

UNIVERSITY OF PAVIA – IUSS SCHOOL FOR ADVANCED STUDIES PAVIA

Department of Brain and Behavioral Sciences (DBBS)
MSc in Psychology, Neuroscience and Human Sciences



Death-Education as Institutional Support for Deathcare Workers: A Delphi Study in Italy

Supervisors:

Prof. Serena Barello

Co-supervisor:

Dott. Mateus Eduardo Romão

**Thesis written by
Yasmin Fernandes Franco**

Academic year 2025/2026

Index

Index	1
Abstract	2
Introduction	3
Deathcare Workers: Social Stigma and Invisibility	4
Further Occupational Challenges in Deathcare Work	5
Death Education as Institutional Support	6
Death Education and Deathcare Workers: Current Gaps	8
Education Provision and Regulation in Deathcare: International Contrasts and the Italian Context	9
Co-designing Death Education for Marginalized Workforces	11
Methods	12
Research Question	12
Study Design	12
Study Setting	13
The Delphi Process	13
Delphi Panel: Eligibility and Recruitment	14
Data Collection	14
Consensus Definition	15
Data Analysis	15
Ethical Approval	16
Results	16
Participants Characteristics	16
Overview of Strategy Development	18
Results Round 1	21
Section 1: Educational Aims	21
Section 2: Content	24
Section 2B: Feasibility	31
Section 3: Teaching and Learning Strategies	35
Section 3: Relevance	35
Section 3: Feasibility	38
Section 4: Delivery Modes and Logistics	42

Section 5: Outcomes for Evaluation	50
Results Round 2	53
Section 2B: Micro Content Area	54
Section 3: Teaching and Learning Strategies	58
Section 4: Delivery Modes and Logistics	62
Section 6: Free-Text Comments	71
Discussion	74
Limitations and Implications	78
Conclusion	79
References	79

Abstract

Deathcare workers are exposed to death and bereavement, yet education for this workforce remains limited in Italy. A two-round anonymous online Delphi survey was conducted to prioritize components of a death education programme for Italian deathcare workers. Experts rated candidate aims, content, teaching strategies, delivery options, and evaluation outcomes on a seven-point scale using predefined consensus thresholds; free-text comments were summarized descriptively. Consensus-supported aims focused on reducing stigma and social invisibility, strengthening professional identity and meaning, improving communication with bereaved families, and supporting coping and self-care. Key domains prioritized communication, relational processes, occupational risk and protective resources, with practice-oriented topics including culturally diverse grief and rituals, ethics and boundaries, moral distress, and relational challenges. Feasibility consensus was clearest for ethics and boundaries, small-group delivery, and facilitation by a mental health professional; co-facilitation with an experienced deathcare practitioner was judged highly suitable. Priority outcomes included improved communication, reduced emotional distress, adaptive coping, strengthened meaning and identity, and participant satisfaction. Findings provide an evidence-informed blueprint for programme implementation and evaluation, and highlight that scaling requires organizational buy-in, protected time, and institutional recognition, implications for other settings where deathcare labor remains marginalized.

Keywords: Death education; deathcare workers; expert consensus; Italy; program development; professional identity; bereavement communication

Introduction

Deathcare workers are professionals who work closely with all matters related to death, and play an indispensable role in facilitating the emotional, ethical, and ritual processes encompassing death (Romão et al., 2025). The deathcare workforce is involved in steps from the moment of death until the burial, offering help, support, and management to bereaving families, bridging private grief and public service (Romão et al., 2025). Deathcare labor refers to work that brings professionals into sustained contact with dead bodies, bereaved families, bureaucratic procedures, disposal infrastructures, ritual practices, and the moral scrutiny surrounding death. In the present study, deathcare workers included professionals working in forensic, palliative, funeral, and cemetery settings in Italy.

Deathcare Workers: Social Stigma and Invisibility

Despite their crucial role in society, deathcare workers and their contributions often remain invisible to both the public and institutions, and their work is frequently classified as “dirty work” (Batista & Codo, 2018). This classification stems from longstanding social stigma associated with close and continuous contact with death, dead bodies, and bereaved individuals. Within the literature on occupational stigma, funeral work is considered a form of socially and physically tainted labor because it involves tasks that many people find emotionally uncomfortable and seek to avoid (Ashforth & Kreiner, 1999, 2014). Scholars have argued that contemporary Western societies increasingly distance death from everyday life, relegating it to specialized institutions and professions, which contributes to the marginalization of those who work with the dead (Walter, 1991; Howarth, 2007). As a result, deathcare workers are often perceived as reminders of human mortality, provoking discomfort, avoidance, and social distancing (Simone, 2011). Research has shown that funeral directors, embalmers, and cemetery workers frequently experience low social prestige, invisibility, and

misunderstandings about the nature and value of their work despite providing an essential service to individuals, families, and communities (Romão et al., 2025).

The deathcare workforce is largely invisible yet does not unfold within a neutral social space (Woodthorpe & Komaromy, 2013). The work is structured through relations of power, governance, and recognition that determine which forms of labor are moralized, made detectable, and institutionally supported or neglected. The work becomes political through the infrastructures, practices, and spaces in which deceased bodies are handled, bereaved families are guided, and human loss is administratively managed. However, different from other realities (e.g., USA), in Italy, the work and the workforce undertaking it remain unevenly valued, regulated, and resourced (Botha et al., 2026; Morena et al., 2019; Romão, Woodthorpe, Setti, et al., 2025; Zavattaro, 2020). A clear example of the institutional neglect faced by deathcare workers was the Covid-19 pandemic, where funeral and cemetery workers were working at an increased workload while having to witness traumatic deaths and disrupted mourning rituals, and with few to none institutional support, social recognition, or psychological assistance (Dyregrov et al., 2024; Overmeire & Bilsen, 2020). Given this, the educational support and provision for deathcare workers is therefore not value-free; it is political in terms of what types of education are provided (or not), what types of knowledge are privileged, and who delivers it. It raises questions of visibility and invisibility, moral valuation, institutional responsibility, and professional legitimacy that shape *who* is recognized as a credible “expert” in death, *whose* suffering is acknowledged, and *how* responsibility for managing death is distributed across workers, organizations, and intersecting public/commercial systems, institutions and infrastructure.

Further Occupational Challenges in Deathcare Work

Beyond issues of stigma and professional invisibility, deathcare workers face a range of occupational challenges that stem from the practical, relational, and organizational demands of their work. Their role frequently requires managing emotionally charged interactions with bereaved families while simultaneously attending to complex logistical, legal, and administrative responsibilities. Funeral directors, embalmers, cemetery personnel, and crematorium workers often operate under significant time pressures, balancing the need for efficiency with expectations of compassion and professionalism during periods of acute family distress (Bugen, 1979; Kirwin, 2008). This dual responsibility can create tensions between the commercial, operational, and caring dimensions of deathcare practice.

Deathcare workers are also regularly exposed to potentially distressing situations, including traumatic deaths, deaths involving children, highly decomposed bodies, or circumstances involving accidents, violence, or suicide (Harrawood et al., 2011; McGarry et al., 2018). While repeated exposure does not necessarily result in psychological harm, it requires workers to engage in ongoing emotional regulation and professional boundary management. Research suggests that many workers develop informal coping mechanisms and practical forms of experiential knowledge to navigate these demands, yet such strategies are often learned on the job rather than through structured education or organizational support (Le et al., 2017; McGarry et al., 2018).

At an organizational level, workers may encounter challenges related to limited opportunities for professional development, inadequate supervisory support, role ambiguity, and the absence of formal spaces to discuss the emotional impact of their work (Le et al., 2017; Rantala et al., 2018). These conditions can contribute to experiences of occupational stress and moral tension, particularly when workers feel unable to provide the quality of care they consider appropriate because of time constraints, organizational pressures, or resource limitations. Importantly, these challenges are shaped not only by individual factors but also by

broader institutional arrangements that influence how deathcare work is organized, valued, and supported. Understanding these occupational realities is therefore essential when considering the development of educational initiatives aimed at strengthening professional competence, well-being, and organizational support within the deathcare sector.

Death Education as Institutional Support

Within this context, death education offers a potentially valuable framework for supporting deathcare workers. Broadly defined as any structured process of teaching and learning about death, dying, bereavement, and related existential issues, death education aims to increase knowledge, facilitate reflection, promote emotional processing, and enhance individuals' capacity to engage with death-related experiences in personal and professional contexts (Corr & Doka, 2025; Ronconi et al., 2023). Emerging from the interdisciplinary field of thanatology during the latter half of the twentieth century, death education developed in response to growing concerns about the marginalization of death in modern societies and the limited preparation individuals receive for encountering mortality, loss, and grief (Leviton, 1977; Wass, 2004). Rather than focusing solely on the transmission of factual knowledge, death education has increasingly been conceptualized as a holistic and transformative process that integrates cognitive, emotional, relational, cultural, ethical, and existential dimensions of learning (Testoni et al., 2020).

Death education initiatives have been implemented across a wide range of settings, including schools, universities, healthcare organizations, hospices, and community contexts, with goals that extend beyond improving knowledge about death itself. These programs frequently seek to foster emotional literacy, encourage meaning-making, develop communication skills, strengthen reflective practice, and support individuals in confronting mortality in ways that enhance psychological well-being and social connectedness (McClatchey & King, 2015; Testoni et al., 2021). Research suggests that participation in death

education can increase death-related competence, improve confidence in discussing end-of-life issues, reduce death anxiety and avoidance, and promote more nuanced understandings of grief and bereavement (McClatchey & King, 2015; Ronconi et al., 2023; Romão et al., 2025).

The relevance of death education may be particularly pronounced for professionals whose work requires regular engagement with death and bereavement. Previous studies have highlighted the potential of death education to support professional identity development, ethical decision-making, communication skills, emotional self-awareness, and resilience among workers exposed to death-related situations (Chan et al., 2010; Peters et al., 2013; Testoni et al., 2021). However, much of the existing literature has focused on healthcare professionals, palliative care practitioners, nursing students, physicians, psychologists, and social workers, reflecting broader assumptions about who is considered a legitimate recipient of death-related professional education (Lehto & Stein, 2009; Testoni et al., 2021). Consequently, deathcare workers have remained largely absent from these discussions despite their sustained and direct involvement with death, bereavement, and the practical realities of mortality.

Death Education and Deathcare Workers: Current Gaps

The absence of formal death education for the population of deathcare workers in Italy is not simply a technical training gap, but a form of structural educational neglect. Existing evidence (Romão, Belli, Jumayeva, et al., 2025; Romão, Setti, Monaci, et al., 2025; Romão, Setti, Thomson, et al., 2025; Romão, Woodthorpe, Setti, et al., 2025) shows that death-related work often involves emotional labor, stigma, invisibility, and institutional barriers to entry. Further research has shown that (Di)stress in these workforces is produced not only by repeated exposure to death, but by organizational and social arrangements that leave staff to absorb the difficulties of the job without sufficient recognition or support (Guidetti et al., 2021; Lombardo et al., 2024; Romão et al., 2025). As a result, deathcare workers are exposed to institutional

conditions that normalize technical responsibility while neglecting emotional, relational, and organizational preparation, positioning them at the forefront as moral shock absorbers (Grandi et al., 2024). A scoping review on burnout in death-related professions suggests that exhaustion in this workforce is shaped by a lack of organizational support and that its consequences extend beyond workers themselves to the care and support received by grieving families (Romão et al., 2025). The same study identified death education as a protective factor in some settings, underscoring the institutional failure – and need - to equip workers for the psychosocial and relational demands of deathcare work (Romão, Belli, Jumayeva, et al., 2025).

Despite the existence of death education programs, particularly in end-of-life care settings and other professional and community contexts (Testoni et al., 2021; Zhang et al., 2023), a significant gap remains in their provision for deathcare workers worldwide (Le et al., 2017). A recent scoping review of 45 studies found that the existing literature on death education and psychosocial support is only partially aligned with the lived experiences of deathcare workers and the organizational realities that shape their daily work (Romão, Belli, Jumayeva, et al., 2025). The review identified deathcare workers as an overlooked occupational group, frequently excluded from educational and support initiatives designed for “healthcare professionals,” despite their routine exposure to death, grief, bereavement, and emotionally demanding interactions with families (Romão et al., 2025a). Consequently, many of the educational opportunities available to these workers focus primarily on technical, legal, or administrative aspects of deathcare practice, while offering limited support for the emotional, relational, ethical, and existential dimensions of their work. This gap is particularly noteworthy given growing evidence that funeral directors, embalmers, and cemetery workers experience occupational stressors including emotional labor, compassion fatigue, stigma, moral distress, and exposure to traumatic circumstances (Breen et al., 2018; Setti et al., 2024). The absence of educational initiatives specifically tailored to these experiences may contribute to the continued

marginalization of deathcare workers within broader systems of death-related care and support. Furthermore, it reflects a wider tendency to recognize expertise in death primarily within healthcare settings, overlooking the unique forms of knowledge, care, and emotional work performed by those responsible for managing the practical and social realities of death after a person's death has occurred. These gaps highlight the need for educational approaches that are responsive to the specific contexts, challenges, and expertise of deathcare workers, and that are developed in collaboration with the professionals they are intended to support.

Education Provision and Regulation in Deathcare: International Contrasts and the Italian Context

Deathcare education and professional requirements vary substantially across countries. In some settings, the pathway into funeral work is partly institutionalized through licensure and accredited training routes. For example, in the United States and parts of Canada, entry to funeral service is typically tied to formal examinations and regulated educational infrastructure, even though requirements can differ by jurisdiction and role (e.g., funeral directing vs embalming) (Cathles et al., 2010; “Mortuary Science Education,” 2009; Alberta Funeral Services Regulatory, n.d.). Elsewhere, education is less consistently embedded within regulation, and professional learning may occur more informally within workplaces and occupational cultures. In England, Wales, and Northern Ireland, a recent government call for evidence explicitly noted that funeral directors are not regulated, with no statutory licensing or registration scheme, no compulsory qualification, and no routine statutory inspection regime (Rowland, 2026).

Italy represents a distinctive case where regulation is comparatively detailed but predominantly administrative and technical, rather than oriented toward workforce education. Mortuary governance (*polizia mortuaria*) coordinated how deaths are declared, certified,

authorized, transported, and managed across municipalities, health authorities, regions, and the judiciary, with national provisions consolidated in long-standing public health and mortuary regulations (e.g., *Decreto del Presidente della Repubblica 10 settembre 1990, n. 285*). Yet, this regulatory density does not translate into a stable educational pathway for the broader deathcare workforce. In the funeral sector specifically, the Italian context has been characterized by fragmentation and uneven development: funeral homes and related facilities have expanded, but regulation is described as lacking a clear and uniform national framework, with substantial variation across regional and municipal initiatives (Morena et al., 2019). This patchwork matters for workforce conditions because it shapes who is responsible for training, who funds it, and whether participation is protected as legitimate work time, especially in field planning publicly funded services (e.g., forensic and palliative settings), and commercial environments (e.g., funeral and cemetery services), where organizations may be in competition.

Why does this matter? Evidence from death-related professions indicates that repeated exposure to death and suffering can be accompanied by psychosocial strain, and that organizational support is central for mitigating negative outcomes and protecting care quality (Guidetti et al., 2025; Romão, Setti, Alfano, et al., 2025b). In this sense, education is not simply a skill upgrade: it can operate as an institutional mechanism that legitimizes relational and ethical competencies, supports coping and role boundaries, and reduces the structural invisibility of deathcare work. However, barriers to education in deathcare are also structural: uneven institutional buy-in, resource constraints, and sectoral fragmentation, particularly where workforce support is not mandated and where commercial pressures shape what is feasible.

Co-designing Death Education for Marginalized Workforces

The present study addresses this gap in educational and institutional support through an integrated evidence chain that moves from lived experience to intervention design and expert

consensus, showing the extent to which (and how) distress in deathcare settings is produced by institutional arrangements, reframing death education as a public health and public policy intervention that can enable public societal recognition and make neglected forms of labor related to death more visible and legitimate. The proposed outcome, the co-designed death education program called CARE, treats emotional and relational competencies not as optional or individual traits, but as legitimate, teachable, and collectively supported aspects of professional practice. Here, co-design refers to the multiple forms of input shaping the program: workers lived experiences and unmet needs, integrated with expert feedback drawn from the Delphi rounds. The Delphi phase detailed in this paper functions as a mechanism to examine tensions between educational relevance and the institutional feasibility of the proposed program.

The present study thus uses a Delphi consensus process to prioritize key components of a death education program for deathcare workers in Italy. The present Delphi study constitutes Phase 4 of a broader research programme; earlier phases (Romão, Belli, Jumayeva, et al., 2025; Romão, Setti, Monaci, et al., 2025; Romão, Setti, Thomson, et al., 2025; Romão, Woodthorpe, Setti, et al., 2025) informed the development of the questionnaire domains and item pool, whereas this paper reports the Delphi methods and findings. By providing item-level prioritization and feasibility judgements, the Delphi offers an evidence-informed foundation for designing training that is both context-sensitive and implementable within Italian deathcare settings.

Methods

Research Question

This study followed the research question: what are the priority components of a death education program for deathcare workers in Italy, in terms of the educational aims to prioritize,

the content areas to include (and their feasibility), the teaching strategies and delivery formats to adopt, and the outcomes that should be used to evaluate effectiveness?

Study Design

A two-round, web-based modified Delphi study using Qualtrics was conducted to develop expert consensus on key priorities for a death education program for deathcare workers in Italy. Delphi methods are widely used in health and educational research to structure expert judgment through anonymity, interactive rounds, and statistical aggregation of responses. Because items were rated using Likert-type ordinal response scales, the study employed non-parametric descriptive summaries (median and interquartile range) and a priori consensus rule to determine agreement. The Delphi constituted Phase 4 of a broader program of research aimed at co-designing a structured death education intervention, and it is also part of a PhD project aimed at developing a death education program. The preceding phases generated the empirical and evidence base used to build the Round 1 questionnaire and to structure the domains assessed in this study (Romão, Belli, Jumayeva, et al., 2025; Romão, Setti, Monaci, et al., 2025; Romão, Setti, Thomson, et al., 2025; Romão, Woodthorpe, Setti, et al., 2025). As part of a broader project, this study also included the partnership and support of professor and researcher Dr. Kate Woodthorpe.

Study Setting

The Delphi panel was composed of Italian experts in death and dying, and data collection was conducted entirely online. The study addressed priorities for death education specifically within the Italian context of deathcare work.

The Delphi Process

The round 1 questionnaire (Supplementary Material 1) comprised six sections. Section 1, educational aims, asked panelists to rate the relevance of nine educational aims for a death education program for Italian deathcare workers on a 7-point Likert scale (1= not at all; 7= extremely). Section 2, content evaluation included a macro-level rating of six broad content domains for overall relevance and micro-level rating of thirteen specific content areas for both relevance and feasibility. Section 3, teaching and learning strategies, asked panelists to rate eleven strategies on both relevance and feasibility. Section 4, delivery modes and logistics, asked panelists to rate seven delivery modes on suitability and feasibility, and to rate seven logistical elements on suitability. Section 5, outcomes for evaluation, asked panelists to rate the importance of ten candidate outcomes. Section 6, program development considerations, included open-ended questions to elicit reflections on evaluation elements, follow-up supports, sustainability conditions, and potential risks and or ethical issues. Round 2 was restricted to items that did not reach the predefined consensus criteria in round 1 and therefore required re-rating. Specifically, round 2 re-assessed micro-content feasibility, teaching and learning strategies feasibility, and delivery modes.

Delphi Panel: Eligibility and Recruitment

Experts were eligible if they had recognized professional experience in death studies, thanatology, end-of-life care, forensic, and or bereavement through clinical practice and or research. Participants were identified through purposive sampling using the Network Italiano di Morte o Oblio (NIMO; Italian Network of Death and Oblivion) website and affiliated contacts, as well as professional networks developed through conferences and seminars. Recruitment aimed to include experts from multiple disciplinary backgrounds, including psychology, medicine, anthropology, nursing, and sociology, to ensure a heterogenous panel. Round 2 invitations were sent to the same pool of experts invited in Round 1. However, because

responses were collected anonymously and no respondent identifiers were retained, we could not verify whether the individuals who completed round 2 were the same as those who completed round 1.

Data Collection

Both rounds were administered via Qualtrics using emailed survey links. In round 1, 15 experts were invited, 10 initiated the questionnaire, and 8 completed it, forming the complete, case analytic sample. This panel size is consistent with commonly cited Delphi methodological guidance for expert consensus studies (Belton et al., 2019; J. Skulmoski et al., 2007). Participants had two weeks to complete round 1, and the questionnaire required approximately 10-15 minutes to complete. In round 2, all 15 experts were reinvited, and 8 completed the questionnaire. Participants had one week to complete round 2, which required approximately 5-10 minutes. Round 1 included all questionnaire domains, whereas round 2 was implemented to address the non-consensus areas identified in round 1. Accordingly, only items that did not meet the predefined consensus criteria in round 1 were re-presented for re-rating. Item-level statistical feedback (e.g., round 1 medians/IQRS) was not displayed to panelists.

Consensus Definition

Consensus criteria were specified a priori. For each item, the median and interquartile range (IQR) were calculated, as well as the proportion of responses in the top categories (6-7). An item was classified as reaching consensus if it met all three thresholds: median ≥ 6 , IQR ≤ 1 , and $\geq 70\%$ of ratings in the top categories (6-7) (Belton et al., 2019; Skulmoski et al., 2007). Items not meeting the consensus rule in round 1 were carried forward for re-rating in round 2.

Data Analysis

Quantitative analyses were conducted in JASP Team (2022). For each item and round, medians, interquartile ranges (IQRs), and top-box proportions (ratings 6-7) were computed and compared against the predefined consensus thresholds to determine whether consensus has been achieved. Analyses were based on complete-case responses only. Consensus was operationalized a priori using a combined rule (median ≥ 6 , IQR ≤ 1 , and $\geq 70\%$ top-box agreement), consistent with Delphi reporting that recommends non-parametric summaries for ordinal Likert-type data and predefined criteria for determining convergence (Nasa et al., 2021). Qualitative feedback was collected via free-text comment boxes and analyzed using descriptive content analysis, which is appropriate for short, suggestion-oriented responses (Doyle et al., 2020). Comments were exported from Qualtrics to MAXQDA (VERBI Software, 2021) and coded in an analytic workflow designed to support transparency and traceability. First, all comments were read in full to familiarize the analyst with the breadth to reflect the function of the comments for Delphi refinement (e.g., missing topics, requests for wording clarification, feasibility barriers and enabling conditions, and implementation risks and ethical concerns). A brief codebook defining each category for inclusion or exclusion criteria was created and iteratively refined during coding. Through the process, analytic memos were used to document coding decisions and ambiguous cases, and an audit trail was maintained linking raw excerpts to category assignments and to any subsequent questionnaire revisions. The transcripts were translated and back-translated by a bilingual researcher.

Ethical Approval

Ethical approval was granted by the Ethics Committee of the Department of Brain and Behavioral Sciences, University of Pavia, Italy (Protocol 176/24). Participation was voluntary, informed consent was obtained electronically, and data were collected anonymously and analyzed in aggregate form in accordance with applicable ethical and data protection standards.

Results

Participants Characteristics

Fifteen experts were invited to participate in this study. However, 8 participated in rounds 1 and 2. Across rounds, the panel was interdisciplinary, spanning psychology/ clinical practice and psychotherapy, palliative care, forensics medicine, anthropology (including cultural/urban and religion-focused backgrounds), thanatology, and philosophy. Participants came from both public and private sectors. Experience with death, dying, and bereavement work was generally mid-to-senior, with most respondents falling in the 3-5 years and 11-20 years of professional experience. Prior exposure to death education varied: in round 1, many respondents reported having designed and or delivered death education, whereas in round 2, the panel more often reported having attended more than one training. Table 1 summarizes the panel in a de-identified form to protect their privacy.

Table 1

Panel Characteristics by Delphi Round

Characteristic	Round 1 (n=8)	Round 2 (n=8)
Completed / Invited	8 / 15	8 / 15
Primary work setting	Public (3); Private (3); non-profit/religious (1); Other (1)	Public (5); Private (3)
Years of experience with death/dying/bereavement	3–5 years (1); 6–10 years (1); 11–20 years (3); >20 years (3)	3–5 years (4); 11–20 years (3); >20 years (1)

Previous death education experience	None 3; Attended >1 training 1; Designed/delivered 4	None 3; Attended >1 training 5
Disciplinary breadth	Forensic medicine; psychology; psychotherapy/palliative care; anthropology; philosophy; death education	Psychology/clinical; forensic medicine; anthropology; psychology (research); psychiatry/psychology area; cultural heritage/anthropology

Note. Values in parentheses indicate number of participants.

Overview of Strategy Development

A summary of the Delphi study process can be found below in Figure 1, including panel identification and recruitment, round 1 and round 2 completion rates, survey structure, and the iterative re-rating procedure for items that did not meet the a priori consensus criteria.

Figure 1

Delphi Study Flowchart Including Panel Invitation, Survey Structure, Completion Rates, and Round-by-Round Refinement Based on A Priori Consensus Criteria

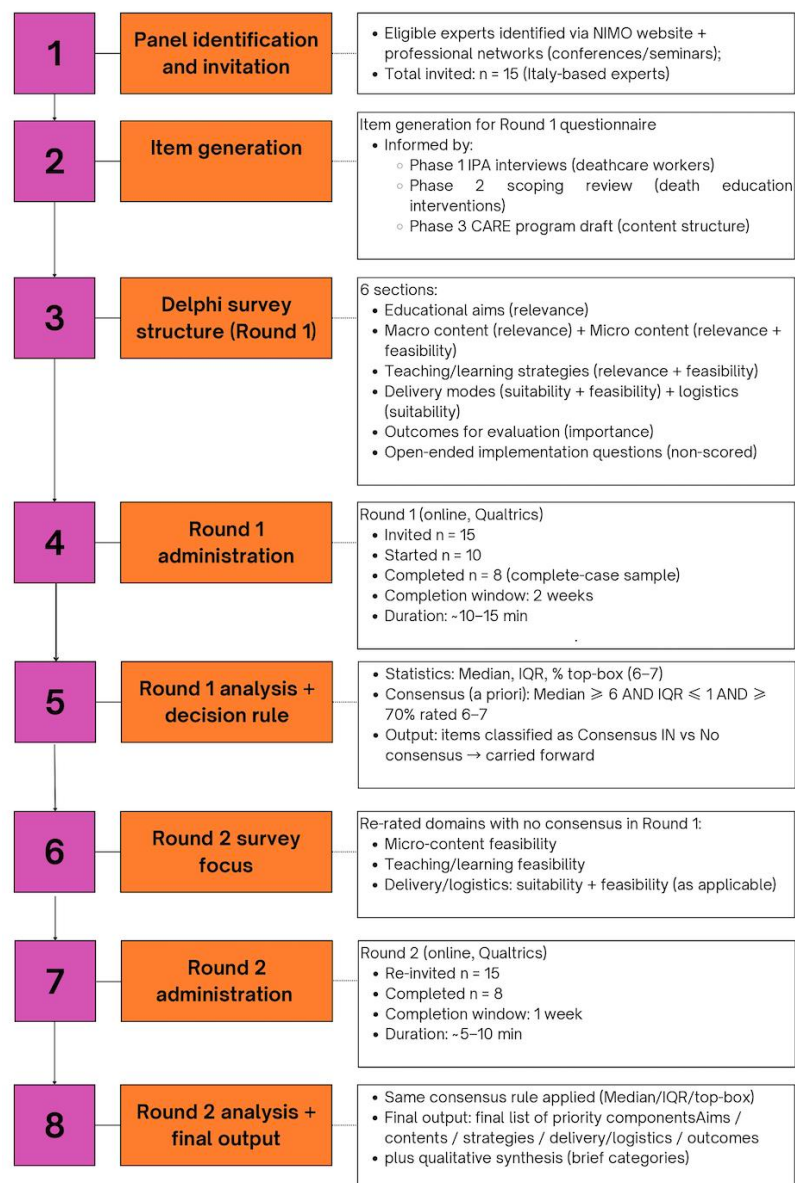


Table 2 provides an integrated summary of consensus findings across program aims, content, pedagogy, delivery, and outcomes, highlighting both recommended core elements and areas where design choices remained context dependent.

Table 2

Delphi Consensus Summary: Recommended Features of a Death Education Program for Italian Deathcare Workers

Program Component	What Experts Recommended (Consensus)	What Remained Context-Dependent (No Consensus / Dispersed)
Primary Aims	Reduce stigma/social invisibility; strengthen professional identity; improve communication with bereaved families; support coping/self-care; foster meaning-making/post-traumatic growth	Burnout prevention (most contested); organizational-level aims (awareness/detection) were near-threshold but dispersed
Core Content (Macro Domains)	Communication/relational processes; occupational risks & protective factors	Foundations of deathcare work; grief/rituals; organizational/collective dimensions (endorsed but heterogeneous)
Core Content (Micro-Relevance)	Families' experiences & cultural variability; rituals/mourning practices; professional identity; ethics/boundaries; moral distress; relational challenges; organizational psychosocial risk management	Theoretical models; socio-historical foundations; communication processes; burnout/CF/VT risk factors; coping/resilience resources; team dynamics (generally rated high but dispersed)
Micro-Content Feasibility (Round 2)	Ethical principles, boundaries, role responsibilities (only item meeting feasibility consensus)	All other micro-content feasibility ratings remained dispersed under the strict consensus rule
Teaching Strategies (Relevance)	Case discussions; guided group reflection; reflexive writing; small-group work on dilemmas; peer support/supervision groups	Short lectures; role-plays/simulations; communication skills training with feedback; manuals/videos; symbolic activities; online modules (near-consensus or mixed)

Teaching Strategies Feasibility (Rounds 1–2)	No strategy met feasibility consensus	Feasibility varied widely across strategies - strongly context-dependent
Delivery/Logistics (Suitability)	Small groups (8–15); co- facilitation (mental health professional + experienced deathcare professional)	Duration, modality, session length, and other configurations dispersed
Delivery/Logistics (Feasibility-Round 2)	Small groups (8–15); facilitator as mental health professional	No single format/modality/length emerged as uniformly feasible
Evaluation Outcomes	Improved communication with families; reduced emotional distress; increased coping/self-care; increased meaning/professional identity; participant satisfaction	Burnout and compassion fatigue reduction near- consensus but dispersed; knowledge gain, team climate, willingness to recommend more variable

Results Round 1

Section 1: Educational Aims

Section 1 consisted of nine items on educational aims for a death education program targeting Italian deathcare workers, and panelists rated each question on a 7-point Likert scale. Consensus was defined a priori as Median ≥ 6 , IQR ≤ 1 , and $\geq 70\%$ of ratings in the top-box (6–7). Overall, ratings were consistently high across aims (medians 6.0–7.0), indicating broad endorsement of the proposed program's goals. Five aims reached consensus for inclusion. Experts strongly converged on the relevance of reducing stigma and social invisibility of deathcare professions (OE_6; Median= 7, IQR= 1; 100% rated 6–7) and supporting professional identity development (OE_7; Median= 6.5, IQR= 1; 100% rated 6–7). Consensus was also achieved for strengthening communication skills with bereaved families (OE_2;

Median= 7, IQR= 1; 87.5% rated 6–7), supporting emotional coping and self-care (OE_3; Median= 7, IQR= 1; 87.5% rated 6–7), and fostering meaning-making/post-traumatic growth (OE_4; Median= 6, IQR= 1; 87.5% rated 6–7).

Four aims did not meet the strict consensus criterion due to greater dispersion and/or weaker top-box agreement, despite generally high central tendency. The most debated aim was preventing occupational stress and burnout (OE_8; Median= 6, IQR= 2; 62.5% rated 6–7), suggesting heterogeneous views about the role of a death education program in burnout prevention specifically. Enhancing foundational knowledge on death/dying/grief (OE_1), increasing organizational awareness of psychosocial risks (OE_5), and supporting organizations in early detection of risk signals (OE_9) all showed high medians (6.0–6.5) and majority top-box endorsement (75%), but failed consensus due to slightly wider interquartile ranges (IQR= 1.25). Below, Figures 2, 3 and 4 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 3 summarizes the consensus level of each item.

Figure 2

Section 1: Median Ratings with IQR

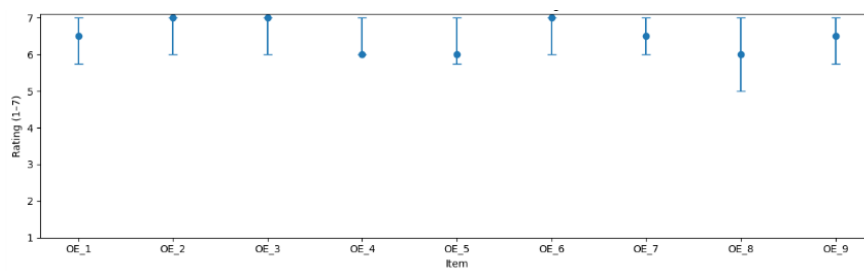


Figure 3

Section 1: Top-box Agreement (Ratings 6-7) by Item

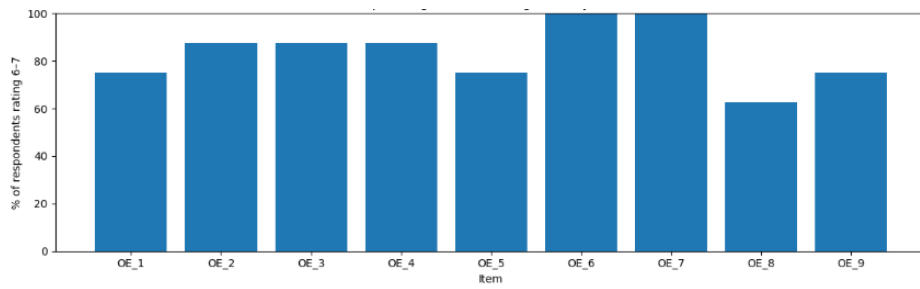


Figure 4

Section 1: Response Distributions (Counts) per Item (1-7)

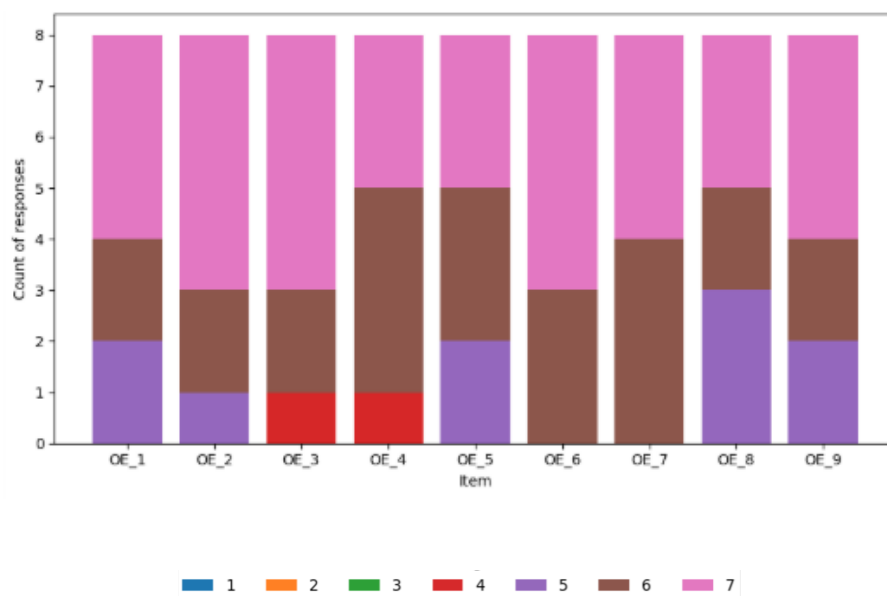


Table 3

Section 1: Consensus Levels and Statistical Summary

Item	Educational Aim	n	Median	IQR	% (6-7)	Consensus
OE_1	Knowledge: death/dying/grief	8	6.5	1.25	75.0%	No consensus (dispersion)
OE_2	Communication with bereaved families	8	7.0	1.00	87.5%	Consensus IN
OE_3	Emotional coping & self-care	8	7.0	1.00	87.5%	Consensus IN

OE_4	Meaning making & post-traumatic growth	8	6.0	1.00	87.5%	Consensus IN
OE_5	Org awareness of psychosocial risks	8	6.0	1.25	75.0%	No consensus (dispersion)
OE_6	Reduce stigma/social invisibility	8	7.0	1.00	100.0%	Consensus IN
OE_7	Support professional identity development	8	6.5	1.00	100.0%	Consensus IN
OE_8	Prevent occupational stress & burnout	8	6.0	2.00	62.5%	No consensus (weak + dispersed)
OE_9	Help orgs detect early risk signals	8	6.5	1.25	75.0%	No consensus (dispersion)

Section 2: Content

Section 2A: Relevance. Section 2 was divided into part 2A (macro-content area) and 2B (micro-content area). Part 2A was rated in terms of overall relevance, and sections in part 2B were rated in terms of overall relevance and feasibility. Overall ratings for part 2A were high (overall median= 6.2), indicating general endorsement of the proposed program content areas. However, dispersion varied across items, resulting in partial consensus. Two aims reached the predefined consensus criteria for inclusion. Experts showed strong convergence on the relevance of communication and relational processes (OE_4; Median= 7.0, IQR= 0.25; 87.5% rated 6–7), reflecting both high central tendency and very low dispersion. Consensus was also achieved for occupational risks and protective factors (OE_5; Median= 6.0, IQR= 1.00; 87.5% rated 6–7), indicating substantial agreement regarding the importance of addressing work-related risk and protective dimensions.

Four aims did not meet the strict consensus threshold, primarily due to wider dispersion and/or insufficient top-box agreement. The most debated aim concerned foundations of death

and deathcare work (OE_1; Median= 5.5, IQR= 2.00; 50% rated 6–7), which showed both lower central tendency and marked variability in ratings. Similarly, grief, bereavement, and rituals (OE_2; Median= 6.0, IQR= 2.00; 62.5% rated 6–7) did not achieve consensus due to dispersed evaluations and limited top-box endorsement. Professional identity, ethics, and moral challenges (OE_3; Median= 6.5, IQR= 1.25; 75% rated 6–7) and collective and organizational dimensions (OE_6; Median= 6.0, IQR= 1.25; 75% rated 6–7) showed high median values and majority endorsement in the upper response categories, but failed to meet the consensus criterion due to slightly elevated interquartile ranges. Overall, findings suggest broad support for the proposed educational framework, with stronger convergence on relational and occupational protection dimensions, and comparatively greater heterogeneity regarding foundational and organizational-level content. Below, Figures 5, 6 and 7 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 4 summarizes the consensus level of each item.

Figure 5

Section 2A (Relevance): Median Ratings with IQR

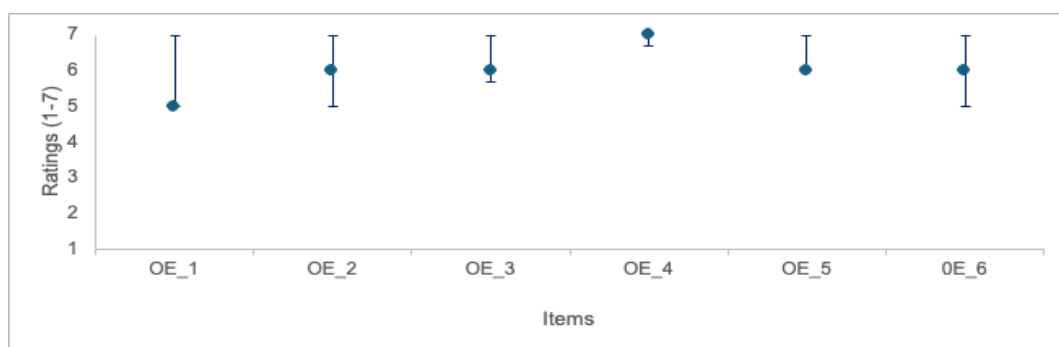


Figure 6

Section 2A (Relevance): Top-box Agreement (Ratings 6-7) by Item

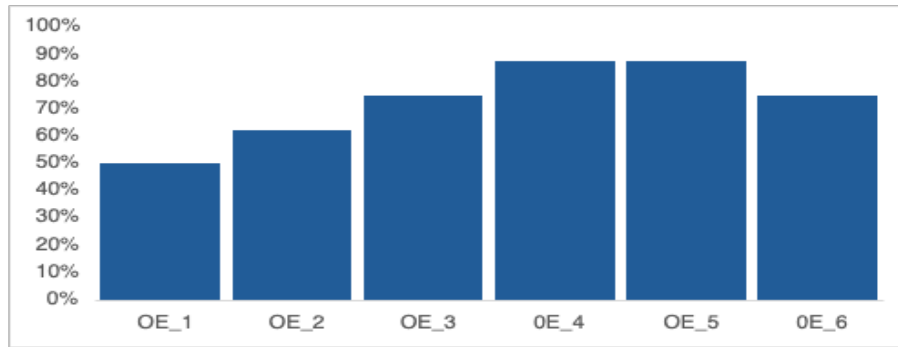


Figure 7

Section 2A (Relevance): Response Distributions (Counts) per Item (1-7)

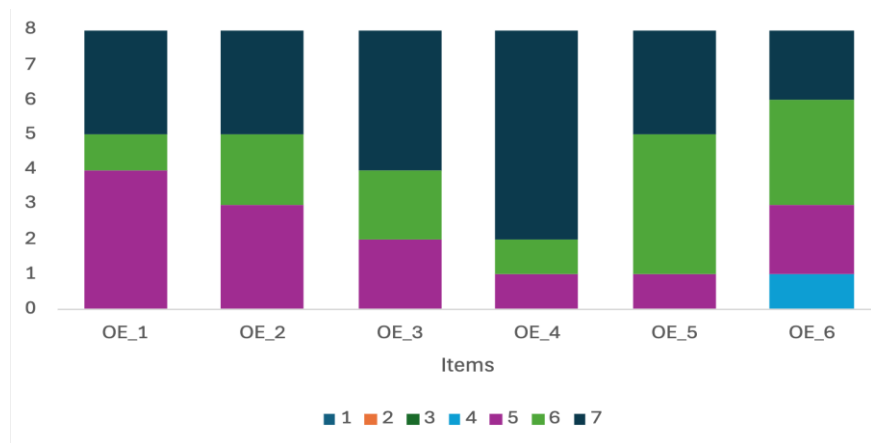


Table 4

Section 2A (Relevance): Consensus Levels and Statistical Summary

Item	Macro Content Area	n	Median	IQR	% (6–7)	Consensus
OE_1	Foundations of death and deathcare work	8	5.5	2.00	50%	No consensus (weak+dispersed)
OE_2	Grief, bereavement, and rituals	8	6.0	2.00	62.5%	No consensus (weak+dispersed)
OE_3	Professional identity, ethics, and moral challenges	8	6.5	1.25	75%	No consensus (dispersion)
OE_4	Communication and relational processes	8	7.0	0.25	87.5%	Consensus IN

OE_5	Occupational risks and protective factors	8	6.0	1.00	87.5%	Consensus IN
OE_6	Collective and organizational dimensions	8	6.0	1.25	75%	No consensus (dispersion)

Section 2B: Relevance. Overall, relevance ratings were consistently high, with medians ranging from 5.5 to 6.5, indicating broad endorsement of the proposed content domains. However, variability in dispersion led to partial consensus across items. Seven micro content areas met the predefined consensus criteria. Strong convergence was observed for families' emotional experiences and cultural variability in grief and bereavement (OE_3; Median= 6.0, IQR= 1.00; 87.5% rated 6–7), rituals, symbols, and cultural practices related to death and mourning (OE_4; Median= 6.0, IQR= 0.25; 87.5% rated 6–7), and professional identity development in deathcare roles (OE_5; Median= 6.0, IQR= 0.25; 87.5% rated 6–7). Consensus was also achieved for ethical principles, boundaries, and role responsibilities in deathcare work (OE_6; Median= 6.0, IQR= 0.25; 87.5% rated 6–7), ethical dilemmas and experiences of moral distress in professional practice (OE_7; Median= 6.0, IQR= 0.50; 75% rated 6–7), relational challenges in interactions with bereaved families and distressed individuals (OE_9; Median= 6.5, IQR= 1.00; 87.5% rated 6–7), and organizational psychosocial risk management and institutional support resources (OE_13; Median= 6.0, IQR= 1.00; 87.5% rated 6–7).

Six content areas did not reach consensus, primarily due to slightly elevated dispersion and/or weaker top-box agreement despite generally strong central tendency. Socio-historical and cultural foundations of deathcare work (OE_1; Median= 6.0, IQR= 1.25; 75% rated 6–7) and communication processes in death-related professional settings (OE_8; Median= 6.0, IQR= 1.25; 75% rated 6–7) demonstrated majority endorsement but exceeded the dispersion threshold. Similarly, occupational risk factors for burnout, compassion fatigue, and vicarious

trauma (OE_10; Median= 6.0, IQR= 1.25; 87.5% rated 6–7) and protective factors such as coping strategies and resilience resources (OE_11; Median= 6.0, IQR= 1.25; 87.5% rated 6–7) showed strong endorsement but slightly wider interquartile ranges. Team dynamics, peer support, and collective coping within organizations (OE_12; Median= 6.0, IQR= 1.25; 62.5% rated 6–7) did not achieve consensus due to both dispersion and comparatively lower top-box agreement. The least strongly endorsed item was psychological and theoretical models of death, dying, and grief (OE_2; Median= 5.5, IQR= 1.25; 50% rated 6–7), reflecting comparatively lower central tendency and weaker convergence.

Overall, findings indicate robust agreement regarding relational, ethical, identity-related, and organizational-support content, while theoretical foundations, communication processes, and occupational well-being components elicited greater variability. These results suggest that experts prioritize applied, relational, and practice-oriented domains, whereas more theoretical or structurally complex areas may require clarification or refinement. Below, Figures 8 ,9 and 10 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 5 summarizes the consensus level of each item.

Figure 8

Section 2B (Relevance): Median Ratings with IQR

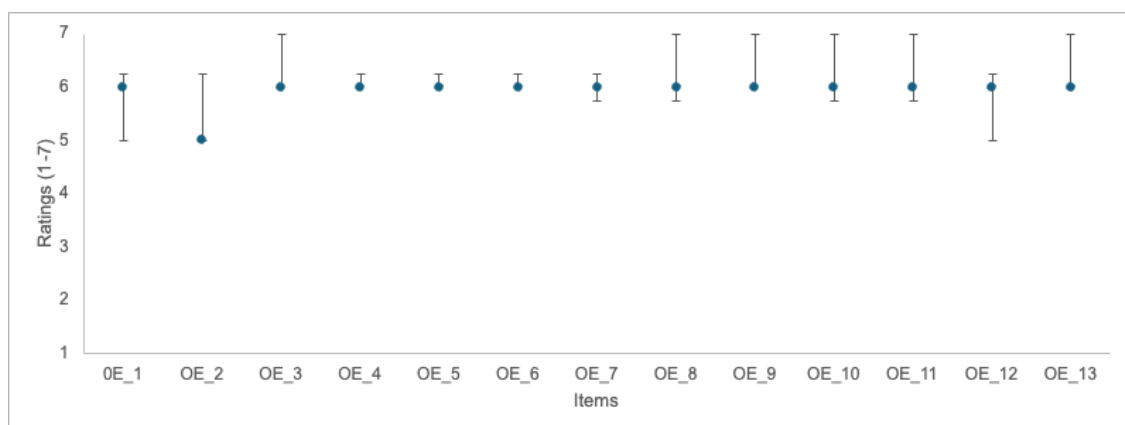
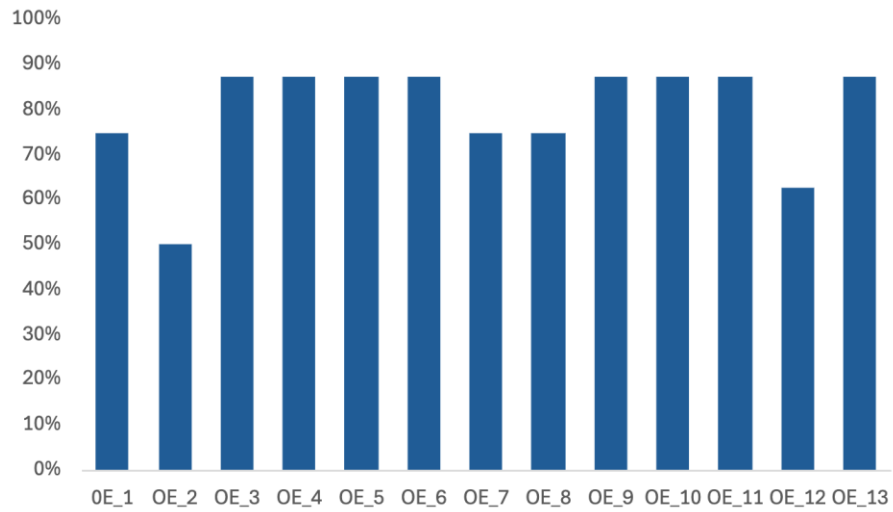
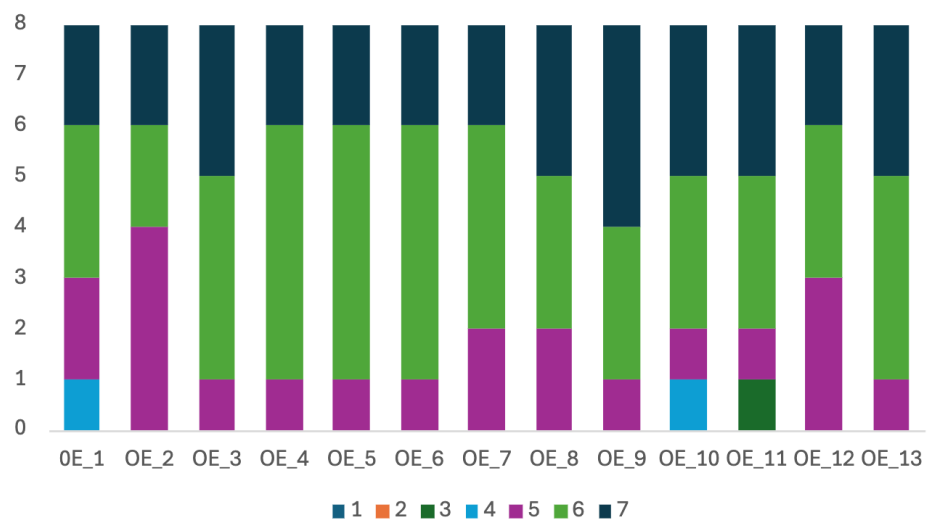


Figure 9

Section 2B (Relevance): Top-box Agreement (Ratings 6-7) by Item

**Figure 10**

Section 2B (Relevance): Response Distributions (Counts) per Item (1-7)

**Table 5**

Section 2B (Relevance): Consensus Levels and Statistical Summary

Item	Micro Content Area	n	Median	IQR	% (6–7)	Consensus
OE_1	Socio-historical and cultural foundations of deathcare work	8	6.0	1.25	75%	No consensus (dispersion)
OE_2	Psychological and theoretical models of death, dying, and grief	8	5.5	1.25	50%	No consensus (weak+dispersed)
OE_3	Families' emotional experiences and cultural variability in grief and bereavement	8	6.0	1.00	87.5%	Consensus IN
OE_4	Rituals, symbols, and cultural practices related to death and mourning	8	6.0	0.25	87.5%	Consensus IN
OE_5	Professional identity development in deathcare roles	8	6.0	0.25	87.5%	Consensus IN
OE_6	Ethical principles, boundaries, and role responsibilities in deathcare work	8	6.0	0.25	87.5%	Consensus IN
OE_7	Ethical dilemmas and experiences of moral distress in death-related professional practice	8	6.0	0.50	75%	Consensus IN
OE_8	Communication processes in death-related professional settings (e.g., with families, colleagues, other professionals)	8	6.0	1.25	75%	No consensus (dispersion)
OE_9	Relational challenges in interactions with	8	6.5	1.00	87.5%	Consensus IN

	bereaved families and distressed individuals					
OE_10	Occupational risk factors for burnout, compassion fatigue, and vicarious trauma	8	6.0	1.25	87.5%	No consensus (dispersion)
OE_11	Protective factors: coping strategies, self-care practices, and resilience resources	8	6.0	1.25	87.5%	No consensus (dispersion)
OE_12	Team dynamics, peer support, and collective coping within deathcare organizations	8	6.0	1.25	62.5%	No consensus (dispersion)
OE_13	Organizational psychosocial risk management and institutional support resources	8	6.0	1.00	87.5%	Consensus IN

Section 2B: Feasibility. Overall, ratings were consistently high (medians ranging from 5.5 to 6.5), indicating broad endorsement of the proposed micro-level components. However, variability in dispersion resulted in partial consensus across items. Seven content areas met the predefined consensus criteria for inclusion. Strong convergence was observed for families' emotional experiences and cultural variability in grief and bereavement (OE_3; Median= 6.0, IQR= 1.00; 87.5% rated 6–7), rituals, symbols, and cultural practices related to death and mourning (OE_4; Median= 6.0, IQR= 0.25; 87.5% rated 6–7), and professional identity development in deathcare roles (OE_5; Median= 6.0, IQR= 0.25; 87.5% rated 6–7).

Consensus was also achieved for ethical principles, boundaries, and role responsibilities in deathcare work (OE_6; Median= 6.0, IQR= 0.25; 87.5% rated 6–7), ethical dilemmas and

experiences of moral distress in professional practice (OE_7; Median= 6.0, IQR= 0.50; 75% rated 6–7), relational challenges in interactions with bereaved families and distressed individuals (OE_9; Median= 6.5, IQR= 1.00; 87.5% rated 6–7), and organizational psychosocial risk management and institutional support resources (OE_13; Median= 6.0, IQR= 1.00; 87.5% rated 6–7).

Six content areas did not reach consensus, primarily due to greater dispersion and/or insufficient top-box agreement despite generally high central tendency. Socio-historical and cultural foundations of deathcare work (OE_1; Median= 6.0, IQR= 1.25; 75% rated 6–7) and communication processes in death-related professional settings (OE_8; Median= 6.0, IQR= 1.25; 75% rated 6–7) showed majority endorsement but failed to meet the dispersion criterion. Similarly, occupational risk factors for burnout, compassion fatigue, and vicarious trauma (OE_10; Median= 6.0, IQR= 1.25; 87.5% rated 6–7) and protective factors such as coping strategies and resilience resources (OE_11; Median= 6.0, IQR= 1.25; 87.5% rated 6–7) demonstrated strong top-box agreement but slightly wider interquartile ranges. Team dynamics, peer support, and collective coping within organizations (OE_12; Median= 6.0, IQR= 1.25; 62.5% rated 6–7) did not meet consensus due to both dispersion and lower top-box endorsement. The most weakly endorsed item concerned psychological and theoretical models of death, dying, and grief (OE_2; Median= 5.5, IQR= 1.25; 50% rated 6–7), reflecting comparatively lower central tendency and limited agreement.

Overall, findings indicate robust support for relational, ethical, and identity-related micro-level content, with comparatively greater heterogeneity regarding theoretical foundations, communication processes, and occupational well-being components. Below, Figures 11, 12 and 13 illustrate the median ratings with IQR, the top-box agreement by item,

and the response distributions by item, and Table 6 summarizes the consensus level of each item.

Figure 11

Section 2B (Feasibility): Median Ratings with IQR

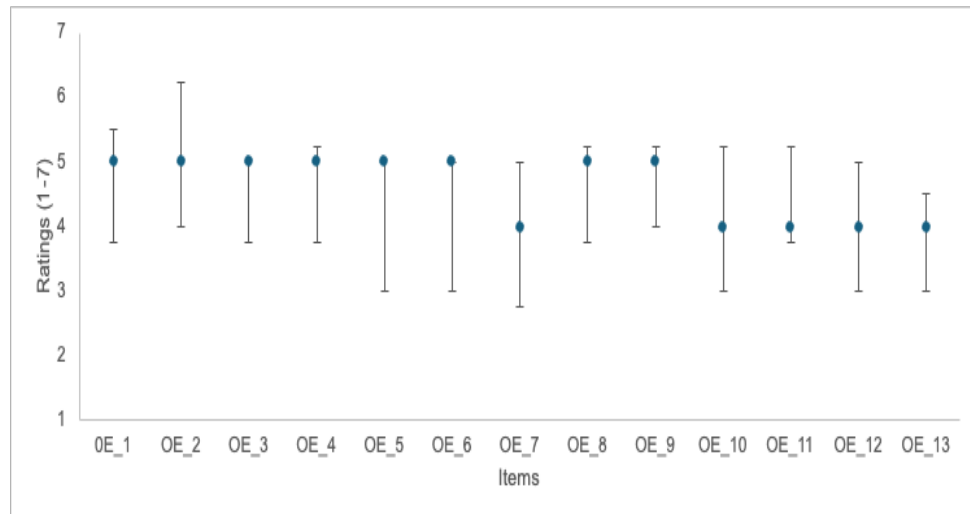


Figure 12

Section 2B (Feasibility): Top-box Agreement (Ratings 6-7) by Item

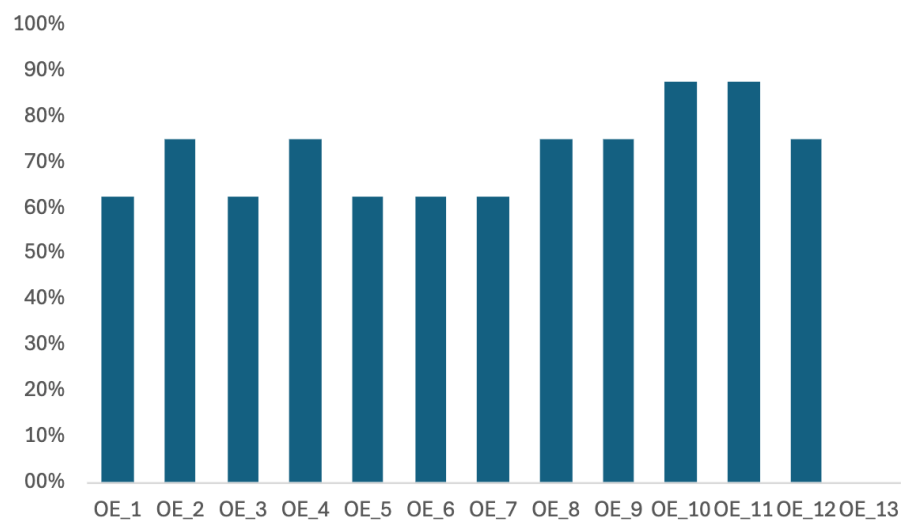
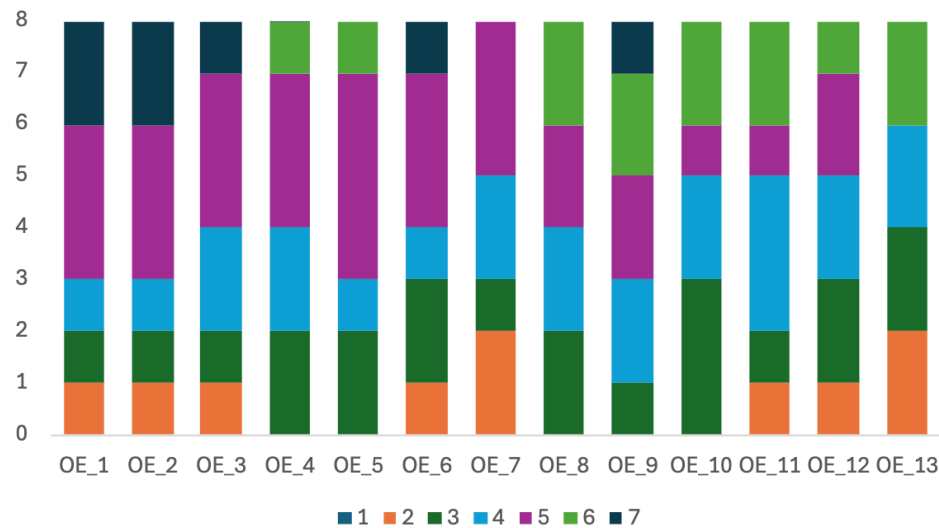


Figure 13

Section 2B (Feasibility): Response Distributions (Counts) per Item (1-7)

**Table 6***Section 2B (Feasibility): Consensus Levels and Statistical Summary*

Item	Micro Content Area	n	Median	IQR	% (6–7)	Consensus
OE_1	Socio-historical and cultural foundations of deathcare work	8	5.0	1.75	62.5%	No consensus (dispersion)
OE_2	Psychological and theoretical models of death, dying, and grief	8	5.0	2.25	75%	No consensus (dispersion)
OE_3	Families' emotional experiences and cultural variability in grief and bereavement	8	4.5	1.25	62.5%	No consensus (dispersion)
OE_4	Rituals, symbols, and cultural practices related to death and mourning	8	4.5	1.50	75%	No consensus (dispersion)
OE_5	Professional identity development in deathcare roles	8	4.5	2.00	62.5%	No consensus (dispersion)
OE_6	Ethical principles, boundaries, and role	8	4.5	2.00	62.5%	No consensus (dispersion)

	responsibilities in deathcare work					
OE_7	Ethical dilemmas and experiences of moral distress in death-related professional practice	8	4.0	2.25	62.5%	No consensus (dispersion)
OE_8	Communication processes in death-related professional settings (e.g., with families, colleagues, other professionals)	8	4.5	1.50	75%	No consensus (dispersion)
OE_9	Relational challenges in interactions with bereaved families and distressed individuals	8	4.6	1.25	75%	No consensus (dispersion)
OE_10	Occupational risk factors for burnout, compassion fatigue, and vicarious trauma	8	4.2	2.25	87.5%	No consensus (dispersion)
OE_11	Protective factors: coping strategies, self-care practices, and resilience resources	8	4.2	1.50	87.5%	No consensus (dispersion)
OE_12	Team dynamics, peer support, and collective coping within deathcare organizations	8	4.0	2.00	75%	No consensus (dispersion)
OE_13	Organizational psychosocial risk management and institutional support resources	8	3.5	1.50	0%	No consensus (dispersion)

Section 3: Teaching and Learning Strategies

Section 3: Relevance. Panelists were asked to rate both the relevance and the feasibility of eleven teaching and learning strategies. Overall, most methods received favorable evaluations (medians ranging from 5.0 to 6.0), suggesting general support for an experiential

and interactive training model. However, variability in dispersion and top-box agreement led to partial consensus across methods. Five methods met the predefined consensus criteria. Experts converged on the relevance of case discussions drawn from real work situations (OE_2; Median= 6.0, IQR= 1.00; 87.5% rated 6–7), guided group reflection and sharing (OE_4; Median= 6.0, IQR= 0.50; 75% rated 6–7), written reflexive exercises (OE_5; Median= 6.0, IQR= 1.00; 75% rated 6–7), small group work on ethical or professional dilemmas (OE_6; Median= 6.0, IQR= 0.25; 87.5% rated 6–7), and peer support or supervision groups (OE_9; Median= 6.0, IQR= 1.00; 87.5% rated 6–7). These findings indicate strong endorsement of reflective, dialogical, and practice-oriented learning strategies.

Six methods did not reach consensus, primarily due to wider dispersion and/or weaker top-box agreement despite generally adequate median values. Short interactive lectures (OE_1; Median= 6.0, IQR= 1.25; 87.5% rated 6–7) and role-plays and simulations (OE_3; Median= 6.0, IQR= 1.50; 87.5% rated 6–7) showed high central tendency and strong top-box endorsement but failed the dispersion criterion. Communication skills training with feedback (OE_7; Median= 6.0, IQR= 2.00; 62.5% rated 6–7) demonstrated greater heterogeneity in expert evaluations, suggesting divergent views regarding its implementation or feasibility.

Psychoeducational materials such as manuals or videos (OE_8; Median= 5.5, IQR= 1.25; 62.5% rated 6–7) and experiential or symbolic activities (OE_10; Median= 6.0, IQR= 1.00; 62.5% rated 6–7) did not achieve sufficient top-box agreement. The least endorsed method was online asynchronous modules (OE_11; Median= 5.0, IQR= 0.75; 50% rated 6–7), reflecting comparatively lower central tendency and limited convergence. Overall, results suggest strong expert preference for interactive, discussion-based, and reflective pedagogical approaches, whereas more didactic, highly experiential, or fully online formats elicited more heterogeneous responses. Below, Figures 14, 15 and 16 illustrate the median ratings with IQR,

the top-box agreement by item, and the response distributions by item, and Table 7 summarizes the consensus level of each item.

Figure 14

Section 3 (Relevance): Median Ratings with IQR

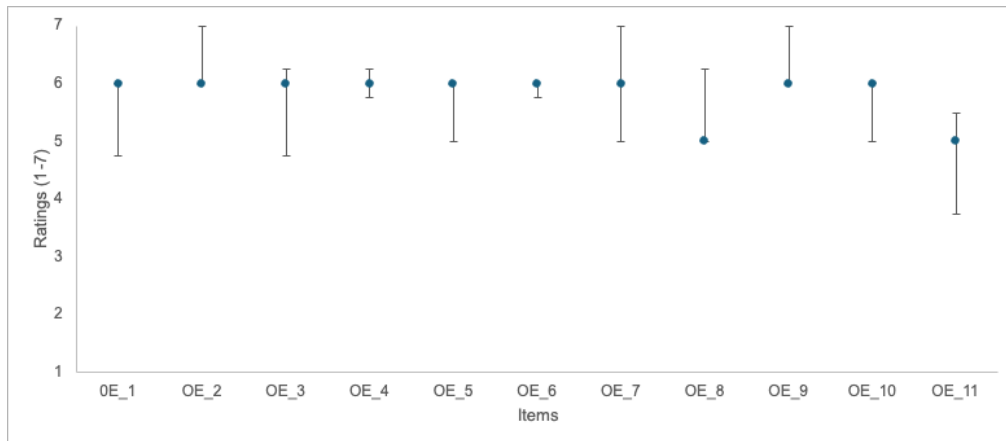


Figure 15

Section 3 (Relevance): Top-box Agreement (Ratings 6-7) by Item

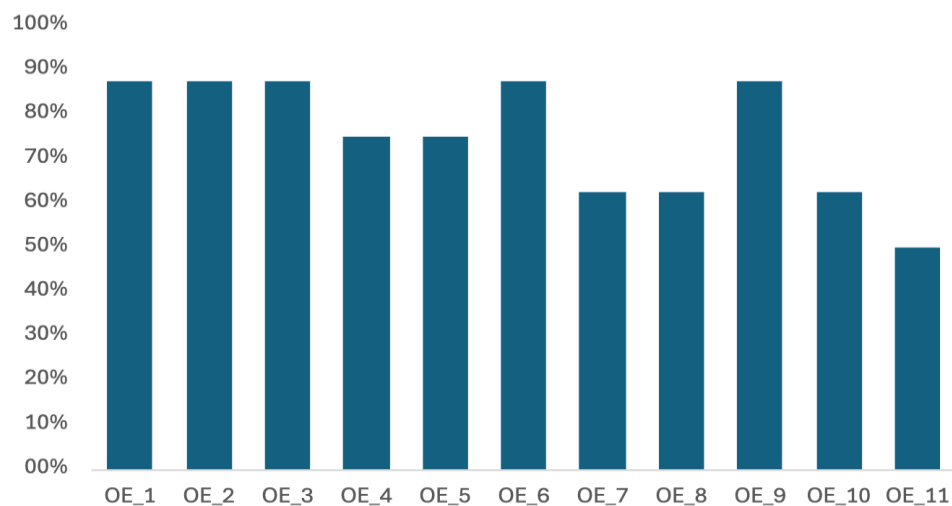
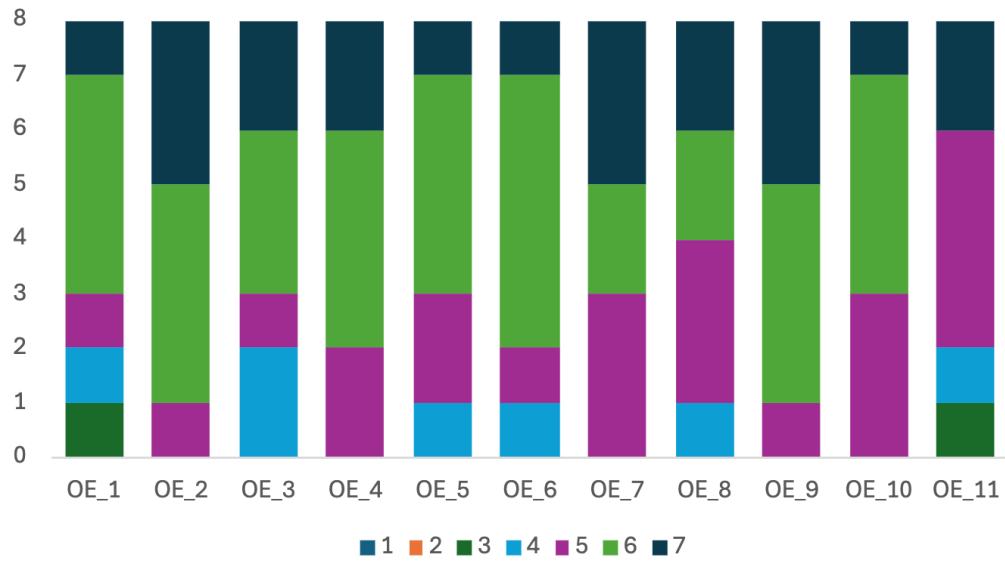


Figure 16

Section 3 (Relevance): Response Distributions (Counts) per Item (1-7)

**Table 7***Section 3 (Relevance): Consensus Levels and Statistical Summary*

Item	Teaching & Learning Strategies	n	Median	IQR	% (6–7)	Consensus
OE_1	Short interactive lectures	8	6.0	1.25	87.5%	No consensus (dispersion)
OE_2	Case discussions from real work situations	8	6.0	1.00	87.5%	Consensus IN
OE_3	Role-plays and simulations	8	6.0	1.50	87.5%	No consensus (dispersion)
OE_4	Guided group reflection and sharing	8	6.0	0.50	75%	Consensus IN
OE_5	Written reflexive exercises	8	6.0	1.00	75%	Consensus IN
OE_6	Small group work on ethical or professional dilemmas	8	6.0	0.25	87.5%	Consensus IN

OE_7	Communication skills training with feedback	8	6.0	2.00	62.5%	No consensus (dispersion)
OE_8	Psychoeducational materials (manuals, videos)	8	5.5	1.25	62.5%	No consensus (dispersion)
OE_9	Peer support or supervision groups	8	6.0	1.00	87.5%	Consensus IN
OE_10	Experiential and symbolic activities (e.g., rituals, site visits)	8	6.0	1.00	62.5%	No consensus (dispersion)
OE_11	Online asynchronous modules	8	5.00	0.75	50%	No consensus (dispersion)

Section 3: Feasibility. Overall, feasibility ratings were moderate and more heterogeneous compared to perceived relevance, with median values ranging from 4.0 to 5.5. Notably, none of the proposed methods met the predefined consensus criteria for feasibility. Short interactive lectures (OE_1; Median= 5.5, IQR= 1.50; 75% rated 6–7) and case discussions based on real work situations (OE_2; Median= 5.5, IQR= 1.25; 75% rated 6–7) showed relatively higher central tendency but failed to reach consensus due to dispersion exceeding the predefined threshold. Role-plays and simulations (OE_3; Median= 4.5, IQR= 2.25; 75% rated 6–7) and written reflexive exercises (OE_5; Median= 4.0, IQR= 2.00; 75% rated 6–7) demonstrated substantial variability in expert judgments, suggesting divergent views regarding practical implementation.

Guided group reflection and sharing (OE_4; Median= 5.0, IQR= 0.50; 50% rated 6–7), communication skills training with feedback (OE_7; Median= 5.0, IQR= 0.50; 50% rated 6–7), and psychoeducational materials (OE_8; Median= 5.0, IQR= 0.50; 50% rated 6–7)

exhibited relatively low dispersion but insufficient top-box endorsement, indicating moderate feasibility perceptions without strong convergence. Small group work on ethical dilemmas (OE_6; Median= 5.0, IQR= 1.50; 62.5% rated 6–7) and peer support or supervision groups (OE_9; Median= 4.5, IQR= 1.25; 75% rated 6–7) also failed to reach consensus due to dispersion and/or limited top-box agreement. Experiential and symbolic activities (OE_10; Median= 4.0, IQR= 1.25; 87.5% rated 6–7) presented a particularly interesting pattern: despite strong top-box endorsement, median values remained below the consensus threshold and dispersion exceeded the criterion. Finally, online asynchronous modules (OE_11; Median= 5.0, IQR= 2.00; 75% rated 6–7) showed considerable variability in ratings.

Overall, while most methods were perceived as relevant in earlier analyses, feasibility ratings were systematically lower and more dispersed. This pattern suggests that experts differentiate between pedagogical value and practical implementability, possibly reflecting concerns related to time constraints, organizational resources, logistical complexity, or workforce availability. Below, Figures 17, 18 and 19 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 8 summarizes the consensus level of each item.

Figure 17

Section 3 (Feasibility): Median Ratings with IQR

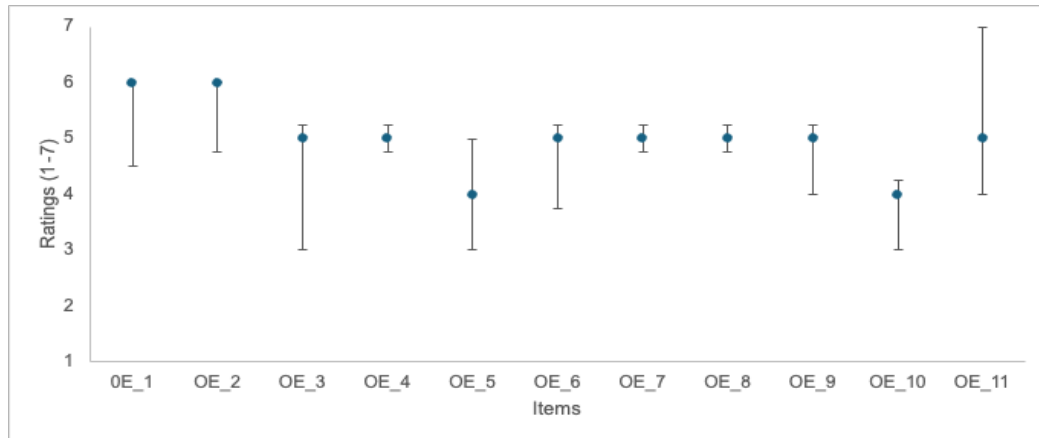


Figure 18

Section 3 (Feasibility): Top-box Agreement (Ratings 6-7) by Item

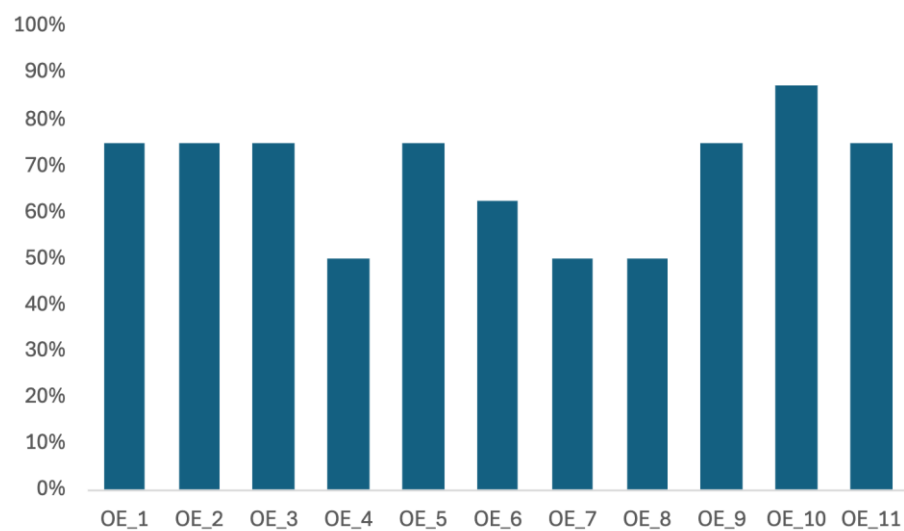
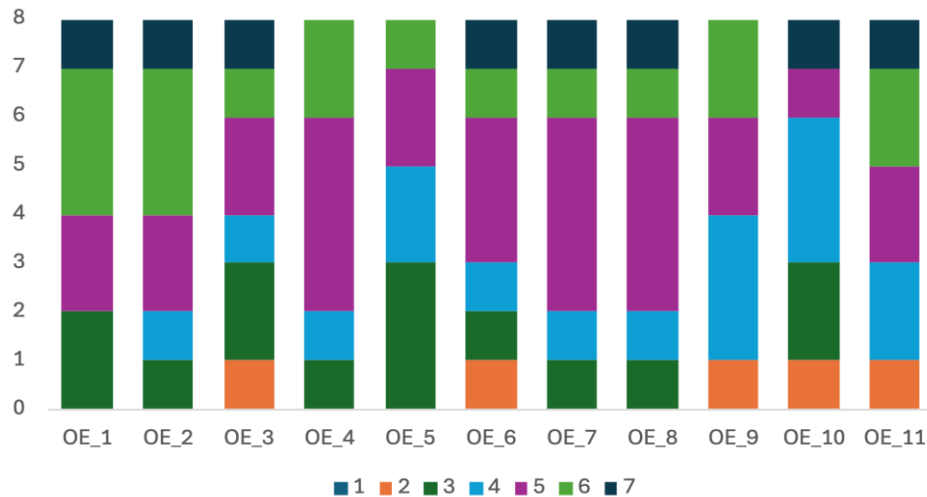


Figure 19

Section 3 (Feasibility): Response Distributions (Counts) per Item (1-7)

**Table 8***Section 3 (Feasibility): Consensus Levels and Statistical Summary*

Item	Teaching & Learning Strategies	n	Median	IQR	% (6–7)	Consensus
OE_1	Short interactive lectures	8	5.5	1.50	75%	No consensus (dispersion)
OE_2	Case discussions from real work situations	8	5.5	1.25	75%	No consensus (dispersion)
OE_3	Role-plays and simulations	8	4.5	2.25	75%	No consensus (dispersion)
OE_4	Guided group reflection and sharing	8	5.0	0.50	50%	No consensus (dispersion)
OE_5	Written reflexive exercises	8	4.0	2.00	75%	No consensus (dispersion)
OE_6	Small group work on ethical or professional dilemmas	8	5.0	1.50	62.5%	No consensus (dispersion)

OE_7	Communication skills training with feedback	8	5.0	0.50	50%	No consensus (dispersion)
OE_8	Psychoeducational materials (manuals, videos)	8	5.0	0.50	50%	No consensus (dispersion)
OE_9	Peer support or supervision groups	8	4.5	1.25	75%	No consensus (dispersion)
OE_10	Experiential and symbolic activities (e.g., rituals, site visits)	8	4.0	1.25	87.5%	No consensus (dispersion)
OE_11	Online asynchronous modules	8	5.0	2.00	75%	No consensus (dispersion)

Section 4: Delivery Modes and Logistics

Section 4: Suitability. Participants were asked to rate both the suitability, and the feasibility of fourteen delivery modes and logistics aims. Overall, suitability ratings were heterogeneous, with median values ranging from 3.5 to 6.5. Dispersion exceeded the predefined threshold for most items, and only one configuration met the strict consensus criteria. Small group size (8–15 participants) (OE_10; Median= 6.0, IQR= 1.00; 100% rated 6–7) reached consensus, indicating strong and uniform agreement regarding the importance of maintaining limited group size for effective delivery. This finding suggests that interactional depth and relational safety were viewed as central structural components of the program.

All other delivery configurations failed to meet consensus, primarily due to dispersion exceeding the IQR threshold, despite in some cases strong top-box endorsement. Among structural formats, a continuous program (e.g., monthly meetings) (OE_3; Median= 6.0, IQR=

2.00; 75% rated 6–7) and in-person delivery (OE_5; Median= 6.0, IQR= 1.50; 87.5% rated 6–7) showed relatively high central tendency but considerable variability in ratings. A co-facilitation model involving both a mental health professional and an experienced deathcare professional (OE_14; Median= 6.5, IQR= 1.50; 100% rated 6–7) demonstrated strong top-box agreement and the highest median across items, yet failed the consensus criterion due to dispersion slightly exceeding the predefined threshold.

Other formats elicited more moderate or polarized evaluations. One intensive workshop (1–2 days) (OE_1; Median= 5.0, IQR= 0.50; 50% rated 6–7) and session length of 90 minutes (OE_8; Median= 5.5, IQR= 1.50; 75% rated 6–7) showed intermediate central tendency but insufficient convergence. A series of shorter modules (OE_2; Median= 4.5, IQR= 2.00; 87.5% rated 6–7) and session length of 120 minutes (OE_9; Median= 4.5, IQR= 3.00; 87.5% rated 6–7) revealed particularly wide dispersion, suggesting divergent views about optimal program structure and time allocation. Fully online delivery (OE_4; Median= 3.5, IQR= 1.00; 0% rated 6–7) received the lowest central tendency and no top-box endorsement, indicating general skepticism regarding exclusive online implementation. Hybrid formats (OE_6 and OE_7) and medium group size (16–25 participants) (OE_11; Median= 4.0, IQR= 0.50; 87.5% rated 6–7) also failed to reach consensus due to dispersion and/or limited top-box agreement.

Regarding facilitation roles, both a mental health professional alone (OE_12; Median= 5.5, IQR= 1.50; 75% rated 6–7) and an experienced deathcare professional alone (OE_13; Median= 5.5, IQR= 2.25; 87.5% rated 6–7) showed relatively high endorsement but considerable variability in expert evaluations. Overall, findings suggest that experts converge most strongly on maintaining small group sizes, while diverging on optimal duration, format, facilitation model, and degree of online integration. The marked dispersion across many items indicates structural uncertainty and differing assumptions regarding feasibility, resource

availability, and professional constraints. Below, Figures 20, 21 and 22 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 9 summarizes the consensus level of each item.

Figure 20

Section 4 (Suitability): Median Ratings with IQR

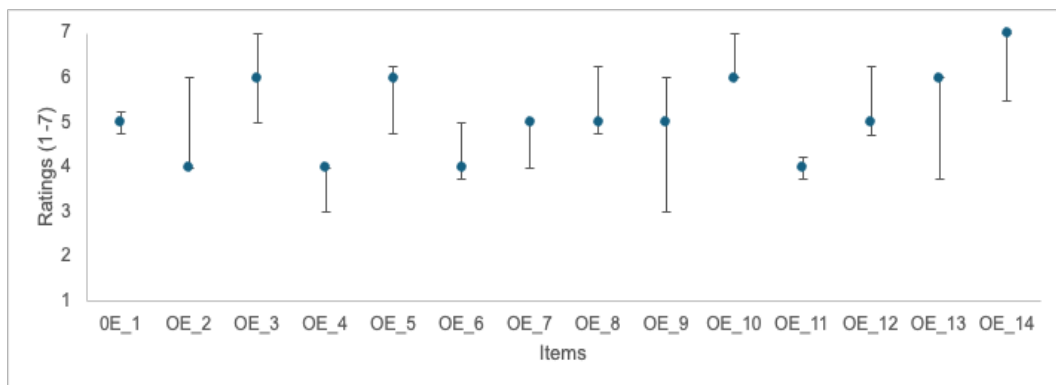


Figure 21

Section 4 (Suitability): Top-box Agreement (Ratings 6-7) by Item

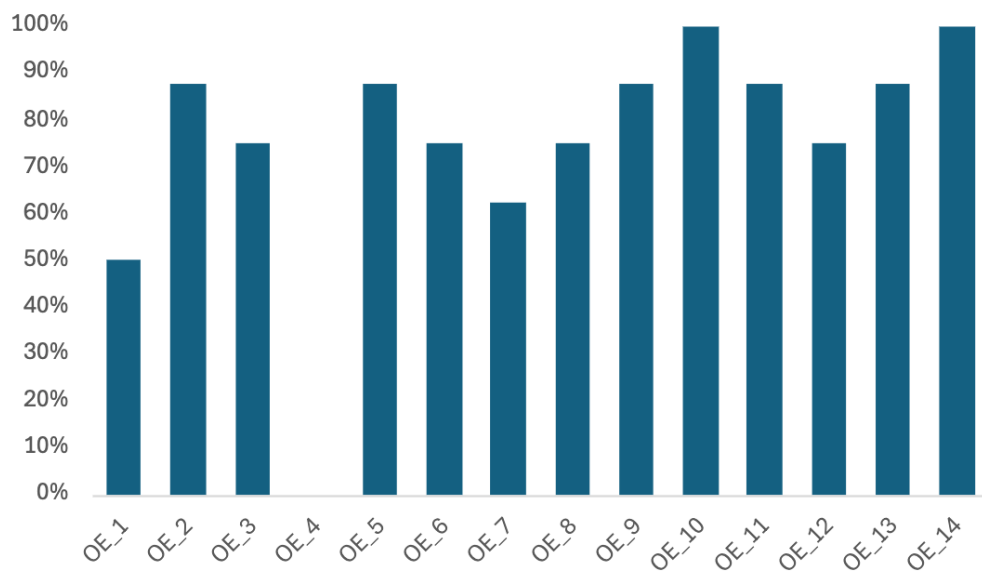
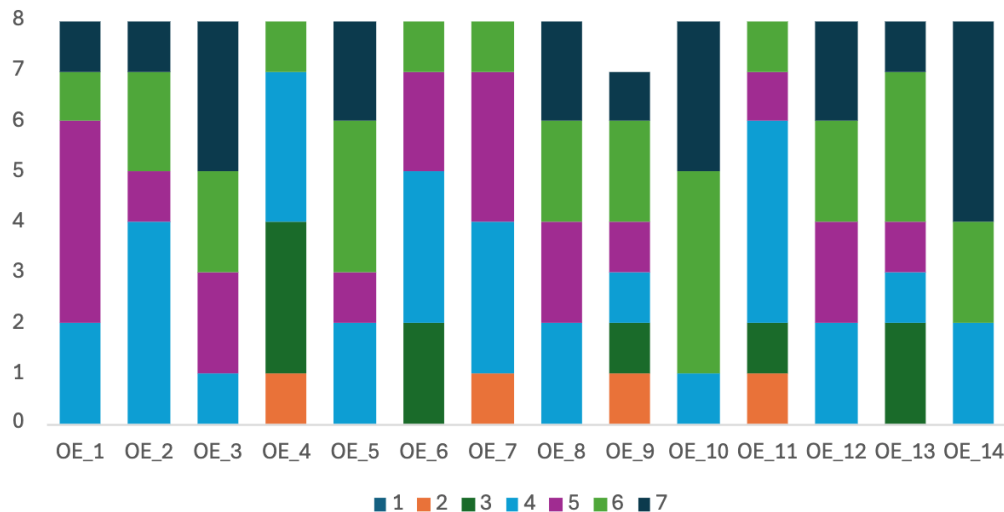


Figure 22

Section 4 (Suitability): Response Distributions (Counts) per Item (1-7)

**Table 9***Section 4 (Suitability): Consensus Levels and Statistical Summary*

Item	Delivery Modes & Logistics	n	Median	IQR	% (6–7)	Consensus
OE_1	One intensive workshop (1-2 days)	8	5.0	0.50	50%	No consensus (dispersion)
OE_2	Series of shorter sessions (4-8 modules)	8	4.5	2.00	87.5%	No consensus (dispersion)
OE_3	Continuous program (e.g., monthly meetings)	8	6.0	2.00	75%	No consensus (dispersion)
OE_4	Fully online	8	3.5	1.00	0%	No consensus (dispersion)
OE_5	In person only	8	6.0	1.50	87.5%	No consensus (dispersion)
OE_6	Hybrid (in-person + synchronous online)	8	4.0	1.25	75%	No consensus (dispersion)

OE_7	Hybrid (in-person + asynchronous tasks)	8	4.5	1.00	62.5%	No consensus (dispersion)
OE_8	Session length: 90 minutes	8	5.5	1.50	75%	No consensus (dispersion)
OE_9	Session length: 120 minutes	8	4.5	3.00	87.5%	No consensus (dispersion)
OE_10	Small group size (8-15 participants)	8	6.0	1.00	100%	Consensus IN
OE_11	Medium group size (16-25 participants)	8	4.0	0.50	87.5%	No consensus (dispersion)
OE_12	Facilitator: mental health professional	8	5.5	1.50	75%	No consensus (dispersion)
OE_13	Facilitator: experienced deathcare professional	8	5.5	2.25	87.5%	No consensus (dispersion)
OE_14	Co-facilitation (mental health professional+ deathcare professional)	8	6.5	1.5	100%	No consensus (dispersion)

Section 4: Feasibility. Overall, feasibility ratings were heterogeneous and generally lower than suitability ratings. Median values ranged from 3.5 to 6.0, and none of the proposed delivery configurations met the predefined consensus criteria due to dispersion exceeding the IQR threshold and/or insufficient top-box endorsement. Regarding structural formats, one intensive workshop (1–2 days) (OE_1; Median= 5.0, IQR= 1.25; 62.5% rated 6–7) and a series

of shorter sessions (OE_2; Median= 5.0, IQR= 1.25; 62.5% rated 6–7) received moderate feasibility evaluations but failed to reach consensus due to dispersion and limited top-box agreement. A continuous program (e.g., monthly meetings) (OE_3; Median= 4.0, IQR= 2.25; 87.5% rated 6–7) showed substantial variability, indicating divergent views regarding long-term implementation feasibility.

Interestingly, fully online delivery (OE_4; Median= 6.0, IQR= 2.25; 0% rated 6–7) displayed a high median but extreme dispersion and no top-box endorsement, suggesting polarized expert positions. In contrast, in-person only delivery (OE_5; Median= 3.5, IQR= 3.00; 0% rated 6–7) demonstrated both low central tendency and wide variability, reflecting significant concerns about exclusive in-person feasibility. Hybrid formats also failed to reach consensus. Hybrid delivery combining in-person and synchronous online components (OE_6; Median= 4.0, IQR= 0.50; 87.5% rated 6–7) showed low dispersion but insufficient central tendency. Hybrid delivery integrating asynchronous tasks (OE_7; Median= 5.0, IQR= 1.00; 50% rated 6–7) revealed moderate feasibility without sufficient convergence.

Session duration was another area of heterogeneity. A 90-minute session length (OE_8; Median= 4.5, IQR= 2.00; 87.5% rated 6–7) and 120-minute sessions (OE_9; Median= 4.0, IQR= 2.50; 87.5% rated 6–7) both exhibited substantial dispersion, suggesting differing assumptions regarding workload and scheduling constraints. Group size and facilitation models also failed to reach consensus. Small groups (8–15 participants) (OE_10; Median= 5.5, IQR= 1.50; 75% rated 6–7) received relatively favorable but dispersed feasibility ratings, while medium groups (16–25 participants) (OE_11; Median= 3.5, IQR= 1.50; 87.5% rated 6–7) showed lower central tendency. Regarding facilitators, a mental health professional (OE_12; Median= 5.5, IQR= 2.25; 87.5% rated 6–7), an experienced deathcare professional (OE_13;

Median= 4.0, IQR= 2.00; 0% rated 6–7), and a co-facilitation model (OE_14; Median= 4.5, IQR= 3.25; 87.5% rated 6–7) all displayed substantial variability in expert evaluations.

Overall, feasibility judgments were characterized by marked dispersion across nearly all delivery and logistical configurations. This pattern suggests significant uncertainty regarding structural, organizational, and resource-related constraints, as well as divergent assumptions about implementation contexts. Below, Figures 23, 24 and 25 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 10 summarizes the consensus level of each item.

Figure 23

Section 4 (Feasibility): Median Ratings with IQR

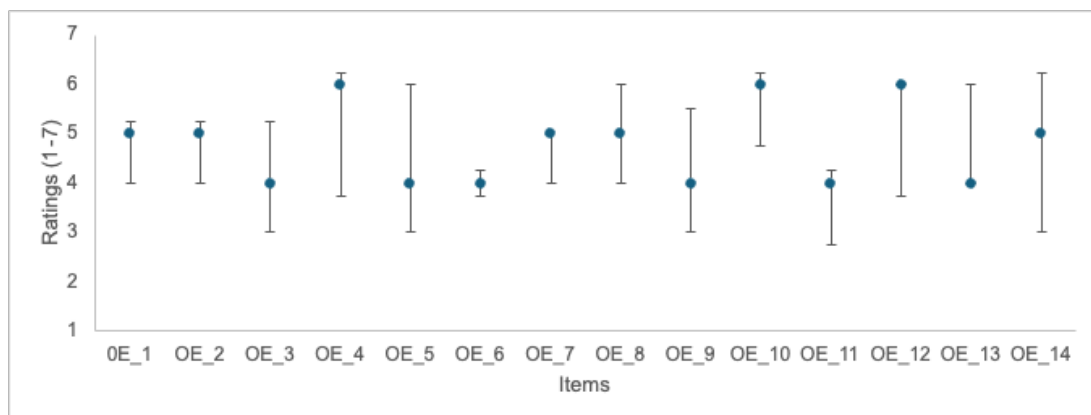


Figure 24

Section 4 (Feasibility): Top-box Agreement (Ratings 6-7) by Item

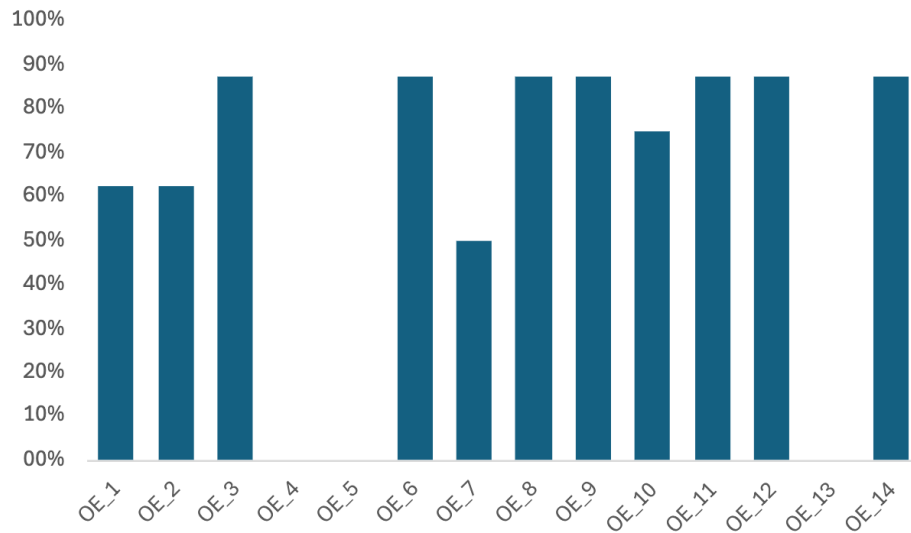


Figure 25

Section 4 (Feasibility): Response Distributions (Counts) per Item (1-7)

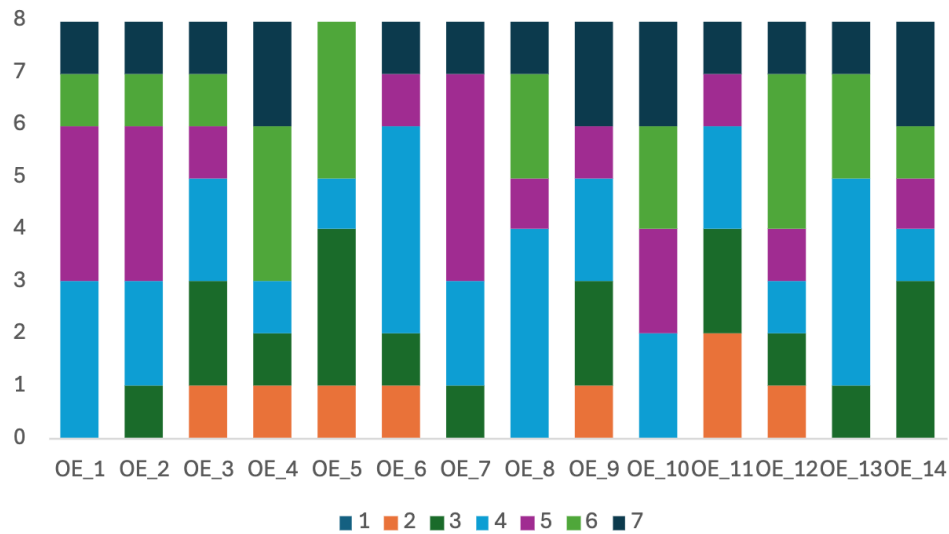


Table 10

Section 4 (Feasibility): Consensus Levels and Statistical Summary

Item	Delivery Modes & Logistics	n	Median	IQR	% (6–7)	Consensus
OE_1	One intensive workshop (1-2 days)	8	5.0	1.25	62.5%	No consensus (dispersion)

OE_2	Series of shorter sessions (4-8 modules)	8	5.0	1.25	62.5%	No consensus (dispersion)
OE_3	Continuous program (e.g., monthly meetings)	8	4.0	2.25	87.5%	No consensus (dispersion)
OE_4	Fully online	8	6.0	2.25	0%	No consensus (dispersion)
OE_5	In person only	8	3.5	3.00	0%	No consensus (dispersion)
OE_6	Hybrid (in-person + synchronous online)	8	4.0	0.50	87.5%	No consensus (dispersion)
OE_7	Hybrid (in-person + asynchronous tasks)	8	5.0	1.00	50%	No consensus (dispersion)
OE_8	Session length: 90 minutes	8	4.5	2.00	87.5%	No consensus (dispersion)
OE_9	Session length: 120 minutes	8	4.0	2.50	87.5%	No consensus (dispersion)
OE_10	Small group size (8-15 participants)	8	5.5	1.50	75%	No consensus (dispersion)
OE_11	Medium group size (16-25 participants)	8	3.5	1.50	87.5%	No consensus (dispersion)
OE_12	Facilitator: mental health professional	8	5.5	2.25	87.5%	No consensus (dispersion)

OE_13	Facilitator: experienced deathcare professional	8	4.0	2.00	0%	No consensus (dispersion)
OE_14	Co-facilitation (mental health professional+ deathcare professional)	8	4.5	3.25	87.5%	No consensus (dispersion)

Section 5: Outcomes for Evaluation

Panelists were asked to rate the importance of ten outcomes for evaluation of the proposed death education programme. Overall, importance ratings were high (medians ranging from 5.5 to 6.5), indicating strong endorsement of most proposed evaluation domains. However, dispersion exceeded the predefined threshold for several items, resulting in partial consensus. Five outcomes met the consensus criteria. Experts showed strong convergence on improved communication with families (OE_2; Median= 6.5, IQR= 1.00; 100% rated 6–7) and reduced emotional distress (OE_3; Median= 6.5, IQR= 1.00; 100% rated 6–7), both of which received the highest median values and full top-box endorsement. Consensus was also achieved for increased adaptive coping and self-care (OE_6; Median= 6.0, IQR= 0.50; 87.5% rated 6–7), increased meaning in work and professional identity (OE_7; Median= 6.0, IQR= 1.00; 100% rated 6–7), and participant satisfaction (OE_9; Median= 6.0, IQR = 0.50; 75% rated 6–7).

Five outcomes did not reach consensus, primarily due to wider dispersion and/or insufficient top-box agreement despite generally high central tendency. Reduced burnout and emotional exhaustion (OE_4; Median= 6.5, IQR= 1.25; 87.5% rated 6–7) and reduced vicarious trauma/compassion fatigue (OE_5; Median= 6.0, IQR= 1.25; 75% rated 6–7) showed strong endorsement but slightly exceeded the dispersion threshold. Improved team climate and peer support (OE_8; Median= 6.0, IQR= 2.00; 62.5% rated 6–7) exhibited substantial

variability, suggesting heterogeneous expectations regarding team-level change. Increased knowledge about death, grief, and bereavement (OE_1; Median= 5.5, IQR= 2.00; 50% rated 6–7) received comparatively lower central tendency and greater dispersion, indicating more divided views on the centrality of knowledge acquisition as an evaluative outcome. Similarly, willingness to recommend the program (OE_10; Median= 6.0, IQR= 1.25; 62.5% rated 6–7) did not achieve sufficient convergence. Overall, findings suggest that experts prioritize relational, emotional, and identity-related outcomes as core indicators of program effectiveness, while more distal, organizational, or attitudinal indicators elicited greater variability in importance ratings. Below, Figures 26, 27 and 28 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 11 summarizes the consensus level of each item.

Figure 26

Section 5: Median Ratings with IQR

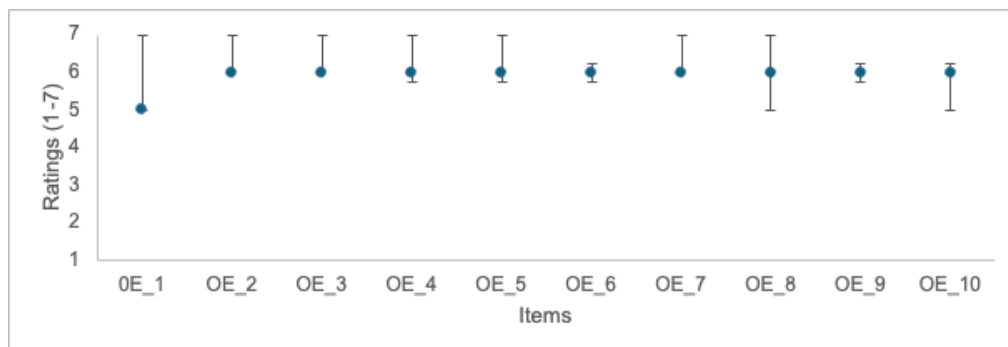


Figure 27

Section 5: Top-box Agreement (Ratings 6-7) by Item

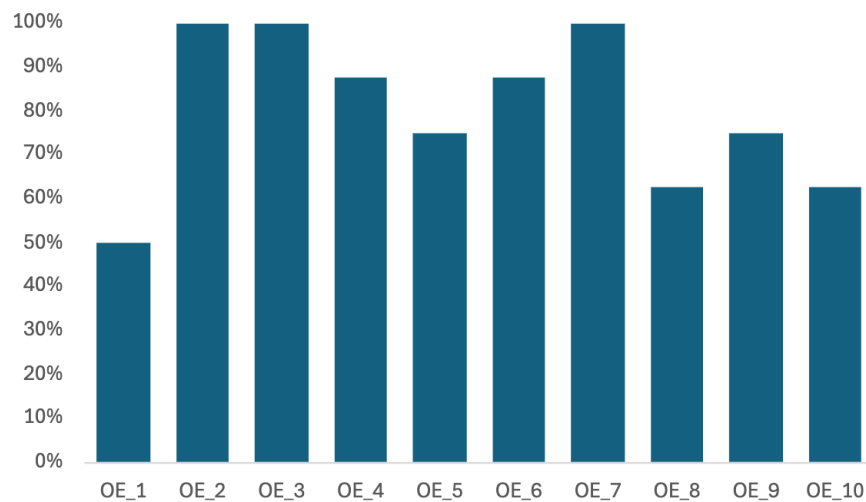


Figure 28

Section 5: Response Distributions (Counts) per Item (1-7)

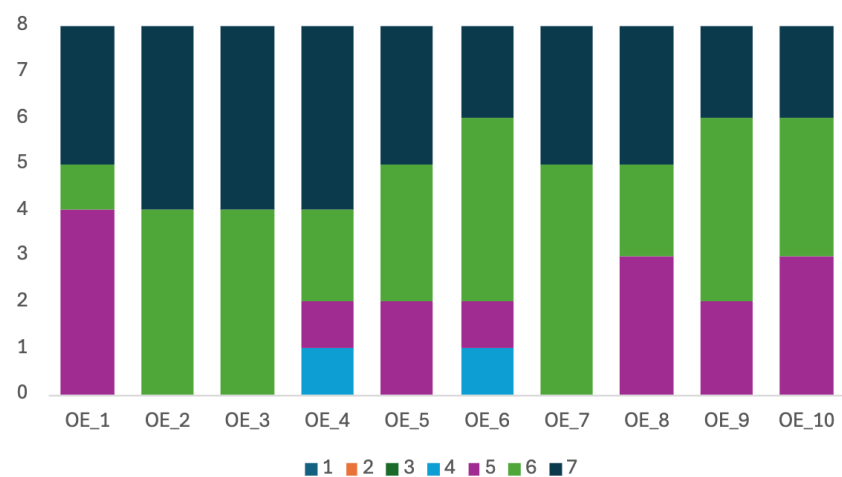


Table 11

Section 5: Consensus Levels and Statistical Summary

Item	Outcomes for Evaluation	n	Median	IQR	% (6–7)	Consensus
OE_1	Increased knowledge about death, grief, and bereavement	8	5.5	2.00	50%	No consensus (dispersion)
OE_2	Improved communication with families	8	6.5	1.00	100%	Consensus IN

OE_3	Reduced emotional distress	8	6.5	1.00	100%	Consensus IN
OE_4	Reduced burnout and emotional exhaustion	8	6.5	1.25	87.5%	No consensus (dispersion)
OE_5	Educed vicarious trauma/ compassion fatigue	8	6.0	1.25	75%	No consensus (dispersion)
OE_6	Increased adaptive coping and self-care	8	6.0	0.50	87.5%	Consensus IN
OE_7	Increased meaning in work and professional identity	8	6.0	1.00	100%	Consensus IN
OE_8	Improved team climate and peer support	8	6.0	2.00	62.5%	No consensus (dispersion)
OE_9	Participant satisfaction	8	6.0	0.50	75%	Consensus IN
OE_10	Willingness to recommend the program	8	6.0	1.25	62.5%	No consensus (dispersion)

Results Round 2

Following round 1, the results were reviewed to identify areas demonstrating the greatest degree of disagreement among panel members. Based on this analysis, round 2 focused on section 2B (feasibility of micro content areas), section 3 (feasibility of teaching and learning strategies), section 4 (suitability and feasibility of delivery modes and logistics), which warranted further exploration and re-evaluation by the expert panel.

Section 2B: Micro Content Area

Overall, feasibility ratings were moderate to high (medians ranging from 4.0 to 7.0), suggesting that experts generally considered most content areas potentially deliverable within the program. However, dispersion exceeded the predefined threshold for nearly all items, indicating substantial variation in judgments about what could be realistically implemented. Only one content area met the full consensus criteria. Experts showed clear convergence on ethical principles, boundaries, and role responsibilities in deathcare work (OE_6; Median = 7.0, IQR = 0.50; 87.5% rated 6–7), indicating strong agreement that this topic is both central and highly feasible for inclusion in the program.

The remaining twelve content areas did not reach consensus, primarily because of wider dispersion despite generally favorable ratings. Several items received relatively strong endorsement but narrowly missed the dispersion threshold, including families' emotional experiences and cultural variability in grief and bereavement (OE_3; Median = 6.0, IQR = 1.25; 87.5% rated 6–7), relational challenges in interactions with bereaved families and distressed individuals (OE_9; Median = 6.5, IQR = 1.25; 87.5% rated 6–7), and communication processes in death-related professional settings (OE_8; Median = 6.5, IQR = 2.00; 75% rated 6–7). These findings suggest that experts broadly recognized the relevance of relational and communication-focused content, but differed in their views regarding how easily such topics could be operationalized within a feasible educational format.

Other items showed even greater heterogeneity. Ethical dilemmas and experiences of moral distress (OE_7; Median = 6.5, IQR = 2.00; 75% rated 6–7), protective factors such as coping strategies, self-care practices, and resilience resources (OE_11; Median = 6.0, IQR = 2.00; 75% rated 6–7), team dynamics, peer support, and collective coping (OE_12; Median = 5.5, IQR = 3.25; 87.5% rated 6–7), and organizational psychosocial risk management and institutional support resources (OE_13; Median = 6.0, IQR = 3.25; 87.5% rated 6–7) all

received relatively positive top-box percentages but showed substantial disagreement in spread. This pattern may indicate that experts viewed these topics as important, but variably feasible depending on assumptions about program length, institutional support, professional role differences, or the extent to which broader organizational issues can be meaningfully addressed within an educational intervention.

Lower-feasibility ratings were observed for more conceptual or foundational topics. Socio-historical and cultural foundations of deathcare work (OE_1; Median = 4.0, IQR = 1.50; 100% rated 6–7), psychological and theoretical models of death, dying, and grief (OE_2; Median = 5.0, IQR = 2.50; 75% rated 6–7), rituals, symbols, and cultural practices related to death and mourning (OE_4; Median = 5.5, IQR = 2.25; 75% rated 6–7), and professional identity development in deathcare roles (OE_5; Median = 5.5, IQR = 3.00; 100% rated 6–7) also failed to meet consensus. These results suggest that while some experts may have viewed such areas as valuable, others may have questioned their fit within a concise, practice-oriented program or considered them harder to translate into directly applicable training content.

Overall, the findings suggest that experts regarded ethics-based content as the most clearly feasible component of the proposed curriculum, while showing more varied views on relational, reflective, and organizational content areas. This variability likely reflects differences in how experts interpreted feasibility, including whether they were judging feasibility in terms of time, teachability, institutional readiness, or practical applicability across diverse deathcare settings. Below, Figures 29, 30 and 31 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 12 summarizes the consensus level of each item.

Figure 29

Section 2B (Feasibility): Median Ratings with IQR

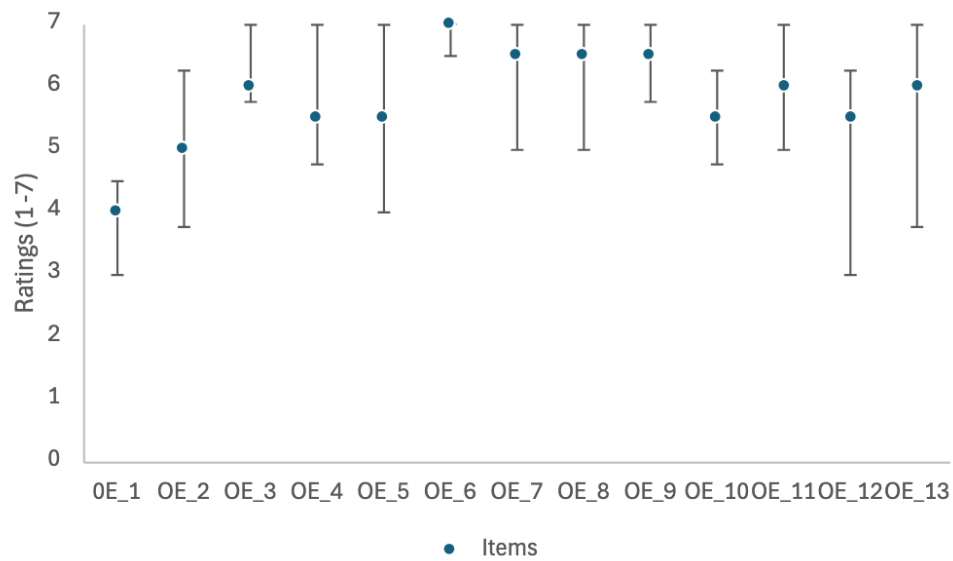


Figure 30

Section 2B (Feasibility): Top-box Agreement (Ratings 6-7) by Item

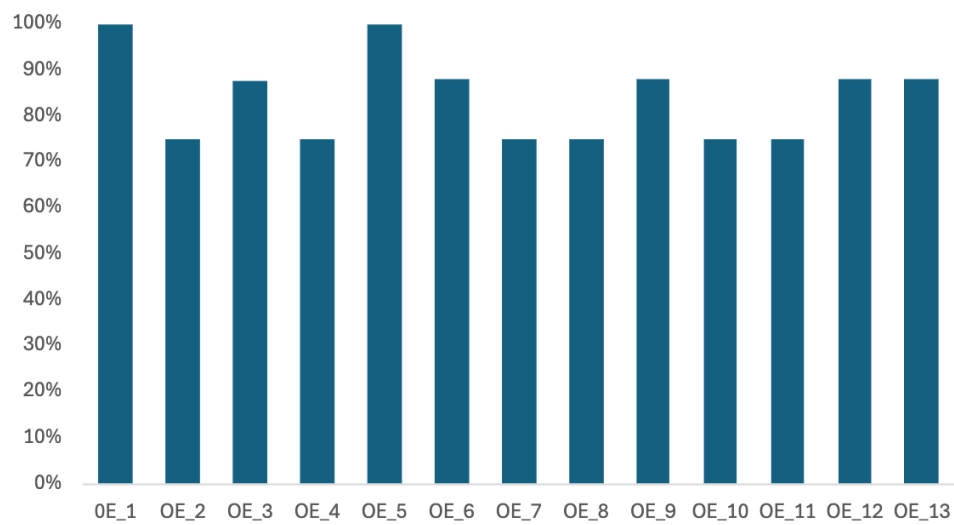
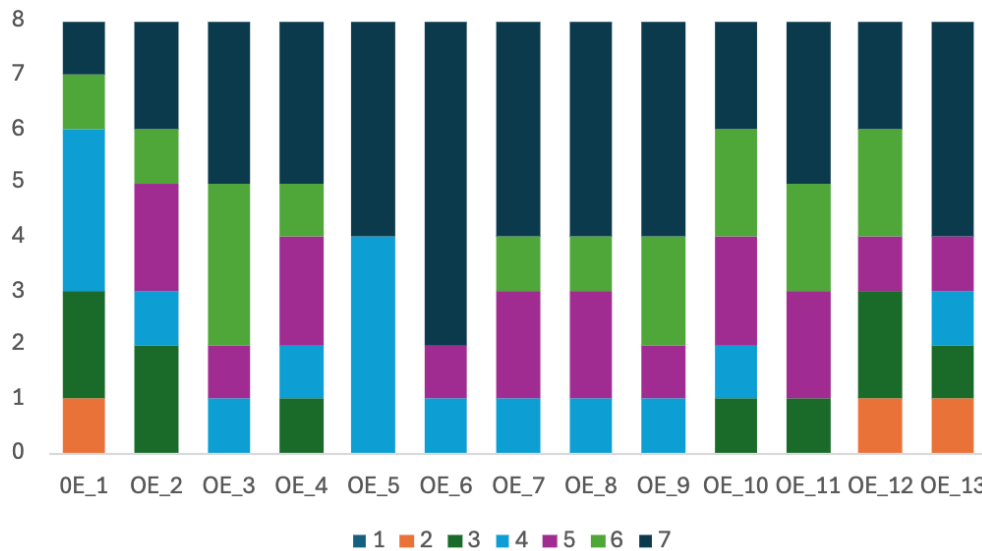


Figure 31

Section 2B (Feasibility): Response Distributions (Counts) per Item (1-7)

**Table 12***Section 2B (Feasibility): Consensus Levels and Statistical Summary*

Item	Micro Content Area	n	Median	IQR	% (6–7)	Consensus
OE_1	Socio-historical and cultural foundations of deathcare work	8	4.0	1.50	100%	No consensus (dispersion)
OE_2	Psychological and theoretical models of death, dying, and grief	8	5.0	2.50	75%	No consensus (dispersion)
OE_3	Families' emotional experiences and cultural variability in grief and bereavement	8	6.0	1.25	87.5%	No consensus (dispersion)
OE_4	Rituals, symbols, and cultural practices related to death and mourning	8	5.5	2.25	75%	No consensus (dispersion)
OE_5	Professional identity development in deathcare roles	8	5.5	3.00	100%	No consensus (dispersion)
OE_6	Ethical principles, boundaries, and role	8	7.0	0.50	87.5%	Consensus IN

	responsibilities in deathcare work					
OE_7	Ethical dilemmas and experiences of moral distress in death-related professional practice	8	6.5	2.00	75%	No consensus (dispersion)
OE_8	Communication processes in death-related professional settings (e.g., with families, colleagues, other professionals)	8	6.5	2.00	75%	No consensus (dispersion)
OE_9	Relational challenges in interactions with bereaved families and distressed individuals	8	6.5	1.25	87.5%	No consensus (dispersion)
OE_10	Occupational risk factors for burnout, compassion fatigue, and vicarious trauma	8	5.5	1.50	75%	No consensus (dispersion)
OE_11	Protective factors: coping strategies, self-care practices, and resilience resources	8	6.0	2.00	75%	No consensus (dispersion)
OE_12	Team dynamics, peer support, and collective coping within deathcare organizations	8	5.5	3.25	87.5%	No consensus (dispersion)
OE_13	Organizational psychosocial risk management and institutional support resources	8	6.0	3.25	87.5%	No consensus (dispersion)

Section 3: Teaching and Learning Strategies

Overall, feasibility ratings were mixed to moderately positive (medians ranging from 4.0 to 6.5), suggesting that experts saw at least some potential for implementing most of the proposed methods. However, none of the eleven strategies met the full consensus criteria, as

dispersion exceeded the predefined threshold across all items. This pattern indicates considerable variation in expert views regarding which methods could be most realistically implemented in practice. Although no teaching and learning strategy reached consensus, several methods received relatively favorable ratings. Case discussions from real work situations (OE_2; Median = 6.5, IQR = 2.00; 62.5% rated 6–7) obtained the highest median score, suggesting that experts generally viewed practice-based discussion as a feasible approach, even though ratings were too variable and top-box agreement fell below the required threshold. Guided group reflection and sharing (OE_4; Median = 5.5, IQR = 1.25; 87.5% rated 6–7) and peer support or supervision groups (OE_9; Median = 6.0, IQR = 2.25; 75% rated 6–7) were also positively regarded, indicating relatively strong support for reflective and peer-oriented methods, despite lack of convergence in feasibility judgments.

Other methods elicited more divided evaluations. Small group work on ethical or professional dilemmas (OE_6; Median = 5.0, IQR = 1.25; 75% rated 6–7) and communication skills training with feedback (OE_7; Median = 4.5, IQR = 1.25; 87.5% rated 6–7) showed reasonably high top-box endorsement but lower medians and dispersed responses, suggesting that while many experts valued these strategies, others may have questioned their practicality within the proposed format or setting. Similar variability emerged for short interactive lectures (OE_1; Median = 5.0, IQR = 1.50; 62.5% rated 6–7), written reflexive exercises (OE_5; Median = 4.0, IQR = 1.50; 62.5% rated 6–7), and psychoeducational materials such as manuals or videos (OE_8; Median = 4.0, IQR = 1.75; 87.5% rated 6–7).

The greatest heterogeneity appeared for role-plays and simulations (OE_3; Median = 5.0, IQR = 3.50; 62.5% rated 6–7), indicating particularly divergent opinions about their feasibility. Experiential and symbolic activities such as rituals or site visits (OE_10; Median = 4.0, IQR = 1.50; 100% rated 6–7) and online asynchronous modules (OE_11; Median = 4.0,

IQR = 1.50; 75% rated 6–7) also failed to meet consensus despite relatively strong endorsement on the top-box measure for some experts. Taken together, these findings suggest that experts differed not necessarily on the general value of active or experiential methods, but on the extent to which such strategies could be practically delivered within the institutional, logistical, or professional constraints of deathcare settings.

Overall, the results indicate that experts tended to view discussion-based, reflective, and peer-oriented strategies as more feasible than highly structured experiential or individually oriented methods, but substantial disagreement remained across all options. This variation may reflect differences in assumptions about available time, participant readiness, organizational support, facilitation resources, or the suitability of certain pedagogical methods for emotionally demanding professional contexts. The absence of consensus across all eleven strategies suggests that feasibility judgments were shaped less by outright rejection of specific methods than by differing views on how such methods could be adapted and sustained in real-world deathcare training environments. Below, Figures 32, 33, and 34 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 13 summarizes the consensus level of each item.

Figure 32

Section 3 (Feasibility): Median Ratings with IQR

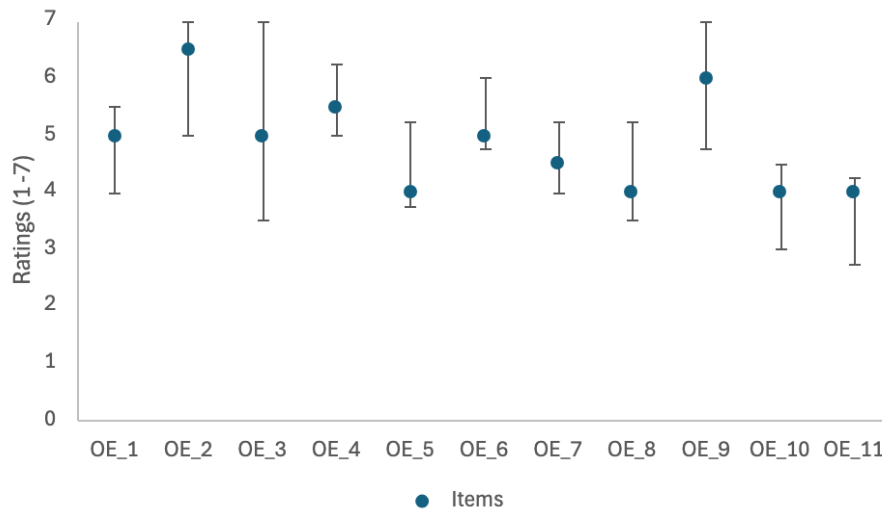


Figure 33

Section 3 (Feasibility): Top-box Agreement (Ratings 6-7) by Item

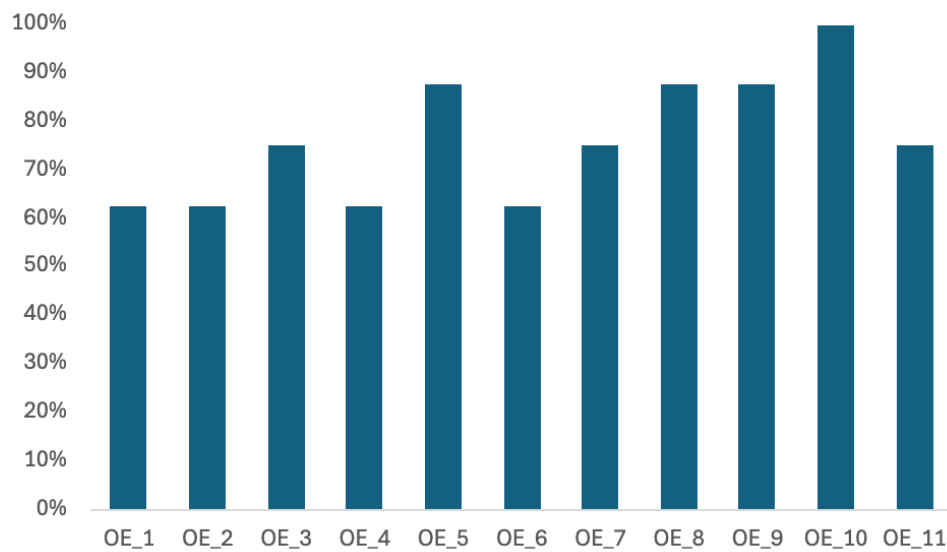
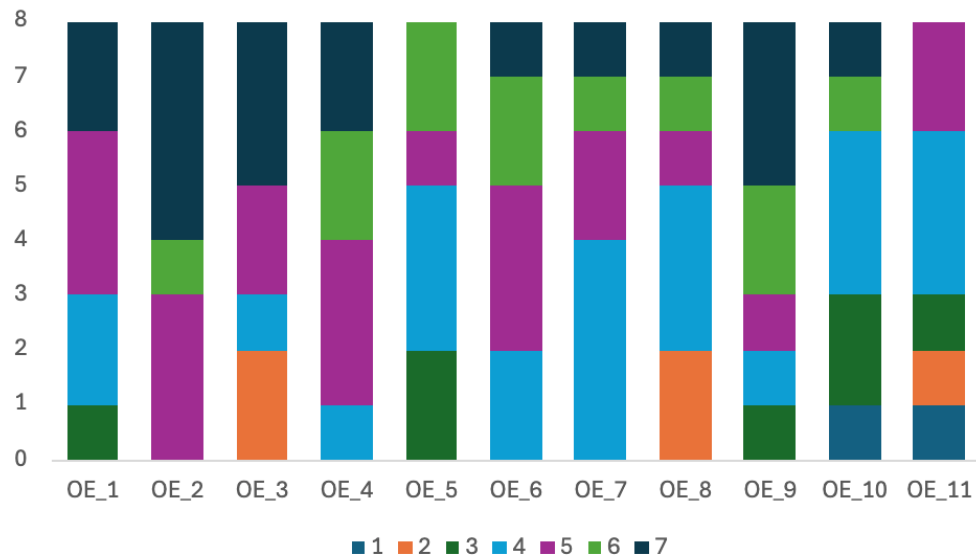


Figure 34

Section 3 (Feasibility): Response Distributions (Counts) per Item (1-7)

**Table 13***Section 3 (Feasibility): Consensus Levels and Statistical Summary*

Item	Teaching & Learning Strategies	n	Median	IQR	% (6–7)	Consensus
OE_1	Short interactive lectures	8	5.0	1.50	62.5%	No consensus (dispersion)
OE_2	Case discussions from real work situations	8	6.5	2.00	62.5%	No consensus (dispersion)
OE_3	Role-plays and simulations	8	5.0	3.50	62.5%	No consensus (dispersion)
OE_4	Guided group reflection and sharing	8	5.5	1.25	87.5%	No consensus (dispersion)
OE_5	Written reflexive exercises	8	4.0	1.50	62.5%	No consensus (dispersion)
OE_6	Small group work on ethical or professional dilemmas	8	5.0	1.25	75%	No consensus (dispersion)
OE_7	Communication skills training with feedback	8	4.5	1.25	87.5%	No consensus (dispersion)

OE_8	Psychoeducational materials (manuals, videos)	8	4.0	1.75	87.5%	No consensus (dispersion)
OE_9	Peer support or supervision groups	8	6.0	2.25	75%	No consensus (dispersion)
OE_10	Experiential and symbolic activities (e.g., rituals, site visits)	8	4.0	1.50	100%	No consensus (dispersion)
OE_11	Online asynchronous modules	8	4.0	1.50	75%	No consensus (dispersion)

Section 4: Delivery Modes and Logistics

Section 4: Suitability. Overall, suitability ratings were mixed (medians ranging from 2.5 to 6.5), indicating that experts saw some delivery and logistical options as clearly preferable, while others elicited more varied judgments. In most cases, dispersion exceeded the predefined threshold, suggesting limited convergence regarding how the program should best be structured and delivered. Two items met the consensus criteria. Experts showed strong agreement on small group size (8–15 participants) (OE_10; Median = 6.5, IQR = 1.00; 100% rated 6–7), indicating clear endorsement of a more contained and interactive group format. Consensus was also reached for co-facilitation by a mental health professional and an experienced deathcare professional (OE_14; Median = 6.5, IQR = 1.00; 100% rated 6–7), suggesting that experts considered an interdisciplinary facilitation model especially suitable for this type of program.

Several other items received relatively strong endorsement but did not meet the full consensus threshold because of wider dispersion. Session length of 90 minutes (OE_8; Median = 6.0, IQR = 1.50; 87.5% rated 6–7), facilitator as a mental health professional (OE_12; Median = 6.5, IQR = 1.50; 100% rated 6–7), and facilitator as an experienced deathcare professional (OE_13; Median = 6.5, IQR = 2.00; 75% rated 6–7) all suggest positive orientations toward

these options, but with differences in expert opinion regarding their overall suitability. This pattern may indicate that experts broadly valued both psychological and field-based expertise, while differing on whether one type of facilitator would be sufficient on its own.

Opinions were more mixed regarding the overall delivery format. One intensive workshop over 1–2 days (OE_1; Median = 5.5, IQR = 1.25; 62.5% rated 6–7), a series of shorter sessions across 4–8 modules (OE_2; Median = 5.0, IQR = 1.25; 62.5% rated 6–7), and a continuous program such as monthly meetings (OE_3; Median = 5.0, IQR = 1.25; 62.5% rated 6–7) all failed to reach consensus, indicating no clear preference for one temporal structure over another. Similarly, session length of 120 minutes (OE_9; Median = 5.0, IQR = 1.50; 62.5% rated 6–7) and medium group size of 16–25 participants (OE_11; Median = 4.0, IQR = 2.25; 75% rated 6–7) elicited more heterogeneous judgments.

Lower suitability ratings were observed for digitally oriented or less interactive formats. Fully online delivery (OE_4; Median = 2.5, IQR = 3.50; 87.5% rated 6–7) showed the lowest median and the greatest dispersion, suggesting highly divergent views about whether a fully online format would be appropriate for this content and population. Hybrid models also did not achieve consensus, including in-person plus synchronous online delivery (OE_6; Median = 4.0, IQR = 0.50; 100% rated 6–7) and in-person plus asynchronous tasks (OE_7; Median = 4.0, IQR = 2.25; 75% rated 6–7). In-person only delivery (OE_5; Median = 5.0, IQR = 1.00; 38% rated 6–7) likewise failed to meet criteria, indicating that no single format emerged as universally preferred.

Overall, the findings suggest that experts viewed small-group, co-facilitated delivery as the most suitable configuration for the proposed program, while remaining more divided on questions of format, duration, and modality. This variability likely reflects differing assumptions about participant availability, organizational constraints, digital accessibility, and

the relational demands of the material. Below, Figures 35, 36, and 37 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 14 summarizes the consensus level of each item.

Figure 35

Section 4 (Suitability): Median Ratings with IQR

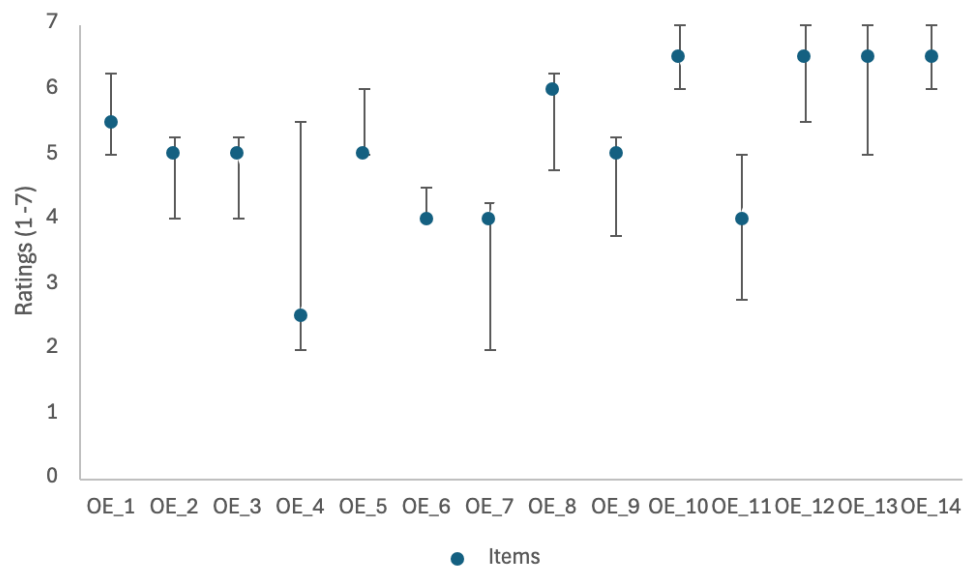


Figure 36

Section 4 (Suitability): Top-box Agreement (Ratings 6-7) by Item

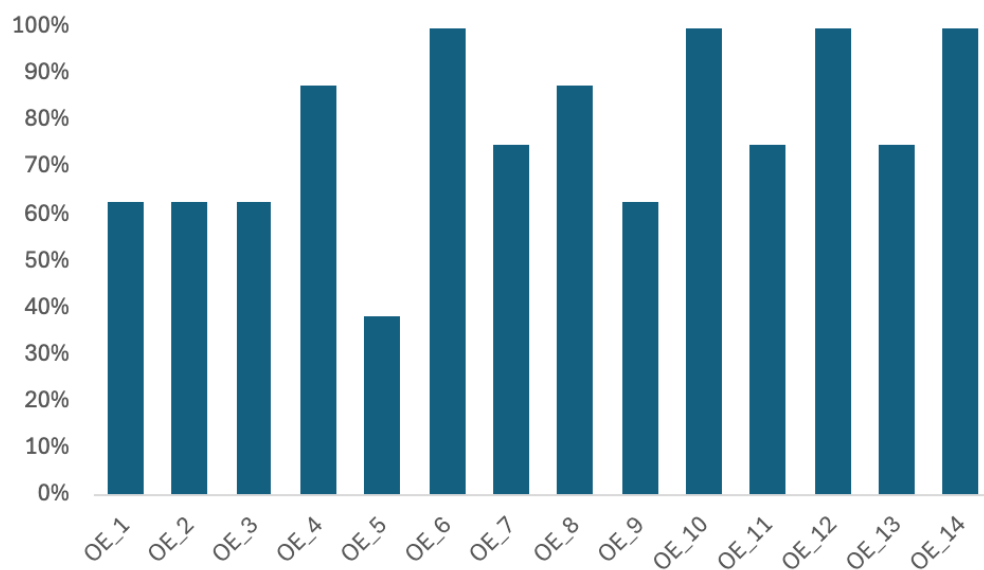
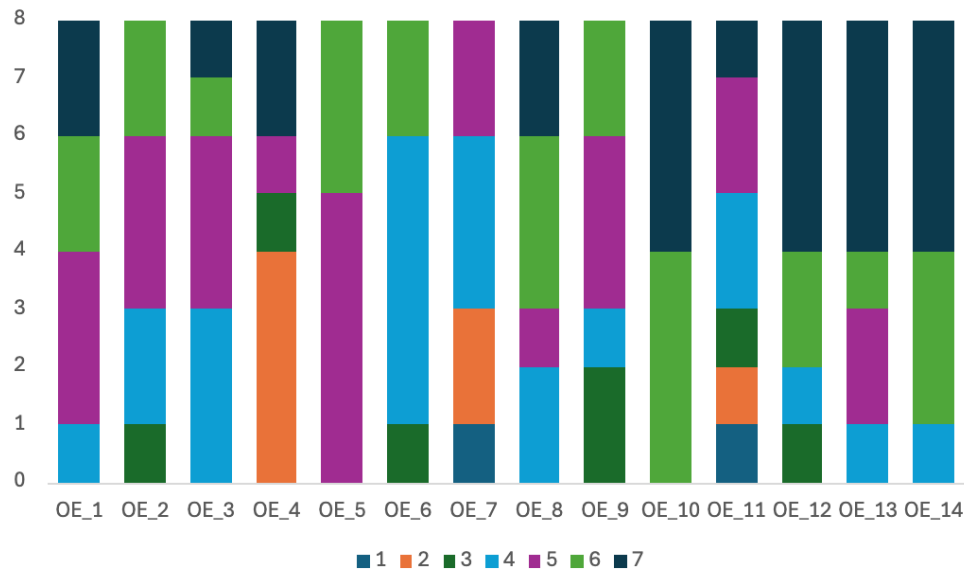


Figure 37

Section 4 (Suitability): Response Distributions (Counts) per Item (1-7)

**Table 14**

Section 4 (Suitability): Consensus Levels and Statistical Summary

Item	Delivery Modes & Logistics	n	Median	IQR	% (6-7)	Consensus
OE_1	One intensive workshop (1-2 days)	8	5.5	1.25	62.5%	No consensus (dispersion)
OE_2	Series of shorter sessions (4-8 modules)	8	5.0	1.25	62.5%	No consensus (dispersion)
OE_3	Continuous program (e.g., monthly meetings)	8	5.0	1.25	62.5%	No consensus (dispersion)
OE_4	Fully online	8	2.5	3.50	87.5%	No consensus (dispersion)
OE_5	In person only	8	5.0	1.00	38%	No consensus (dispersion)
OE_6	Hybrid (in-person + synchronous online)	8	4.0	0.50	100%	No consensus (dispersion)

OE_7	Hybrid (in-person + asynchronous tasks)	8	4.0	2.25	75%	No consensus (dispersion)
OE_8	Session length: 90 minutes	8	6.0	1.50	87.5%	No consensus (dispersion)
OE_9	Session length: 120 minutes	8	5.0	1.50	62.5%	No consensus (dispersion)
OE_10	Small group size (8-15 participants)	8	6.5	1.00	100%	Consensus IN
OE_11	Medium group size (16-25 participants)	8	4.0	2.25	75%	No consensus (dispersion)
OE_12	Facilitator: mental health professional	8	6.5	1.50	100%	No consensus (dispersion)
OE_13	Facilitator: experienced deathcare professional	8	6.5	2.00	75%	No consensus (dispersion)
OE_14	Co-facilitation (mental health professional+ deathcare professional)	8	6.5	1.00	100%	Consensus IN

Section 4: Feasibility. Overall, feasibility ratings were mixed (medians ranging from 3.5 to 6.5), indicating that experts saw some logistical arrangements as more realistically implementable than others. However, most items showed dispersion above the predefined threshold, suggesting limited convergence regarding how the program could most feasibly be delivered in practice. Two items met the full consensus criteria. Experts showed clear agreement on small group size (8–15 participants) (OE_10; Median = 6.5, IQR = 1.00; 87.5% rated 6–7), indicating that a smaller and more contained group format was regarded as feasible within the intended context. Consensus was also achieved for facilitation by a mental health professional (OE_12; Median = 6.0, IQR = 0.25; 87.5% rated 6–7), suggesting strong agreement that this type of professional profile could realistically support program delivery.

Several other items received relatively positive endorsement but did not reach consensus because of wider dispersion. One intensive workshop over 1–2 days (OE_1; Median = 5.5, IQR = 2.25; 75% rated 6–7) and fully online delivery (OE_4; Median = 6.5, IQR = 1.25; 87.5% rated 6–7) were both rated favorably overall, yet experts differed in how consistently feasible they considered these options. Similar patterns emerged for in-person only delivery (OE_5; Median = 4.0, IQR = 1.25; 87.5% rated 6–7), hybrid delivery combining in-person and synchronous online sessions (OE_6; Median = 4.5, IQR = 2.00; 87.5% rated 6–7), and hybrid delivery combining in-person sessions with asynchronous tasks (OE_7; Median = 4.0, IQR = 1.25; 100% rated 6–7). These findings suggest that experts may have seen multiple modalities as potentially workable, while differing in their assumptions about infrastructure, accessibility, participant availability, or institutional readiness.

Other logistical configurations elicited more mixed or comparatively lower feasibility judgments. A series of shorter sessions across 4–8 modules (OE_2; Median = 4.0, IQR = 1.50; 87.5% rated 6–7), a continuous program such as monthly meetings (OE_3; Median = 3.5, IQR = 1.50; 75% rated 6–7), session length of 90 minutes (OE_8; Median = 5.5, IQR = 1.25; 50% rated 6–7), session length of 120 minutes (OE_9; Median = 4.0, IQR = 1.75; 87.5% rated 6–7), and medium group size of 16–25 participants (OE_11; Median = 4.0, IQR = 1.50; 87.5% rated 6–7) all failed to meet consensus. This pattern indicates substantial heterogeneity in how experts judged the practical demands of scheduling, pacing, and group composition.

Facilitator configuration also produced varied responses. While facilitation by a mental health professional reached consensus, facilitation by an experienced deathcare professional alone (OE_13; Median = 5.5, IQR = 2.25; 75% rated 6–7) and co-facilitation by a mental health professional and a deathcare professional (OE_14; Median = 5.5, IQR = 2.25; 75% rated 6–7) did not. This may suggest that experts broadly valued disciplinary and field-based expertise,

but differed in whether these models were equally realistic or sustainable within existing resource constraints.

Overall, the findings indicate that feasibility was most clearly established for smaller groups and facilitation by a mental health professional, whereas opinions remained more divided regarding modality, session structure, and facilitator configuration. These differences likely reflect variation in how experts interpreted feasibility, including in terms of staffing, time commitment, organizational resources, digital infrastructure, and the realities of implementation across diverse deathcare settings. Taken together, the results suggest that no single delivery model was seen as universally feasible, but that certain structural conditions, particularly small-group delivery and appropriate professional facilitation, were viewed as more readily achievable than others. Below, Figures 38, 39, and 40 illustrate the median ratings with IQR, the top-box agreement by item, and the response distributions by item, and Table 15 summarizes the consensus level of each item.

Figure 38

Section 4 (Feasibility): Median Ratings with IQR

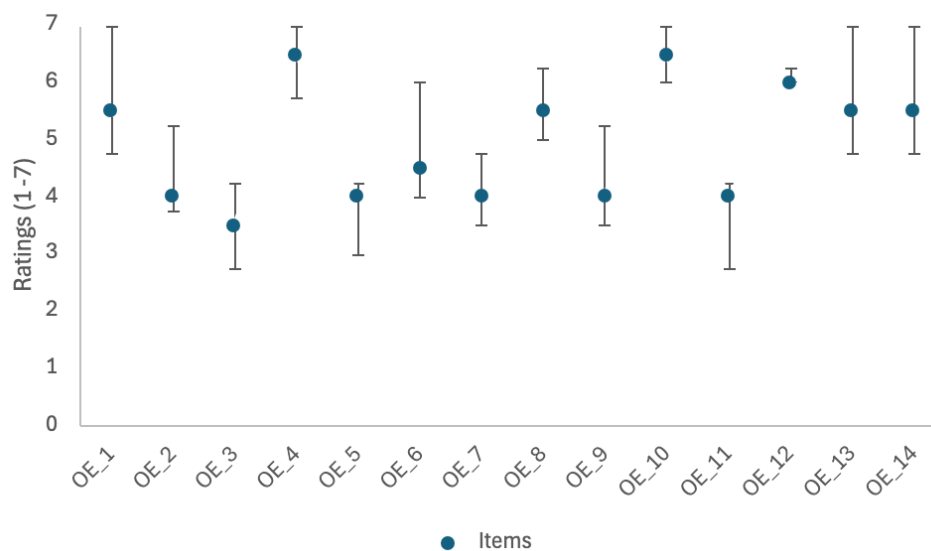
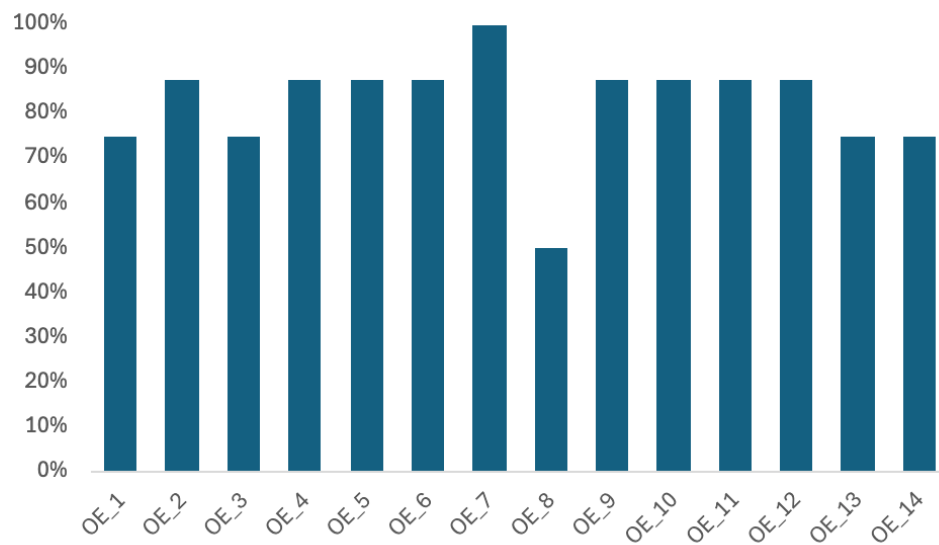
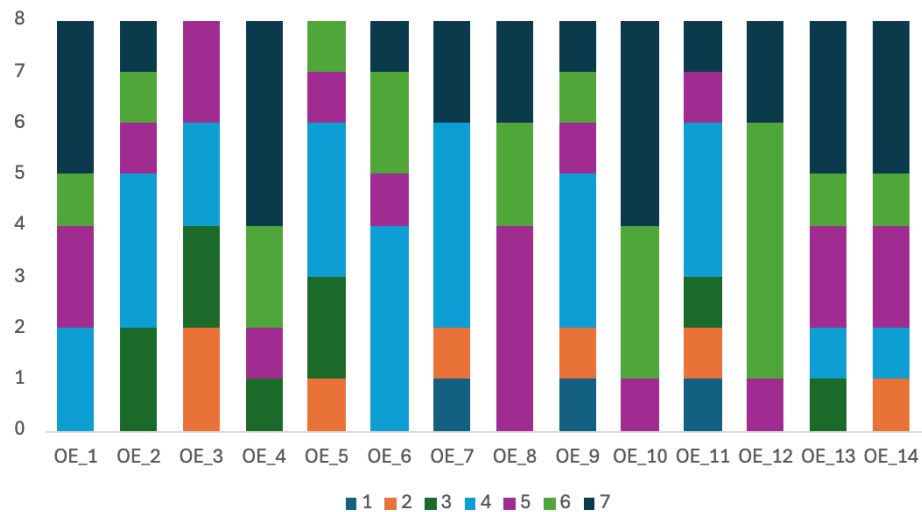


Figure 39

Section 4 (Feasibility): Top-box Agreement (Ratings 6-7) by Item

**Figure 40**

Section 4 (Feasibility): Response Distributions (Counts) per Item (1-7)

**Table 15**

Section 4 (Feasibility): Consensus Levels and Statistical Summary

Item	Delivery Modes & Logistics	N	Median	IQR	% (6–7)	Consensus
------	----------------------------	---	--------	-----	---------	-----------

OE_1	One intensive workshop (1-2 days)	8	5.5	2.25	75%	No consensus (dispersion)
OE_2	Series of shorter sessions (4-8 modules)	8	4.0	1.50	87.5%	No consensus (dispersion)
OE_3	Continuous program (e.g., monthly meetings)	8	3.5	1.50	75%	No consensus (dispersion)
OE_4	Fully online	8	6.5	1.25	87.5%	No consensus (dispersion)
OE_5	In person only	8	4.0	1.25	87.5%	No consensus (dispersion)
OE_6	Hybrid (in-person + synchronous online)	8	4.5	2.00	87.5%	No consensus (dispersion)
OE_7	Hybrid (in-person + asynchronous tasks)	8	4.0	1.25	100%	No consensus (dispersion)
OE_8	Session length: 90 minutes	8	5.5	1.25	50%	No consensus (dispersion)
OE_9	Session length: 120 minutes	8	4.0	1.75	87.5%	No consensus (dispersion)
OE_10	Small group size (8-15 participants)	8	6.5	1.00	87.5%	Consensus IN
OE_11	Medium group size (16-25 participants)	8	4.0	1.50	87.5%	No consensus (dispersion)
OE_12	Facilitator: mental health professional	8	6.0	0.25	87.5%	Consensus IN
OE_13	Facilitator: experienced deathcare professional	8	5.5	2.25	75%	No consensus (dispersion)
OE_14	Co-facilitation (mental health professional+ deathcare professional)	8	5.5	2.25	75%	No consensus (dispersion)

Section 6: Free-Text Comments

Across free-text responses from both Round 1 and 2, participants broadly supported the rationale and aims of death education for deathcare workers but repeatedly reframed it as cultural and professional formation rather than a therapeutic intervention. Several comments stressed that the purpose is not to prepare for death in a technical or reassuring sense, but to cultivate a more mature way of living and working with finitude, acknowledging that the programme can be transformative without becoming clinical care. Another recurring message was that the deathcare work in Italy is not only about grief and support, but also about power, money, time and the body. Participants argued that these difficult dimensions are often avoided, yet they are central to the credibility and ethical complexity of the sector, raising difficult questions about personhood, boundaries, and moral decision-making in real practice.

Participants emphasized the growing importance of cultural and religious pluralism in death-related work. They highlighted the need to address multicultural and spiritual diversity in rituals, spaces, and mourning practices, and to deal concretely with tensions between secular governance, citizenship, and community demands for specific rites, timing, and burial practices, especially under conditions of shrinking cemetery space and increasing cremation. Participants' opinions consistently pointed to implementation conditions: preferences leaned strongly toward in-person delivery, small groups, and the involvement of field-based deathcare professionals (including non-academics) alongside psychological expertise. Several participants questioned the capacity of online formats to reproduce the complexity of interpersonal interaction and expressed caution about role-plays and simulations because they may lack the emotional realism that is central to deathcare encounters. Regarding evaluation and follow-up, experts favored mixed and or qualitative approaches and argued that effectiveness should be assessed not only immediately post-course but also after a meaningful delay (e.g., months) to capture transfer into practice. The experts proposed follow-up structures

such as booster sessions, reflective supervision, or peer groups, and building networks that can support continuity over time. Moreover, sustainability was repeatedly framed as dependent on institutional buy-in, protected time, and resources (including funding), alongside clarity of aims and boundaries. A key ethical risk identified was that training might be perceived as performance control or external judgment, generating resistance; therefore, experts stressed transparency, role clarity, and safeguards to prevent role confusion and emotional overload. Table 3 provides illustrative verbatim excerpts from experts' free-text comments, organized by qualitative category.

Table 16

Key Qualitative Categories from the Free-Text Comments

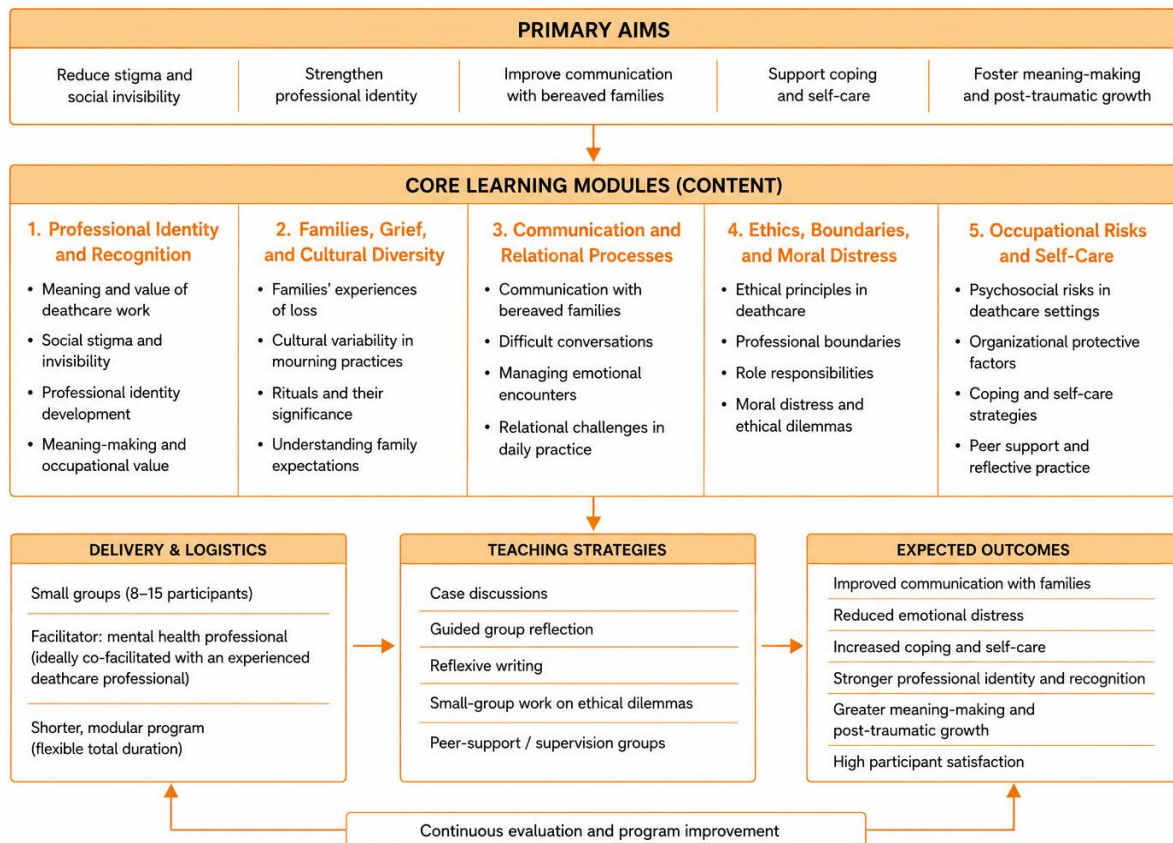
Theme	Verbatim Excerpt
Death education as cultural/professional work (not therapy)	"Death education is not meant to 'prepare for death'... but... to prepare for life knowing that it ends... These are not therapeutic interventions... it is cultural work, not clinical."
Power/body/money/time as "hard" but central topics	"The deathcare sector still talks too much about death and too little about power, time, body and money... when does a body stop being a person? It's a gigantic ethical area..."
Multicultural/religious pluralism and structural tensions	"I consider it fundamental to reflect on... the relationship between secularism and citizenship... and... access to... spaces, times, practices and rituals... decrease of funerary spaces... and... recourse to cremation..."
Limits of online learning and emotional realism of role-plays	"Online... does not return the rich complexity of personal interaction... Role-plays and simulations... lack the essential component... the emotional aspect... central in real... experience."

What “effectiveness” means and why delayed follow-up matters	“A death education programme is effective when... [it] produces real shifts... ability to stay within uncertainty... continuity over time... effectiveness is measured not by the wellbeing produced...”
Sustainability requires resources and institutional support	“Support institutional... to make participation... easy... the employer... should do everything to facilitate... Issuing certificates is... useful... and easy... to implement.”
Resistance and legitimacy	“The biggest problem is... discomfort at ‘having the job explained’ by an outsider... The hardest part will be making them understand that they need refresher courses and support.”

Taken together, the Delphi results suggest that an educational program for deathcare workers should move beyond a solely technical focus and address the relational, ethical, emotional, and professional dimensions of deathcare work. Experts consistently emphasized the need for education that supports professional recognition, communication with bereaved families, and workers’ psychological well-being, while acknowledging the organizational realities that shape practice. The revised CARE program presented in Figure 41 was therefore developed by incorporating all components that achieved consensus across the Delphi rounds.

Figure 41

Delphi-Informed Revision of the CARE Death Education Program for Deathcare Worker



Note. The revised program integrates all educational aims, content areas, delivery characteristics, and evaluation outcomes that reached expert consensus across the two Delphi rounds. Components not reaching feasibility consensus were not included as core elements of the final framework.

Discussion

This Delphi study aimed to identify priority and implementable components of a death education program for deathcare workers, composed of what Italian death scholars believe to be essential and practical in a death education program. Rather than pointing to a single training format, the panel's judgment outlines a program logic: death education for deathcare workers should primarily strengthen relational competence, professional identity, ethical boundary work, and meaning-oriented coping, while acknowledging that feasibility is strongly conditioned by organizational constraints and sectoral legitimacy.

A key contribution is what experts prioritized the most: reducing stigma and social invisibility, strengthening identity and meaning, and improving communication with bereaved families, paired with coping and emotional impact outcomes. This pattern is consistent with – and extends - broader evidence that death education can shift death-related attitudes and psychosocial functioning, including fear and avoidance, in palliative care settings (references needed here). For instance, a recent study in medical students reported that death education interventions were associated with improvements in several death attitudes dimensions and palliative care attitudes, with exploratory indications that blended learning and longer courses may be advantageous and that follow-up systems matter for sustaining changes (Wang & Wang, 2026). This study expands this logic beyond the moment of death: for deathcare workers, participants in this study treated relational capacity, identity legitimacy, and ethical navigation as core priorities, arguably because these workers are already immersed in death, but frequently lack institutionalized preparation for the social and moral demands in their role (Crozier et al., 2025).

This interpretation aligns with a scoping review of death education interventions, which shows that programs often combine reflective and experiential components (discussion, journaling, case-based learning) and can influence fear/avoidance, death acceptance, coping, and related psychosocial outcomes, while also suggesting that depth may require either a longer duration of high-intensity experiential design (Romão, Belli, Jumayeva, et al., 2025).

Importantly, the Delphi panel's emphasis on cultural and professional formation provided a plausible explanation for why burnout prevention was the most contested aim: participants appeared to support activities regarding meaning, identity, coping, and relational skill, while resisting a framing that implies clinical treatment, organizational risk management surveillance, or a promise of downstream endpoint change.

A second interpretative signal is the repeated gap between relevance and feasibility. Participants broadly endorsed many content areas and methods, yet they rarely converged on feasibility. The open comments indicated that feasibility judgments hinge on protected time, organizational buy-in, credible facilitation, and safeguards against role confusion and perceived performance control. These concerns resonate with a more general problem described in professional education: that competence gaps persist where death-related learning is not *structurally embedded*. In counselor education, for instance, Bellegarde and Chintakunta (2025) describe “dearth” of formal preparation for death-related conversations and competence development, suggesting that even in helping professions, death competence is often treated as optional or peripheral rather than core curricula. Our study indicates that for deathcare workers, this marginalization is intensified by stigma and occupational invisibility, increasing the risk that training is perceived as externally imposed rather than as a legitimate professional.

The international contrast on funeral service education highlights how institutional embedding changes the baseline: in the USA and Canada, licensure pathways and accredited mortuary education programs create formal education infrastructures, albeit variable by jurisdiction and role (“*Mortuary Science Education*,” 2009). In Italy, by contrast, deathcare education is far less institutionalized, and this study panel emphasizes the urgent need for recognition, resources, and organizational backing that feasibility is fundamentally a governance issue, not merely a didactic one.

The single micro-content areas achieving feasibility consensus are theoretically and practically revealing. Ethics and boundary work operate as shared denominators across heterogeneous deathcare settings (e.g., forensic, funeral, cemetery, and palliative care), and they provide a common language for addressing difficult topics (such as power, body, money, personhood) without turning the death education program into a therapeutic-focused one. This mirrors a pragmatic design principle found in intervention development research, whereby

when contexts are diverse and resources uneven, the most implementable core is typically that which is broadly relevant, teachable, and institutionally defensible. From a program-design perspective, this suggests that CARE can be structured around an ethics-boundaries spine, with relational communication, identity, and meaning making, and culturally plural ritual literacy as modules that can be expanded depending on setting and organizational readiness. For instance, to operationalize reflective discussion around practical and ethical issues in funeral provision, existing case-based resources such as the *Care in Funerals Casebook* can be used as supporting materials (Entwistle et al., 2023).

This Delphi study findings converge with intervention evidence in three actionable ways. First, the preference for reflective, discussion-based learning parallels the broader death education literature, where structured reflection and case-based approaches recur and appear compatible with measurable changes (e.g., death attitudes, coping, communication) (Romão, Belli, Jumayeva, et al., 2025). Second, the panel's call for delayed evaluation and follow-up is congruent with the study recommendation to build longer-term follow-up systems, given that attitudinal and behavioral shifts may consolidate over time rather than immediately post-course (Wang & Wang, 2026). Third, the feasibility ambiguity around delivery format echoes what is seen when death education moves from student curricula to real workplaces, a 'best format' is less important than the conditions that enable participation and credibility.

These findings are particularly salient in Italy, where deathcare is governed largely through administrative and technical infrastructures (e.g., municipal *polizia mortuaria*, cemetery regulation, and authorisations for transport, burial, and cremation), while education and psychosocial preparation for the workforce remain uneven and non-standardised. The recurring relevance–feasibility gap, therefore, reflects less disagreement about *what* matters than uncertainty about whether organisations, across a mixed ecology of public services and commercial providers, can legitimate protected training time, resourcing, and credible

facilitation. In this sense, CARE functions not only as education but as an institutional test of recognition for the emotional and relational labour of deathcare. Beyond Italy, the pattern is transferable: where education is mandated and embedded, these priorities can be integrated more directly into curricula; where provision is voluntary or fragmented, programmes may need an “implementable core” (e.g., ethics/boundaries and small-group reflective work) that can scale with organisational readiness.

Limitations and Implications

This study has several limitations. First, the small complete-case panel, which limits representativeness and increases sensitivity to idiosyncratic judgments. The strict a priori consensus rule likely reduced the number of items classified as consensus, especially on feasibility, and may partly explain the frequent relevance feasibility gap. Feasibility is also inherently interpretation-dependent; without standardized assumptions about program duration, resources, and institutional supports, panelists may have been rating different implementation scenarios. Finally, the free-text component was designed for pragmatic refinement and was analyzed with descriptive content analysis rather than an in-depth interpretative method. Despite these constraints, the study provides actionable, implementation-oriented guidance for CARE; a core, defensible spine centered on ethics, boundaries, and role responsibilities, delivered in small groups, with psychologically informed facilitation. The consistent divergence on 'feasibility' indicates that programme success will depend less on a single 'best format' and more on organizational conditions (protected time, funding, managerial endorsement, and clear boundaries to avoid perceptions of surveillance or performance control). For evaluation, the panel's emphasis supports mixed-method and delayed follow-up designs to capture transfer into practice, with optional booster sessions and peer

support structured to sustain effects. Future work should move from consensus to pilot testing and continuous evaluation of the relevance and feasibility of the program.

Conclusion

This Delphi study identifies a coherent and context-sensitive foundation for a death education program for Italian deathcare workers: a small-group, psychologically informed training model prioritizing ethical boundary work, relational communication, stigma/ visibility, and professional identity/ meaning, while making clear that real-world feasibility depends on institutional recognition, protected time, and safeguards against therapeutic drift and surveillance-like interpretations. Together, these results offer an evidence-informed blueprint for developing CARE in ways that are both educationally credible and politically/organizationally viable within deathcare settings.

References

- Ashforth, B. E., & Kreiner, G. E. (1999). How can you do it?: Dirty work and the challenge of constructing a positive identity. *Academy of Management Review*, 24(3), 413–434.
- Ashforth, B. E., & Kreiner, G. E. (2014). Dirty work and dirtier work: Differences in countering physical, social, and moral stigma. *Management and Organization Review*, 10(1), 81–108.
- Batista, A. S., & Codo, W. (2018). Dirty work and stigma: Caretakers of death in cemeteries. *Revista de Estudios Sociales*, 63, 72–83. <https://doi.org/10.7440/res63.2018.06>

- Bellegarde, N., & Chintakunta, S. V. (2025). Dearth of death competence in counselor education programs. *Illness, Crisis & Loss*, 33(3), 600–612. <https://doi.org/10.1177/10541373241268040>
- Belton, I., MacDonald, A., Wright, G., & Hamlin, I. (2019). Improving the practical application of the Delphi method in group-based judgment: A six-step prescription for a well-founded and defensible process. *Technological Forecasting and Social Change*, 147, 72–82. <https://doi.org/10.1016/j.techfore.2019.07.002>
- Botha, N. N., Segbedzi, C. E., Dumahasi, V. K., Kodom, R. V., Ogum, M. A., Maneen, S., Tsedze, I. S., Akoto, L. A., & Ansah, E. W. (2026). Lived experiences of deathcare workers in managing infectious dead bodies. *Public Health Challenges*, 5(1), e70205. <https://doi.org/10.1002/puh2.70205>
- Breen, L. J., Kawashima, D., Joy, K., Cadell, S., Roth, D., Chow, A., & Macdonald, M. E. (2018). Grief literacy: A call to action for compassionate communities. *Death Studies*, 44(7), 457–463.
- Bugen, L. A. (1979). Human grief: A model for prediction and intervention. *American Journal of Orthopsychiatry*, 49(2), 196–206. <https://doi.org/10.1111/j.1939-0025.1979.tb02600.x>
- Cathles, A., Harrington, D. E., & Krynski, K. (2010). The gender gap in funeral directors: Burying women with ready-to-embalm laws? *British Journal of Industrial Relations*, 48(4), 688–705. <https://doi.org/10.1111/j.1467-8543.2010.00808.x>
- Chan, W. C. H., Tin, A. F., Wong, K. L. F., Tse, D. M. W., & Chan, C. L. W. (2010). Impact of death work on self: Existential and emotional challenges and coping of palliative care professionals. *Health & Social Work*, 35(1), 7–17. <https://doi.org/10.1093/hsw/35.1.7>

- Corr, C. A., & Doka, K. J. (2025). Death education. *Educational Psychology*.
<https://doi.org/10.71358/pw.2613>
- Crozier, D., Fleury, K., & Bickle, K. (2025). Mental health concerns and stigma: A qualitative study of funeral directors in Ontario. *Mortality*, 0(0), 1–16.
<https://doi.org/10.1080/13576275.2025.2534495>
- Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, 25(5), 443–455. <https://doi.org/10.1177/1744987119880234>
- Dyregrov, A., Kristensen, P., Fjærestad, A., Johnsen, I., Gjestad, R., & Hauken, M. A. (2024). Funeral directors' experiences during the COVID-19 pandemic: A mixed method study. *Mental Health, Religion & Culture*, 27(8), 838–855.
<https://doi.org/10.1080/13674676.2024.2359604>
- Grandi, A., King, N., & Colombo, L. (2024). Psychosocial demands in death care during COVID-19 pandemic: Qualitative study on Italian workers. *Social Sciences*, 13(12).
<https://doi.org/10.3390/socsci13120678>
- Guidetti, G., Grandi, A., Converso, D., Bosco, N., Fantinelli, S., Zito, M., & Colombo, L. (2021). Funeral and mortuary operators: The role of stigma, incivility, work meaningfulness and work–family relation to explain occupational burnout. *International Journal of Environmental Research and Public Health*, 18(13), 6691.
<https://doi.org/10.3390/ijerph18136691>
- Guidetti, G., Grandi, A., Converso, D., & Colombo, L. (2025). Exposure to death and bereavement: An analysis of the occupational and psychological wellbeing of funeral and mortuary operators. *OMEGA—Journal of Death and Dying*, 90(4), 1936–1950.
<https://doi.org/10.1177/00302228221130611>

- Harrawood, L. K., Doughty, E. A., & Wilde, B. (2011). Death education and attitudes of funeral directors: Implications for training and practice. *OMEGA—Journal of Death and Dying*, 64(2), 135–150. <https://doi.org/10.2190/OM.64.2.c>
- Howarth, G. (2007). *Death and dying: A sociological introduction*. Polity Press.
- J. Skulmoski, G., T. Hartman, F., & Krahn, J. (2007). The Delphi method for graduate research. *Journal of Information Technology Education: Research*, 6, 1–21. <https://doi.org/10.28945/199>
- Kirwin, J. (2008). The practice and challenges of funeral directing: Occupational experiences in contemporary deathcare. *Mortality*, 13(2), 145–160.
- Le, A. B., Witter, L., Herstein, J. J., Jelden, K. C., Beam, E. L., Gibbs, S. G., & Lowe, J. J. (2017). A gap analysis of the United States death care sector to determine training and education needs pertaining to highly infectious disease mitigation and management. *Journal of Occupational and Environmental Hygiene*, 14(9), 674–680. <https://doi.org/10.1080/15459624.2017.1319570>
- Le, C., MacDonald, M. E., & Doyle, P. C. (2017). Educational needs of funeral service professionals: A scoping review. *Death Studies*, 41(10), 623–635. <https://doi.org/10.1080/07481187.2017.1328462>
- Lehto, R. H., & Stein, K. F. (2009). Death anxiety: An analysis of an evolving concept. *Research and Theory for Nursing Practice*, 23(1), 23–41. <https://doi.org/10.1891/1541-6577.23.1.23>
- Leviton, D. (1977). *The scope of death education*. Hemisphere Publishing.

- Lombardo, C., Capasso, E., Li Rosi, G., Salerno, M., Chisari, M., Esposito, M., Di Mauro, L., & Sessa, F. (2024). Burnout and stress in forensic science jobs: A systematic review. *Healthcare*, 12(20), 2032. <https://doi.org/10.3390/healthcare12202032>
- McClatchey, I. S., & King, S. (2015). The impact of death education on fear of death and death anxiety among human services students. *OMEGA—Journal of Death and Dying*, 71(4), 343–361. <https://doi.org/10.1177/0030222815572606>
- McGarry, J., Walklate, S., & Mythen, G. (2018). Death work, emotional labour and occupational resilience. *Sociology Compass*, 12(11), e12647. <https://doi.org/10.1111/soc4.12647>
- Morena, M., Truppi, T., Ieracitano, V., & Lorusso, G. (2019). New perspectives in the Italian property market: The funeral sector. *Property Management*, 37(4), 579–596. <https://doi.org/10.1108/PM-07-2018-0042>
- Mortuary Science Education. (2009). In C. Bryant & D. Peck (Eds.), *Encyclopedia of death and the human experience*. SAGE Publications. <https://doi.org/10.4135/9781412972031.n246>
- Nasa, P., Jain, R., & Juneja, D. (2021). Delphi methodology in healthcare research: How to decide its appropriateness. *World Journal of Methodology*, 11(4), 116–129. <https://doi.org/10.5662/wjm.v11.i4.116>
- Overmeire, R. V., & Bilsen, J. (2020). COVID-19: The risks for funeral directors. *Journal of Public Health*, 42(3), 655–655. <https://doi.org/10.1093/pubmed/fdaa089>
- Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., Morphet, J., & Shimoinaba, K. (2013). How death anxiety impacts nurses' caring for patients at the end

- of life: A review of literature. *The Open Nursing Journal*, 7, 14–21.
<https://doi.org/10.2174/1874434601307010014>
- Rantala, A., Eklund, M., & Hansen, H. P. (2018). Emotional labour and professional support in occupations dealing with death and bereavement. *International Journal of Qualitative Studies on Health and Well-being*, 13(1), 1441591.
<https://doi.org/10.1080/17482631.2018.1441591>
- Romão, M. E., Belli, G., Jumayeva, S., Visonà, S. D., Woodthorpe, K., Setti, I., & Barelo, S. (2025). Death education in practice: A scoping review of interventions, strategies, and psychosocial impact. *OMEGA—Journal of Death and Dying*. Advance online publication. <https://doi.org/10.1177/00302228251338643>
- Romão, M. E., Setti, I., Alfano, G., & Barelo, S. (2025). Exploring risk and protective factors for burnout in professionals working in death-related settings: A scoping review. *Public Health*, 241, 1–11. <https://doi.org/10.1016/j.puhe.2025.01.038>
- Romão, M. E., Setti, I., Monaci, M., Cavallari, E., & Barelo, S. (2025). One must know things, but above all, one must know how to be: An existential–phenomenological study of professional identity in palliative care.
- Romão, M. E., Setti, I., Thomson, G., Alfano, G., & Barelo, S. (2025). Navigating medicine and justice: A life history and phenomenological study of forensic doctors’ experiences. *Journal of Forensic Sciences*. Advance online publication.
<https://doi.org/10.1111/1556-4029.70089>
- Romão, M. E., Woodthorpe, K., Setti, I., & Barelo, S. (2025). Between silence and service: An interpretative phenomenological study of the lived experiences of funeral directors and cemetery workers. *OMEGA—Journal of Death and Dying*. Advance online publication. <https://doi.org/10.1177/00302228251390126>

- Ronconi, L., Biancalani, G., Medesi, G. A., Orkibi, H., & Testoni, I. (2023). Death education for palliative psychology: The impact of a death education course for Italian university students. *Behavioral Sciences*, 13(2), 182. <https://doi.org/10.3390/bs13020182>
- Simone, S. R. (2011). The stigmatization of deathcare workers (Master's thesis, University of Central Florida).
- Testoni, I., Biancalani, G., Ronconi, L., & Varani, S. (2021). Let's start with the end: Bibliodrama in an Italian death education course on managing fear of death, fantasy-proneness, and alexithymia with a mixed-method analysis. *OMEGA—Journal of Death and Dying*, 83(4), 729–759. <https://doi.org/10.1177/0030222819863613>
- Testoni, I., Palazzo, L., De Vincenzo, C., & Wieser, M. A. (2020). Enhancing existential thinking through death education: A qualitative study among high school students. *Behavioral Sciences*, 10(7), 113. <https://doi.org/10.3390/bs10070113>
- VERBI Software. (n.d.). MAXQDA. Retrieved October 12, 2025, from <https://www.maxqda.com/about>
- Walter, T. (1991). Modern death: Taboo or not taboo? *Sociology*, 25(2), 293–310.
- Wang, N., & Wang, Z. (2026). Effect of death education interventions on death attitudes in medical students: Systematic review and meta-analysis. *Frontiers in Public Health*, 13, 1754182. <https://doi.org/10.3389/fpubh.2025.1754182>
- Wass, H. (2004). A perspective on the current state of death education. *Death Studies*, 28(4), 289–308. <https://doi.org/10.1080/07481180490432315>
- Woodthorpe, K., & Komaromy, C. (2013). A missing link? The role of mortuary staff in hospital-based bereavement care services. *Bereavement Care*, 32(3), 124–130. <https://doi.org/10.1080/02682621.2013.854545>

- Zavattaro, S. M. (2020). We've cared for the dead since we started caring: COVID-19 and our relationship to public and private deathcare. *Public Administration Review*, 80(4), 701–705. <https://doi.org/10.1111/puar.13221>
- Zhang, G., Wang, H., & Li, M. (2023). A little thanks changes my world: When and why dirty work employees feel meaningfulness at work. *Journal of Business Research*, 163, 113913. <https://doi.org/10.1016/j.jbusres.2023.113913>