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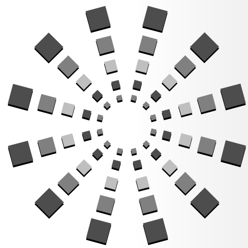

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Attitudes and Experiences of Nurses Toward Death and Caring for Dying Patients in Turkey

KEY WORDS
Caring for dying people
Death
Death attitude
End-of-life care
Nursing

Background: Caring of the dying patients and facing the death can be a stressful and difficult experience for nurses. Besides personal and professional experiences, nurses' own attitudes toward death may affect the care given to dying individuals. **Objective:** The aim of this study was to examine Turkish nurses' attitudes toward and experiences with death and caring for dying patients. **Methods:** A descriptive, cross-sectional study was conducted at 2 university hospitals and 1 state hospital located in Ankara, Turkey. Data were collected via sociodemographics form, the Death Attitude Profile–Revised, and Frommelt's Attitude Toward Caring for Dying Patients. **Results:** The attitudes of Turkish nurses toward death and caring for dying patients are less positive than the reported attitudes of nurses in other studies. Significant relationships were found among level of education, willingness to care for dying patients, and scores on Frommelt's Attitude Toward Caring for Dying Patients and on Death Attitude Profile–Revised subscales ($P < .05$). Although the majority of nurses (85%) stated that they had received education on end of life, most of them (82%) were not comfortable talking about death. **Conclusions:** A lack of education and experience may contribute to the negative attitudes. Providing a reflective narrative environment in which nurses can express their personal feelings about death and dying could be a potentially effective approach. **Implications for Practice:** This study highlights the need for further educational research and development of better educational programs to help nurses to explore and understand their attitudes toward death, overcome fears, increase communication skills, and enhance coping strategies.

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Death is a universal reality that affects all people. For some, death is a frightening, though inevitable, experience. Although a person is aware of the inevitability of death, how or when it will occur is not known. Death, although inevitable, can be distressing to contemplate, and doing so may even be taboo in many cultures. Although people generally do not develop positive attitudes toward death, factors such as occupation, gender, education, personal life experiences, and beliefs affect people's perceptions of death, their search for the meaning of life and death, their attitudes and behaviors toward death, and the degree to which they fear death.[1,2]

People who work in healthcare, especially nurses, encounter death and dying in their everyday practice, and although it is difficult to predict or generate responses to the dying process, when nurses face death, their responses and attitudes may vary depending on their previous experiences. Caring for dying patients and coping with death can be one of the most difficult aspects of the nursing profession. When nurses care for dying patients, they must face the reality of death while supporting and caring for dying patients and their significant others. Thus, nurses need to recognize and confront their own perceptions and attitudes toward death before they can assist their patients in dealing with death.[3–5]

Caring for patients with terminal and incurable disease is an emotional experience for nurses that may result in death anxiety. Dealing with death on an everyday basis can cause anguish and feelings of helplessness, frustration, and a lack of confidence due to a perceived failure of professional actions.[6] To better prepare nurses to deal with death, educational programs that provide the knowledge and skills needed to help the families of dying patients, to effectively communicate with patients and families, to express their own emotions, to confront their own feelings of death anxiety and reactions to death, and to recognize their own attitudes toward death should be part of the nursing curriculum and should be offered as professional training for nurses in the field.[7]

In the literature, there is a considerable amount of research on nurses' attitudes toward death and dying; however, research on Turkish nurses' attitudes toward the subject is lacking. Therefore, it is important to conduct baseline assessments of nurses' attitudes toward caring for dying patients.

Literature Review

Patients who are in the process of dying face many physical, psychological, social, and spiritual problems, and as they come closer to the end of their lives, they often require more assistance. Patients who are in the end-of-life stage need to be provided comfort, quality of life to whatever degree possible, and support as they prepare for their own death.[8,9]

Nurses must offer emotional support to the person who is dying and to his/her family in accord with the families' beliefs and desires. It is important that the nurse speak about death with the patient who is dying; however, to be able to provide the needed support for the patient and the family, the nurse must recognize his/her own fears, emotions, and attitudes about death and learn to cope with them. Furthermore, as the families will probably need information on how to ease the dying family member's anxiety and fears and on how to best assist the dying person, the nurse can serve as a primary source of information.[8]

There is increasing emphasis on improving the quality of end-of-life care to promote and achieve a "good death," a concept that has become prominent social and political priority, especially in Western countries.[10–12] The concept of a good death has different meanings, depending on the perspective of the patient, the family, the healthcare professional, and the public. From the nurse's perspective, a good death requires a high standard of care that involves optimal symptom management and holistic care provided to both patient and family. Nurses who work on acute care units are expected to provide high standards of end-of-life care in a curative-oriented environment. Patients and their families demand effective pain and symptom management, effective decision making, and effective treatment that do not extend the dying process. Moreover, patients want to be prepared for death, to be able to say goodbye, to be able to spend time with their relatives and loved ones, to be able to reflect back on their life, to be respected, to maintain personal dignity, and to be able to share with other people.[4,13,14]

The quality of care delivered by an individual nurse may be influenced by the nurse's personal attitudes toward the care for dying patients and toward death itself. The attitudes that a person holds toward death are dependent on the meaning that death has for the individual,[15] which is influenced by personal, religious, cultural, social, and philosophical belief systems.[2] Several studies have found that people who are more religious have lower death anxiety. Studies have determined that religious beliefs, that is, a belief in God and a belief in the afterlife, are correlated with more positive attitudes about death and dying among doctors, nurses, and the general public.[16,17]

Attitudes can be changed through education, through experiences, and through an exploration of one's feelings, attitudes, and beliefs about the self and others.[18] Care for the most seriously ill patients requires special knowledge and training for all healthcare professionals,[19,20] and a part of that training includes educating nurses and helping them to develop positive attitudes toward death. Studies have found that a strong relationship exists between the length of experiences of nurses caring for patients in the terminal period of life and positive attitudes toward death.[2,21,22] Many research findings support the importance of education in changing attitudes toward caring for dying patients.[23]

The aim of education programs concerning death is to allow and to help people determine and identify their own attitudes toward the reality of death. Such education programs can be effective in increasing the awareness of death among nurses and thus decreasing death anxiety and promoting positive attitudes regarding the care for patients with terminal disease.[6] Research on education about death and dying began at the end of the 1960s, first, in the United States and then in countries such as England and Canada. In a relatively short period, education programs about death were established, and education about death and dying was incorporated into nursing program curricula.[20,24] It is important for nurses to realize how their knowledge and attitudes about death affect the quality of care that they provide to their dying patients. Because death is an issue that deeply affects human life, it is not possible to claim that

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only knowledge about death determines the behavior of the caregiver. For this reason, education about death should not only transfer information but also help to shape and develop positive personal attitudes toward and awareness about death.

Methods

The aim of this study was to examine Turkish nurses' attitudes toward and experiences with death and caring for dying patients. A descriptive and cross-sectional study was conducted at 2 university hospitals and 1 state hospital located in Ankara, Turkey. This study was approved by Baskent University institutional review board and ethics committee (project KA09/109). Approval to conduct the study was obtained from all institutions. Nurses working in adult inpatient clinics at these hospitals between July and November of 2009 were invited to participate, and a total of 300 nurses' responses were received out of 370 nurses (overall response rate, 81%).

The data used for analyses were derived from a 35-item questionnaire based on the literature.[5,8,25,26] The questionnaire includes questions regarding sociodemographic factors, end-of-life-care education, and experience caring for dying patients. Additionally, the Death Attitude Profile–Revised (DAP-R)[27] and Frommelt's Attitude Toward Caring for Dying Patients (FATCOD)[28] were also used in the study.

A Turkish translation and validation have been performed for this study using the back-translation technique after obtaining permission from authors of these scales. Both of the scales were first translated from English to Turkish separately by 3 experts: a bilingual linguistic, a medical professional, and nursing professional. Another expert compared the Turkish translations with the original English forms to identify inconsistencies, and minor revisions were made in some areas. One Turkish version was then created for each scale. Subsequently, the scales were translated back from Turkish to English by 2 bilingual language experts. The back-translated and original forms of the scales were compared and found to be highly similar in meaning. The back-translated versions of the scales were also sent to the authors and received confirmation regarding sameness in meaning. Then, an expert panel of 12 members (faculty members from the medical, nursing, sociology, physiology, philosophy, theology, and communication departments, as well as from the clinic) was asked to rate each item of the Turkish version of FATCOD and the DAP-R in terms of relevance, clarity, and simplicity as 1 (not relevant), 2 (somewhat relevant), 3 (relevant), or 4 (very relevant). Finally, in accord with their recommendations, minor changes were made, and a pilot test was conducted with 100 nurses. The content validity index was used to determine the item validity, and the average content validity index was found to be 0.99 for the DAP-R and 0.83 for FATCOD in the final versions, thus indicating adequate content validity.[29] Cronbach α was used to estimate the internal consistency reliability, and a good level (Cronbach α for DAP-R: .80 and FATCOD: .73) was attained.

Frommelt's Attitude Toward Care of the Dying Scale[28] is a 30-item scale that uses a 5-point Likert scale to measure respondents' attitudes toward caring for dying patients. The instrument consists of an equal number of positively and negatively worded statements with response options of strongly disagree, disagree, uncertain, agree, and strongly agree. Positive items are scored 1 (strongly disagree) to 5 (strongly agree). Scores are reversed for negative items. Possible scores range from 30 to 150. A higher score indicates a more positive attitude toward caring for dying patients. The FATCOD Scale has been widely used in studies in the United States,[2,21,22] Japan,[30] Iran,[31] and Israel.[15] The computed Pearson coefficient was found to be 0.94.[28]

The DAP-R[27] is a 32-item scale that uses a 7-point Likert scale to measure respondents' attitudes toward death. The scale consists of 5 subscales to determine specific aspects regarding respondents' attitudes toward death. These factors include (*a*) fear of death, (*b*) death avoidance, (*c*) neutral acceptance, (*d*) approach acceptance, and (*e*) escape acceptance. Fear of death is demonstrated by negative thoughts and feelings about death (7 items: items 1, 2, 7, 18, 20, 21, and 32). Death avoidance describes the respondent's attempts to avoid thoughts of death as much as possible (5 items: items 3, 10, 12, 19, and 26). A neutral acceptance of death suggests that the respondent neither welcomes nor fears death (5 items: items 6, 14, 24, 17, and 30). Approach acceptance indicates that the respondent views death as a passageway to a happy afterlife (10 items: items 4, 8, 13, 15, 16, 22, 25, 27, 28, and 31). Escape acceptance means that the respondent considers death to be an escape from a painful existence (5 items: items 5, 9, 11, 23, and 29). Each of the 5 subscale scores is calculated by adding respondent's scores on each of the items in that subscale and dividing the sum by the number of items in that subscale. Thus, scores for each subscale can range between 1 and 7. The mean subscale score is computed by calculating the sum of all participants' scores for each subscale and then dividing by number of participants. A higher score indicates a stronger tendency to identify with that particular subscale.[27]

Data Analysis

The data were analyzed using a descriptive analysis, independent *t* test, correlation, and stepwise logistic regression tests. Descriptive statistics were used to analyze the demographic data; the means and SDs are reported to specify the scale scores, and the Pearson correlation was used to analyze the relationships among the scores of the DAP-R and FATCOD. Logistic regression analyses (backward logistic regression) was used to examine the main variables such as age, gender, marital status, educational status, years in nursing, work settings, religious belief, previous education on end-of-life care, willingness to care for a dying patient, and contact with dying patients as predictors of nurses' attitudes toward caring for dying patients. The open-ended questions were grouped into themes and summarized as percentages. For all analyses, $P < .05$ was considered significant.

Results

The descriptive characteristics of the nurses in our study are presented in Table 1. The mean age was 28 (SD, 4.9) years; the

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Table 1 • Demographics Characteristics of the Nurses

Demographics	n	%
Age (mean, 27.88 [SD, 4.94] y; range, 18–48 y), y		
18–25	113	37.7
26–30	114	38.0
≥31	73	24.0
Gender		
Female	263	87.7
Male	37	12.3
Marital status		
Single	176	58.7
Married	124	41.3
Educational status		
Bachelor	217	72.4
Vocational health school (2-y university education)	44	14.6
Vocational high school	39	13.0
Years in nursing (mean, 6.07 [SD, 5.5]; range, 1–29)		
<1	67	22.3
2–5	113	37.7
6–10	55	18.3
>11	65	21.7
Work settings		
Surgical clinics	77	25.7
Medical clinics	72	24.0
Surgical intensive care unit	60	20.0
Medical intensive care unit	54	18.0
Oncology clinics	37	12.3
Total	300	100.0

majority of the nurses in our study were women (87.7%), were single (57.4%), had a bachelor degree (70%), and had a mean years of experience in nursing of 6 (SD, 5.5) (Table 1).

The majority of nurses (89%) indicated that they had experienced the loss of a loved one, and 68% stated this loved one was a relative. As can be seen on Table 2, the majority of nurses stated that they have strong (52.3%) or very strong (16%) religious beliefs. Less than half (45%) responded that being religious greatly affects their attitude toward death and caring for a dying patient. On the other hand, the majority stated that their lack of belief had little (26%) or no affect (43.3%) on their attitudes toward death and caring for a dying patient (Table 2).

The majority of nurses (85%) stated that they had received education on end-of-life care, and of that 85%, 81% found the education to be sufficient. Most of the nurses (83.3%) indicated having had direct involvement with caring for dying patients, and 37% of them indicated having provided daily care for patients with terminal disease. The emotional responses of the nurses while caring for dying patients included feelings of grief (37.5%), helplessness (34%), anxiety (10.7%), and fear (10.5%). The majority of the nurses (82%) were not comfortable talking about death with their patients (Table 3). Nurses responded to open-ended question about the reasons for their lack of comfort as "do not want to scare the patient" (43.6%), "difficult subject to talk about" (26%), "do not want the patient to become sad" (12.6%), and "feeling helpless" (6.2%). The most cited coping strategies identified by the nurses included "trying to view death as a natural part of life," "praying," and "talking with friends" (not included in the table).

The majority of the nurses (92%) believe that it is extremely important to respect the religious beliefs and cultural values of the dying patient and the patient's family. The majority of the nurses (88%) also believe that "the family and friends of the patient should be permitted to visit at any time."

When analyzing the differences in means of DAP-R subscales according to religious belief that was reduced into 2 groups as "moderate" and "strong," significant differences were found in approach acceptance, fear, and avoidance of death ($P < .05$). Nurses who stated they had a strong religious belief reported less fear and avoidance of death and higher approach acceptance in comparison to nurses who have moderate religious beliefs (Table 4).

The mean of DAP-R subscales was from 3.5 to 5.5; the average score for all respondents on FATCOD was 99.9 (SD, 8.7), with a range from 77 to 129. Nurses in the sample reported moderate levels of fear of death (mean, 4.2 [SD, 1.1]), death avoidance (mean, 4.0 [SD, 1.2]), neutral acceptance (mean, 5.5 [SD, 0.7]), approach acceptance (mean, 4.8 [SD, 1.0]), and escape acceptance (mean, 3.5 [SD, 1.4]).

Examining associations among the DAP-R subscale scores and FATCOD scores using Pearson analyses revealed few significant correlations. Very weak positive correlations were found between escape acceptance and both avoidance and neutral acceptance. There are moderate correlations between fear and avoidance and between approach acceptance and escape acceptance. There are very weak negative relationships between fear, avoidance, and FATCOD. Nurses with a greater fear of death were found to have less positive attitudes about providing care to dying patients (Table 5).

Table 2 • Nurses' Religious Beliefs and Their Influence on Their Attitudes Toward Death and Care of Dying Patient

Religious Belief	n	%
Moderate	95	31.7
Strong	157	52.3
Very strong	48	16.0
Influence of religious belief on their attitudes toward death and care for the dying patient		
Very influential	135	45.0
Little effect	86	28.7
Do not affect	79	26.3
Influence of not being religious on their attitudes toward death and care for the dying patient		
Very influential	92	30.7
Little effect	78	26.0
Does not effect	130	43.3
Total	300	100.0

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Table 3 • Nurses' Degree of Preparation, Involvement, and Emotional Experiences With Respect to Caring for Dying Patients

	n	%
Previous education including death and dying content		
Yes	255	85.0
No	45	15.0
Finding the education sufficient		
Yes	243	81.0
No	57	19.0
Comfortable to speaking "dying" with patients and relatives		
Comfortable to speak	55	18.3
Not comfortable to speak	245	81.7
Having in-service education on end-of-life care in institution		
Yes	67	22.3
No	233	77.7
Willingness to care for dying patients		
Yes	113	37.7
No	187	62.3
Direct involvement in caring for dying patients		
Yes	250	83.3
No	50	16.7
Emotional experiences of nurses while caring for dying patients[a]		
Grief	164	37.5
Helplessness	149	34.0
Anxiety/distress	47	10.7
Fear	46	10.5
Feeling unsuccessful	21	4.7
Anger	9	2.1
Hopelessness	2	0.5
Total	438	100.0

[a]More than 1 answer was given.

Logistic regression analysis (backward logistic regression, leaving in variables at the $\alpha < .15$ level) was used to determine to what extent attitudes toward death (DAP-R subscales), demographic variables (age, gender, marital status, religious belief, level of education), and experience (work settings, years in nursing, previous education on end-of-life care, willingness to care for a dying patient, and contact with dying patients) contribute to the prediction of nurses' attitudes toward caring for dying patients (as rated by the FATCOD Scale as the dependent variable). Overall, the model explained a total of 18.7% of the variance in nurses' attitudes toward caring for dying patients, with only education, willingness to care for dying patients, and escape acceptance as significant predictors in this model (Table 6). Nurses who have vocational health school and high school degree had lower scores for FATCOD compared with those with a bachelor's degree ($P < .05$). Nurses who indicated not willing to care for dying patients had lower score for FATCOD.

■ Discussion

The results of this study reveal that the attitudes of Turkish nurses toward death and toward caring for dying patients are less positive than the reported attitudes of nurses in other studies. Similar studies that used FATCOD reported higher scores than those obtained in our study. For example, a study conducted in the United States reported scores between 125.9 (SD, 11) and 130 (SD, 12.7),[2,21,22] whereas a study in Japan reported an average score of 112.3,[30] and a more recent study conducted in Israel reported a score of 125 (SD, 12.7).[15] It has been demonstrated that the attitudes toward death and toward caring for dying patients may influence the behavior of nurses as well as the quality of care that they administer. Attitudes toward caring for dying patients were negatively correlated with death avoidance, fear of death, and approach acceptance. Similar to our results, it has been posited that negative correlation exists between FATCOD scores and fear of death and that nurses with a greater fear of death have less positive attitudes about providing care to dying patients.[2,15,21,22] However, further investigation into why Turkish nurses score lower on the FATCOD than do other nationalities is needed.

The majority of nurses stated that they had strong or very strong religious beliefs, and nearly half of the nurses (45%) expressed that being religious greatly affects their attitude toward death and toward the dying patient. On the other hand, 43.3% of the nurses expressed that not being religious does not affect their attitude toward death and toward the dying patient. Other

Table 4 • Differences in Mean Scores of the Scales of Religious Beliefs

	Religious Belief			
DAP-R Subscales	Moderate (n = 95), Mean (SD)	Strong (n = 205), Mean (SD)	*t*	*P*
Fear	4.4 (1.0)	4.0 (1.1)	2.63	.009[a]
Avoidance	4.2 (1.3)	3.9 (1.2)	2.03	.042[a]
Neutral acceptance	5.5 (0.7)	5.5 (0.8)	0.71	.474
Approach acceptance	4.3 (1.0)	4.9 (0.8)	−5.47	.000[a]
Escape acceptance	3.4 (1.3)	3.5 (1.4)	−0.94	.345
FATCOD	99.4 (8.8)	100.1 (8.6)	−0.70	.48

Abbreviations: DAP-R, Death Attitude Profile–Revised; FATCOD, Frommelt's Attitude Toward Care of the Dying Scale.
[a]$P < .05$.

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Table 5 • Correlations Among the Death Attitude Profile–Revised (DAP-R) Subscales and Frommelt's Attitude Toward Care of the Dying Scale (FATCOD)

DAP-R Subscales	Fear	Avoidance	Neutral Acceptance	Approach Acceptance	Escape Acceptance
Fear	—	0.604[a]	0.006	−0.106	0.188[a]
Avoidance	0.604[a]	—	0.091	−0.011	0.171[a]
Neutral acceptance	0.006	0.091	—	0.264[a]	0.124[a]
Approach acceptance	−0.106	−0.011	0.264[a]	—	0.428[a]
Escape acceptance	0.188[a]	0.171[a]	0.124[a]	0.428[a]	—
FATCOD	− 0.184[a]	−0.227[a]	0.063	−0.042	−0.121[a]

[a]$P < .05$.

studies on this subject have determined that religious beliefs and having faith are important factors that affect attitudes toward death and toward the dying patient.[9,21,23,31]

Nurses who stated they had strong religious belief reported less fear and avoidance of death, and higher approach acceptance compared with nurses who have less religious beliefs. In similar to this findings, studies indicate that a belief in God and in the afterlife is associated with a more positive attitude toward death and dying among nurses, doctors, and the general population.[15,16,32] Alvarado et al,[16] for example, found that a strong religious belief and a belief in life after death (afterlife) are associated with less fear of death and less anxiety about death. In a study including 147 nurses, Braun et al[15] found that religious nurses reported more acceptance of death in comparison to secular nurses. However, no significant correlation between FATCOD Scale items and the religious beliefs of the nurses was found in our study.

In our study, caregivers of dying patients noted that they had experienced grief (37.5%) and helplessness (34%). In the study from Turkey, 41.7% of the nurses reported that while working with patients in the terminal stage, they experienced frustration, and 32.3% experienced depression.[33]

Gender has been identified as a factor affecting attitudes toward death and toward the dying patient[23]; however, the literature shows no effect of gender with respect to nursing for the dying patient.[2,22,25] Because of the small number of male nurses in the study, a comparison was made by randomly selecting a matching number of samples from the female group. Hence, the effects of gender were analyzed by matching numbers and comparing the average scores obtained according to the DAP-R Scale and FATCOD Scale . The differences between mean scores of FATCOD Scale and the DAP-R Scale were not statistically significant.

In a study of 403 nurses, Lange et al[22] found that nurses with 11 or more years of experience scored higher on the DAP-escape and DAP-avoidance subscales than did nurses with 5 to 10 years of experience, suggesting that nurses with more years of work experience are more likely to view death as an escape from a painful existence. In our study, the subgroup average score for "death avoidance" is higher for those who have more work experience than for those who have less work experience.

Previous studies found that nurses with greater exposure to dying patients reported more positive attitudes toward death and that nurses who have cared for many patients with terminal disease behave more positively than do those who have cared for only a few patients with terminal disease.[2,21–23] In this study, however, as no significant difference was found, there is a need for further study.

In our study, although the majority of nurses stated that they had received education on end-of-life care and found the education to be sufficient, but still are not comfortable speaking to dying patients and relatives. Possible explanation for this result may be because they are uncomfortable talking about death; maybe they say their education is sufficient because they do not want any more education in a topic that makes them uncomfortable. It has been reported that one of the main coping strategies used by nonspecialist nurses with regard to perceived inadequacies in communication skills was the use of blocking techniques.[34] Blocking behaviors were described by Kruijver et al[35] as the use of avoidance techniques or distancing tactics in situations that nurses perceived as stressful.

Care for dying patients requires special knowledge and training for all healthcare professionals.[19] It is known that attitudes toward death and caring for dying patients can be improved via education. However, education in palliative and end-of-life care

Table 6 • Logistic Regression Analysis Predicting Nurses' Attitudes Toward Caring for Dying Patients (FATCOD)

Variable	*B*	SE β	β	*t*	*P*
Education (bachelor's)	1.00				
Vocational high school	−2.908	1.380	−.113	−2.107	.036[a]
Vocational health school	−2.781	1.319	−.113	−2.109	.036[a]
Not willing to care for dying patients	−5.631	.959	−.314	−5.874	.000[a]
DAP-R escape acceptance	−1.301	.369	−.188	−3.526	.000[a]
DAP-R neutral acceptance	0.983	.591	.088	1.663	.097

Abbreviation: DAP-R, Death Attitude Profile–Revised.
[a]$P < .05$.

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is complex; it requires not only special knowledge and training, but also developing attitudes, approaches to care, and the ability to work with emotionally difficult situations.[19,23,36,37]

Limitations

The sample included only nurses working in adult clinics, and the respondents were predominantly female. Therefore, our data, which is based on the limited sample and the results obtained under the nurses' self-declarations, cannot be generalized beyond the sample.

Conclusion

A lack of education and experience may contribute to the negative attitudes that the surveyed nurses expressed toward some aspects of caring for people who are dying. Providing a reflective narrative environment in which nurses can express their personal feelings about death and dying could be a potentially effective approach that would allow nurses to identify the factors that influence their interactions with dying patients. Furthermore, offering continuing education courses on death and dying may help nurses as they strive to improve the quality of care for dying patients. It has been emphasized, however, that more positive effects can be attained if the education not only teaches the knowledge and skills required to care for the dying but also fosters an attitude of caring and compassion and takes into account the personal beliefs and emotions of the nurses by including discussions and information on self-care, self-healing, coping with loss and grief, and mutual support.[23]

Implications for Practice

This is the first report from Turkey on nurses' attitudes toward and experiences with death and caring for dying patients. We hoped that this study offers insight into the need for further educational research and the development of better educational programs to help nurses to explore and understand their attitudes toward death, overcome their fears and anxieties about death, increase their communication skills when talking about death, and enhance their coping strategies with respect to death. The DAP-R Scale can be used to analyze personal attitudes.

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