A PERSPECTIVE ON THE CURRENT STATE
OF DEATH EDUCATION

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The author offers some views on the current state of death education with focus on the sparing attention given the death education of health professionals and of grief counselors. There is need for improved integration of the knowledge accumulated in the study of death, dying, and bereavement into the basic curricula of the parent disciplines and professional schools. Facilitation of personal engagement with the issue of mortality is an important component of the educative process. Various assessment problems are outlined and some suggestions for improvements are offered. The death education needs of various groups, including school age children and older adults, are noted. The article contains a list of references, many not cited in the text, recommended for an extensive review of developments in death education.

It is satisfying to see this special issue of Death Studies devoted to honoring and remembering Herman Feifel, philosopher, psychologist, research scientist, professor, and the pivotal force in the death awareness movement and the development of the study of death. His achievement as prime mover and contributor to thanatology has been recognized by his colleagues through numerous honors and awards. The latest in his life was the “Gold Medal Award for Life Achievement in the Application of Psychology.”

In paying tribute to Herman Feifel in a discussion of death education, it is fitting to note that he was the first modern death educator. The
scientific symposium on “Death and Behavior” he organized and presented to the 1956 Annual Meeting of the American Psychological Association, was a powerful and consequential educational act. The fact that it took more than two years to locate a publisher for the Proceedings speaks not only to the prevailing silence on the subject of death in the 1950s, but also to Feifel’s strength of conviction and determination to break the taboo. He agreed that the “death awareness movement” can be considered a synonym for “death education” in the broadest sense.

Beginning with the 1960s, considerable efforts have been expended to develop and refine death education programs. Attention has been paid to important aspects of death education. They include (a) articulation of goals, (b) consideration of content and perspectives, (c) teaching methods, (d) teacher competencies, and (e) evaluation. Compared to the pioneering days of thanatology, we have seen advances in death education offered to a variety of stakeholders including college students, the general public, primary- and secondary-level students, health professionals, and grief counselors. In a wide range of programs, such as full semester courses, teaching units for public school students, and short workshops for professionals, it is apparent that attention has been paid to planning, goal setting, execution, and evaluation.

Herman Feifel’s influence, as his emphasis on the multidisciplinary nature of death studies and his insistence that death education benefits all (including children), (Feifel, 1977) is apparent. Most particularly, the humanistic perspective—the philosophical foundation of the study of death he articulated—is reflected in the goals of death education, which stress both acquisition of knowledge and development of self-understanding and clarification of values, meanings, and attitudes toward death. The range of experiential activities designed to assist with such personal engagement illustrates the commitment to this goal. It is a tribute to his leadership that despite institutional pressures, the overwhelming amount of death literature available, and the temptation to intellectualize death, this humanistic goal is still pursued (e.g., Attig, 1992; Gould, 1994; Papadatou, 1997).

Because of space limitations in this special issue, I have chosen to examine the current state of death education for health professionals

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3Personal communication at the Conference on Death and Dying: Education, Counseling, and Care, December 1–3, 1976, Orlando, Florida.
and for grief counselors. I present some overall conclusions about the place and state of death education today, based in part, on a review of aspects of death education not included in this article. However I have listed references not cited in this text that I recommend for an extensive review of death education. The conclusions I offer come from the vantage point of a person who has lived as these developments occurred and who has, for better or worse, contributed in some part to this history.

There have been considerable advances in knowledge pertinent to care at the end of life, contributing to the understanding of dying persons and their loved ones. Application of this understanding in education has improved the quality of care provided in a variety of health care settings, hospices in particular, but also including hospitals and homes. Promising developments are underway in education and program development focusing on care in neglected clinical settings (e.g., intensive care units) and for neglected populations (e.g., African Americans in urban and rural communities, and residents in prisons). They are important steps toward achieving equity in the care of dying persons.

The development and increasing use of counseling and consulting services to organizations and agencies involved in emergency response to terror attacks, plane crashes, multiple murders, and natural catastrophes is a substantial achievement in the area of grief counseling. Likewise, crisis intervention programs in the public schools have been offered for public school students, including attempts to introduce long-term suicide prevention (e.g., Leenaars & Wenckstern, 1991; Stevenson, 1994).

Nonetheless, death education for health professionals and death education for grief counselors are of considerable concern. It is important, however, to keep in mind Feifel’s (1982) observation that “we are embedded in our time and culture... each generation contends with the presence of death—raging against it, embracing it, attempting to domesticate it”, and, at the same time, his further observation that although we are more knowledgeable and realistic about death, there is a persisting avoidance. There are numerous indications of avoidance and ambivalence in our current death system as well. Breath-taking advances in medical and biological sciences, such as genetics, genomics,

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4Feifel organized a symposium on “Death in Contemporary America” to the American Psychological Association in 1981 and presented the proceedings in a special issue of Death Education which he guest-edited in 1982, 6(2).
proteonics, and in new technologies, such as nanotechnology and regeneration technology, raise expectations for further extending human lives and unrealistic hopes for physical immortality bolstered by a flourishing anti-aging industry. Thus, criticism of death education efforts must be tempered by consideration of the larger cultural context in which these efforts are made.

Death Education for Health Professionals

Pioneers in the study of dying patients and their care during the 1960s called for reform and spent their careers working toward achieving it. Leading educators in the health professions have been mindful of the humanistic component in death education, attempting to balance training for practical skills with attention to personal understanding and attitudes (e.g., Bertman, 1991; Papadatou, 1997; Quint Benoliel, 1967, 1982). During the early years great advances were made in the study of pain control and symptom management for the terminally ill, eventually leading to legislation in the United States that entitles patients to “compassionate pain relief” including controlled substances. One might expect that those responsible for preparing health professionals would have been eager to revise their curricula based on the data accumulating since the 1960s. However, it was primarily nursing schools that developed courses in death education. The most visible effect of the new teaching was the development of hospice programs as an alternate to traditional “care.”

Care for the Dying in Hospice and Hospitals

In professional education, the ultimate test of quality education lies in the effectiveness of care or counseling. Even though successful, hospice workers have been criticized for the paucity of empirical evidence (by traditional standards of scientific inquiry) documenting efficacy. This evidence of hospice success has come largely from qualitative studies, clinical reports, and a wealth of personal narratives and testimonials by patients and their families. Despite nearly 30 years of hospice care in the United States, the mainstream medical community failed to generally adopt its principles and practices for caregiving in hospitals. Because one of the major findings in early studies (Quint, 1967) showed
the lack of communication between physicians and patients with subsequent adverse effects on patients, it is important to determine what changes have occurred since then.

Klenow and Young (1987) reviewed the literature on physicians’ communication with terminally ill cancer patients from the 1960s to the 1980s. They reported a dramatic shift from withholding diagnosis and prognosis to telling patients the truth. However, they also pointed to shortcomings in this literature (e.g., sample selection, response rates) that undermine these findings. With the establishment of advance directives, the communication issue has become more complex. Findings from the most extensive study of dying in hospitals (involving over 9,000 patients in five major medical centers) indicate that most physicians do not know about patients’ end-of-life wishes, and of those who know, only 15% talk with patients (SUPPORT/Investigators, 1995). Similarly, a key concern of hospice pioneers was to achieve optimal pain/symptom control in order to allow patients to live their last days and to die with dignity. Many more pain centers have been established in the United States and abroad since the early days of hospice care, enabling sophisticated pharmaceutical and other means to control pain. Yet in the study cited above nearly half of the dying patients in hospitals endured moderate to severe pain, and nearly half spent their last 10 days in intensive care units.

Medical and Nursing Education

Not surprisingly, there has been inadequate attention to death and dying in medical curricula at all levels. Dickinson is a long-time observer of death education in medical, nursing, and other health-related professional schools. In a 1975 survey of U.S. medical schools he found that only half of them offered something more than “a lecture or two” on the subject of death. Moreover, most course offerings listed were electives, and fewer than 10% offered a full course (Dickinson, 1976). More recent surveys indicated improvement. By the 1990s nearly all medical, nursing, pharmaceutical, and social work schools offered some education about death and dying, most of it integrated into the basic curricula. In most schools, that consisted of only a few lectures. Full course offerings were improved over the past but still inadequate (13% in schools of medicine, 15% in nursing). Full-course electives were taken by a fourth of the students. When queried about future plans, half of the medical and
nursing schools had no plans to offer or expand death education. Time constraints, no need, and limited faculty resources were the main explanations given (Dickinson, Sumner, & Frederick, 1992; Dickinson & Mermann, 1996). Serious inadequacies in palliative care education in the United Kingdom have been reported as well. Surveys showed the average medical student received approximately 6 hours of death-related instruction, and at best, 20 hours in a 5-year medical curriculum (Doyle, 1991). Surveying nursing and medical school faculties in Canada and the United Kingdom, Downe-Wambow & Tamlyn (1997) reported results similar to those by Dickinson for the United States. Death education was included in most programs, mostly integrated into regular curricular offerings or offered as an elective, and only a small minority required a full course. Nursing programs in both countries provided a broader range of topics and allocated a greater number of hours to class and clinical sessions than did programs in medicine which focused primarily on pain control/hospice care and ethical/legal issues. In both countries, the theorist most often discussed in death education was Elizabeth Kübler-Ross. Death education content was taught primarily by faculty members of the respective disciplines, except for the United States medical programs in which half the teaching was provided by other disciplines, such as psychiatrists, social workers, and nurses (Dickinson et al., 1992).

Content analysis of professional textbooks further indicated the serious neglect of care for dying patients. An examination of 50 best-selling medical textbooks in multiple specialties in terms of content in 13 end-of-life domains, found that with few exceptions (e.g., family medicine, geriatrics), content in end-of-life care is minimal or absent (Rabow et al., 2000). Nursing textbooks have been found similarly deficient. Examination of 50 major textbooks used in nursing schools on 9 essential content areas in end-of-life care showed, overall, less than 2% of the content was devoted to end-of-life care (Ferrel, Virani, & Grant, 1999).

Paramedics are among other professionals that routinely work in death-related situations and are often first-line respondents to families in distress and grief. The literature is scant on death education for this group. In a national survey of paramedic programs, Smith and Walz (1995) reported that nearly all programs offered some death education that is integrated into their curricula and only a small fraction offered a separate course. The didactic method of instruction was most frequently
used. Most textbooks practically ignore death and only a minority of respondents use supplemental material so that paramedic graduates may have read less than one page of death-related text. What death education is available is inadequate. It offers little opportunity for participants to become knowledgeable about death and grief, to deal with their own feelings, or to develop empathy.

New Developments in End-of-Life Care Education

Since 1995, medical and nursing associations have made recommendations for and developed end-of-life education programs. These programs have been designed to assist physician and nurse educators in self-directed study, to conduct continuing education programs, and to integrate end-of-life information into their basic curricula. For example, the American Academy of Hospice and Palliative Medicine in 1996 developed Unipacs, a training program in hospice and palliative care for physicians, consisting of eight modules, with content including assessment and treatment of pain and other symptoms, alleviating psychological and spiritual pain, ethical and legal decision making, communication skills, hospice/palliative approach to caring for patients with HIV/AIDS and for pediatric patients (www.aahpm.org/).

In 1998 the American Medical Association developed the program “Education for Physicians on End-of-Life Care” (EPEC) (www.epec.net/), consisting of 20 modules. In addition, programs were developed to fit into particular programs. For example, the American Academy of Family Physicians prepared guidelines for a curriculum for family practice residents on end-of-life care. This organization added physicians’ personal attitudes toward death as a component of the program. Similar programs have been developed for nurses. The American Association of Colleges of Nursing recommended competencies and curricular guidelines for end-of-life nursing and in 2000, based on these guidelines, designed the “End of Life Nursing Education Curriculum” (ELNEC) (www.aacn.nche.edu/elneccurriculum.htm).

Death Education for Grief Counselors

Most counseling models for bereaved people were derived from traditional psychotherapeutic interventions and focused almost exclusively
on traumatic bereavement and complicated grief reactions. Therapy for trauma and pathological grief traditionally have been the domain of psychiatrists or clinical psychologists, often affiliated with psychiatric hospitals, outpatient services, or in private practice (Raphael, Middletoa, Martinek, & Misso, 1993). Early studies in adult bereavement led to the establishment of mutual and self-help services and organizations. As more data were generated, grief counseling evolved into a professional specialty. Leading experts have questioned the need for such a specialty, suggesting that well-trained and experienced mental health professionals, such as clergy, funeral directors, and physicians, can learn with short-term training what is needed to counsel “normally” bereaved people, whereas the issues in grief therapy require more in-depth preparation (Worden, 1991). However, others observed that this distinction is not being made in practice (e.g., Raphael et al., 1993).

The preparation of grief counselors has consisted primarily of continuing education programs such as workshops, seminars, summer institutes, and the like and has been widely dispersed. The need for such further education is shown in studies. Less than 50% of graduate programs in clinical psychology and related professions cover death-related problems, such as suicide (Bongar & Harmatz, 1991). And there is evidence to suggest that beginning counselors feel intensely uncomfortable when faced with client issues concerning grief or impending death (Kirchberg & Neimeyer, 1991). A follow-up study showed that high levels of discomfort were predictors of personal fear of death, suggesting that death and grief counselors with high death anxiety are vulnerable. In addition, an overall low level of empathy was found (Kirchberg, Neimeyer, & James 1998). Participants in death education programs for grief counselors may include graduates with beginning or advanced degrees in psychology, the health professions, or other areas. They may be offered by educational institutions, professional associations, and they may be hospital-, community-, or agency-based and provided by private organizations. Because of their large numbers, they are difficult to track or to study to ascertain quality and consistency. The inadequacy of preparation of counseling practitioners revealed in the Kirchberg/Neimeyer studies were also found in surveys. In a national survey of counselors and counselor educators, Rosenthal (1981) found more than 80% of the respondents recognized the need for grief education and

Internet search engines provide thousands of links to training programs.
only slightly over half had any. In a national survey of the formal mental health training of paid hospice staff, more than half reported the need for further training (Garfield, Larson, & Schuldberg, 1982). About half of the respondents were trained by social workers or physicians, a third by nurses, and a fourth by counselors. The training format was didactic, 90% lecture, and 84% readings.

To further complicate the picture regarding the preparation of grief counselors, many of the agents that provide training have made certificates available, of special importance in the United States and Canada where no state or provincial grief counseling or therapy certification is required (Wolfe, 2003). Reports of dubious and bogus credentials in mental health counseling (Woody, 1997) make this issue urgent. A few studies have begun to examine credentials of grief counselors (Zinner, 1993).

In recent years attempts have been made to avoid some of the fragmentation and truncation in preparing grief counselors. Several universities and colleges have begun to offer an alternative to continuing education for preparing professionals. For example, Brooklyn College of New York City offers a 33 credit hour concentration in conjunction with an M.A. degree program in Community Health. Hood College in Frederick, Maryland offers a Masters Degree, and King’s College in London, Ontario offers undergraduate and graduate certificates in death-related counseling.

**Some Conclusions**

*Need for Integration*

Less than a fifth of students in the health professions are offered a full course on death; the rest typically are provided death-related content in a few lectures. This lack of depth dissatisfies teaching faculties and leaves graduates entering their professions inadequately prepared to care for dying people and their families or to counsel bereaved or suicidal people.\(^6\) Thus although the contemporary study of death, dying, and bereavement is remarkable in scope and range, the knowledge accumulated has not substantially affected the curricula of the health,

\(^6\)And only a minority of primary and secondary school students are provided death education or suicide intervention/prevention, depriving too many of the potential benefit of these interventions.
counseling, or teaching professions or related disciplines of psychology and sociology.

What happens to this knowledge? Much of it will reside in the journal literature to be shared with other professionals in thanatology without benefit to the mainstream fields and parent disciplines and ultimately the general public whom it is intended to serve. Data suggest a pattern of resistance at the institutional level. The barriers essentially consist of the failure to acknowledge the need for death education and, closely related, a lack of commitment, primarily of resources. The pursuit of better integration should be the shared responsibility of thanatologists and professionals in the related fields. Fortunately, some of the barriers are starting to come down. Recent programs in education for end-of-life care for nurse/physician educators and practitioners are promising beginnings toward correcting existing deficiencies.

**Attending to the Personal Dimension**

Short exposure to death education invariably means that the knowledge transmitted is inadequate and that little or no attention is paid to the personal dimension, that is, encouraging students to confront, clarify, and share personal understandings and attitudes about death. The personal dimension is the component intended to help students to deal with their anxieties, to become comfortable interacting with people in crisis, and to develop empathy—attributes that make caregiving a humane and compassionate task for professionals and non-professionals alike. It is also a reason why educators should be familiar with the basics of group dynamics and able to create psychologically “safe” environments for small group discussions, role-playing, and other experiential activities.

Packaging and bundling death education into portable modules or packs may be efficient but discourages spontaneity in interactions between teachers and participants. Self-directed study may be economical but it deprives the learner of the opportunity for face-to-face interactions with a live teacher and others in a group of participants—essential aspects of the learning experience. In self-directed study it is more difficult to become comfortable with the subject of death, to ease anxiety and worry, and to develop empathy. Self-directed and distance education are valuable and appropriate if the goal of death education is transmission of knowledge. It is far less appropriate for attending to the
personal dimension in learning about death, dying, and bereavement. In the face of ever-increasing reliance on technology, personal interactions become critical.

Need for Assessments

Missing Data

It would be desirable to obtain data on death educators, for instance, their preparation, competencies, parent disciplines or fields, length of time in the position, continuing education programs they completed, and to whom they are accountable. An urgent need concerns the preparation of professional grief counselors. The wide dispersion and fragmentation of death education for grief counselors and the lack of adequate data leave unanswered questions about the adequacy of preparation. This state of affairs threatens the quality of the interventions bereaved people receive and the integrity and image of the grief counseling profession. A step toward a solution would be the establishment of agreed upon principles and guidelines. Grief experts, counselors, and educators might collaborate (and even reach consensus) to address fundamental questions, such as, What interventions are appropriate for what situations? What knowledge, skills, and personal understandings are necessary, and what kind of certification is appropriate? What research and evaluation exists, and what areas need to be examined? Leaders in grief research can facilitate these efforts by working toward settling some fundamental disagreements among them, such as the definition of grief and distinctions between “normal” and “abnormal” grief. Recent efforts to integrate grief theories and models, as done by Stroebe and Schut (2000), should be continued. Such work may make the study of grief more manageable and assist in the integration of grief-related knowledge into the curricula.7

Effectiveness Studies

In keeping with the humanistic philosophy underlying death education, emphasis has been placed on personal understandings, attitudes, and meanings. However, these aspects are not adequately reflected in

7The considerable amount of “missing data” in several areas related to death education should be priorities for future research. Reliable estimates of death education occurring at the college level and at primary and secondary school levels would be useful for developing strategies for active promotion.
the formal evaluation of the effects of death education on attitudes. For one, most studies have used death anxiety scales that inadequately represent the complexity of death-related attitudes of which death anxiety is only one dimension. Standardized instruments measuring the range of attitudes from anxiety to acceptance and other more positive and cognitive aspects of death attitudes are available and are recommended for use (Robbins, 1994; Wong, Reker, & Gessel, 1994). Any expectation that personal confrontation with death in a death education program automatically reduces the participants’ death anxiety is unrealistic. The data show that individuals in a given group differ in their responses to confronting their own death. Indeed, as Feifel (1990) observed, both death acceptance and death anxiety may be present in the same person. To assess effects of person-focused death education we need to use approaches and methods that yield information on the individual participants. This assessment goal cannot be accomplished by quantitative research alone. Even though such research yields useful trends, it systematically ignores individual differences. Thus, the unimpressive findings on effects of death education on death attitudes may not so much point to mediocre death education, than to the inadequacy of our means and methods of assessment. There is a need for qualitative assessment. New approaches to assessing qualitative data, such as journal entries and other personal narratives are already available and may lead to more appropriate assessment of these goals (Neimeyer, 1997–1998).

Formal evaluation of the effectiveness of death education can benefit from a broadened conceptualization. Teaching method (primarily used in effectiveness studies) certainly is an important variable to consider, but there are others as well. Teaching and learning are complex processes in which psychological, social, and situational variables interact in dynamic ways. For example, personality characteristics of the instructor, teaching experience, expectations of participants, group dynamics, and physical environment may all be contributing factors.

**Attending to Neglected Groups**

**Other Professionals Working in Death-Related Situations**

Medical emergency technicians routinely work in situations that involve death or the threat of death and receive minimum or no preparation, even though they are often first-line respondents to patients/victims
and their families (Smith & Walz, 1995). Police officers are frequently exposed to life-threatening danger and regularly have to handle lethal weapons. They are as vulnerable to post-traumatic stress disorder as soldiers in combat (Sugimoto & Oltjenbruns, 2001). Firefighters are such a group, as are emergency rescue workers, and certainly members of the military such as mortuary officers. These and similar groups should be adequately prepared to carry out their difficult assignments.

**School-Age Children**

Even though death education and crisis intervention programs exist, they are available to only a minority of the 48 million students attending public school in the United States. Death education should be three-pronged:

1. **Cultural education.** Death is a reality and part of our culture and therefore should be part of children's cultural education, as Herman Feifel (1977) admonished. Provided in a low-keyed manner and embedded in larger curricular contexts, it would be unlikely to cause psychotic episodes as some alarmists have feared.

2. **Suicide/violence prevention.** In view of the increasing rates of suicides and suicide attempts in young people, both suicide crisis intervention and long-term prevention programs need to be offered in all schools. Youth violence is a new focus in crisis intervention and prevention. Recommendations for violence prevention and intervention programs are available (Surgeon General’s Report, 2000; Wenckstern & Leenaars, 1993), as are various online educational materials (e.g., The National Center for Children Exposed to Violence, Yale Child Study Center). Pro-social skills, anger management, and conflict resolution skills can be discussed and offered as alternatives to violent behavior.

3. **Death education as antidote.** Death education can help children and adolescents cope with the overwhelming presence of violent death in the entertainment media and its potentially negative effects (King & Hayslip, 2001; Wass, 2003). Media literacy, actual crime statistics, and discussion of “natural dying” may correct distorted images that glorify or trivialize death.

In communities where parents object to death education in school, parent education programs, community sponsored death education, or
death education offered by churches and synagogues may be alternatives.

**Old People**

Adults of all ages, including old adults, have fears of dying and fears of the unknown (Ciricelli, 2001). Death education can help to reduce these fears. Discussion of the dying process, management of pain and symptoms, various care alternatives, and so on, may remove some worries and uncertainties regarding dying. Information regarding advance directives is needed for all adults and especially those with greater proximity to dying, in light of the legal complexities of the directives (Lens & Pollack, 2000), the gap between patients who wish to die and health professionals who keep them alive (Teno et al., 1997), or who may not be aware that patients have given advance directives (SUPPORT/Investigators, 1995). Spiritual issues and conflicts might be addressed by discussing various beliefs about existence after death and by inviting representatives of churches, synagogues, and other faiths to clarify their various theologies.

Nursing home residents are disenfranchised people. First, they are old and ill or frail—serious handicaps in our youth-oriented society. Second, many suffer from illnesses and conditions with unpredictable dying trajectories that do not qualify as “terminal” and do not fit within the time period projected for dying people to die. They are dying too slowly and often without the benefit of the care and compassion that more quickly dying people receive. Sensitivity training seminars are recommended for families of residents, nursing home administrators, and all staffs. With empathy may come better understanding, communication, and care. For residents with full capacities, death educators/counselors may be asked to periodically release residents from an hour of television watching, or finger painting and invite them to group discussions in which they can feel free to voice their concerns about dying and death and free to talk about and share the losses of other residents that is an all to frequent experience.

**Final Comment**

In the years the study of death evolved into a field, we have seen a number of death-related euphemisms disappear. However, new euphemisms
have been creeping into our language. They are even in the language of
death and dying experts. We are taking the “D” words out of new death
education programs, calling them education for “end-of-life care”, or
time-efficiently, “EOL,” “EPEC.” “Hospice” care is becoming “pallia-
tive,” “palliative” is taking the place of “terminal,” and dying patients
are merely “life-threatened.” This avoidance of death words is reminis-
cent of George Orwell’s world in which certain words are eliminated
from the language, so that people will no longer think and talk with
them and eventually forget what they represented!

Death education can benefit all people from childhood to old age. It is
critical for helping professionals. Future death education for all popula-
tions—but especially these groups—needs to be expanded in scope and
depth and provide opportunities for personal engagement. We need to
remind ourselves that the field of death, dying, and bereavement in
Herman Feifel’s vision, is both science and humanity. Death education
needs to attend to both its scientific and humanistic goals.

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