaire so it is difficult to determine to what extent exposure to dying patients changed attitudes.
Gillan et al. 2013 Australia	120 third year nursing students at one university.	Self-completion survey that included quantitative and qualitative questions, administered at the end of an end-of-life care module.	To evaluate a new learning strategy utilizing simulated end-of-life care scenarios with high-fidelity mannequin students playing the role of family members.	The majority of students found simulation to be a valuable learning tool in that it; helped prepare them to care for dying patients, to link theory to practice, to communicate with family of dying patients, and to actually observe a death.	Educator self-report and reports only on qualitative data collected
Cavaye and Watts 2014 UK	Published literature that reported on death education within pre-registration nurse education from 1986 to 2013 years.	An international integrated literature review or past research was summarized by drawing overall conclusions from many studies. Data collected by electronic searches of major bibliographic databases.	To contribute to knowledge about the nature and extent of death education in pre-registration curricula.	Being inconsistencies across educational provision with variations in quantity, content, and approach. A deficit in key areas such as knowledge, skills, organization of care, and teamwork of death education in pre-registration curricula.	

Adapted from Cavaye, and Watts (2014)

Some studies used death education program in medical students. Medical students experienced a positive change in attitude about treating dying patients and dealing with dying patient's families after a death education course (Kaye, Gracely & Loscalzo, 1994). Reed (1996) examined the effects of a death education course in an experimental pretest-posttest comparison group design. The experimental treatment group consisted of 12 randomly assigned second-year medical students who were given a combined didactic and experiential death education/empathy skills training program in conjunction with 10 weekly videotaped relationship-building sessions with a terminally ill cancer patient. The comparison group consisted of 11 second-year medical students who attended the 10 weekly relationship-building sessions with a terminally ill cancer patient but received no educational intervention or feedback. There were no statistically significant differences between the experimental and comparison groups on the self report death anxiety. Schools of medicine have recently seen the need for improved End-Of-Life Care Education (EOL) and have begun to introduce EOL education in their curricula. After a three-hour session including didactic and small group discussions, the majority of medical students agreed that care of the dying could be a rewarding experience for physicians and expressed an interest in learning more about the subject (Ross, O'Mara, Pickens, et al., 1997). Another study found that clinical interventions with physicians led to increased use of patient preferences for EOL care and provided limited evidence that physician education reduced the use of life-sustaining treatments. Clinical interventions did not have an effect on behaviors regarding pain management or suffering (Hanson, Tulsky, & Danis, 1997). Another group of medical students spent five days in a didactic and clinical rotation in a hospice and palliative care setting. The one-week program proved to be an effective means of changing students' attitudes toward death and care of the dying (Steen, Miller, Palmer, et al., 1999). Linder, Blais, Enders, Melberg, and Meyers (1999) studied palliative education by a didactic and experiential approach to teaching end-of-life care for health professionals. They assessed attitude change and knowledge of medical students regarding EOL care. They reported that enhanced care-delivery skills for participants in all three modules of On-site, Off-site and Inmate training in health professionals. They compared didactic and experiential approaches to EOL education. Results found that EOL education can be enhanced when delivered close to the point of care using multi-modal techniques that influence attitudes as well as knowledge. Karnad (1999) used a unique approach to educate medical students about EOL care. The students had to read the book, The Diving Bell and the Butterfly: A Memoir of Life in Death by Jean-Dominique Bauby. After reading the book, students were required to mark passages in the book that meant something to them, and then the instructor led small group discussions on the book. More than 90% of the residents felt that reading the book improved their attitudes toward care of the dying patient. The interesting thing about each of these most recent research studies on EOL medical care reveals that only one of the studies used a standardized or previously used instrument for assessing attitudes toward death or care of the dying. That study by Levetown, Hayslip and Peel (2000) published an EOL care attitude scale for physicians to measure outcomes of palliative care education. It was tested and found to be valid and

reliable and is currently being used to explore its utility in reflecting the consequences of different types of educational experiences. Kim, Nam, Lee, and Lee (2012) examined awareness and attitude change after end-of-life care education for medical students. Results showed that before receiving the education, students most frequently answered "at the end of life", was appropriate time to write an advance medical directive. After the education, the most frequent answer was "in healthy status". More students agreed to withholding or withdrawing futile life-sustaining treatment increased after the education. Kim, Kim, Ahn, et al (2014) reported that as a result of conducting the thanatology lecture as a class of liberal studies for one semester, one lecture a week for 4 weeks to death preparation experts would be suitable by making it as a regular class of university curriculum. The education on death for undergraduate students of health and medical science department lead to an increased need for understanding and death education on death by allowing them to look at their life and the phenomena related to death from the perspective of humanities and also the psychological and spiritual views. It was utilized as preliminary data for the development of death education program in addition to an improvement for the negative awareness of death among students. They responded that meaning and awareness of death and value of life, fear for death, reduction of fear and method to overcome fear were some of the most required contents. They also said that the most required thing was understanding of modern people about death, followed by reflection and organizing the past life, medical tips and prevention for sudden death, writing will and legal effect, heritage handling, things that one want to leave to the world (sharing and social contribution), hospice education, caring cancer patients, telling truth about disease and planning one's funeral in advance.

Other studies used death education program in university/college students. Knight and Elfenbein (1993) conducted a study to determine anxiety and fear of death among 103 college students, some who had and some who had not taken a course in death education, They found that students enrolled in the death education course reported increased anxiety and fear about death-relative to those who had not taken the course. Students from the death education course also reported an increase in thinking about their own death. Whether that thinking was good or bad is unknown. Increased anxiety about death and more thoughts about death might be positive in that it might cause students to appreciate their lives more (Dennis, 2008). Mogi, Masuda, Hattori, et al (2003) presented a 90 min university-level death education lecture in the death education group and the usual lecture to university students in the control group. On the DAS, no significant differences were detected between the pre-test and post-test results, nor between the death education group and the control group. In the death education group there was a significant increase in the number writing about the deaths of significant others and in the number providing voluntary comments. The death education lecture had the effect of deepening the students' thoughts regarding their own death and/or their attitudes to medical autonomy. Kim and Lee (2009) developed the death education program and used with 22 college students for 5 weeks, once a week for 150 min. Results showed that death education program significantly improved life satisfaction but had no statistically significant effect on attitude toward death. Death education program had an

affirmative effect on life satisfaction in college students and some impact on attitude toward death. They suggested that death education program should be used with all human beings to help them recognize the values of themselves and their current lives and improve their satisfaction with life. Chang (2012) explored the effects of death education, focusing on death orientation and suicidal ideation, among college students majoring in social welfare over a period of four weeks. Results showed that death orientation and suicidal ideation in the experimental group were significantly lower in the control group. The experimental group demonstrated greater comfort with the concept of death, as well as death being the prolongation of one life and new hope for an ensuing life, and a greater appreciation for life, more confidence in setting future goals for their lives, and an awareness of, and ability to deal positively with suicidal tendencies in themselves and others. Findings demonstrated a strong practical benefit associated with death education and suicidal ideation awareness. Johnson II (2014) reported that universities rarely offered death and dying training for their faculty, which could result in awkward situations in the classrooms. Students wanted all the information they could have regarding their classmate's death. Most professors agreed that they did not feel suited to manage and teach on death and dying issues, so they strongly supported including death education and training in their orientation.

Death education is a controversial, yet highly important subject for the public school system in the United States (US). The provision of death education in the nation's public high schools would go a long way to reducing death anxiety amongst United States teenagers, and also give the adolescents a model for creating their own sense of meaning for all of life that includes death (Ruffin, 2011). An answer to the question, who should receive death education, revolves around two main areas: 1. Education of professional grief counselors and medical personnel and 2. Education of children beginning in elementary school (Ruffin, 2011). Kim, Lee, Kim, et al (2013) reported that those groups that participated in a community service had higher level of awareness on well-dying than those without. The sense of well-dying showed a pure correlation with death preparation. In order to meet dignified death and to establish a culture of well-dying, influencing variables on the sense of well-dying must be considered by the nurses and health professionals to be able to play an important role in establishing the related programs and especially the program operations related to death should be able to contribute to the spread of well-dying culture. McLeod-Sordjan (2013) reported that death preparedness involves a transition of facilitated communication with a healthcare provider that leads to awareness and/or acceptance of end of life, as evidenced by an implementation of a plan. An appraisal of attitudes towards death and one's mortality precedes the concept, followed by an improved quality of death and dignity at end of life. Mak (2013) recruited fifteen university teachers using a qualitative method. Results revealed that most teachers' views on death and related issues were largely affected by their death experiences, religious beliefs, professional background, and the mass media. Although they had a general negative response toward death and dying, some teachers begun to affirm their meanings of life and death. Most teachers agreed that they did not feel adequate about managing and teaching on life and death issues, so they strongly supported including death education in the formal

programs in Hong Kong. Humans evolved the capacity to cope with anxiety induced by the awareness of death's inevitability. Processing of linguistic cues related to death was characterized by decreased neural activity in human insular cortex. Amplitude of an early frontal/central negativity at 84-120 ms (N1) decreased to death-related words but increased to life-related words relative to neutral-valence words. The N1 effect associated with death-related and life-related words was correlated respectively with individuals' pessimistic and optimistic attitudes toward life. Death-related words also increased the amplitude of a frontal/central positivity at 124-300 ms (P2) and of a frontal/central positivity at 300-500 ms (P3). The P2 and P3 modulations were observed for both death-related and negative-valence words but not for life-related words (Liu, Shi, Ma, et al., 2013).

Counselors and counselors in training need to a global perspective and a set of experiences influenced on their understanding of grief for clients in the future (Harrawood, Doughty, & Wilde, 2008; Harrawood, White, & Benshoff, 2008; Harrawood, 2009; Harrawood, Doughty, & Wilde, 2009; Laura, Doughty, & Wilde, 2009; Harrawood, Doughty, & Wilde, 2011). Astramovich, and Pehrsson (2009) stated that the new view of counselor training, is an international counselor, it is a profession that has been devoted to training and supervision for counselors in the worldwide. Counselors and counselors in training will work to the clients who encounter to grief and loss issues. However it is possible that many of them never train in courses that underline on current conceptualizations and strategies for dealing with these issues (Wass, 2004). Researchers overviewed of the use of an international perspective in the training of counselors to work with issues of grief and highlighted the importance of integrating of death education in the curriculum of consulting. Also they a brief overviewed on the adaptive styles of mourning, and offered the relevant international approach to bereavement counseling (Harrawood, Doughty, & Wilde, 2009; Doughty, Harrawood, & Crews, 2011; Doughty, Crews, & Harrawood, 2013).

Some studies used death education program in older adults. In death education program development for elders, determinants of the attitude toward death should be identified (Yang, 1991; Corr, 1991; Ahu, 1999; Nam, 1999; Kim, 2001; Choi, 2002; Lee, 2005; Choi, 2008; Kang, 2008; Lyke, 2013). Some factors influenced in the sense of well-dying in elders (Kim, Lee, Kim, & Kim, 2013). How-to-die education impacted on the older adults anxiety, attitude and life satisfaction toward death (Ghalebandi, 1988; Kim, Choi, & Chung, 2005). McGee's (1980) study of middle-aged and older adults found a small but significant change in death anxiety attitudes after a death education module. Carmen, Belen, and Jose (1999) described changes in attitudes, anxiety, and depression toward death along the life span and explored the effects of two different educational modes on the levels of death anxiety and fear of death in young adults, middle-aged, and elderly people. Each of the three age groups received two types of intervention: Experiential Workshop and Conference. Each age group had a control group. The educational intervention lasted five hours. Four months later, a follow up was performed. The results indicated that the young adults subjected to the Conference treatment increased their despair, sadness and depression about death, whereas those participating in the Experiential Workshop had decreased terror and death anxiety levels, although their level

of despair' increased. In the middle-aged group, significant differences were only found after the Experiential Workshop intervention, with an increase in despair, loneliness, and death depression levels. In the groups of elderly people participating in the Experiential Workshop death anxiety levels decreased. Abengozar, and Bueno (1999) compared experiential and didactic death education and its effects on death anxiety across the lifespan. They found that middle-age adults experienced decreased death anxiety after experiential education, whereas older adults and younger adults experienced no changed and increased anxiety respectively. Yoon (2009) in one group pre-posttest design analyzed the effect of death preparing education (consisted of five steps) on death anxiety, spiritual well-being and meaning of life in adults. Results showed that the death preparing education program was an effective intervention to lower death anxiety and to improve spiritual well-being and the meaning of life. Oh, and Kim (2009) conducted the 10 weeks training program on the elderly people in order to study about a positive changes on the attitude towards death and depression of the elderly. They reported that attitude towards death was positively changed after the education than before, and in the analysis result of the correlation between the attitude before and after the education on the death preparation, it has reported that when the attitude towards death was positive, the depression was significantly reduced, and if the education on the death preparation can positively change the attitude of the elderly on death so that the elderly can have a positive attitude towards death, their quality of life will be improved and they can meet the comfortable death. Therefore, through the education on the death preparation, it can be seen that the awareness on well-dying as a comfortable death can be increased. Park (2009) reported that death education impacted on the emotion, cognition and behavior of the elderly. Kang (2011) used the death preparation program comprising four sections was given for four hours per week, and the program ran for 11 weeks for helping middle-aged adults deal with life and death anxiety. Results showed that death anxiety score of the experimental group was significantly lower than that of the control group and death preparation program was effective in alleviating death anxiety, but quality of life did not show significant difference between the experimental and control groups. Song, and Yoo (2011) indicated that death education reduced death anxiety and increased life satisfaction, psychological well-being in older adults. Kim (2012) showed that well-ending education program increased healthy women. Yun, and Lee (2012) indicated that planning for education on death for the elderly should be focused on religious perspective.

Death education is related to our own emotion toward ourselves, our live and the world in which we are living. It is not about avoiding grief. Rather, it is about helping handle it creatively to reflect on their life and establish a value for death (Lee, 2004). Death education changes the attitude toward death and dying positively so that one can prepare well for death. As a result, it can help dying people and their family (Yi, 2003). Kim, Cho and Yoo (2011) investigated the effects of death education program in family caregivers of disabled individuals using structured questionnaires for assessment of the patients and their family member's conceptions on the meaning of life, and their resilience, burden, and attitude towards death , and a 2.5-hour session was conducted once a week for 10 weeks. The results

showed that death education program had an affirmative effect on the burden of family caregivers of disabled individuals and their attitude towards death. Regardless of job title, age, gender, ethnicity, religious affiliation, or years of experience, the majority of individuals did not share death anxiety of self or others. Providing a new knowledge is beneficial for future researchers, policy makers, health care leaders, and health care professionals who aspire to improve the delivery status for quality end of life care and acceptance of a good death in patients (Schaeffer, 2013).

Kim, and Byun (2014) analyzed the studies and their trends, specifically 124 master's and doctoral theses, as well as research papers on the topic of education on death published from 1990 to 2014. Findings showed that in terms of trends by year, there were only 8 papers in the 1990s but this figure saw a dramatic jump from 2005 to 2009 to a total of 50 papers (40.3%). The majority of them, 59 papers in total, were master's theses (47.6%); theological studies took the lead and studies on social welfare accounted for 29 papers (28.4%) which was the largest share. Third, in terms of study subjects, senior citizens were used in the majority of papers or 35 papers (40.7%) in total. Fourth, in terms of methodology, literature studies accounted for 61 papers (49.2%) which was the largest share. Fifth, for mediation programs education on death, the preferred method of study was to have a before-after design using a control group and experiment group. The most common number of total sessions was 5-8 sessions with one session per week and each session lasting for about 100-120 minutes. Sixth, as for the effect variable of mediation programs for education on death, death anxiety was the most frequently studied variable at 23 papers (31.5%). Wittkowski, Doka, Neimever, and Vallerga (2015) identified important trends in thanatology as a discipline, they analyzed over 1,500 articles that appeared in *Death Studies* and *Omega: Journal of Death and Dying* over a 20-year period, coding the category of articles (e.g., theory, application, empirical research), their content focus (e.g., bereavement, death attitudes, end-of-life), and for empirical studies, their methodology (e.g., quantitative, qualitative). In general, empirical research predominated in both journals, with quantitative methods outnumbering qualitative procedures 2 to 1 across the period studied, despite an uptick in the latter methods in recent years. Purely theoretical articles, in contrast, declined in frequency. Research on grief and bereavement was the most commonly occurring (and increasing) content focus of this work, with a declining but still substantial body of basic research addressing death attitudes. Suicidology was also well represented in the corpus of articles analyzed. In contrast, publications on topics such as death education, medical ethics, and end-of-life issues occurred with lower frequency, in the latter instances likely due to the submission of such work to more specialized medical journals. Differences in emphasis of *Death Studies* and *Omega: Journal of Death and Dying* were noted, and the analysis of publication patterns was interpreted with respect to overall trends in the discipline and the culture, yielding a broad depiction of the field and some predictions regarding its possible future.

A considerable number of studies have reported on the treatment of death anxiety in non-clinical samples of nurses, healthcare professionals, students, lay people, and individuals facing serious, chronic, or terminal illnesses, such as cancer or HIV/AIDS (Furer, & Walker,

2008). In these studies, various procedures to treat death anxiety have been used, including psychotherapy (Barrera, & Spiegel, 2014), individual and group psychosocial therapy (Spiegel, 1995), dignity therapy (Chochinov, et al., 2004), systematic desensitization (Bohart, & Bergland, 1978; Peal, et al., 1981; Testa, 1981), group implosive therapy (Testa, 1981), relaxation training (Peal, et al., 1981; White, et al., 1983), general anxiety reduction techniques (Rasmussen, 1997), humor therapy (Richman, 2006), brief gratitude induction therapy, and several other death education programs and workshops (Bell, 1975; Bohar, & Bergland, 1978; McClam, 1980; Tausch, 1988). Bohart, and Bergland (1978) examined the effects of in vivo systematic desensitization and systematic desensitization with symbolic modeling on college students who participated in counseling groups on death and dying. The design employed a three-factor mixed model; three treatments crossed with four leaders, with two groups nested within treatment and leader. No significant differences were found between the treatment groups and control groups as measured by the immediate posttests or the follow-up posttest. Pettigrew and Dawson (1979) assessed female undergraduate students at Louisiana State University on four measures of death anxiety: "Emotional" associations to "death" words, association response latencies to "death" vs. "neutral" words, the DAS, and the DCS. They assigned to four treatments: (1) Hypnosis, with anxiolytic post-hypnotic relaxation suggestions; (2) Nonhypnotic anxiolytic prestige suggestions; (3) EEG alphacontingent biofeedback; and (4) A 15-minute waiting period. Students viewed a tape-slide presentation that emphasized personal death and overestimated its probability from various causes. Results showed that the students failed to differentiate groups on either increases or decreases of death anxiety. Bibeau and Eddy (1985) in a quasi-experimental design with an experimental and a control group assessed the impact of a traditional cognitive-oriented instructional approach to death education on changes in death knowledge, attitudes, anxiety, and fear. The experimental group enrolled in a one-credit health education course entitled "Death Education: Concepts Across the Lifespan," at the Pennsylvania State University. The control group enrolled in other one-credit health education courses such as human sexuality and alcohol education. All courses met for 75 minutes once a week for 10 weeks. The lecture method format was used in all courses with limited discussion occurring as a result of student initiated questions. The course did not include instruction which would normally be considered in the affective or life skills domains. Four instruments were used: the Eddy Knowledge Test of Death and Dying (Eddy, 1979), the Hardt Death Attitude Scale (Hardt, 1975), the DAS (Templer, 1970), and the CLFDS (Collett, & Lester 1969). The results showed that there were significant differences between the groups on posttest knowledge scores and on the fear of dying other (FODYO) subscale of the CLFDS. Rasmussen, Templer, Kenkel, and Cannon (1998) used concentrated relaxation and stress management as a tool to try to reduce death anxiety in nursing students. They found no difference in death anxiety levels of their treatment group than the two control groups. Findings regarding the treatment of death anxiety among nurses, healthcare professionals, students, and lay people, have been mixed. Although significant reductions in death anxiety have been reported following a person-centered death discussion group (Tausch, 1988), and following desensitization and

relaxation training for nursing students (White, et al., 1983), conflicting findings have also been reported. In particular, Rasmussen (1997) reported that general anxiety reduction techniques were no more effective than no treatment in reducing death anxiety and death depression for nursing students, and other studies have reported no significant reductions in death anxiety following desensitization therapy for college students and nurses (Bohart, & Bergland, 1978; Testa, 1981). Non-significant findings have also been reported in studies investigating the impact of death-related courses and education programs on death anxiety in college students, healthcare workers, and HIV-infected homosexual men (Bell, 1975; Braunstein, 2000; McClam, 1980). Further studies suggested that the accuracy of outcome measurement for desensitization and relaxation treatment among university students with high death anxiety may be influenced by the choice of death anxiety inventory used (Peal, et al., 1981), highlighting the importance of using psychometrically-sound and well-validated measures of death anxiety when determining treatment outcomes. Despite conflicting evidence regarding the efficacy of death anxiety treatment in non-illness groups, extensive support has been found for psychosocial interventions in oncology, hospice and palliative care settings (Barrera, & Spiegel, 2014; Chochinov, et al., 2004; Spiegel, 1995). Although there is some evidence that individuals with terminal conditions may report lower death anxiety than healthy controls, this may be a function of death denial (Dougherty, et al., 1986; Hayslip, et al., 1991). In contrast, there is considerable evidence that end-of-life conditions may be associated with death anxiety, depression, and psychological distress (Barrera, & Spiegel, 2014; Lagerdahl, et al., 2014; Lo, et al., 2014; Royal, & Elahi, 2011; Spiegel, 1995). There is also evidence that higher death anxiety in end-of-life care is associated with higher prevalence and severity of psychiatric disorders such as generalized anxiety and depression (Gonen, et al., 2012; Krause, et al., 2014; Sherman, et al., 2010). These suggest that death anxiety may be a transdiagnostic construct across terminal conditions. Based on theses evidence, reducing psychological distress and death anxiety is a fundamental element of end-of-life care and treatment (Lo, et al., 2014; Lo, et al., 2011; Sherman, et al., 2010). According to Spiegel (1995), both individual and group psychotherapies in end-of-life care focus upon three central approaches: social support, emotional expression, and cognitive symptom management. These approaches address the psychological consequences associated with dying, including death anxiety, and have been associated with several psychosocial improvements, such as reduced depression and anxiety, enhanced quality of life, decreased pain, and improved coping skills (Lo, et al., 2011; Lo, et al., 2014; Sherman, et al., 2010; Spiegel, 1995). Findings from end-of-life care bolster our understanding regarding the treatment of death anxiety, and indicate the potential for applying these treatment strategies across psychological conditions associated with death anxiety. Pipe, Bortz, and Dueck (2009) reported that a mindfulness meditation course for nursing leaders was extremely effective in reducing stress levels. Chambers-Klein (2012), using reviewe of the structured interviews, described three perspectives of death based on the medical facility staff' responses (i.e. the actual death of a patient, anticipation of death of self, and anticipation of the death of family members). Regardless of job title, age, gender, ethnicity, religious affiliation, or years of

experience, the majority of individuals did not share death anxiety of self or others. The medical facility staff described having increased mindfulness of medical conditions, awareness/appreciation of life, and knowledge and beliefs on life sustaining equipment. Medical personnel may benefit from medical facilities promoting positive self-care through enlisting motivational speakers, providing in-services on the topic, and providing training programs (e.g., stress management). Another positive program implemented with newly qualified nursing staff is a Signal Post Development Scheme, integrating preceptorship, clinical supervision, role development and leadership development (Tapping, Muir, & Marks-Maran, 2013). A "Zen-like mindset" is essential to handle the stress of 12-hour shifts, lack of sleep, and a poor diet. Those issues can often lead to chronic sleeping problems, obesity, diabetes, and cardiovascular disease in nurses (Capella. 2015; cited in Brady, 2015). Kovner (2015; cited in Brady, 2015) indicated that some evidence supported the calming effect of yoga and meditation, but Kamienski (2015; cited in Brady, 2015) embraced the Zen-like approach and thought others won't either. Some might find it helpful, but most wouldn't.

Death is extraordinarily common as a topic in popular movies. Using realistic, promoting conceptions films in death education can portray death acceptance in an instructive way to the public, and lessen death anxiety. Schultz, and Huet (2000) noted in their examination of 65 popular, American films that death is one of the most common elements, finding 857 death-related scenes, wherein the average film (100 min) a death-related scene emerged every 7 to 8 min. Sensational and unrealistic portrayal of death was the norm. The high frequency of death scenes, words, and references, particularly those of an outlandish and unrealistic nature, sets the context for a public denial of death, repression of emotion, and avoidance of authentic death concerns. Masters (2003) noted the utility of *Tuesdays with Morrie* (Albom, 1997) in educating college students about death and dying. Heuser (1995) described their use in a college-level death education course focusing on death attitudes and experiences. The course relied substantially on input from both student and instructor (active-participatory learning), he provided details on course background, content, and format, course requirements and assessment, and student evaluation, further noting the use of films in the educational process. Cox, Garrett, and Graham (2005) analyzed 10 popular, full-length Disney films. Specifically, 23 death scenes were analyzed, and although some death misconceptions were perpetrated within the films, the films appeared to have some good potential as effective tools for teaching children about death. In study of Heuser (2008; cited in Niemiec, & Schulenberg, 2011), student evaluation indicated that there was a sense among the students of being better prepared for dealing with the process of death and bereavement. Cinematherapy, the use of movies in a clinical setting, has been shown to facilitate therapeutic growth, build optimism and coping, improve communication, and foster insight (Berg-Cross, Jennings, & Baruch, 1990; Hesley & Hesley, 2001; Schulenberg, 2003; Wedding, & Niemiec, 2003). Under the guidance of a sensitive therapist, a client can learn to confront death anxiety through various death images while exploring character avoidance and acceptance behavior. Some clients will be directed to view specific positive psychology movies in order to directly enhance character strengths to meet their therapeutic goals, including those related to managing unhealthy death attitudes (Niemiec, & Wedding, 2008).

Conclusion

Research evaluating death education programs has yielded ambiguous results. In study of Cavaye and Watts (2014), there were inconsistencies across educational provision with variations in quantity, content, and approach; and a deficit in key areas such as knowledge, skills, organization of care, and teamwork of death education in pre-registration curricula. Educators have used a variety of methods to teach death and dying related issues (Dadfar, & Lester, 2014). Research has documented the effectiveness of education about death in reducing death anxiety (Reed, 1996; Iranmanesh, et al., 2008; Chan, et al., 2010; Doughty, & Hoskins, 2011; Warren, 2012; Wittkowski, Doka, Neimever, & Vallerga, 2015). The beneficial effect of death education has also been shown on nurses' attitudes toward death and dying. For example, Mooney (2006) found that undergraduate nursing students who had received death education had less death anxiety than controls, while İnci and Öz (2009) reported that nurses who had received death education obtained lower mean scores on the DAS and DDS compared with untrained nurses. Brien, et al (2008), reported that death training course by using mixed approaches, had positive effect on nursing students' attitudes and development of their interpersonal skills. Study of Hyun (2014) showed that death education program reduced the negative attitude toward death, increased the meaning in life significantly in the experimental group; and suicidal ideation was decreased but no statistically significant in college students. Dadfar (2015) showed that there were significant differences between pretest and posttest for didactic approach on the scales scores of the DCS, and the DOS in the nurses. There was a significant difference between posttest for experiential and control groups on the scale score of the DOS. Although, scores of the RFDS, the DOS, and the DDS increased in posttest for control group, but there were no significant differences between pretest and posttest for control group on the scales scores. On the DAS, the DOS and the DDS scores more increased in control group in posttest compared to experiential and didactic approaches and 8A model. But these differences were no significant statistically. The most Eta (Effect size) was on the DOS (14%), and the DDS (11%), respectively.

Many studies have been reported effect of death education program in nurses and nursing students. For example, effect of death education on more positive attitude toward caring for terminally ill persons and their family members (Frommelt, 1991); on the death anxiety and attitude toward nursing care of the dying patients of nursing student (Jo, 2004), on the concern and coping about death and dying (Jeong, et al., 2005), to enhance the attitude to death and meaning in life (Kim, et al., 2005), in changing the behavioral intentions (Tracy, 2006), to improve of life satisfaction and attitude toward death in nursing students (Kim, & Lee, 2009), on the end of-life care (Matsui, & Braun, 2010), on death attitude, death anxiety and life satisfaction (Lim, 2011), on awareness of issues related to terminal illness, death, and loss in nursing students (Kopp, & Hanson, 2012), on the willingness to accompany a dying patient, self-estimation of competence in communication with dying patients and their relatives, and self-estimation of knowledge and skills in Palliative Care before and after of intervention (Schulz, et al., 2013), on the attitude patterns toward a good death, and quality of long-term hospital nurses (Kim, & Kim, 2014).

Johansson and Lally (1990) found that their death education program decreased death anxiety in some senior nursing students but had the opposite effect on junior nursing students. For explanation of this discrepancy, they attributed that senior nursing students had more clinical experience and opportunities to work with dying patients. Hutchison and Sherman (1992), in a non-random trial of didactic or experiential death and dying education for nursing students reported that on the DAS, no differential effects of training technique were found, death anxiety posttest scores were significantly lower than the pretest scores for both groups, and a very little difference was found in change in student's death anxieties, but effects of the attitude change was maintained in follow-up.

Overall review of literature was found didactical teaching methods were the most successful (Adriaansen, & van Achterberg, 2008). This finding has been confirmed by Walker and Avant (2011). Research has yet to identify the most appropriate educational method to teach death and dying courses to emergency medical technicians (EMS) providers (e.g., lecture, small group discussions, case studies, patient scenarios, interviews with dying patients, role-plays, and videotapes). Despite this, lecture has become the most common method used to teach death education (Mak, 2013). Workshops on life-and-death issues can help nurses discover that they are not alone and that they can support each other and learn how to manage their own emotions (Lu, et al., 2011); and their death stress (Ayyad, 2013).

Some studies have been showed that didactic and experiential death education led to more death anxiety, especially didactic interventions (Maglio, & Robinson, 1993). Reed (1996) using a combined didactic and experiential death education/empathy skills training program, found that there were no statistically significant differences between the experimental and comparison groups on the self report death anxiety in medical students. Ross, et al (1997) indicated that didactic and small group discussions improved care of the dying patients in medical students. Linder, et al (1999) reported that palliative education by a didactic and experiential approach to teaching end-of-life care enhanced care-delivery skill in all three models On-site, Off-site, and Inmate training in for medical students. After comparison didactic and experiential approaches to end-of-life education, findings revealed that end-of-life education can be enhanced when delivered close to the point of care using multi-modal techniques that impact on attitudes, and knowledge of of health professionals. Another study showed that experiential death education was effective in reducing negative perspectives toward death, increasing more positive perspectives in nursing students (Kono, 2006). In study of Lu, et al (2011), nursing students could learn their fear of death and possible emotional reactions towards dying patients through self-reflection during a workshop on life-and-death issues, this workshop could help nurses discover that they are not alone and that they can support each other and learn how to manage their own emotions. Experiential education not only helped students grow personally but also increased their motivation to learn.

Using death education program in life span, showed that in young adults conference intervention increased their despair, sadness and depression about death, experiential workshop had decreased terror and death anxiety levels, but increased level of despair; in the middle-aged people, experiential workshop significantly increased despair, loneliness,

and death depression levels; and in elderly people experiential workshop decreased death anxiety (Carmen, et al., 1999). In a study which compared experiential and didactic death education, middle-age adults experienced decreased death anxiety after experiential death education, but older adults and younger adults experienced increased anxiety respectively (Abengozar, & Bueno, 1999). Death preparing education program increased death anxiety and improved spiritual well-being and the meaning of life in adults (Yoon, 2009). In elderly people, education on the death preparation improved attitude towards death, significantly reduced depression (Oh, & Kim, 2009), death education changed emotion, cognition and behavior (Park, 2009). Death preparation program alleviated death anxiety in middle-aged adults (Kang, 2011). Death education reduced death anxiety, and increased life satisfaction, psychological well-being in older adults (Song, & Yoo, 2011).

Baek, et al (2001) indicated that a hospice care class decreased significantly death orientation after the class as compared to before the class on the death orientation in nursing students. Providing of well-dying education program by oncology and hospice palliative nurses has been reported effective to prepare good death, on the meaning in life and death attitude in patients (Kang, 2010; Kim, et al., 2014). Hope, et al (2011) reported that a simulation exercise in end-of-life care and role play improved humanistic and problem solving abilities in nursing students and also helped to develop their psychomotor, technical skills, and overall confidence. Lu, et al (2011) found that didactic instruction in end-of-life care is a critical component of nursing education and for most health professions training in general. Kim, et al (2012) revealed that awareness and attitude change increased after end-of-life care education for medical students. Findings study of Kim (2013) provided the basis for expanding practice and education to hospice-palliative care for nursing. Effect of Palliative Care Professional education program on the recognition of good death, to accept death as a positive experience, palliative care, and the meaning of life for nurses has been reported in study of Yeun, et al (2015). Once the notion of dying well gained attention of healthcare professionals, end-of-life research was generated to obtain perspectives of a good death from caregivers, healthcare providers, and patient's viewpoints. A good death became the ultimate goal for many patients and caregivers yet healthcare providers often struggle with delivering a good death versus medical intervention directed toward cure. Utilizing of the experienced nurses' wisdom will improve nursing ethics education in the end of life care which ultimately translates to providing good/better deaths for patients (Hold, 2013). Dying patients experience different stages from denial to acceptance, and caring these patients in physical and psychological aspects is the responsibility of nurses. When caring of the dying patients, palliative care education must be considered, because other interventions are no longer effective (Schulz, et al., 2013). Palliative care begins from the time a life-threatening condition is diagnosed and continues to recovery or death and grieving (Shahnazari, 2014). Lo, Hales, Zimmermann, et al (2011), Krause, Rydall, Hales, et al (2015) indicated that the alleviation of distress associated with death and dying is a central goal of palliative care in nursing, Nurses' ability to recognize and manage their own emotional reactions towards death and dying patients should be included as part of end-of-life education.

Opportunities for students to care for end-of-life patients are limited in undergraduate nursing programs. Educational process requires providing nursing students with opportunities to reflect on death and dying along with guidance during nursing practice in coping with emotional reactions to caring for dying patients. End-of-life simulation is a strong and viable pedagogical approach to learning. Fluharty, Hayes, Milgrom, et al (2012) demonstrated a significant increase in knowledge, regardless of role played in the scenario, as well as high levels of self-confidence, self-reported communication skills, and satisfaction with the pedagogical approach. There was significantly enhanced nursing students knowledge in end-of-life care. Education is a key. Nursing programs vary a lot across the country and vary in terms of how they teach and work with students around the issue of death and dying. College of Nursing at New York University NYU's undergraduate program does address the topic (Kovner, 2015). Dalisay (2015) explored the knowledge, attitudes, and education needs of skilled nursing facility staff in regards to the administration of advance directives to patients and families, and indicated that skilled nursing staff had only a moderate level of knowledge about advance directives. Furthermore, education about advance directives was primarily received from facility-based in-service lectures.

Some findings of Dadfar (2015) were not consisted with previous results. Findings on changes in affect (death fears and anxieties), however, were inconsistent, depending in part on the teaching methods employed: emphasis on didactic methods was more likely to result in slight decreases in fears, and emphasis on experiential methods had no or slightly negative effects. Inconsistency between the results of Dadfar (2015) and previous studies death education imply that previous studies on death have been performed based on the metaphysical and psychological, philosophical, cultural and religious aspects. The subjects were educated independently in each area with the different direction of analyzing the effectiveness of death education from the medical and social aspects. In study of Dadfar (2015) effect of religiousness did not evaluated. Religiousness can influence the amount of effectiveness of experiential death education on the perspective toward death. Zargham Brojeni, et al (2007) stated that belief in a life after death can help nurses to better deal with death, death acceptance, relax, comfort for them and dying patients and their relatives.

The role of Dadfar's study characteristics, including type of death education program (didactic/experiential/8A model), length of education, occupation, educational level, number of nurses, age and gender of nurses, number of days between end of education and posttest, exposure to death, and religiosity, were no examined to determine if these factors influenced obtained effect sizes. It is possible that effect of the death education program vary according to the age of the nurses, years they worked, manner of being affected from terminal phase patient nursing and meaning they attributed to death. Cui, et al (2011) found that three factors of educational background, previous training about death education, and hospital size influenced on the nurses' needs in death education. Differnces in the design of the previous study for example quasi-experimental, non-synchronized with a non-equivalent control group, one-group pretest posttest design, experimental pretest posttest comparison group design can be justify inconsistency findings of Dadfar (2015) with results of other studies.

Wilson, and Kirshbaum (2011) showed that themes related to death of patients in a hospital setting that can impact on nursing staff were included: the theoretical context; the emotional impact; the culture of the healthcare setting; staff's previous life experiences; and support available for healthcare staff. They suggested that education around grief theory and support from others are helpful for staff in developing strategies for coping with patient deaths. Varaei, Vaismoradi, Jasper, and Faghihzadeh (2012) indicated that some factors influence in nursing image, and it is closely tied to the nurse's role and identity, influencing clinical performance, job satisfaction and quality of care.

Considering the mid range scores and the lack of significant difference after the intervention, the study of Dadfar (2015) shows that there is a need to analyze the content of death education programs and the need to change death orientation. This is especially true when the participants are professional hospice nurses who are being prepared to give care to people who are dying. In order to develop more appropriate programs there is a need to examine the process by which nurses come to view death more positively. Dadfar's study (2015) contributes new knowledge about staff experiences of patient death in the acute setting. The findings could have implications for clinical practice and the provision of support for nursing staff, and could also inform future policies regarding end of life care in acute medical setting.

Dadfar (2015) used four meaning-oriented films (The *Dragonfly, The Green Mile*, The *Flatliners*, and *The Song of Bernadette*) in experiential death education program. The role of meaning in films is pivotal for understanding death attitudes. In a pilot study of nursing students, a death education program in which participants viewed a film of death experience was assessed to determine effects on death anxiety (Johansson, & Lally, 1990). Results showed nicely conceptualized, and death anxiety decreased in senior students and increased in juniors. Niemiec, and Schulenberg (2011) emphasized the use of films as an important adjunct for both teachers and clinicians addressing death attitudes with students and clients. They developed a program of death education using movies and integrated movies, positive psychology, and meaning management in death education. Research on how films may change attitudes toward life and death remains sparse. Despite these few examples, empirical studies of movies and death attitudes are few and far between. Jung (2012) indicated that among the several learning tools, utilizing cinema with its audio and visual components can be one of the most powerful learning tools in death education (Jung, 2012). In research of Dadfar (2015) films were from other cultures, and were only a small part of the overall death education program. The small sample size was further limited in terms of generalizability, given the nurses were Iranian and well-educated. Maybe use to films focused on Iranian culture, and a long part of death education program can useful in reducing and managing of death distress, facilitating discussion of related issues such as death, dying, and the grieving process, and providing nurses with information and experiences they may use to relate to their own lives. Future research may be designed to address three primary areas. First and foremost, studies should be conducted in the academic environment and with community samples to better delineate the nature and extent that films positively influence death attitudes and death-related distress. Secondly, similar research is needed to document the

utility of movies in the training of medical and mental health professionals who work in contexts where death is frequently encountered (e.g., palliative care). Specific focus should be placed on whether such movies influence the attitudes of professionals in training, and therefore the quality of the treatment provided to clients and patients. Finally, it is important to systematically study movies with a focus on death attitudes and death-related distress on the lives of clients and patients. In other words, there are currently no controlled studies on the treatment of death anxiety in the clinical context (Furer, & Walker, 2008). As such trials emerge, she would like to see movies as an element not only as an exposure treatment for anxiety, but also included as part of the educational repertoire of managing death distress. Systematic studies are also needed to examine which character strengths are highest in those individuals with high levels of death acceptance.

Findings of Dadfar (2015) showed that there were significant differences between pretest and posttest for 8A model on the scales scores of the DDS. On the SCS, there were significant differences between pretest and posttest for 8A model on the Alienation and the Access stages scores. There was a significant difference between posttest for 8A and control groups on the scale score of the DOS. On the SDEPE, there was a significant difference between didactic approach and 8A model. The nurses evaluated 8A model more useful compared to didactic approach.

The 8A model is a community networking model for life and death education; for promoting positive attitudinal and behavioral changes to maintain the human social bond in the face of death. The 8A model has potential benefits, seeks to help people understand their thinking and experiences in different phases of change in death knowledge, attitude and practices; it integrates death education into all levels of society. The 8A model provides a roadmap that allows potential phase-matching intervention for maximizing people's sense of autonomy in dealing with death-related issues. This model in practice serves as the guiding framework for the ENABLE's overall community organizing efforts as well as its two major death education programs (Chan, Tang, Tin, et al., 2006; Chan, 2008; Chan, & Ho, 2010; Chan, et al., 2010; Conway, 2011; Chan, 2014). To eradicate a long-standing death avoiding, death fearing culture among traditional Chinese communities, the ENABLE project offered a viable and practical framework to integrate the ideals public health and primary care (HPPC) into a board spectrum of society. The experience illuminated the vital significance to applying a public board health approach in such undertaking; one that encompassed empirical research in amplifying the voices and identifying the needs of dying people and bereaved families, development of evidence-based public death education and specialist training that enhance personal autonomy and professional competency in the face of mortality, as well as a social networking regime to facilitate community involvement, empowerment and participation in the governance of death and dying (Chan, Tin, Chan, et al., 2008; Chow, 2009; Ho, & Chan, 2011; Conway, 2011). The 8A model has potential benefits for death education. By introducing 8A model in death education training to healthcare professionals, Chan, et al (2010) expected that these professionals can better understand the changing needs of clients at different stages of preparation for death. For instance, instead of perceiving the clients as "unmotivated" or "resistant" to preparing for death, the 8A model suggests a new perspective

in understanding the needs of clients in the initial stage that may manifest as "avoidance" and "alienation." In turn, professionals can also provide to their clients appropriate interventions involving different individual, group, and community levels, to facilitate planning for end-of-life care. The 8A model may also remind professionals that, although death is a major topic in planning for end-of-life care, the meaning of life, which involves appreciation and actualization, is equally important if clients are able to prepare positively for death. Similar to the existential perspective, the 8A model implies the possibility of transformation in death preparation (Frankl, 1984; Wong, 2008).

On the basis report of the ENABLE project, the initial feedback of training sessions by 8A model death education was positive (Chan, et al., 2010). Key research findings from the ENABLE project were: 1) The death education workshops and professional training modules reduced the death-related anxiety; 2) There are attitudinal changes on death taboo in the local community compared with the figures in year 2007; and 3) Middle-aged adults and elderly people are now more ready to initiate death preparation. To date, the ENABLE provided specialist training for nearly 2000 frontline healthcare and community social workers. Further, around 74,000 members of general public have received face-to-face death education services. Evaluation studies (circa 3000 respondents) provided very encouraging results (Conway, 2011; Chan, 2014). Moreover, the ENABLE Alliance has attracted the participation of 50 hospital groups, community service agencies and NGOs, who have worked collaboratively and in harmony to promote death education in Hong Kong (The official website of Empowerment Network for Adjustment to Bereavement and Loss in End-of-life ENABLE, 2015). Findings from a series of vigorous efficacy studies with nearly 3,000 respondents show that, the ENABLE project together with its death education workshop and professional training modules have helped to increase the knowledge base on death and dying for healthcare and allied health professionals, patients, elders and their families. Specifically, the project was successful in relieving participants' death-related anxiety, increasing their comfort in talking about death while supporting positive attitude and behavioral change towards death and dying. Furthermore, results from a prospective cohort study between 2007 and 2010 that looked at the changes in attitude and behavior on death and dying among 1475 Hong Kong Chinese respondents are also encouraging and promising. In particular, the percentage of people who believed that talking about death and seeing a dead body or coffin would bring bad luck has noticeably decreased, while being in social contact with, or visiting a recently bereaved family is seen less as a curse and more as act of care and compassion. This study also found that the percentage of middle-age adults and elderly adults who have taken initiatives in preparing for their own death has risen significantly, and more middle-aged and older adults had engaged in death preparation. Compared to 2007, 20%-30%, more middle-age and elderly adults have purchased life insurance in 2010, 10%-25% individuals more have set up a will, 6%-20% more individuals have planned and purchased burial plots and arrangements, while 15%-20% more individuals have opt for organ donations (Chan, & Ho, 2010; Conway, 2011; the official website of Empowerment Network for Adjustment to Bereavement and Loss in End-of-life ENABLE, 2015). Overall, the Chinese people in Hong

Kong are talking a much more active stance in relation to death, dying and bereavement (Chow, Tin, Cheung, et al., 2009; Chan, & Ho, 2010; Conway, 2011; Chan, 2014).

It seems that the ENABLE has done its mission (promote public awareness on death, dying and bereavement; provide facilities for the elderly population, as well as people with chronic and incurable diseases and their family members to better prepare for death, dying and bereavement; and develop overall competence of professionals in supporting dying patients and mournful/bereaved persons; expand and increase the overall competence of specialists in palliative care, end of life and bereavement; and create a social network model, to make pressure to advance a social movement, to integrate end of life care at all levels of society). Cecilia Chan, project director, has stated that it is truly heartening to see that the general public has endorsed a more positive outlook when dealing with death related issues. Death has become less of a cultural taboo in Hong Kong, while people are much more willing to accept the fact that death is a natural part of life and therefore have more capacity to face their own deaths and those of their loved ones. Andy Ho, head researcher, has indicated that it is indeed encouraging to see the positive attitudinal and behavioral change among the middle-age, and especially the old-age population; however, much more work needs to be done with younger age groups. He pointed out that death is still heavily perceived as a taboo topic among young people in Hong Kong. Not only are they afraid of death, they are also uncertain about life, often feeling lost and powerless towards life changes and adversities (The official website of Empowerment Network for Adjustment to Bereavement and Loss in End-of-life ENABLE, 2015).

A study showed that many variables affect nurses' mental health, nurses with better mental health had worked more years on their unit, used distancing coping strategies, did not use escape-avoidance and self-controlling coping strategies, felt supported in the workplace and had a lower workload (Chang, Daly, Hancock, et al., 2006). Rose and Glass (2006) in a qualitative research showed that community mental health nurses suggested that their emotional well-being was essential for them to fulfill their professional practice. Çelik, et al (2014) concluded that death anxiety is a major problem and affecting the quality of care given to the dying patient among the School of Health students. The education that student take about the approach to dying patients and dyed persons may be useful in reducing death anxiety if the education be more comprehensive and effective. Like guarding against death anxiety, preventing nurse burnout often came down to what support systems the nurses had to help them manage their stress. Also the nurses with good emotional support experienced better work-life balance, which helped them stay engaged in their work and prevent negative patient outcomes (University of Bedfordshire, 2015; cited in Brady, 2015). Chana, Kennedy and Chassell (2015) reported that work stressors, coping strategies and self-efficacy were significantly correlated with nursing staffs' burnout and psychological distress; caring behaviors were correlated with coping strategies and self-efficacy; correlations were found between caring behaviors and nursing staffs' burnout and psychological distress. The work stressor of experiencing patients' 'death and dying' increased, and nursing staffs' emotional exhaustion and anxiety also increased. Nurses are especially vulnerable to the debilitating

condition because of the nature of their work and the constant exposure to death (Bradly, 2015). Nurses face death anxiety from work in Emergency Rooms (Green, 2015). Emergency room nurses should be coped, much less function, when they're constantly surrounded by death. Some mentally shut down. They just do their job, robotic-like. It's possible to do a job that way, but down the road the nurse likely would face consequences. Many others experience death anxiety, a state that makes them more conscious of their own mortality and creates a high level of stress and unease (Kovner, 2015; Kamienski, 2015; cited in Green, 2015; Bradly, 2015). Nursing students at the end of their curricula feel unprepared to care for the dying. Nursing students' attitudes to caring of dying patients can play a key role in the nursing education (Leombruni, Miniotti, Bovero, et al., 2014). Nurses should be aware of death anxiety. Educational institutions adequately should be prepared nurses, to embark in such a death anxiety laden profession. Kalischuk (1992) studied nurses' perception on death education. Results showed that nurses perceived that existing death education remains inadequate as preparation for sound clinical nursing practice. Several statistically significant findings related to the provision of professional terminal care were reported among nurses. They identified concerns and deficits within existing nursing death education and offered several specific suggestions for improvement. The improvement of death education for nurses most likely results in the delivery of safe, effective, quality nursing care practice to the dying person and family. Basu, and heuser (2004) indicated that pedagogical strategy offered exciting potential for grounding death education in real life experiences. The precautionary steps for a renewed discourse on ethical considerations in death education should be indicated (Brabant, & Kalich, 2008). Brady (2015) suggested some interventions that could prevent the debilitating effects of death anxiety, to improve staff's mental health and the care they provide to patients. Ho et al (2012) recommended further education about end of life care for Spanish renal nurses. Death preparedness leaded to awareness and/or acceptance of end of life (McLeod-Sordjan, 2013). Hospital institutional managements should be provided adequate and effective support systems and opportunities for continuing education. Support systems include on-site counselors, formal support groups, informal support, mentor/instructor support, and spiritual support. Research must be the way forward to assist nurses to deal with death anxiety. Education enhances nurses' knowledge and skills, addresses the nurses' perceptions of clinical inadequacies, empowers nurses to provide care that is sensitive to the patients' and the families' needs, equips nurses with better communication and counseling skills, and includes self-care and self-awareness techniques. Self-care maybe a means to adopt a confrontation attitude rather than avoidance coping mechanisms, awareness of one's strengths and limitations, explore the dimensions of grief, enhance nurses' satisfaction, cultivate personal stability, and exploring how culture responds to loss and grief. Supports include on-site counselors, formal support groups, informal support, mentor/instructor support, and spiritual support (Scalpello Hammett, 2012). Although human beings are thought to develop adaptive methods for coping with death anxiety, periods of heightened stress or threats to the health of self or loved ones can result in inefficient and pathological modes of coping for some individuals. Chafin and Biddle (2013) identified barriers and

benefits to nursing staff satisfaction with their job and the likelihood that they continue to work in correctional settings. Results showed that practice and patient care favorably impacted if correctional nurses were provided with services such as new hire orientation, clinical ladder programs to recruit and retain nursing staff, and teambuilding. The Mid Staffordshire NHS Trust's Francis Report (Mid Staffordshire NHS Trust) (2013) indicated that the well-being of its staff needs was a primary concern. The King's Fund (2013) emphasized that to promote a positive culture of care in the NHS staff must be supported to do so, through supervision and protection of their well-being. Liter, Sinclair, Yuan and Mohr (2014) examined how trait differences in death anxiety relate to employee occupational health outcomes, how death anxiety affected nurses in a multi time point, and how death anxiety might exacerbate the negative effects of mortality salience cues experienced at work or the impact of death anxiety in firefighters. The results showed that trait death anxiety was associated with increased burnout and reduced engagement and that death anxiety further exacerbated the relationship between mortality salience cues (e.g., dealing with injured and dying patients) and burnout. In their multitime point study, death anxiety related to burnout, engagement, and absenteeism. The results further showed that death anxiety moderated the relationship between mortality cues and burnout, where people high in trait death anxiety experience higher levels of burnout as a result of mortality cues than people lower in death anxiety. Despite differences in the methods (e.g., time lag; measures), the effect sizes and the form of the significant interactions were quite similar. They recommend death education and vocational counseling, and provided some avenues for future research. Evidence suggests that continuing education is one of the modern strategies to maintain and elevate knowledge and professional skills of nurses. Study of Hamzehgardeshi and Shahhosseini (2014) highlighted policy makers and nursing managers' role on improving the accessibility to provided continuing education programs by enforcement of facilitators and reducing barriers focusing on the personal and structural barriers. For effectiveness of the Medical Emergency Teams (METs), for instance ICU and CCU, a better interprofessional education is needed (Pusateri, Prior, & Kiely, 2011).

One of issues related to death education is organ donation in brain dead (BD) and cardiac death donors. Fukushima, Konaka, Kato, and Ashikari (2012) in a professional education and hospital development for organ donation, developed a special education program includes the practical training in each donor case, and topics of the education program were the revised transplant act and guidelines, family approach to organ donation, BD diagnosis, donor evaluation and management, organ procurement and preservation, allocation system, hospital development and family care. Azmandian, Poorhoseini, Shokouhi, and Mirzaei (2013) in a test-retest semi-experimental study, examined education effect on nurses' knowledge and attitudes of ICU and emergency wards about organ donation at the time of brain death in the educational seminar of brain death. Results showed that more educational programs are necessary for increasing knowledge about brain death and organ donation among health staff. In death education programs for nurses, issues related to organ donation should be considered.

The study of Dadfar (2015) in Iran had some limitations. The wide array and numerous self-report inventories have been developed to evaluate the presence and severity of death anxiety for clinical and research purposes that confirmed the importance of evaluating death anxiety in both non-clinical and clinical populations. However, the psychometric properties of some of these inventories have been questioned. For instance, The DAS forced choice response format, internal consistency, discriminant power, and factorial validity have been criticized. Many death anxiety scales are regarded as unidimensional in nature and only provide a single measure of death anxiety (i.e., the total amount of death anxiety). These unidimensional measures have also been found to tap into multiple dimensions of death anxiety. Thereby, confirming the multifaceted nature of death anxiety and the need for multidimensional assessment tools. Multidimensional measures, hold promise for future research evaluating the complex dimensions of death anxiety. Movement toward multi-dimensional measures of death anxiety, death depression, and death obsession may prove useful in understanding the many facets of them, and in evaluating changes in them following treatment. Death anxiety, death depression, and death obsession inventories be supplemented with several self-report measures of anxiety, depression, distress, and psychological functioning, such as the Beck Depression and Anxiety Inventories BDI-II, BAI; the Symptom Checklist-90-Revised (SCL-90-R); and the General Health Questionnaire (GHQ), and the Kessler Psychological Distress Scales (K10/K6). The cross-sectional nature of the study also limits the ability to determine causality. Future research should undertake longitudinal studies to investigate the effect of these variables over time or correlation studies should be complemented by intervention studies, which would aid in providing evidence of causality in the relationship between burnout, psychological distress and caring behaviors. Another limitation was the relatively small sample of nurses examined. Furthermore, due to the large number of unreturned questionnaires and the possibility that nursing staff with the highest levels of burnout and psychological distress may have been less likely to engage with the topic or have time to complete the extensive set of tests, a response bias could lead to an ungeneralisable sample. Also, although the participants came from a number of clinical settings, the sample was restricted to one hospital, further limiting the representativeness of the findings. Finally, as the sample was 90% female, the findings cannot be generalised to the well-being and caring behaviours of male nursing staff and further research should be conducted to capture their views. Another limitation lied with the measure of caring behaviours, The Caring Behaviour Inventory, which demonstrated ceiling effects. It is possible that the wording of instructions meant that nursing staff reported their attitudes towards rather than frequencies of caring behaviours and these may not be directly related. Furthermore, the potential issue of social desirability means that nurses may not have wished to give answers that could be perceived as ‘uncaring’. Future research might find it useful to use a revised version of the original questionnaire which asks about frequency of behaviours in a specific timeframe and uses a wider response scale. Sample was small and the study had no follow-up phase so there was difficulty in generalizing results. Training was not done by teamwork of death education and was carried only by one educator. The 8A model for death education has limitations. The

content and sequence of this model were not developed with reference to empirical data. Instead, they were greatly influenced by the experience and observations of team members in working with patients and elderly people. Although all team members were experienced in the field of death and dying, systematic quantitative and qualitative studies with different groups of clients may help to examine the appropriateness of this model. For example, 8A model seems to assume that clients in different age groups may experience similar concerns, like avoidance, alienation, etc. It will be helpful if further research can explore how different age groups may react during death preparation. But 8A model for death education has future development. The ideas of developing the 8A model for death education stem from TTM. Thus, Chan, et al (2010) deliberately developed a model in which the eight areas (as represented by the 8As) can be discussed with reference to different stages of the TTM. Again, further research is required to verify if these areas match the progress of the stage model, as stated in TTM. Another goal of this team was to develop specific criteria or measurement empirically with reference to the 8A model. This may further advance the 8A model from a descriptive and theoretical model to a practical clinical assessment tool in death and dying.

Recommendations for future interventions

In the light of mentioned results, the following action points are suggested: nurses' content needs in death education and the characteristics associated with those needs should be investigated. Maybe effect of the death education program vary according to the age and cultural context of the nurses, years of experience in nursing, manner of being affected from terminal phase patient nursing, highest degree held, basic type of nursing preparation and previous education on death and dying. Educators and administrators should be strived to provide high-quality training for nurses and considered the roles of culture, religion, and socio demographic characteristics when designing death education programs. Planning of death education should be focused on religious perspective. For example, cultural norms of considering the dead person during war will be as martyr and will go to heaven and lost here is not permanent and that the dead person is alive in heaven and looking to their action in the daily life. Creating a reflective narrative environment in which nurses can express their own feelings about death and dying seems to be a potentially effective approach to identify the factors influencing their interaction with the dying. Medical Emergency Team (MET) death education prepares nurses for their role and improves both patient care and their working conditions. Most nursing and medical schools in Iran do not provide adequate education in end-of-life care. The need to improve end-of-life care education and the effect of the education on nursing students' awareness and attitude towards hospice and palliative care for terminally ill patients should be assessed.

Based on the above results, it is apparent that the death education program has some affirmative impact on the nurses. We suggest, therefore, that the death education program should be used with all human beings to help them recognize their attitude toward death for improve of them. Future research should be examined multiple factors to explain nurses' levels of burnout, such as socio-demographic variables, job stressors, personality traits and

coping strategies. Research into the factors associated with nursing staffs' burnout will be essential as burnout is linked to patients' perceptions of poor care and decreased quality of care. Reducing nurse burnout may be an effective strategy for improving nurse-rated quality of care in hospitals. Findings should be viewed as an initial investigation into the links between the multiple variables measured. Personal accomplishment appeared to be the least indicative of occupational burnout as it can relate to stressors rather to individual determinants, such as personal resilience.

Psychosocial correlates associated with how Iranian nurses react to death and dying, and also and predictive effect related and variables events on death anxiety symptoms, should be assessed. Nurses who are comfortable with listening for and discussing existentially related concerns may be in a better position to promote the patient's psychological adaptation. Nursing staff would benefit from psychosocial training to equip them in responding to the psychological and emotional needs of patients and their families. Psychosocial training will be beneficial for nursing staffs' communication with their patients. Training programs must be created for nurses working in hospitals and conflict including community sessions to increase their awareness about the impact of death on their psychosocial health and ways of coping with such problems in similar situation. New intervention programs must be established for nurses using individual psychotherapy, psychoeducation, group crisis intervention, and community based intervention.

Exploration of the concept of death anxiety, raising death anxiety awareness, coping strategies nurses adopt in the attempt to ameliorate or reduce the threat of this complex emotional response and the role of nurse education in the preparation of nurses to effectively deliver quality care and professional support in the event of death related incidents within the health care setting. Oncology nurses need to recognize and understand how to cope with their own aversive thoughts and emotions. Nurses could share strategies with more novice oncology nurses. To fight death anxiety, hospitals should be created education programs to make supervisors, nurses and paramedics aware of the issue. Programs could also help Emergency Room nurses prepare mentally for the strain of working in these areas. The importance of conducting more research to explore the incidence of death anxiety among emergency workers should be cited. While many emergency nurses and paramedics may be unaware of death anxiety, they are exposed to it in their everyday practice. Healthcare providers, university staff and employers must understand and try to prevent the development of this potentially debilitating psychopathology to improve the health of their staff and the care of patients. Assessing staff involved in critical incidents against a trauma risk-management tool. There is another potential solution, leaders can rotate emergency workers' schedules to prevent staff from being overly exposed to death anxiety. It's important facility leaders recognize the risks of death anxiety and make workers aware of the risk. Additionally, execs should put support systems in place to help the nurses improve their own health, and prevent burnout and stress from affecting patients' care. Leaders should be considered different ways to provide their support. Methods such as peer coaches, journaling after work and reflective supervision, where staffs share problems they've experienced with each other and

senior staff members, are suggested. Rotating schedules, debriefing, and teaching of "chaos therapy" have been suggested as ways to help Emergency Room personnel deal with the anxiety that can come from dealing with death on a daily basis. Hospital leaders should to be recognized the signs and symptoms of this condition and put interventions in place to help improve the mental health of their staff. Occupational risk-assessment tools for staff and nursing students should be developed and more research carried out to explore the incidence of death anxiety among emergency workers. There has been little effort to incorporate topics regarding mortality salience and death anxiety into workplace literature. The importance of understanding death anxiety in the workplace should be highlighted, particularly in occupations where mortality salience cues are common. Death education programs could help to reduce levels of death anxiety by preparing nursing students and nurses to confront their beliefs about death, and staff involved in critical incidents should be assessed against a trauma risk-management tool. Staff involved in organizing rotations should also be tried to rotate emergency healthcare workers so that they are not over-exposed to mortality cues. Compassionate nurses should be accounted.

Continuing education as one of the new strategies to maintain and elevate knowledge and professional skills of nurses which in turn elevate the health status of society, is necessary. Continuing nursing death education in settings where the hospital provides both acute and extended care services causes a greater availability of educational programming is recommended. Continuing death education for nurses will be useful. Since several factors affect nurses' participation in continuing education, it's essential to know promoters and obstacles in this issue and plan accordingly. Continuing death education may be required for Iranian nurses in order to improve the patients' quality of care at the end of life. A continuing death education program can be applied as an effective nursing intervention for other subjects. A training course may help nurses develop their view on the meaning of death, which in turn would enhance their performance in caring dying patients.

Special death education should be started from university level and should be continued in the form of in-service training. A major concern for the pioneers in death education at the college level is the need to recognize those nursing students who enrolled in the course in order to get help with death related issues, primarily suicidal thoughts and unresolved grief. Educational programs about death and caring for dying patients should be added to undergraduate nursing curricula. Further research recommended examining nursing students' knowledge about caring for dying patients and the effect of education on their knowledge. Another way nursing schools can help students cope with the stress they'll encounter on the job is to teach them the "chaos theory" so they can handle the intensity of the Emergency Room and keep calm in stressful situations. There's a place for the chaos theory in healthcare, further research would be required to determine, if learning it really can reduce death anxiety. The entire concept should be defined and then explored.

Nurses who working in emergency settings should be made aware of the risks of this debilitating psychopathology and given access to interventions to prevent it from affecting their physical and mental health (Brady, 2015). Nurses' ability to recognize and manage

their own emotional reactions towards death and dying patients should be included as part of end-of-life education. Interventions are suggested: Death education programs: these could help to reduce levels of death anxiety by preparing nursing students and nurses to confront their beliefs about death; Occupational risk-assessment tools: healthcare workers involved in critical incidents should be assessed against a trauma risk-management tool; and Job rotation: staff involved in organizing rotations should also be tried to rotate emergency healthcare workers so that they are not overexposed to mortality cues. Nurses need to construct separate special death education programs for categories of organ donation in brain dead and cardiac death donors. In professional death education programs, family approach regards to these categories should be considered. Retention of nursing staff is more complex in a correctional facility. Without retention of qualified correctional nurses, there are decreases in access to care, gaps in continuity of care, and less time for mentorship. Trained correctional nurses improve patient and staff safety, provide more education, and are more team-oriented.

Social support to have a strong influence on nursing staffs' psychological well-being is necessary. The key role of transactional elements (coping and appraisals), rather than work stressors or personal factors such as social support or resilience in should be determined in quality of nursing care. Well-being of nursing staff is crucial to provide patients with quality care. To support and encourage of self-efficacy in of nursing staff as belief in one's ability at work will be beneficial for nurses' well-being and moreover through improved self-efficacy practice behaviors may improve, bringing benefits to patients. Employers should be ensured that nursing staff have a manageable workload, with predictable staffing and scheduling, and enough time and staff available to complete tasks. Clinical supervision to improve nursing staffs' well-being and help them to value both their work and themselves will be leads to better quality of care, will provide an effective opportunity to direct staff to appropriate support. Clinical supervision could be used to promote adaptive coping strategies and self-efficacy, factors which have been demonstrated to improve nursing staffs' well-being and the quality of care they provide. Supervision would give nurses the opportunity to discuss emotionally difficult aspects of their job. Access all nursing staff to similar schemes and support throughout their career, is necessary. The coping strategies correlate with increasing of well-being and caring includes cognitive coping strategies. Self-help materials, which encompass cognitive-behavioral techniques, may be useful in any intervention or psycho education with nursing staff. Another way to promote the well-being of nursing staff is through schemes such as Schwartz Center Rounds (Rounds), a training program, including information about a patient's condition and role playing exercises. Supporting hospital staff to provide compassionate care, will be found to aid caregivers in providing compassionate health care. Goodrich (2012) reported that many positive benefits of the Schwartz Center Rounds (Rounds), being viewed as a support, and have been found both for patients and teams. Lupo, Arnaboldi, Santoro, et al (2013) reported that the Schwartz Center Rounds (Rounds) decreased nurses' levels of burnout. Rounds are a multidisciplinary forum enabling discussion of difficult social and emotional issues that arise while caring for patients. Rounds will provide with postqualification training opportunities to ensure nurses have adequate

information regarding medical treatments provided, essential for both patient safety and in supporting nursing staffs' well-being.

Healthcare providers, university staff and employers must understand and try to prevent the development of this potentially debilitating psychopathology to improve the health of their staff and the care of patients. Healthcare organizations must be made nurses aware of the risks of the disorder, also known as thanatophobia, and provide staff with access to interventions to prevent the condition from affecting their physical and mental health. Organizations should be considered rotating emergency healthcare workers so they aren't overly exposed to mortality. Healthcare administrators must also be assessed employees who are involved in critical cases against a trauma risk-management tool to see if they are at high-risk for death anxiety. However, it is dubious that rotating would help, isn't a practical solution at all. Emergency Departments (ED) staff must be prepared to encounter life and death situations as often as they occur. This is also true for oncology and ICU nurses, and neonatal ICU areas. Nurses should be obtained help from the organization, within the community. Providing debriefing sessions after a traumatic incident is another way to combat death anxiety. Organizations should be conducted small, weekly group meetings for staff members perpetually around trauma, and must be supported the concept of debriefing employees following exposure to death or near death situations in, among other places, the ED. It is possible many nurses will resist this approach because they feel it's mandatory to simply move on. Some strategies to manage these concerns and future research are required to explore the efficacy of clinical supervision, training and the promotion of personal well-being. Developing of a Health and Social Care Information Centre (HSCIC) for monthly National Health Service (NHS) Hospital and Community Health Service (HCHS) Workforce Statistics in Iran is suggested. In a health care service striving to provide high-quality patient-centered care, it is essential that factors affecting nursing staffs' well-being and their caring behaviors are examined. It is extremely important that the emotional well-being of nursing staff should be supported, both for them, and for the effect that has on patient care. Action points should be suggested for health care service employers to enable this to happen. To address the death-related emotional problems found, it is suggested that changes are needed within current clinical practice, for example through provision of enhanced training, use of model-based clinical supervision and reviews conducted on staffing levels and workload issues. Health care organizations need to prioritize and attend to the psychosocial needs of their nursing staff: need for an integrated view when making any attempts to improve the well-being of nursing staff to ensure safe practice. The studies paved the way for the establishment of a similar program in hospitals in the future and the use of the program was expected to improve the quality of the palliative nursing services as well as the satisfaction of the patients and their families. However, more attention and study should be directed to the educational needs of nurses. Health educators should be involved in death education.

Nursing staff and other health care professionals would benefit from training both within their own team and across multidisciplinary teams to prevent conflict, through promoting team work, respectful attitudes and communication skills. Kalisch, Lee, and Rochman (2010)

has shown that when nursing staff rated the teamwork in their workplace as higher they also reported greater job satisfaction. Behavior of teams will influence clinical performance and that training will improve performance (Schmutz, & Manse, 2013). Working environment that actively supports nursing care and involves nursing staff can lead to improved team functioning, inter-professional relations and positively affect patient outcomes. Nursing staff should, make every effort to positively foster their social support, and be supported to do so by their employers, as it appears that this support will enable nursing staff to better deal with the stressors that come with working in a caring profession, which will ultimately benefit patient care.

The findings of the investigation of Dadfar (2015) indicated that increasing an nurses' knowledge concerning death and dying will not significantly impact on their attitude, anxiety, or fear toward death and dying. Since the mean scores on the attitude, anxiety, and fear scales indicated that on the CLFDS and DAS all groups of nurses remained in the range of scores that are interpreted as indifferent, there is a need to include affective education in a death education experience in an attempt to favorably influence these factors, Thus, it appears these approaches to death education were not an acceptable ones for health educators in dealing with these groups. From a pedagogical viewpoint, there were many reasons that necessitate changing attitude, anxiety, and fear in a favorable direction. When a person is indifferent toward the issues surrounding death or dying, this attitude may act as a block to receiving new information concerning these issues, any blocking of new information puts a person at greater risk of making inappropriate decisions in the future. The point being made here is best represented by a statement from Feifel (1977): "Because we as humans possess the capacity to conceptualize a future, and along with it an inveitable death, the meaning of and attitudes toward death that we hold can be an important variable in determining what we do with our lives in the present". By educating people away from these neutral attitudes, it makes it possible for nurses to more deeply examine the meaning of their life. Another reason for educating toward more favorable attitudes deals with the knowledge, attitude, and behavior relationship. The effect of attitude on knowledge was discussed above. It is believed that behaviors are the result of a person knowing something and their feelings attached to that knowledge. Therefore, even if the knowledge is present, life-enhancing behavior may not occur if attitudes are indifferent or unfavorable. This occurrence is readily observable in our everyday life in the many high-risk behaviors that nurses exhibit. The failure of most people to make out wills is another example of how indifferent attitudes block appropriate behavior and may even lead to the distress of others by burdening them with our unfinished business when we die. Finally, there are social and mental health reasons that necessitate educating for favorable attitudes. A person with in-different or unfavorable attitudes may feel discomfort when he or she encounters an aged person, as people often associate age with death (Noland, & Crosby, 1983). This can lead to avoidance and isolation of the elderly, as has been a recent trend in our society. Also, a person that understands dying persons and has a favorable attitude toward them is more likely to be able to interact positively with that person in a time of need. This is important for most people in our culture in dealing with close friends and

relatives. Associated with this occurrence is an assertion by Leviton (1976) that the death-educated person will experience a healthier bereavement in a loss situation. Although the above conclusions follow from the results of this, there are three points that must be raised about the validity of the conclusions. First, it is possible that there will be a delayed impact on death attitudes, anxiety, and fear as a result of this education experience, this suggests the need for studies to include long term follow-up measures on death education nurses. Second, changes in the length of the course or the number of meeting times per week may have altered the results obtained in a favorable direction. Finally, people must be cautious in directing or facilitating predetermined changes in the affective domain when they have little or no in-formation on the "ideal" levels for an individual regarding death attitudes, anxiety, or fear (Dadfar, 2015).

At this point researches must recommend more than a cognitive approach to dying arid death education if the goal of the experience is to have the participant "know" about dying and death through the cognitive, affective, and life skills domains. Experimental, existential, Cognitive Behavior Therapy (CBT), and Acceptance Commitment Therapy (ACT) or an integrated version of these approaches can successfully treat death anxiety, death depression, and death obsession. More research into the clinical aspects of death anxiety across disorders is needed. Adding of existential and cognitive-oriented approach to death education will be an acceptable one for health educators. Treatment of transdiagnostic constructs, such as death anxiety, may increase treatment efficacy across a range of disorders. Large-scale, controlled studies to determine the efficacy of well-established psychological therapies in the treatment of death anxiety as a transdiagnostic construct are warranted. The larger research and studies to determine the efficacy of well-established treatment strategies for death anxiety, death depression, and death obsession in non-clinical and clinical samples (somatic illnesses and psychiatric patients) are suggested. Death education programs using the Theory of Planned Behavior (TPB) to predict nurses' death related behavioral intentions, attitudes are recommended. Many research showed that using of the TPB is useful for prediction and change of behavior (Smith-Cumberland, 2006; Karimy, Niknami, Hidarnia, & Hajizadeh, 2012; Bashirian, Hidarnia, Allahverdipour, & Hajizadeh, 2012; Hukkelberg, Hagtvet, & Kovac, 2014; Travlos, Kalokairinou, Sachlas, & Zyga, 2014; Karimy, Zareban, Araban, & Montazeri, 2015).

While basic assumptions and goals of death education may be agreed on, wide variation in specific objectives, populations, and settings have made it difficult to establish general standards and to evaluate the overall effectiveness of the diverse efforts. Because thanatology (the study of death) has become a complex multidisciplinary field with a considerable amount of research, scholarship, and practice, and because the subject is personal and intimate, death education is challenging and requires solid qualification. There seems to be agreement on a number of basic competencies of an effective death educator: confrontation of personal mortality and comfort with the topic of death; knowledge of the subject matter and commitment to keep up with new developments; ability to develop objectives consistent with the needs, interests, and educational levels of learners; familiarity with basic principles of learning and

instruction; knowledge of group dynamics; and skills in interpersonal communication and, when necessary, in identifying students' needs for support and counseling. The Association for Death Education and Counseling (ADEC) is currently developing standards for training death educators based on teacher competencies that can be used for death educators in future research. The concept of death preparedness in the process of dying should be the focus of research to explore areas to improve advanced directive planning and acceptance of palliation for chronic health conditions. Formal death education for health care and allied health professionals who work extensively with dying patients and bereaved families is fairly limited. The training of palliative experts should be emphasis on psych socio spiritual care. A multidisciplinary team of Iranian scholars, practitioners and researchers in the field of thanatology, life and death education, social work and psychology should be formed and organized in the country. In this regard hospitals groups, elderly care and family service units, social services agencies and nongovernmental organizations can work with this team.

Death education for the public, grief counselors, physician, health professionals, college students, and public schools are suggested. Development of comprehensive community empowerment program under guidance of a public health agenda with emphasis on the prevention, harm-reduction and early intervention for reducing of death anxiety, death depression and death obsession are recommended. An agenda that also recognizes public education, professional training, interdisciplinary partnership, community ownership, research and policy advocacy, will be all essential elements in determining the success and sustainability of such a program. Community death education program, teaching and learning, online death education, are recommended. Modest progress has been made in evaluating death education. The challenge of achieving an overall objective evaluation of educational outcomes remains. State-of-the-art death-related content needs to be reflected in the educational curricula for professionals. All groups can benefit from studying the larger social and cultural contexts in which they live and work. Advances in the communications technologies enabling rapid information gathering-and sharing-and the increasing use of these technologies for online distance learning and teaching can greatly facilitate and enhance death education at all levels.

Instruments for assessment of death distress

There are various tools for measurement of attitude towards death and dying such as Death Concern Scale (DCS), Collett-Lester Fear of Death Scale (CLFDS), Templer's Death Anxiety Scale (DAS), Arabic Scale of Death Anxiety (ASDA), Reasons for Death Fear Scale (RDFS), Death Obsession Scale (DOS), Death Depression Scale (DDS), Wish to be Dead Scale (WDS), and so on (Abdel-Khalek, 1998, 2002, 2003, 2004; Abdel Khalek, & Saleh, 1999; Abdel-Khalek, & Lester, 2004; Lester, & Abdel-Khalek, 2003; Lester, & Castromayor, 1993; Collett, & Lester, 1969; Templer, 1970; Dickstein, 1972; Lester, 1990, 1994, 2003, 2004, 2013; Dadfar, Asgharnejad Farid, Atef Vahid, Lester, et al., 2014a; Dadfar, Lester, Asgharnejad Farid, Atef Vahid, et al., 2014b).

Instruments for assessment of death distress are included:

1- The Death Concern Scale (DCS)
2- The Collett-Lester Fear of Death Scale (CLFDS)
3- The Reasons for Death Fear Scale (RDFS)
4- Templer Death Anxiety Scale (DAS)
5- The Arabic Scale of Death Anxiety (ASDA)
6- The Death Obsession Scale (DOS)
7- The Death Depression Scale (DDS)
8- The Stages of Change Scale (SCS)
9- The Scale of Death Education Program Evaluation (SDEPE)

1- The Death Concern Scale (DCS)

The Death Concern Scale (DCS), developed by Dickstein (1972), contains 30 items in two parts and has four scales. Items of 1 to 11 are related to thinking about death and are answered (1) Never; (2) Rarely; (3) Sometimes; and (4) Often. Items 12 to 30 are associated with fear or anxiety about death and are answered strongly agree; somewhat agree; somewhat disagree; and strongly disagree. The DCS also has 8 items to control for an acquiescence response set. Total scores can range from 30 to 120 and are categorized a slow scores (30–67), average scores (68–80), and high scores (81–120). Internal consistency, test-retest and split half reliabilities of the DCS were 0.85, 0.87, 0.85, respectively, and the scale had good construct validity with other death scales (Dickstein, 1975, 1978). Tobacyk (1983) obtained significant positive correlations between the DCS scores and paranormal beliefs. Greater death concern was associated with a stronger belief in paranormal phenomena. The Pearson correlation of the DCS scores with the DAS scores was 0.40 (Rajabi, & Bahreini, 2001; Yilmaz, 2010). The factor structure of the DCS has been explored by Klug and Boss (1976) and by Hammer and Brookings (1987). Yilmaz (2010) reported Cronbach alpha and split-half reliability coefficients of 0.81 and 0.83, respectively. Item-total correlations, with the exception of item 12, revealed significant positive associations ranging from 0.15 to 0.62. Dadfar and Lester (2015) showed that Cronbach alpha of the DCS was .72, and two-week test-retest reliability was .77 in nurses. There is a copy of the DCS in the Appendix A.

2- The Collett-Lester Fear of Death Scale (CLFDS)

The Collett-Lester Fear of Death Scale (CLFDS) was developed in the USA (Collett, & Lester, 1969). It is perhaps the most commonly used instrument that clearly and systematically distinguishes between two key dimensions involving death, (1) The state of death vs. the process of dying, and (2) One's own death vs. the death of others. As such it includes four subscales: Death of Self (e.g., total isolation of death, shortness of life, never thinking or experiencing); Dying of Self (e.g., pain involved in dying, intellectual degeneration, lack of control over process, grief of others); Death of Others (e.g., losing someone close, never being able to communicate again, feeling lonely without the person); and Dying of Others (e.g., watching the person suffer, having to be with someone who is dying). The CLFDS has

forms of 36, 32, and 28 items. Since its original development, the CLFDS has been revised, reducing the number of items from 36 to 28 in order to have equal weighting across subscales for scoring purposes, and to remove problematic or deviant items (Lester, 1994; Lester & Abdel-Khalek, 2003).

Examination of the relationships amongst the four CLFDS subscales has tended to show moderately strong positive correlations between the different dimensions. For example, Mooney and O'Gorman (2001) reported correlations of .54 between Death of Self and Dying of Self, .49 between Death of Self and Death of Others, .51 between Death of Self and Dying of Others, .49 between Dying of Self and Death of Others, .61 between Dying of Self and Dying of Others, and .67 between Death of Others and Dying of Others. These results are similar to more recent analyses by Lester (2004), although the correlations tend to be higher than some previous studies (Lester, 1994). Such relationships indicate that, for example, individuals who score high on the fear of Death of Self will tend also to score high on the fear of Death of Others, and vice versa, those who score low on fear of Death of Self will also score low on fear of Death of Others. However, given the magnitude of reported correlations, there are obviously many individuals who do not follow this relationship. A respondent can respond to each question using a Likert scale of 1-5 with one and two being low death anxiety, three and four being somewhat anxious and five being very anxious (Lester, 1990). In another scoring the CLFDS is rated to not (1), somewhat (2, 3, 4), and very (5). The CLFDS's cut off score for low death anxiety is two or less for each question.

However, there are differing views regarding the factorial validity of this scale and therefore about the usage of the scale in its proposed four-factor structure. Typically, factor analysis of the scale items reveals five to seven factors with cross-loadings for several items, particularly for the Death of Others and Dying of Others subscales (Mooney, & O'Gorman, 2001; Neimeyer, et al., 2003) which tend to indicate factorial instability and thus equivocal support for the validity of the proposed constructs. It has been proposed, therefore, that researchers should consider disregarding its "attractive and symmetrical factor structure" (Neimeyer, et al., 2003) and instead utilize a factor structure empirically derived even though it may be more difficult to interpret. Conversely, it has also been argued that because of the natural association between fear of own death and fear of others, and fear of death and fear of dying, such a factor pattern is likely and it does not contradict the existing allocation of items to each of the four subscales on a meaningful basis (Lester, 2004). Despite a potentially problematic factor structure, it has been used extensively in a wide range of research areas, and more recently has been adapted for use with languages other than English (Abdel-Khalek, & Lester, 2004; Tomas-Sabado, Limonero, & Abdel-Khalek, 2007; Yasukawa, 2006). The CLFDS has also been used in evaluating the impact of training programs on participants' fear of death, such as palliative care volunteer training (Claxton-Oldfield, Crain, & Claxton-Oldfield, 2007; Hayslip, & Walling, 1985-1986), and death education for nursing students (Mooney, 2005; Mooney, & O'Gorman, 2001).

Psychometric studies of other death anxiety instruments and related variables such as death competency (Robbins, 1990-1991) have also utilized the CLFDS in order to establish

validity (e.g., Abdel-Khalek, 2002b). For example, Robbins found that the Coping with Death Scale was negatively associated with the CLFDS which provided some degree of convergent validity for the measure. Durlak (1973) examined the relationship between psychometrically measured fear of death and five separate measures of death concern or contact. Results did not demonstrate any relationship whatsoever between any of the measures and fear of death. He suggested that a further search must be made for critical variables related to personal reactions toward death and dying. Vargo (1980) found that correlations between the DAS (Templer, 1970) and the CLFDS were highest for the fear of own death and dying subscales which indicated concurrent validity for the DAS. Lester (1990) reviewed research using the CLFDS and found that the scale has acceptable reliability and validity. A revised version of the scale includes a more balanced number of items in each subscale, and a simplified scoring system. Zeyrek, and Lester (2008) reported in a sample of 100 Turkish undergraduates, the CLFDS had adequate interterm reliability and adequate concurrent validity with the DAS. Pearson correlation between the CLFDS and the ASDA was significant and positive (Abdel-Khalek, 2004). Naderi, and Roushani (2010) reported that concordant validity the CLFDS with the DAS was $r = 0.57$, $P < 0.0001$. Reliability with method of Chronbach's alpha was .92 in Ahwaz senile women.Venegas, Alvarado, and Barriga (2011) reported that the CLFDS possessed good internal consistency and construct validity, confirmed by the significant correlation with the Attitude toward death Scale. Factor analysis partially supported content validity of the subscale items, but presented a modified multidimensional structure that pointed towards the reconceptualization of the subscales in nursing students. Dadfar (2015) showed that Cronbach alpha of the CLFDS was .92, and two-week test-retest reliability was .58 in nurses. There is a copy of the CLFDS in the Appendix B.

3- The Reasons for Death Fear Scale (RDFS)

The Reasons for Death Fear Scale (RDFS), developed by Abdel-Khalek (2002), consists of 18 brief items, and Abdel-Khalek identified four factors: (I) Fear of Pain and Punishment, (II) Fear of Losing Worldly Involvements, (III) Religious Transgressions and Failures, and (IV) Parting from Loved Ones. The response for the RDFS items uses the following format: Strongly disagree (1), disagree (2), neutral (3), agree (4) and strongly agree (5). Total scores can range from 18 to 90.

A high-loaded factor was extracted in which the RDFS's loading was .45, while the loadings of the scales of the DAS, DDS, and DOS ranged between .80 and .90. Correlation between the RDFS and DAS was higher than that with general anxiety. Abdel-Khalek (2002) reported good reliability coefficients (> 0.80), and concurrent validity with the DAS. There was significant correlation between the RDFS and the ASDA (Abdel-Khalek, 2004). Aflakseir (2014) identified four factors for the RDFS in Iranian college students: (I) Fear of Pain and Punishment, (II) Fear of Losing Worldly Involvements, (III) Religious Transgressions and Failures, and (IV) Parting from Loved Ones. The RDFS had good internal consistency for Fear of Pain and Punishment (.90), Fear of Losing Worldly Involvements (.68), Religious Transgression and Failures (.78), and Parting from Loved Ones (.72), and it had the modest

correlation (r= .40) with the DAS. Dadfar (2015) showed that Cronbach alpha of the RDFS was .92, and two-week test-retest reliability was .64 in nurses. There is a copy of the RDFS in the Appendix C.

4- The Templer's Death Anxiety Scale (DAS)

The Templer's Death Anxiety Scale (DAS) construction and validation was completed in 1967, presented in 1969, and designed in 1970 designed by Templer (Conte, Weiner, & Plutchik, 1982). A later version, the DAS-extended, was developed in 2006 (Templer, Awadalla, Al-Fayez, Frazee, et al., 2006; Sharif Nia, et al., 2014). The DAS is a standard questionnaire and it has been used in different researches worldwide in order to measure the death anxiety. The DAS has the most practicality of its own (Tavakoli, & Ahmadzadeh, 2011; Ziapour, et al., 2014).

The DAS is a self-operating questionnaire consisting of 15 true-false questions, and based on the true or false answer a score of 0 to 1 is given to it (score 1 if the respondent answer shows anxiety and score 0 if the respondent answer do not show any anxiety). For example, thinking about death never bothers me, the true answer indicates that the respondent has no anxiety and this means obtaining 0, and the false answer indicates that the respondent has anxiety and this means obtaining 1. The scale scoring is from 0 (lack of death anxiety) to 15 (very high death anxiety) and the average level (6-7) is the cut-point, more than that (7-15) shows high death anxiety and less than that (0-6) shows low death anxiety (Masoudzadeh, et al., 2008).

In the original culture, the DAS retest reliability coefficient has been reported to be 0.83. In order to survey the validity of the DAS two tests of death anxiety scale and overt anxiety scale were used, and the result for correlation coefficient of the DAS with the DCS was 0.40, and for the correlation coefficient of death anxiety and overt anxiety scale it was 0.43 (Rajabi, & Bahrani, 2001; Ziapour, et al., 2014). Lester, and Castromayor (1993) determined construct validity of the DAS in a sample of Filipino nursing undergraduate students. The scores of the DAS were most strongly associated with the subscales of the CLFDS: fear of others' death (r= .45), then the fear of one's own dying (r= .36), the fear of one's own death (r= .34), and least strongly associated with the fear of others' dying (r= .24). The correlations between the DAS and the ASDA ranged from .60 to .74 (Abdel-Khalek, 2004).

Sharif Nia, et al (2014) obtained four factors with eigenvalues of greater than 1 on the Death Anxiety Scale-Extended (DAS-E). Its test–retest and Cronbach's alpha was 0.91 and 0.89, respectively. They demonstrated that DAS-E has a multi-dimensional structure. Dadfar (2015) showed that Cronbach alpha of the DAS was .68, and two-week test-retest reliability was .63 in nurses. There is a copy of the DAS in the Appendix D.

5- The Arabic Scale of Death Anxiety (ASDA)

The Arabic Scale of Death Anxiety (ASDA) was developed and constructed by Abdel-Khalek (2004). It has been validated in a sample of undergraduates in 3 Arab countries, Egypt, Kuwait, and Syria (Abdel-Khalek, 2004). The ASDA has been developed, originally

in Arabic, on the basis of an Arabic and Islamic context. The ASDA consists of 20 statements. Each item is answered on a 5-point intensity scale anchored by 1 (no) and 5 (very much). Alpha reliabilities ranged from .88 to .93, and item-remainder correlations ranged between .27 and .74; the 1-week test–retest reliability was .90 (Egyptians only), denoting high internal consistency and temporal stability. The total score can range from 20 to 100, and a high score denotes high death anxiety. Among college students from Egypt, Kuwait, and Syria, alpha reliabilities ranged from .88 to .93, and the one-week test-retest reliability was .90, denoting high internal consistency and temporal stability. The correlations between the ASDA and DAS ranged between .60 and .74, denoting high convergent validity. Cronbach's alpha, was 0.93 and split half was 0.87 (Abdel-Khalek, 2004). Pearson correlations between the total scores of the DAS, the ASDA, and the CLFDS were significant and positive. One high-loaded factor was extracted and labeled General Death Anxiety, indicating good convergent and factorial validity of the scales (Abdel-Khalek, 2004).

Dadfar, Abdel-Khalek, Lester, and Atef Vahid (sumitted) valideated the ASDA. One-week test-retest was high, indicating its high temporal stability. Cronbach's alpha value of the ASDA reached 0.90 for college students and 0.92 for psychiatric outpatients, Spearman-Brown and Guttman Coefficient 0.91, indicating its good internal consistency and reliability. The ASDA correlated 0.46 with the DOS, 0.56 with the DDS, 0.41 with the DAS, 0.40 with the WDS, and -0.02 with the Love Life Scale (LLS), indicating good construct and criterion-related validity. Finally, a principal axis analysis with Varimax rotation was carried out. Four factors were extracted in the sample of Iranian college students, accounting for 61.03% of the total variance. These factors were labeled: (F1) Fear of lethal disease and death fear (21.69%), (F2) Fear of dead people (16.76%), and (F3) Fear of tombs (11.30%), and (F4) Fear of postmortem events (11.27%). Also four factors were extracted in the sample of Iranian psychiatric outpatients, accounting for 67.99% of the total variance. These factors were labeled: (F1) Fear of lethal disease (43.97%), (F2) Fear of dead people and death fear (10.05%), and (F3) Fear of tombs (8.21%), and (F4) Fear of postmortem events (5.75%). Male students had significant higher scores than female. The results indicate that the ASDA administered to this Iranian sample yields good internal consistency, temporal stability, criterion-related validity and a four-factor structure reflecting important features of death anxiety. There is a copy of the ASDA in the Appendix E.

5- The Death Obsession Scale (DOS)

The 15-item of Death Obsession Scale **(**DOS) was developed among the University of Alexandria students in Egypt (Abdel-Khalek, 1998). The DOS is a complementary tool for instruments related to death (the DAS and DDS). It is responded to on a 5-point Likert-type rating scale ranging (1) No, (2) A little, (3) A fair amount, (4) Much and (5) Very much. Total scores can range from 15 to 75.

The DOS has shown high internal consistency and test-retest reliability, and its factor structure apparently varied according to context and samples. Abdel-Khalek and Lester, 2003; Maltby, 2000 did not factor in gender in their analysis, but Rajabi, 2009; Abdel-Khalek

et al., 2006; Abdel-Khalek, 1998 did. Abdel-Khalek and Lester (2003); Maltby and Day (2000a); Abdel-Khalek (1998) reported that the DOS had high internal consistency (αs= 0.90s) in different samples. It showed high test-retest reliability, over a one-week period, for male and female students (*rs*=0.90s; Abdel-Khalek, 1998). Maltby and Day (2000a); Abdel-Khalek (1998) reported that the total score of the DOS positively correlated with both death depression and death anxiety (*rs*=0.568, & 0.617, *ps*<0.01, respectively), and neuroticism but not extraversion from the Revised Eysenck Personality Questionnaire (REPQ), demonstrating concurrent validity. Discriminant validity with other death distress-related scales was larger than its relations with general obsession, anxiety and depression scales (Maltby, & Day, 2000a). Tomas-Sabado and Gomez–Benito (2003) reported that good correlations, internal consistency and concurrent validity in Spanish college students. They concluded that this scale had good psychometric properties and was differentiated people with preoccupation about death from normals. There was significant correlation between the DOS and the ASDA (Abdel-Khalek, 2004). Abdel-Khalek, Al-Arja, and Abdalla (2006) showed high internal consistency with alpha coefficients (0.92) in a Palestinians sample. Lester (2003); Abdel-Khalek (2004); Al-Sabwah, and Abdel-Khalek (2006) reported significant positive correlations for death distress different Scales (the DAS, DDS and DOS) in college students. Rajabi (2007) reported that convergent validity coefficients the DOS with the Padua Obsessive-Compulsion Inventory (POCI) were significant (0.43, P<0.0001). Mohammadzadeh, Asgharnejad Farid, and Ashouri (2009) revealed desirable reliabilities coefficients for the DOS in college students: 4 weeks test-retest the DOS (0.73), spilt half (0.57), internal consistency (0.59) and its concurrent validity with the DAS (0.76). Lester (2013) indicated a modest correlation between the DOS with total score of the WDS (r= 0.37).

Factor analysis studies of items of the DOS indicated that the scale did not measure a one–dimensional trait. The factor analysis of the Arabic version of the scale produced a three-factor solution consisting of “death rumination”, “death dominance” and “death idea repetition”, accounting for 47.6%, 9.8% and 8% of the variance, respectively. Construction the DOS has been evaluated in various contexts. Maltby (2000a) assessed the English version of the scale among English adults and students, and found identical three factor structures, which in turn replicated Abdel-Khalek’s (1998) original structure. Abdel-Khalek and Lester (2003) found a single, “general death obsession” factor for a Kuwaiti student sample, and a two factor (“death rumination” and “death dominance and repetition”) solution among American students. In study of Tomas–Sabado and Gomez–Benito (2003) factor structure was consistent with the original Arabic and English versions. They concluded that this scale had good psychometric properties and could differentiate people with preoccupation about death from normals. Abdel-Khalek, Al-Arja and Abdalla (2006) administered the DOS to the Muslim and Christian Palestinian participants in the Bethlehem area. They found a single “general death obsession” factor for women, and three factors (“death ruminations”, “death dominance”, and “death idea repetition”) for men. Rajabi’s (2009) analysis of the DOS among Iranian first-entering, undergraduate students yielded the two factors of “death rumination

and dominance" and "death idea worry". Mohammadzadeh, et al (2009) yield three factors in college students: death rumination, death dominance, and death idea repetition. Correlations between three factors with the DAS were (0.69, 0.61, and 0.58, respectively). Moripe and Mashegoane (2013) identified two and three factor solutions among South African university female and male students on the DOS. The scale had high reliability levels. The DOS correlated with death anxiety and fear, but no correlate with religious orientation that showed concurrent validity of the scale. Dadfar and Lester (2015) showed that Cronbach alpha of the DOS was .77, and two-week test-retest reliability was .74 in nurses. There is a copy of the DOS in the Appendix F.

6- The Death Depression Scale (DDS)

The Death Depression Scale (DDS) was made by Templer, et al (1990), is a useful clinical tool for determination of time changes due to the bereavement, terminal illness and various life events. The DDS is a 17-item self-report questionnaire, and consists of six elements: death despair (items of 8, 11 and 16), death loneliness (items of 4, 9, 10 and 13), death dread/ fear (items of 14, 15 and 16), death sadness (items of 2 and 3), death depression (items of 2 and 12) and death finality/end (items of 6 and 7). The DDS has two different formats (a false and true or yes/no format, and a five-point Likert format). In false-true format, items are answered (0) False and (1) True. In a five-point Likert format, items are answered (1) strongly agree, (2) agree, (3) neutral, (4) disagree, and (5 strongly disagree. The DDS has 2 items to control an acquiescence response set (items of 11, and 12). The DDS are answered conversely in both of formats. Total scores can range from 0 to 17. Higher scores on the DDS is indicator more death depression (Fischer, & Corcoran, 2007).

Many studies showed that the DDS has good internal consistency. It correlated positively with death anxiety, death obsession, Zakerman general depression and anxiety (Templer, et al., 1990; Abdel-Khalek, 1998; Roshdieh, et al., 1998–1999; Templer, et al., 2001-2002; Tomas-Sabado, & Gomez-Benito, 2005; Tomas-Sabado, & Limonero, 2007; Almostadi, 2012). There was significant correlation between the DDS and the ASDA (Abdel-Khalek, 2004). Validity and reliability of Likert format of the DDS was higher than its False/True format and use of Likert format of the DDS is more favorite (Aghazadeh, et al., 2014). The correlation between two formats of the DDS was 0.77 (Fischer, & Corcoran, 2007). Aghazadeh, et al (2014) reported that the DDS has good validity and reliability in Iranian college students. Multidimensional structure of the DDS by Principal Component Analysis with Promax rotation extracted four factors (49.71% of total variance) that were labeled death despair, death finality, death loneliness and death acceptance. Concurrent validity of the DDS was reported well with parallel using of the DAS. Three types of reliability of the DDS were reported well: Test retest (r= 0.78), split half (r= 0.77), internal constancy (r= 0.76). They concluded that the DDS as valid measure can be used in empirical studies surrounding death distress. Rajabi, et al (2015) reported that exploratory factor analysis on Death Depression Scale-Revised (DDS-R) revealed 3 factors among the nurses. Cronbach's alpha coefficient was 0.93, with alphas ranging from .80 to .94 for the individual

factors. The DDS-R had concurrent validity with the DAS, DOS, and Short-Form of Beck Depression Inventory (BDI-13). Dadfar (2015) showed that Cronbach alpha of the DDS was .84, and two-week test-retest reliability was .75 in nurses. There is a copy of the DDS in the Appendix G.

In study of Dadfar (2015), Pearson correlations between the death distress scales were between .29 and .60, indicating only a moderate association between the measures; for the DSC and CLFDS (.59); DSC and RDFS (.36); DSC and DAS (.60); DSC and DOS (.45); DSC and DDS (.52); for the CLFDS and RDFS (.38); CLFDS and DAS (.42); CLFDS and DOS (.47); CLFDS and DDS (.47); for the RDFS and DAS (.50); RDFS and DOS (.29); RDFS and DDS (.32); for the DAS and DDS (.58).

7- The Stages of Change Scale (SCS)

The Stages of Change Scale (SCS) is an eight items made-researcher tool: Alienation (item 1), Avoidance (item 2), Access (item 3), Acknowledgment (item 4), Acceptance (item 5), Action (item 6), Appreciation (item 7), and Appreciation (item 8). The scale is a complementary instrument related to stages of 8A model death education program. It is responded to on a 5-point Likert-type rating scale ranging (1) Strongly disagree, (2 Disagree, (3) Neutral, (4) Agree and (5) Strongly agree. Total scores can range from 1 to 8. Cronbach's Alpha coefficient of the SCS was .62 and two-week test-retest reliability of the scale was .65. (Dadfar, 2015). There is a copy of the SCS in the Appendix H.

8- The Scale of Death Education Program Evaluation (SDEPE)

The Scale of Death Education Program Evaluation (SDEPE) is a made-researcher tool for assessing of nurses' opinions about the usefulness of death education programs, based on the grading of the spectrum 0-10. Also in the end of the scale, there was an open qualitative option for writing of their comments or suggestions in order to more effective death education program in the future (Dadfar, 2015). There is a copy of the SDEPE in the Appendix L.

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Appendixes

Appendix A
Death Concern Scale (DCS)

Contemplation of death evokes a variety of thoughts and feelings. To some degree, our philosophies about the place of death in human existence and about what—if anything—follows death affects our responses. The Death Concern Scale consists of 30 statements that measure the anxiety or apprehension we feel when we think about death.

Directions: The questionnaire contains two parts. Respond to questions 1 through 11 by entering the code below:

1 = Never
2 = Rarely
3 = Sometimes
4 = Often

□ 1. I think about my own death.
□ 2. I think about the death of loved ones.
□ 3. I think about dying young.
□ 4. I think about the possibility of my being killed on a city street.
□ 5. I have fantasies of my own death.
□ 6. I think about death just before I go to sleep.
□ 7. I think of how I would act if I knew I were to die within a given period of time.
□ 8. I think of how my relatives would act and feel upon my death.
□ 9. When I am sick I think about death.
□ 10. When I am outside during a lightning storm I think about the possibility of being struck by lightning.
□ 11. When I am in an automobile I think about the high incidence of traffic fatalities.

Respond to questions 12 through 30 by using the code given below and then enter the corresponding number in the white box:

SA = I strongly agree
A = I somewhat agree
D = I somewhat disagree
SD = I strongly disagree

□ 12. I think people should first become concerned about death when they are old.
SA A D SD
1 2 3 4

□ 13. I am much more concerned about death than those around me.
SA A D SD
4 3 2 1

□ 14. Death hardly concerns me.
SA A D SD
1 2 3 4

□ 15. My general outlook just doesn't allow for morbid thoughts.
SA A D SD
1 2 3 4

□ 16. The prospect of my own death arouses anxiety in me.
SA A D SD
4 3 2 1

□ 17. The prospect of my own death depresses me.
SA A D SD
4 3 2 1

□ 18. The prospect of the death of my loved ones arouses anxiety in me.
SA A D SD
4 3 2 1

□ 19. The knowledge that I will surely die does not in any way affect the conduct of my life.
SA A D SD
1 2 3 4

□ 20. I envision my own death as a painful, nightmarish experience.
SA A D SD
4 3 2 1

□ 21. I am afraid of dying.
SA A D SD
4 3 2 1

□ 22. I am afraid of being dead.
SA A D SD
4 3 2 1

□ 23. Many people become disturbed at the sight of a new grave but it does not bother me.
SA A D SD

1 2 3 4

□ 24. I am disturbed when I think about the shortness of life.
SA A D SD
4 3 2 1

□ 25. Thinking about death is a waste of time.
SA A D SD
1 2 3 4

□ 26. Death should not be regarded as a tragedy if it occurs after a productive life.
SA A D SD
1 2 3 4

□ 27. The inevitable death of a person poses a serious challenge to the meaningfulness of human existence.
SA A D SD
4 3 2 1

□ 28. The death of the individual is ultimately beneficial because it facilitates change in society.
SA A D SD
1 2 3 4

□ 29. I have a desire to live on after death.
SA A D SD
4 3 2 1

□ 30. The question of whether or not there is a future life worries me considerably.
SA A D SD
4 3 2 1

Appendix B
Collett-Lester Fear of Death Scale (CLFDS)

How disturbed or made anxious are you by the following aspects of death and dying? Read each item and answer it quickly. Don‘t spend too much time thinking about your response. We want your first impression of how you think right now. Indicate the number that best represents your feeling.

Subscales **Your own death**	**Not**		**Somewhat**		**Very**
1. The total isolation of death	1	2	3	4	5
2. The shortness of life	1	2	3	4	5
3. Missing out on so much after you die	1	2	3	4	5
4. Dying young	1	2	3	4	5
5. How it will feel to be dead	1	2	3	4	5
6. Never thinking or experiencing anything again	1	2	3	4	5
7. The possibility of pain and punishment during life –after -death	1	2	3	4	5
8. The disintegration of your body after you die	1	2	3	4	5
Your own dying	**Not**		**Somewhat**		**Very**
1. The physical degeneration involved in a slow death	1	2	3	4	5
2. The pain involved in dying	1	2	3	4	5
3. The intellectual degeneration of old age	1	2	3	4	5
4. That your abilities will be limited as you lay dying	1	2	3	4	5
5. The uncertainty as to how bravely you will face the process of dying	1	2	3	4	5
6. Your lack of control over the process of dying	1	2	3	4	5
7. The possibility of dying in a hospital away from friends and family	1	2	3	4	5
8. The grief of others as you lay dying	1	2	3	4	5
The death of others	**Not**		**Somewhat**		**Very**
1. The loss of someone close to you	1	2	3	4	5
2. Having to see their dead body	1	2	3	4	5
3. Never being able to communicate with them again	1	2	3	4	5
4. Regret over not being nicer to them when they were alive	1	2	3	4	5
5. Growing old alone without them	1	2	3	4	5

Subscales **Your own death**	**Not**				**Very**
6. Feeling guilty that you are relieved that they are dead	1	2	3	4	5
7. Feeling lonely without them	1	2	3	4	5
8. Envious that they are dead	1	2	3	4	5
The dying of others	**Not**		**Somewhat**		**Very**
1. Having to be with someone who is dying	1	2	3	4	5
2. Having them want to talk about death with you	1	2	3	4	5
3. Watching them suffer from pain	1	2	3	4	5
4. Having to be the one to tell them that they are dying	1	2	3	4	5
5. Seeing the physical degeneration of their body	1	2	3	4	5
6. Not knowing what to do about your grief at losing them when you are with them	1	2	3	4	5
7. Watching the deterioration of their mental abilities	1	2	3	4	5
8. Being reminded that you are going to go through the experience also one day	1	2	3	4	5

Appendix C
The Reasons for Death Fear Scale (RDFS)

Many people fear death for a variety of reasons. Here are some statements which indicate such causes. Please read each statement carefully and circle the choice which best expresses your opinion on the scale shown, starting with strongly disagree (1) to strongly agree (5).

Reasons for fearing death	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. Fear of heavenly punishment	1	2	3	4	5
2. Worry about one's offspring	1	2	3	4	5
3. Too many sins	1	2	3	4	5
4. Life teems with meaningful things	1	2	3	4	5
5. Parting from the relatives and beloved	1	2	3	4	5
6. Leaving behind secular pleasures	1	2	3	4	5
7. Fear of hell and doomsday	1	2	3	4	5
8. The terribly strenuous moment when the soul parts from the body	1	2	3	4	5
9. Failure to perform religious duties and obligations	1	2	3	4	5
10. Death entails so many vague and unknown issues	1	2	3	4	5
11. The element of surprise in death	1	2	3	4	5
12. Lack of faith	1	2	3	4	5
13. The grieving of loved ones	1	2	3	4	5
14. Torture of the grave	1	2	3	4	5
15. Acute pains associated with dying	1	2	3	4	5
16. Grieving over what one will leave behind, e.g. wealth, valuables, etc.	1	2	3	4	5
17. Loss of self or identity	1	2	3	4	5
18. Death puts an end to one's plans and objectives	1	2	3	4	5

Appendix D
Templer Death Anxiety Scale (DAS)

Directions: Please indicate your age and sex, and then answer the 15 questions. If a statement is true or mostly true as applied to you, circle "T". If a statement is false or mostly false as applied to you, circle "F".

Age **Male** **Female**

Items	T	F
1. I am very much afraid to die.		
2. The thought of death seldom enters my mind.		
3. It doesn't make me nervous when people talk about death.		
4. I dread to think about having to have an operation.		
5. I am not at all afraid to die.		
6. I am not particularly afraid to getting cancer.		
7. The thought of death never bothers me.		
8. I am often distressed by the way time flies so very rapidly.		
9. I fear dying a painful death.		
10. The subject of life after death troubles me greatly.		
11. I am really scared of having a heart attack.		
12. I often think about how short life really is.		
13. I shudder when I hear people talking about a World War III.		
14. The sign of a dead body is horrifying to me.		
15. I feel that the future holds nothing for me to fear.		

Appendix E
The Arabic Scale of Death Anxiety (ASDA)

Instructions: Read the following statements, and then decide to what extent each one describes your feelings, behavior and opinions. Show how it applies or not to you in general by circling the appropriate number after each statement.

	No	A little	A fair amount	Much	Very much
1. I fear death whenever I because ill.					
2. I fear looking at the dead.	1	2	3	4	5
3. I fear visiting graves.	1	2	3	4	5
4. The possibility of having a surgical operation terrifies me.	1	2	3	4	5
5. I am afraid of suffering heart attack.	1	2	3	4	5
6. I worry that death deprives me of someone dear to me.	1	2	3	4	5
7. I am apprehensive of unknown things after death.	1	2	3	4	5
8. I am afraid of looking at a corpse.	1	2	3	4	5
9. I fear the torture of the grave.	1	2	3	4	5
10. I fear getting a serious disease.	1	2	3	4	5
11. Witnessing the burial procedure terrifies me.	1	2	3	4	5
12. I dread walking in graveyards.	1	2	3	4	5
13. I am preoccupied with thinking about what will happen after death.	1	2	3	4	5
14. I am afraid of sleeping and not waking up again.	1	2	3	4	5
15. The pain accompanying death terrifies me.	1	2	3	4	5
16. I get upset by witnessing a funeral.	1	2	3	4	5
17. The sight of a dying person frightens me.	1	2	3	4	5
18. Talking about death upsets me.	1	2	3	4	5
19. I am afraid of getting cancer.	1	2	3	4	5
20. I fear death.	1	2	3	4	5

Appendix F
The Death Depression Scale (DDS)

Directions: Please indicate your age and sex, and then answer the 17 questions. If a statement is true or mostly true as applied to you, circle "T". If a statement is false or mostly false as applied to you, circle "F".

Age **Male** **Female**

Items	T	F
1. I get depressed when I think about death.		
2. Hearing the word death makes me sad.		
3. Passing by cemeteries makes me sad.		
4. Death means terrible loneliness.		
5. I become terribly sad when I think about friend or relatives who have died.		
6. I am terribly upset by the shortness of life.		
7. I cannot accept the finality of death.		
8. Death deprives life of its meaning.		
9. I worry about dying alone.		
10. When I die, I will completely lose my friends and loved ones.		
11. Death does not rob life of its meaning.		
12. Death is not something to be depressed by.		
13. When I think of the death, I feel tired and lifeless.		
14. Death is painful.		
15. I dread to think of the death of friends and loved ones.		
16. Death is the ultimate failure in life.		
17. I feel sad when I dream of death.		

Appendix G
The Death Obsession Scale (DOS)

Instructions: Read the following statements, and then decide to what extent each one describes your feelings, behavior and opinions. Show how it applies or not to you in general by circling the appropriate number after each statement.

Items	No	A little	A fair amount	Much	Very much
1. Many questions about death come to my mind which i am unable to answer.	1	2	3	4	5
2. The idea that i will die keeps occurring to me.	1	2	3	4	5
3. I can't get the notion of death out of my mind.	1	2	3	4	5
4. I am preoccupied by thoughts of death.	1	2	3	4	5
5. I find it greatly difficult to get rid of my thoughts about death.	1	2	3	4	5
6. I think about the alarming and painful aspects of death.	1	2	3	4	5
7. I feel compelled to think about death.	1	2	3	4	5
8. The idea of death overwhelms me.	1	2	3	4	5
9. I have an exaggerated concern with the idea of death.	1	2	3	4	5
10. I find myself suddenly thinking about death without warning.	1	2	3	4	5
11. I fear being preoccupied by the idea of death.	1	2	3	4	5
12. I think about death continually.	1	2	3	4	5
13. Thinking about death causes me a great deal of tension.	1	2	3	4	5
14. I am annoyed that I keep thinking about death.	1	2	3	4	5
15. I am overwhelmed by the thought that I will die suddenly.	1	2	3	4	5

Appendix H
The Stages of Change Scale (SCS)

Instructions: Please read each statement carefully and circle the choice which best expresses your opinion on the scale shown, starting with strongly disagree (1) to strongly agree (5).

Items	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I feel indifferent to death because I view that it is too distant.	1	2	3	4	5
2. I try to avoid death because I believe that it brings bad luck for me.	1	2	3	4	5
3. I have access or information about death preparedness.	1	2	3	4	5
4. I believe triggering of emotions during death preparation makes me feel uncomfortable.	1	2	3	4	5
5. I treat death as a natural part of my life.	1	2	3	4	5
6. I am actively involved in related life planning.	1	2	3	4	5
7. I can appreciate life and the search for life meaning.	1	2	3	4	5
8. I can readjust life priorities, live in the preset moment, and integrate the meaning of life in future goals.	1	2	3	4	5

Appendix L

The Scale of Death Education Program Evaluation (SDEPE)

Thanks for your cooperation, please rate your opinion about the usefulness of death education program based on the calibration range here.

0	1	2	3	4	5	6	7	8	9	10

Write your comments and suggestions about the benefits and effectiveness of death education program in below: