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VIEWS OF UNIVERSITY STUDENTS ON DEATH ANXIETY AND NEAR-DEATH TREATMENTS

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Abstract

The study was planned to evaluate the views of university students about death anxiety and near-death treatments. Between October and December 2018, the Andel Khalek death anxiety scale and the survey questions were applied to 742 university students. 66% of the participants are female. The Cronbach Alpha values of the dimensions were found to be 0.909 for fear of dead body cemetery, 0.820 for fear of terminal illness, and 0.724 for fear of post-mortem. The death anxiety score of women was higher than that of men. The majority of the participants stated that death was associated with distressing social conditions and psychological problems. They are undecided about the usefulness of drug treatments and individual autonomy. A relationship was found between these statements and the death anxiety scale dimension scores. The majority of them stated that there should be qualified treatments, the importance of providing economic opportunities, and that gender discrimination should not be made. In the study, it was concluded that university students have death anxiety and are sensitive to end-of-life treatments. It is suggested that their anxiety can be reduced with health education, improvement of social conditions and psychological support.

Keywords: ethics, death, anxiety

Opiniones de estudiantes universitarios sobre la ansiedad ante la muerte y los tratamientos de proximidad a la muerte

El estudio evaluó las opiniones de los estudiantes universitarios sobre la ansiedad ante la muerte y los tratamientos al final de la vida. Entre octubre y diciembre de 2018 se aplicó la escala de ansiedad ante la muerte de Andel Khalek a 742 estudiantes universitarios, 66% mujeres. Los valores del Alfa de Cronbach de las dimensiones resultaron ser 0,909 para el miedo al cementerio de cadáveres, 0,820 para el miedo a la enfermedad terminal y 0,724 para el miedo a la autopsia. La puntuación de ansiedad ante la muerte de las mujeres fue mayor que la de los hombres. La mayoría de los participantes declaró que la muerte estaba asociada a condiciones sociales angustiosas y a problemas psicológicos. Se muestran indecisos sobre la utilidad de los tratamientos farmacológicos y la autonomía individual. Se encontró una relación entre estas afirmaciones y las puntuaciones de la dimensión de la escala de ansiedad ante la muerte. La mayoría de ellos afirmó que debería haber tratamientos cualificados, proporcionar oportunidades económicas y que no se debería discriminar por género. En el estudio se concluyó que los estudiantes universitarios tienen ansiedad ante la muerte y son sensibles a los tratamientos al final de la vida. Se sugiere que su ansiedad puede reducirse con educación sanitaria, mejora de las condiciones sociales y apoyo psicológico.

Palabras clave: ética, muerte, ansiedad

Visões de Estudantes Universitários sobre Ansiedade de Morte e de Tratamentos Próximos da Morte

Resumo: O estudo foi planejado para avaliar as visões de estudantes universitários sobre a ansiedade de morte e de tratamentos próximos da morte. Entre outubro e dezembro de 2018, a escala de ansiedade de morte de Andel Khalek e questões do inquérito foram aplicadas a 742 estudantes universitários. 66% dos participantes eram mulheres. Os valores do Alpha de Cronbach encontrados para as dimensões da escala foram de 0,909 para medo de cadáveres, 0,820 para medo de doença terminal e 0,724 para medo do pós morte. O escore de ansiedade de morte de mulheres foi maior que o dos homens. A maioria dos participantes afirmaram que a morte estava associada com condições sociais estressantes e problemas psicológicos. Eles estavam indecisos sobre a utilidade de tratamentos medicamentosos e da autonomia individual. Foi encontrada uma relação entre estas afirmações e os escores dimensionais na escala de ansiedade de morte. A maioria deles afirmaram que deveria haver tratamentos qualificados, da importância de fornecer oportunidades econômicas e que não deveria haver discriminação por gênero. No estudo, foi concluído que estudantes universitários apresentam ansiedade de morte e são mais sensíveis a tratamentos do fim-da-vida. Foi sugerido que sua ansiedade pode ser reduzida com educação em saúde, melhora das condições sociais e apoio psicológico.

Palavras chave: ética, morte, ansiedade

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Introduction

The phenomenon of death causes anxiety in individuals due to its traits such as death (pain, illness, etc.), loss (loss of things belonging to the world of objects), unpredictable nature (time), unknown existence (experience of death)*(1).* Eric Fromm*(2)* noted two death concerns. One is the normal anxiety of every individual having to die, and the other is the anxiety of death, which makes the individual anxious all the time. The feeling of individuals in the world that they will end up "existing" was defined as anxiety for death*(3).* According to C. Ross*(4)*, individuals are developing some defence mechanisms against the reality of death, for example, avoiding thinking. Abdel-Khalek developed the Arabic Scale of Death Anxiety in 2004 to examine the concept of death in Muslim communities. The validity and reliability study was conducted in Syria, Egypt*(5)*. The scale has been used in research in Western countries (Spain, USA)*(6,7).* In the field of ethics, end-of-life treatments are discussed. The concept of death is being examined from the top down.

Health practices that are beneficial and harmful, intimacy, gender discrimination and ethical dilemmas regarding the autonomy of individuals may be encountered with regard to the notion of death. Some studies suggest that age affects the view on death. As one became more aware of one's feelings and thoughts, their fears became more recognized*(8).* Young people are excited about life. However, they want to live by intimidation, taste all their wishes and get to know the world. However, coming to mind may turn the enthusiasm of the youth into a concern*(9)*. If the young generation's approach to the notion of death is positive, their quality of life may improve. There is a need for research. Detailed information on the dimensions of the concept can be found as research on death anxiety increases. In this sense, the study was planned to evaluate university students' views on death anxiety and near-death treatments.

Materials and Methods

Descriptive is cross-sectional type research. The research was conducted between October and December 2018. In order to obtain the data source of the study, the informed, voluntary participant survey method within the primary data collection procedure was used. In the survey forms, questions are asked about the respondents' demographic characteristics. The section utilized an Arabic Measure on Death Anxiety, which was based on that the perception of death in Muslim societies by Abdel-Khalek in 2004*(5)* was different. There are 20 articles containing five pieces of Likert type (1=none and 5=very much) that assess death anxiety on the scale. Scale Scoring: Scale scores range from 20 to 100. Assessment of the Scale: A high score obtained from each subdimension indicates a highly desired feature. Students studying the validity and reliability of the scale in Turkish were studied by Aydoğan, A.S. et al. in 2015*(1).* The questionnaire form was applied to 742 voluntary students from the Faculty of Health Sciences, the Faculty of Science, the School of Foreign Languages, and the School of Applied Sciences to obtain the data of the study. While the minimum number of observations that must be present is considered to be at least 5 observations per variable, the prevailing opinion is that at least 20 observations per variable should be ideal*(10).* The study sample was determined based on this calculation. The approval of the Ethics Committee was obtained for the research. Before the questionnaire application, information was given to each participant, an explanation was made, their questions were answered, their signature was obtained to participate, and informed voluntary consent was obtained from the participants. The SPSS 19 was used in the analysis. Explanatory factor analysis is used to determine the factor structure in the data based on the observed variables*(10).* In this study, descriptive factor analysis, descriptive statistics, ANOVA, t-test were used.

Results

Table 1. Descriptive Statistics on Demographic Characteristics

		Frequency	Percentage	Cumulative Percent
Age	Ages 17-21	556	74,9	75,0
	Ages 22-26	177	23,9	98,9
	Ages 27-31	8	1,1	100,0
	Total	741	99,9	
Gender	Female	489	65,9	66,0
	Male	252	34,0	100,0
	Total	741	99,9	
Marital Status	Married	12	1,6	1,6
	Single	719	96,9	99,5
	Separate from Spouse	4	0,5	100,0
	Total	735	99,1	
Economic situation	No Income	407	54,9	55,7
	Under 1300	171	23,0	79,1
	Between 1300 and 3000	111	15,0	94,3
	3,000 and over	42	5,7	100,3
	Total	731	98,5	
Do you have any existing diseases?	Yes	63	8,5	8,6
	No	670	90,3	100,0
	Total	733	98,8	
Do you have regular health checks?	Yes	195	26,3	26,6
	No	417	56,2	83,5
	Undecided	121	16,3	100,0
	Total	733	98,8	
Do you have a regular physical activity habit?	Yes	238	32,1	32,2
	No	412	55,5	88,0
	Undecided	89	12,0	100,0
	Total	739	99,6	
Do you think you have a balanced diet?	Yes	255	34,4	34,5
	No	341	46,0	80,6
	Undecided	143	19,3	100,0
	Total	739	99,6	
Have you been diagnosed with depression?	Yes	54	7,3	7,3
	No	684	92,2	100,0
	Total	738	99,5	

In Table 1, 75% of young people are between the ages of 17 and 21, 66% of them are females, 55% do not have income, most of them do not have regular health checks, do not exercise, or have a balanced diet.

In Table 2, the majority of young people stated that death is related to problematic processes and psychological problems related to treatments and problems that may cause death, that they are not sure about the benefits of end-stage drug treatments, that the autonomy of treatments and that it is essential to ensure gender inequality and economic opportunities in recent treatments.

Factor Analysis Findings

Suppose the significance value determined by the Bartlett globalization test is less than 0.05. In that case, it is shown that the data is taken from the primary mass that corresponds to multiple normal distributions*(11).*

Table 2: Descriptive statistics of participants on end-of-life treatment views

Questions	Answers	Frequency	Percentile
Do you think death is a situation with problematic processes in terms of medical treatment?	Yes	349	47.0
	No	201	27.1
	Undecided	175	23.6
	Total	725	97.7
Do you think death has anything to do with psychological problems?	Yes	545	73.5
	No	103	13.9
	Undecided	92	12.4
	Total	740	99.7
Do you think troubled social life conditions and problems lead to death?	Yes	606	81.7
	No	54	7.3
	Undecided	76	10.2
	Total	736	99.2
Do you think that medications administered near to death are beneficial practices?	Yes	242	32.6
	No	177	23.9
	Undecided	320	43.1
	Total	739	99.6
Is it important for individuals to make their own decisions about treatment during the final stage of life?	Yes	525	70.8
	No	100	13.5
	Undecided	113	15.2
	Total	738	99.5
Is it important to provide privileged and quality treatment to individuals at the end of life?	Yes	600	80.9
	No	60	8.1
	Undecided	78	10.5
	Total	738	99.5
Those close to death in treatment services who: is it important that there is no discrimination between men and women?	Yes	516	69.5
	No	188	25.3
	Undecided	36	4.9
	Total	740	99.7
Is it important to provide adequate economic means for the treatment in the healthcare sector for the last period of life?	Yes	604	81.4
	No	46	6.2
	Undecided	86	11.6
	Total	736	99.2

Table 3: Total Results of Described Variance, KMO, Bartlett Globality Tests

Components	Original Value			Sum of the square loads of the original		
	Total	Variance (%)	Accumulated percentage	Total	Variance (%)	Accumulated percentage
1	6.688	47.771	47.771	6.688	47.771	47.771
2	1.574	11.244	59.015	1.574	11.244	59.015
3	1.070	7.644	66.659	1.070	7.644	66.659
4	.741	5.293	71.952			
5	.709	5.064	77.016			
Kaiser-Meyer-Olkin (KMO) Sample proficiency criterion				.902		
Bartlett test of globality			Hey, Approx. Chi-Square	5551.937		
			tf	AD 91		
			Sec.	.000		

In Table 3, it was decided that there are three factors in the structure because the equity of the three factors is greater than 1. The first three factors explain 66 % of the facts according to their cumulative values.

Table 4: Factor Loads Matrix

	Components		
	Fear of dead bodies and cemeteries	Fear of deadly illness	Post-mortem fear
2. I'm afraid to look at the dead	.901		
8. I am afraid to look at a corpse	.896		
11. Witnessing the funeral terrifies me	.805		
3. I am afraid to visit the cemetery	.786		
12. Walking through the cemetery terrifies me	.777		
17. The appearance of a dying person frightens me	.635		
16. Witnessing a funeral upsets me	.562		
18. Talking about death upsets me	.530		
19. Afraid of getting cancer		.893	
10. I am afraid of catching a severe disease		.838	
5. I'm afraid of having a heart attack		.607	
13. I'm constantly pondering what happens after death			.887
7. I'm concerned about the unknown after death			.787
14. Afraid of sleeping and then not waking up again			.578

Factors	**Cronbach alpha value**	**Number of items**	**Skewness**	**Kurtosis**
Fear of dead bodies and cemeteries	0.909	8th	0.713	-0.338
Fear of deadly illness	0.820	3.	-0.286	-0.966
Post-mortem fear	0.724	3.	0.536	-0.527

In Table 4, the scale was determined to be 3 factors: fear of dead bodies and graveyards, fear of terminal illness, fear of post-mortem. Data for Likert type scales can have discrete characteristics *(12).* If the Skewness (Distortion) and Kurtosis (Distortion) values are in the range ± 1.5, the data may be said to exhibit a normal distribution *(13).* İn the study, it can be said that the data may contain accurate information about the primary mass with which it is distributed normally.

Table 5: Findings regarding the T-test

		Fear of dead bodies and cemeteries		Fear of Fatal Illness		Post-mortem fear	
		Average	P-value and Levene test (level of significance)	Average	P-value and Levene (significance level	Average	P-value and Levene (significance level
Gender	Female	2.44	**.000** (.000)	3.42	**.000** (.323)	2.60	**.000** (.069)
	Male	1.62		2.93		2.05	
Do you have a disease?	Yes	2.26	.397 (.794)	3.39	.351 (.500)	2.41	.950 (.238)
	No	2.15		3.24		2.42	
Have you been diagnosed with depression?	Yes	2.33	.252 (.008)	3.43	.269 (.375)	2.75	.019 (.191)
	No	2.15		3.24		2.39	
Economic situation	No income	2.14	.693 (.780)	3.32	.109 (.500)	2.41	.109 (.500)
	Under 1300	2.15		3.11		2.39	
	Between 1300 and 3000	2.25		3.14		2.38	
	3,000 and over	2.05		3.50		2.58	
Do you have regular health checks?	Yes	2.15	.138 (.328)	3.28	.260 (.406)	2.38	.733 (.027)
	No	2.12		3.20		2.41	
	Undecided	2.33		3.40		2.47	
Do you have a regular physical activity habit?	Yes	1.94	**.000** (.038)	3.12	.124 (.719)	2.23	**.006** (.669)
	No	2.30		3.31		2.51	
	Undecided	2.12		3.33		2.40	
Do you think you eat a balanced diet?	Yes	2.07	.093 (.006)	3.15	**.034** (.325)	2.25	**.009** (.005)
	No	2.18		3.23		2.52	
	Undecided	2.27		3.48		2.45	

In Table 5, significant gender differences were identified in the dimensions of both the fear of dead bodies and cemeteries, the fear of fatal diseases and post-mortem fears (0,000<0.05). The average scores of women were higher than men in terms of the dead body and graveyard fear, fear of fatal diseases, and fear after death. Statistically significant differences were found to be the extent of fear from dead bodies and cemeteries, and the dimension of fear after death, according to the state of young people in physical activity (p<0.05). Because of the lack of an assumption of equality in terms of lethal disease related to balanced nutrition and in terms of post-mortem fear, welch testing has been provided to detect differences. Statistically significant differences between the dimensions of fear of fatal diseases and fear after death were determined according to the balanced eating status of young people (p<0.05). A significant difference was identified between the young people stating they have a balanced diet and those undecided about having a balanced diet, i.e., the dimension of fatal disease fear (p<0.05). Statistically significant differences were found between the post-mortality horror size and those with balanced nutrition (p<0.05).

Table 6: ANOVA test results of participants end-of-life treatment views

		Fear of dead bodies and cemeteries		Fear of Fatal Illness		Post-mortem fear	
		Average	P-value and Levene test(significance level)	Average	P-value and Levene (significance level	Average	P-value and Levene (significance level
Do you think death is a situation with problematic processes in terms of medical treatment?	Yes	2.25	**.001** (.159)	3.46	**.000** (.326)	2.52	**.028** (.203)
	No	1.95		2.93		2.27	
	Undecided	2.24		3.25		2.41	
Do you think death has anything to do with psychological problems?	Yes	2.20	**.047** (.440)	3.34	**.001** (.588)	2.48	**.010** (.159)
	No	1.94		2.86		2.16	
	Undecided	2.16		3.13		2.30	
Do you think troubled social life problems lead to death?	Yes	2.19	**.004** (.016)	3.33	**.000** (.079)	2.49	**.000** (.000)
	No	1.80		2.58		1.75	
	Undecided	2.23		3.14		2.32	
Do you think that medications administered near to death are beneficial practices?	Yes	2.19	**.000** (.871)	3.37	**.002** (.183)	2.38	.302 (.102)
	No	1.90		2.97		2.34	
	Undecided	2.28		3.32		2.48	
Is it important for individuals to make their own decisions about treatment during the final stage of life?	Yes	2.08	**.003** (.003)	3.16	**.002** (.324)	2.33	**.002** (.732)
	No	2.45		3.34		2.48	
	Undecided	2.29		3.59		2.72	
Is it important to provide quality treatment to individuals at the end of life?	Yes	2.20	.077 (.288)	3.30	**.021** (.550)	2.44	.193 (.159)
	No	1.91		2.86		2.18	
	Undecided	2.07		3.17		2.37	
Is it important not to discriminate between men and women in treatment and care services?	Yes	2.19	.627 (.178)	3.30	.176 (.375)	2.47	.108 (.260)
	No	2.12		3.16		2.29	
	Undecided	2.06		3.00		2.31	
Is it important to provide adequate economic facilities for the end-of-life treatment in the healthcare-sector?	Yes	2.15	.901 (.024)	3.29	.198 (.511)	2.43	.516 (.081)
	No	2.24		3.01		2.36	
	Undecided	2.15		3.13		2.30	

In Table 6, there were statistically significant differences between young people who stated that death from the lower dimensions of fear of dead bodies and cemeteries and deadly diseases was not the difficult process for treatments and those who claimed that it was difficult or uncertain ($p<0.05$). Individuals with the lowest average scores on the fear of dead body graveyards have shown that death is not a difficult process for treatments. Those who state that death is a difficult process for treatments have higher average scores for fear of fatal diseases and fear after death. In terms of the fear of dead body graveyards, fear of fatal diseases, and fear of post mortality, there has been a significant difference between young people who think that death is related to psychological issues and those who do not ($p<0.05$). Those who believe that death has nothing to do with psychological problems have lower average scores in three dimensions, and the lowest average score was observed as fear of dead body graveyards. Individuals who think death has something to do with psychological problems have a strong fear of fatal diseases. "Do you think that difficult social conditions lead to death?" A significant difference was found in the answers to the question in three dimensions ($p<0.05$). In terms of fear of the dead body and the cemetery, significant differences have been identified between young people who think that difficult conditions in social life will not lead to death and those who believe that tough conditions in social life may lead to death ($p<0.05$). Individuals who are uncertain about the consequences of dying out of social life have high scores in the first dimension. In contrast, those who think that tough conditions are likely to result in death in social life have high average scores in the second and third di-

Table 7: Descriptive statistics of the items that make up the dimensions of the scale

Dead body and graveyard fear dimension	Valid	Missing	Mean	Median	Mode	Std. Deviation	Min.	Max
2. I'm afraid to look at the dead	742	0	2,46	2,00	1	1,438	1	5
8. I am afraid to look at a corpse	741	1	2,56	2,00	1	1,497	1	5
11. Witnessing the funeral terrifies me	718	24	2,17	2,00	1	1,350	1	5
3. I am afraid to visit the cemetery	740	2	1,62	1,00	1	1,023	1	5
12. Walking through the cemetery terrifies me	717	25	1,77	1,00	1	1,090	1	5
17. The appearance of a dying person frightens me	721	21	2,59	2,00	1	1,368	1	5
16. Witnessing a funeral upsets me	721	21	2,13	2,00	1	1,244	1	5
18. Talking about death upsets me	719	23	2,01	2,00	1	1,182	1	5
Fatal disease fear dimension								
19. Afraid of getting cancer	719	23	3,44	4,00	5	1,409	1	5
10. I am afraid of catching a serious disease	723	19	3,43	4,00	5	1,360	1	5
5. I'm afraid of having a heart attack	727	15	2,92	3,00	2	1,440	1	5
Post-mortality horror dimension								
13. Post-mortem thoughts keeps my mind occupied	723	19	2,53	2,00	2	1,305	1	5
7. I'm concerned about the unknown after death	739	3	2,75	3,00	1	1,455	1	5
14. Sleeping again, then afraid not to wake up	719	23	1,98	1,00	1	1,234	1	5

mensions. "Do you think drug treatments close to death are useful?" When the differences of the answers to the death anxiety scale were examined in terms of sub-dimensions, there were significant differences between the fear of dead bodies and cemeteries and fear of fatal diseases ($p<0.05$). Significant differences were observed between the young people, who stated that drug treatments close to death in two dimensions were not useful practices, and undecided people ($p<0.05$). Those who are indecisive about the benefits of near-death drug treatments have a high score on both corpse and cemetery fear, while those who say yes on the fear of fatal disease have a high score on average on the fear of post-mortem fear among those who are indecisive about the benefits of medication. "Does the autonomy of individuals matter in the final stage of life treatments?" There are significant differences in the three dimensions of the responses to her question ($p<0.05$). Significant differences were found between the young people who considered the autonomy of the individuals as important for the treatment of the dead-me-to-the-cemetery-size treatment and those who answered insignificantly ($p<0.05$). Significant differences were identified between those who claimed quality treatments were necessary and those who claimed they were unnecessary at the end of life ($p<0.05$).

Most of the answers to the question, "I'm afraid of looking at the dead," are "a little" and "I don't fear at all" in Table 7. Answers to the one "I'm afraid to look at the body." in most instances. "Witnessing the burial process terrifies me." answer to "none". "I'm afraid of a cemetery visit" and "I'm terrified of walking through the cemetery." the average value of the answers to their questions is lowest, and those who answer "none" are higher than the other questions. "I fear the appearance of dying man." The average value of the answers to her question is the highest. "I'd be upset to attend a funeral." "I'd be upset to talk about death." the majority who answer "none" to their questions. "I'm afraid of getting cancer." the average score of young people is high when they are asked, "I'm afraid of getting seriously ill." "I'm afraid of having a heart attack." young people are moderately afraid. "Thoughts about what happens after a death keep me preoccupied." the answers to his question are usually concentrated on the alternatives: "none" and "somewhat." I am mostly "a little afraid." "I am concerned about the unknown after death." answer to the question "none" at most. Young people's concerns about unknown things after death are greater than their concerns about what will happen after death. The lowest sensitivity for this dimension appears with the question "I am afraid of sleeping and not waking up again afterwards". This question was answered as "not afraid at all."

Discussion

Aydoğan AS. 2015*(1)* Abdel Khalek confirmed the validity of the death anxiety scale in Turkish and found its Cronbach alpha value at 0.86. The study found that the Cronbach alpha values of the dead anxiety scale are high. Abdel-Khalek applied 2004*(5)*, and Abdel-Khalek 2005*(6)* found that Cronbach alpha value of death anxiety scale is increased.

In the study, most people stated that they do not have any existing diseases and over half of people did not receive health checks and did not exercise, and people do not think that nutrition is balanced. In the literature, nearly 10% of university students have diseases*(14).* Seventy per cent of university students also had not health checks*(15).* People are reported to lack activity and be inadequate about balanced nutrition*(16,17).*

The number of people diagnosed with depression is 7.3% of the sample. The prevalence of depression in the world has been reported as approximately 10%(18-20).

Most people reported that death is a problematic process for medical treatment and death is a process related to psychology, and social life and qualified treatment are important, undecided about the usefulness of drug treatments and autonomy. The economy is important and doesn't discriminate between genders in the treatments. The literature suggests that the near-death period is difficult, linking psychology with death and social problems associated with death and the need to meet quality care standards. Individuals have concerns about the usefulness of treatments, and autonomy, economy, and gender are important*(18,21-29).*

Abdel-Khalek AM. 2004 and other studies found that women's death anxiety average scores were higher than men*(5,30)*. Female participants had higher scores than male ones in death anxiety.

The study found a relationship between death-depression, income-dead anxiety, health control-death anxiety, activity-dead anxiety, nutrition-dead anxiety. In the relevant literature, it is mentioned that something similar about these subjects*(31-40)*.

The study found that those who stated that death is not a difficult process for medical treatment and care had the lowest score on the part of the fear of dead body graveyards. The literature describes the late treatment as a highly challenging process for the family and healthcare team because there is worry about patients and their relatives near death. Research has highlighted the difficulty of people close to death in dealing with physical problems such as respiratory distress, pain, constipation, and death anxiety*(21,41-45)*.

The study found that young people who think difficult social conditions would not cause their death did not score low on the death scale. The literature describes social support as making a positive contribution to physical and psychological health by fulfilling social needs such as family, close friends, and neighbours such as love, loyalty, self-esteem, belonging to a group while reducing the anxiety of death*(46)*.

Aksoy 2009 study states*(26)*, "Do you care for your relatives at a healthcare institution near the death?" Nearly half of the individuals responded negatively. The reasons: desecration, care is the duty of the family, it has included expressions of economic loss in vain what others may say*(47)*. The study shows that drug treatments close to death cannot be beneficial, and young people have low average scores on the fear of dead body graveyards.

In the study, there have been significant differences between the young people who think autonomy is important in recent treatment and the fear of cemeteries to those who think autonomy is unimportant. Aksoy 2009*(26)* revealed that it is a crucial ethical dilemma for individuals to decide whether to spend their last days in hospitals or not. However, in our country practice, people are excluded from the decision-making process in such cases. He stated that individuals want to make their own decisions*(47)*.

Those who did not consider privileged quality treatments to be immaterial in the final stages of life in the study scored low on three dimensions of the death anxiety scale. The study confirmed that approximately half of the individuals had received answers on the necessity of quality treatment and its significance*(21,26)*.

Among those who stated that it is important that no gender discrimination is made in the treatment of patients with nearing death as part of the study, there is no statistical differentiation; however, the youth who claimed that gender non-discrimination is important among those with high average scores were rated as "fear of fatal diseases." Studies in the sociology field emphasize that gender discrimination still prevails in all societies but that non-discrimination individuals have increased in modern societies. It has been stated that the individuals who are against discrimination have a positive view of life and high quality of life, and their death anxieties are low *(28,48)*.

The study shows that economic opportunity is important in the treatment, while people have a strong fear of fatal diseases. In the literature, mortality statistics show that the financial burden of chronic diseases is high in societies. It is emphasized that in order to provide the necessary economic opportunities for each individual, efforts are needed to correctly plan health expenditures in cooperation with multi-stakeholder social actors*(49)*.

Looking at the score levels of the death anxiety scale in the study, we observed that they experience low anxiety at the first and moderate anxiety at the second and third levels. The literature reports high levels of mortality anxiety in youth*(5,50,51)*.

Conclusions

Today, both in Muslim societies and in Europe, the social, psychological and health problems and the issue of death have become debatable and are

seen as a problem that should be carefully considered. In this study, which reveals the perspective of young people who will shape the future about end-of-life treatments and about death anxiety, it was concluded that university students in Turkey have death anxiety and that death anxiety is higher in women than in men. It was determined that they had sensitivities and concerns about end-of-life treatments. It was determined that death anxiety was high in those undecided about treatment usefulness and autonomy and those who thought that social-psychological problems could cause death. On the other hand, it has been observed that these people do not exercise, ignore nutrition and do not make regular health checks. In this sense, it is recommended that students be given health education and awareness on nutrition, exercise and regular health check-ups in order to reduce their death anxiety. It can be suggested that their anxiety can be reduced by improving social problems and conditions and planning psychological support programs. It is recommended that women as a special group be dealt with in more detail on death. Further research should be conducted on the causes of anxiety. All state bodies, media, and health professionals should carefully consider special support programs for this group. It can be suggested that students should be educated, and awareness should be raised so that healthcare professionals can display sensitive approaches to patient benefit and autonomy in order to address their concerns about the usefulness, quality and autonomy of end-of-life treatments.

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