International Journal of Medical & Pharmaceutical Science
Volume 2, Number 2, June 2021
http://www.cedtechjournals.org
ISSN: 2756-4622

ASSESSMENT OF ATTITUDES OF NURSES TOWARDS DEATH AND DYING OF PATIENTS IN TARABA STATE, NIGERIA

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ABSTRACT

The purpose of this study was to investigate the attitudes of Nurses toward death and dying of patients in Taraba State, Nigeria. In order to achieve the purpose of the study, survey research design was employed. 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 twenty-four-item Attitudes of Nurses Towards Death and Dying of Patients Questionnaire (ANTDDPQ) developed by the researchers. Mean statistic was used to answer the research questions while Pearson product moment correlation 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 negative attitudes towards death and dying of 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 attitudes 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: Attitudes, Death, Dying, Patients and Nurses

INTRODUCTION

It is a known fact that 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 judgement 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 (2011) 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.

Attitudes, was a key concept in the study and 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 (2016), 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 (2018) 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 (2018), 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.

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. Pachlski and Forfar (2015) stressed that there are about twenty demographic and personality factors, which exist as correlates of death attitudes. Some of the demographic variables according to them are: sex, age, experience with death, occupation, health status, order/ordinal position, level of education, ethnicity, location, risk taking, marital status, and religious affiliations. Only three of these variables: gender, age and death experience were addressed in the present study. They were selected based on literature. Besides, these variables were chosen because of their usefulness to demographic officers and since they are most likely to serve as pointers for effective planning and administrative procedures.

There are only two dimensions of health beliefs, which are either moral or magical. The two were used in the present study. Out of the five dimensions of death attitudes, only two: death anxiety and death fear, were chosen for the present study. They were selected because literatures seem to portray them as universal of all other forms of death attitudes. Again, Okafor (1993) observed that definitely, death acceptance need not be investigated for now since the present assumption is that the society seems to deny and avoid death. Death attitudes have been looked at by thanatologists as being multidimensional. Literature indicates the following features: fear of death, death concern, death anxiety, death threat and death denial or aversion. Kerlinger (2014) described death attitude as an integral part of personality and that personality measurement is mostly of traits. Trait being a relatively enduring characteristic of the individual to respond in a certain manner in most situations. Bolan (2018) posited that attitudes about health and health related behaviours help to determine what an individual does in a given situation. Kalsih (2015) observed that attitudes do not only differ among people or societies, but also vary across times for a given individual society. Allport (2015) described attitude as mental or neutral state of

readiness, organized through experience, exerting a dynamic influence upon the individual's response to all objects and situations with which it is related. In the same vein, Kreteh, Crutchfield and Balachey (1982) conceptualized attitudes toward a situation as an enduring system of emotional feelings, positive or negative evaluation, and pro or con action tendencies with respect to that object or subject (which could be death or dying patients). To lend credence to the above, Tiandis (2017) looked at attitude as a multi-dimensional, consisting of three components. According to him are the components of cognitive or perpetual, affective and the action tendency dimensions.

The cognitive according to Day (2017) represents the area of information about a subject or object (which could be death or dying). In addition, Schiffman and Kanuk (2018) supported the above and posited that the cognitive aspect consists of awareness, beliefs (a variable tested in this work) opinions, comprehension-perceptions, while the affective and evaluation components deal with the individual's over-all feelings of liking or disliking. Conversely, Hall (2012) that attitudes have distinguished two major dimensions, the attitude of extraversion and introversion. To him, extraversion attitudes orients the person towards the external, objective world. The introverted attitude orients the person toward the inner, subjective world. These two opposing attitudes, he asserted, are both present in the personality but ordinarily one of them is dominant and conscious, while the other is subordinate and unconscious. He further explained that if the ego is predominantly extraverted in its relation to the world, the personal unconscious will be introverted.

Based on the third class of attitude as described by Triandis (2017), Chrisnall (2015) submitted that the cognitive aspect of attitudes is the action-tendency component and concerns the disposition to exhibit behaviour towards death and dying. To further buttress the above, Morgan (2018) maintained that individual's attitudes to death are shaped by their philosophy –especially the ideas of the person about cosmology (our view of the world). If we believe that we are subject to the laws of nature, then nurses attitudes toward the terminally ill in death and dying will differ from those whose views are that we have significant control over the forces of nature. This is why Feifel (2014) described death attitude as being multi-dimensional and varies not only between individuals but also within the same person.

STATEMENT OF THE PROBLEM

Ideally, 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 attitudes of the nurse are ethically compliant. Regrettably, the researchers observed that Nurses in the General and Specialist Hospitals in Taraba State do not sometimes find the reasons why 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".

Furthermore, that dramatic attempted "death bed rescue" scenes are rare. 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 aforementioned attitudes 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 attitudes 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 painted above have therefore necessitated the study into the attitudes of nurses towards death and dying of terminally ill patients in Taraba State, Nigeria.

Purpose of the Study

The main purpose of the study was to assess the attitudes of Nurses towards death and dying of patients in Taraba State, Nigeria.

Specific Objective of the Study

Specifically, the study was meant to:

1. ascertain the attitudes of nurses towards death and dying of patients,
2. find out the influence of recent death experience (RDE) and non-death experience (NDE) on the attitudes of nurses towards death and dying of patients.

Research Questions

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

1. What are the attitudes of nurses towards death and dying of patients?
2. What is the influence of recent death experience (RDE) and non-death experience (NDE) on the attitudes of nurses towards death and dying of patients?

Hypothesis

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

1. Ho_1: there is no significant relationship between non-death experiences (NDE) and recent death experiences (RDE) on attitudes of nurses towards death and dying of patients.

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 attitudes 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 attitudes of nurses in Taraba State.

Findings of attitudes of nurses towards death and dying when published in academic journals and placed in libraries will enrich global data on the

subject and will be of benefit to the public in general and health educationists in particular. Also, it will be of benefit to health policy makers since it will provide the basis upon which current programs in death and dying could be re-examined and evaluated. Individuals and families who are consumers of health services may use the results of the study to make better choices of where to go for health care whenever the need arises. Results on influence of recent-death experience and non-death experience on attitudes of nurses will provide the status quo in the study area. This may serve as the basis for understanding and helping population in forming better philosophy concerning death and dying of patients. It may also decrease incidence of abandonment and frustration among nurses.

In fact, within the field of thanatology in general and nurse's 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 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 attitudes.

Scope of the Study

The study covered attitudes of nurses towards death and dying of patients in Taraba State, Nigeria. The study was delimited to health institutions managed by Taraba State Ministry of Health. In addition, only those health institutions upgraded to the status of general or specialist hospitals shall be used for the present study. This was because, it is, assumed that they are the ones with facilities 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 data 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 hypotheses or answering questions concerning the present status of subject under study.

Explaining further, Gay (2015) 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 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 under the employment of the Ministry of Health, Taraba State and who were in either general or specialist hospitals as at June 2019. They consisted of eight hundred and eighty-three (883) nurses. The reason s for choosing only general or specialist hospitals and the nurses working in these health institutions were assumed to have facilities for taking care of the terminally ill. Also, the National Health Policy (NHP) (2019), explained that these are the categories of health institutions that can receive referral, and manage cases of terminal illness

Sample and Sampling Technique

In relation to the sample size, Ogbazi and Okpala (2019), and World Health Organization (WHO) (2020) 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 which was 262 Nurses.

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 was a 24-item nurse's death attitude scale most of which were designed by the researchers.

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.

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 ANTDDPQ 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 investigator 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.

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). The frequencies of the responses were awarded points and their means were calculated. The responses were scored to produce a Likert type scale of summated ratings. In determining attitudes of the subjects towards death and dying, the mean score was used as a criterion for evaluation as was done by several researchers including Templer (2012), Hoelter and Hoelter (2016), Leming (2015), and Okafor (1993). Adding all the scores assigned to the degrees of agreement and disagreement to a statement or item, and dividing it by the number of possible responses to that statement as follows:

$$\frac{5 + 4 + 3 + 2 + 1}{5} = \frac{15}{5} = 3.0$$

Therefore, attitude was negative if the grand mean of the responses was equal to or greater than 3.0. Conversely, it was considered to be positive if the grand mean was less than 3.0. The means obtained were used to answer all the research questions. The person product moment correlation co-efficient was employed for Ho to test nurses attitude according to death experience.

Results

Research Question 1

What are the attitudes of nurses towards death and dying of patients? Data answering this research question are presented in Table 1.

Table 1: Attitudes of Nurses Towards Death and Dying of Patients (n = 262)

S/N	Attitudes	Responses	
		$\bar{x}$	SD
1.	Loss of life due to fatal illness makes me apprehensive	3.5	1.2
2.	Like to care for dying patients	1.9*	1.0
3.	Fear seeing a patient dying a painful death	3.6	1.2
4.	Afraid of a patient dying a long slow death	3.6	1.2
5.	Loss of physical attractiveness that accompanies dying patients is disturbing to me	3.5	1.2
6.	Isolation of death patients does not bother me	3.5	1.1
7.	Dread the helplessness of dying patients	3.6	1.0
8.	Separation from patients loved one's at death make anxious	3.2	1.3
9.	Not knowing what death patients feel like makes me uneasy	3.6	1.1
10.	No problem being alone with a death patient	2.4*	1.1
11.	The subject of life after death of patients troubles me	3.4	1.1
12.	Thought of punishment after death of patients are sources of apprehension for me	3.6	1.0
13.	The idea of never thinking after death of a patient frightens me	2.7*	1.2
14.	Idea that a patient dies young does not bother me	3.6	1.3
15.	Loss of identity at death of patients alarms me	3.5	1.0
16.	Emotionally unprepared to accept the death of my patient	2.8*	1.2
17.	Thoughts of a patient's body decomposing does not bother me	3.4	1.3
18.	Sight of a death body makes me uneasy	3.4	1.2
19.	Idea of a dead patient's being buried frightens me	2.5*	1.2
20.	I am afraid that TIPs may be declared death when they are still alive	2.9*	1.3
21.	Not bother by the idea that a death patient is placed in a casket	2.6*	1.2
22.	Have misgivings about the fact that dying patient may be isolated	3.0	1.1
23.	Fear seeing a patient hooked to machines and gadgets	3.4	1.2
24.	Not quite bothered by the grief TIPs may cause relatives and friends	3.8	1.3
	Overall mean	3.2	1.3

* Accepted as positive attitudes of nurses

Table 1 revealed that nurses "like to care for dying patients" ($\bar{x}$ = 1.9), "have no problem being alone with a death patient" ($\bar{x}$ = 2.4), "idea of never thinking after death of a patient frightens me" ($\bar{x}$ = 2.7), and "I am emotionally unprepared to accept the death of my patient" ($\bar{x}$ = 2.8). Others are, "Idea of a dead patient's being buried frightens me" ($\bar{x}$ = 2.5), "I am afraid that TIPs may be declared death when they are still alive" " ($\bar{x}$ = 2.9) and "I am not bother by the idea that a death patient is placed in a casket when he/she dies" ($\bar{x}$ = 2.6) were the accepted positive attitudes of nurses. Generally, the response ($\bar{x}$ = 3.2) shows that nurses had negative attitudes as indicated by a mean score on the 5 – point attitude scale greater than the criterion of 3.0.

Hypothesis 1

1. Ho_1: there is no significant relationship between non-death experiences (NDE) and recent death experiences (RDE) on attitudes of nurses towards death and dying of patients. Data verifying the above hypothesis are contained in Table 2.

Table 2

Summary of Pearson Product Moment Verifying Nurses' Attitudes According to Death Experience

Gender		N	X	SD	Cal.r	Table.r		df
	level	decision						
RDE	253	3.2	1.3					
				.07	.19	260	.05	Accepted
NDE		9	3.3	1.4				

Table 2 reveals that the calculated r-value was .07 and the critical r-value at .05 level of significance was .19. this shows that the critical r-value ($r = .07 < .19$, $p < .05$). The hypothesis of no relationship was therefore accepted. This means that there was no significant relationship between RDE and NDE on the attitudes of nurses towards death and dying of patients.

DISCUSSION

The discussion is presented under the following heading which represent the major themes that were investigated.

The findings in Table 1 revealed that nurses had negative attitudes towards death and dying. Though they generally showed negative attitudes, their attitudes were not totally negative because the nurses

showed positive attitudes in seven aspects of death and dying which include: "caring for dying patients" ($\bar{x}$ = 1.9), "no problem being alone with a dead body" ($\bar{x}$ = 2.4), "never thinking after the death of a patient" ($\bar{x}$ = 2.2), "emotionally prepared to accept the death of their patients" ($\bar{x}$ = 2.8) and "never frightened by the idea that dead patient is buried" ($\bar{x}$ = 2.5). Others are, "not frightened that TIPs may be declared dead while they are still alive ($\bar{x}$ = 2.9), and "not bothered by the idea that a dead patient is placed in a casket when he/she dies" ($\bar{x}$ = 2.6).

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.

Table 1 revealed overall mean scores of 3.1 males and 3.2 females. These are greater than the criterion means of 3.0, which means that both sexes had negative attitude. However, both sexes had some items, which were positive. In addition to these, the male respondents showed positive responses in "I am afraid patients may be declared dead when they are still alive" ($\bar{x}$ = 2.7) and "I have misgivings for dying patients being isolated by others" ($\bar{x}$ = 2.8). the fact that both sex generally showed negative attitudes towards death and dying was not expected because, one would have expected some differences to exist between the two groups. Reason being that some studies, Lamb (2018) and Floman (2019) had discussed differences between the two sexes. In any case, this could have been due to the fact that the respondents must have attended institutions that are similar and working in the same system or ministry.

The only two statements that give the little difference between the two groups could be attributed to the belief that males generally want to prove that they are less fearful and anxious compared to females in most

situations. On the other hand, the females must have responded negatively to the statements because, they are generally believed to be more caring than males. This difference seems normal even in the traditional sex roles of the respondents.

This negates the reason given by Stallion (2015) who predicted that males would be less willing to admit to discuss personal fears. Females, on the other hand, should be more willing to share fears and anxieties about death. She explained that the reason for this is that males are less expressive than females in all areas of their internal life. The male is a powerful loner, while females have the clinging vine stereotype. These findings did occur with that of Lamb (2018) which indicated that significantly sex differences were observed with male medical students showing higher death anxiety than both male students and male and female nursing students.

In relation to the above, the study seems to agree with the findings of Floman (2019) who reported that males had more positive attitudes towards death and dying than females. This difference between the two sexes might be as a result of traditional influence of individual roles. This is viewed as normal because in Nigeria, particularly the northern states (of which Kaduna is one) women are seen generally and treated as the weaker sex. this is suggestive that when sex is isolated as correlate of death attitude it may portray the female sex as weaker.

Giving a general view, Kuber-Ross (2018) further pointed out that the fear of death, to varying extent, is present in all people. This premise implies that there is nothing unhealthy or abnormal about having a fear of death. However, the report of the present study supports the findings of Okafor (1994) also reported that differences between death attitudes of males and those of females were not significant at .05 level. This seems to suggest that people from the same nation regardless of profession and location within the country are likely to have similar attitudes towards death and dying.

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 (2016), Leminton (2015) and Kastanbaum (2017) that different groups varied in their attitudes towards death.

In Table 2, the overall means for recent death experiencers and non-death experiencers indicated a slight but negative attitudes ($\bar{x}$ = 3.2, RDE, $\bar{x}$ = 3.3, NDE) respectively. Table 2 showed that the calculated r-value was less than the table r-value (r = 08 < 1.96, p < .05). which means that the relationship between attitudes and death experience was not significant at .05 level. This implies that death experience was not a factor in determining death attitudes of the respondents. This result was not expected because Kastenbaum (2017) explained that a death attitude is dependent on longevity and exposure. As stated above, one would assume that an individual that has experienced the death of loved one may enough reasons to trigger death attitudes (although this is dependent on how of the death experience) which was not the case with result on Table 2. The finding is not the same with the statement credited to Warren and Chopra (2019) indicated that those who lost a member of the immediate family consistently scored lower on the sub-scales of MFODS than those with no experience. The difference with the present result might be tagged to the premise that a different attitude scale was used and that the settings differ as well as the respondents.

Influence of Death Experience on the Attitudes of Nurses Towards Death and Dying

In Table 2, the overall means for recent death experiencers and non-death experiencers indicated a slight but negative attitudes ($\bar{x}$ = 3.2, RDE, $\bar{x}$ = 3.3, NDE) respectively. Table 2 showed that the calculated r-value was less than the table r-value (r = 08 < 1.96, p < .05). which means that the relationship between attitudes and death experience was not significant at .05 level. This implies that death experience was not a factor in determining death attitudes of the respondents. This result was not expected because Kastenbaum (2017) explained that a death attitude is dependent on longevity and exposure. As stated above, one would assume that an individual that has experienced the death of loved one may enough reasons to trigger death attitudes. The finding is not the same with the statement credited to Warren and Chopra (2019) indicated that those who lost a member of the immediate family consistently scored lower on the sub-scales of MFODS than those with no experience. The

difference with the present result might be tagged to the premise that a different attitude scale was used and that the settings differ as well as the respondents.

CONCLUSIONS

Based on the findings of the study the following conclusions were drawn;

1. Nurses had the following attitudes; "like to care for dying patients", "have no problem being alone with a dead patient", "idea of never thinking after the death of a patient frightens me", "I am emotionally unprepared to accept the death of my patients", "idea of a dead patient being buried frightens me", "I am afraid that patients may be declared death when they are still alive" and "I am not bothered by the idea that a dead patient is placed in a casket when he or she dies". These answer research question two.
2. There was no significant relationship between death experience and attitudes of nurses towards death and dying of patients. This answers research question eight and verifies hypothesis one.

RECOMMENDATIONS

Following from the findings of the present study, the discussion and conclusions, the study recommended that:

1. 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 attitudes 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.
2. To take care of the differences found in the study, that is, on such demographic factors as sex, age and death experience on attitudes of nurses, 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 attitudes of the respondents.
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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