SUDDEN DEATH IN NIGERIA

PSYCHOLOGICAL PERSPECTIVE

Analysis of causes, grief processes and treatment

Editors
Helen Okhiaofe Osinowo, Ph.D
Benjamin O. Ehigie, Ph.D
Adegbenga M. Sunmola, Ph.D
Taiwo O. Lawoyin, MBBCH, FMCPH

Stirling-Horden Publishers (Nig.) Ltd.

Lagos • Ibadan • Benin City • Jattu-Uzairue

Preface

The variety of titles in this book shows how those who are interested in issues of sudden death for old and young people have all come to the same conclusion: that the phenomenon of sudden death deserves attention so as to control its increasing incidence and disheartening consequence in Nigeria.

It occurs to most of us that sudden death is sometimes actually preventable. In large part the cause of the death is occasionally shaped by victim's own decision and behaviour as well as the victims interactions with the social environment.

This is well observed and portrayed by creative writers, artists, musicians, and even in folk narratives. Nevertheless, it appears this has just dawn on those whose work is to advance health and development.

This book is relevant: it is a Nigerian Psychological Association, the papers presented at the Inaugural Conference on Sudden Death of the Nigerian Psychological Association, Clinical Psychology Division, South West Zone, Nigeria.

The chapters in the book depict to us the ramifications of Sudden Death in Nigeria. Mostly, deaths in the context of its causes, diversities, consequences preventive, management and control strategies. The book appears comprehensive in approach utilizing both rational and empirical analyses. The edited collection provides an accessible resource book that overcomes some of the deficiencies encountered in the literature, where the focus has often not addressed African cultural and societal issues of death.

The authors of the chapters are mostly experts working in various Nigerian universities, teaching hospitals and research institutions. In their contribution, they examine critically the enabling and controlling factors of sudden death that have arisen in their research. They are also able to draw on their own experience as members of Nigerian society with first-hand insights about occurrence of sudden death in the society, and in addition as experts in their fields to offer well-informed guidance on how to overcome the problematic occurrence of sudden death.

We are indeed grateful to the contributors for giving so generously of their time to reflect on their papers and to share their experience with others who are either new to the field of sudden death or looking to extend and appraise their knowledge of the field.

H.O. Osinowo
B.O. Ehigie
A.M. Sunmola
T.O. Lawoyin
Editors (1999)

SUDDEN DEATH IN NIGERIA: PSYCHOLOGICAL PERSPECTIVES: Analysis of Causes, Grief Processes and Management

CHAPTER FIFTEEN

LOSS, DEATH, GRIEF AND CARE GIVERS

Aderike Onibokun, RN, PhD, FUICC
Department of Nursing, University of Ibadan, Nigeria

Introduction

Birth, loss and death are universal and individually unique events of the human experience. Life is a series of losses and gains. A child beginning to walk gains independence with mobility. An older person with visual and hearing changes may lose self-reliance. Illness and hospitalization frequently cause losses. A nurse works with many clients who experience different types of loss. Coping mechanisms determine people's ability to face and accept loss.

Loss is a period of deprivation of something you had before, while grief is a natural response and the subjective state that follows loss. Human beings can anticipate death. This causes anxiety, planning, denial, love, loneliness, achievement, and lack of achievement. Death can be an overwhelming experience that affects dying persons and their families, friends, and care givers. When a person becomes terminally ill, others can be reminded of their mortality. The style of dying reflects a person's style of living, and attitudes about death depend on a person's beliefs and emotional strengths.

Porter and Perry (1993) identified five categories of loss and these are:

1. Loss of external objects.
2. Loss of a known environment.
3. Loss of a significant other
4. Loss of an aspect of self; and
5. Loss of life.

Since the theme of this paper is "*sudden death*"; this paper will focus more on loss of life, concepts and theories of the grieving process and briefly discuss the nursing implications.

Loss of Life:

Persons who face death live, feel, think and respond to events and people around them until the moment of death. Concern is often not about death itself but about pain and loss of control. Although most people are afraid and anxious about death, the same issues will not be equally important to each person. Each person responds differently to death. For people who have lived long and suffered long terminal illnesses, death may be a relief – some perceive death as an entry into an afterlife to be reunited with loved ones in paradise. Others fear separation, abandonment, loneliness or mutilation. The threat of death often causes individuals to become dependent. The helplessness and shame of dependence experienced by some clients create a challenge for the nurse.

Loss, Death, Grief and Nursing

Nurses need to understand loss and grief. Because death is a frequent reality in many nursing care settings, most nurses interact daily with clients and families experiencing loss and grief. Nurses may find that it is easy to relieve physical symptoms associated with illness and death; however, it is difficult to become involved in meaningful

interpersonal relationships to support a person who is suffering or dying.

Personal feelings, values, and experiences influence the extent to which nurses can support clients and families during loss or death. Self - assessment, exploring personal attitudes, feelings, and values is necessary before nurses can [illegible]tive, therapeutic approach with [illegible]eveloping the art of being with [illegible]g and dying requires an inner [illegible] that arises from knowledge of and a positive belief in self. Formulation of a philosophy of life helps nurses function during difficult times. Knowledge of the concepts of loss and the grieving process enables nurses and other care givers to use creative interventions to promote health, prevent illness, and support dying clients.

Concepts and Theories of the Grieving Process

Grief is a normal response to any loss. Behaviors and feelings associated with the grieving process occur in individuals suffering losses such as physical deformities or deaths of close friends. They also occur when individuals face their own deaths. The person undergoes loss and the family experience grief. The concept and theories of grief are only tools that can be used to anticipate the emotional needs of clients and families and plan interventions to help them understand their grief and deal with it.

A nurse should not classify the client's grief; that is, the nurse should not identify a client as experiencing a certain phase of grief or working on a certain grief-related task. The nurse's role is to assess grieving behaviors, recognize the influence of grief on behavior, and provide emphatic support.

Engel's Theory

Engel (1964) proposes that the grieving process has three phases that can be applied to grieving and dying persons. These phases are:

1. Shock and disbelief;
2. Developing awareness; and
3. Reorganization and Restitution.

In the first phase, the individual denies reality of the loss and may withdraw, sit motionless, or wander aimlessly. To observers, it may seem that the person has not realized the implications of the loss. Physical reactions may include fainting, diaphoresis, nausea, diarrhea, rapid heart rate, restlessness, insomnia and fatigue.

In the second phase, the individual begins to feel the loss acutely and may experience desperation. Suddenly, anger, guilt, frustration, depression, and emptiness occur. Crying is typical as the individual becomes preoccupied with the loss. Crying seems to involve "*both an acknowledgement of the loss and the regression to a more helpless and childlike status*" (Engel, 1964).

In the third phase, inevitability of the loss is acknowledged. Anger or depression is no longer needed. The loss is clear to the individual, who begins to reorganize life. By experiencing these phases, a person moves from a lower to a higher level of emotional and intellectual integration. New self awareness is also developed.

Table 1: Comparison of 3 Theories of the Grieving Process

Engel (1964)	Kubler-Ross (1969)	Martocchio (1985)
Shock And Disbelief	Denial	Shock And Disbelief
	Anger	Yearning And Protest
Developing Awareness	Bargaining	Anguish, Disorganization and Despair
	Depression	Identification in Bereavement
Reorganization and Restitution	Acceptance	Reorganization and Restitution

Kubler-Ross Stages of Dying

The framework provided by Kubler-Ross (1969) is behavior oriented and includes five stages. In the denial stage the individual acts as though nothing has happened and may refuse to believe that a loss has occured. Statements such as "*No, that can't be so*", and "*It can't be happening to me!*" are common.

In the anger stage the individual resists the loss and may '*act out*' to everyone and everything in the environment. In the bargaining stage, there is postponement of the reality of the loss. The individual may attempt to make a deal in a subtle or overt way to prevent the loss. The client frequently seeks opinions of others, during this stage. A hospitalized client may show model behavior because of a belief that the staff will find a cure if he or she is a "*good patient*".

The depression stage occurs when the loss is realized and the full impact of its significance is apparent. This stage may be accompanied by overwhelming loneliness and withdrawal. The depression stage provides an opportunity to work through the loss and begin problem solving.

In the fifth stage, acceptance is reached. Physiological reactions cease and social interactions resume. Kubler-Ross defines acceptance as coming to terms with the situation rather than submitting to resignation or hopelessness.

Martocchio's Phases of Grieving

Although the grieving process has a predictable course and distinctive symptoms. No two persons progress through it in the same way or over the same time. A person progresses and then regresses until the loss is finally resolved. Martocchio (1985) describes five phases of grief that have over lapping boundaries and no expected order. The duration of grief is variable and depends on the factors influencing the grief response. Intense reactions of grief usually subside within 6 to 12 months and active mourning may continue 3 to 5 years. The saying: "*once bereaved, always bereaved*" remains true. To expect clients to progress in some specified manner over a specified time would be incorrect, inappropriate, and possibly harmful.

Table 2: Nursing Implications of Martocchio's Phases of Grief and Kubler-Ross' Stages of Dying (Porter and Perry, 1993)

BEHAVIORS	NURSING IMPLICATIONS
SHOCK AND DISBELIEF Denial Denial is an immediate response to news of loss or impeding loss. Physiological responses may include muscular weakness, tremors, deep sighs, flushed or cold and calmly skin, diaphoresis, and discomfort. Individuals avoid accepting reality of situation by not making decisions, they may attempt activities that they are no longer able to do, fail to comply with treatment, search for evidence that loss has not or will not occur, and appear artificially happy. Mood swings are common. Individuals isolate themselves from sources of accurate information or reject offers of comfort and support	Support emotional needs without reinforcing denial. Offer to remain with clients, without discussing reasons for behavior or need to cope, unless they bring it up. Offer regressive care, such as food, drink and safety.
YEARNING AND PROTEST Anger Individuals may express anger and retaliate against family, staff, physicians, or supreme being. Bereaved may express anger toward deceased. Individuals become demanding and accusing. Anger may precipitate guilt and lead to anxiety and lowered self-esteem. Individuals may feel resentful and jealous of others who still have loved object or loved one. Individuals may be reluctant to share feelings and thoughts.	Provide anticipatory guidance about feeling and their intensity experienced as part of grief; focus especially on anger. Do not take anger personally. Meet needs that cause angry response.
Bargaining Individuals are willing to do anything to avoid loss or change prognosis of fate. Individuals make bargains with supreme being. Individuals accept new forms of therapy.	Provide information needed for decision making.
ANGUISH, DISORGANIZATION, AND DEPSAIR Depression Reality and permanence of loss become recognized. Confusion, lack of motivation, disinterest, indecision, and crying are common.. Withdrawal from relationships and activities occurs. Individuals may become quiet and non-communicative. Feelings of loneliness surface. Reminiscence about past and lost object beings. Individuals may loose interest in appearance. Individuals may become suicidal or cope by beginning unhealthy behaviors such as excess drug use.	Provide support and empathy. Support caring by offering touch that communicates caring. Listen attentively. Assess risk of harm to self and refer to mental health professional if needed.

ACCEPTANCE Reorganization and Restitution Individuals accept terms of loss and death and begin plans for it. Individuals can share feelings about loss. Reminiscence about past occurs. Periods of depression and well-being occur. Good times begin to outweigh bad. Life begins to stabilize.	Offer opportunities to share feelings verbally, in writing or art, or by tape recordings. Allow and encourage review as often as clients want to talk. Show acceptance of liability of feelings. Assist in discussing future plans.

Conclusion

In conclusion, grieving has a therapeutic value, enabling people to think through their losses, recollect their thoughts, and resume life with new insights and direction. Caregivers must therefore endeavour to meet the physiological emotional, developmental and spiritual needs of clients during the grieving process or when approaching death.

Summary

This paper addresses the concept of loss, death, and grief and how various caregivers react to these conceprts. Loss is categorized, death is defined and grief is explained in its entirety. Furthermore caregivers like nurses are highlighted as important people in assisting relatives of sudden death victims and are believed to be emotionally involved when cases of sudden death arise.

References

Engel, G.L. (1964). Grief and Grieving. *American Journal of Nursing* 64:93.

Jenkintown, P.A. (1977). *Dealing with death and dying.* Chicago. Intermed. Communi-cations Inc.

Kubler-Ross, E.C. (1969). *Living with death and dying.* New York. Macmillan Publishing Company, Inc.

Marticchio, B.C. (1985). Grief and Bereavement: healing through hurt. *Nursing Clinician of North America* 20:327.

Porter, P. and Perry, A.G. (1993). *Fundamentals of Nursing: Concepts, Process and Practice* (3rd Edition). St. Louis. Mosby-year Book.

CHAPTER SIXTEEN

FEAR OF SUDDEN DEATH AND DYING AMONG RESIDENT POSTGRADUATE STUDENTS OF UNIVERSITY OF IBADAN

*A.N. Shenge and *S.K. Balogun, Ph.D.
Department of Psychology, University of Ibadan, Ibadan

Introduction

Death is the cessation of all life (metabolic) processes. It is inescapable among all living things (human beings inclusive). Death is a topic of importance to us all. The statistics on death are very convincing. Every human being, indeed every living thing, is bound to die. Owing to the fact that most people do not enjoy discussing death, most of us are poorly informed about a process that is as basic as birth. Death may involve the organism as a whole (somatic death) or may be confined to cells and tissues within the organism. The discontinuance of cardiac activity and respiration and the eventual death of all body cells from lack of oxygen characterize the death of an organism as a whole.

Death may come in two forms. Firstly, it may come suddenly, i.e. in a matter of minutes, hours or days; and secondly, it maybe un-sudden. Whereas sudden death refers to abrupt, immediate, instantaneous or unexpected death, un-sudden death refers to a non-abrupt, gradual and expected death. Coon (1997) notes that sudden death may result from a severe reaction of the parasympathetic system. During intense fear, for example, the parasympathetic may overreact. This reaction is called a parasympathetic bound. When it is severe it can sometimes cause death. In the case of older person or those with heart problems, Coon (1997) writes that the direct effects of sympathetic activation may be enough to bring about heart attack and collapse. Psychiatrist George Engel (1977) studied hundreds of sudden death occurrences and concluded that almost half of all sudden death are associated with the extremely traumatic disruption of a close relationship, such as the anniversary of the death of a loved one.

As opposed to sudden death, the process of un-sudden death is gradual and most times expected. Some people fall sick for three months or longer and die. Others experience terminal illness that lasts from a few days to three months or several years. They end up dying an un-sudden death. The non-abrupt, gradual and expected nature of un-sudden death stems from the fact that it sends signals or feelers pertaining to its occurrence. These feelers and signals are normally received by way of illness, injury or some other identified or unidentified cause(s). But unlike un-sudden death, sudden death does not give signals or send feelers of its impending occurrence to its victims by way of illness or injury. Even if and when signals or feelers are sent they are at least not known or received by the individual or victim. As it happens, many people never have time to deal with their own death in psychological terms. These are the people who die young or suddenly either from natural or accidental cause.