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Death Anxiety: Concept Analysis and Clarification of Nursing Diagnosis

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PURPOSE: To analyze the concept of "Death anxiety" (00147) and to propose modifications in the components of this diagnosis in Taxonomy II of NANDA-I.
METHODS: A conceptual analysis was developed based on the eight steps proposed by Walker and Avant.
FINDINGS: Twenty-six articles were included from a search in four databases. Three defining attributes, nine antecedents, and two consequent ones were identified from concept analysis.
CONCLUSIONS: Conceptual analysis made possible the clarification of this diagnosis and the proposition of modifications in its components, which could provide a diagnostic accuracy.
IMPLICATIONS FOR NURSING PRACTICE: Clarification of the diagnosis will allow the accurate identification of this phenomenon in clinical practice and, consequently, more appropriate nursing interventions.
OBJETIVO: Analisar o conceito de "Ansiedade relacionada à morte" (00147) e propor modificações nos componentes deste diagnóstico na Taxonomia II da NANDA-I.
MÉTODOS: Uma análise conceitual foi desenvolvida com base nos oito passos propostos por Walker e Avant.
RESULTADOS: Vinte e seis artigos foram incluídos a partir de uma busca em quatro base de dados. Três atributos definidores, nove antecedentes e dois consequentes foram identificados a partir da análise deste conceito.
CONCLUSÕES: A análise conceitual possibilitou a clarificação deste diagnóstico e a proposição de modificações em seus componentes, o que poderá proporcionar uma acurácia diagnóstica.
IMPLICAÇÕES PARA A ENFERMAGEM: A clarificação do diagnóstico possibilitará a identificação precisa deste fenômeno na prática clínica e, consequentemente, intervenções de enfermagem mais adequadas.

Problem Identification

Death and dying are seen in different ways, depending on the historical and cultural context of the individual (Silva, Campos, & Pereira, 2011). In western society, for example, they are seen as taboo and, therefore, tend to generate repression or denial of the daily discussions, as well as distancing these issues in specific environments, such as hospitals, and even preventing the participation of children in farewell ceremonies (Costa & Lima, 2005). The great gift of denial and repression is to allow one to live in a fantasy world where there is an illusion of immortality (Kovács, 2005).

However, denying death is a way of not contacting painful experiences and, subsequently, of preventing the development of coping mechanisms.

When faced with pathological conditions without effective therapeutics and associated with terminality, impending death becomes a relevant aspect to people, that demands a complex coping mechanism, especially if the terminality has been denied and repressed on social living. This phenomenon triggers many human responses, which some unwanted ones can cause psychobiological harm to the individual and family, conceptualized as anxiety or more precisely as death anxiety. This anxiety can improve the perspective on suffering that people, family members, and friends are experiencing in the process of death and dying (Neel, Lo, Rydall, Hales, & Rodin, 2015).

The imminent risk of losing one's life can also serve as a trigger for the occurrence of changes in the meaning of one's existence, such as intensification of beliefs, strengthening of social and relationship bonds, individual growth, and pursuit of an authentic existence (Lehto & Stein, 2009). And these phenomena experienced by patients and their families, especially in health care settings, allowed professions from several areas of knowledge to identify them, developing diagnoses, among which anxiety disorder stands out. In this sense, the phenomenon experienced as an anxiety response related to impending death emerges in the nursing care scenario and requires a conceptual representation that can indicate the concept and conduct relevant professional assessments.

The diagnostic language of NANDA International, Inc. incorporates among its diagnostic concepts the "Death anxiety" (00147) to guide the clinical judgment of the nurse. It is defined as a "vague, uneasy feeling of discomfort or dread generated by perceptions of a real or imagined threat to one's existence." The diagnosis was incorporated into Domain 9: Coping/Stress Tolerance; Class 2: Coping responses; defined as "Process of dealing with environmental stress" (Herdman & Kamitsuru, 2018).

This conceptual core of diagnosis resembles others in the same class, among them: "Fear" (00148) and "Anxiety" (00146), sharing some clinical indicators (defining characteristics and related factors), which has the potential to confuse judgment diagnosis. The ambiguity between diagnoses causes the less accurate selection of nursing interventions, reducing the effectiveness of care and the achievement of results.

From this perspective, a study that applied the Fehring model with 202 Spanish nurses who were expert in end-of-life care to validate the content of the nursing diagnosis "Death Anxiety" (00147) pointed out the need for its exclusion or refinement, due to the interchangeable use of the concepts of "Anxiety" (00146). Also, considers that Death anxiety should reflect the feeling of a threat that is not necessarily taking place, which individuals may experience at particular condition, not only at the end of their lives (Fernández-Donaire, Romero-Sánchez, Paloma-Castro, Boixader-Estévez, & Porcel-Gálvez, 2018).

In fact, on clinical practice, differentiating one diagnosis from another can be an extremely difficult task, especially when the constructs have few or no indicators verifiable by objective measures, as is the case of "Death anxiety" (00147). Given this, it is essential to demonstrate the validity of the relationships between clinical manifestations and nursing diagnoses (Bousso, Poles, & Cruz, 2014).

The methods of concept analysis have been used to find the best conceptual definition with support in clinical manifestations, to the construction or revision of nursing diagnoses. These methods are adopted for the conceptual decomposition and identification of the elements of a concept. For nursing diagnosis, the strategy is widely used and applied as a resource for diagnostic validation, the preliminary phase of validation by experts and clinic (Lopes & Silva, 2016). In the analysis the antecedents, consequents, and critical or essential attributes of the concept are usually identified (Lopes, Silva, & Araújo, 2013).

An article published in 2009 identified defining attributes, antecedents, and consequences of the concept of death anxiety using Rodgers evolutionary method of concept analysis by literature review published between 1980 and 2007 (Lehto & Stein, 2009). However, advances in clinical and theoretical knowledge, changes in the nursing diagnostic components and the relevance of the theme justify further analysis.

Death anxiety is referred to, in this study, as a conceptual core. Possible conceptual confusion about the diagnostic elements tends to remain until an analysis of the concept is performed. Thus, the authors performed a concept analysis as proposed by Walker and Avant (2011). Purposes were to analyze the concept of Death anxiety and to propose modification on composing this "Death anxiety" (00147) NANDA-I nursing diagnosis.

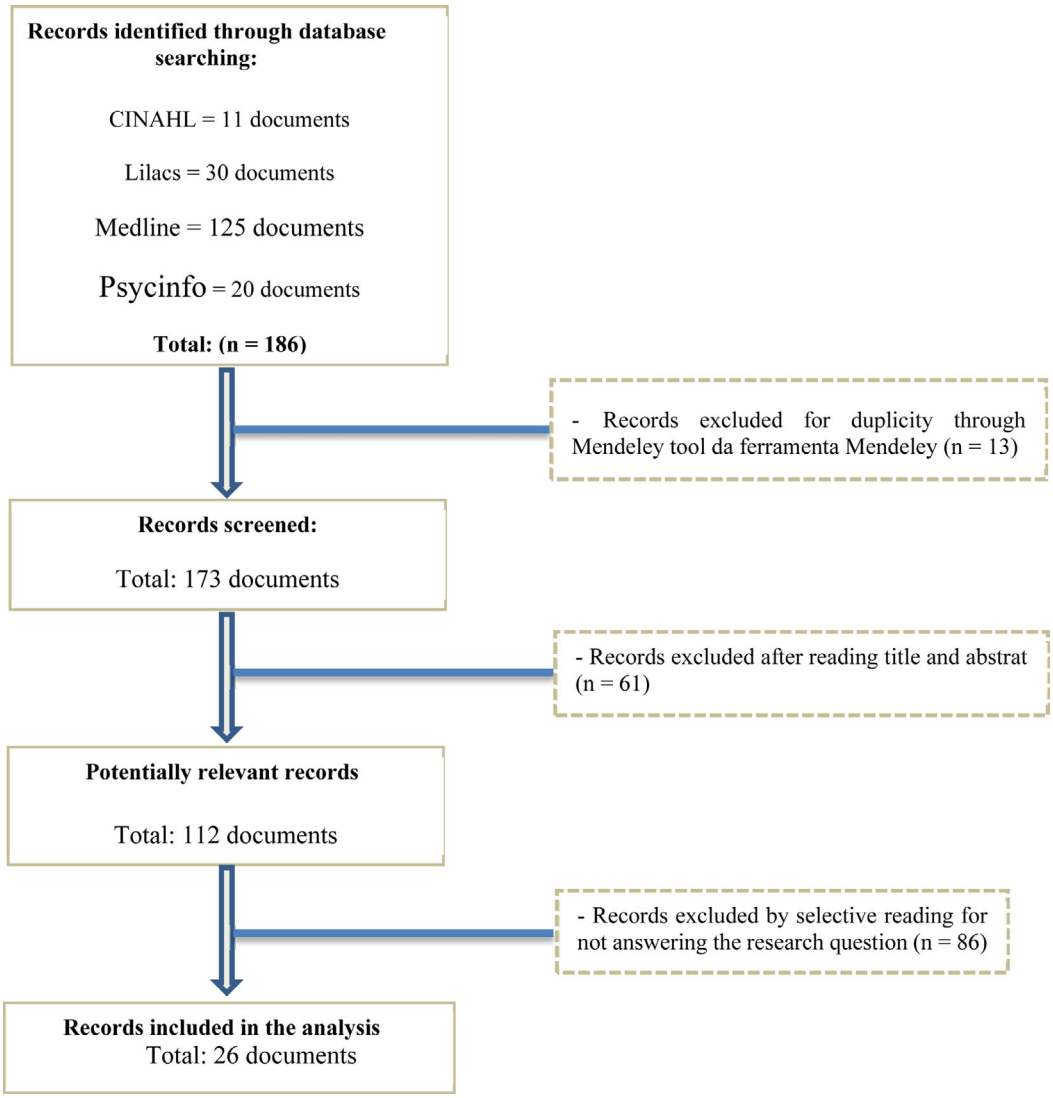
Methods

Concept analysis study adopting the strategy proposed by Walker and Avant was used. The proposal involves eight steps, such as select a concept, determine the aims of the concept analysis, identify possible uses of the concept, determine defining attributes, development of a model case, development of other cases, identify antecedents, and consequences and define empirical referents (Walker & Avant, 2011).

The selection of the concept of "Death anxiety" was based on the following aspects: indissolubility of the concept "Death anxiety", which cannot be divided into "anxiety" and "death"; clinical relevance of concept in the context of professional nursing practice, and absence of analytical studies of the concept. The aim of the analysis was to clarify the nursing diagnosis "Death anxiety" (00147) to provide a more accurate description of the diagnostic components.

Identification of possible uses of the concept was carried out through an integrative review of the literature composed of following six stages identification of the theme and

Figure 1. PRISMA Flow Chart of Studies Identified and Selected for Inclusion in the Integrative Review



Source: the authors

elaboration of the research question; search in the literature of primary studies; extraction of data from studies; evaluation of studies included in the review; analysis and synthesis of the results of the review and presentation of the integrative review (Mendes, Silveira, & Galvão, 2008).

The review question was elaborated using the acronym PICo, where populations were the patients/individuals; phenomenon of interest were antecedents, attributes, and consequences of concept "Death anxiety"; and the context involved all settings of health care. The final question was what are the antecedents, attributes, and consequences of death anxiety in patients/individuals in different health care settings?

The search of the studies was carried out in May and June 2018, through the online access in the following databases: Index to Nursing and Allied Health Literature (CINAHL), Latin American Literature in Health Sciences (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE), and Behavioral Sciences and Mental Health (PSYCINFO).

Search terms used were "signals and symptoms," "anxiety and death," "fear and death," "concepts," "antecedents," and "consequences," combined with Boolean operators AND/OR. Inclusion criteria were qualitative, quantitative, mixed studies, published in Portuguese, English, or Spanish. And exclusion criteria were literature reviews; experience reports; theoretical essays; editorials and letters to the editor.

The process of searching and selecting in the databases was performed by an author, in following five stages: (a) search in databases; (b) removal of duplicates; (c) application of the inclusion and exclusion criteria from reading the titles

and abstracts; (d) reading and selecting the content of the full texts; and (e) reading and analysis of full texts by four researchers. From this process were selected 26 articles, which were analyzed according to PRISMA criteria to evaluate the quality of articles.

An instrument was constructed to extract information from the selected articles such as antecedents, attributes, or consequences of the concept. Four of six researchers performed an independent reading of the selected texts, extracting the elements of the concept. Then, the attributes, antecedents, and consequents of the material identified by each of the analysts were compared for agreement. A given element was considered valid only if at least three of the four analysts agreed. This procedure aimed to increase the reliability of the analysis performed, reducing the bias of individual interpretation. Thus, the analysis of this concept produced nine antecedents, three attributes, and two consequences.

The analysis and synthesis of the results were descriptive, based on descriptive statistics, with the use of absolute and relative frequency. The study findings were analyzed from the content analysis. All documents selected for analysis were published in scientific journals between 1996 and 2018 and met the inclusion criteria.

Results

Initially, 186 articles were identified by the literature review. After applying investigation criteria, there were 26 articles to include in the concept analysis. Picture 1 represents the process of selecting the material.

As for characterizing the 26 selected articles, highlights that there was the predominance of articles published in English (88.5%). Among the nine countries in which the articles were published, the United States of America had 38.5% of the productions, followed by England with 23.0% and Brazil with 7.7%.

In relation to the discipline of the authors of selected articles, highlights the nursing with 42.3% of the publications, followed by psychology (38.5%), medicine (15.4%), and social service (3.8%). Concerning to the specialty area, most publications refer to the Oncology area with 42.3% of the articles, followed by the teaching area with 19.2%, and geriatrics with 7.7%. Regarding the distribution of publication years, the predominance in the period between 2012 and 2015 (38.5%), followed by 2016 and 2018 (26.9%), 2008 and 2011 (19.2%), 2004 and 2007 (11.5%), and 2000 and 2003 (3.8%), but it is worth noting that for the study it was not possible to observe the year 2018 completely, since the research occurred until June 2018.

Attributes, Antecedents, and Consequences of "Death Anxiety"

Consensus of the analysts allowed the study to incorporate nine antecedents, three attributes and two consequences ones. Table 1 shows the elements mentioned in relation to the articles that contained them.

Defining Attributes

Impotence, dysphoria, and fear were the attributes found for the concept of "Death anxiety," of which only dysphoria was not explicitly listed in the last revision of the NANDA International Taxonomy 2018–2020.

The feeling of impotence is common in patients that fight against serious disease, as for example cancer, that is seen as a "death penalty" experience or has a bad medical prognosis. The stigma that involves this pathology makes some people fearful of becoming dependent on their activities, and of not being able to develop self-care during the process of the illness, interfering in the quality of life and death (Tong et al., 2016).

Dysphoria is the characteristic that emphasizes the feelings and unpleasant physical/physiological symptoms experienced by people when they think about death, referring to feelings of being tired, upset, and emotionally isolated. From the analysis of the evidence contained in the reviewed articles, it was found that other terms could be associated with the dysphoria such as anxiety, depression, restlessness and agitation. These terms have been grouped and understood as having similar characteristics, allowing them to be considered as part of the dysphoria process (Cai, Tang, Wu, & Li, 2017; Tomás-Sábado, Fernández-Narváez, Fernández-Donaire, & Aradilla-Herrero, 2007).

Regarding fear, similar characteristics were identified in different types of fears.

Indeed, it seems that the fear of death is a very relevant attribute in death anxiety. For example, fear of pain was prominently mentioned when compared to other types of fear. This highlight can be understood when we go back to the common-sense association between death and pain. Also, the analysis of evidence observed an association of death with physical and psychological pain, which broadens the relevance of the experience of fear of pain (Aydoğan, Gülseren, Sarikaya, & Özen, 2015; Safdar & Rahman, 2016). When compared cancer patients and noncancer participants, the results indicated that cancer patients had a higher level of death anxiety as compared to noncancer. Most prominent types of fear among cancer patients are fear of pain, fear of dependency, and fear of afterlife concerns. Among noncancer participants was fear of finality of death most prominent (Safdar & Rahman, 2016).

The attribute "fear of the dying process"/"fear of death" was the most mentioned in the analyzed studies. The fear of death is a more concrete belief that death is frightening, and is related to the physical awareness of the loss of existence. Biological research has shown that anxiety and fear are separate constructs that arise from separate, but proximal and related anatomical structures, with anxiety associated with septohippocampal system activation and fear related to the activation of the amygdaloid complex (Lehto

Table 1. Elements of the Concept of "Death Anxiety" Identified in the Integrative Review Studies

Element category	Conceptual element	Reviewed studies
Antecedents	Impaired religiousness/spirtuality (n = 15/57.7%)	Adelbratt and Strang (2000), Aquino et al. (2010), Braun, Gordon, and Uziely (2010), Brêtas et al. (2006), Gonen et al. (2012), Neel et al. (2015), Nozari and Dousti (2013), Nyatanga and Vocht (2006), Safdar and Rahman (2016), Shimomai et al. (2018), Soleimani, Lehto, Negarandeh, Bahrami, and Chan (2017), Soleimani et al. (2016), Tomás-Sábado et al. (2007), Tong et al. (2016), Yan and Chen (2009)
	Young age (n = 11/42.3%)	Cai et al. (2017), Lehto and Stein (2009), Mohammadpour et al. (2018), Slaughter and Griffiths (2007), Sherman et al. (2010), Shimomai et al. (2018), Soleimani et al. (2017), Tomer and Eliason (1996), Yang and Chen (2009)
	Previous experiences with death (n = 10/38.5%)	Brady (2015), Brêtas et al. (2006), Juhl and Routledge (2016), Lehto and Stein (2009), Slaughter and Griffiths (2007), Soleimani et al. (2016), Tomás-Sábado et al. (2007), Tomer and Eliason (1996), Tong et al. (2016), Yan and Chen (2009)
	Low self-esteem (n = 7/26.9%)	Azaiza et al. (2010), Juhl and Routledge (2016), Lehto and Stein (2009), Neel et al. (2015), Routledge (2012), Tomer and Eliason (1996), Tong et al. (2016)
	Diagnosis of a disease associated with terminality (n = 7/26.9%)	Lehto and Stein (2009), Safdar and Rahman (2016), Sherman et al. (2010), Soleimani et al. (2017), Tomás-Sábado et al. (2007), Tomer and Eliason (1996), Tong et al. (2016)
	Women (n = 7/26.9%)	Azaiza et al. (2010), Lehto and Stein (2009), Sherman et al. (2010), Shimomai et al. (2018); Soleimani et al. (2016, 2016), Yan and Chen (2009)
	Conscience of death (n = 6/23.1%)	Brady (2015), Braun et al. (2010), Juhl and Routledge (2016), Sherman et al. (2010), Tong et al. (2016), Yan and Chen (2009)
	Loneliness (n = 5/19.2%)	Aquino et al. (2010), Azaiza et al. (2010), Mohammadpour et al. (2018), Shimomai et al. (2018), Safdar and Rahman (2016)
	Physical symptoms of a disease (n = 4/15.4%)	Aquino et al. (2010), Gonen et al. (2012), Neel et al. (2015), Soleimani et al. (2016)
Attributes	Fear (n = 18/69.2%)	
	Fear of pain related to dying (n = 11/42.3)	Adelbratt and Strang (2000), Aydoğan et al. (2015), Aquino et al. (2010), Brêtas et al. (2006), Cai et al. (2017), Mohammadpour et al. (2018), Nyatanga and Vocht (2006), Safdar and Rahman (2016), Sherman et al. (2010), Tong et al. (2016), Tomer and Eliason (1996)
	Fear of the dying process (n = 6/23.0%)	Aydoğan et al. (2015), Braun et al. (2010), Cai et al. (2017), Mohammadpour et al. (2018), Nozari and Dousti (2013), Yang and Chen (2009)
	Fear of suffering related to dying (n = 4/15.4%)	Aquino et al. (2010), Brêtas et al. (2006), Sherman et al. (2010), Tong et al. (2016)
	Fear of loneliness (n = 6/23.0%)	Aquino et al. (2010), Brêtas et al. (2006), Neel et al. (2015), Nyatanga and Vocht (2006), Safdar and Rahman (2016), Sherman et al. (2010)
	Fear of separation from loved ones (n = 6/23.0%)	Adelbratt and Strang (2000), Brêtas et al. (2006), Neel et al. (2015), Safdar and Rahman (2016), Sherman et al. (2010), Tong et al. (2016)
	Fear of the unknown (n = 7/27.0%)	Adelbratt and Strang (2000), Brêtas et al. (2006), Mohammadpour et al. (2018), Safdar and Rahman (2016), Sherman et al. (2010), Yang and Chen (2009)
	Fear of death (n = 10/38.5%)	Aquino et al. (2010), Aydoğan et al. (2015), Azaiza et al. (2010), Braun et al. (2010), Brêtas et al. (2006), Lehto and Stein (2009), Mohammadpour et al. (2018), Nozari and Dousti (2013), Nyatanga and Vocht (2006), Slaughter and Griffiths (2007)
	Fear of premature death (n = 3/11.5%)	Gonen et al. (2012), Sherman et al. (2010), Yang and Chen (2009)
	Dysphoria −anguish, restlessness, and apprehension (n = 5/19.2%)	Adelbratt and Strang (2000), Brêtas et al. (2006), Cai et al. (2017), Lehto and Stein (2009), Mohammadpour et al. (2018)
	Impotence (n = 7/26.9%)	Adelbratt and Strang (2000), Aquino et al. (2010), Brêtas et al. (2006), Safdar and Rahman (2016), Tong et al. (2016), Sherman et al. (2010), Nyatanga and Vocht (2006)
Consequents	Low quality of life (n = 4/15.4%)	
	Adverse psychological consequences (n = 3/15.5%)	Sherman et al. (2010), Soleimani et al. (2016, 2017), Tong et al. (2016)
		Juhl and Routledge (2016), Soleimani et al. (2016), (2017)

& Stein, 2009). "Death anxiety" is a multidimensional construct, and fear of death plays a foundational role in the generation of death anxiety (Cai et al., 2017). Fear of suffering showed a strong connection to change the quality of life and autonomy of patients seriously ill. This feeling was exacerbated with a greater dependency on professional care and with a decrease in the quality of life (Tong et al., 2016). Fear of loneliness and fear of separation from loved ones were attributes found in concept analysis but are not listed in the updated version of NANDA-I 2018–2020 Taxonomy. Such fears are experienced more constantly as the disease progresses (Safdar & Rahman, 2016; Sherman, Norman, & McSherry, 2010).

It has been found that the better the cognitive status and mental health less fear of the dying process, and consequently the lower the "death anxiety." Usually, mentally competent people think have more control over their health and their lives that promotes independent decision making, and, consequently, reduces the anxiety levels. The fear is a condition shared with other people, and not only lived by those with a disease associated with terminality (Aydoğan et al., 2015; Mohammadpour, Sadeghmoghadam, Shareinia, Jahani, & Amiri, 2018). The feelings are susceptible of modification, through information on the progression of the disease, the symptoms and the changes that can be experienced in the process of dying (Brêtas, Oliveira, & Yamaguti, 2006; Sherman et al., 2010). These features illuminate the dynamic and relational face of fear and death anxiety.

Fear of premature death is directly linked to fear of nonfulfillment of life goals. Study on Personal Constructs of death and fear of death among Taiwanese adolescents found that attachment-high emerged as an effective predictor of fear of premature death; that is, those who worried about unfinished business and relatives expressed more fear about dying prematurely (Yang & Chen, 2009). Probably, this perception may have greater relevance among youth and adults given the higher level of plans.

Various types of fear have a negative and significant correlation in quality of life. Conversations about death and dying can create opportunities for health professionals to identify and offer emotional and spiritual support to those who experience them, decreasing the anxiety of death and consequently intervening satisfactorily in quality of life (Brêtas et al., 2006; Nyatanga & Vocht, 2006; Sherman et al., 2010).

Case Study

Constructing cases helps to refine attributes of a particular concept, and consequently, facilitates its understanding. The model case is an example of the concept in which all attributes are present. In this way, it is possible to understand and recognize each attribute empirically. On the contrary, defining attributes of the concept cannot be recognized, presenting the opposite description of the model case. They are clear examples of what is not the concept, so they are useful because it is often easier to say what something is not than what it is (Walker & Avant, 2011). For the concept of "Death anxiety," two cases were constructed.

Model Case

A 42-year-old, divorced female (M.R.S.), is diagnosed with advanced breast cancer, in palliative care, and on condition of expectation of death. She has a 12-year-old son. M.R.S. has experienced some unpleasant symptoms, such as pain, fatigue, anxiety, restlessness, depression, and a sense of existential emptiness. She complains: "*When thinking of death, I usually feel scared*" *and* "*I have often gotten upset and feeling tired.*" M.R.S refers "*I fear the pain will progress with suffering, and it will separate me from my son and family leaving us lonely. My son does not accept the possibility of my death.*" She claims to fear of becoming dependent on others and unable to make their own decisions, viewing the present as stressful and future events as uncertain occurrences.

Contrary Case

A 68-year-old, married female (J.S.A), Roman Catholic, mother of two children. She has advanced rectal cancer, and is in palliative care. She performs all daily life activities. She participates in religious activities and frequent meetings with friends and family. She refers: "*No one knows what is in death, do you? I even think I'm close to finding out. But, I'm convinced that when I die, I will go to heaven and meet God, it calms me*."

Antecedents

Death awareness was identified as an antecedent that is affected by the personal ability to reflect on their finitude. Further, conscious death anxiety leads to active defenses, for example, such as distraction that deals with the threatening material, serving to lower conscious death anxiety. However, this conscious property does little to manage unconscious death anxiety. Death anxiety is largely denied or repressed by an adaptive human resource that reduces the possibility of paralyzing fear and terror. Studies that have manipulated death awareness have provoked heightened death anxiety in subjects (Lehto & Stein, 2009; Routledge, 2012). Previous negative background or experience with the death or loss of close people raises the reflection about the end of life that becomes a problem when they convert in repetitive thoughts.

Age is also a variable that interferes on the Death anxiety level. Studies indicate that it is inversely proportional to death anxiety in people who experience an advanced disease process (Cai et al., 2017; Neel et al., 2015; Sherman et al., 2010; Soleimani, Lehto, Negarandeh, Bahrami, & Nia, 2016). That is, the higher the age, the lower the level of

anxiety experienced in relation to death, and the higher the understanding of the final stage of life (Slaughter & Griffiths, 2007).

On the other hand, high self-esteem is considered a protective factor for "Death anxiety," which can lessen the effects of saliency and awareness of death. When self-esteem is threatened, people become vulnerable to fear of death; on the contrary, when it is elevated it attenuates states of anxiety (Neel et al., 2015; Routledge, 2012).

Regarding sex, it was observed that women presented higher "Death anxiety" and lower quality of life when compared to men. They have a more negative emotional state, experiencing (or presenting) more often depression and frustration when discussing the subject, being more resistant to accepting death and loss, which generates low acceptance of death (Yang & Chen, 2009). These findings may reflect some extent cultural norms that encourage women to express emotions such as fear and, discourage men from doing so. However, there may be characteristics in the sociocultural context of the men and women who contributed to these differences (Azaiza, Ron, Shoham, & Gigini, 2010).

Similarly, the onset of symptoms from a disease, such as pain, nausea, sleep disturbances, fatigue, changes in physical appearance, directly contributes to the emergence of anxiety. After the diagnosis of some diseases associated with terminality, such as cancer, perceptions about future uncertainty increase and aggravate suffering. As the symptoms appear and become accentuated there is an increase in suffering and anxiety, with concerns about death (Neel et al., 2015).

It was found that high levels of religiosity are associated with low levels of "Death anxiety" and prayer activities contribute to this correlation, that is, people involved in religious activities have low levels of anxiety. Therefore, this activity is considered a significant predictor for the reduction of this disease, as well as improvement of the quality of life (Safdar & Rahman, 2016; Soleimani et al., 2016; Yang & Chen, 2009).

The analysis and codification of the antecedents of the revised articles indicate that most of the authors used the concepts of religiosity and spirituality interchangeably in their studies. Following this trend, the concepts were grouped. However, these are different concepts. Religiosity concerns the beliefs and dogmas of a particular religion, while spirituality is broader and related to the existential process of life in another dimension (Arrieira et al., 2018).

Over time, in many cultures, the end of life has ceased to occur in a familiar environment and has converted to an institutionalized process. This process causes patients a feeling of loneliness due to the restrictions of contact with the people of the community, and the stay in an unknown place during the period of hospitalization becomes stressful or discouraging. Loneliness may also be related to how the person assigns life meaning, the feeling of loneliness has been shown as a factor that increases "Death anxiety" (Aquino et al., 2010).

Consequences

In this study, the following were presented in two main categories: low quality of life (Soleimani et al., 2016) and adverse psychological consequences for individuals (Juhl & Routledge, 2016). The quality of life is an abstract and multidimensional concept causing controversy that recommends a conceptual definition proposition. Depending on the approach and conceptualization, the quality of life can be evaluated through economic, demographic, political and health determinants, collectively or individually.

Adverse psychological consequences related to death are evidenced by the adoption of a defensive worldview, difficulty in establishing bonds, especially, by the fear of the loss of loved ones. The person living with fear and the feeling of existential emptiness has a greater tendency to depressive events and social isolation.

Consequences are useful to new research directions and to find insights on neglected ideas (Walker & Avant, 2018). From the knowledge of these consequences, nursing care can be understood as an important factor to reach a positive or negative outcome. When the person has support in coping with death, he/she becomes capable of possessing a better quality of life and greater acceptance of death. Thus, the comparison of the health-related quality of life in relation to the presence of anxious and/or depressive symptoms is an important issue to evaluate the impact of the disease and the treatment in the living conditions and, thus, direct the care to these patients, contributing to the improvement of the quality of life (Ottaviani et al., 2016).

Empirical Referents

In the literature, there are several instruments used to measure the phenomenon represented by the concept of "Death anxiety." The Death Anxiety Scale (DAS) is used to measure the death anxiety level (Templer, 1970). The Death and Dying Distress Scale is a DAS adapted for use in patients with advanced cancer (Krause, Rydall, Hales, Rodin, & Lo, 2015); and The Collett-Lester fear of death scale evaluates the process of dying and personal death, and also the process of dying of others (Lester, 1990). Empirical referents are presented in these instruments as statements or descriptions acting as operational definitions related to the concept. Operational definitions are useful for specifying defining characteristics in the use of nursing diagnosis in clinical practice. In death anxiety, the attributes are usually abstract, so, empirical referents are useful for assessment and accurate diagnosis judgment.

Synthesis of Findings

Through the concept analysis, it was possible to propose a new definition for the nursing diagnosis "Death anxiety" (00147), that proposes to replace the term "feeling"

expressed in the current definition of "vague and uncomfortable feeling of discomfort or dread generated by the perception of a real or imagined threat to one's existence" by the term "emotional reaction" (Herdman & Kamitsuru, 2018). The proposed change takes into account the fact that an emotion represents a complex reaction pattern involving experimental, behavioral, and physiological elements by which an individual attempt to deal with a personally significant subject or event, and a feeling is the unfolding of emotions (Vandenbos, 2010). Also, the term "reaction" is compatible with the semantics of nursing diagnosis as a judgment on human responses (Herdman & Kamitsuru, 2018). The new definition would be "emotional reaction provoked by anticipation of death generated by perceptions of a real or imaginary threat to existence of one´s own or of people close to them."

Also, considering the new definition, this phenomenon can be experienced both by those who have a disease associated with terminality and by those who share this circumstance of the process of dying, as close people, members of the cycle of friendship, family, or care. This allows us to include in the definition of nursing diagnosis a broader human response that involves the family or community beyond the individual.

It was possible to verify the existence of some attributes that are strongly associated with the concept, and that help in the accurate identification of the diagnosis. These attributes are not discriminated in the classification of NANDA-I and can be included as defining characteristics, being: dysphoria (restlessness, anguish, and apprehension), fear of loneliness, fear of separation from loved ones, fear of the unknown (fear of afterlife concerns and others future issues), and fear of death (self and others).

Likewise, we propose the inclusion of new related factors such as low self-esteem, unpleasant physical symptoms of a disease, and loneliness. Replacing "the perceived imminence of death" by the "death awareness"; "uncertainty about encountering a higher power," "uncertainty about the existence of a higher power," and "uncertainty about life after death" changed to "impaired religiousness/spirituality."

Regarding at-risk populations is suggested the inclusion of populations with "previous experiences with death," "young age," and "women." And finally, in the associated condition is proposed replacing "terminal illness" by "diagnosis of a disease associated with terminality."

Finally, in the Brazilian version of the NANDA-I Taxonomy, the nursing diagnosis appears as "*Ansiedade relacionada à morte*" (something like anxiety related to death). Some confusion has occurred between the name of the diagnosis and the Problem-etiology-symptom (PES) method for writing a diagnostic statement, where "death" is misunderstood as a related factor of anxiety. The term death anxiety has several translations in Portuguese as "*ansiedade frente à morte*" (Sanches & Carvalho, 2009), "*ansiedade diante da morte*" (Venegas, Alvarado, & Barriga, 2011), "*ansiedade face à morte*" (Barros, Humerez, Fakih, & Michel, 2003) "*ansiedade da morte*" (Camarneiro & Gomes, 2015). This aspect must be carefully considered in research on the concept of death anxiety in Portuguese-speaking countries.

Table 2. Proposal to Reformulate the Nursing Diagnosis of "Death Anxiety" (00147)

Domain	Domain 9—Stress coping/tolerance
Title	Death anxiety
Definition	Emotional reaction provoked by anticipation of death generated by perceptions of a real or imaginary threat to existence of one's own or of people close to them
Defining characteristics	Dysphoria (anguish, apprehension, and restlessness)*
	Fear of pain related to dying
	Fear of the dying process
	Fear of suffering related to dying
	Fear of loneliness*
	Fear of separation from loved ones*
	Fear of the unknown (fear of afterlife concerns and others future issues)*
	Fear of death (self and others)*
	Fear of premature death
	Fear of developing terminal illness
	Fear of loss of mental abilities when dying
	Fear of prolonged dying process
	Negative thoughts related to death and dying
	Concern about strain on the caregiver
	Worried about the impact of one's death on significant other
	Feeling of impotence
	Deep sadness
Related factors	Anticipation of adverse consequences of anesthesia
	Anticipation of suffering
	Anticipation of impact of death on others
	Low self-esteem*
	Death awareness**
	Discussions on the topic of death
	Uncertainty of prognosis
	Nonacceptance of own mortality
	Impaired religiousness/spirituality**
	Unpleasant physical/physiological symptoms of a disease*
	Loneliness*
	Observations related to death
At risk populations	Near-death experience
	Experiencing dying process
	Previous experiences with death*
	Young age*
	Women*
	Observations related to dying process
Associated condition	Diagnosis of a disease associated with terminality**

*Inclusion of a term.
**Replacement of a term.

Table 2 summarizes the content proposal for the nursing diagnosis, based on the concept analysis performed.

Limitations of the Study

The first limitation of the study may be related to culture. Due to the selection of texts in English and Portuguese,

other culturally sensitive publications may have been left out. Western and Eastern cultures differ in their conception of death and transcendence issues that can modify the human response of anxiety.

The second limitation refers to the age of the person experiencing the nursing diagnosis. None of the articles included a pediatric population, which should be taken into consideration when applying the results of this study. The different stages of childhood imply different conceptual development, which should be considered by the diagnostician in his/her judgment about death anxiety.

Both limitations, together with the conceptual nature of the study, point to the need for clinical studies to advance the development of the nursing diagnosis of death anxiety.

Conclusions

Death anxiety is a concept representative of a phenomenon often experienced by patients in different health contexts, requiring a clear conceptual understanding and clarification. This study proposes a new definition for the NANDA-I nursing diagnosis "Death anxiety" (00147) and the inclusion and revision of elements, which can improve the nurses' understanding of this phenomenon and conceptualization, and consequently help in the planning and implementation of more appropriate interventions.

The Conceptual analysis identified that "Death anxiety" is a subjective and multidimensional concept, with a high level of abstraction, conforming itself in an emotional reaction. Defining attributes were impotence, dysphoria, and fear. Antecedents and consequents were highlighted with clinical evidence that contributed to the conceptual development.

Relevance of this study lies in the clarification of the concept and nursing diagnosis terminology. It is believed that this study will help the nurses on an understanding of the phenomenon, increasing precision and identification of cases, contributing to the adoption of more effective nursing interventions and outcomes. Consequently, it cooperates with integral and quality nursing care.

Implications for Nursing Knowledge and Language Development

Considering that the NANDA International diagnostic language is constantly improving, the conceptual analysis can contribute to raising the current level of evidence of this nursing diagnosis, currently in 2.1, according to the level of evidence criteria of the NANDA-I Education and Research Committee. It has the potential to collaborate for the advancement of nursing knowledge and the development of diagnostic language with implications on the accuracy of the diagnosis. It clarifies ambiguities, being able to assure the use of nursing diagnoses and provide an effective care plan.

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