


# Death Acceptance Process in Thai Buddhist Patients With Life-Limiting Cancer: A Grounded Theory

Global Qualitative Nursing Research  
Volume 9: 1–10  
© The Author(s) 2022  
Article reuse guidelines:  
sagepub.com/journals-permissions  
DOI: 10.1177/23333936221111809  
journals.sagepub.com/home/gqn  


Ratchaneekorn Upasen<sup>1</sup>, Sureeporn Thanasilp<sup>1</sup> ,  
Lanchasak Akkayagorn<sup>1,2</sup>, Janya Chimluang<sup>1</sup> , Wilailuck Tantitrakul<sup>3</sup>,  
Dawn Liam Doutrich<sup>4</sup>, and Weeraphol Saengpanya<sup>1</sup>

## Abstract

Cancer patients with life-limiting illnesses have varied levels of death acceptance pervarious scales. Nevertheless, the process of developing death acceptance in patients with life-limiting cancer remains unclear. This study explores the death acceptance process among patients with life-limiting cancer. We used grounded theory methodology. Data were collected through in-depth interviews of 13 patients with cancer in a palliative care setting, and researchers completed field notes. Data were analyzed using constant and comparative methods. Thai Buddhist patients with cancer in palliative care process death acceptance through three dynamic phases: engaging suffering, being open-minded about death, and adhering to Buddhist practices for increasing death consciousness. The death acceptance process described in this study could serve as a guideline to support death acceptance in Thai Buddhist patients with cancer, and other patients with cancer in palliative care, to improve peaceful life and attain good death.

## Keywords

death acceptance, cancer, palliative care, grounded theory, Thailand

Received November 6, 2021; revised June 15, 2022; accepted June 20, 2022

Despite being recognized by all, discussion of death remains taboo, especially among people suffering from a serious illness and those close to dying (Upasen & Thanasilp, 2020; Wysokinski et al., 2019). People confront or avoid confronting death using different strategies. In fact, most people cannot initially accept their own death. They may try to deny death and bargain for longer life, citing familial responsibilities and the inability to leave their family as key reasons. Many fear death because they have regrets (Kuppako, 2017). All these feelings can cause people to feel helpless, abandoned, insecure, and distressed at times. For some, fear of death can cause anxiety and physical discomfort (Filippo, 2006). Overall, fear of death affects people physically, mentally, and socially (Charuchinda, 2018).

In addition to physical and emotional distress related to a cancer diagnosis, patients with life-limiting cancer begin to acknowledge their impending death. Thus, these patients may be stressed, experience anxiety and fear of death, lack motivation to combat the illness, be uncertain about their future, and have low spiritual well-being (Ferrell et al., 1998). Nevertheless, some patients with cancer in palliative care have high levels of death acceptance and accept death as

a normal and natural process of life (Huang et al., 2018; Long et al., 2018; McLeod-Sordjan, 2014; Philipp et al., 2019; Upasen & Thanasilp, 2020). These patients, mainly Buddhist patients who adhere to the Buddha's teachings about death, believe that death is a part of *Aniccata* or "impermanence" and death accompanies us with each breath (Wachiramaetee, 2019). Thus, Buddhist patients' beliefs may underpin their death acceptance and influence its process.

Inpatients with life-limiting cancer, death acceptance denotes the expression of physical, verbal, and psychological experiences that are understood and accepted by the person who is to die (Akkayagorn, 2018). During life, everyone

<sup>1</sup>Chulalongkorn University, Bangkok, Thailand

<sup>2</sup>King Chulalongkorn Memorial Hospital, Bangkok, Thailand

<sup>3</sup>Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer at Sakonnakhon, Khampramong Temple, Thailand

<sup>4</sup>Washington State University, Vancouver, USA

## Corresponding Author:

Sureeporn Thanasilp, Faculty of Nursing, Chulalongkorn University, Boromarajonani Srisatapat Building, Floor 11, Pathumwan, Bangkok 10330, Thailand.

Emails: s\_thanasilp@hotmail.com, sureeporn.t@chula.ac.th



experiences suffering caused by, for example, separation from who and what we love, what we have, and who and what we are; those who are more accepting of their deaths have come to terms with these losses.

Death acceptance is a process. People have different experiences, beliefs, and perceptions that could lead to different ideas about death acceptance and; thus, create differences in the process of death acceptance. For example, the trajectory for people who believe that death is a natural part of life and can occur at any time is noticeably different from those believing it is not their time to die or those who are motivated to fight for extra time. In addition, cultures, beliefs, and life experience can influence how people think about death and death acceptance (Connelly, 2003).

To date, quantitative studies about death acceptance have focused on measuring death acceptance and factors influencing it (Huang et al., 2018; Krapo et al., 2018; McLeod-Sordjan, 2014; Thanasilp et al., 2020). Previous qualitative studies focused extensively on elucidating the manifestation/characteristics of death acceptance among patients with cancer or other terminal illnesses (Khaw et al., 2020; Long et al., 2018; Upasen & Thanasilp, 2020). For example, in their study of Thai Buddhist older adults with advanced chronic organ failure, Khaw et al. (2020) reported four attributes of death acceptance: (i) understanding that death is a natural part of life; (ii) accepting that death will come 1 day; (iii) having no fear of death; and (iv) letting go of life and the earthly existence.

Although qualitative studies furthered understanding of how death acceptance of patients is characterized, little is known about the death acceptance process in patients with life-limiting cancer. A qualitative study in the Philippines used a grounded theory approach to examine the death experience, death consciousness, and acceptance toward death in an individual's lifetime among five older adults (Mamuang, 2019). The findings revealed that death consciousness influenced death acceptance, death acceptance led to death preparation, and spirituality was an essential element in the death experience, death consciousness, death acceptance, and death preparedness (Mamuang, 2019). However, this study did not explain participants' activities for accepting their deaths. In addition, the study sample were not experiencing life-limiting cancer and were not Buddhist, both which could affect the death acceptance process and, thus, somewhat different from the aim of our research.

Kübler-Ross (1969) described processes associated with death, delineating five stages of grief, namely, denial, anger, bargaining, depression, and acceptance. In later years, however, her model of the stages of grief has been contested. Corr (2019), as well as Stroebe et al. (2017), offered critique and cautions against adopting Kübler-Ross's stage model in current palliative care and palliative treatment. Nevertheless, her work heralded a change in palliative care, especially in some Western countries where disclosure and communication about patient and family wishes at the end of life increasingly became the norm. Our grounded theory study is not

based on her work but focuses on the experience and processes of death acceptance of Thai Buddhist patients with cancer approaching death.

Although a Buddhist Death Acceptance Scale (BDAS) development study (Thanasilp et al., 2020) provided a psychometrically sound measurement of death acceptance for Thai Buddhist patients with cancer, no study describes the death acceptance process, especially among patients with cancer in palliative care. Reportedly, an awareness that one is dying correlates with death acceptance, indicating that open communication about the end of life among patients, caregivers, and healthcare providers contributes to the quality of the dying process (Lokker et al., 2012).

In addition, Meier et al. (2016) reported that acceptance of impending death is a component of life completion, which is a crucial part of the good death process. Other studies indicate that understanding the death acceptance process could facilitate psychological, spiritual gratification, and peaceful death (Khaw et al., 2020; Zimmermann, 2012). Hence, understanding the death acceptance process of patients with cancer in palliative care is crucial, which will provide the necessary knowledge for caring for those patients to support them having a peaceful life and assist them to face death serenely.

People who accept their own death could have time to prepare themselves before dying and use what time they have left happily, with family. Healthcare professionals, including educators and psychologists, look for strategies to support patients in palliative care in accepting their impending death. Hence, this study aims to investigate the death acceptance process among Thai Buddhist patients with cancer in palliative care to develop a theoretical description of the death acceptance phenomena in this population.

## Methods

### Study Design

This research was guided by Corbin and Strauss' (2015) interpretive grounded theory methods. This approach supported our aim of developing substantive knowledge regarding the process by which patients with life-limiting cancer accept their own deaths. Further, this approach to grounded theory recognizes that researchers' deep knowledge of the phenomenon, such as that of the researchers involved in this study, can strengthen the research.

### Study Sites and Participants

The research was conducted at the Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer (HETTCM), a Thai Buddhist Temple located in Northeast Thailand, which provides residential holistic interventions and hospice care, especially alternative and complementary therapies, for patients with cancer and their families. Since 2004, over 6,200 patients with cancer have been cared for at the HETTCM.

Patients with stage III or IV cancer, who were treated for various durations at the HETTCM, were our potential participants. We contacted the nursing gatekeeper, an advanced practice nurse, master's prepared nurse, who introduced us to potential participants and facilitated recruitment. Purposive and theoretical sampling were used for the recruitment of participants. The potential participants were asked to complete the Buddhist death acceptance scale (BDAS) to evaluate their death acceptance levels (Thanasilp et al., 2020). It was recently developed to measure death acceptance among Thai Buddhist patients with life-limiting cancer. It is a self-reported questionnaire containing 13 items covering two dimensions: "acceptance of the natural process of death" (9 items), and "preparing for death" (4 items); this questionnaire has a 4-choice rating scale, scoring each item from 1 to 4 (strongly untrue=1, untrue=2, true=3, and strongly true=4). The mean score was calculated for the scale. The scale score was interpreted as the level of death acceptance (low level=1.00–2.00, moderate level=2.01–3.00, and high level=3.01–4.00; Thanasilp et al., 2020). All potential participants scored at a high level on the Buddhist Death Acceptance Scale.

The initial inclusion criteria were as follows: (i) patients with cancer who resided at the HETTCM or were outpatients; (ii) patients diagnosed with stage III or IV cancer; (iii) patients with a high Buddhist Death Acceptance Scale (BDAS) death acceptance score (3.01–4.00); (iv) patients able to communicate in the Thai language and willing to participate in the study; and (v) practicing Thai Buddhists.

The exclusion criteria were as follows: (i) having excessive pain; (ii) having severe fatigue; and (iii) other severe symptoms that would make the interview burdensome for patients.

After obtaining the consent for the digital recording of the interview, we booked an appointment with each participant. We used a theoretical sampling approach to enroll participants. Glaser and Strauss (1967) defined theoretical sampling as "the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his [sic] data and decides what data to collect next and where to find them" (p. 45). After interviewing participants, the researchers coded the data, analyzed it to identify tentative categories and relationships between the categories, and subsequently continued data collection informed by the ongoing analysis. Later, the theoretical sampling method was used to recruit the next participant until the data were saturated. A total of 13 participants (9 female and 4 male) were enrolled in this study. No participants were excluded from the study, and none chose to leave.

### *Data Collection*

Data were collected through extensive interviews in a private place selected by participants or by telephone for patients discharged to home or outpatients. The data were collected between October 2020 and February 2021. Each interview

lasted for about 30 to 45 minutes. The interviews were tape-recorded. Upasen and Akkayagorn experienced in in-depth interviewing in qualitative research, interviewed participants. Tantitrakul also conducted each interview. Before the interviews, the interviewers discussed their ideas and previous experiences, informing how they planned to examine the participants' death acceptance process. During each interview, the researchers primarily used layperson's language, empathic expression, and open-ended questions to build rapport and trust and provide space for patients to share their experiences with the death acceptance process. The initial major questions were: "How do you feel about what's going on with your health condition?" "Was there anything that happened that made you concerned when talking about your illness?" "Some people try to deal with loss or change in different ways. How do you deal with it?" "Could you tell me any examples related to how your death acceptance occurred?" and "Can you talk in detail?" These questions helped participants feel free to answer and provide as many details as possible. Moreover, field notes regarding participants' behaviors observed during the interview, such as facial expressions, tone of voice, and posture, were coded.

### *Data Analysis*

Data collection and analysis were performed simultaneously. Each case was analyzed to identify tentative core concepts or categories to recruit the next participant. This obtained data guided the researchers regarding what should be collected next (what questions to ask) and where to find the following participants.

We used the constant comparative method and axial coding (Corbin & Strauss, 2015; Glaser & Strauss, 1967). The data analysis process started immediately after the first interview was transcribed verbatim, and data collection continued until no new information about the emerging theory was elicited. In addition, the data analysis process started with each of the researchers individually and independently reading the entire transcription multiple times and then diving in with line-by-line labels to mark the data with substantive codes reflecting participants' experience that contributed to their death acceptance. Then, category development was discussed, and relationships between the categories were coded. Some data were reanalyzed until consensus was reached on the major categories, their properties, and the process of death acceptance.

Of note, most researchers are Thai practicing Buddhists who have worked as physicians or nurses in palliative care; thus, there was an awareness of the potential for bias. Several members of our research team had witnessed patients who accepted their deaths move to closer relationships with family/finishing unfinished business, forgiving each other and toward a calmer acceptance of the inevitable. Owing to this potential for bias, non-Thai researchers and those not practicing Buddhists were crucial to challenge the analysis to avoid

a “group think” situation. The understanding arising from the researchers’ experience allowed for a deep engagement with participants and sensitivity to the topic, and the diversity of perspectives among them resulted in richer data and more rigorous analysis. When the substantive codes proliferated, they were compared, and linked codes were grouped into categories. Then, the researchers examined the properties of the categories. For example, the category of “Engaging suffering” contained four properties: acknowledging their illness as cancer; learning how to deal with the crisis of illness; realizing my own and other people’s affliction; and accepting cancer as a part of life. Later, some categories were subsumed within other categories, and emerging categories and properties were linked with theoretical codes. We used Glaser’s 6Cs framework during theoretical code linking, including applying cause, context, contingency, consequence, covariance, and condition, to create and elucidate the connections between each category (Glaser, 1978). In addition, we developed a fundamental social process as the death acceptance process from theoretical codes to explain how participants’ death acceptance occurred. At each step of the analysis, the researchers’ thoughts, suggested questions or ideas, codes, categories, hypotheses, and ideas about relationships among categories were written down in the form of memos, which were not only crucial in the data collection and analysis but also the formation of the final draft of this study.

Corbin and Strauss (2015) suggest that study rigor is supported with multiple perspectives confirming the data and a theory that makes sense and hangs together, especially among those who share participants’ experiences. Furthermore, the rigor was enhanced by selecting participants with high death acceptance levels who could reflect on their experiences. The credibility of this study is supported by the vividness, faithfulness, and detail included in the thick descriptions of the death acceptance process. We also engaged in peer debriefing by sharing the analysis with the entire research team for validation and confirmation. Finally, the research team’s experience and diversity is a factor supporting interpretations of the data that led to these study findings.

### Ethics

The Ethics Committee at the Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer in Thailand (Approved No. 001/2020) approved this study. The purpose of the study, research procedure, risks and benefits, right to decline participation or later withdraw from the study, data confidentiality, and name and address of the research contact person were explained to each potential participant before signing the consent forms. Consent was conceptualized for this study as an ongoing process, and participants were assured that they could stop at any time and that they could also withdraw their data at any time without any consequence.

## Results

The death acceptance process explained in this study is a fundamental social process in which patients with life-limiting cancer accept their own deaths through three phases: engaging suffering, being open-minded about death, and adhering to Buddhist practice for increasing death consciousness. Of note, these phases were nonlinear and did not occur step-wise but were circular, dynamic, and iterative.

### Engaging Suffering

Engaging suffering was often an initial phase of the death acceptance process among patients with life-limiting cancer. Among participants, suffering occurred from various aspects from their illness, daily living, and other social aspects. Most participants described that suffering as related to one or more off our experiences: acknowledging their illness as cancer, learning how to manage the crisis of illness, realizing self/other people’s affliction, and accepting cancer as a part of life.

*Acknowledging their illness as cancer.* Acknowledging their illness as cancer appeared to be a necessary step in motivated participants to engage in their suffering. Most patients were aware of their current symptoms and understood that cancer can be a severe disease and one that often leads to death. However, upon being informed of their cancer diagnosis, their first response was to question the diagnosis. They wondered if they really had cancer. For some, it was only after seeking confirmation through a second opinion that they accepted they had cancer. One of the participants stated:

In the beginning, I felt a little bit bad. I asked myself why I was diagnosed cancer. I did not have shock, but I went to another hospital to check out the size of the malignancy. I had cancer. I received medication for the cancer and after seeing the CT scan, I felt a bit of dread about pain. (Case 3, female, aged 52 years)

Another participant also shared that being diagnosed as cancer can be an acceptable thing.

When I knew that I was diagnosed as cancer, I didn’t understand why I had cancer. I did something wrong. Now, I understand no matter what disease, it could make us to be painful or death. Nobody could avoid the painful when being with the illness. (Case 7, female, aged 54 years)

*Learning to manage the crisis of illness.* After acknowledging their illness as cancer, participants started living with it in various ways. At this point, they faced cancer fully, as the symptoms occasionally lessened until a crisis phase. In this study, the participants discussed how they had to face severe symptoms, including severe pain. In addition, they discussed and shared experiences about times when they did not accept their death and experienced death fear. They felt immense suffering and were very sad. Despite using various strategies to reduce pain, they felt distressed and deemed almost unable



to live with the suffering. Moreover, the participants perceived that they were coming close to dying. One of the participants stated:

It's very painful. Sometimes, I could not sleep. It was torture when I had pain. I have no patience to bear it. The pain was relentless. I cried and couldn't rest. But then I accepted the pain. I used ways to distract myself from the pain, such as singing a song. (Case 7, female, aged 54 years).

Another participant shared an experience when facing a crisis phase in his cancer. When he was diagnosed with cancer, he could accept everything that happened because he did not fear death. This was a common idea with other participants as well. Although the participants experienced severe pain multiple times, they talked about how they would pay homage to the holy thing (the Buddha) and think of their family's needs. Nevertheless, managing the crisis phase affected participants, and they learned to accept their suffering in the meanwhile. They knew and understood their physical limitations, but they still wished to do good things for their family and other people. One participant stated:

I raise my hands to pay respect over my head at that time because I had severe pain, I said please let me die. Don't be torturing me. I asked for death. Now, sometimes, I had the feeling that if I must die, I would die. If my family wanted me to survive, I want to live with value. Now, I could not do anything. My body is worn out. (Case 6, male, aged 50 years).

*Realizing my own and other people's affliction.* After participants experienced crisis phases of their illness, most shared that they started having more recognition that suffering or problems could happen in all situations, in particular, suffering that occurred from cancer, such as being in pain. These symptom experiences prompted participants to gain a better understanding of their symptoms by monitoring them and how often they occurred each day. One of the participants stated:

Sometimes, it was painful. Sometimes, it made me lose consciousness. When I had pain, I had poor work function and stress. There would be pain, and I would let it be, I accepted it. Now, it occurs often times. In the past, it only occurred once in a while. (Case 11, female, aged 63 years)

While describing an awareness of his own affliction, another participant stated:

In the past, I knew that my right ear cannot hear any sound, I thought that I had some water inside the ear. Besides that, I could not speak clearly. Sometimes I have pain and sometimes I don't have any pain. Now I do not have any symptoms. I can live carefully. It is very much better. (Case 6, male, aged 50 years).

Moreover, some participants understood self-distress caused by cancer. In fact, some participants also shared how they

saw other patients with cancer distress. Thus, they developed more understanding and awareness about their own suffering and others' suffering. One of the participants stated:

I knew that some patients had more distress than us. I had distress as well when I could not walk. The cancer had spread into bone. I could not walk. Then, I used a wheelchair. Now I can walk. (Case 2, female, aged 50 years)

*Accepting the cancer as a part of life.* Our participants accepted their cancer, even though at the beginning of the illness, they felt sad, hopeless, and lacked motivation for daily living. Later, they had the opportunity to consult other patients with cancer and understand that others were also diagnosed with cancer. Eventually, they developed more acceptance of cancer and realized that they were not the only person suffering but that it is a universal situation. The following comment demonstrates this point:

Cancer is with us all the time. We could control it. It was not cured until it disappeared. But I didn't have pain. Some patients might have pain, but now I did not have any pain. If I had an appointment with the doctor, I went to see the doctor. It's a way to control the cancer. (Case 1, female, aged 69 years)

In addition, the participants thought that having an illness is a natural part of life. They realized that they could not withdraw or avoid illness. Besides, they had positive thinking about their cancer. They shared how cancer motivated them to have time for living with their families and how they had opportunities to prepare themselves before dying. In short, they accepted and learned to live with their cancer. One of the participants stated:

I felt that cancer has advantages for us as well. It made me think many things. It made me take time for living with my family. Being diagnosed with cancer, it was not so bad. When I had accepted it and lived along with the cancer, I realized I must live with the cancer. I also had an understanding about it and accepted living with the cancer. (Case 7, female, aged 54 years)

### *Being Open-Minded About Death*

Along with engaging their illness, participants used an approach of being open-minded about death. Being open-minded about death denotes being willing to listen to, and consider suggestions about death. Again, it is crucial to recall that these phases and the subcategories of each phase are not discreet but overlap and are nonlinear but dynamic, circular, and iterative. We found two subcategories of this phase: paying attention to death, and death awareness and understanding death as a standard or ordinary thing.

*Paying attention to death.* Paying attention to death is one strategy that supported participants in becoming open-minded about death. The participants discussed how they

paid more attention to death when they had cancer. They had conversations about death and dying with other people. Moreover, they had listened and were taught about death and dying at the Buddhist Temple hospice whose abbot leader is a palliative care expert, known as Luang Ta. In the unique setting of the Buddhist Temple hospice (HETTCM), they practiced or rehearsed the dying process, such as sleeping like a person who died and thinking how that felt. All these practices drew participants' attention to learn and, eventually, accept death. One of the participants stated:

Luang Ta talked and taught me about death. Besides, Luang Ta told me to lay down like a person who died for nine minutes. When we die, we will be like this. People who died are like this. The first time, I felt fear. When I had more practice, I could do that without being afraid. (Case 2, female, aged 50 years)

Another participant mentioned that they received some books about dharma (Buddha's teachings) from Luang Ta, particularly texts of death and dying. Furthermore, the participant stated that it was a strategy to think and accept their own death.

I was reading some books about dharma that I received from Luang Ta. I liked to read about the Buddha's teaching about dying. I also considered and thought carefully about death. In the past, I liked to listen to Buddha's teachings about death. However, death was not close to me. Now, I listened and also considered deeply. It made me to be conscious and accept death. (Case 7, female, aged 54 years).

**Death awareness and understanding death as an ordinary thing.** Death awareness and understanding death as an ordinary thing inspired participant to be more open-minded toward death. Most participants had an awareness of death and understood that death is not just something that takes place in the distant future, but it is always happening, everywhere, and all-around people. This point is illustrated in the following comments:

When we were calm that means that we were able to accept everything. If I must die, I would die. I think that it should not be fixed that we would not die. After 10 years, I returned home, I saw younger persons who were not diagnosed with cancer had died before me. (Case 5, female, aged 59 years).

Another participant stated:

Everyone must die. Everyone can die, but it is not known when and how. If we must die, please let it be peaceful like sleeping. We do not know if we can be peaceful in death or not. (Case 13, female, aged 56 years)

### **Adhering to Buddhist Practices for Increasing Death Consciousness**

Most participants in this study had participated in Buddhist activities that increased their death consciousness. These activities are captured in the following subcategories:

applying Buddhist practice in daily life, experiencing the benefits of practicing dharma, and death preparedness. Moreover, participants explained that undertaking these Buddhist activities in daily life not only stimulated them to be more conscious of death and also more willing to accept whatever happens, including their own death.

**Applying Buddhist practices in daily life.** The participants described the ways they applied Buddhist practices in daily life and the influence on their acceptance of death. The Buddhist practices are a way of expressing devotion to the Buddha through ceremonies, festivals, and other activities like chanting and meditation. The participants shared how they used the word "Buddho" to represent the Buddha, and they thought about this word while eating, walking, and going to sleep. Thinking of Buddho is considered a consciousness training that helped participants have additional recognition of the Buddha's teaching about the inevitability of death and the impermanence of all things, as well as increased their self-awareness. Besides, participants practiced Buddhist activities, such as chanting and making merit, every day, which seemingly encouraged them to have added consciousness in all circumstances. Moreover, the participants stated that their religious activities, especially listening to dharma that focused on the death and the dying process, furthered their understanding of death, providing them more calmness, and enabled them to let everything go before dying. One of the participants stated:

I followed Luang Ta's teaching by chanting while eating and walking. As well as when I slept, dreamed, and chewed, I spoke the word Buddho. I also thought about Buddho. Luang Ta told me to chew slowly and finely before swallowing. It made me to have more concentration. Then, I was gradually calm. I want to let everything go before dying and after practicing those, I understood about death. (Case 3, female, aged 52 years)

Another participant had learned about death and dying by listening to dharma from various media sources, such as a radio, smartphone, and reading dharma books. Furthermore, the participant was meditating; the main content while meditating focused on understanding death and also death consciousness. This participant stated:

I listened dharma from a radio and smartphone. Besides, I read books and had in my imagination that someday I would die as well. Moreover, usually I meditated and chanted. It gave calmness and more concentration no matter what was happening. (Case 2, female, aged 50 years).

**Experiencing the benefits of practicing dharma.** Our participants experienced benefits from following the teachings of the Buddha, particularly on the topic of death acceptance. The participants stated that dharma could contribute and encourage people to accept all things. Moreover, they perceived the benefits of dharma for helping themselves and

other patients be calm, die peacefully, and have a good death. One of the participants stated:

Dharma is a part of daily living. It enlightens our heart to accept all things happening. I practiced with the monk at Wat Pa SuanMok. I still applied the Luang Ta's teaching about whatever will happen will be. If it will die, it must die. When I stayed at Luang Ta's temple for 2–3 days, I had a chance to chant for a patient who was close to dying. I also helped the patient to have concentration with breathing in and out. Then, the patient gradually passed away. (Case 5, female, aged 59 years)

Another participant stated that practicing dharma helped her and other patients with cancer immensely, allowing her to be happy, and the practice enabled her to decrease sleep medication. She said:

Until coming through at this point, I must think about dharma. Every day I considered about dharma education such as reading books. After reading the books, I could sleep well and be happy. Besides, many people who stayed at Kham Pramong temple (the HETTCM) do not take sleep medication. Moreover, they could eat more. (Case 13, female, aged 56 years)

**Death preparedness.** Death preparedness can be defined as a feeling of readiness and awareness of their impending death. The participants mentioned that they knew that death could occur anytime, and they had prepared several things before death, including managing the funeral, life insurance, and assets. In addition, they conveyed to family members how to handle everything. Death preparedness provided participants with comfort that they had their affairs in order before dying. One of the participants stated:

I have a daughter to do everything instead of me. She will manage my life insurance and assets. Besides, my funeral also will be managed by her and other relatives. I can't live longer. I told what I want to do to my daughter and offspring. (Case 1, female, aged 69 years)

Adhering to Buddhist activities was another crucial technique that helped the participants accept their own death, allowing them to be comfortable, calm, and live happily. However, when time passed, the participants knew that they might face suffering both from illness or major life events again. They began to acknowledge all suffering gradually in their life. Meanwhile, the participants were open-minded about death and practiced Buddhist activities again to achieve calmness, death acceptance, and a good death. The relationships between the three major categories in this study can be conceptualized as circular and iterative, as shown in Figure 1.

## Discussion

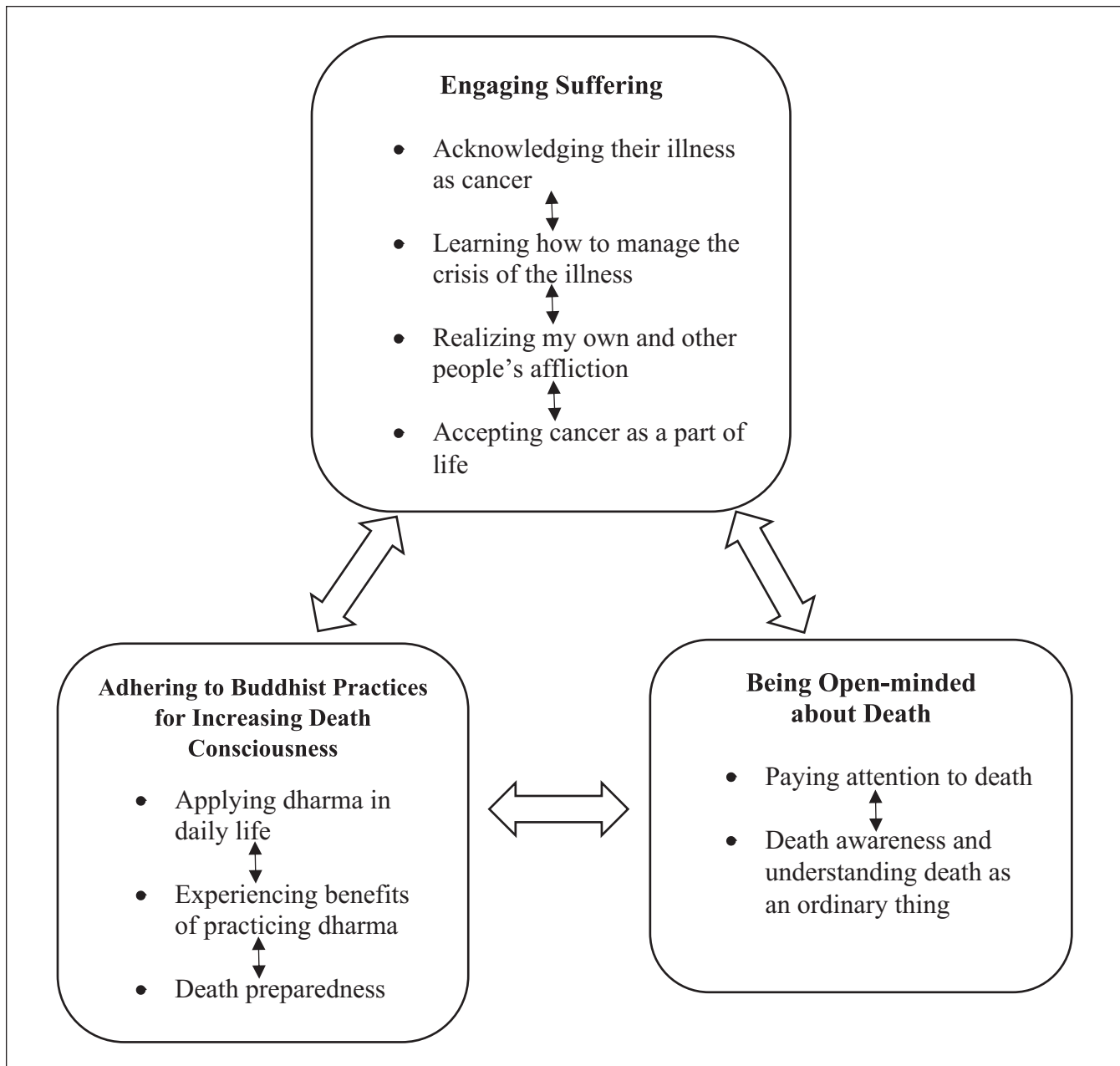
The study findings, based on the experiences of 13 patients with life-limiting cancer, describe death acceptance as a

dynamic and iterative process that involves three phases, namely, engaging suffering, being open-minded about death, and adhering to Buddhist practices for increasing death consciousness. Despite differences in gender, age, and marital status, the study sample comprised Thai Buddhists with life-limiting cancer treated at the HETTCM and described their death acceptance processes in similar ways. “*Engaging suffering*” was one phase of accepting death that occurred when the participants first encountered cancer. Most participants' responses reflected their initial denial, their shock or numbness, and their early reactions. Their illness was a major life event that led to changes and other problems unique to each person. This can be recognized as suffering (Payouthto, 2014).

Nevertheless, the participants had opportunities to learn how to manage suffering and the illness crises by speaking, sharing, and discussing the causes of cancer and the treatment guidelines with physicians, other patients, and their families and friends. Some of these occurred as part of the planned interventions at the HETTCM, which raised their self-awareness and awareness about the illness. From a Buddhist standpoint, suffering and illness are considered a natural part of life (Payouthto, 2014); this approach contributed to the participants' ability to accept and understand their suffering. Not only did they engage their suffering but also opened their minds to the idea that death can occur at any time.

“*Being open-minded about death*” emerged as another part of the death acceptance process in this study. The participants paid attention to death when they had time to listen and discuss death and dying with the monk/abbot at the HETTCM, called “Luang Ta.” Besides, they paid attention and attempted to make themselves aware and understand about death in daily living and through practice or rehearsal of dying. They followed Luang Ta's teachings involving listening to dharma and reading books about death and dying. From the Buddhist perspective, there are the dharma principles, known as the four noble truths, including suffering (Dukkha), the origin of suffering (Samudaya), the cessation of suffering (Nirodha), and the path leading to the cessation of suffering (Magga), through enlightenment (Dhammavijiro et al., 2020). Some of the study participants could not follow these dhamma principles until they accepted their own death, which is considered the most difficult truth to accept for a human being. Eventually, the participants became more open-minded about death and were more accepting of their own deaths. This finding conforms with Connelly's (2003) statement that various activities and situations could strengthen the intention to be ready to accept death.

“*Adhering to Buddhist practices for increasing death consciousness*” was identified as the final phase of the death acceptance process in this study. The Buddhist activities practiced by participants focused on understanding death and dying, the readiness to die, and the beneficial results of death acceptance. Perhaps, the participants' religious practice and beliefs likely enabled them to gradually absorb accepting their death. Using Buddhist activities to support mental development, they were



**Figure 1.** Death acceptance process in Thai Buddhist patients with life-limiting cancer treated at the hospital of excellence in Thai traditional and complementary medicine for cancer (HETTCM).

able to be peaceful and stable enough to experience the quality of universal truth and death acceptance. Then, they had time to prepare their assets and funerals.

A previous study in Thailand revealed that Buddhist beliefs about death were significant factors influencing death acceptance (Krapo et al., 2018). Although some of the participants returned home, they still practiced Buddhist activities regularly. Perhaps, for these participants, adhering to Buddhist practice was a crucial strategy to increase their death acceptance process. The palliative care patients at the

HETTCM could discuss their death acceptance process profoundly; their insights and processes might be applied to other patients.

### *Implications*

Healthcare professionals, including physicians, nurses, psychologists, educators, and other support persons, can use this information to learn more about death acceptance. In addition, they could use various activities to augment knowledge and



understanding of the death and dying process with patients to increase a more open-minded stance toward death. Meanwhile, inspiring patients to consider religious or spiritual activities when they are open to them could allow them to increase their comfort with the notion of death. The death acceptance process might also apply to patients who are not in palliative care. Even, healthy people might want to consider their attitudes toward death, knowing that everyone dies at some point and there are benefits to this awareness. Moreover, the nursing and psychology professions might investigate further the death acceptance process and the development of effective interventions to help patients to have peaceful lives and experience a good death in the future. Furthermore, interventions could include supporting patients as they engage in suffering, encouraging patients to be open-minded about death, and providing access to various religious or spiritual activities to increase death consciousness.

### Limitations

The limitations of this study are typically consistent with qualitative research. The “sample” is a small and specific group of participants with stage III and IV cancer who are Thai, Buddhist, and have chosen a Buddhist Temple hospice setting with their caregivers. These limits must be a part of the conversation. Generalizability is typically not expected with qualitative research; instead, transferability is used in qualitative studies to evaluate the extent that the findings could be transferred to other groups or settings (Polit & Hungler, 1999). This study reveals how this subset of people articulates their death acceptance process. Though a specialized group of Thai Buddhists with life-limiting cancer were treated at a Thai Buddhist hospice, the process they describe could be helpful to relieve several types of suffering. As mentioned earlier, some of the practices could be beneficial for not only Thai Buddhist patients not in palliative care but also non-Thai palliative patients. Moreover, understanding this process can inform healthcare providers, enabling them to help their patients find calmness, peace, and preparedness, as the patients journey through their own acceptance processes.

### Conclusions

The study findings indicate that the death acceptance process is a dynamic, non-linear, and iterative process that is influenced by Buddhist practices. These findings provide direction for managing suffering while living and supporting all people, including patients with cancer, to have an easier time with their lives and tranquility in the process of dying.

### Acknowledgments

The authors thank Venerable Dr. Paponpatchara Pibanpaknatee, The Abbot of Kampramong Temple, for his support and wish to express a special thanks to all the participants in this research.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by TSRI Fund, Thailand (CU\_FRB640001\_01\_36\_1).

### ORCID iDs

Sureeporn Thanasilp  <https://orcid.org/0000-0001-6638-2863>

Janya Chimluang  <https://orcid.org/0000-0001-5096-4607>

### References

- Akkayagorn, L. (2018). การยอมรับความตาย [Death acceptance]. *Chulalongkorn Medical Journal*, 62(5), 761–772. <https://doi.org/10.14456/clmj.2018.10>
- Charuchinda, V. (2018). การลดความวิตกกังวลเกี่ยวกับความตาย ด้วยหลักพุทธจิตวิทยา [Decreasing the death anxiety using Buddhist psychology]. *Journal of Buddhist Psychology*, 3(1), 1–12.
- Connelly, R. (2003). Living with death: The meaning of acceptance. *Journal of Humanistic Psychology*, 43(1), 45–63. <https://doi.org/10.1177/0022167802238813>
- Corbin, J. M., & Strauss, A. L. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). SAGE.
- Corr, C. A. (2019). The ‘five stages’ in coping with dying and bereavement: Strengths, weaknesses and some alternatives. *Mortality*, 24(4), 405–417. <https://doi.org/10.1080/13576275.2018.1527826>
- Dhammavijiro, P. V., Vaisopha, K., & Srinonyang, K. (2020). Four noble truths: Path leading to cessation of suffering. *Journal of Roi KaensarnAcademi*, 5(2), 256–270.
- Ferrell, B. R., Grant, M., Funk, B., Otis-Green, S., & Garcia, N. (1998). Quality of life in breast cancer. Part II: Psychological and spiritual well-being. *Cancer Nursing*, 21, 1–9. <https://doi.org/10.1097/00002820-199802000-00001>
- Filippo, S. D. (2006). *Perspectives on the fears of death and dying*. Kimball Publishing. [https://digitalcommons.nl.edu/faculty\\_publications/30](https://digitalcommons.nl.edu/faculty_publications/30)
- Glaser, B. G. (1978). *Advances in the methodology of grounded theory: Theoretical sensitivity*. Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Routledge. <https://doi.org/10.4324/9780203793206>
- Huang, H., Zeng, T. Y., Mao, J., & Liu, X. H. (2018). The understanding of death in terminal ill cancer patients in China: An initial study. *Cambridge Quarterly of Healthcare Ethics*, 27, 421–430. <https://doi.org/10.1017/S0963180117000809>
- Khaw, T., Nilmanat, K., Thaniwattananon, P., & Kongsuwan, W. (2020). Attributes of death acceptance: A qualitative study in Thai Buddhist older adults with advanced chronic organ failure. *Songklanagarind Journal of Nursing*, 40(4), 1–10.
- Krapo, M., Thanasilp, S., & Chimluang, J. (2018). Factors associated with death acceptance among Thai patients with advanced cancer. *Asian Journal for Public Opinion Research*, 6(1), 8–30. <https://doi.org/10.15206/ajpor.2018.6.1.18>

- Kübler-Ross, E. (1969). *On death and dying*. Macmillan Company.
- Kuppako, D. (2017). Buddhism in Thai life: Thai model for ASEAN. *Mahachula Academic Journals*, 3(1), 138–158.
- Lokker, M., van Zuylen, L., Veerbeek, L., van der Rijt, C. C., & van der Heide, A. (2012). Supportive care in cancer. Awareness of dying: It needs words. *Supportive Care in Cancer*, 20(6), 1227–1233. <https://doi.org/10.1007/s00520-011-1208-7>
- Long, N. H., Thanasilp, S., & Doutrich, D. (2018). Death acceptance in Vietnamese cancer patients: A phenomenological study. *Journal of Transcultural Nursing*, 29(6), 563–569. <https://doi.org/10.1177/1043659618765081>
- Mamuang, M. (2019). Older adults' acceptance of death: A grounded theory. *Advances in Health Science Research*, 15, 85–90. <https://doi.org/10.2991/icosihsn-19.2019.20>
- McLeod-Sordjan, R. (2014). Death preparedness: A concept analysis. *Journal of Advanced Nursing*, 70(5), 1008–1019. <https://doi.org/10.1111/jan.12252>
- Meier, E. A., Gallegos, J. V., Montross-Thomas, L. P., Depp, C. A., Irwin, S. A., & Jeste, D. V. (2016). Defining a good death (Successful dying): Literature review and call for research and public dialogue. *The American Journal of Geriatric Psychiatry*, 24(4), 261–271. <https://doi.org/10.1016/j.jagp.2016.01.135>
- Payouthto, P. (2014). พุทธธรรม [Buddhist moral code]. โรงพิมพ์พิมพ์จุฬาลงกรณ์ราชวิทยาลัย.
- Philipp, R., Mehnert, A., Lo, C., Muller, V., Reck, M., & Vehling, S. (2019). Characteristic death acceptance among patients with cancer. *Psycho-Oncology*, 28, 854–862. <https://doi.org/10.1002/pon.5030>
- Polit, D. F., & Hungler, B. P. (1999). *Nursing research: Principles and methods* (6th ed.). Lippincott.
- Stroebe, M., Schut, H., & Boerner, K. (2017). Cautioning health-care professionals: Bereaved persons are misguided through the stages of grief. *OMEGA-Journal of Death and Dying*, 74(4), 455–473. <https://doi.org/10.1177/0030222817691870>
- Thanasilp, S., Akkayagorn, L., Suwannapong, S., Long, N. H., Chimluang, J., Upasen, R., Kedcham, A., & Doutrich, D. L. (2020). Development and psychometric testing of the Buddhist death acceptance scale. *Pacific Rim International Journal of Nursing Research*, 24(4), 527–537. <https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/227363>
- Upasen, R., & Thanasilp, S. (2020). Death acceptance from a Thai Buddhist perspective: A qualitative study. *European Journal of Oncology Nursing*, 49, 1–7. <https://doi.org/10.1016/j.ejon.2020.101833>
- Wachiramaetee, W. (2019). *Our time is limited*. Amarin Book Center.
- Wysokinski, M., Fidecki, W., & Jarosz, M. (2019). Elderly people's acceptance of death: A study of a polish cohort. *International Journal of Environment Research and Public Health*, 16(18), 1–9. <https://doi.org/10.3390/ijerph16183374>
- Zimmermann, C. (2012). Acceptance of dying: A discourse analysis of palliative care literature. *Social Science and Medicine*, 75(1), 217–224. <https://doi.org/10.1016/j.socscimed.2012.02.047>

### Author Biographies

**Ratchaneekorn Upasen**, PhD, RN, Dip PMHN are assistant professor, and member of “Asian Wisdom Care” Research Unit at Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand.

**Sureeporn Thanasilp**, DNS, RN, Dip APMSN are associate professor, and director of “Asian Wisdom Care” Research Unit at Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand.

**Lanchasak Akkayagorn**, MD are palliative care physician at Cheewabhibaln Palliative Care Center, King Chulalongkorn Memorial Hospital, and member of “Asian Wisdom Care” Research Unit at Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand.

**Janya Chimluang**, PhD, RN is assistant professor, researcher of “Asian Wisdom Care” Research Unit at Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand.

**Wilailuck Tantitrakul**, RN, Dip APMSN is palliative care nurse at The Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer at Sakonnakhon, Khampramong Temple, Sakonnakhon, Thailand.

**Dawn Liam Doutrich**, PhD, RN, CNS is associate professor emeritus, Washington State University, College of Nursing, Washington, USA.

**Weeraphol Saengpanya**, PhD is assistant professor at Faculty of Education, Chulalongkorn University, Bangkok, Thailand.