
Research Article

END OF LIFE: PREPARING BODY, MIND, AND SOCIETY FOR A PEACEFUL DEATH

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Abstract: This mixed-methods research aimed to: (1) investigate the levels of physical, psychological, and social preparation for a peaceful death among elderly people in Thai Buddhist communities; (2) examine factors influencing peaceful death preparation; and (3) develop a conceptual model for holistic end-of-life preparation integrating Buddhist psychology and modern palliative care principles. The research population comprised elderly individuals aged 60 years and above residing in Buddhist communities in Central Thailand. A stratified random sampling technique was employed to select 420 participants for the quantitative phase, while purposive sampling was used to select 30 key informants for the qualitative phase. Research instruments included a validated questionnaire (IOC = 0.89, Cronbach's alpha = 0.91) and semi-structured interview guidelines. Data were collected during October 2024 to January 2025. Quantitative data were analyzed using descriptive statistics, Pearson correlation, and multiple regression analysis. Qualitative data were analyzed using thematic analysis and triangulation. Results indicated that overall peaceful death preparation was at a high level (Mean = 3.78, SD = 0.62). Physical preparation (Mean = 3.85, SD = 0.58) was highest, followed by social preparation (Mean = 3.76, SD = 0.71) and psychological preparation (Mean = 3.73, SD = 0.69). Buddhist mindfulness practice, family support, and access to palliative care services were significant predictors of peaceful death preparation ($p < 0.001$). The developed holistic model, the Triadic Peaceful Death Preparation Model (TPDP), integrates Dhamma practice, social connectedness, and medical care. Findings suggest that integrating Buddhist psychological principles with contemporary palliative care can significantly enhance quality of dying among Thai elderly populations.

Keywords: Peaceful Death, End-of-Life Care, Buddhist Psychology, Palliative Care, Elderly Thailand

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1. INTRODUCTION

The phenomenon of aging and death represents one of the most profound universal human experiences. In Thailand, the proportion of elderly persons (aged 60 and above) has risen dramatically from 10.7% in 2007 to 19.6% in 2021, positioning Thailand as one of the most rapidly aging societies in Southeast Asia (National Statistical Office of Thailand, 2023). This demographic transformation carries significant implications for healthcare systems, social structures, and cultural institutions, particularly with regard to end-of-life care and preparation for a peaceful death.

From a Buddhist perspective, which forms the cultural bedrock of Thai society, death is not viewed as a terminus but rather as a transition within the cycle of rebirth (samsara). The quality of consciousness at the moment of death (maranasanna citta) is considered profoundly influential for subsequent rebirths.

Consequently, Buddhist teachings emphasize the importance of maintaining a calm, mindful, and compassionate state of mind during the dying process (Payutto, 2016; Upasen & Thanasilp, 2020). This perspective fundamentally shapes how Thai people conceptualize and prepare for death, distinguishing Thai end-of-life care from Western models that predominantly focus on biomedical and psychological dimensions.

Contemporary Western palliative care, as articulated by the World Health Organization (WHO, 2020), emphasizes the physical, psychological, social, and spiritual dimensions of care for the terminally ill. However, scholars have noted that Western frameworks often underrepresent Buddhist and Asian cultural perspectives (Keown, 2005; Harvey, 2000). The integration of Buddhist psychological principles with modern palliative care represents both a theoretical challenge and a practical opportunity for improving the quality of dying among Thai populations.

Research on end-of-life experiences in Thailand reveals several concerning patterns. A national survey conducted by the Department of Mental Health (2022) found that 67.3% of Thai elderly expressed fear about the dying process, while only 34.8% reported having made concrete preparations for death. Furthermore, Suwannapong et al. (2024) documented that death anxiety was negatively associated with death acceptance among Thai older persons, while Buddhist beliefs, Buddhist practices, and social support were positively associated with death acceptance, suggesting structural and cultural determinants of end-of-life preparation. These findings underscore the need for culturally congruent frameworks for end-of-life preparation that can be effectively implemented within Thai Buddhist communities.

Physical preparation for death encompasses advance care planning, symptom management, and ensuring bodily comfort during the dying process (Steinhauser et al., 2000). Psychological preparation involves resolving unfinished emotional business, achieving a sense of life completion, and cultivating equanimity in the face of mortality (Chochinov, 2002; Byock, 1997). Social preparation includes maintaining meaningful relationships, legacy creation, and ensuring practical arrangements for surviving family members (Kellehear, 2007). Within Thai Buddhist culture, these dimensions are deeply intertwined with dharma practice, including meditation, merit-making activities (*tambun*), and the study of Buddhist teachings on impermanence (*anicca*) and the nature of suffering (*dukkha*).

Despite growing scholarly interest in Buddhist approaches to dying and death, empirical research examining the specific mechanisms through which Buddhist practice facilitates preparation for a peaceful death among Thai elderly remains limited. Furthermore, validated instruments for measuring holistic end-of-life preparation within Thai Buddhist cultural contexts are largely absent from the literature. This research gap represents both a scientific concern and a practical challenge for healthcare providers and community leaders working with aging Thai populations.

This study addresses these gaps by investigating the levels of physical, psychological, and social preparation for peaceful death, identifying key predictors of comprehensive end-of-life preparation, and developing an empirically grounded conceptual model that integrates Buddhist psychology with contemporary palliative care principles. The findings are intended to inform policy development, clinical practice, and community-based interventions aimed at enhancing the quality of dying among Thai Buddhist elderly populations.

2. OBJECTIVE

The objectives of this research were as follows:

2.1 To investigate the levels of physical, psychological, and social preparation for a peaceful death among elderly people in Thai Buddhist communities.

2.2 To examine factors influencing peaceful death preparation, including Buddhist mindfulness practice, family support, access to palliative care services, sociodemographic variables, and health status.

2.3 To develop and validate a Triadic Peaceful Death Preparation Model (TPDP) that integrates Buddhist psychological principles with contemporary palliative care frameworks.

3. RESEARCH METHODOLOGY

This study employed a mixed-methods research design, integrating quantitative survey methodology with qualitative in-depth interviews. The explanatory sequential design was used, in which quantitative data were collected and analyzed first, followed by qualitative data collection to help explain and contextualize the quantitative findings (Creswell & Plano Clark, 2018). The mixed-methods approach was selected because it allowed for both broad measurement of end-of-life preparation levels across a large sample and deep exploration of the cultural, spiritual, and personal dimensions of the phenomenon.

3.1 Population and Samples

The research population comprised elderly individuals aged 60 years and above who resided in Buddhist communities in the Central Region of Thailand. Based on data from the National Statistical Office (2023), the estimated population of elderly Buddhists in the Central Region is approximately 2,847,500 persons. For the quantitative phase, sample size was calculated using the Yamane (1967) formula with a 5% margin of error, yielding a minimum required sample of 400 participants. An additional 5% was added to account for potential incomplete responses, resulting in a target sample of 420 participants.

Stratified random sampling was employed in the quantitative phase, with provinces serving as strata. Six provinces were randomly selected from the Central Region: Phra Nakhon Si Ayutthaya, Pathum Thani, Nonthaburi, Samut Prakan, Nakhon Pathom, and Saraburi. Within each province, 70 participants were selected through systematic random sampling from community health center registration lists. Inclusion criteria required participants to be: (1) aged 60 years or above; (2) self-identified Buddhist; (3) residing in the selected province for at least two years; and (4) cognitively capable of completing a structured questionnaire, as assessed by the Thai version of the Mini-Mental State Examination (MMSE-T) with a cutoff score of 24 or above.

For the qualitative phase, purposive sampling was employed to select 30 key informants from the quantitative sample, with maximum variation sampling used to ensure diversity in terms of age, gender, health status, religious practice intensity, and life experience with death. Sample size adequacy in the qualitative phase was determined by data saturation, which was achieved by the 25th interview, with the remaining five interviews confirming saturation.

3.2 Research Instrument

The research instruments comprised two tools: (1) a structured questionnaire for the quantitative phase, and (2) semi-structured interview guidelines for the qualitative phase. The questionnaire was developed based on an extensive literature review integrating Steinhäuser et al.'s (2000) framework of good death, Kellehear's (2007) social history of dying, and Payutto's (2016) Buddhist teachings on impermanence and end-of-life preparation. The questionnaire consisted of four parts: Part 1: Sociodemographic information (10 items); Part 2: Physical preparation scale (15 items); Part 3: Psychological preparation scale (15 items); Part 4: Social preparation scale (15 items). All scale items used a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Content validity was established by a panel of five experts in geriatric care, Buddhist psychology, palliative care nursing, and social gerontology. The Item-Objective Congruence (IOC) index ranged

from 0.80 to 1.00, with an average IOC of 0.89, exceeding the minimum acceptable threshold of 0.50 (Rovinelli & Hambleton, 1977). A pilot study was conducted with 30 elderly participants from a non-sampled province. Internal consistency reliability was assessed using Cronbach's alpha coefficient, yielding values of 0.87 for physical preparation, 0.89 for psychological preparation, and 0.91 for social preparation. The overall scale demonstrated excellent reliability ($\alpha = 0.91$).

3.3 Collection of Data

Quantitative data collection was conducted between October and December 2024. Research assistants who had completed standardized training in survey administration visited community health centers and senior citizen clubs in the selected provinces. Participants were administered the questionnaire in a face-to-face format to accommodate varying levels of literacy. Out of 420 distributed questionnaires, 412 were returned, yielding a response rate of 98.1%. After data cleaning, 408 questionnaires were deemed complete and suitable for analysis.

Qualitative data were collected through in-depth semi-structured interviews conducted between November 2024 and January 2025. Interviews lasted between 45 and 90 minutes and were conducted in participants' homes or at community health centers, based on participants' preference. All interviews were audio-recorded with participants' written informed consent. Field notes were maintained throughout the data collection process. Credibility was established through member checking, peer debriefing, and data triangulation using multiple sources including interview transcripts, field notes, and documentary evidence from community records.

3.4 Data Analysis

Quantitative data analysis was performed using SPSS Statistics version 28.0. Descriptive statistics including frequencies, percentages, means, and standard deviations were calculated to characterize the sample and describe levels of end-of-life preparation. Pearson correlation coefficients were computed to examine relationships among variables. Multiple regression analysis was employed to identify significant predictors of overall peaceful death preparation, with the assumptions of normality, homoscedasticity, and multicollinearity verified prior to analysis. Statistical significance was set at $p < 0.05$.

Qualitative data analysis followed Braun and Clarke's (2006) six-phase thematic analysis procedure: (1) familiarization with data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report. NVivo version 14 software was used to organize and code qualitative data. Inter-rater reliability was assessed using the kappa coefficient, achieving a value of 0.82, indicating strong agreement. Triangulation across quantitative findings, interview themes, and existing literature informed the development of the TPDP conceptual model.

4. RESULT

The results are presented according to the three research objectives: (1) levels of end-of-life preparation; (2) factors predicting peaceful death preparation; and (3) the Triadic Peaceful Death Preparation Model (TPDP).

4.1 Sociodemographic Characteristics of Participants

The final sample of 408 participants had a mean age of 68.4 years ($SD = 6.2$), with ages ranging from 60 to 87 years. The majority were female (62.3%, $n = 254$), had completed primary education (48.5%, $n = 198$), were married (52.9%, $n = 216$), and were retired (73.3%, $n = 299$). With regard to religious practice, 68.6% reported practicing Buddhist meditation regularly (at least once per week),

while 81.9% reported engaging in merit-making activities at the temple regularly. Table 1 provides a comprehensive summary of participant characteristics.

Table 1
Sociodemographic Characteristics of Participants (N = 408)

Characteristics	n	Percentage (%)	Mean (SD)
Age (years)			68.4 (6.2)
60–69 years	232	56.9	
70–79 years	138	33.8	
80+ years	38	9.3	
Gender			
Female	254	62.3	
Male	154	37.7	
Education Level			
Primary school	198	48.5	
Secondary school	112	27.5	
Higher education	98	24.0	
Marital Status			
Married	216	52.9	
Widowed	131	32.1	
Single/Divorced	61	15.0	
Buddhist Meditation Practice			
Regular ($\geq$ once/week)	280	68.6	
Occasional	84	20.6	
Rarely/Never	44	10.8	

Note. Percentages may not total 100% due to rounding.

4.2 Levels of Peaceful Death Preparation

Overall levels of peaceful death preparation were assessed across three domains. As shown in Table 2, the overall mean score for peaceful death preparation was 3.78 (SD = 0.62), indicating a high level of preparation. Physical preparation achieved the highest mean score (M = 3.85, SD = 0.58), followed by social preparation (M = 3.76, SD = 0.71) and psychological preparation (M = 3.73, SD = 0.69). All three domains were rated in the high range (3.51–4.50) according to the five-level interpretation criteria.

Table 2
Levels of Peaceful Death Preparation by Domain (N = 408)

Preparation Domain	Mean	SD	Level	Rank
Physical Preparation	3.85	0.58	High	1
Advance care planning	3.92	0.61	High	
Symptom management preparation	3.88	0.55	High	
Bodily comfort arrangements	3.75	0.63	High	
Social Preparation	3.76	0.71	High	2
Family relationship closure	3.84	0.67	High	
Legacy and life review	3.71	0.74	High	

Preparation Domain	Mean	SD	Level	Rank
Practical posthumous arrangements	3.73	0.72	High	3
Psychological Preparation	3.73	0.69	High	
Acceptance of mortality (anicca)	3.81	0.65	High	
Mindfulness and equanimity	3.77	0.70	High	
Life meaning and completion	3.61	0.72	High	
Overall Peaceful Death Preparation	3.78	0.62	High	

Note. Interpretation criteria: 1.00–1.50 = Very Low; 1.51–2.50 = Low; 2.51–3.50 = Moderate; 3.51–4.50 = High; 4.51–5.00 = Very High.

Source: Field research data (2025).

4.3 Correlation between Variables and Peaceful Death Preparation

Pearson correlation analysis revealed significant positive correlations between all predictor variables and overall peaceful death preparation (Table 3). Buddhist mindfulness practice showed the strongest correlation with overall preparation ($r = 0.68$, $p < 0.001$), followed by family support ($r = 0.61$, $p < 0.001$), access to palliative care services ($r = 0.54$, $p < 0.001$), social connectedness ($r = 0.49$, $p < 0.001$), and self-rated health status ($r = 0.43$, $p < 0.001$). These findings indicate that both spiritual practice and social support systems are central factors in end-of-life preparation among Thai Buddhist elderly.

Table 3

Pearson Correlation between Predictor Variables and Peaceful Death Preparation (N = 408)

Variable	Physical	Psychological	Social	Overall
Buddhist Mindfulness Practice	.59**	.65**	.61**	.68**
Family Support	.55**	.58**	.63**	.61**
Access to Palliative Care Services	.57**	.48**	.51**	.54**
Social Connectedness	.41**	.46**	.52**	.49**
Self-Rated Health Status	.48**	.39**	.42**	.43**
Education Level	.31**	.29**	.27**	.31**
Age	.18**	.22**	.20**	.20**

Note. ** $p < .001$.

4.4 Predictors of Peaceful Death Preparation: Multiple Regression Analysis

Multiple regression analysis was conducted to identify significant predictors of overall peaceful death preparation. The regression model was statistically significant, $F(5, 402) = 89.47$, $p < 0.001$, explaining 52.6% of the variance in overall peaceful death preparation ($R^2 = 0.526$, Adjusted $R^2 = 0.520$). Table 4 presents the standardized and unstandardized regression coefficients. Buddhist mindfulness practice emerged as the strongest predictor ($\beta = 0.38$, $p < 0.001$), followed by family support ($\beta = 0.29$, $p < 0.001$), access to palliative care services ($\beta = 0.18$, $p < 0.001$), social connectedness ($\beta = 0.14$, $p < 0.001$), and self-rated health status ($\beta = 0.11$, $p < 0.01$). These findings highlight the central role of Buddhist spiritual practice and social support in facilitating comprehensive end-of-life preparation.

Table 4

Multiple Regression Analysis: Predictors of Overall Peaceful Death Preparation (N = 408)

Predictor Variable	B	SE	β	t	p
(Constant)	0.98	0.19	—	5.16	< .001

Predictor Variable	B	SE	β	t	p
Buddhist Mindfulness Practice	0.42	0.05	.38	8.40	< .001
Family Support	0.31	0.05	.29	6.20	< .001
Access to Palliative Care Services	0.19	0.05	.18	3.80	< .001
Social Connectedness	0.15	0.05	.14	3.00	< .001
Self-Rated Health Status	0.11	0.04	.11	2.75	.006

Note. $R^2 = .526$; Adjusted $R^2 = .520$; $F(5, 402) = 89.47$, $p < .001$.

Source: Field research data (2025).

4.5 Qualitative Themes: Lived Experiences of End-of-Life Preparation

Thematic analysis of the 30 in-depth interviews yielded five major themes: (1) The Role of Dhamma Practice in Accepting Impermanence; (2) Family as the Foundation of Peaceful Dying; (3) Merit as Spiritual Currency for the Death Transition; (4) Fear and Acceptance as Coexisting Realities; and (5) Community and Institutional Support in End-of-Life Care. Representative quotations from participants illustrate each theme, as presented in Table 5.

Table 5

Qualitative Themes and Representative Quotations

Theme	Representative Quotation	Sub-themes
Dhamma Practice and Impermanence Acceptance	“When I meditate and truly see anicca—impermanence—I no longer fear death. My mind becomes light, like releasing a heavy burden.” (Participant 8, female, 72)	Mindfulness; Acceptance; Dhamma study
Family as Foundation of Peaceful Dying	“The most important thing for me is to reconcile with my son before I die. I do not want to carry unresolved conflict into my next life.” (Participant 14, male, 78)	Relationship closure; Forgiveness; Family presence
Merit as Spiritual Currency	“I go to the temple every week to make merit. The more merit I accumulate, the more peaceful my death will be and the better my next life.” (Participant 3, female, 65)	Merit-making; Karma; Rebirth preparation
Fear and Acceptance as Coexisting Realities	“I accept that death is natural, but I still fear suffering and being a burden to my family. Both feelings exist together in my heart.” (Participant 21, male, 70)	Death anxiety; Equanimity; Pain fear
Community and Institutional Support	“The monks come to chant at our community center every month. When they speak of death in their Dhamma talks, I feel prepared and not alone.” (Participant 27, female, 82)	Temple support; Palliative services; Community care

Source: In-depth interview data (2025). Quotations translated from Thai.

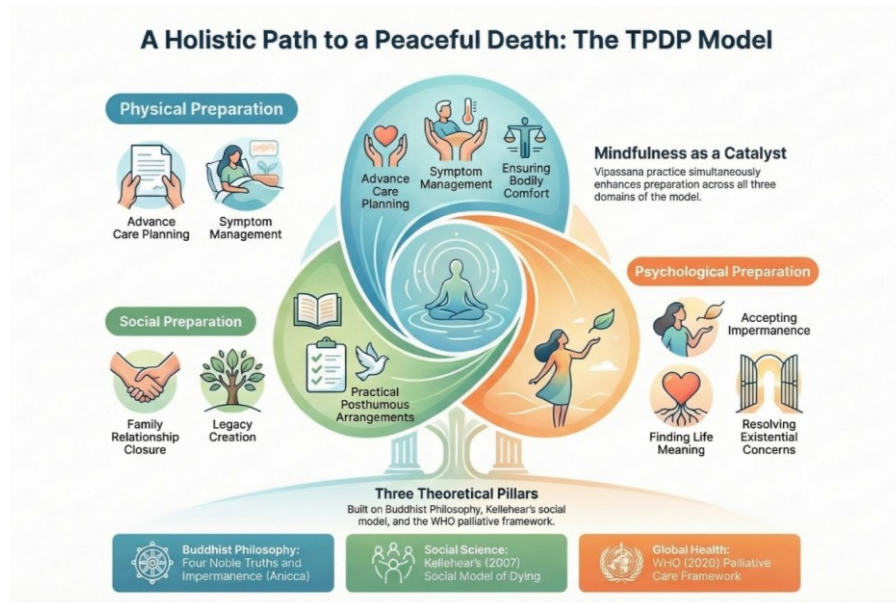
4.6 The Triadic Peaceful Death Preparation Model (TPDP)

Based on the integrated analysis of quantitative and qualitative data, the Triadic Peaceful Death Preparation Model (TPDP) was developed. The model proposes that peaceful death preparation is achieved through the dynamic interaction of three interconnected domains: (1) Physical Domain—encompassing advance care planning, symptom management, bodily comfort arrangements, and access to palliative care; (2) Psychological Domain—including acceptance of impermanence (anicca), mindfulness and equanimity, life meaning construction, and resolution of existential concerns; and (3) Social Domain—comprising family relationship closure, legacy creation, community connectedness, and practical posthumous arrangements.

The model is grounded in three theoretical pillars: Buddhist philosophy (specifically the Four Noble Truths and the teaching of impermanence), Kellehear's (2007) social model of dying, and the WHO (2020) palliative care framework. A central insight of the TPDP model is that Buddhist mindfulness practice (vipassana) functions as a catalytic mechanism that simultaneously enhances preparation across all three domains, by cultivating the cognitive and emotional capacities necessary for acceptance, relational reconciliation, and practical planning. Figure 1 below illustrates the structural components and dynamic relationships within the TPDP model.

Figure 1

The Triadic Peaceful Death Preparation Model (TPDP) for Thai Buddhist Elderly



Source: Developed from field research data and theoretical synthesis (2025).

5. DISCUSSION

The findings of this study provide empirical support for a culturally integrated approach to end-of-life preparation that centers Buddhist psychological principles alongside conventional palliative care frameworks. The high overall level of peaceful death preparation ($M = 3.78$) found in this sample is consistent with previous research suggesting that elderly Buddhists who maintain active religious practice tend to demonstrate greater psychological readiness for death (Wink & Scott, 2005; Krause, 2005). However, the study extends these findings by demonstrating the specific mechanisms through which Buddhist practice influences preparation across physical, psychological, and social domains.

The finding that Buddhist mindfulness practice was the strongest predictor of peaceful death preparation ($\beta = 0.38$, $p < 0.001$) aligns with theoretical positions in both Buddhist psychology and contemporary thanatology. Payutto (2016) argues that meditation practice cultivates the capacity for direct insight into impermanence (anicca), a cognitive-emotional transformation that Buddhist teaching identifies as foundational to releasing attachment and accepting death. This is congruent with terror management theory (Greenberg et al., 1986), which proposes that worldview defense—in this case, Buddhist cosmological understanding—serves as a buffer against existential death anxiety. Critically, however, the Buddhist approach differs from Western existentialist frameworks in its emphasis on impermanence as an empirically verifiable reality rather than merely a philosophical stance (Harvey, 2000).

The prominence of family support as the second most significant predictor ($\beta = 0.29$, $p < 0.001$) reflects the deeply relational nature of dying in Thai cultural contexts. Unlike Western individualistic

models that emphasize personal autonomy in end-of-life decision-making (Steinhauser et al., 2000), Thai elderly participants in this study conceptualized a good death as fundamentally relational—dependent on the presence, care, and spiritual support of family members. This finding resonates with Kellehear's (2007) social history of dying, which highlights how dying is always socially embedded, and extends this insight to Thai Buddhist cultural contexts. The qualitative data further illuminate this dynamic, with participants describing the need for relational reconciliation (particularly with estranged family members) as a prerequisite for psychological peace at death.

The relatively lower scores on the psychological preparation dimension—specifically the life meaning and completion subscale ($M = 3.61$)—merit particular attention. This pattern suggests that despite participants' familiarity with Buddhist teachings on impermanence, the translation of these teachings into a subjective sense of life completion remains challenging. This gap between doctrinal knowledge and experiential acceptance is consistent with observations by Chochinov (2002), who found that a sense of meaning and legacy is frequently incompletely resolved even among individuals who are cognitively aware of their mortality. Future interventions should specifically target meaning-making processes, potentially drawing on narrative approaches such as Dignity Therapy (Chochinov, 2012) adapted to Thai Buddhist cultural contexts.

The significant association between access to palliative care services and peaceful death preparation ($\beta = 0.18, p < 0.001$) highlights an important structural dimension of end-of-life preparation. Despite the WHO's (2020) emphasis on universal access to palliative care, access in Thailand remains inequitable. A report by the Health Systems Research Institute (2022) indicated that only 41% of elderly Thais in need of palliative care were able to access specialized services, with particularly limited availability in community and rural settings. The finding that service access significantly predicts preparation underscores the need for policy initiatives to expand community-based palliative care, including home-visit programs and training of community health volunteers in basic palliative care principles.

The qualitative themes enriched and contextualized the quantitative findings in several important ways. The theme of Merit as Spiritual Currency reflects a specifically Thai Buddhist cultural mechanism through which preparation for death is enacted. Merit-making activities (*tambun*)—including offering food to monks, releasing animals, and sponsoring temple construction—are understood within Buddhist cosmology as generating positive karma (*kamma*) that will benefit the practitioner in the death transition and subsequent rebirth. This cultural-religious practice has no direct equivalent in Western palliative care frameworks, and its integration into end-of-life care models represents an important contribution of this study to the cross-cultural thanatology literature (Keown, 2005).

The coexistence of fear and acceptance within participants' psychological experiences of anticipated death (Theme 4) is consistent with the ambivalence documented in the broader death acceptance literature (Neimeyer, 1994). Importantly, Buddhist teachings do not prescribe the elimination of fear but rather the cultivation of a spacious awareness that can hold both fear and acceptance simultaneously. This phenomenological complexity is important for clinicians and care workers to understand, as premature encouragement of acceptance without acknowledging fear may inadvertently invalidate patients' genuine emotional experiences. This finding suggests that culturally competent end-of-life care must create space for emotional ambivalence while supporting movement toward greater equanimity (Upasen & Thanasilp, 2020).

6. CONCLUSION

This mixed-methods study provides the first comprehensive empirical investigation of peaceful death preparation among Thai Buddhist elderly, integrating quantitative measurement with qualitative

exploration of lived experiences. The findings demonstrate that overall end-of-life preparation is at a high level among this population, with physical preparation scoring highest and psychological preparation—particularly life meaning and completion—being the most challenging dimension. Buddhist mindfulness practice, family support, and access to palliative care services were identified as the three most powerful predictors of comprehensive end-of-life preparation.

The Triadic Peaceful Death Preparation Model (TPDP) offers a culturally grounded conceptual framework that bridges Buddhist psychological traditions with contemporary palliative care science. The model's key innovation lies in positioning Buddhist mindfulness practice as a catalytic mechanism that simultaneously enhances physical, psychological, and social dimensions of end-of-life preparation, thereby offering a uniquely integrated approach to supporting the dying process in Thai Buddhist communities.

These findings have significant implications for healthcare policy, community-based interventions, and clinical practice in aging Thai society. They underscore the importance of culturally congruent end-of-life care that honors Buddhist traditions while incorporating evidence-based palliative care practices. The TPDP model provides a practical framework for the development of holistic end-of-life programs in Thailand and, potentially, in other Buddhist communities across Asia.

7. RECOMMENDATION

Recommendations from the Research: Healthcare providers and community health workers should integrate Buddhist mindfulness training into standard palliative care protocols for elderly Thai patients. Specifically, vipassana meditation instruction and guidance on applying Buddhist teachings on impermanence to the dying process should be routinely offered as part of holistic end-of-life care. Temple communities should be engaged as active partners in community-based end-of-life care programs, given the demonstrated importance of religious community support.

Policy Recommendations: The Thai Ministry of Public Health should prioritize expansion of community-based palliative care services, with particular attention to underserved rural areas. Integration of Buddhist chaplaincy services into the national palliative care framework is recommended. Training programs for community health volunteers should include modules on Buddhist end-of-life care principles to enhance the cultural competence of frontline care workers.

Recommendations for Future Research: Future studies should employ longitudinal designs to examine changes in end-of-life preparation over time and to investigate the mechanisms through which mindfulness practice influences preparation. Cross-cultural comparative studies examining similarities and differences in end-of-life preparation across Buddhist communities in different Asian countries (e.g., Myanmar, Sri Lanka, Japan) would significantly advance the field. The TPDP model should be subjected to confirmatory factor analysis and structural equation modeling using larger, more diverse samples to assess its generalizability and validity.

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