

**ASSESSMENT OF NURSES COPING STRATEGIES AS REGARDS DEATH OF
PATIENTS IN A SELECTED TERTIARY HEALTH FACILITY, BENIN CITY,
NIGERIA.**

BY

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BENIN CITY

NOVEMBER, 2025.

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**IN PARTIAL FULFILMENT OF THE AWARD OF BACHELOR OF NURSING
SCIENCES [BNSC], COL, UNIVERSITY OF BENIN, BENIN CITY.**

NOVEMBER, 2025.

DECLARATION

This is to declare that this research project titled “**Assessment of Nurses Coping Strategies as Regards Death of Patients in A Selected Tertiary Health Facility, Benin City, Nigeria.**” was carried out by **OGBUZE RITA ANWULI** is solely the result of my work except where acknowledged as being derived from another person(s) or resource.

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CERTIFICATION/APPROVAL

This is to certify that this research project by **OGBUZE RITA ANWULI** with a Matriculation Number **BMS2001119** has been examined and approved for the award of **BACHELOR OF NURSING SCIENCE CERTIFICATE.**

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DEDICATION

This project work is dedicated to Almighty God for His Grace, Protection and Mercy throughout the period of this research, to my loving family and friends, as well as my colleagues who have supported me throughout this journey. Thank you for your encouragement, guidance, love and support. This work is also dedicated to myself for tireless efforts and sleepless nights that have brought me to this stage.

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ABSTRACT

Nurses frequently experience emotional and psychological distress when confronted with patient death, which can affect their mental well-being and professional performance. Coping strategies are therefore vital in managing grief, preventing burnout, and sustaining quality care. This study assessed the coping strategies adopted by nurses and the factors influencing their use in a selected tertiary institution in Benin City, Nigeria. A descriptive cross-sectional design was employed, involving 227 nurses. Data were analyzed using SPSS version 27.0 to identify coping strategies, their perceived effectiveness, and the relationship between utilization, effectiveness, and influencing factors. Findings revealed that the most commonly adopted strategies included religious or spiritual practices, seeking emotional support from colleagues, debriefing sessions, suppressing emotions, maintaining professional emotional distance, and reliance on cultural beliefs. These approaches were generally perceived as effective, while formal training and institutional support programs were the least utilized and considered less effective. Results further indicated that factors such as years of professional experience, prior exposure to patient death, age, and marital status significantly influenced the type and effectiveness of coping strategies adopted. A significant association was also observed between higher utilization of coping strategies and greater perceived effectiveness ($p = 0.01$). The study concludes that nurses in the selected institution primarily depend on personal and peer-based coping mechanisms, which are largely effective. However, formal training and institutional support programs remain underutilized. It is therefore recommended that healthcare institutions prioritize structured training, grief counseling, and supportive programs while considering individual and demographic factors that shape coping patterns.

Keyword: Nurses, Coping Strategies, Death of Patients, Selected Tertiary Institution

TABLE OF CONTENT

Cover page	
Title page	i
Declaration	ii
Certification	iii
Acknowledgement	iv
Dedication	vii
Abstract	vi
Table of content	vi
List of Tables	x
List of Figures	xi

CHAPTER ONE

1.0. Introduction	1
1.1. Background of study	1
1.2. Statement of Problem	3
1.3. Objective of study	5
1.4. Research question	5
1.5. Hypotheses	5
1.6. Significance of Study	6
1.7. Scope of Study	7
1.8. Operational definition of terms	7

CHAPTER TWO

2.1 Conceptual Review	9
2.2 Death of Patient	9
2.3 Emotions surrounding Death of Patient	10

2.4	Coping Strategies	12
2.4.1	Adaptive Coping Strategies	13
2.4.2	Maladaptive Coping Strategies	14
2.4.3	Outcomes of Coping Strategies	15
2.5.	Theoretical Framework	16
2.5.1	Lazarus and Folkman’s transactional Model of stress and coping	17
2.5.2	Model construct and application to the current study	17
2.5.3	Relevance of the theory to the research	19
2.6	Empirical Review	21
2.6.1	Studies that identify the common coping Strategies employed by nurses when dealing with the death of patients	21
2.6.2	Studies that assess the perceived effectiveness of the coping strategies utilized by nurses	24
2.6.3	Studies that identify the factors that influence the various coping strategies adopted by nurses in managing the death of patients.	26
2.7	Summary of Literature Review	28
CHAPTER THREE		
3.1	Research design	30
3.2	Research setting	31
3.3	Target population	31
3.4	Sampling method and technique	31
3.5	Method of data collection	32
3.6	Instrument for data collection	33
3.7	Validity of instrument	34
3.8	Reliability	34
3.9	Method of Data Analysis	34

3.10 Ethical Consideration 35

CHAPTERFOUR

Results 36

CHAPTER FIVE

5.1 Discussion of major Findings 42

5.2 Implication to nurses 44

5.3 Limitations of study 45

5.4 Summary 45

5.5 Conclusion 45

5.6 Recommendation 46

5.7 Suggestion for Further study 46

References 59

Appendixes : Questionnaire 62

LIST OF TABLES

Table 3.1 Proportional Allocation of Sample Size by Ward/Unit X

Table 4.1 Socio-demographic characteristics of respondents Y

Table 4.2 Showing the coping strategies employed by nurses Z

Table 4.3 Showing the perceived effectiveness of coping strategies A

Table 4.4 Showing the factors influencing the various coping strategies among nurses B

Table 4.5 Showing relationship between the utilization of coping strategies and the perceived effectiveness of coping strategies among nurses C

LIST OF FIGURES

Figure 2.1 Conceptual model illustrating the Theory of Planned Behavior applied to nurses' Standard Precaution adherence D

Figure 4.1 Bar Chart Showing the coping strategies employed by nurses E

Figure 4.2 Bar chart showing the perceived effectiveness of coping strategies F

Figure 4.3 Pie Chart showing factors influencing the various coping strategies among nurses G

CHAPTER ONE

INTRODUCTION

1.1 Background of study

It is believed that Nurses are the major point of contact that patients encounter during hospitalization compared to other health practitioners. In some aspects of clinical care, a patient may be hospitalized consequently or for long periods of time which enable the Nurse to get to know the patients and their families well, thereby establishing an emotional connection with said patients (Kostka et al., 2021). Death is inevitable. It is a natural part of life that is psychological as well as physical and affects not only the dying person but also the people that surround them which also includes the Nurses who have been saddled with the responsibility of providing care that respects the values of the dying patient and decent conditions that make the last stage of patients life tolerable which is the most important moments in a professional Nurses work (Cybulska et al., 2022).

Nursing care extends from when a patient has been admitted into the hospital until the patient is discharged or when patient dies. Death is a natural phenomenon of human life. Nurses care for the dying patient in order to promote a peaceful death which is an important job in critical care nursing. In their provision of care nurses spend a large amount of time with the patient and patient relatives which fosters a connection between the Nurse and the patient. The Nurse feels great compassion for the patient while delivering care.

When a patient is rushed to the hospital, the goal of nursing care is to assist the patient in recovery and if recovery is not possible assist the patient to a peaceful death. The expected outcome of bringing a patient to the hospital to receive care is recovery, however this isn't the

case sometimes. During the course of the illness, the Nurse develops an emotional bond with the patient and family members, and it is known that not all patients recover from illness and they eventually die despite the high level of care provided by the Nurse and technological advancements. However, the Nurses job doesn't end at death but after death as the Nurse is required to perform Last Office which is a sign of final respect to the deceased patient and also aides in preparation of corpse for the mortuary (Agyei et al., 2022).

Nurses have been known to experience stressors that hinder their work performance, stressors like long working hours, shortage of staff, shortage of equipment, unpaid salaries and below standard working conditions. In a study carried out in Nigeria in the year 2019, death of a patient was said to be one of the most stressful situations right after shortage of staff and equipment (Kostka et al., 2021).

Nurses play a vital role in every countries healthcare therefore it is important that their health both physical and psychological be taken into consideration. When Nurses fail to cope with grief that comes with death of a patient they cared for, they experience mental and emotional strain, lack of employee engagement, performance decline, elevated departure rates, substandard care and severely compromised wellbeing (Zhang et al., 2022).

Coping strategies have been used by human beings to manage stressful situations and regulate their emotions. Effective coping strategies are important to navigate through situations that can lead to burnouts thereby leading to a decrease in productivity. A study carried out in Ghana found that some Nurses when faced with grief associated with death of a patient make use of spiritual activities such as prayer and meditations (Agyei et al., 2024). Furthermore, creating an atmosphere where the Nurses can talk about their emotions instead of isolating themselves when grief occurs and also allowing Nurses have access to professionals during lunch breaks can help

them cope with the grief thereby preventing the Nurses from leaving their jobs due to burnouts (Agyei et al., 2024).

1.2 Statement of the problem

The demanding and often emotionally taxing nature of nursing within tertiary healthcare institutions, such as the University of Benin Teaching Hospital (UBTH) in Benin City, Nigeria, frequently exposes nurses to the inevitable reality of patient death (Bloomer et al., 2023). As frontline caregivers, these professionals are not only responsible for providing skilled clinical care but are also consistently present during end-of-life situations, requiring them to navigate their own personal grief responses while simultaneously offering crucial emotional and practical support to bereaved families (World Health Organization, 2020).

Extensive international research has consistently highlighted the profound and multifaceted psychological impact of patient death on nurses' well-being. Studies have documented a range of negative consequences, including heightened levels of perceived stress, increased emotional exhaustion, and a greater propensity for burnout (Zhang et al., 2022). These burdens can have a significant impact on nurses' overall psychological health, job satisfaction, and potentially compromise the quality and compassion of the patient care they are able to deliver. Furthermore, unresolved grief and inadequate coping can lead to adverse personal outcomes for nurses, such as insomnia, loss of appetite, feelings of depression, and reduced functionality at work and home (Agyei et al., 2022).

Within the specific Nigerian healthcare context, while there is a growing recognition of the significant occupational stressors faced by nurses – often linked to systemic issues – there remains a critical and specific gap in our understanding of how these dedicated professionals at

the University of Benin Teaching Hospital (UBTH) effectively cope with the emotional and psychological aftermath of experiencing patient death. While existing research within Nigeria may touch upon broader issues of occupational stress and general attitudes towards death and dying among nurses, there is a noticeable absence of focused empirical investigation into the particular coping strategies and mechanisms that nurses at UBTH utilize to manage the unique emotional challenges associated with patient loss.

The consequence of not addressing this gap in knowledge is multifaceted. Without understanding how nurses at UBTH currently cope with patient death, their specific support needs will remain unidentified, potentially leading to increased emotional distress and burnout (Zhang et al., 2022). This can negatively impact nurse retention, ultimately affecting the stability and experience level of the nursing workforce within UBTH. Moreover, a lack of insight into coping mechanisms hinders the development of targeted interventions and support programs that could promote healthier responses and resilience among nurses. Consequently, nurses may continue to rely on potentially maladaptive coping strategies, further jeopardizing their well-being and potentially diminishing the quality of end-of-life care provided to patients and their families (Bloomer et al., 2023; Agyei et al., 2022). Failing to address this issue within the specific cultural and organizational context of UBTH means that interventions developed elsewhere may not be relevant or effective for this population.

Therefore, to address this significant gap in knowledge regarding the specific coping strategies employed by nurses at the University of Benin Teaching Hospital in response to patient death, this study is proposed. Understanding these context-specific coping mechanisms is the necessary first step towards informing the development of evidence-based support systems and

interventions tailored to the unique needs of nurses at UBTH, ultimately aiming to improve their well-being and the quality of care they provide in the face of loss.

1.3 Objective of study

The aim of this study is to assess Nurses coping strategies as regards death of patients while the specific objectives of this study therefore are to;

1. Identify the common coping strategies employed by nurses when dealing with patient death in a selected tertiary institution in Benin City Nigeria.
2. Assess the perceived effectiveness of the coping strategies utilized by nurses in a selected tertiary institution in Benin City Nigeria.
3. Identify the factors that influence the various coping strategies adopted by nurses in managing the death of patients.

1.4 Research Questions

1. What are the most commonly used coping strategies among nurses when dealing with patient death in a selected tertiary institution in Benin City Nigeria?
2. How effective do nurses perceive their coping strategies to be in managing their emotional responses to patient death in a selected tertiary institution in Benin City Nigeria?
3. What are the factors that influence the various coping strategies adopted by nurses in managing the death of patients.

1.5 Research Hypothesis

1. There is no significant relationship between the utilization of coping strategies and the perceived effectiveness of coping strategies among nurses in a selected tertiary institution in Benin City Nigeria.

1.6 Significance of study

The significance of this research lies in its potential contribution to the field of nursing practice and nursing education. The findings of this study can have several implications:

The research can identify effective coping strategies leading to interventions that promote nurses emotional health and reduce burnout and compassion fatigue which translates to more stable and resilient nursing workforce.

For patients, it will lead to improved patient and patient family experiences as Nurses with better coping mechanisms are more likely to provide compassionate, high-quality care, especially during end-of-life situations.

The findings of this research will contribute to the body of knowledge on nurses coping strategies, informing the development of evidence-based interventions and support programs. The study will also highlight the need for targeted training and education on coping strategies for nursing students and practicing nurses.

The study will raise awareness of the emotional toll that patient death takes on nurses, reducing stigma and promoting open discussion. The study will also equip nursing students with effective coping mechanisms making them better prepared to handle the emotional challenges of their profession.

By assessing the coping strategies of nurses as regards death of patients, the gap of knowledge in existing research on coping strategies of nurses will be addressed by contributing to the already existing literature. It will also serve as a foundation for future research and stimulate further exploration into innovative assessment approaches in nursing education.

1.7 Scope of study

The scope of the study is to assess the coping strategies of Nurses as regards death of patients in a selected tertiary health facility in Benin City.

1.8 Operational definition of terms

Nurses:For the purpose of this study, "nurses" will be defined as registered nurses who are currently employed and actively providing direct patient care within a selected tertiary institution in Benin City, Nigeria.

Coping Strategies:Coping strategies will be defined as the cognitive and behavioral efforts employed by nurses to manage the emotional distress and psychological impact associated with patient death. They will be categorized as either:

- i. Adaptive Coping Strategies: (e.g., seeking social support, problem-solving, acceptance, and self-care) - those behaviors considered to have a positive effect on the nurse.
- ii. Maladaptive Coping Strategies: (e.g., avoidance, denial, substance use, self-blame) - those behaviors considered to have a negative effect on the nurse.

Death of Patients: Death of patients will be defined as the cessation of vital functions in a patient under the care of the participating nurses, as documented in the patient's medical

record. This includes deaths occurring in any setting where the nurse provides care within the selected tertiary institution in Benin City, Nigeria.

Assessment: Assessment refers to the process of evaluating and measuring the frequency, type, and perceived effectiveness of nurses' coping strategies in a selected tertiary institution in Benin City, Nigeria.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents the review of related literatures to the study under the following sub-headings; conceptual review, theoretical framework, empirical studies, and summary of literature review

2.1 Conceptual Review

2.2 Overview on death of patients.

Death is characterized by the irreversible cessation of brain function, signifying that brain activity is permanently lost and cannot spontaneously resume or be restored through intervention. It is marked by the total absence of consciousness, encompassing both wakefulness and awareness, as well as the lack of brainstem reflexes, including the capacity for independent respiration. Devastating brain injury or the loss of blood flow to the brain following circulatory arrest may cause this. Death determination is not precluded by residual brain cell activity that is not linked to consciousness or brainstem function (e.g., posterior pituitary antidiuretic hormone release, temperature control, or cellular-level neuronal activity). Any degree of consciousness and/or residual brainstem function, no matter how decreased, precludes the declaration of death (Shemie et al., 2023).

Death is a natural occurrence in human life. It signifies the end of a person's physical, social, psychological, and spiritual life on earth. Death can occur when a person loses their ability to breathe or their hearts stops pumping blood. The physician checks for pulse, listens for respiration, tests for nasal condensation using a mirror, and checks for fixed pupils (Onah & Oriekwo, 2024).

Modern medicine has made tremendous strides in treating diseases that were once incurable, improving clinical outcomes, and reducing pain and suffering, but the age-old issue of human death is still an inevitable part of life that modern medicine will never be able to solve. Ironically, even though we nurses are highly qualified medical professionals who are trained to diagnose and treat a wide range of illnesses, we frequently find ourselves completely unprepared and uneasy when confronted with death and dying in clinical settings. This is because it acts as an unpleasant reminder of the limitations of contemporary medicine and the certainty of our mortality, evoking primal feelings of fear and anxiety (Isaac et al., 2024).

2.3 Emotions surrounding death of patients.

The death of a patient is regarded as a typical professional scenario in nursing, which elicits both positive emotions like calmness and composure as well as negative ones like grief and hopelessness. As a result, nurses may be more susceptible to anxiety and the negative consequences of negative emotions (Kowalenko et al., 2024).

A study carried out among midwives in Poland noted that midwives experience feelings of helplessness and depression following patient death (Hanna et al., 2024).

According to Bloomer et al. (2023), Nurses who have built a connection to the patient experienced feelings of sadness, anger, guilt, shock and relief if the death was an expected death. Nurses also expressed distress, disappointment, frustration and incompetency following patient death. Some Nurses also expressed that due to the occurrence of patient death, they had become desensitized to the situation (Bloomer et al., 2023).

According to Ma et al. (2021), in their study carried out among pediatric oncology nurses in China, found that the nurses often feel nervousness, worry, sadness, unwillingness to accept that

their patient had died even after resuscitation yielded futile results and even begin to doubt their abilities resulting in sense of loss and powerlessness.

Onah and Oriekwo (2024) established that the emotional responses of Nurses towards death varied in several contexts of the patient death. The contexts being the age of the deceased patient, the suddenness of the patients death, the emotional attachment between the nurse and the patient or patient death as a result of staff shortage, medical errors, lack of equipment and delay in attending to the patient (Onah & Oriekwo, 2024). Frustration, sadness, guilt, regret and anxiety have been identified to be the prominent effect of patient death on Nurses as well as crying, fatigue, avoidance and burnout (Onah & Oriekwo, 2024).

According to Agyei et al. (2022), in their study reported that Nurse Experience grief and sense of loss following the loss of a patient. Compassion, sadness and helplessness are the most common feelings that proceed patient death (Kostka et al., 2021).

2.4 Coping Strategies.

Coping strategies refers to the conscious or unconscious cognitive and behavioral techniques used by people to deal with stress. The coping process is divided into two stages; the primary assessment of the event as dangerous or threatening and the secondary assessment of the coping options or mechanisms that can be utilized to deal with the potentially stressful situation (Shahin et al., 2022).

In order to reduce work stress the American Psychological Association has suggested coping mechanisms such as monitoring (recognizing the stressful situation at work), creating healthy reactions (e.g. getting enough sleep, exercising), setting boundaries between work and home life,

taking breaks, using relaxation techniques like deep breathing exercises, speaking with supervisors and/or seeking professional assistance (Shahin et al., 2022).

Coping strategies are characterized as cognitive and behavioral strategies employed to address particular internal and/or external pressures perceived as burdensome or surpassing an individual's resources. Individuals who lack the coping resources necessary to effectively handle a situation and place a high value on the threat implied by the consequences of this poor handling will be psychologically vulnerable to it (Maresca et al., 2022). Coping is a general phrase that encompasses a wide range of behavioral and cognitive techniques for handling emotionally or situationally stressful events (Dev et al., 2024).

2.4.1 Adaptive coping strategies.

Healthcare professionals, especially nurses, utilize adaptive coping strategies as deliberate and thoughtful actions and mental processes to effectively handle and lessen the adverse emotional, psychological, and physical effects of stressful situations. These strategies aim to tackle the source of the stress or change one's reaction to it in a healthy and constructive way, ultimately fostering well-being and the ability to bounce back. When faced with challenges like alarm overload, the COVID-19 pandemic, and ethical dilemmas, adaptive coping becomes vital. For instance, problem-focused coping, an adaptive approach, involves actively trying to alter the stressful situation, such as pushing for improvements in alarm systems (Obisesan et al., 2024) or actively seeking information and training during a health crisis (Smallwood et al., 2021; Perilli et al., 2022).

Effectively managing emotions, another key aspect of adaptive coping, includes practices like being present and accepting (Perilli et al., 2022), along with seeking support from others for emotional understanding and practical help (Smallwood et al., 2021).

Furthermore, adaptive coping involves managing thoughts and behaviors constructively. While not specifically detailed in these summaries, a central part is changing negative thought patterns and finding positive meaning in difficult situations. Behaviorally, engaging in self-care activities that support physical and mental health, such as exercise and getting enough rest, is crucial for effectively managing stress. Seeking and using support networks from colleagues, supervisors, family, and friends also plays a significant role in adaptive coping by providing a buffer against the negative impacts of stress (Smallwood et al., 2021). The practice of mindfulness and focusing on the present moment, as highlighted by Perilli et al. (2022), allows for a non-judgmental observation of one's thoughts and feelings, promoting a sense of calm and aiding in stress management.

When dealing with specific professional challenges, such as alarm fatigue (Obisesan et al., 2024) and moral distress (Chen et al., 2024), adaptive coping includes actively seeking knowledge and skills to address these issues. This might involve participating in training programs or improving communication skills. Recognizing and encouraging these adaptive coping methods among healthcare professionals is essential for improving their overall well-being, increasing job satisfaction, and building resilience when facing demanding work environments. Ultimately, healthcare professionals who effectively employ adaptive coping mechanisms are better positioned to deliver high-quality patient care.

2.4.2 Maladaptive coping strategies.

Maladaptive coping strategies represent unhealthy or unhelpful ways that individuals react to stress, ultimately failing to resolve the underlying issue and often worsening negative emotions, psychological distress, and long-term well-being (Vidanagama et al., 2024). Unlike adaptive strategies that build resilience, maladaptive coping offers temporary relief at best and can lead to harmful consequences for the individual and their professional life, particularly in the demanding healthcare environment (Obisesan et al., 2024).

A key characteristic of maladaptive coping is avoidance, where individuals try to sidestep the stressor or the negative feelings associated with it. This can manifest as physically withdrawing from stressful situations, becoming emotionally detached, or denying the problem altogether. In the context of professional grief, while Zhang et al. (2024) focus on the experience itself, avoidance could hinder the necessary process of dealing with loss. Furthermore, maladaptive coping can involve difficulty managing intense emotions, leading to unhealthy expressions like anger or blaming others. Some individuals under significant stress might also turn to substance use as a temporary escape, which can lead to addiction and other problems. Unhealthy thought patterns, such as excessive self-criticism and dwelling on negative thoughts, are also maladaptive, contributing to feelings of guilt and helplessness. Finally, denying the reality of a stressful situation or relying on unrealistic hopes can prevent individuals from taking effective action. The use of maladaptive coping strategies by healthcare professionals can lead to impaired job performance and burnout. As noted by Vidanagama et al. (2024), it also increases the risk of mental health problems, strains relationships, and reduces resilience. The cumulative effect of stressors, such as professional grief as explored by Zhang et al. (2024), can be worsened by maladaptive coping, hindering healthy adjustment. Recognizing and addressing these unhealthy patterns is crucial for promoting the mental health, resilience, and professional effectiveness of

healthcare professionals (Obisesan et al., 2024). Efforts should focus on identifying those at risk of using maladaptive coping and implementing strategies to encourage the adoption of healthier, adaptive coping mechanisms.

2.4.3 Outcomes of coping strategies.

The consequences of how healthcare professionals manage stress profoundly affect their well-being, mental health, and effectiveness at work. Generally, adaptive coping strategies lead to positive results, building resilience and promoting better adjustment to difficult situations (Perilli et al., 2022; Smallwood et al., 2021). For example, using adaptive and mindful coping was linked to less anxiety in primary care doctors during the COVID-19 pandemic (Perilli et al., 2022). Similarly, frontline healthcare workers who adopted effective adaptive approaches during the pandemic likely experienced better psychological health (Smallwood et al., 2021). When dealing with alarm fatigue, adaptive coping probably leads to a healthier management of this stressor and could prevent burnout (Obisesan et al., 2024). Even when facing profound experiences like professional grief, utilizing adaptive coping mechanisms likely helps intensive care unit nurses process loss in a healthier way and adjust better in the long run (Zhang et al., 2024). Ultimately, adaptive coping aims to lessen the negative impact of stressors, resulting in improved mental health, greater job satisfaction, and continued professional engagement.

In contrast, maladaptive coping strategies tend to have negative outcomes, often making stress worse and harming well-being (Vidanagama et al., 2024). When individuals rely on unhealthy ways to deal with stress, they are more likely to develop anxiety, depression, burnout, and other psychological issues (Vidanagama et al., 2024). In the context of alarm fatigue, maladaptive coping likely contributes to increased stress and potential burnout in nurses (Obisesan et al., 2024). Likewise, if nurses facing ethical challenges resort to maladaptive coping, it could

hinder their ability to address these issues effectively and might lead to moral injury and decreased job satisfaction (Chen et al., 2024). The combined effect of multiple stressors, especially when coupled with maladaptive coping, as potentially seen in the experiences of ICU nurses dealing with professional grief (Zhang et al., 2024), can impede healthy adjustment and negatively impact their long-term mental health and professional functioning. Essentially, while adaptive coping helps protect against stress and promotes positive results, maladaptive coping tends to worsen negative consequences and hinder overall well-being and professional effectiveness.

2.5 Theoretical Framework.

The present inquiry, centered on assessment of nurses coping strategies as regards death of patients within the setting of Benin City, Nigeria, will be structured by the Transactional Model of Stress and Coping articulated by Lazarus and Folkman in 1987.

2.5.1 Lazarus and Folkman's Transactional Model of Stress and Coping.

This theoretical construct posits that psychological strain emerges as a dynamic interplay between an individual and their surrounding environment, a process mediated by cognitive evaluation and adaptive efforts. This framework holds particular salience for elucidating the means by which nurses navigate the emotionally demanding encounter of patient demise, a considerable occupational stressor inherent in the healthcare domain. The ongoing investigation will incorporate insights derived from recent scholarly work, notably the cross-sectional study by Baranauskas et al. (2024) focusing on clinical nurses in Lithuania, which explored the interconnectedness of self-reported strain, affective experiences subsequent to patient death, and

the perceived adequacy of coping mechanisms. Although conducted within a distinct cultural context, the findings of Baranauskas et al. (2024) furnish valuable empirical substantiation for the application of the Transactional Model in understanding the responses of nurses to patient death and delineate key variables warranting consideration.

2.5.2 Model Constructs and Application to the Current Study:

1. Stressor (Patient Death): Analogous to the study by Baranauskas et al. (2024), the event of a patient's death constitutes a noteworthy occupational demand experienced by nurses in Benin City. The frequency of such occurrences, the specific circumstances surrounding them (e.g., abrupt, anticipated), and the nature of the nurse's connection with the deceased patient can all exert influence upon the intensity of this stressor.

2. Primary Appraisal: Nurses operating in Benin City will initially engage in an evaluative process concerning the event of patient death. Drawing upon Baranauskas et al.'s (2024) emphasis on emotional experiences, this initial assessment will likely involve a consideration of the personal significance attributed to the death, potentially taking into account elements such as the nurse's emotional investment in the patient, their perceived accountability in the situation, and their culturally and religiously grounded beliefs pertaining to mortality (as previously highlighted). A negative primary evaluation (e.g., perceiving the death as a substantial loss or a professional shortcoming) is likely to precipitate a stress response.

3. Secondary Appraisal: Subsequent to the primary evaluation, nurses in Benin City will undertake an assessment of their available adaptive resources. This aligns with Baranauskas et al.'s (2024) examination of "coping adequacy." Nurses will evaluate their perceived capacity to

manage the affective distress and professional obligations associated with the death. This process will involve a consideration of their intrinsic resources (e.g., emotional resilience, adaptive skills, abilities for emotional regulation, and spiritual fortitude) and extrinsic resources (e.g., support from colleagues, supervisors, familial networks, religious figures – potentially prominent within the Nigerian cultural landscape).

4. Adaptive Strategies: Nurses will employ a range of adaptive strategies to contend with the strain engendered by patient death. Based on the framework proposed by Lazarus and Folkman (1987) and informed by the types of coping evaluated in Baranauskas et al. (2024) (notwithstanding potential differences in specific measurement), these strategies can be broadly categorized as:

i. Problem-focused adaptation: Actions directed at managing the stressful situation itself or its resultant effects (e.g., seeking pertinent information, participating in debriefing sessions, modifying established work routines).

ii. Emotion-focused adaptation: Efforts aimed at regulating the affective distress elicited by the death (e.g., seeking social and emotional support, engaging in expressions of emotion, employing distancing techniques and drawing upon religious practices for solace).

5. Outcomes: The relative effectiveness of the adaptive strategies implemented will shape various outcomes for nurses in Benin City. Consistent with Baranauskas et al.'s (2024) focus on self-reported strain and emotional experiences, this study will examine:

i. Nurse Well-being: Encompassing indicators such as levels of self-perceived strain, the manifestation of burnout (characterized by emotional depletion, depersonalization, and a diminished sense of personal accomplishment), and overall psychological distress.

ii. Perceived Impact on Care Provision: Nurses' subjective evaluations of how their adaptive strategies and emotional state influence their capacity to deliver high-quality care to other patients under their charge.

2.5.3 Relevance of the theory to the Research

The Lazarus and Folkman Transactional Model stands as a highly pertinent theoretical framework for this research endeavor for several fundamental reasons:

Directly Addresses Stress and Adaptation: It offers a specific and well-established framework for comprehending how individuals respond to events perceived as stressful, rendering it ideally suited for examining the reactions of nurses to the emotionally charged experience of patient death.

Emphasizes Cognitive Processes: The model underscores the pivotal role of cognitive appraisal (how nurses conceptualize patient death and their perceived capacity to manage its impact) in shaping their affective and behavioral responses. This focus allows for the exploration of individual variations in adaptive behaviors.

Considers Contextual Factors: While fundamentally a psychological model, it explicitly acknowledges the reciprocal interaction between the individual and their surrounding environment. This is particularly important for understanding how the specific context of nursing practice in Benin City, Edo, Nigeria (including prevailing cultural norms, available healthcare

resources, and characteristic workplace dynamics) might influence both the appraisal of stressors and the selection of adaptive strategies.

Links Adaptation to Outcomes: The model explicitly establishes a connection between the adaptive strategies employed and a range of resultant outcomes, notably including psychological well-being (such as burnout, a key outcome of interest in this study) and, by extension, the potential influence on professional conduct, such as the provision of care to patients.

Supported by Empirical Evidence: The recent study by Baranauskas et al. (2024) provides a compelling example of how this model continues to be applied effectively to understand the experiences of nurses confronting patient death, thereby affirming its ongoing relevance and utility within contemporary healthcare research. Their findings concerning the relationships between affective experiences, coping efficacy, and experienced stress lend empirical weight to the adoption of this framework for the present study within a distinct cultural setting. By employing the Lazarus and Folkman model, this research can systematically investigate the process through which nurses in Benin City adapt to the challenges posed by patient death, taking into account their cognitive appraisals, available adaptive resources, and the subsequent impact upon their overall well-being and their perceived capacity to deliver quality patient care. The model's well-established theoretical structure, coupled with its continued application in recent scholarly work such as that of Baranauskas et al. (2024), renders it a robust and highly relevant choice for the proposed inquiry.

2.6 Empirical Review.

2.6.1 Common coping strategies employed by nurses when dealing with the death of patients.

A study explored the typical coping mechanisms of nurses in Lithuania encountering patient death, utilizing the Brief COPE scale (Baranauskas et al., 2024). Their findings indicated that nurses frequently employed both adaptive strategies, such as acknowledging the reality of the situation, reinterpreting events positively, and seeking emotional support, alongside less adaptive strategies like mental distraction, denial, and behavioral disengagement (Baranauskas et al., 2024). The study offered a broad overview of coping behaviors in this context. Results highlighted acceptance and positive reframing as more common adaptive strategies, while self-distraction and behavioral disengagement were notable maladaptive choices. A strength of this study was its use of a standardized and recognized measure, facilitating comparisons. However, the cross-sectional design limited understanding of coping changes over time, and the Lithuanian context might affect transferability to Benin City.

Another study investigated the prevalent coping approaches of Guyanese nurses facing patient deaths, using a modified Ways of Coping Questionnaire (Sampson et al., 2023). The research revealed frequent reliance on problem-focused actions, maintaining emotional control, finding positive meaning, and seeking social support, emphasizing proactive and socially oriented coping in this culture. The study reported higher use of problem-focused and support-seeking strategies. Its strength lies in its focus on a Global South context relevant to Nigeria and its consideration of cultural influences. However, the modified scale complicates comparisons, and the cross-sectional design offers a static view of coping.

Recent research offers valuable insights into the common ways nurses manage the emotionally challenging experience of patient death, a significant aspect of their professional lives. Sampson et al.'s (2023) cross-sectional study of Guyanese nurses revealed that active coping, involving direct efforts to address problems, was frequently used when dealing with patient deaths, as was

planning, which includes strategizing and preparing for how to handle the stress (Sampson et al., 2023). Furthermore, these nurses commonly reported using acceptance, acknowledging the reality of the loss, and positive reframing, attempting to see the situation in a more positive light (Sampson et al., 2023). This suggests a reliance on both proactive problem-solving and emotion-focused techniques to navigate the impact of patient loss within this specific cultural context (Sampson et al., 2023). While providing direct evidence related to the research heading by identifying these common coping strategies, the study's cross-sectional design limits the ability to determine cause-and-effect relationships, and its findings may not be fully generalizable to nurses in other cultural settings (Sampson et al., 2023).

Babkair et al. (2024), carried out a cross-sectional study on stress and coping among intensive care nurses, a population frequently exposed to patient mortality, also identified several key coping strategies. The most commonly reported were active coping, planning, acceptance, and the use of both emotional and instrumental support (Babkair et al., 2024). This study reinforces the importance of proactive strategies and highlights the significant role of seeking help and understanding from others in managing stress within this demanding specialty, which likely extends to coping with patient deaths (Babkair et al., 2024). While the focus was broader than solely patient death, the findings are relevant to the heading by indicating common coping mechanisms in a high-mortality environment (Babkair et al., 2024). However, similar to Sampson et al. (2023), the cross-sectional design prevents causal inferences, and the study's setting in Saudi Arabia may limit its generalizability to other cultural contexts (Babkair et al., 2024).

Sun et al. (2024), in their path analysis of stress and coping among frontline nurses during the COVID-19 pandemic, a period marked by significant patient mortality, further contributes to our

understanding. Their findings indicated that nurses frequently utilized active coping, seeking emotional support, planning, and self-distraction to manage pandemic-related stress (Sun et al., 2024). This study corroborates the importance of active problem-solving and social support in coping with situations involving frequent patient death (Sun et al., 2024). The use of path analysis allowed for the examination of complex relationships between variables within this specific crisis (Sun et al., 2024). However, the unique circumstances of the pandemic might limit the direct applicability of all findings to routine experiences of patient death, and the study was conducted in China, potentially influencing the observed coping strategies (Sun et al., 2024).

In summary, the empirical evidence from these studies consistently points to active coping, planning, acceptance, and seeking social support as common coping strategies employed by nurses when dealing with the death of patients (Babkair et al., 2024; Sampson et al., 2023; Sun et al., 2024). Positive reframing (Sampson et al., 2023) and self-distraction (Sun et al., 2024) also appear in some contexts. While each study contributes valuable insights and directly addresses the research heading by identifying these strategies, their cross-sectional designs limit causal inferences, and their specific cultural or contextual settings necessitate caution regarding broad generalizability. Future research employing longitudinal and qualitative methods is needed to further elucidate the coping processes and their long-term effectiveness in this critical area of nursing practice.

2.6.3 Perceived effectiveness of the coping strategies utilized by nurses when dealing with the death of patients.

Rony et al. (2023), in their qualitative investigation into the coping methods of frontline nurses during the COVID-19 pandemic indicated that nurses frequently found seeking social connections to be a valuable way to process their experiences and gain emotional support. Similarly, engaging in religious or spiritual activities was a commonly reported source of inner strength and comfort. The nurses' descriptions also suggested that taking a proactive, problem-solving approach, by seeking information and adhering to safety guidelines, and using emotion-focused techniques, such as trying to maintain a positive mindset and finding distractions, were seen as beneficial in navigating the stressful and often tragic circumstances of the pandemic. The recurring mention of these behaviors implies that the nurses felt they were helpful in managing the significant stressors, including the frequent loss of patients (Rony et al., 2023).

In their cross-sectional study, Baranauskas et al. (2024) explored the relationship between stress, emotional reactions to patient death, and how adequately nurses in Lithuania felt they were coping. Although the study didn't objectively measure the "effectiveness" of specific coping strategies through outcomes, it did assess the nurses' personal sense of how well they were managing. The results showed that nurses who believed their coping methods were sufficient reported lower levels of stress following a patient's death. While the study identified various coping strategies, its main contribution here is the direct assessment of the nurses' own perception of how helpful their coping strategies were (Baranauskas et al., 2024).

Agyei et al. (2022), conducted a quantitative study on the grief and coping strategies of nurses after patient deaths in Ghana. While the main goal was to identify how often different strategies were used, the frequent use of strategies such as seeking support from others, adopting a task-oriented approach to their work, using emotion-regulating techniques such as distraction, and relying on spiritual coping implies that nurses found these methods useful in dealing with their

grief. However, the study did not directly ask nurses to rate how effective they felt each strategy was in reducing their distress (Agyei et al., 2022).

The scoping review by Nopa et al. (2024) synthesized numerous studies on how nurses coped with the distress of the COVID-19 pandemic. This review highlighted the repeated use of strategies like seeking emotional and practical assistance, taking direct actions to manage stressors, planning, finding positive ways to view situations, accepting the reality, and using religion or spirituality. The consistent appearance of these strategies across different studies suggests that nurses generally found them to be helpful in managing the many challenges of the pandemic, which included the emotional impact of patient mortality (Nopa et al., 2024).

While Rony et al. (2023) provides rich qualitative evidence indicating the frequent use of various coping strategies during a pandemic with high mortality, Agyei et al. (2022) offers quantitative data on the prevalence of specific coping mechanisms among nurses dealing with patient death in a specific healthcare setting. Nopa et al. (2024), in their scoping review further supports the prevalence of several coping strategies by highlighting their recurring appearance across multiple studies examining nurses' distress during the COVID-19 pandemic. These studies collectively point towards the significant prevalence of social support, problem-focused coping, emotion-focused coping, and spiritual practices as key ways nurses manage the emotional challenges associated with patient death and high-stress work environments

Baranauskas et al. (2024), directly assessed nurses' self-reported adequacy of coping after patient deaths, providing a measure of their perceived effectiveness. Rony et al. (2023), in their qualitative findings illustrate how nurses described the benefits of specific coping strategies in the context of high death rates during the pandemic. Agyei et al. (2022) and Nopa et al. (2024) identify frequently used coping mechanisms, suggesting an inherent level of perceived

usefulness, even without direct effectiveness ratings. Collectively, these studies indicate that nurses often see social support, proactive actions, emotion regulation techniques, and spiritual engagement as helpful ways to navigate the emotional impact of patient death and other high-stress healthcare situations. Future research could further explore and quantify nurses' perceptions of how effective specific coping strategies are in alleviating grief and distress.

2.6.3 Factors that influence the various coping strategies adopted by nurses in managing the death of patients.

In a study carried out by Lin, et al., (2022) in Hangzhou, China, the death-coping self-efficacy (DCS) and its influencing factors among nurses were examined. A cross-sectional design was employed using a convenient sampling technique, with a total of 572 nurses recruited from a tertiary hospital. Data were collected using a general information questionnaire and the DCS scale. The results revealed that the overall DCS of nurses was at a medium level, with scores ranging from low to high in the order of coping with grief, preparation for death, and hospice care. Importantly, attendance in hospice care education within the previous year, prior experience of accompanying dying family members, and personal attitudes towards death were identified as significant influencing factors. The study concluded that nurses' self-efficacy in coping with grief and preparation for death needs to be strengthened. The authors recommended that managers should provide early assessment, grief adjustment guidance, and continuous training platforms to improve nurses' coping ability and promote their mental health.

Similarly, Gong, Chen, and Liu (2024) conducted a national cross-sectional study in China to identify factors influencing coping with death competence among oncology nurses. A total of multiple linear regression and Pearson correlation analysis were employed to examine data. The findings showed that oncology nurses had a moderate coping competence, with a mean score of

133.57 ± 26.78. The results further indicated a significant positive correlation between coping competence and death attitude, as well as education needs. Years of oncology care experience, bereavement experience, death attitude, and need for death-related education together explained 30.6% of the variance in coping competence. The study concluded that oncology nurses' coping competence must be improved to ensure high-quality end-of-life care. It was recommended that death education programs tailored to oncology nurses be provided, alongside the incorporation of innovative approaches such as virtual reality training, to strengthen coping skills and promote acceptance of death.

In South Africa, Makgoba (2022) carried out a qualitative explorative, descriptive, and contextual study in Mopani District, Limpopo Province, to investigate challenges and coping mechanisms of nurses involved in resuscitation in emergency units. A total of 18 professional nurses were selected using purposive sampling, and data were collected through semi-structured interviews until data saturation. Findings revealed that nurses faced multiple challenges, including inadequate medical equipment, insufficient pharmaceutical supplies, poor infrastructure, and lack of multidisciplinary and managerial support. These challenges significantly affected their work during patient resuscitation and contributed to psychological distress. Nurses reported coping through self-developed mechanisms such as peer discussions, emotional suppression, and reliance on professional experience. The study concluded that trauma arising from failed resuscitation required institutional interventions such as debriefing sessions, group therapy, counselling, and increased staffing. It was recommended that hospitals provide adequate resources and grant nurses study leave for advanced trauma training to enhance their capacity in emergency care.

Likewise, Kostka, Borodziej, and Krzemińska (2021) carried out a pilot study in Poland to analyze nurses' feelings and emotions regarding patient death across four departments: surgery, internal medicine, emergency, and intensive care. A total of 160 nurses participated, drawn equally from each department. A diagnostic survey design was used, employing questionnaires such as Mini-COPE and PSS-10 alongside researcher-designed items. Results showed that the most common emotions were compassion, sadness, and helplessness, with 53.9% of participants reporting high stress levels related to patient death. Anxiety levels were found to be significantly higher among nurses in internal medicine wards compared to those in intensive care or emergency departments. Coping strategies varied by job seniority and workplace, indicating that experience and context shape how nurses respond to patient death. The study concluded that nurses experience intense emotional distress and stress when caring for dying patients, and highlighted the urgent need to develop structured and effective coping interventions.

Rony et al. (2023), in their qualitative study, conducted with frontline nurses during the COVID-19 pandemic in a developing country, did not aim to quantify the prevalence of specific coping strategies. However, it identified several strategies that were consistently reported by the participants, indicating their frequent use. Seeking social support was a prominent theme, with nurses repeatedly mentioning their reliance on colleagues, family, and friends. Similarly, spiritual and religious practices emerged as a frequently cited source of comfort and strength. While not numerically quantified, the depth of the qualitative data suggests that problem-focused coping (adhering to protocols, seeking information) and emotion-focused coping (maintaining positivity, distraction) were also commonly adopted approaches by the nurses in managing the stressful and often death-filled environment of the pandemic (Rony et al., 2023). The study's strength lies in revealing the range and perceived importance of these strategies through the

nurses' narratives, suggesting their prevalence within the study population, even without providing exact figures.

In contrast, the quantitative study by Agyei et al. (2022) directly aimed to determine the prevalence of various coping strategies among nurses following patient death in Ghana. Through the use of questionnaires, the researchers were able to quantify the frequency of different coping mechanisms. Their results showed that seeking social support was the most frequently utilized strategy. Problem-focused coping, characterized by focusing on work tasks, and various emotion-focused coping strategies, such as distraction and acceptance, also demonstrated high levels of use among the nurses. Furthermore, spiritual coping, involving reliance on prayer, was identified as a prevalent coping mechanism within this specific context (Agyei et al., 2022). This study's strength lies in its ability to provide statistical data on the prevalence of these strategies within the studied population of nurses who had experienced patient death.

Nopa et al. (2024), in their scoping review, while synthesizing findings from multiple studies on coping during the COVID-19 pandemic, provides an overview of coping strategies that were frequently reported across the literature. The review highlights the recurring themes of seeking emotional and instrumental support as common coping mechanisms. Active coping, involving direct action, and planning were also frequently mentioned. Furthermore, positive reframing, acceptance, religion/spirituality, and self-distraction consistently appeared as strategies employed by nurses to manage the distress associated with the pandemic, which inherently involved exposure to patient death (Nopa et al., 2024). While the scoping review does not provide prevalence rates for each individual study, it underscores the recurring nature of these coping strategies across a broader body of research, suggesting their general prevalence among nurses facing pandemic-related stressors, including patient mortality.

2.7 Summary of Literature Review.

This chapter explores nurses' coping strategies in response to patient death in a tertiary institution in Benin City, Nigeria. It begins by defining patient death, emphasizing the emotional and professional challenges nurses face. The chapter then discusses the range of emotions experienced by nurses, from sadness to guilt, and the varying impacts of these emotions based on factors like patient age and death circumstances.

The concept of coping strategies is outlined, distinguishing between adaptive strategies (e.g., seeking support, problem-solving) and maladaptive strategies (e.g., avoidance, substance abuse), with implications for nurse well-being and care quality. The chapter highlights the importance of these strategies in preventing burnout and promoting emotional resilience.

Lazarus and Folkman's Transactional Model of Stress and Coping is used to frame the study, focusing on the appraisal process that nurses undergo when faced with patient death, and how these appraisals influence their coping strategies and outcomes, such as burnout and care quality.

The empirical review presents studies on the;

- Common coping strategies employed by nurses when dealing with patient death in a selected tertiary institution in Benin City Nigeria.
- Prevalence of the various coping strategies among nurses in a selected tertiary institution in Benin City Nigeria.
- Perceived effectiveness of the coping strategies utilized by nurses in a selected tertiary institution in Benin City Nigeria.

These studies underscore the role of adaptive strategies like emotional support and positive reframing in reducing burnout, while maladaptive strategies, such as denial, are linked to negative outcomes.

In summary, the chapter provides a comprehensive foundation for understanding the emotional and professional challenges nurses face regarding patient death, and the importance of coping strategies in mitigating these challenges and improving care outcomes.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter describes the research methodology that the researcher adopted in conducting this study. The various components of research methodology will be discussed under their respective headings, including research design, study setting, target population, sample and sampling technique, instruments of data collection, validity and reliability of instruments, method of data collection, method of data analysis, and ethical considerations.

3.1 Research Design.

This study adopted a descriptive cross-sectional survey design to assess nurses' coping strategies as regards death of patient. A cross-sectional approach is appropriate because it allows for the collection of data at a single point in time, providing insights into nurses' coping strategies as regards death of patients (Tsegaye et al., 2023). A quantitative research approach was used, as

it enabled the researcher to objectively measure nurses' coping strategies using structured questionnaires. This method ensured data consistency and facilitates statistical analysis to determine relationships between variables (Takona, 2023). The choice of a survey design is justified because it allows for data collection from a large sample of nurses working in different units (surgical wards, recovery rooms, and intensive care units).

3.2 Research Setting

This study was carried out in University of Benin Teaching Hospital (UBTH), Benin City, Edo State. UBTH is a tertiary healthcare facility which was established in 1973. It is located in Ugbowo, Egor Local Government Area. Edo State comprise of 18 local government areas. Egor Local government area where University of Benin Teaching Hospital is located falls within the southern senatorial district of Nigeria. UBTH offers both clinical and diagnostic services and offers a wide range of services, which makes it an important healthcare facility in the state, region and the nation at large. It is estimated that UBTH has a bed capacity of over nine hundred and ten (910) (UBTH, 2024). UBTH has nineteen (19) clinical departments and three (3) Medical Laboratory Department and 3 emergency departments. These departments offer emergency services for the general/primary health needs of the people. They offer both outpatient and in-patient services and they are staffed with health professionals such as Doctors, Nurses and paramedics to carry out their daily routines.

3.3 Target population.

The study population comprises nurses actively involved in frontline patient care at University of Benin Teaching Hospital. These nurses work in critical units where death of patients is a common phenomenon, including:

Ward/Unit	Number of Nurses
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Accident and Emergency Unit A	74
Accident and Emergency Unit B	72
Medical Unit A	76
Medical Unit B	78
Surgical Unit	77
Pediatrics	65
Obstetrics and Gynecology	86
Intensive Care Units (ICUs)	42
Total	570

(Source, Human Resources Department, February 2025).

3.4 Sample Size Determination

The sample size was calculated as indicated below:

Using Taro Yamane's Formula

$$n = \frac{N}{1 + N(e)^2}$$

Where

N= Population under study

E= Constant 0.05%) margin error

$$n = \frac{570}{1 + 570(0.05)^2}$$

$$n = \frac{570}{1 + 570(0.0025)}$$

$$n = \frac{570}{1 + 1.425}$$

$$n = \frac{570}{2.425}$$

n=

Therefore, the sample size was 235

3.5 Sampling Technique

The stratified sampling technique was used in this study. Stratified sampling is a probability sampling technique where the population is divided into homogeneous subgroups or "strata" based on shared characteristics such as gender, age, income, education level or unit/ward

Proportional sampling calculation

Academic level	Determination of sample size in each level	Sample size per level
Accident and Emergency Unit A	$74/570 \times 235$	31
Accident and Emergency Unit B	$72/570 \times 235$	30
Medical Unit A	$76/570 \times 235$	31
Medical Unit B	$78/570 \times 235$	32
Surgical Unit	$77/570 \times 235$	32
Pediatrics	$65/570 \times 235$	27
Obstetrics and Gynecology	$86/570 \times 235$	35
Intensive Care Units (ICUs)	$42/570 \times 235$	17
	Total	235

3.6 Instrument for Data Collection

The instrument for data collection in this study was a self-structured questionnaire. This was developed based on the objectives of the study. The questionnaire was made up of

five sections with. Questions which were carefully drafted, sequenced and constructed in a bid to get in-depth information that is useful and relevant to the study will be used.

Section A: consist of the demographic data of the participants (Age, Marital Status, Current Educational Level, Ethnicity).

Section B:the common coping strategies employed by nurses when dealing with patient death

Section C: The perceived effectiveness of the coping strategies utilized by nurses

Section D: factors that influence the various coping strategies adopted by nurses in managing the death of patients

3.7 Validity of the Instrument

The instrument's validity pertained to its capability to accurately measure the intended construct or concept (Surucu&Maslakci, 2020). Researchers assessed various validity types such as content, construct, criterion, and faceto evaluate the instrument's accuracy. For this research, face and content validity will be utilized to validate the research tool. The questionnaire underwent validation by both the project supervisor and a field expert, and necessary adjustments were implemented by the researcher before starting the main study.

3.8 Reliability of the Instrument

The reliability of an instrument referred to its stability and consistency in delivering uniform outcomes when assessing the same criteria under identical circumstances (Surucu&Maslakci, 2020). It essentially gauged how consistently the instrument produced similar results across multiple trials. A reliable instrument is one that could produce the same results if the behavior was measured again by the same scale. The Cronbach's alpha reliability technique was employed

in this study. This researcher conducted reliability testing on the instrument by distributing 26 questionnaires, which constituted 10% of the total sample size of 235, to working nurses of Faith MediPlex (which are outside the sampled population). A coefficient of 0.71 was obtained and the instrument was considered reliable.

3.5 Method of Data Collection.

Data for this study was collected using a structured questionnaire designed to assess nurses' coping strategies as regards death of patient. The questionnaire was self-administered and distributed to 235 nurses in accident and emergency Unit A, accident and emergency unit B, medical unit A, medical unit B, surgical unit, pediatrics, obstetrics and gynecology, and intensive care units at UBTH.

3.9 Method of Data Analysis

The data collected was analyzed using the Statistical Package for the Social Sciences (SPSS) version 27.0. Descriptive statistics such as mean, frequency, and percentages was computed to summarize the data. Hypothesis testing was conducted using the Chi-square test of association, with the level of significance set at $p < 0.05$. The results of the analyses was then presented using tables, graphs, frequencies, and percentages to provide a clear overview of the findings.

3.10 Ethical Consideration

Ethical approval was obtained from the Health Research Committee, University of Benin Teaching Hospital, Benin City. Permission was obtained from the various ward managers before proceeding with the research. Before data collection began, participants received detailed explanations about the research's purpose, content, and implications. They will be assured of

confidentiality, ensuring the protection of their personal and private information. Throughout the research, ethical guidelines were strictly adhered to, including the following considerations:

1. Confidentiality: Respondents' information was treated confidentially, with no request for names or addresses in the questionnaire. Participants understood that their responses were confidential and solely used for research purposes. No personal identifiers were used in any document or questionnaire to maintain anonymity.

2. Voluntary Participation: Participants were informed of their right to voluntary participation without facing penalties or bias. They could choose to withdraw or decline to provide information at any point if they felt uncomfortable or unsure.

3. Avoidance of Plagiarism: Proper citation of all authors used in the study was ensured, both within the content and in the reference page.

CHAPTER FOUR

RESULTS

This chapter deals with the representation of data collected from respondents on the Assessment of Nurses' Coping Strategies as Regards the Death of Patients in a Selected Tertiary Institution, Benin City, Nigeria. A total of 235 questionnaires were distributed to nurses in the selected tertiary health institution, out of which 227 were properly filled and valid for data analysis, giving a response rate of 97%.

Table 4.1: Socio-demographic characteristics of respondents

Variable	Frequency (n = 227)	Percent (%)
Age in years		
20–29	62	27.3
30–39	88	38.8
40–49	51	22.5
50 and above	26	11.5
Gender		
Male	89	39.2
Female	138	60.8
Educational background		
Diploma	78	34.4
BSc Nursing	102	44.9
MSc Nursing	32	14.1
Others (Specify)	15	6.6

Years of Nursing Experience		
1–5 years	70	30.8
6–10 years	81	35.7
11–15 years	48	21.1
Above 15 years	28	12.3
Current Work Setting/Unit/Department		
Accident and Emergency Unit A	28	12.3
Accident and Emergency Unit B	26	11.5
Medical Unit A	32	14.1
Medical Unit B	31	13.7
Surgical Unit	37	16.3
Pediatrics	29	12.8
Obstetrics and Gynecology	24	10.6
Intensive Care Units (ICUs)	20	8.8

Table 4.1 presents the socio-demographic characteristics of the respondents. The socio-demographic data of the 227 respondents reveal a diverse group in terms of age, gender, educational background, years of nursing experience, and current work setting. The age distribution shows that the majority of respondents fall within the 30–39 years category, making up 38.8% of the sample. This is followed by those aged 20–29 years, who constitute 27.3% of the respondents. Nurses aged 40–49 years account for 22.5%, while those 50 years and above represent the smallest age group, at 11.5%. This pattern suggests that the nursing workforce in the selected institution is largely composed of young to middle-aged adults. In terms of gender, the sample was predominantly female (60.8%), while male respondents made up 39.2%. This reflects the general trend in the nursing profession, where females typically outnumber males. Regarding educational background, the data indicate that the most common qualification among respondents is a Bachelor of Science in Nursing (BSc Nursing), held by 44.9% of the sample. 34.4% of the nurses have a Diploma, while 14.1% possess a Master of Science in Nursing (MSc Nursing). A smaller proportion, 6.6%, reported having other forms of educational qualifications, which may include certificates, training programs, or foreign degrees. The

distribution of respondents by years of nursing experience reveals that a significant number, 35.7%, had been in the profession for 6–10 years. This is closely followed by those with 1–5 years of experience, who account for 30.8% of the sample. Respondents with 11–15 years of experience make up 21.1%, while those with more than 15 years of experience represent 12.3%, indicating a relatively balanced mix of early-career, mid-career, and experienced professionals. With regard to current work settings, the highest proportion of respondents, 16.3%, were stationed in the Surgical Unit, followed by Medical Unit A (14.1%), and Medical Unit B (13.7%). Pediatrics (12.8%), Accident and Emergency Unit A (12.3%), and Accident and Emergency Unit B (11.5%) each had a notable representation. Additionally, Obstetrics and Gynecology accounted for 10.6%, while the Intensive Care Units (ICUs) had the lowest proportion of respondents at 8.8%. This variety indicates that the sample draws from a wide range of clinical departments, allowing for a more holistic understanding of nurses' coping strategies across units with different patient care dynamics.

Answering research question

Research question 1: What are the most commonly used coping strategies among nurses when dealing with patient death in a selected tertiary institution in Benin City Nigeria?

Table 4.2: Showing the coping strategies employed by nurses

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
I commonly seek emotional support from my colleagues when a patient dies.	86 (37.9)	92 (40.5)	31 (13.7)	18 (7.9)	3.1	High
I use religious or spiritual practices (e.g., prayer, worship) to cope with patient death.	104 (45.8)	79 (34.8)	26 (11.5)	18 (7.9)	3.2	High
I prefer to cope with patient death through personal reflection and solitude.	57 (25.1)	81 (35.7)	52 (22.9)	37 (16.3)	2.7	High

I find professional counseling services helpful in coping with the death of patients.	49 (21.6)	76 (33.5)	58 (25.6)	44 (19.4)	2.6	High
I suppress my emotions in order to continue working after a patient's death.	68 (30.0)	84 (37.0)	45 (19.8)	30 (13.2)	2.8	High
I participate in support groups or peer discussions to manage grief after a patient's death.	54 (23.8)	83 (36.6)	56 (24.7)	34 (15.0)	2.7	High
My cultural beliefs influence the way I cope with patient death.	72 (31.7)	78 (34.4)	44 (19.4)	33 (14.5)	2.8	High
I have received formal training on coping strategies for dealing with patient death.	40 (17.6)	70 (30.8)	60 (26.4)	57 (25.1)	2.4	Low
I cope with patient death by maintaining a professional emotional distance from patients.	65 (28.6)	77 (33.9)	50 (22.0)	35 (15.4)	2.8	High
Debriefing sessions with my team help me cope with the death of a patient.	74 (32.6)	91 (40.1)	39 (17.2)	23 (10.1)	3	High
Grand mean					2.8	High

Mean cut-off = 2.5

Table 4.2 highlights the coping strategies employed by nurses in relation to patient death, with a grand mean score of 2.8, indicating a generally high level of coping mechanisms among respondents. The highest mean score of 3.2 is attributed to the use of religious or spiritual practices (e.g., prayer, worship) as a coping method. This is followed by seeking emotional support from colleagues with a mean of 3.1, and debriefing sessions with the team with a mean of 3.0, suggesting these are prominent strategies among the nurses. Coping by suppressing emotions, maintaining a professional emotional distance, and drawing on cultural beliefs each scored a mean of 2.8, reflecting their widespread use. Participation in support groups or peer discussions and coping through personal reflection and solitude both had a mean of 2.7, while professional counselling services recorded a slightly lower mean of 2.6. The lowest mean of 2.4 was observed for formal training on coping strategies, indicating a gap in institutional or

structured support in this area. Overall, the results reflect a heavy reliance on personal and peer-based strategies, with limited engagement in formal coping programs.

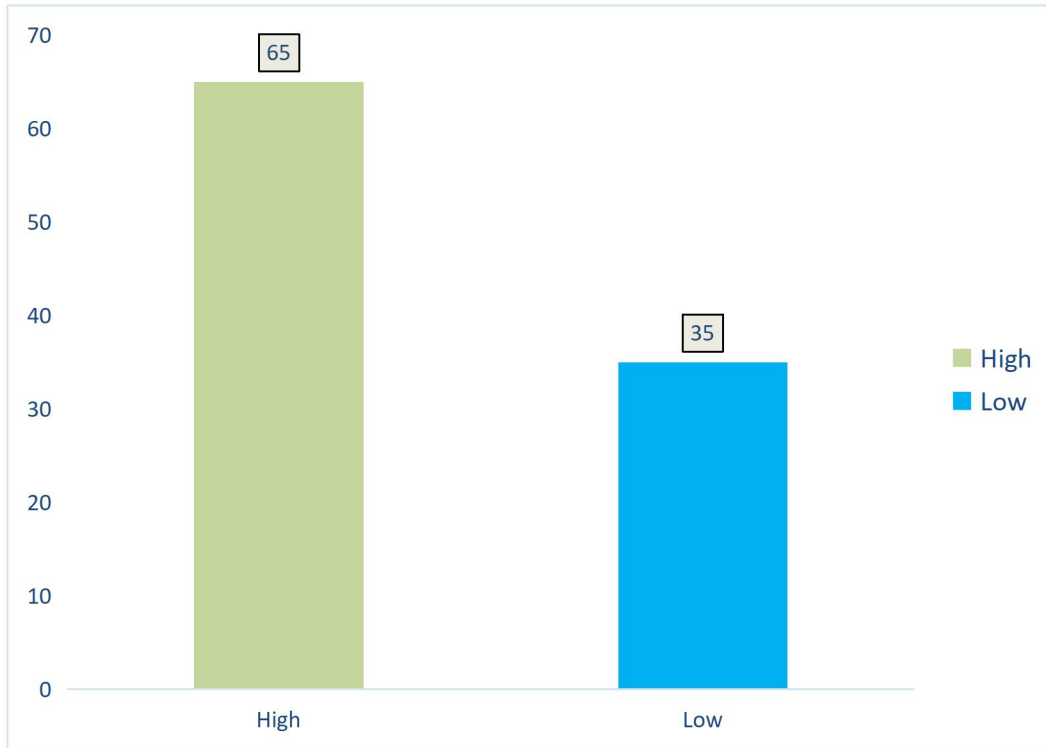


Figure 4.1: Bar Chart Showing the coping strategies employed by nurses

The bar chart shows that 148 (65%) of the respondents highly employed the above as coping strategies in dealing with patient death, while 79 (35%) lowly employed them as coping strategies.

Research questions 2: How effective do nurses perceive their coping strategies to be in managing their emotional responses to patient death in a selected tertiary institution in Benin City Nigeria?

Table 4.3 Showing the perceived effectiveness of coping strategies

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
Seeking emotional support from colleagues helps me effectively cope with patient death.	81 (35.7)	93 (41.0)	32 (14.1)	21 (9.3)	3	Effective
Engaging in religious or spiritual activities effectively reduces my emotional distress after a patient's death.	98 (43.2)	83 (36.6)	27 (11.9)	19 (8.4)	3.1	Effective
Avoiding thoughts about patient death helps me manage my emotions effectively.	43 (18.9)	72 (31.7)	63 (27.8)	49 (21.6)	2.5	Effective
Sharing my feelings with family or friends outside the workplace helps me recover emotionally after a patient's death.	69 (30.4)	86 (37.9)	44 (19.4)	28 (12.3)	2.9	Effective
Professional counseling has been effective in helping me deal with the death of patients.	46 (20.3)	74 (32.6)	55 (24.2)	52 (22.9)	2.5	Effective
Participating in debriefing or reflection sessions after a patient's death improves my coping ability.	53 (23.3)	79 (34.8)	56 (24.7)	39 (17.2)	2.6	Effective
Using work or other activities as a distraction is an effective coping mechanism for me.	64 (28.2)	87 (38.3)	46 (20.3)	30 (13.2)	2.8	Effective
Suppressing my emotions allows me to continue working effectively after a patient's death.	59 (26.0)	81 (35.7)	52 (22.9)	35 (15.4)	2.7	Effective
Hospital-provided coping programs (e.g., grief counseling, workshops) are effective in helping me deal with patient death.	42 (18.5)	68 (30.0)	58 (25.6)	59 (26.0)	2.4	Non-Effective
Using humor or light conversations with colleagues effectively helps me manage grief after a patient's death.	73 (32.2)	90 (39.6)	41 (18.1)	23 (10.1)	2.9	Effective
					Grand mean 2.8	Effective

Mean cut-off = 2.5

Table 4.4 presents the perceived effectiveness of coping strategies among nurses, with a grand mean score of 2.8, indicating a generally positive perception. The most effective strategy, with the highest mean of 3.1, is engaging in religious or spiritual activities to reduce emotional distress. This is followed by seeking emotional support from colleagues with a mean of 3.0, and using humour or light conversations with colleagues and sharing feelings with family or friends, both scoring 2.9. Using work or other activities as a distraction follows with a mean of 2.8, while suppressing emotions has a mean of 2.7. Participating in debriefing or reflection sessions scored a mean of 2.6, showing moderate perceived effectiveness. Avoiding thoughts about patient death and professional counselling both had a mean of 2.5, meeting the threshold for effectiveness. In contrast, hospital-provided coping programs had the lowest mean of 2.4, categorizing it as a non-effective strategy according to the respondents.

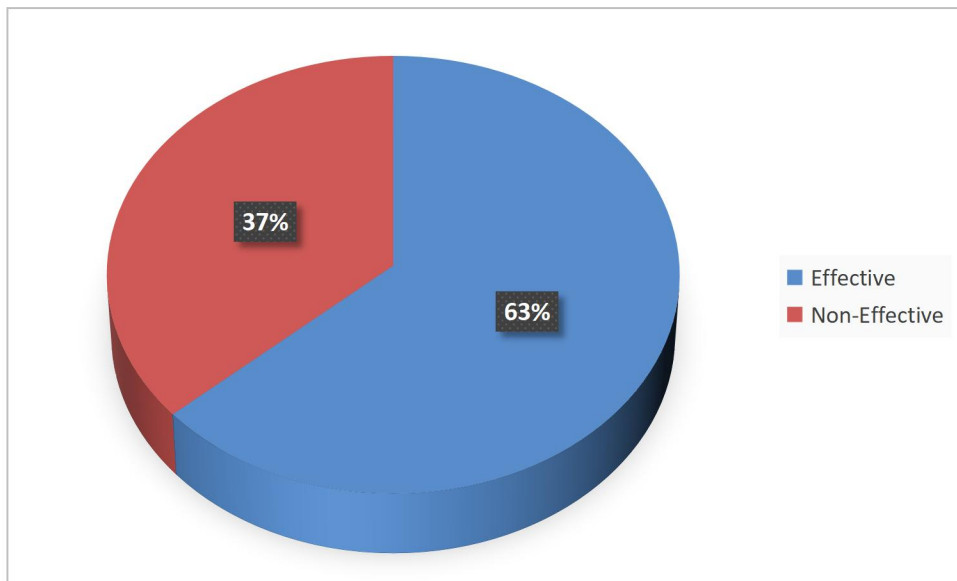


Figure 4.3: Pie Chart showing the perceived effectiveness of coping strategies

The pie chart reveals that 144 (63.5%) of the respondents perceive the coping strategies employed after patient death as effective, while 83 (36.5%) consider them non-effective.

Research question 3: What is the factors that influence the various coping strategies adopted by nurses in managing the death of patients?

Table 4.4: showing the factors that influence the various coping strategies adopted by nurses in managing the death of patients

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
My cultural beliefs influence the coping strategies I adopt when a patient dies.	78 (34.4)	92 (40.5)	36 (15.9)	21 (9.3)	3	Factors
My religious or spiritual orientation plays a significant role in the coping strategies I use after patient death.	99 (43.6)	80 (35.2)	28 (12.3)	20 (8.8)	3.1	Non-Factors
Support from colleagues and the nursing team influences the way I cope with patient death.	39 (17.2)	65 (28.6)	68 (30.0)	55 (24.2)	2.4	Factors
The availability of professional counseling services affects my coping strategies.	71 (31.3)	83 (36.6)	45 (19.8)	28 (12.3)	2.9	Factors
Hospital policies and support programs (e.g., debriefing sessions, workshops) influence my choice of coping methods.	45 (19.8)	74 (32.6)	64 (28.2)	44 (19.4)	2.5	Factors
My level of professional experience affects how I cope with patient death.	52 (22.9)	77 (33.9)	54 (23.8)	44 (19.4)	2.6	Factors
Workload and staffing levels influence the coping strategies I am able to use.	66 (29.1)	88 (38.8)	43 (18.9)	30 (13.2)	2.8	Factors
Family and social support outside the hospital influence my coping strategies.	61 (26.9)	82 (36.1)	50 (22.0)	34 (15.0)	2.7	Factors
Fear of being judged or stigmatized by colleagues affects the coping strategies I adopt.	36 (15.9)	66 (29.1)	60 (26.4)	65 (28.6)	2.3	Non-Factors

Training or education on grief management influences the coping strategies I use.	69 (30.4)	89 (39.2)	40 (17.6)	29 (12.8)	2.9	Factors
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Grand mean 2.7 Factors

Mean cut-off = 2.5

Table 4.4 presents the factors that influence the coping strategies adopted by nurses in managing patient death. The grand mean of 2.7, which is above the cut-off point of 2.5, indicates that these factors generally play a significant role in shaping coping behaviors. The highest mean score of 3.1 was recorded for religious or spiritual orientation, showing that personal faith and spirituality strongly influence how nurses cope with the death of patients. Cultural beliefs also emerged as important, with a mean score of 3.0. Availability of professional counseling services (2.9) and training or education on grief management (2.9) were also considered influential. Organizational and workplace-related factors were highlighted as well. Workload and staffing levels (2.8), family and social support outside the hospital (2.7), professional experience (2.6), and hospital policies or support programs (2.5) all showed moderate influence on coping strategies. In contrast, support from colleagues (2.4) and fear of judgment or stigmatization (2.3) scored below the cut-off, suggesting that they were not considered strong influencing factors by most respondents.

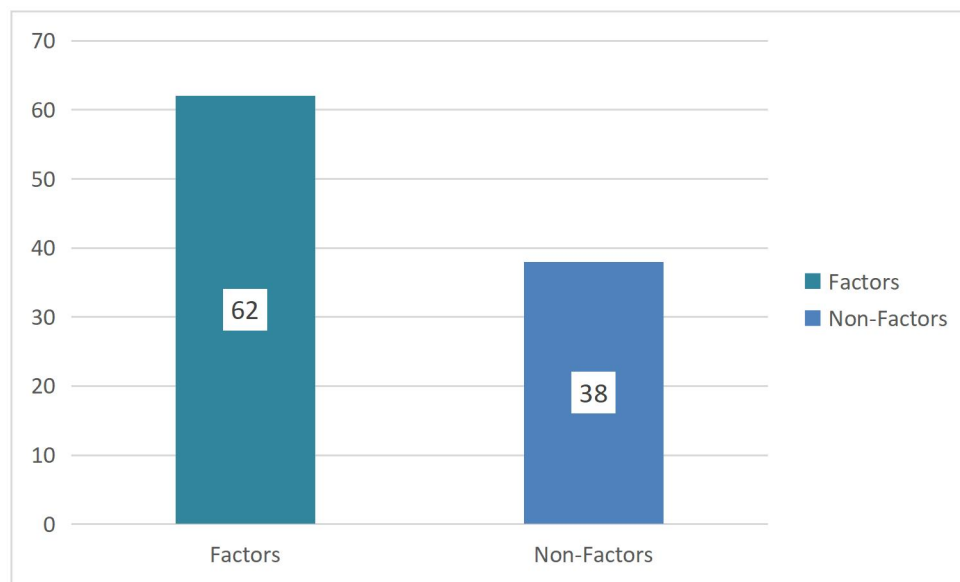


Figure 4.2: Bar chart showing the factors influencing coping strategies among nurses

The bar chart indicates that 141 (62%) of the respondents identified factors that significantly influence the coping strategies they adopt in managing patient death, while 86 (38%) reported non-factors that have little or no influence on their coping approaches.

Hypothesis

Ho1: There is no significant relationship between the utilization of coping strategies and the perceived effectiveness of coping strategies among nurses in a selected tertiary institution in Benin City Nigeria

Table 4.5: showing relationship between the utilization of coping strategies and the perceived effectiveness of coping strategies among nurses in a selected tertiary institution in Benin City Nigeria

Utilization of coping strategies	Perceived effectiveness		Test Statistics (χ^2)	df	P value	Decision
	Effective	Non-effective				
High	132 (53.4)	103 (46.6)	3.121	1	0.001	Rejected
Low	126 (58.6)	103(43.4)				

Table 4.4 show the relationship between the utilization of coping strategies and their perceived effectiveness among nurses in a selected tertiary institution in Benin City revealed a statistically significant association. The chi-square test showed that nurses who reported higher utilization of coping strategies were more likely to perceive them as effective compared to those with lower utilization. The test result produced a chi-square value of 3.121 with a p-value of 0.001, which is less than the 0.05 level of significance. This led to the rejection of the null hypothesis, indicating

that the extent to which nurses use coping strategies significantly influences their perception of the strategies' effectiveness.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter discusses the major findings of the research compared with the literature reviewed, the implication for nursing, summary, conclusion, Recommendations and Suggestions for further Studies.

5.1. Discussion of major Findings

The study assessed nurses' coping strategies regarding patient death in a selected tertiary institution in Benin City, Nigeria. The socio-demographic characteristics of the respondents show the majority (38.8%) were between the ages of 30-39, followed by 27.3% in the 20-29 age group. This age distribution aligns with previous research, such as that conducted by Baranauskas et al. (2024), which underscores the importance of nurses' age in shaping their emotional responses and coping mechanisms when facing patient mortality. Younger and mid-career nurses often experience different emotional reactions to patient death compared to more seasoned professionals. The gender distribution indicated a predominance of female nurses (60.8%), reflecting the typical gender composition in nursing, similar to findings by Sampson et al. (2023), which identified gender-specific coping patterns among healthcare professionals. This suggests that gender-related factors may influence how nurses process grief and manage stress following patient deaths. Educational attainment also emerged as a significant factor, with 44.9%

of respondents having completed BSc Nursing and 34.4% holding diplomas. This correlates with Babkair et al. (2024), which found that educational background significantly influenced nurses' selection of coping strategies when dealing with high-mortality environments. Years of nursing experience revealed that 35.7% of respondents had 6-10 years of experience, while 30.8% had 1-5 years, indicating a relatively young to mid-career professional sample. The experience distribution parallels findings from Agyei et al. (2022), suggesting that professional experience plays a crucial role in developing effective coping mechanisms when confronting patient death. The diverse clinical settings represented in the sample, including Surgical Unit (16.3%), Medical Units (27.8% combined), and Emergency Units (23.8% combined), further emphasizes the need for context-sensitive approaches in addressing grief and coping, as demonstrated in the qualitative study by Rony et al. (2023), which showed varying emotional responses and coping strategies across different clinical environments with varying exposure to patient mortality.

Coping Strategies Employed by Nurses

Based on the findings, 65% of respondents demonstrated high-level coping strategies when dealing with patient death, while 35% employed low-level coping strategies. This finding aligns with several previous studies but shows relatively better coping mechanisms compared to some international contexts. When compared to the study by Baranauskas et al. (2024) in Lithuania, where nurses frequently employed both adaptive and less adaptive strategies, the Benin City nurses showed a stronger tendency toward high-level coping approaches. Similarly, this result contrasts with findings from Sun et al.'s (2024) study during the COVID-19 pandemic, where higher levels of maladaptive coping were observed among nurses under extreme stress. Regarding specific coping strategies, the findings reveal that religious or spiritual practices were the most commonly employed mechanism (mean=3.2). This is notably higher than the

findings from Babkair et al. (2024), where spiritual coping was less prominent among intensive care nurses. This difference likely reflects the strong religious orientation of Nigerian culture compared to other contexts, emphasizing the importance of culturally-specific approaches to grief management.

The study found high levels of reliance on seeking emotional support from colleagues (mean=3.1), which aligns with findings from Sampson et al. (2023) in Guyana, where seeking social support was identified as a prevalent coping strategy. Similarly, debriefing sessions with team members (mean=3.0) were highly valued, suggesting the importance of collaborative processing of grief experiences in healthcare settings. Emotion regulation among Benin City nurses was notable, with emotional suppression (mean=2.8) and maintaining professional emotional distance (mean=2.8) commonly reported. This shows similar patterns to Agyei et al.'s (2022) study of Ghanaian nurses, though the Benin City nurses appeared to rely more heavily on these strategies, potentially reflecting institutional or cultural norms around emotional expression in professional settings. Regarding personal coping mechanisms, nurses showed moderate use of personal reflection and solitude (mean=2.7) and participation in support groups (mean=2.7). However, formal training on coping strategies received the lowest rating (mean=2.4), indicating a significant gap in professional preparation. This echoes the pattern observed in Rony et al.'s (2023) qualitative study, where nurses relied heavily on informal coping mechanisms due to limited formal support systems.

These findings align with Nopa et al.'s (2024) scoping review, which identified similar patterns of coping across multiple studies examining nurses' responses to patient death. The overall coping level, represented by a grand mean of 2.8, suggests that while effective strategies exist, there are still significant areas requiring improvement, particularly regarding formal training and

support. This finding supports the recommendations made in various studies, including Baranauskas et al. (2024) and Sampson et al. (2023), emphasizing the need for structured interventions to enhance nurses' ability to cope with patient death in healthcare settings

Perceived Effectiveness of Coping Strategies

The findings reveal that 63.5% of nurse respondents at the selected tertiary institution in Benin City perceived their employed coping strategies as effective when dealing with patient death, while 36.5% considered them non-effective. This distribution suggests that while the majority of nurses believe their coping mechanisms are beneficial, a substantial proportion still find their approaches inadequate for managing the emotional impact of patient mortality. Religious coping was perceived as the most effective strategy (mean=3.1), with 98 respondents strongly agreeing and 83 agreeing that engaging in spiritual activities effectively reduces their emotional distress following patient death. This high perceived effectiveness of spiritual coping corresponds with Rony et al.'s (2023) qualitative findings, where nurses consistently described religious practices as a valuable source of strength and comfort during periods of high patient mortality. The strong perception of effectiveness likely reflects the cultural context of Nigeria, where religious beliefs often provide meaningful frameworks for understanding and accepting death. This aligns with Baranauskas et al.'s (2024) observation that coping strategies aligned with cultural values tend to be perceived as more effective by healthcare professionals.

Seeking emotional support from colleagues also demonstrated high perceived effectiveness (mean=3.0), with 81 respondents strongly agreeing and 93 agreeing that this approach helps them cope with patient death. This finding mirrors Agyei et al.'s (2022) research in Ghana, where

social support emerged as not only prevalent but also viewed as particularly beneficial. Similarly, sharing feelings with family or friends outside the workplace (mean=2.9) and using humour or light conversations with colleagues (mean=2.9) were rated highly effective, underscoring the perceived value of both professional and personal social connections in processing grief. These findings reinforce Sampson et al.'s (2023) conclusion that socially oriented coping approaches provide significant perceived benefits across diverse healthcare settings.

Self-distraction through work or other activities showed substantial perceived effectiveness (mean=2.8), with 64 respondents strongly agreeing and 87 agreeing that this approach serves as an effective coping mechanism. This aligns with Sun et al.'s (2024) findings that distraction-based coping, while not necessarily addressing the root emotional experience, was perceived as helpful by nurses for managing immediate stress responses. Emotional suppression at work was also rated as moderately effective (mean=2.7), though previous research by Nopa et al. (2024) has cautioned that while such strategies may provide short-term relief, they could potentially compromise long-term psychological adjustment. Participation in debriefing or reflection sessions showed moderate perceived effectiveness (mean=2.6), while avoidance of thoughts about patient death (mean=2.5) and professional counselling (mean=2.5) received more mixed evaluations. These findings echo the nuanced patterns observed in Babkair et al.'s (2024) study, where formal and structured approaches to processing grief showed variable perceived benefits among intensive care nurses, often dependent on implementation quality and accessibility. Notably, hospital-provided coping programs received the lowest effectiveness rating (mean=2.4), falling into the "non-effective" category. This perception aligns with findings from multiple studies, including Agyei et al. (2022) and Rony et al. (2023), which highlighted the

often-limited availability, quality, or cultural appropriateness of formalized support programs in various healthcare settings, particularly in developing nations.

Factors Influencing the Various Coping Strategies Adopted by Nurses in Managing the Death of Patients

The findings of this study revealed that 62% of respondents identified factors that significantly influenced the coping strategies they adopted in managing the death of patients, while 38% reported non-factors. The overall grand mean of 2.7, above the cut-off of 2.5, indicates that the majority of the listed factors play a role in shaping how nurses cope with patient death. Among the most influential were religious or spiritual orientation (mean = 3.1), cultural beliefs (mean = 3.0), professional counseling services (mean = 2.9), training or education on grief management (mean = 2.9), and workload or staffing levels (mean = 2.8). Conversely, fear of stigma or judgment by colleagues (mean = 2.3) was considered a non-factor by most respondents.

This finding is consistent with the results of Lin et al. (2022) in Hangzhou, China, who reported that education and previous experience with death significantly enhanced nurses' coping self-efficacy. Similarly, in the present study, nurses who had received training or education on grief management strongly agreed that such preparation shaped their coping strategies. This aligns with Lin et al.'s conclusion that continuous training and early assessment are vital for strengthening death-related coping skills. The results also resonate with Gong et al. (2024), who demonstrated that death attitudes, bereavement experience, and education needs were key predictors of coping competence among Chinese oncology nurses. In the current study, professional experience (mean = 2.6) and the availability of professional counseling (mean = 2.9) were recognized as important influences, suggesting that both personal exposure and institutional resources are pivotal. Together, these findings reinforce the global evidence that structured education and professional support directly shape coping outcomes.

In terms of workplace factors, this study highlighted the importance of hospital policies, workload, and team support. This is in line with Makgoba's (2022) findings in South Africa, where nurses in emergency units described inadequate infrastructure, poor managerial support, and staff shortages as barriers that shaped their coping mechanisms. Like in Mopani District, the Benin City nurses emphasized the importance of institutional support, particularly through counseling and debriefing sessions, as facilitators of coping. Cultural and religious orientation emerged as dominant influences in this Nigerian context, which contrasts with the findings of Kostka et al. (2021) in Poland, where the main determinants of coping were related to workplace context and years of service rather than cultural or spiritual factors. This contrast likely reflects the stronger role of religion in Nigeria, where spiritual practices provide culturally meaningful frameworks for interpreting and managing grief.

The findings also align with Rony et al. (2023), who, in a qualitative study during the COVID-19 pandemic, emphasized reliance on colleagues, family, and religious practices as central coping strategies. Similarly, the present study showed that family and social support (mean = 2.7) and team support (mean = 2.4) were significant influences. Agyei et al. (2022), in Ghana, quantified this pattern, finding that social support and spiritual coping were the most prevalent strategies — a pattern mirrored in the Benin City results, underscoring the cross-cultural importance of relational and faith-based influences. Finally, the present findings echo the synthesis provided by Nopa et al. (2024), who in a scoping review identified emotional support, positive reframing, religion, and distraction as recurring coping factors across multiple studies. The prevalence of religious orientation and social support as key influences in this study confirms the universality of these themes, even though cultural weightings differ across contexts.

5.2 Implication to nurses

The findings of this study underscore several critical implications for nurses in the context of coping with patient death, especially within tertiary healthcare settings. Given the high prevalence of emotional and spiritual coping strategies among nurses, it is evident that nurses play a vital role in shaping a compassionate and resilient care environment. They must be supported and empowered to develop effective coping mechanisms that balance professional responsibilities with emotional well-being.

Nurses can leverage their experiences and training to foster a workplace culture that acknowledges grief and supports healing. By participating in peer-support groups, debriefing sessions, and mentorship programs, nurses can normalize discussions about loss and promote collective coping. These initiatives are particularly important in high-stress clinical settings where repeated exposure to death is common.

Moreover, the study highlights the need for nurses to actively engage in advocating for institutional support systems that address grief and emotional stress. This includes pushing for the establishment of regular psychological counselling, wellness programs, and spiritual care services within hospitals. Nurses should also be involved in the design and implementation of these programs to ensure they are culturally relevant and practically effective.

In addition, nursing educators and administrators should prioritize the integration of emotional resilience and bereavement care into professional development and academic training. Equipping nurses with evidence-based strategies to process grief can improve their mental health outcomes and reduce the risk of burnout, thereby enhancing the quality of care provided to patients and their families.

Lastly, nurses should strengthen partnerships with interdisciplinary healthcare teams to ensure a holistic approach to end-of-life care. By collaborating with psychologists, chaplains, social workers, and palliative care specialists, nurses can better manage the emotional challenges associated with patient death. Ongoing education and training in grief management will not only support nurses personally but also reinforce their role as advocates for compassionate and human-centered healthcare delivery.

5.3 Limitations of study

This study has several limitations. It focused on nurses at a single tertiary institution in Benin City, Nigeria, limiting the generalizability of the results to other settings or regions. The reliance on self-reported data may also introduce response bias, as nurses might provide socially desirable answers or underreport emotional distress. Additionally, variations in institutional support systems, such as counselling services, were not considered, which could influence coping strategies. The cross-sectional design prevents establishing causal relationships, and longitudinal studies would provide more insight into how coping mechanisms evolve. Lastly, while the sample size was adequate, the study did not explore other socio-demographic factors (e.g., marital status or work environment) that could impact coping. Future research should address these limitations for a more comprehensive understanding of nurses' coping strategies.

5.4 Summary

This study coping strategies as regards death of patient in a tertiary institution in Benin City. A total of 227 nurses participated, with a majority falling within the 31–40 age group and possessing over five years of professional experience. Most respondents were female, reflecting the gender distribution typical in the nursing profession.

The findings revealed that nurses employ a range of coping strategies, with emotional, spiritual, and professional approaches being the most common. Many nurses reported relying on prayer, support from colleagues, and emotional detachment to manage the psychological stress of losing a patient. These strategies highlight a complex interplay between personal beliefs, workplace culture, and professional demands in shaping how nurses respond to patient death.

Despite the widespread use of coping mechanisms, some nurses expressed difficulty processing grief due to a lack of institutional support systems, such as counselling services or debriefing sessions. Additionally, variations in coping were observed based on socio-demographic factors such as age, years of experience, and marital status, indicating the influence of personal background on grief management.

Overall, the study underscores the importance of developing structured support frameworks and training programs to equip nurses with effective tools for coping with patient death. Addressing these needs can enhance nurses' emotional well-being, reduce burnout, and improve the overall quality of care provided within healthcare institutions.

5.5 Conclusion

This study highlights important insights into the coping strategies employed by nurses when dealing with patient death at a tertiary institution in Benin City, Nigeria. The findings indicate that nurses with more experience tend to use a variety of coping mechanisms, with many reporting a strong reliance on social support, spirituality, and emotional regulation strategies. However, the study also revealed gaps in the perceived effectiveness of these coping strategies, particularly in relation to institutional support and resources for emotional well-being.

While the nurses generally demonstrated resilience and commitment to their roles, the study identified a need for improved institutional support systems to assist nurses in managing the emotional and psychological toll of patient death. Additionally, the persistence of emotional distress despite employing various coping strategies suggests that targeted interventions, such as counselling services and professional development programs, could further enhance the emotional well-being of nurses.

In conclusion, to improve the coping abilities of nurses and their overall mental health, it is crucial for healthcare institutions and policymakers to create supportive environments that address both the emotional and practical aspects of coping with patient death. By providing resources, training, and emotional support, healthcare systems can better equip nurses to navigate the emotional challenges of their profession, ultimately improving care outcomes for both patients and healthcare providers.

5.6 Recommendation

Based on the findings of this study, several recommendations are made to improve the coping strategies of nurses dealing with patient death in healthcare settings:

- 1.** Healthcare institutions should establish or strengthen support systems for nurses, such as counseling services or support groups, to help them manage the emotional impact of patient death. Regular psychological training and stress management workshops could be integrated into professional development programs to enhance emotional resilience among nurses.
- 2.** Nursing schools and training programs should incorporate coping strategies and emotional management techniques into their curricula. Educating nurses on effective

ways to cope with patient death from the outset of their careers will better prepare them for the challenges they will face in practice.

3. Institutions should consider implementing formal policies on coping and grief management, offering guidelines on how nurses should be supported during and after patient death. Such policies could include mandatory debriefing sessions, peer support, and access to mental health professionals.
4. Nurses often cope better when they have a strong support system from their colleagues. Encouraging team-based care and peer support groups within healthcare settings can help nurses process their emotions and share coping strategies, thus fostering a healthier work environment.

5.7 Suggestion for Further study

- Future studies should investigate the long-term effects of educational interventions on nurses' coping strategies regarding patient death. Understanding how different training approaches (e.g., workshops, counselling programs) influence coping mechanisms could provide valuable insights for improving support systems for healthcare workers.
- Research should explore the role of institutional support, such as counselling services and management involvement, in shaping nurses' coping strategies. Comparative studies across various healthcare institutions could reveal differences in coping practices and institutional influences.

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APPENDIX 1

QUESTIONNAIRE

Department of Nursing Science,
School of Basic Medical sciences,
University of Benin,
Benin City,
Edo State.

Dear Respondent,

I am a 500 Level student of the department of Nursing, of the above mentioned institution conducting a research study on **“assessment of nurses coping strategies as regards death of patients in a selected tertiary health facility, Benin City , Nigeria.”** as part of the requirement for the completion of a Bachelor’s Degree in Nursing Science. Kindly and sincerely provide answers to the questions in the spaces provided. Every information provided is highly confidential and strictly for academic purpose. No names are required. You may decide to answer questions that best suits your understanding and for the accuracy in statistics. Please be independent and truthful as possible. Thank you.

Yours faithfully,

ASSESSMENT OF NURSES COPING STRATEGIES AS REGARDS DEATH OF PATIENTS IN A SELECTED TERTIARY HEALTH FACILITY, BENIN CITY, NIGERIA

Section A: Demographic Information

Please answer the following questions by ticking the appropriate box or filling in the blank.

1 Age (in years):

20-29

30-39

40-49

50 and above

2 Gender:

Male

Female

3 Educational Qualification:

Diploma

BSc Nursing

MSc Nursing

Others (Specify) _____

4 Year of Nursing Experience: _____

5 Current Work Setting/Unit/Department

Accident and Emergency Unit A

Accident and Emergency Unit B

Medical Unit A

Medical Unit B

Surgical Unit

Pediatrics

Obstetrics and Gynecology

Intensive Care Units (ICUs)

Section B: Coping Strategies Employed by Nurses (Objective One)

Instruction:

Please indicate your level of agreement with the following statements regarding your coping strategies when dealing with the death of a patient.

S/N	Statement	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
1	I commonly seek emotional support from my colleagues when a patient dies.				
2	I use religious or spiritual practices (e.g., prayer, worship) to cope with patient death.				
3	I prefer to cope with patient death through personal reflection and solitude.				
4	I find professional counseling services helpful in coping with the death of patients.				
5	I suppress my emotions in order to continue working after a patient's death.				
6	I participate in support groups or peer discussions to manage grief after a patient's death.				
7	My cultural beliefs influence the way I cope with patient death.				
8	I have received formal training on coping strategies for dealing with patient death.				
9	I cope with patient death by maintaining a professional emotional distance from patients.				
10	Debriefing sessions with my team help me cope with the death of a patient.				

Section C: Perceived Effectiveness of Coping Strategies

Instruction:

Please indicate your level of agreement with the following statements regarding the effectiveness of the coping strategies you use after the death of a patient.

S/N	Statement	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
1	Seeking emotional support from colleagues helps me effectively cope with patient death.				
2	Engaging in religious or spiritual activities effectively reduces my emotional distress after a patient's death.				
3	Avoiding thoughts about patient death helps me manage my emotions effectively.				
4	Sharing my feelings with family or friends outside the workplace helps me recover emotionally after a patient's death.				
5	Professional counseling has been effective in helping me deal with the death of patients.				
6	Participating in debriefing or reflection sessions after a patient's death improves my coping ability.				
7	Using work or other activities as a distraction is an effective coping mechanism for me.				
8	Suppressing my emotions allows me to continue working effectively after a patient's death.				
9	Hospital-provided coping programs (e.g., grief counseling, workshops) are effective in helping me deal with patient death.				
10	Using humor or light conversations with colleagues effectively helps me manage grief after a patient's death.				

Section D: Factors Influencing Coping Strategies Among Nurses (Objective Three)

Instruction:

Please indicate your level of agreement with the following statements regarding factors that influence your coping strategies when dealing with the death of a patient.

S/N	Statement	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
1	My cultural beliefs influence the coping strategies I adopt when a patient dies.				
2	My religious or spiritual orientation plays a significant role in the coping strategies I use after patient death.				
3	Support from colleagues and the nursing team influences the way I cope with patient death.				
4	The availability of professional counseling services affects my coping strategies.				
5	Hospital policies and support programs (e.g., debriefing sessions, workshops) influence my choice of coping methods.				
6	My level of professional experience affects how I cope with patient death.				
7	Workload and staffing levels influence the coping strategies I am able to use.				
8	Family and social support outside the hospital influence my coping strategies.				
9	Fear of being judged or stigmatized by colleagues affects the coping strategies I adopt.				
10	Training or education on grief management influences the coping strategies I use.				

**APPENDIX II
RELIABILITY OF INSTRUMENT**

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	No. of Items
0.71	0.70	30

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I commonly seek emotional support from my colleagues when a patient dies.	53.4931	15.077	-.047	.701
I use religious or spiritual practices (e.g., prayer, worship) to cope with patient death.	54.1111	15.302	.204	.210
I prefer to cope with patient death through personal reflection and solitude.	53.4167	15.126	-.061	.185
I find professional counseling services helpful in coping with the death of patients.	87.3188	27.590	-.123	.099
I suppress my emotions in order to continue working after a patient's death.	87.4813	26.138	.053	.092
I participate in support groups or peer discussions to manage grief after a patient's death.	53.4931	15.077	-.047	.565
My cultural beliefs influence the way I cope with patient death.	53.2986	14.141	.055	.196
I have received formal training on coping strategies for dealing with patient death.	82.2313	27.034	-.044	.071
I cope with patient death by maintaining a professional emotional distance from patients.	87.3188	27.590	-.123	.099
Debriefing sessions with my team help me cope with the death of a patient.	87.4813	26.138	.053	.092
I seek emotional support from colleagues after the death of a patient.	87.2313	27.034	-.044	.078
I engage in prayer or other religious activities to cope with patient death.	87.3188	27.590	-.123	.099
I avoid thinking about the patient's death as a way of coping.	87.3188	27.590	-.123	.099
I share my feelings with family or friends outside the workplace after a patient's death.	87.4813	26.138	.053	.092
I seek professional counseling or therapy after a patient's death.	53.4931	15.077	-.047	.165

I attend debriefing or reflection sessions after a patient death.	87.4500	25.582	.125	.071
I distract myself with work or other activities to cope with patient death.	87.3188	27.590	-.123	.099
I suppress my emotions to avoid showing grief at work.	87.4813	26.138	.053	.092
I rely on formal coping programs provided by the hospital (e.g., grief counseling, stress management workshops).	87.3188	27.590	-.123	.099
I use humor or light conversations with colleagues as a coping strategy after a patient's death.	87.4813	26.138	.053	.092
Seeking emotional support from colleagues helps me effectively cope with patient death.	87.3188	27.590	-.123	.099
Engaging in religious or spiritual activities effectively reduces my emotional distress after a patient's death.	87.4813	26.138	.053	.092
Avoiding thoughts about patient death helps me manage my emotions effectively.	82.2313	27.034	-.044	.071
Sharing my feelings with family or friends outside the workplace helps me recover emotionally after a patient's death.	87.6438	27.325	-.076	.081
Professional counseling has been effective in helping me deal with the death of patients.	87.5938	26.658	.058	.077
Participating in debriefing or reflection sessions after a patient's death improves my coping ability.	87.3188	27.590	-.123	.099
Using work or other activities as a distraction is an effective coping mechanism for me.	87.4813	26.138	.053	.092
Suppressing my emotions allows me to continue working effectively after a patient's death.	86.2813	26.719	-.064	.095
Hospital-provided coping programs (e.g., grief counseling, workshops) are effective in helping me deal with patient death.	86.3500	25.675	.024	.090
Using humor or light conversations with colleagues effectively helps me manage grief after a patient's death.	86.3000	24.714	.114	.081

Comment: The reliability analysis using Cronbach's Alpha, yielding a result of 0.71, for the overall scale. Additionally, the Cronbach's Alpha of 0.52 when the items are standardized. These values suggest a good level of internal consistency among the items in this scale.