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AGE AS A PREDICTOR OF NURSES'BELIEFS TOWARDS DEATH AND DYING PATIENTS IN TARABA STATE, NIGERIA

[1]Gemson, George Simon *Ph.D*, [2]Tochi, Emmanuel Iwuagwu, *Ph.D*., [3] James Iliya Kymaru., *Ph.D*., [4]Izang, Yakubu Dauda, [5]Saleh Ahmed., [6]Dahiru, Umar & [7]Gemson, Linus Simon

Department of Human Kinetics and Health Education, Taraba State University, Jalingo, Taraba State
[2,4]Department of Human Kinetics and Health Education, University of Nigeria, Nsukka,
[3,5]Abubakar Tafawa Balewa University Teaching Hospital, School of Nursing, Bauchi State, Nigeria.
[6]Department of Primary Health Care, Gashaka Local Government Area, Taraba State, Nigeria
[7]General Hospital, Bali, Taraba State, Nigeria
Email:drgeorgegemson@gmail.com
Corresponding author: Gemson, George Simon

ABSTRACT

The purpose of the study was to examine Age as a Predictor of beliefs of Nurses toward death and dying patients in Taraba State, Nigeria. The population of the study consisted of all the Nurses working in General Hospitals as well as Specialist Hospitals, which was estimated at eight hundred and eighty-three (883). Multistage sampling procedure with appropriate techniques were used to draw 262 nurses working in General and Specialist Hospitals in Taraba State. The instrument for data collection was a thirteen-item Age as a Predictor of Nurses' Beliefs Towards Death and Dying Patients Questionnaire (AAPNBTDDPQ) developed by the researchers. Mean statistic was used to answer the research questions while One-way - ANOVA statistic was used to test the hypothesis postulated for the study at .05 level of significance. The findings of the study showed that nurses had positive beliefs towards death and dying patients. It was recommended among other things that The Nursing and Midwifery Council of Nigeria should improve the curriculum content for training nurses in order to pave way for more effective death education programme that can modify nurse negative beliefs towards death and dying of patients. This could be done by setting up a committee to look into the present curriculum with a view to adopting the integrating approach to the revision. When this is done the same committee should be entrusted with the supervision of the implementation of the revised curriculum who will report directly to the officer in charge of nursing education at the Nursing and Midwifery Council of Nigeria.

Keywords: *Age, Beliefs, Death, Dying, Patients and Nurses*

INTRODUCTION

Life has two extremes, the day one is born and the day one dies. Death is a part of each living day. We read, write, and talk about it whenever the opportunity naturally presents itself. Instead of being ignored, the subject needs to be included in the daily rituals of living. The reason being that it cannot be escaped since it is part of life. The concept of death and dying according to Rose and Mico (2014) falls within the realm of health education which is a process within intellectual, psychological, and social dimensions relating to activities which increase the ability of people to make informed decisions about their personal, family, and community well-being.

As observed by Kalish (2015), death is being perceived in so many ways, such as a punishment for sins committed, an atonement, a judgment of a just God, loneliness and abandonment. In addition, it is viewed as a change of state that merely alters the manner of interaction between the living and the death, a redemption, a friend, a fulfilment or an accomplishment, and finally a destroyer of human happiness. He further explained that death can have many meanings, since the specific meanings that actually are attached to death and the reactions that death prompts vary from individual to individual and case to case. The meaning of death varies historically and culturally. Though everyone know that death is a reality and not myth, there is evidence that individuals find it difficult to accept it presence as a fact, and as a debt that must be paid by everyone born into the earth. Death as described by Kalish (2015) is the conclusion of the dying process, the termination of life, as we know it. It has remained the untouchable and tabooed subject for open discussion in many societies, because of the fear of the unknown it conjures in the minds of humans, he noted. In spite of these fears, Kalish stressed that death remains a reality, the ultimate end of all humans, and the final phase of human existence.

The idea of taboo as asserted by Forberow (2013) has two different, almost contrary meanings: the first is 'sacred' (involves one's belief) or consecrated, the second refers to that which is dangerous, unknown, phenomenon, or forbidden. However, to some individuals, death fulfills both meanings. Observations seem to suggest that human beings are not able to fight against death, misery and ignorance. They have decided to be happy, not to think of them at all. It seems that the only possible way of softening the emotional impact and circumventing tragic reality is to accept death. This is because it serves an important biological purpose by helping

in the natural selection process, which is a way of stabilizing the population of the world, as there will be young ones to always replace the dead. Death is used in this work to mean the conclusion of the dying process when lifelessness is pronounced.

Describing dying, Lamerton (2014) stated that it is a stage in which feelings are being transferred to the feeling of lost independence, burden and holding emotions. In like manner, Kastenbaum (2017) explained that dying is the act or process of ceasing to live. He added that dying refers to a more general sense of perishing, languishing, and fading away. Discussing from life experience at one time or the other, individuals are faced with situations in which they have to deal with a dying patient. This may occur unexpectedly making it difficult to cope with. Dying has the secret that is unfounded because of the non-disclosure of the stages of the patient's health. This denies the individual of the chance to get his/her life in other and to prepare for a dignified death. However, medical advancement has become sophisticated that it is possible to accurately diagnose that individual has an illness. This has provided everyone: the dying person, friends as well as relative's time to prepare for the event. Dying is used in this work as the observable process of perishing that precedes the ultimate end of life on earth.

Death and dying cannot in anyway be said to be a pleasant phenomenon, but for each person to accept its reality is an important aspect of a mature personality. In spite of the fact that death and dying are common happenings in all societies, individuals find it abnormal discussing the phenomenon. Many appears to look at death with surprise as if it were not there or something that we are not part of. Indeed, Okafor (1994) observed that it is likely that no day passes without, at least, one or more Nigerians dying, in each local government area in the country. He posited that current Nigerian attitudes toward death may be assumed to be representative of avoidance and denial or aversion. While some people are within minutes of their own death, yet death seems ignored and denied. Death is being used in this work to mean the conclusion of the dying process when lifelessness is pronounced. Despite general consensus on the meaning of death, people's perception of the phenomenon varies according to beliefs. Beliefs according to Green, Kreuter, Deeds and Patridge (2018) are convictions that a phenomenon or object is true or real. They emphasized that faith, trust and truth are words used to express or imply belief. In another submission, Simpson and Weisman (2017)

described belief as the metal action, condition or habit of trusting for or confining in a person. In other to buttress the meaning of belief stated above, Kastenbaum (2017) pointed out that beliefs are relative, stable and broad interpretations of the world and our place in it. When these beliefs relate to death, as is the case in the present study, they are called death beliefs. Furthermore, Hobson, (2016) expressed that value systems are built upon traditional beliefs and concepts of disease, and change only when these beliefs are altered by new experience, technical innovations, education, economic trends, or such upheavals as wars and revolutions. The essential of belief systems is that it is either moral or magical.

Moral beliefs as explained by Hobson (2016) constitute a useful explanation of incomprehensive phenomenon, and that by taking certain social action the situation can be put right. Newell (2017) pointed out that in Newzealand, people believed that disease was caused mainly by social wrong doing, which exposed one to attack by a spirit and was a form of punishment, which could be put right by exorcism and retribution. Consequently, the desire to find explanations for certain kinds of misfortunes has led some people to frequently assume magical influence. As Loudon (2015) emphasized in relation to the Zulus, magic accounts for only part of aetiology of sickness, and many misfortunes are explained and solutions provided on a purely rational basis.

Conversely, when the misfortune is not of the ordinary, the sufferer begins to ask why? And the answer is often the operation of the supernatural forces. Since beliefs seems personal, people in Kaduna State may reflect some of these magic and /moral concepts of aetiology. This may have no significance for the culture as a whole. When these beliefs are held by groups or tribes and are reinforced, solution becomes more difficult. This is of importance to the health educator because, though many are harmless, some of these beliefs are dangerous. Some might be described as lethal, for instance, the notions that cancer is not curable, and that disease is the will of God. There may be many others, which every experienced nurse must have come across. When these beliefs relate to death as in the present study, they termed death beliefs. Attitudes, another concept in the study, was described by Allport (2015) as a mental or neutral state of readiness organized through experience, exerting a directive or dynamic influence upon the individual's responses to all objects and situations with which it is related. This implies that attitude is a preparation or readiness to act. In addition, Kerlinger (2014) explained attitude to mean organized

predisposition to think, fell, perceive and behave towards a referent object where referents refer to a category, class or set of phenomenon. When attitudes relate to death as in present study, they are called death attitudes. Generally, attitudes are explained by Triandis (2017) as multi-dimensional consisting of cognitive, effective and action tendency. However, death attitude has been explained by thanatologists as being multi-dimensional with the following features: fear of death, death concern, death anxiety, death threat and death denial or aversion. Death attitude is used in the present study to mean likes and dislike of individuals that come as a result of experience that influence them to respond towards death and dying.

The main problem death and dying presents for society is the task of coping with the fear of death, fear of experience itself and what follows later. It is possible that everyone has difficulties in managing fears. Most individuals eventually a stage of acceptance of death. As expressed by Kalish (2015), the concept of death is in the feature, it is frequently an unknown subject in many ways. It is usually seen as a negative, unpleasant or evil. It seems more likely to elicit anxiety than is the dying process. Paltison (2015) summarized the complexity of death in cultural attitudes which he postulated rarely exist in pure form. He explained that Americans have moved from a rather death-denying culture toward a more open death integrating one. Perhaps it is the complexity and constant shift of many attitudes toward death as a result of beliefs which nurses must be aware. Nigerian attitudes toward death and dying are equally complex and changing (Okafor, 1993).

As emphasized by Drolet and Fetro (2017), no age bracket or socioeconomic class is spared from the effects and impact of death. Adolescents, young adults, rich or poor, working and non-working classes of people who are moving from one stage of development to another are more likely to perceive it even as fearful. Responses to fears may interfere with growth and development. Awareness and understanding of contemporary fearful event is an essential first step in helping any group of people cope with their fears. Discussing Nigerian attitudes toward death and dying Okafor (1994) pointed out that it is possible that individuals may wish to learn more about death, factors seem to exist in Nigerian practice that lessen people's familiarity with the subject. Some of such social technological factors may include: displacement of death from the home, gradual replacement of the extended family, changing causes of death, and geographical mobility. Others are, lower mortality rates, increase in average

life expectancy, advances in medical science and in applied health care technology. All these factors are not only likely to contribute to demographic changes, but they may also alter the setting where dying most often occurs especially in hospitals where nurses practice their profession.

Another key concept of the study is 'Patient', it was explained by Hornby and Cowie (2014) as an individual receiving medical treatment. Discussing about the Patient, Rando (2016) expressed that a Patient may become aware that he is dying in many ways other receiving a direct diagnosis from a physician. These include: comments made by others, statement from health care personnel (including a nurse), a family member as well as changing behaviours of individuals, signals with them and others. As a way of coping with illness, she explained that patients use direct and indirect ways to secure, maintain and assert as much control as possible. The unfortunate situation she emphasized, is that, the patient's control is not only challenge by the intrinsic aspects of illness and its treatment, but also by the health care and family systems within which the patient exists. To help this situation, Kubler-Ross (2018) posited that the family, friends and nurses should make sure that abandonment, so frequently a part of dying-patient's experience should not occur. A patient is used in this work to mean an individual whose condition has caused him/her to be concerned with the body system to seek medical help.

Emphasizing on terminal illness, Kubler-Ross (2018) posited that there is an increase in the number of people that die of cancer, increasing the chances of nurses being exposed to persons dying of cancer. It would seem that nurse that are experiencing numerous stresses, which can lead to high level of occupational stress. Veatch (2016) reported studies, which indicated that many physicians in the united states, and probably to a somewhat lesser extent, other health care professionals (of which the nurses are) have a tendency to resist telling dying patients the nature of their illness especially where the prognosis is bleak, such as in the case of dying cancer and AIDS patients. He pointed out that studies have indicated the overwhelming desire of dying cancer patients, non-cancer patients and those at a cancer detection clinic to be told about their prognosis.

On the other hand, Adamolekun (2018) stressed that the patient those not typically want to hear that he/she is dying of an illness. He expressed that in Nigeria, it is the tradition of doctors and nurses not to convey bad news and the patients do not see themselves as dying of illnesses. The doctors

are not enthusiastic about informing the patients that their disease is terminal, though doctors and nurses in Nigeria are of the opinion that patients or relatives should be informed of patient's diagnosis. The above indicated belief of doctors and nurses was a pointer to the need to determine whether or not a similar trend of belief and attitude currently exist among the nurses in Taraba State. It is possible that in Taraba State, nurses seem to be the most important health professionals in the palliative care team due to there continues presence and the wholism of their therapeutic approaches, nurses can make all the differences in the hospitalization experiences of the terminally ill and the dying patient as well as in the long-term mental health of the family.

The importance of ensuring that the dying patient feels supported and accepted cannot be overemphasized. One of the greatest fears of dying, according to Rando (2016), is that the patient will be left alone. Ironically, this is one of the easiest problems to be solved in the entire dying experience. While no one can take away the pains of loss, and none is unable to make death disappear, the nurse is the individual who must definitely make sure the patient is not abandoned, isolated, or made to feel unacceptable. Therefore, the investigator considered the use of nurses for the present study timely and appropriate.

Adamolekun (2018) used the following factors: gender, age, religion, and education to determine the extent of beliefs and factors influencing the beliefs of individuals. Since it was impossible to study all the stated variables in the present work, only gender and age were considered in this study. One important aspect of death attitude is that they are multidimensional and have the following dimensions: fear of death, death anxiety, death acceptance, death concern, death threat, and death denial or aversion. They can be influenced by several variables. Mauner (2012) isolated certain factors: age, gender, intelligence, social skill, and experience with death/serious illness (either personally or in the family), and frequency of thoughts concerning death. He then postulated that for on to plan a death education to aid participants in coping with death and dying attitudes, it would be very necessary to consider seriously how each of these influences listed above might exert itself upon the members of such a class. Since it was not possible to study all such factors in the present study only three of those independent variables, age, gender, and death experience selected based on literature. In addition, other factors could not

be selected due to the sensitive nature of religion and culture of the different groups of people involved in the study.

Many thanatologists contended that there are many factors related to the experience of death and death related situations, which can lead to fear or anxiety. It would be expected that differences between individuals exist with respect to sex and the sex role of the people concerned, the type, intensity, and even fear of death experience. The experiences may differ one age bracket to another. The present study considered such variables.

STATEMENT OF THE PROBLEM

Conventionally, Nurses do not just only allay the physical suffering of patients as best they can, but also help the patients prepare for recognition and acceptance of death so that they can undertake their last task in life with credit and dignity. The presence of the nurse can bring comfort and reduced anxiety. The non-judgmental and warm attitudes of the nurse can elicit the feelings and thoughts the patients need to make them have a sense of security and control over life and their environment. All these and other benefits will accrue and fear of death reduced only if the beliefs of the nurse are in line with the cultural norms and values of the people. Regrettably, the researchers observed that sometimes some Nurses abandon patients, fight with the relatives of patients, slap patients, do not give care to the patients, disagree among themselves and their patients. Besides, they expressed that this is normally witnessed in situations where the lingering patient had become only a 'bed' to be managed rather than a distinctive personality. There are also tendencies among nurses to assume that a person on lingering trajectory (especially if an aged adult) is "ready for death". Nurses are apt to believe that such efforts would not be successful in prolonging what they called "quality life". In addition, they expressed that, often involved is the further belief that the dying person is ready for the end, having suffered through a long, progressive loss of function and no longer finds much satisfaction in life.

Such behaviour, as a result of the beliefs of nurses have often been a source of concern to the society, and is frowned at because, they violate professional and cultural rules, as well as moral values. Consequent upon these beliefs of nurses and the resulting effects, it is implicit that certain factors yet unidentified are implicated in the trend. Again, available literature showed that very few reports on death and dying in Nigeria and even no published study on the subject using nurses as respondents in the

area of the study exists. The foregoing scenario have therefore necessitated the study into Age as a Predictor of beliefs of nurses towards death and dying of terminally ill patients in Taraba State.

Purpose of the Study

The main purpose of the study was to investigate Age as a Predictor of beliefs of Nurses towards death and dying of patients in Taraba State, Nigeria. Specifically, the study sought to:

1. determine the beliefs of nurses towards death and dying of patients,
2. ascertain the influence of age on the beliefs of nurses towards death and dying of patients.

Research Questions

To guide the study, the following research questions were posed:

1. What are the beliefs of nurses towards death and dying of patients?
2. What is the influence of age on the beliefs of nurses towards death and dying of patients?

Hypothesis

One hypothesis was formulated to guide the study and was tested at .05 level of significance.

Ho_1: There is no statistically significant difference between age and the beliefs of Nurses towards death and dying of patients in Taraba State.

Significance of the Study

The study generated data that may be important to doctors, nurses, public health officers and health educators to improve their understanding of death beliefs system as they relate to medical practice and illness. This will enable them give advice to clients within the framework of their beliefs. The data generated may also serve as an innovation made within the existing framework of their beliefs and attitudes of the group. It is in this respect that the present study generated data which may create understanding of the death beliefs of nurses in Taraba State. Data generated on age and its influence on beliefs of Nurses may greatly enrich the understanding of officers dealing with demographic studies, public health workers and health educators on the nature of beliefs and attitudes that would concern the nurse in Nigeria. Data generated on death experiences and attitudes of nurses may be significant not only to nurses but also to Taraba State Ministry of Health, and administrators in charge of

health institutions. These are governmental and non-government agencies involved in health-related matters whose work may be by way of their training, seminars or conferences or for administrative procedure. In fact, within the field of thanatology in general and nurse's beliefs and attitudes towards death and dying of terminally ill patients in particular, the data generated add to the pool of existing data. These data include the beliefs and attitudes of nurses, which will serve as reference materials and stepping base for further studies in other areas that may have to do with nurse's beliefs and attitudes.

Scope of the Study

The study covered Age as a Predictor of Beliefs of Nurses towards Death and Dying of Patients in Taraba State, Nigeria. The study was also delimited to health institutions managed by Taraba State Ministry of Health. In addition, only those health institutions upgraded to the status of Specialist Hospitals was used for the study. This was because, it is assumed that these health facilities have the mandate for admitting and managing referred patients.

MATERIALS AND METHODS

Research Design

In other to achieve the purpose of the study, the survey research design was employed. Ejifugha (2018) pointed out that the survey research method is considered one of the best available designs to the researcher who is interested in collecting original for the purpose of describing a population that is fairly large. Gay (2015) and Nwana (2016) described the design as useful for studying a variety of problems involving data collection for either testing hypothesis or answering research questions concerning the present status of subject under study. Explaining further, Gay (2018) stated that the design permits the description of conditions as they exist in their natural settings. The survey research design therefore was considered appropriate for use in this study which describes the beliefs and attitudes of nurses towards death and dying of terminally ill patients in Taraba State as they exist in their natural settings.

Population for the Study

The population for the study consisted of all the Nurses employed and were working in General and Specialist Hospitals in Taraba State as at June

2019. They consisted of eight hundred and eighty-three (883) nurses. The reason for choosing only General and Specialist Hospitals and the Nurses working in them is that these health institutions were assumed to have facilities for taking care of the terminally ill patients in Taraba State, Nigeria.

Sample and Sampling Technique

The sample for the study consisted of 271 Nurses. In relation to the sample size, Ogbazi and Okpala (2019), and World Health Organization (WHO) (2019) suggested that where the population is large, from 10% to 30% of the population could be used as sample size in a survey research design. For the present study, the population was stratified according to gender and 30% were selected using proportionate sampling technique.

In this method, Thomas and Nelson (2013) explained that within each group, the subjects selected should be proportionate to the size of their group in relation to the size of other groups. In addition, they asserted that the process ensures more accurate representation of the population. Based on the above information, 30% of the population (based on sex) of nurses in each Hospital was selected. This was done through simple balloting with replacement. A total of 271 respondents formed the sample size for the study.

Instrument for Data Collection

A 2-part- questionnaire was designed for the study as follows; Section A contained information of demographic factors selected for the study. Section B had 13-item- information or statements regarding death and dying beliefs of Nurses in Taraba State.

Validity of the Instrument

In other to make sure that the instrument for the present study got relevant statements that provided the data required to each meaningful conclusion, the following steps were taken. Both the face validity of the instrument was satisfied by five professionals drawn from Human Kinetics and Health Education and allied fields such as Educational Psychology and Test and Measurement Evaluation, all of Taraba State University, Jalingo.

The experts were given a draft copy of the beliefs of nurses towards death and dying of patient's questionnaire (BANTDDPQ). The expert suggested various improvements on the draft (of thirteen- item) questionnaire

presented to them. Suggestions by experts were used to design the final copy of the questionnaire that was used for data collection in this study.

Reliability of the Instrument

Reliability of the instrument was determined through the outcome of the pretest using the split-half method. This is because it is mostly used in determining internal consistency of written test (Ogbazi and Okpala, 2019). A step up procedure, the Cronbach (1951) alpha coefficient formula was used to estimate the reliability of the instrument. A reliability coefficient of .70 was obtained. It was considered appropriate for accepting the instrument as reliable.

Method of Data Collection

The investigators with the help of three trained research assistants carried out data collection with the BANTDDPQ personally. The research assistants were trained on the methods for administering and retrieving back the instrument. One research assistant was used for a particular hospital at a time, while the investigators provided the overall supervision of the process. A big envelop was provided for each of the hospitals involved in the study. The nurses were requested to drop completed copies of the questionnaire into the envelops. This was done to ensure a maximum return. To enhance better response, the research assistants and investigators were available to provide explanations to any nurse requesting clarification. In all, 271 copies of the questionnaire were distributed. All the copies of the instrument were collected back after completion therefore giving a 100% return rate.

Method of Data Analysis

The returned copies of the questionnaire were cross-examined for completeness of responses. Out of the 271 copies returned, 262 copies were found useable giving a working rate of 96.6%. The questionnaire responses were coded and recorded on the computer coding sheets. The entered data were computed, analyzed with the use of statistical package for the social sciences (SPSS batch system). Mean statistic was used to answer the research questions while one – way Analysis of Variance (ANOVA) was used to test the hypothesis at .05 level of significance.

RESULTS

Research Question 1

What are the beliefs of nurses about death and dying patients? Data in Table 1 provide the answer to the above research question.

Table 1
Beliefs of Nurses About Death and Dying of Patients (n = 262)

S/N	Beliefs	Responses	
		$\bar{x}$	SD
1.	Life after death	3.7*	1.5
2.	TIPs should be told that they are dying	3.6*	1.2
3.	You die when your time comes up	4.0*	1.0
4.	Taking one's life is justified when terminally ill	3.7*	1.2
5.	I believe that dying patient should be		
	i. Told the truth about their conditions	3.8*	1.2
	ii. kept hopeful by spearing them the fact	2.0	1.4
6.	Certain drugs work for particular patient when terminally ill	2.6	1.4
7.	Cancer is never curable	2.5	1.2
8.	AIDS patients are stigmatized	2.9	1.1
9.	Mere diagnosis of AIDS can trigger suicide	2.4	1.3
10.	Renal diseases can be contracted through contact with patients	3.5*	1.3
11.	Diseases is the will of God	2.7	1.3
12.	Diseases are caused by spirits	3.4*	1.3
13.	TIPs should not be told that they are dying	2.0	8.7
	Overall mean	3.0	1.0

* Accepted as nurses' beliefs

Data in Table 1 show that "life after death" ($\bar{x}$ = 3.7), "TIPs should be told that they are dying" ($\bar{x}$ = 3.6),"you die when your time comes up" ($\bar{x}$ = 4.0), "taking one's life is justified when terminally ill" ($\bar{x}$ = 3.7), "dying patient should be told the truth about their conditions" ($\bar{x}$ = 3.8), "renal diseases can be contracted through contact with patients" ($\bar{x}$ = 3.5) and "diseases are caused by spirits" ($\bar{x}$ = 3.4) were the accepted beliefs of nurses. The overall response shows that nurses had positive beliefs about death and dying ($\bar{x}$ = 3.0) which is equal to the criterion mean of 3.0.

Research Question 2

What is the influence of age on the beliefs of nurses about death and dying of patients? Data answering this research question are contained in

Table 2.

Nurses' Beliefs About Death and Dying of Patients by Age

S/N	Beliefs	Responses					
		20-25 (N = 62)		26-30 (N = 60)		31 & above (N = 140)	
		$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
1.	Life after death	3.7	1.3	3.6	1.5	3.7	1.5
2.	TIPs should be told that they are dying	3.6*	1.2	2.9	1.2	3.4*	1.1
3.	You die when your time comes up 3.2	1.1	3.7	1.0	4.0	.82	
4.	Taking one's life is justified when terminally ill I3.3*		1.1	2.7	1.2	3.7*	1.2
5.	I believe that dying patient should be						
	i. Told the truth about their conditions	3.8	1.1	3.7	1.2	3.3	1.3
	ii. kept hopeful by spearing them the fact	2.9	1.2	2.6	1.3	2.8	1.1
6.	Certain drugs work for particular patient when terminally ill	2.6	1.0	1.6	1.3	2.6	1.3
7.	Cancer is never curable	2.5	1.1	2.2	1.4	2.4	1.1
8.	AIDS patients are stigmatized	1.9	1.0	2.4	1.0	2.5	1.3
9.	Mere diagnosis of AIDS can trigger suicide	2.4	1.0	2.0	1.2	2.8	1.4
10.	Renal diseases can be contracted through contact with patients	3.6*	1.1	2.8	1.4	3.5*	1.3
11.	Diseases is the will of God	2.5	1.4	3.3*	1.2	2.8	1.2
12.	Diseases are caused by spirits	3.5*	1.3	2.6	1.2	3.4*	1.3
13.	TIPs should not be told that they are dying	2.7	1.3	1.8	1.4	2.6	1.3
	Overall mean	2.9		2.7		3.0	

*Exceptionally accepted beliefs of nurses

Table 2 shows that "TIPs should be told that they are dying", "taking one's life is justified when terminally ill", "renal diseases can be contacted through casual contact with patients", and "diseases are caused by spirits" were beliefs accepted by only age brackets (20-25years) and (31-years and above), "diseases is the will of God" ($\bar{x}$ = 3,3) was exclusively accepted by nurses showed no difference in either positive or negative response to each belief. This outcome indicates that age, is to some extent, influential in death and dying, this is because age group 31 years and above had an overall mean response score equal to the criterion mean of 3.0 while the other age brackets had their less.

Hypothesis 1

Ho_1: There is no statistically significant difference between age and the beliefs of Nurses towards death and dying of patients in Taraba State.

Data verifying the above hypothesis are contained in Table 3.

Table 3
Summary of one-way Analysis of Variance (ANOVA) on death Beliefs of Nurses According to Age

Level of Age	N	Sources of variance	Mean difference	df	Mean square	Cal.F	Tab.F
Decission							
20-25	62	*BG	3.064E-02	60	.207		
		*WG	4.796E-02				
26-30	60	BG	3.054E-02	58	.173	1.19	3.04
Accepted							
		WG	3.471E-02				
31 & above	140	BG	3.101E-02	138	.414		
		WG	2.576E-02				

*BG = Between groups
*WG = Within groups

Table 3 reveals that the calculated F-ratio is 1.19 and the critical F-ratio at .05 level of significance is 3.04. this shows that the calculated F-ratio is less than the critical F-ratio (cal.F = 1.19 < Tab.F = 3.04, p < .05). the hypothesis, which stated that age, makes no significant difference in the beliefs of nurses about death and dying was therefore accepted. This means that age made no significant difference on nurses' belief about death and dying of patients.

DISCUSSION

The term 'beliefs' as described by Gadsby (2017) are the feeling that something is definitely true or definitely exist. Hobson (2016) stressed that beliefs influence an individual's attitude. He explained that value systems are built up on traditional beliefs and concepts of disease, and change only when those beliefs are altered by new experience, technical innovations, education, economic trends or such upheavals as wars and revolutions. Toynbee (2016) noted that when the belief in personal immortality is associated with a belief in a judgement after death – the price of human beings' beliefs in the survival of his personality after his death is anxiety during his lifetime. He emphasized that all religions demand that is not self-serving, whose purpose is something higher than oneself in other words, religion commands mortality. Aday (2014) noted that beliefs help individuals to believe that life can continue after the person has died. They further asserted that for the religious, symbolic immorality is often related to the concept of soul, which either returns to its pre-existing stage, goes to an afterlife, is re-incarnated in another body, or is united with the cosmos. He expressed that for the person whose primary orientation is temporal,

symbolic immorality is achieved by being remembered by others, creating something, which remains useful, or of interest to others, or by being part of a cause or social movement that continues after the individual's death.

Browne (2014) believed that in the beginning there was fear, and fear was in the heart of man, and that fear controlled man. This fear according to him, had different forms and faces: there the fear of dying, there was the fear of death or being dead, there was the fear of the consequences of being dead, either to the individual or to others, and there was the fear of the death of others. To buttress the above, Vernon (2013) posited that beliefs and religion undoubtedly grew on the ground of fear. He added that without them, self-preservation would have been impossible. Again, that man was obliged to believe that somehow the hostile thing around him could be controlled and that death could be averted. He further emphasized that it must have his instinctive adjustment to the conditions of the world that was too much for him. He emphasized that man has to has faith or die, and stress that fear about death can be reduced by changing public opinion and proper education, which could be achieved by a study as the present one.

Beliefs of Nurses Towards Death and Dying of Patients

Table 1 showed that the nurses had positive beliefs ($\bar{x}$ = 3.0) about death and dying. The results were expected because an individual has an accepted belief about a phenomenon, the person will do everything possible to stop or avoid any threat that may hinder him/her from achieving it. This is in line with the health belief model in which Galli (2018) explained that perceived threat health are an individual's perceived vulnerability to the threat, the period severity of the threat and cost benefit pay off that is associated with adopting attitudes.

He further explained that in life situation, individuals are pulled towards the forces that are positively valued and away from those that are negative. From this stand point, the nurses' positive beliefs may go a long way in helping them to achieve the well-known medical care purpose, which is to improve the conditions of the sick in order to make him or her well. May be that is why Pokes (2017) posited that members of the healing profession express delight and happiness when patients get better. To buttress the above assertion, Vernon (2013) stressed that man was obligated to belief that somehow the hostile thing around him could be controlled and that death could be averted.

Also, in Table 1, the most spectacular and surprising response was the respondent's indication of an accepted belief response to the statement that "diseases are caused by spirits" ($\bar{x}$ = 3.4). One would have expected them to indicate that it was not so since they had obtained scientific knowledge as it concerns germs. This is a carry-over value of the common beliefs among many cultures in Kaduna State, that certain health problems are caused by spirits. This negates the explanation given by Lambo (2013) that undoubtedly, the scientific nature of the germ theory models and framework used by doctors, nurses and other allied health workers have their success to being closely linked with scientific areas of biology and chemistry among others. Rather, it has favoured the multiple causality model which is non-scientific and is used by traditional leaders, oraclelists and herbalist being closely linked to ethnicity and traditional beliefs.

The findings were not surprising because Kubler-Ross (2018) pointed out that the fear of death, to varying extent was present in all people. Also, as posited by Lemming and Dickenson (2015) that death fears are not instinctive, but exist because our culture may have created and perpetuated fearful meanings and ascribed them to death. In addition, it may not have been surprising that the respondents may have developed their own ideology based on experience and religious beliefs which might have prompted their reactions to death and dying. The findings that nurses had negative attitudes towards death and dying in the present study agreed with that of Okafor (1994) which he attributed to the Nigerian cultures of the subjects which at a discussion level not learnt to be free and comfortable with death and dying related issues.

Influence of Age on the Beliefs towards Death and Dying of Patients

Table 3 revealed that the different age-groups of the respondents had to some extent divergent beliefs about death and dying as indicated by overall mean scores of 2.9(20-25years), 2.7(26-30years), and 3.0(31 years and above) respectively. It was stated that age, to some extent, influence the beliefs of nurses about death and dying of patients. When ANOVA was used to determine these slight differences, it was discovered that those differences were not significant at .05 level. The results in Table 3 were expected because beliefs are our relative stable and broad interpretation of the world and our place in it. Individuals are bound to have divergent interpretation of phenomena that surround them. It is possible that the differences noticed could be attributed to the stages of minds and sex of the respondents as at the time the instrument was distributed to them.

Table 3 revealed that the different age groups of the respondents had divergent beliefs about death and dying. The result is expected in part because Lemming and Dickinson (1985) explained that one should expect that age will be less influential in explaining death conceptualization for adult population than other age groups. Based on the result in Table 5, age-bracket 20-25years and 31years and above showed acceptable response in the same two items in addition to other ones that were generally accepted; "renal diseases can be contacted through casual contact with patients" ($\bar{x} = 3.6, (20 - 25\text{years}), \bar{x} = 3.5, (31 \text{ years and above})$ while "disease is the will of God" was exclusively accepted by age-bracket 26-30 years ($\bar{x} = 3.3$). However, age bracket 31 years and above had a general mean response equal to the criterion mean of 3.0.

This result agrees with that of Gesser, Wong and Redker, (2018) who found out that the elderly was significantly most accepting ($t = 2.82 > 1.98$) the "life after death" compared to middle aged ($t = 1.72 < 1.98$) and the young ($t = 1.68 < 1.98$) respectively. However, the result negates the findings of Kubler-Rose (2018) who found out that age was not specifically related to beliefs. This may be because age might not necessarily influence beliefs but experience may.

In Table 3, the overall mean scores of 3.3 (20-25years), 3.2 (20-30years) and 3.3 (31years and above) for the three groups indicate negative attitudes towards death and dying of patients. This result was surprising because, some studies have indicated that there is a decrease in fear and anxiety of individuals according to age (as year advance). The results of the table indicated almost the reverse with youngest age group bracket (20-25 years) slightly higher than any of the other two and maintaining the same mean score for those between the ages of 26-30 years, and 31 years and above. Again, the attributory factor could be as Pollner (2019) pointed out, based on the level of spirituality and because the nurses might be dealing with almost the same types of patients which may influence their attitudes. The results agree with the submission by Kastenbaum (2019) and different age groups varied in their attitudes towards death. It is possible that the difference could be as a result of working experience, because the youngest group (20-25years) with their youthful exuberance may tend to think more of immortality. This is not in line with the position of Stillion (2015) who explained that this category of individuals protects themselves from death anxiety by viewing death as something that happens only to the elderly or

will occur to them only after a great deal of time has passed. On the other hand, the other groups are likely to have shown more positive responses due to their experience in life and especially if they have been caring for the terminally ill for a long time.

The findings were in line with the statement by Langhey (2019) who stressed that age as a demographic variable is capable of affecting the responses of people to a questionnaire on death related behaviour. In addition, the result did not agree with that of Okafor (1994) who found significant differences between the three age brackets, which he attributed to opinions postulated by some life-span psychologists such as Nevgaten (2018), Leminton (2017) and Kastanbaum (2017) that different groups varied in their attitudes towards death.

CONCLUSIONS

Based on the findings of the study the following conclusions were made:

1. Nurses in Taraba State have the following beliefs about death and dying; "life after death", "patients should be told that they are dying", "you die when your time comes up", "taking one's life is justified when terminally ill", "dying patients should be told the truth about their conditions", "renal disease can be contacted through casual contact with patients" and "diseases are caused by spirits". Theses answers research question one.
2. Age made no significant difference in nurses' beliefs about death and dying of patients.

RECOMMENDATIONS

Based on the findings of the study, discussions and conclusions, the following recommended were made:

1. Taraba State Ministry of Health should improve the curriculum content for training nurses in order to pave way for more effective death education program that can modify nurse negative attitudes. This could be done by setting up a committee to look into the present curriculum with a view to adopting the integrating approach to the revision. When this is done the same committee should be entrusted with the supervision of the implementation of the revised curriculum who will report directly to the officer in charge of nursing education at the State Ministry of Health.

2. The nurses should be exposed to workshops, conferences and seminars in the area of death education. This may help in providing knowledge, in this way, improving the beliefs of the Nurses.
3. The Ministry of Health of Taraba State can help update the knowledge of nurses by sending those already working in the field on in-service training especially in the area of health education to further improve their understanding of death and dying issues.

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