Effectiveness of death education program by methods of didactic, experiential, and 8A model on the reduction of death distress among nurses

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ABSTRACT

Death distress includes death anxiety, death depression, and death obsession. There are different approaches to death education program include didactic, experiential, and 8A model. Death distress of nurses 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. Aim of this study was comparison of effectiveness of death education program by methods of didactic, experiential, and 8A model on the reduction of death distress among nurses. The study was a quasi-experimental method with four-group pretest/posttest design. The participants were 42 nurses in four groups (12 didactic, 10 experiential, 10 8A model, and 10 controls). The groups were selected randomly from different wards of the Khatom-Al-Anbia General Hospital in Tehran city, and they matched with together for demographic variables. The nurses completed Death Concern Scale (DCS), Collett-Lester Fear of Death Scale (CLFDS), Death Anxiety Scale (DAS), Death Obsession Scale (DOS) and Death Depression Scale (DDS), before and after intervention. Death education programs were held by 36-hours 6 workshops weekly. Data were analyzed through χ²,t-test, One-Way ANCOVA, and One-Way ANOVA using SPSS/WIN 16.0 program. On the DAS, DOS and DDS scores more increased in control group in posttest compared to didactic and experiential 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 the present 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 is apparent that the death education programs have some affirmative impacts on the death distress of nurses. Our 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, end of life care as well as the satisfaction of the patients and their families.

Key Words: Death Education, Didactic, Experiential, 8A Model, Death Distress, Nurses

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INTRODUCTION

Death is a natural process that occurs each day. Death is an inevitable part and an unavoidable event in human life [1-2]. Life and death are two aspects/dimensions of the same reality [3]. 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

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life [4]. 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 [5]. Death and dying are a process that every human being must experience [6]. Death is perhaps the most paramount loss an individual can experience. When death occurs, every individual is affected physically, psychologically, socially, and spiritually. Thanatology is the scientific study of death, dying and the practices associated with them [7-9]; and includes a range of fields and domains such as philosophical and ethical; psychological; sociological; anthropological; clinical; political and educational [10]. Death distress includes death anxiety, death depression and death obsession [11]. Death anxiety or thanatophobia 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 of death or fear of death [12-14]. Correlates of death anxiety include age, gender, culture, religiosity/spirituality, health, and mental health problems [15-22]. Death obsession is preoccupations thoughts, ruminations or persistent and intrusive beliefs that are focused on the death of the self and other significant people [23]. 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 [24-25].

Death education is at the heart of thanatology [26]. It is an interdisciplinary and multidisciplinary approach; and has cognitive and effective components [27]. There are formal and informal death educations. The four central dimensions of death education include cognitive, affective, behavioral, and valuational [3]. Death education refers to activities and learning experiences associated with death, meanings and attitudes towards death, dying and bereavement process and care of people have been affected by the death of the covers. Overall, helping professionals' views on death work competencies include having knowledge competence; practice competence; self-competence (personal resources, existential coping and emotional coping) can be used in death education and training of these professionals in working with death, dying, and bereavement; also for them, training in self--competence can be developed in some ways such as experiential activities to understand ourselves as people; reflection; integration of knowledge, practice, and self-competence and applications in basic professional education and supervision[28].There are different approaches to death education program, and various methods have been used in each of them. These approaches are including didactic, and experimental [29-33]; and 8A model (Alienation, Avoidance, Access, Acknowledgment, Action, Acceptance, Appreciation, and Actualization) was developed 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 adapted the Transtheoretical model (TTM) (Precontemplation, Contemplation, Preparation, Action, Maintenance and Transformation) for understanding the needs of clients in different phases of behavior change proposed by Prochaska and Velicer in 1997 [34].

Death education in its both forms is essential for the training of practitioners, for the advancement of knowledge about death, dying, and loss through the work of scholars and researchers, and for the consumers of death-related information [8, & 26]. Death education program has several basic goals. Efficacy of death education program has been shown in some of studies [for example, 35-37]. On the Multidimensional Fear of Death Scale (MFDS), McClatchey, and King (2015) reported that there was a statistically significant decrease in death anxiety among the human services students who participated in death education compared to those who did not [38].Sharif Nia et al (2016) found that psychoeducational interventions can help nurses to use appropriate coping strategies for managing death anxiety; to counteract negative outcomes e.g. leaving positions, and poor communication; and to increase quality of life, life style and individual health [14].

Nurses, as health care personnel of hospitals, are especially vulnerable to the debilitating condition because of the nature of their work and the constant exposure to death [39-40].Nurses often have to work with dying patients, and their death distress 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. Halliday and Boughton (2008) reported high scores on the Revised Death Anxiety Scale (RDAS) in hospice nurses [41]. Nurses face death anxiety from work in emergency rooms, and they should be coped much less function, when they are constantly surrounded by death. Some mentally shut down. 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 [42]. Nursing students at the end of their curricula feel unprepared to care for the dying patients. Their attitudes to caring of dying patients can play a key role in the nursing education [43]. Nurses have the most important role in providing health of the patients and also they face death the most thus regarding the fact that fear of death and attitude toward death has an important role in maintaining the mental health of them [44-48], and since, no research about the death education program on the death distress of health personnel of hospitals has been conducted in Iran, so this research has important and seems necessary.

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MATERIALS AND METHODS

The study was a quasi-experimental method with four-group pretest/posttest design. Among 580 convenient samples of nurses of the Khatom-Al-Anbia General Hospital, 231 were selected by Cochran's sample size formula. The purpose of the study was explained to them and they completed consent letters. For implementation and scoring of the scales, two clinical psychologists with Ms Degree were trained by the researcher alternately. In the first phase, the scales was performed and scored by the first trained person. Nurses were evaluated on the scales. Among of 231 nurses, 90 nurses earned higher scores on the scales. Then, amongst of 90 nurses, 60 nurses were selected randomly to participate in the study. They were assigned randomly to four groups (three experimental groups and one control group) (15 nurses in each group). Finally 42 nurses remained in the study (10-12 nurses in each group).

The experimental groups were trained by death education approaches include didactic, experiential and 8A model. The didactic death education program approach containing lectures, readings, audiovisual presentations, slides/computer/overheads, video/audio tapes, and case discussion, was used to the dissemination and improvement of knowledge and information about the death and dying. Discussion of content-driven material was used to promote and increase of cognitive awareness about death related issues. There were no exploration and disclosure of personal feelings in this approach. The experiential death education program approach was involved to share personal feelings and experiences in group discussions, role playing exercises, experiential and personal awareness exercises, skill-practice exercises, a variety of other imitated activities, dialog, definitive and precise discussions, question-and-answer period, guided discussion and case discussion, professional sharing, problem solving, fantasy, media presentation and four meaning-oriented movies(The *Dragonfly, The Green Mile*, The *Flatliners*, and *The Song of Bernadette*). Exploration and sharing of personal feelings and experiences about death were encouraged through the utilizing of above methods, examined of feelings and issues related to death, and by evoking feelings were permitted death-related attitudes to be modified. Personal views and feelings about death achieved through a combination of mentioned methods. This approach provided a focus on affective factors, and was considered an atmosphere of mutual trust. The 8A model death education program was according to the Transtheoretical Model (TTM). This model used for understanding of the needs of nurses in different phases of behavior change and positive death preparation behaviors. The control group received an education program, but no related to death and dying. They enrolled in another one-credit health education courses such as psychological care education. Also testers were explained to the control group they will be reassessed on the scales of the study, and moreover they will be able to participate in educational sessions, after assessing of the second stage.

Death education programs were held by 36-hours 6 workshops, taking into account the break time. The workshops were held weekly for each of the groups. Amongst 60 nurses, 42 nurses remained in the study.18 nurses did not continued to participate in the death education workshops because of their fear, anxiety from death issues (10 nurses), work shift change (4 nurses), vacation (2 nurses), and trip (2 nurses). Participant nurses were 10-12 in the workshops. After the end of workshops of death education programs, participating nurses in these workshops, as well as control group were reevaluated on the mentioned scales. In the stage, the scales were performed and scored by the second trained person. Researcher was blind of the scales scores in all 2 stages. Having a chronic physical disease or having a mental disorder was considered as exclusion criteria. Also, it is noted that to control for confounding variables, nurses receive no individual/group psychoeducational program and psychological treatment simultaneously.

The information sheet asked for some demographic and clinical variables. 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) [49]. 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 [50-51]. The Pearson correlation between the DCS scores and the DAS scores was 0.40 [52]. Yilmaz (2010) reported Cronbach alpha and split-half reliability coefficients of 0.81 and 0.83, respectively. With exception of item 12, item-total correlations was significant positive associations from 0.15 to 0.62 [53]. The Collett-Lester Fear of Death Scale (CLFDS) was developed in the USA [54]. Examination of the relationships amongst the four CLFDS subscales has tended to show moderately strong positive correlations between the different dimensions [55]. These results are similar to more recent analyses by Lester

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(2004) [56], although the correlations tend to be higher than some previous studies [57]. 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. In another scoring the CLFDS is rated to not (1), somewhat (2, 3, 4), and very (5) [58]. The CLFDS has been used in evaluating the impact of death education for nursing students [59]. Naderi and Roushani (2010) reported that Chronbach's alpha was 0.92; concordant validity the CLFDS with the DAS was r=0.57, P < 0/ 0001[60]. The Death Anxiety Scale (DAS) construction and validation was completed in 1967, presented in 1969, and designed in 1970 designed by Templer. The DAS is a self-operating tool 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). The DAS 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. In the original culture, the DAS retest reliability coefficient has been reported to be 0.83. Correlation coefficient of the DAS with the DCS was 0.40, and with overt anxiety scale was 0.43 [52, & 61]. Lester and Castromayor (1993) determined construct validity of the DAS in a sample of Filipino nursing undergraduate students [62]. The correlations between the DAS and the ASDA ranged from 0.60 to 0.74 [63]. Tavakoli and Ahmadzadeh (2011) obtained five factors with eigenvalues of greater than 1 in Iranian students, donating a multidimensional structure for the DAS. The test-retest, split-half, and Cronbach alpha reliability coefficients of the DAS were 0.87, 0.59, and 0.75, respectively [64]. The Death Obsession Scale (DOS) was developed among the University of Alexandria students in Egypt. It has 15-items and is responded to on a five -point Likert-type rating scale ranging No (1), A little (2), A fair amount (3), Much (3) and Very much (5). Total scores can range from 15 to 75. Rajabi (2007) reported that convergent validity coefficients DOS with Padua Obsessive-Compulsion Inventory (POCI) were significant (0.43, P<0/0001) [65]. Mohammadzadeh, Asgharnejad Farid, and Ashouri (2009) revealed desirable reliabilities coefficients for DOS in college students: 4 weeks test-retest DOS (0.73), spilt half (0.57), internal consistency (0/59) and its concurrent validity with DAS (0.76). They yield three factors: Death rumination, Death dominance, and Death idea repetition. Correlations between three factors with DAS were (0.69, 0.61, and 0.58, respectively) [66]. The Death Depression Scale (DDS) was made by Templer, Lavoie, Chalgujian et al (1990) [24], 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 strongly agree (1), agree (2), neutral (3), disagree (4), and strongly disagree (5). The DDS has 2 items to control an acquiescence response set (items of 11, and 12), and on both of formats of the DDS were answered conversely. Total scores can range from 0 to 17. Higher scores on the DDS is indicator more death depression. Many studies showed that the DDS has good internal consistency. It correlated positively with death anxiety, death obsession, Zakerman general depression and anxiety [24, & 67]. 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. The DDS has good validity and reliability in Iranian college students. Multidimensional structure of the DDS extracted four factors (49.71% of total variance) that were labeled death despair, death finality, death loneliness & death acceptance. Concurrent validity of the DDS was reported well with parallel using of 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) [68]. 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. Reliability and validity all of the scales were determined in the pilot study. Cronbach's Alpha coefficients of the scales were between .68 for the DAS and 0.92 for the CLFDS, indicating moderate to high internal consistency coefficients of the measures. Two-week test-retest reliabilities of the scales were from 0.63 for the DAS to 0.77 for the DCS, indicating moderate to high reliability coefficients of the measures. The Pearson correlation between the scales was between for the DOS to 0.60 for the DCS and DAS, indicating only a moderate association between the measures. Data were analyzed by chi-square test (χ^2), T-test, One-Way ANCOVA, and One-Way ANOVA. The SPSS/PC WIN. 16.0 programs were used to analyze the data. Ethical issues were considered.

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RESULTS

The groups matched with together for some variables. Mean age of nurses was 36.17, (SD=9.08). 88.1% were female. The nurses more often had a bachelor's degree (83.3%), were married (59.5%), and 42.9% of them had children. Type of recruitment of the majority of nurses was contract (59.5%) vs. formal (40.5%). Mean years of work experience was 10.48, (SD 7.76). Organizational position was staff nurse (90.5%) vs. head nurse (21.1%). The majority of work shift was rotational (64.3%) vs. fixed (31%), and work shift time was two or more shift times (54.8%). Percent working in general and intensive wards was the same (50%). Number of care patients in per shift was 0-9 (76.2%),number care of end stage patients in the past 3 months was 0-6 (57.1%), number of direct participation in reclamation operations in the past 3 months in past 3 months was 6 and higher (52.4%), and number observed death of patients in the past 3 months was 5 and higher (54.8%).Findings showed that there were no significant differences between independent groups in variables of age (F=.851, df=3, p>.000), children (x^2=.610, df=1, p>.000), type of recruitment (x^2=1.52, df=1, p>.000), years of work experience (F=.874, df=3, p>.000), ward of work place (x^2=.000, df=1, p>1.000), number care of end stage patients in the past 3 months (x^2=.857, df=1, p>.000), number of direct participation in reclamation operations in the past 3 months (x^2=.095, df=1, p>.000), and number observed death of patients in the past 3 months (x^2=.381, df=1, p>.000).Not significant differences between means in four groups indicate that before the education, the groups were homogenous for the matched variables.

Findings showed the DAS, DOS and 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. Eta (Effect size) indicated to the variance percent of scales scores that it was due to performing of death education program. The most Eta (Effect size) was on the DOS and DDS, respectively. 14% of changes in the scores of the DOS, and 11% of changes in the scores of the DDS were due to performing of death education program. The least Eta (Effect size) was on the CLDFS, the DAS, and the DCS, respectively (See Table 1).

Table 1. One-Way ANCOVA on the scales scores for didactic, experiential approaches, 8A model and control group in posttest stage

Dependent variables	Source Posttest	df=3	Tests of between-subjects effects Mean square	F	Sig.	Eta (Effect size)
The DCS			77.95	.94	.433	.07
The CLDFS			79.45	.28	.842	.02
The DAS			1.79	.38	.770	.03
The DOS			140.58	2.11	.114	.14
The DDS			26.23	1.53	.224	.11

There were significant differences between evaluation death education programs (F=8.096, df=31, p<.000) (See Table 2).

Table 2. One-Way ANOVA the evaluation of death education on the Scale of Death Education Program Evaluation (SDEPE)

Source	Sum of Squares	Df	Mean Square	F	P
The Scale of Death Education Program Evaluation (SDEPE)					
Between Groups	39.23	2	19.62	8.09	.002
Within Groups	70.27	29	2.42		
Total	109.50	31			

On the SDEPE, there was significant difference between didactic approach and 8A model at the 0.05 level (See Table 3).

Table 3. Post Hoc test (Scheffe) for multiple comparisons of evaluation three death education programs on the SDEPE

Scheffe Pair		Mean difference	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Didactic	Experiential	-1.47	.67	.107	-3.18	.25
	8A	-2.67*	.67	.002	-4.38	-.94
Experiential	Didactic	1. 47	.67	.107	-.25	3.18
	8A	-1.20	.69	.243	-2.99	.59
8A	Didactic	-2.67*	67	.002	.94	4.38
	Experiential	1.20	.69	.243	-.59	2.99

* The mean difference is significant at the 0.05 level.

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DISCUSSION

Our study showed that scores of death anxiety, death obsession and death depression more increased in control group in posttest compared to three death education approaches. But these differences were no significant statistically. The most Eta (Effect size) was 14% for death obsession, and 11% for death depression. 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 [7]. Educators have used a variety of methods to teach death and dying related issues [32]. Kim (2015) conducted a meta-analysis of effectiveness of death education with a total of 22 master's and doctoral theses published between 2004 and 2014. Finding showed that the death preparation education had a mid-size effect. When education was given through a total of 10-15 sessions, twice a week, and less than 60 minutes per session, the effect size was the greatest [37]. Smith-Cumberland (2006) revealed effectiveness of two didactic and experiential death education programs in the change of death-related behaviors [69]. Findings the study of Smith-Cumberland and Feldman (2006) showed change in attitudes toward death after exposure to a death education program [70]. Other researchers have documented the effectiveness of education about death in reducing death anxiety [71-72]. Corr (2015) has addressed to provide true information and presentation in teaching of death and dying courses [73]. The beneficial effect of death education has also been shown on nurses' attitudes toward death and dying. For example, Mooney (2005) found that undergraduate nursing students who had received death education had less death anxiety than controls [59], while İnci and Öz (2009) reported that death education significantly impacted on decreasing of the DAS and DDS scores after education in nurses. They showed that nurses who had received death education obtained lower mean scores on measures of the DAS and DDS compared with untrained nurses [35]. 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 [74]. Effect of death education program in nurses and nursing students has been reported in some of studies. For example, effect of death education on more positive attitude toward caring for terminally ill persons and their family members [75]; on the death anxiety and attitude toward nursing care of the dying patients [76]; on the concern and coping about death and dying [77]; on death attitude, death anxiety and life satisfaction [78]; and on the change of attitude toward caring for dying patients [79].

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 students' death anxieties, but effects of the attitude change was maintained in follow-up [80]. Overall review of literature has found that didactical teaching methods were the most successful [81]. 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.

Some studies have been showed that didactic and experiential death education led to more death anxiety, especially didactic interventions [82]. 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 death anxiety in medical students [83]. 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 [84]. Another study showed that experiential death education was effective in reducing negative perspectives toward death, increasing more positive perspectives in nursing students [85]. Workshops on life-and-death issues can help nurses how to manage their death stress [86].

We used four meaning-oriented films in experiential death education program. The role of meaning in films is pivotal for understanding death attitudes. Johansson and Lally (1990) in a pilot study of nursing students were assessed a death education program in which participants viewed a film of death experience to determine effects on death anxiety. Results showed nicely conceptualized, and death anxiety decreased in senior students and increased in juniors. For explanation of this discrepancy, they attributed that senior nursing students had more clinical experience and opportunities to work with dying patients [87]. 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

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management in death education [88]. 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 [6]. In our research 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. 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.

Some our findings 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: In our study 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 current results 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 our research effect of religiousness did not evaluate. 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 [89]. The God has mentioned about death, its realization and impossibility of escape from death in many Surah/Verses of the *Holy Quran*. Imani Far, Bostani, Dodman, and Raiesi (2011) compared views of *Holy Quran* and psychology about confront with death. They found that both of views emphasize on the willingness for immanent and the fear of death and agree with emotional reactions of individuals in the face with death and its acceptance depend on their behavior, personality, and coping mechanisms to deal with the past problems during the time of life. The most important difference between two views was the belief or non-belief in life after death that causes different operational definitions of quality of death, therapy targets and ways of encounter with death [90].

The role of this 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 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 and meaning they attributed to death. Cui, Shen, Ma, and Zhao (2011) found that three factors of educational background, previous training about death education, and hospital size influenced on the nurses' needs in death education [91]. Differences 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 our findings 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 education around grief theory and support from others are helpful for staff in developing strategies for coping with patient death [92].

On the CLFDS and DAS scores, the lack of significant difference after the intervention, increasing of a nurses' knowledge concerning death and dying, did not significantly impact on their attitude, anxiety, or fear toward death and dying. Therefore, 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. The improvement of death education for nurses most likely results in the delivery of safe, effective, quality nursing care practice to the dying persons and their family. The precautionary steps for a renewed discourse on ethical considerations in death education should be indicated [93]. 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 [94]. 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

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families' needs; equips nurses with better communication and counseling skills; and includes self-care and self-awareness techniques.

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 death education, and provides a roadmap that allows potential phase-matching intervention for maximizing people's sense of autonomy in dealing with death-related issues [95-97].

Overall, we concluded that death education programs have some affirmative impacts on the death distress of nurses. Use of the program was expected to improve the quality of the palliative nursing services, end of life care as well as the satisfaction of the patients and their families. Our study paved the way for the establishment of a similar program in the hospitals and community in the future. This study contributes new knowledge about nursing staff experiences of patient death in the acute settings. The findings could have implications for clinical practice and the provision of support for nursing staff. The results could inform future policies regarding End Of Life care (EOL) in acute medical settings. The study has implications for health/welfare care professionals, theory, practice, and policy.

Our study has some limitations include psychometric properties of some of the scales; the some number of unreturned scales; small sample size; the sample restricted to one hospital; the sample of 90% female and Muslim nurse; nurses with the highest levels of burnout and psychological distress were not assessed; no follow-up phase; and one death educator (lack of teamwork of death education). The content and sequence of 8A model were not developed with reference to empirical data; the model influenced by the experience and observations of team members in working with patients and elderly people; and 8a model is a descriptive and theoretical model.

In the light of our results, the following points for health care professionals, theory, practice, and policy are suggested:

Investigation of nurses' content needs in death education and the characteristics associated with those needs; assessment of psychosocial correlates associated with how Iranian nurses react to death and dying, also predictive effect of related variables and events on death anxiety symptoms; focused on religious perspective in planning of death education; creating a reflective narrative environment and work rotating for nurses working in emergency, intensive critical care, oncology, dialysis wards, and hospice; a continuing death education program in hospital settings providing acute and extended care services; new intervention programs using psychotherapy (existential therapy, CBT, and ACT or an integrated approach), psycho education, group crisis intervention, and community based intervention in treatment of death distress for nurses; the controlled research and with larger sample to determine the efficacy of well-established treatment strategies for death distress in non-clinical and clinical samples (somatic illnesses and psychiatric patients); and death education programs using of the Theory of Planned Behavior (TPB)to predict nurses' death related behavioral intentions and attitudes. 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 should be provided. A 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 distress should be developed. An agenda that 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 must be developed. 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. Systematic quantitative and qualitative studies with different groups and populations may help to examine the appropriateness of 8A model. Further research is required to verify if these areas match the progress of the stage model, as stated in TTM; and for more advancement of 8A model from a descriptive and theoretical model to a practical clinical assessment tool in death and dying studies.

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