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Prevalence of Depression among Patients with Type 2 Diabetes Mellitus

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ABSTRACT

Objective: Estimate the prevalence of Depression among patients with Type 2 Diabetes mellitus and to assess the association between glycemic control and depression.

Materials and Method: The design adopted for the study was Cross sectional survey.The participants consisted of 240 patients with Type 2 diabetes mellitus with at least one year of duration disease, who were on prescribed treatment for Diabetes. The survey was conducted in a semi urban community there were a mix of people in various socio demographic strata. Exclusion criteria were chronic liver disease, chronic renal disease cancer, and severe anemia, people with recent blood loss or blood transfusion and pregnancy. A short depression scale validated in similar population was used for assessing the depression and glycemic control was estimated by glycosylated haemoglobin (HbA_{1C}) level using nepleometry.

Results: The overall prevalence of depression in the study group was 42.13% (101/240).There was a statistically significant association between depression and glycemic status, Chi square 5.183 at $1d_{(f)}$, P value 0.023.

Conclusion: The study concluded that the group with poor glycemic control are more depressed than the group with good glycemic control.

Keywords: *Depression, Type 2 Diabetes Mellitus, Glycemic Control.*

INTRODUCTION

Prevalence of type 2 diabetes mellitus is steadily increasing in our country with estimates of 8–15% in urban areas[1]. Optimal glycemic control is the major therapeutic goal in Diabetes mellitus. Hyperglycemia has been linked to the development of diabetic complications[1]. Treatments that lower blood glucose levels reduce the risks of retinopathy, neuropathy, and nephropathy in patients with type 1 or type 2 diabetes[2-6]. The presence of depression in a patient with diabetes has been suggested as one of the possible causes of an inadequate metabolic control. Literature showed that depressed patients could not achieve an adequate glycemic control despite intensive medical recommendations.

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An accurate estimate of co-morbid depression prevalence is needed to understand the potential impact of depression in patients with diabetes. Depression has been bi-directionally associated with Diabetes mellitus. Depressed patients are more likely to develop type 2 diabetes mellitus. It may be because of the metabolic abnormalities caused by the drugs used to treat depression or because of poor food choices and lack of physical activity that may accompany major depressive episode[7]. A study conducted in American Indians shown that The prevalence of depression was slightly, but not significantly, higher among participants with diabetes than those without diabetes (12.8% vs. 9.4%, p = .053). Among participants with diabetes, mean glycosylated hemoglobin levels were significantly

higher among depressed individuals than among those who were not depressed (9.0% vs. 8.4%, p = .02). Studies shown that Depression has been associated with diabetes[1] and poor glycemic control[8]. Anderson et al. conducted a meta-analysis of 42 studies investigating the association between depression and diabetes[9]. Diabetes affects 25.8 million people in the U.S., according to the 2011 National Diabetes Fact Sheet, and about 30 percent of these people also experience symptoms of depression. Depression is also associated with poor adherence to diabetic medications and dietary regimes. There is also lesser physical activity, reduced quality of life, and increased heath care expenditure in patients with diabetes and depression[10-14] .

MATERIAL AND METHOD

The objective of the study was to estimate the prevalence of Diabetes mellitus and to assess the association between poor glycemic control and depression. The design adopted was cross sectional survey. The patients with the diagnosis of type 2 Diabetes and on prescribed medical treatment were selected as participants of the study. Their diabetic status was ascertained by the physician's prescription. The patients with the history of chronic liver disease, Chronic renal disease cancer, severe anemia, people with recent blood loss or blood transfusion and pregnant women were excluded from the study because these are the factors that have an influence on glycemic status. The setting of the study was a semi urban area in Thriruvananthapuram district. The protocol got ethical clearance from the Institutional research committee. The estimated sample size was 240 diabetic patients. The gatekeepers were informed and prior permission was sought from the participants for data collection. A written informed consent was obtained from the patient before data collection. The data collected include socio demographic data, clinical characteristics. Depression was assessed by a brief questionnaire which was validated in the similar population which has a reliability, Cronbach's alpha 0.8048. Glycosylated heamoglobin level was considered as the proxy measure of glycemic control, which was estimated by boronate affinity assay.

FINDINGS

Data were entered in the software were Microsoft excel, data cleaned & statistical analysis was done using R and Epi info. The first step in the data analysis was to assess the descriptive statistics of the baseline variables of the participants enrolled in the study. Descriptive statistics were calculated for baseline variables (table 1). Out of 240 participants, 69 (28.8%) males and 171 (71.3%) females were included. The mean age was 59.87 (SD 9.71) years. Majority of the participants were Hindus 155 (64.6%) followed by Muslims 43 (17.9%) and Christian 42 (17.5%). About 143 (59.6%) were lived in urban area and 10 (4.2%) were from the costal region. In the group majority were married 187 (77.9%) and the remaining 53 (22.1%) were a mix of unmarried, widow/widower, Divorced and separated. The majority were belonged to middle class 87.5%) and 08 (3.2%) were in Upper class and 09 (3.6%) in Lower class.

Table 1- Baseline Characteristics of the participants

Variable		Number (percentage)
Age	< 60 years	138 (57.5%)
	> 60 years	102 (42.5%)
Sex	Male	69 (28.8%)
	Female	171 (71.3%)
Religion	Hindu	155 (64.6%)
	Muslim	43 (17.9%)
	Christian	42 (17.5%)
Area of residence	Rural	143 (59.6%)
	Urban	87 (36.6%)
	Costal	10 (4.2%)
Marital Status	Married	187 (77.9%)
	Un married	01 (0.4%)
	widow/ widower	42 (17.5%)
	Divorced	07 (2.9%)
	Separated	03 (1.3%)
Family type	Nuclear	171 (71.3%)
	Joint	07 (2.9%)
	Extended	62(25.8%)
Socio economic status	Upper class	08 (3.2%)
	Upper middle class	162 (67.5%)
	Lower middle class	48 (20%)
	Upper lower class	14 (5.7%)
	Lower class	09 (3.6%)

The major clinical parameters assessed were duration of DM, Co morbidity, Body mass index

And history of hospitalization. The data on clinical characteristics were included in table No 2.

Table – 2 Clinical characteristics of participants

Variable		Number (percentage)
Duration of DM	< 1 year	22 (9.3%)
	5 years	107 (44.6%)
	6-10 years	33 (13.6%)
	> 10 years	78 (32.5%)
Co morbidity	Yes	96 (40%)
	No	144 (60%)
BMI	Normal	97 (40.4%)
	pre obese	68 (28.2%)
	obese I	39(16.1%)
	obese II	36(15.3%)
History of hospitalization	Yes	86 (36.3%)
	No	154 (64.2%)
Adherence to drug	High adherence	67(27.9%)
	Medium adherence	92 (38.2%)
	Low adherence	81(33.9%)
Adherence to diet	Complete adherence	135(56.4%)
	Partial adherence	81 (33.9%)
	Poor adherence	24(9.6%)
Blood glucose estimation	less than 1 month	127(52.9%)
	2 - 3 months	23 (19.6%)
	4 - 6 months	48 (20.0%)
	> 6 months to 1 year	11(4.6%)
	> 1 year	71(2.9%)

The percentage of depression among patient with good glycemic control was 30.30% (20/66) but in group with poor glycemic control the percentage of depression was 46.55% (81/174). Thus the effect size was 16.25%. The association between depression and glycemic status was estimated by Chi-square test 5.183 at 1d $_{(f)}$, P value 0.023.The odds ratio is 2 with a confidence interval of 1.05 to 3.83

Table–3 Association of Depression and glycemic control

Glycemic status	Depre-ssion absent	Depre-ssion present	Total	Significance	
Good control	46	20	66	$\chi 2$ =5.183 P = 0.023 Significant	**Odds ratio** OR = 2 CI 1.05 to 3.83 Significant
Poor control	93	81	174		
	139	101	240		

DISCUSSION

The growing burden of non-communicable diseases constitutes of the major challenges facing our country in the present century. Among these, increasing incidence of Diabetes is a pressing issue. The available literature suggest that many cross sectional surveys revealed that co morbid depression is present among patients with type 1 and type 2 Diabetes mellitus. The present study also adopted a cross sectional survey. The findings corresponds th metas analysis done by Lustman PJ, Anderson RJ, Freedland KE, et al. in 2000 8. The odds ratio obtained in the study OR = 2 with a Confidence interval of 1.05 to 3.83 also corresponds to the Indian study done in Ludiana in 2014.

CONCLUSIONS

It is concluded that that the group with poor glycemic control are more depressed than the group with good glycemic control. There is a significant difference in depression across two groups. These evidences suggest that, for the achievement of optimal glycemic level it is essential to address the presence of co morbid depression.

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Conflict of Interest: There were no conflicts of interest reported.

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A Comparative Study to Assess the Level of Social Phobia among Adolescents in Selected Urban and Rural Higher Secondary Schools at Bengaluru, with a View to Develop an Information Guide Sheet

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ABSTRACT

Background of study: Social phobia is the most common anxiety disorder and the third most common psychiatric disorder, after major depressive disorder and alcohol dependence. Lifetime prevalence estimates for social phobia vary greatly and range from 0.4 to 20.4 % in different studies. Among the more well know epidemiological studies, the Epidemiological Catchment Area Survey in 1991 suggests a lifetime prevalence of social phobia at 2.73%. Also, estimates of more than 8,000 individuals from the National Co morbidity Survey in 1994, suggests the lifetime prevalence of social phobia at 13.3%.To provide comprehensive care, nurse has to assess the level of social phobia among adolescents. Hence this study has been conducted to assess the level of social phobia among adolescents of selected rural and urban higher secondary schools with a view to develop an information guide sheet.

Objectives of study: To assess the level of social phobia among adolescents in selected urban and rural higher secondary schools. To compare the level of social phobia between adolescents of urban and rural higher secondary schools. To find the association between level of social phobia among adolescents of urban and rural higher secondary schools with selected socio demographic variables.

Method: The study involved non experimental approach, and comparative descriptive research design with simple random sampling technique. To collect the data from respondents, modified social phobia inventory was used and administered to 120 adolescents (60 rural and 60 urban adolescents) following inclusion and exclusion criteria. The tool consisted 30 items regarding assessment of social phobia. The results were described by using descriptive and inferential statistics.

Results: The mean score of rural participants 51.50 with mean percentage 42.9% and standard deviation 10.1 was high when compared to mean knowledge score of urban participants 35.45 with mean percentage 29.5% and standard deviation 11.0. Hence the 't' value 4.58* was significant at 5% level. Hence rural adolescents are having more social phobia than urban adolescents.

With regard to rural participants there is significant association between the Level of Social Phobia and selected demographic variables like age (years) (c2 =6.67), gender (c2 = 6.27), religion (?2 =8.10) and type of family (?2 = 6.75) at 5% level. There is no significant association between demographic variables

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such as class studying (?2= 2.88), special talent(?2= 1.91), education of father (?2 =4.38), education of mother ((?2 = 6.22), family income/month (?2 = 2.13) and source of information(?2 = 3.39)With regard to urban participants there is significant association between the Level of Social Phobia and selected demographic variables like age (years) (c2 =4.34), gender (c2 = 5.34), religion (?2 =4.17) and type of family (?2 = 6.01) at 5% level. There is no significant association between demographic variables such as class studying (?2= 0.61), special talent (?2= 1.44), education of father (?2 =3.17), education of mother ((?2 = 5.54), family income/month (?2 = 1.57) and source of information(?2 = 5.55)

Interpretation and Conclusion: The overall findings of the study clearly showed that most of the rural adolescents are having mild (80%) to moderate (20%) social phobia and only few of urban adolescents are having mild (56.7%) and most of them (43.3%) have no social phobia. Rural adolescents are having more social phobia than urban adolescents. Hence Health education programme should incorporated in urban and rural areas to reduce the level of social phobia and its complications in adolescents.

Keywords: *Assess, Social phobia, Adolescents age group of 13-16 years , rural , urban and Information guide sheet*

INTRODUCTION

Illness and hospitalization are the first crisis, children face during early infancy and childhood, hospitalization is the disruption of the life of children and their families the children reaction to the hospitalization and coping strength depend on the age, development stage, body image, fear, reason for hospitalization and previous hospitalization[1] .Anxiety is an emotional response to a threatening situation and its most commonly seen in children specially who are undergoing invasive procedures and treatment[2]. In clinical anxiety classified in to four forms, situational anxiety, disease related anxiety, treatment related anxiety and pre-treatment anxiety disorder[3]. Pre-operatively anxiety correlates with a high incidence of post-operative pain, it leads increase in analgesics, anesthetics requirement and delayed recovery and discharge from hospital[7]. Investigator felt acupressure is effective reduction of anxiety among hospitalized children under going invasive procedures. Acupressure is a traditional Chinese medicine body work technique based on the same ideas as acupuncture, it involves placing physical pressure by hand, elbow or with the aid of various device on different pressure point on the surface of the body and metabolic energies in the body. These points commonly called as a acupoint or acupressure points[4].

STATEMENT OF THE PROBLEM

"A comparative study to assess the level of social phobia among adolescents in selected urban and rural higher secondary schools at Bengaluru, with a view to develop an information guide sheet".

Conceptual framework: The present study conceptual framework is based on Roy's adaptation model.

ASSUMPTIONS

1. The adolescents may have social phobia.

2. There may be a difference between the level of social phobia among urban and rural adolescents.

Research methodology: A non-experimental research approach was considered the best to assess the level of social phobia among adolescents of selected rural and urban higher secondary schools. A Comparative descriptive research design was adopted. The study was conducted in the following selected rural and urban higher secondary schools in Bangalore district. The ***V.E.S Model convent Tavarekere*** (Rural school) and St***. Catherine high school Cotton pet, Bangalore*** (Urban school) was selected for the study. In the present study, the populations were adolescents between age group of 13to 16 years studying. The ***V.E.S Model convent Tavarekere*** comprising 1500 students and out of adolescents between age group of 13 to 16 years were about 350 in number. In urban the populations

were adolescents between age group of 13to 16 years studying at St. Catherine high school cotton pet, Bangalore (Urban school).The St. Catherine high school cotton pet, Bangalore comprising of 800 students and about 250 students between age group of 13 to 16years. The total sample size of the study consists of 120 adolescents and further it is divided into 60 adolescents from selected rural higher secondary school and 60 adolescents from selected urban higher secondary school. Subjects were selected by simple random sampling technique.

The data was collected by using modified social phobia inventory. The tool was selected and developed based on the research problem, review of the related literature and with suggestions and guidance of the experts in the field of psychiatric Nursing, The tool consisted of 2 Sections.

Section I: Consists of questions on demographic variables such as age, gender, religion, place of study, studying in, residing at, education of father, education of mother, family income per month, type of family, special talents and source of information.

Section II: It consists of 30 items to assess the level of social phobia among adolescents.

SCORING INTERPRETATION

The number of items in modified social phobia inventory included 30 and each item is rated 0, 1, 2, 3,4 that is not at all, a little bit, somewhat, very much and extremely. In this a response carries one score and maximum score of 4 and total maximum score of 30 items is 120.

The total samples of the main study consisted of 60 rural and 60 urban adolescents. After obtaining consent from participants, data was collected from the samples by administrating modified social phobia inventory. It has taken 40 minutes to complete the social phobia inventory and it took four weeks to complete the study. It was found that the items were simple and comprehensive.

FINDINGS OF STUDY

i. Findings related to demographic characteristics

Among rural participants 50% were between 13-14years, and 50.0% belonged to 15-16 years. Among urban participants 50% were between 13-14years, and 50.0% belonged to 15-16 years.

Among rural participants majority of them, 60.0% were females and 40.0% were males. Among urban participants majority of them, 51.07% were females and 48.03% were males.

Among rural participants with regard to class of studying, 56.07% were 10th Std, 30.0% were 9th Std and 13.03% were 8th Std. Among urban participants with regard to class of studying, 33.03% were 10th Std, 31.07% were 9th Std and 35.0% were 8th Std.

Among rural participants with regard to residing place majority of 100.0% were residing at home. Among urban participants majority of, 100.0% were residing at home.

Among rural participants majority 53.04% had Special talent in Games, 33.3% had Special talent in singing and 13.3% had Special talent in Dancing. Among urban participants majority 41.7% had Special talent in Games, 40.0% had Special talent in singing and 18.3% had Special talent in Dancing.

Among rural participants with regard to income of family, 40.0% have income of Rs 5000-10000, 38.3% have income of Rs. 11,001-25,000 and 21.07% have income of Above Rs. 25,000. Among urban participants with regard to income of family, 46.6% have income of Above Rs. 25, 000, 41.7% have income of Rs. 11,001-25,000 and 11.07 % have income of Rs. 5, 000-10,000.

Among rural participants most of them 83.3% belong to nuclear family and 16.7% belong to joint family. Among urban participants majority of them 63.3% belong to nuclear family and 36.7% belong to joint family.

Among rural participants majority 93.3% belong to Hindu and 6.7% belong to Muslim religion. Among urban participants majority 91.7% belong to Hindu and 8.3% belong to Muslim religion.

Among rural participants with regard to source of information most of, 48.4% were getting information from health professional, 40.0% from electronic media, 8.3% from others and 3.3% from print media.

Among urban participants with regard to source

of information majority are, 65.0% were getting from Electronic media, 21.7% from Print media, 11.7 from health professional and 1.6% from others.

Among rural participants with regard to education of father 30.0% had secondary education, 30% had degree education, 25.0% PUC and 15% had primary education. Among urban participants with regard to education of father majority 51.7% had secondary education, 23.3% had primary education, 20.0% had PUC and 5.0% had degree education.

Among rural participants with regard to education of mother majority, 51.7% had secondary education, 21.7% had PUC, 11.6 % had degree education, 10% had primary education and 5% had no formal education. Among urban participants with regard to education of mother 30% had primary education, 30% secondary education, 28.4% had no formal education, 8.3% had PUC and 3.3% had degree education.

ii. Finding related to Assessment of level of social phobia among adolescents of

RURAL AND URBAN HIGHER SECONDARY SCHOOLS

The highest mean percent score of rural participants found in the aspect of speaking with unknown person (45.6%), standard deviation (%) (9.2). the lowest mean percent was found in the aspect of participation in school activities (37.0%) standard deviation (%) (15.1). the overall mean score of rural participants found to be 51.50, mean (%) 42.9% and SD value 12.1, SD (%) 10.1%.

The highest mean percent score of urban participants found in the aspect of speaking with unknown person (34.4%), standard deviation (%) (13.2). the lowest mean percent was found in the aspect of Participation in school activities (20.5%), standard deviation (%) (16.2). the overall mean score of urban participants found to be 35.45, mean (%) 29.5% and SD value 13.2, SD (%) 11.0%.

iii. Finding related to Comparison of the level of social phobia among adolescents

Of rural and urban higher secondary schools

The mean score of rural participants 51.50 with mean percentage 42.9% and standard deviation 10.1was high when compared to mean knowledge score of urban participants 35.45 with mean percentage 29.5% and standard deviation 11.0. Hence the 't'value 4.58* was significant at 5% level. Hence rural adolescents are having more social phobia than urban adolescents.

iv. Finding related to Association between level of social phobia among adolescents of urban and rural higher secondary schools with selected socio demographic variables

With regard to rural participants there is a significant association between the Level of Social Phobia and selected demographic variables like age (years) ($\chi2$ =6.67), gender ($\chi2$ = 6.27), religion ($\chi2$ =8.10) and type of family ($\chi2$ = 6.75) at 5% level.

There is no significant association between demographic variables such as class studying ($\chi2$= 2.88), special talent($\chi2$= 1.91), education of father ($\chi2$ =4.38), education of mother (($\chi2$ = 6.22), family income/month ($\chi2$ = 2.13) and source of information($\chi2$ = 3.39)

With regard to urban participants there is a significant association between the Level of Social Phobia and selected demographic variables like age (years) ($\chi2$ =4.34), gender ($\chi2$ = 5.34), religion ($\chi2$ =4.17) and type of family ($\chi2$ = 6.01) at 5% level.

There is no significant association between demographic variables such as class studying ($\chi2$= 0.61), special talent($\chi2$= 1.44), education of father ($\chi2$ =3.17), education of mother (($\chi2$ = 5.54), family income/month ($\chi2$ = 1.57) and source of information($\chi2$ = 5.55)

Acknowledgement: Nil

Conflict of Interest: Social phobia is the most common anxiety disorder and the third most common psychiatric disorder, after major depressive disorder and alcohol dependence. Lifetime prevalence estimates for social phobia vary greatly and range from 0.4 to 20.4 % in different studies. In India, there has been study conducted on social phobia (among high school adolescents) which mentions a prevalence of 12.8% and also an association with impairment in academic functioning.

Ethical Clearance: Ethical clearance was obtained from the ethical committee of the college

Funding Sources: Not obtained any from funding sources

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Effectiveness of Structured Teaching Programme on Knowledge Regarding Contraceptive Methods among Married Women of Reproductive age Group: a Pre-experimental Study

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ABSTRACT

The trysts on contraceptive use have received scholarly attention in family planning literature, but there have been few attempts to understand the reasons behind apprehension, and the context of future Millennium Declaration where universal access to contraceptive methods was reemphasized as the cost-effective way of reducing maternal mortality. Family planning research intention to use contraceptives in India[1].

A Pre-experimental study-one group pre test and post test design was selected to assess the effectiveness of structured teaching programme on knowledge regarding contraceptive methods among married women of reproductive age group in selected areas, Jalandhar, Punjab through convenience sampling technique. Data was collected through using self structured knowledge questionnaire. Researcher introduced herself and explained the purpose of study to the sample. Written informed consent was taken from each sample. Pre test was administered to the group followed by structured teaching programme which took about 45 minutes. Post test was taken after one week of administration of structured teaching programme.

The findings of the study showed that pre test mean knowledge score was 14 out of 33 whereas post test mean knowledge score was 22 out of 33. Therefore, the difference of pre test and post test mean knowledge score of married women was statistically significant. Hence it was concluded that structured teaching programme regarding contraceptive methods had significant impact on knowledge of married women.

Knowledge of married women was found to be statistically associated with source of information. Based on the study findings, it suggests that health education programmes regarding contraceptive methods should be conducted timely for married women.

Keywords- *Knowledge Structured teaching programme, Effectiveness, Contraceptive methods, Married women.*

INTRODUCTION

Knowledge is power. Information is liberating. Education is the premise of progress, in every society, in every family..... ***Kofi Annan***

Birth spacing refers to the time interval from one child's birth date until the next child's birth date. However, researchers agree that 2 ½ years to 3years between births is usually best for the well being of mother and her children. Infants and children under five years of age, births spaced at least 36 months apart are associated with the lowest mortality risk.

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Likewise birth to conception intervals of less than 6 months as well as abortion, pregnancy intervals of less than 6 months are associated with increased risk of preterm births, low birth weight and small for gestational age as well as are associated with increased risk of maternal mortality and morbidity. Birth spacing is the interval between births that provides the greatest health, social and economical benefits for family. Enabling couples to determine when they will have children is vital to safe motherhood and healthy children.[2]

A method which is quite suitable for one group may be unsuitable for another because of different cultural patterns, religious beliefs and socio – economic milieu. A full range of contraceptive methods includes male and female condoms, barrier methods, oral contraceptives, implants, injectables, intra uterine devices, female sterilization and emergency contraceptive. The success of any contraceptive method depends not only on its effectiveness in preventing pregnancy but on the rate of continuation of its proper use. Consistent and correct use of modern methods of contraception can prevent mistimed or unwanted pregnancies.[3]

Female sterilization is the most prevalent form of contraception in India, accounting for 76% of all use among women. Use rates of temporary modern contraceptive methods are very low. Previous studies have identified barriers to contraceptive use, which include the monetary and time costs of obtaining contraception the social stigma of using contraceptives in an unsupportive setting, lack of knowledge desire for more children the costs of acquiring additional information and worry over possible side-effects and fears that reversible methods are ineffective. Historically, Indian health providers have emphasized female sterilization; this may also limit the uptake of reversible contraception.[4]

Many a times women shy away from using contraception mainly because they lack knowledge and are afraid of sterilization; copper T or pills does not suit them; or injection is not available etc; thereby have to carry the burden of unwanted pregnancies or go for abortion which is mainly unsafe, having knowledge of wide range of contraceptive methods helps women to overcome such difficulties.[5]

The rise in contraceptive practices however did not match the significant fall in estimated birth rate. The dynamics of contraceptive use among women in postpartum period i.e. the period of a year after the birth of a child, is of interest at the family planning programme level, since the delay of contraceptive use until the return of menstruation might increase of unwanted pregnancy. Further, unintended pregnancy poses a major challenge to the reproductive health of young adults in developing countries like India. With the age decreasing of menarche and onset of sexual activity, youths are exposed early to unplanned and unprotected sexual intercourse leading to unwanted pregnancies and invariable abortions. The essential aim of family planning is to prevent the unwanted pregnancies.[6]

Worldwide only 56.1% of women aged 15-45 who are married or in a union are using modern contraception. There are an estimated 220 million women in developing countries with an unmet need or modern contraception. These are women of reproductive age who are sexually active and wish to avoid pregnancy but are not using modern contraceptive method.[7]

Contraceptives provide a safe and effective method and more than 50% of married women of the reproductive age worldwide use it. Contraceptives are a low cost and low maintenance method rendered in its use. While many studies have tried to investigate women's knowledge, attitude and practice regarding contraceptives. These issues have proven difficult to measure. Estimates of how much women know about contraceptives vary greatly.[8]

As of the above studies showed that knowledge regarding contraceptive methods is less among married women, by providing the knowledge regarding contraceptive as a part of routine reproductive health can help married women to avoid unplanned pregnancy and also prevent complications associated. So, the investigator felt the need to identify the knowledge of women regarding contraceptive use and to plan structured teaching programme to increase their knowledge regarding contraceptives**.**

MATERIAL AND METHOD

Research design: The research design selected for the study was Pre-experimental (one group pre test and post test) design to evaluate the effectiveness of Structured Teaching Programme on Knowledge regarding contraceptive methods.

Research setting: The study was conducted in Kukar Pind and Kot kalan Jalandhar, Punjab among married women. The population of married women was 1900

and in Kot kalan 630. There was one secondary school, one anganwadi and one dispensary at Kot Kalan.

Target population: The target population of this study consisted of Married women of reproductive age from village Kukar Pind, Kot kalan, Jalandhar.

Sample and Sampling technique: The total sample size was 120 Married women of reproductive age selected by using convenience sampling technique.

Inclusion and Exclusion criteria

Inclusion criteria

- Married women who were present at the time of data collection.

Exclusion criteria:

- Married women who were having age above the reproductive age.

Variables

- Dependent variable: knowledge regarding contraceptive methods.
- Independent variable: structured teaching programme on contraceptive methods.
- Socio-demographic variables: Age (in years), Parity, educational status, occupation, monthly family income, religion, source of information, present use of contraception by either partner.

Selection and development of tool

The tool was developed by referring books, articles, journals, websites, and guidance of experts. Structured teaching programme and self structured knowledge questionnaire was developed to collect the data.

Description of tool

To accomplish the objectives of the study, a tool consisted of three sections.

Section I- Selected socio demographic variables

This part consisted of 8 items for obtaining information about socio demographic variables related to nursing students such as Age (in years), Parity, educational status, occupation, monthly family income, religion, source of information, present use of contraception by either partner.

Section II- Self structured knowledge questionnaire which contained 33 multiple choice questions regarding definition of contraceptive methods, types of contraceptive methods, description of temporary contraceptive methods. For every correct response score was 1 and for every incorrect response score was 0. Maximum score was 33 and minimum score was 0.

Criterion measure

Level of knowledge	Score	Percentage
Excellent	>22-33	≥66%-100%
Good	>11-≤22	>33%-≤66%
Average	00-≤11	≤33%

Maximum score- 33

Minimum score-00

Section III- Structured teaching programme on contraceptive methods.

Validity of tool: Content validity was established by obtaining valuable opinions and suggestions from experts to know about the adequacy, appropriateness and completeness of the content of instrument and to make amendments in the final study to get better results. The tool was edited by English and Punjabi language expert.

Reliability of the tool: The reliability of the tool was obtained by split half method by using Karl Pearson's co-efficient of correlation and spearman's brown prophecy formula. The reliability of the tool was 0.9. Hence the tool was reliable.

Data collection procedure: Data was collected during the month of July 2014 among 120 married women by using convenience sampling technique. Kukar Pind and Kot kalan villages were selected to conduct the study as investigators found lack of knowledge regarding contraceptives among married women. Firstly pre test was taken for base line assessment and then structured teaching programme was given on contraceptive methods to enhance the knowledge of married women of reproductive age group and after 3 days post test was done.

Ethical consideration: Written permission was taken from Principal of SGL Nursing College Semi, Jalandhar, Punjab. Written permission was taken from ethical clearance committee of the college. Written Informed consent was taken from each study sample.

Plan for data analysis: Analysis was done according

to the objectives of the study. Descriptive and inferential statistics was used to do analysis.

Major findings

- 31 Married women belong to age group of 21 - 25years
- 56 Married women were Multipara.
- 59 Married women were Matric pass.
- 101Married women were House wives.
- 40 Married women had family monthly income Rs≤ 5,000.
- 61married women belong to Hindu family.
- 56 married women had source of information from health professional.
- 51 married women partner's were using condom.
- The overall Pre test mean knowledge score was 14 out of 33 whereas post test mean knowledge score was 22 out of 33.
- Majority of the 64% married women had good knowledge in pre test but in post test 70%

  had excellent knowledge score.
- The difference between pre test and post test mean knowledge score was statistically significant. It was interpreted that Structured teaching programme regarding contraceptive methods was effective.
- Regarding association between knowledge and selected socio demographic variables it was concluded that there was significant association between knowledge and source of information.

CONCLUSION

- The overall Pre test mean knowledge score was 14 out of 33 whereas post test mean knowledge score was 22 out of 33.
- Majority of the 64% married women had good knowledge in pre test but in post test 70%

  had excellent knowledge score.
- The difference between pre test and post test mean knowledge score was statistically significant. It was interpreted that Structured teaching programme regarding contraceptive methods was effective.

Acknowledgement: With immense joy and love I deeply indebted to our esteemed Ms. Lalita Kumari Professor cum Principal, Ethical Clearance Committee and Research Expert of S.G.L Nursing College, Semi, Jalandhar whose encouragement and support were source of inspiration throughout the study period.

CONFLICTS

It was difficult to collect sample together at one place and investigator has to provide teaching on individual basis.

Source of Funds- Project carried on individual basis.

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Effectiveness of Self-instructional Module (SIM) on Knowledge of Parenting Skills for Parents of Adolescents Living in a Selected Community in Mangalore

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ABSTRACT

BACKGROUND: Everyday there is a rise in the percentage of adolescents who commit suicide, dropout from school, consume drugs, involve in assaults, rapes and robbery. Adolescents require longer periods of assistance from parents to face the "storm and stress" in their transition phase. Learning to rear moral children in today's immoral world and learning to be good and effective parents are challenging. In order to nurture the special relationship between the parents and adolescents and fulfil the roles as parents, there are a number of things that can be done. Parents have a major share in socialising their adolescents, helping them to achieve a sense of reality and identity in meeting their needs by using effective parenting skills. If parents fail in these areas, it is reasonable to expect that their adolescent will be damaged socially and psychologically.

AIM: To determine the effectiveness of self-instructional module on knowledge of parenting skills developed for parents of adolescents.

METHOD: An evaluative approach with quasi-experimental one group pretest-posttest design was used in the study. Sixty parents of adolescents from 60 families were drawn from the population as sample by using network sampling technique. Pre-test was conducted by using demographic proforma and structured closed ended knowledge questionnaire and a self-instructional module on "parenting skills for adolescence" was distributed for the parents. The post-test was conducted on the seventh day using the same tool. Data collected from the sample was analysed using descriptive and inferential statistical techniques.

RESULT: The mean post-test knowledge score of parents (24.18) was apparently higher than mean pre-test knowledge score (15.30)which showed the effectiveness of self instructionalmodule.The significance of difference between the pre-test and post-test knowledge scores of parents was statistically tested using paired 't' test and was found to be highly significant ($t_{(59)}$ =34.99, $p < 0.05$).The pre-test knowledge of parents compared with demographic variables showed an association between pre-test knowledge of parents and religion.

CONCLUSION: The present study revealed that the parents had less knowledge regarding "parenting skills for adolescence" and the overall findings of the study indicated that there was an increase in the knowledge of parents on parenting skills following the distribution of self-instructional module. Therefore it was concluded that the self-instructional module was highly effective in improving the knowledge of parents.

Keywords: *Parenting skills; parents; adolescents*

BACKGROUND & OBJECTIVES

"Parenting as a process, is as old as humanity. While parenting is not rocket science, it is probably the most overwhelming and important endeavour many of us undertake in our life time"[1]. It is recognized that in a rapidly changing world, there

are children who are badly affected by neglectful, inappropriate and sometimes abusive parenting. Globally 1.2 billion adolescents are preparing to enter into adulthood[2]. In India, adolescents constitute 21.4 percent of the population, comprising one fifth of the total population[3]. Although adolescence is a stage of life which is exciting, it is also one of the most difficult times of their lives, during which he or she may experience a crisis. Adolescent crisis occurs because this stage is characterized by rapid biological and psychological changes, intensive readjustment to the family, school work and social life and an unrelenting process of preparation for adulthood. During this turbulent phase of life the demands for new social roles take place; the adolescent is compelled to face new and stunning emotions[4]. Today millions of adolescents are faced with the prospects of depression, suicide, substance abuse, juvenile crime and adolescent pregnancy. Researchers report that 70 percent of mortality among adults in India can be linked to habits picked up during adolescence[5]. Adolescents in India are also having increasing incidence of problems such as depression (one in eight), mental health disorder (one in five), emotional disturbance (one in ten), suicide (one in three), pregnancy and crime. Globally, among adolescents, suicide is the third leading cause of death[6]. Peer pressure and the desire for experimentation make many adolescents to become enslaved to tobacco use as well as liquor. These two addictions have been recognised as preventable causes of death and disability worldwide. According to World Health Organisation reports it is estimated that, among adolescents, 4.9 million deaths annually are attributed to tobacco use in the global scenario. One fifth of world wide death due to tobacco use occurs in India. The figure is expected to rise to 10 million in 2030, with 7 millions of deaths occurring in developing countries, mainly China and India[7]. Also there is a huge body of research literature on the prevalence of emotional and behavioral problems in adolescents which are expected to have an impact on ongoing levels of well-being and functioning and also on the developmental trajectory towards adulthood. Thus in the search for equilibrium, the adolescent may struggle against many situations which puts them in a mental dilemma or confusion. This could be a turning point for an adolescent to be an excellent social personality in adult life or an unacceptable antisocial personality. Unless the crisis is dealt with properly, the adolescent cannot smoothly overcome this transient phase to become a responsible adult.

The educational and health status of adolescents, their readiness to take on adult role and responsibilities and the support they receive from their families and communities will determine their own future and the future of communities[8]. The family, especially parental influence on upbringing of an adolescent is vital for the overall development. But the changing family structures, living conditions, parent's childrearing practices, overtly strict parental discipline, marital discord between parents, family economic status and lack of communication among family members are observed to be responsible for adolescent problems[9].

Unless the crisis is dealt properly, the adolescent cannot smoothly overcome this transient phase to become a responsible adult.Parents are a very important influence in an individual's life, since they are the first social and environmental model influencing the overall development, this is more so in the life of an adolescent who is going through a period of storm and stress due to physical, physiological and emotional changes. Lack of parenting techniques and skills affect an adolescent differently. Parents face multiple challenges that may inhibit their ability to effectively raise and support their children. Historically, parents have had knowledge and skills passed down to them by their own. But, as families have become smaller and separated by distance, the ease of passing on the accumulated child rearing wisdom has decreased. This has led to inadequate parenting techniques and skills which result in the adolescent becoming poorly behaved. Parental education help to make parenting a little easier, and can be followed to correct and improve a person's parenting skills. In addition, parent education provides information and skills to support healthy family and child development and assist parents in building the capacity of their families and the resilience of their children.

The objectives of the study were to:

1. assess pre-test knowledge scores among the parents on parenting skills for adolescence.
2. determine the effectiveness of self-instructional module on knowledge of parenting skills developed for parents of adolescents.
3. find the association between the pre-test

knowledge of parents and selected demographic variables.

MATERIAL & METHOD

The research design adopted for the study was quasi experimental, one group pretest-posttest design. The study was conducted in Talapady village under Kotekar PHC, Mangalore.The study sample consisted of sixty families having adolescents and one parent from each family was selected as the sample using network sampling. A demographic proforma to gather the baselinedata and a structured closed ended knowledge questionnaire on "Parenting Skills for adolescence" was developed as the tool to collect data. The multiple choice questions in the tool was sectionalised into meaning and problems of adolescence, meaning, elements, types, techniques and skills of parenting There were 30 items in the tool with a maximum possible score of 30. The score was categorized arbitrarily as 740% (Poor), 41 – 60%(Average), 61 – 80%(Good) and 81 – 100%(Very good). A SIM on "Parenting skills for adolescence" was developed to distribute to the parents in order to provide information on parenting skills. The investigator contacted each parent personally and obtained their consent for the study. Pre-test was administered to them using demographic proforma and questionnaire on day 1. Self-instructional module on "Parenting skills for adolescence" was distributed to the subjects on the same day. Post-test was conducted using the same questionnaire on the seventh day of pre-test. Both descriptive and inferential statistics was used to compute the data.

RESULT

Frequencies, percentage, mean, median, mean percentage and standard deviation was used to analyse the knowledge score. The't' value was computed to show the effectiveness of self-instructional module and chi-square test was done to determine the association between the pre-test knowledge of parents and demographic variables. The demographic information of the sample revealed that maximum percentage of the parents (38.3%) was in the age group of 31 – 40 years, majority were females (70%), and completed their primary school (48.3%). Majority of parents involved in the study were house wives (60%), and were Hindu (46.7%), and the findings related to marital status showed that majority of the parents (86.7%) were married. Distribution of samples related to number of children in the family revealed that maximum percentage of the parents (33.3%) had more than three children. The findings showed that the mean post-test knowledge score of parents (24.18) was apparently higher than their mean pre-test knowledge scores (15.30) on parenting skills. Section-wise analysis showed that the post-test mean percentage knowledge score of parents in all content areas were higher than their pre-test mean percentage knowledge score. The maximum modified gain score was in the area of meaning of parenting (0.84) and the least was in the area of problems of adolescence (0.52). Pre-test findings showed that majority of parents of adolescents (81.7%) had "average" knowledge and 18.3% of them had "poor" knowledge regarding parenting skills whereas in the post-test for majority of the parents of adolescents (60%) their achievement was "very good" knowledge and 40% parents had improved with "good" knowledge. Paired 't' test used to analyze the difference between pre-test and post-test knowledge scores of parents showed that the calculated't' value ($t_{(59)}$=34.99) was greater than the table value ($t_{(59)}$=2.00) which revealed that there is a significant increase in the mean post-test knowledge score compared with mean pre-test knowledge score. The section-wise 't' value computed between pre-test and post-test scores showed that the calculated 't' value in all the content areas was greater than the table value ($t_{(59)}$=2.00). This showed that the self-instructional module on "Parenting Skills for adolescence" was effective in improving the knowledge of parents. Pre-test knowledge of parents compared with demographic variables showed that there was an association between pre-test knowledge score and religion (χ^2 = 9.69, $p<0.05$, table value 5.99) of the parents. The findings showed that the pre-test knowledge score was independent of other variables like age, gender, educational status, occupation, marital status and number of children.

CONCLUSION

There was significant difference between pre-test and post-test knowledge scores of parents which showed that self- instructional module on "parenting skills for adolescence" was effective. The findings revealed that Self Instructional module (SIM) is an effective teaching strategy. This indicates that more independent learning materials need to be developed

for parents which help to improve the knowledge and skills of parents regarding parenting skills.

SUGGESTIONS

1. A training programme may be organised to teach parents on parenting skills for children of different age groups.
2. Information booklets on parenting skills may be made available in centre points like post office, hospitals and schools for distribution.
3. Education on parenting skills must be provided to parents in their community settings and at their work place, in schools, paediatric settings and also in psychiatric outpatient departments.

RECOMMENDATIONS

On the basis of present study, the following recommendations are formed for future study:

1. A future study can be conducted on a larger sample with a control group for better generalisation.
2. A comparative study may be carried out to assess the level of knowledge regarding parenting skills between father and mother.
3. A study may be carried out to identify perception of adolescents on parenting skills by their parents.
4. A survey to identify the parenting skills adopted by parents in different communities.
5. A comparative study to identify the outcome of authoritative and authoritarian parenting in adolescents.
6. A follow-up study can be conducted to determine the effectiveness of SIM on parenting skills.
7. A descriptive study to identify the factors in family environment that influence the well-being of the adolescents.

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Conflict of Interest : Nil

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Token Economy- a Positive Reinforcement Program for Children

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ABSTRACT

Token Economy is a form of behavior modification program designed to increase desirable behavior and decrease undesirable behavior with the use of tokens. It is based on operant conditioning. It helps in building up and maintaining appropriate class room performance and behavior. The teacher may need additional training or consultation with a person trained in behavioral therapies in order to successfully implements a token reinforcement program.

Keywords: *Token, behavior modification, reinforcers, training*

INTRODUCTION

Definition: Token Economy is a form of behavior modification program designed to increase desirable behavior and decrease undesirable behavior with the use of tokens. It is based on operant conditioning [1].

Goals of Token Economy:

- To teach appropriate behaviors and social skill that can be used in one's natural setting.
- To decrease undesirable behaviors.

Element in Token Economy:

Several elements are necessary in every token economy.[2]

- **Tokens**: Anything that is visible and countable can be used as a token. Tokens should preferably be attractive, easy to carry and dispense, and difficult to counterfeit. Commonly used items include Poker chips, stickers, point tallies, or play money. When an individual displays desirable behavior, he or she is immediately given a designated number of tokens. Tokens have no value of their own. They are collected and later exchanged for meaningful objects, privileges or activities. Individuals can also lose tokens (response cost) for displaying undesirable behavior.

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- **Clearly defined target behavior**: Individuals participating in a token economy need to know exactly what they must do in order to receive tokens. Desirable and undesirable behavior is explained ahead of time in simple, specific terms. The number of tokens awarded or lost for each particular behavior is also specified.

- **Back- up reinforcers**: Back- up reinforcers is the meaningful objects, privileges, or activities that individuals receive in exchange for their tokens. Examples include food items, toys, extra free time, or outings. The success of a token economy depends on the appeal of the back- up reinforcers. Individuals will only be motivated to earn tokens if they anticipate the future reward represented by the tokens. A well-designed token use back- up reinforcers chosen by individuals in treatment rather than by staff.

- **A system for exchanging tokens**: A time and place for purchasing back- up reinforcers is necessary. The token value of each back- up reinforcers is pre-determined based on monetary value, demand, or therapeutic value. For example, if the reinforce value, is expensive or highly attracts, the token value should be higher. If possession of or participation in the reinforcers would aid in the individual's acquisition of skills, the token value should be lower. If the token value is set too low, individuals will be less motivated to earn tokens. Conversely, if the value is set too high, individuals may become easily discouraged. It is

important that each individual can earn at least some tokens.

- **A system for recording data**: Before treatment begins, information (baseline data) is gathered about each individual's current behavior. Changes in behavior are then recorded on daily data sheets. This information is used to measure individual's progress, as well as the effectiveness of the token economy. Information regarding the exchange of tokens also needs to be recorded.

- **Consistent implementation of the token economy by staff**: In order for a token economy to succeed, all involved staff members must reward the same behaviors, use the appropriate amount of tokens, avoid dispensing back –up reinforcers for free, and prevent tokens from being counterfeited, stolen, or otherwise unjustly obtained. Staff responsibilities and the rule of the token economy should be described in a written manual. Staff members should also be evaluated periodically and given the opportunity to raise questions or concerns.

Initially tokens are awarded frequently and in higher amounts, but as individuals learn the desirable behavior, opportunities to earn tokens decrease. For example, in a classroom, each student may earn 25 to 75 tokens the first day, so that they quickly learn the value of the tokens. Later students may earn 15 to 30 tokens per day. By gradually decreasing the availability of tokens (fading), students should learn to display the desirable behavior independently, without the unnatural use of tokens. Reinforcers that individuals would normally encounter in society, such as verbal praise, should accompany the awarding of tokens to aid in the fading process[2].

STEPS INVOLVED IN THE PROCEDURE:

The steps involved in establishing a token economy program are outlined below[1]:

Step 1: Select behaviors to target for change: The teacher should choose two to four of the most important problem behaviors to target for change. Additional behaviors can be substituted in as student's behaviors changes. It is important for these behaviors to be defined clearly.

First, the behaviors should be defined in such a way that it is clear to the child and everyone else involved. The behavior should be clear, specific, and observable. A good rule of thumb is; if the behavior can be counted and two different people observing the behavior can agree when it occurs, then behavior is probably well defined. Vague target behaviors make it difficult for teachers to monitor them and children to know when they have preformed them.

Second, a token reinforcement program is designed to be positive and motivational, focusing on increasing desired behaviors. Behaviors target for change should be defined in terms of what the child should do rather than what the child should stop doing.

The third characteristic relates to targeting classroom products rather than conducts or process behaviors. Programs targeting disruptive behavior or academic "process" such as staying on task, sitting still, or staying seated, are successful in changing these, however, they do not necessarily lead to increased work productivity Programs targeting the products of academics can lead to increased productivity, as well as improvements in behaviors.

Step 2: Develop a method for keeping track of tokens or points: The teacher must develop a method for keeping track of the tokens or points. It is recommended that physical tokens be used for young children (4 to 7 years old), such as poker chips, stars, stamps, or stickers. These tokens can be given to the child to place in a container at or near the child's desk. For older children, points, number, or check marks can be made on a card placed on their desk or in a journal.

Step 3: Identify powerful rewards: The identification of powerful rewards is critical to the success of a token program. In order for the rewards to be motivating, it must be perceived by the child as desirable and worth working for. One way to assure that the rewards are meaningful is to involve the children in the process of generating a list of potential rewards. Another method of identifying meaningful rewards is to observe what the children do in their free time. Behaviors that children engage in frequently can be used as rewarding activities. Parents also can be helpful in identifying favored activities. In addition, there may be some classroom responsibilities that children may find rewarding, such as assisting the teacher or erasing the chalkboard. For children with Attention Deficit Disorder, new rewards should be continually rotated into the reward "menu" in order to keep the rewards meaningful. What may be rewarding to a child one week may be less so the next week.

Step 4: Establish goals: The next step is to determine an appropriate goal, or number of tokens or points needed to obtain the reward. It is important to initially set the goal at a level that is easily achieved. If the goal is set too high, the child may perceive it to be unachievable and may put forth the effort. The best way to establishing an appropriate starting goal is to keep track of how often the child performs the desired behaviors for one week period prior to starting the program. The starting goal should be set just above this "baseline" level of performance. For example, if a student was completing 40 percentage of her assigned work before intervention, then an appropriate starting goal might be 50 percentages. This reasonable starting goal will allow the child to obtain success and experience the reward of appropriate behaviors early in the program. The goal can be gradually increased over time.

Step 5: Explain the program to the child: The program should be explained to the child at a neutral time. The behaviors target for change and how to successfully perform the behaviors should be discussed. In addition, the goal for earning the rewards and when the rewards will be given should be discussed.

Step 6: Teacher provides feedback: The teacher should decide how the token would be distributed. They can be given for each occurrence of a desired behavior or at specified intervals. For example, if a teacher is trying to increase a child's raising of hand before speaking, a token can be given each time the child performs this behavior. If work productivity is targeted, the child can earn a token for every five math problems completed accurately. It is essential that the teacher reward the target behaviors with tokens in a consistent and accrued manner. In addition, the teacher should use frequent praise and social attention for appropriate behaviors throughout the day and when dispensing the tokens. A punishment technique called response cost can be built into the program. This technique involved the loss of tokens, points or privileges following the occurrence of some inappropriate behavior or failure to meet some specified goal. However, it is recommended that response cost be included only after the program has been tried with just rewards for several weeks.

Step 7: Teacher provides reward: At a predetermined time, the teacher should review the child's progress towards the goal. If the child obtained the goal for the day, the child should be allowed to choose a reward from the reward menu. If child fails to obtain the goal for the day, he/she can be informed in a matter- of – fact manner that she/he did not earn the reward for the day. Avoid "corrective" critical statements.

Step 8: Changing the program: When the child's behavior improves to a desirable level for a period of time, the program can be changed in a number of ways. The number of token required for a reward can be increased. For example, initially, a child may be allowed to exchange tokens many times per day. As the behavior improves, the tokens can be exchanged once per day. When making changes to the program, praise the child for the success and explain the changes and expectations. If the child's behavior worsens during these changes and does not improve after a period of time, return to the previous system.

ADVANTAGES OF TOKEN ECONOMY

- Provide immediate rewards for desirable behaviors.
- Rewards are the same for all member of the group.
- Individual can learn skills related to future.
- More helpful in improving school behavior.

Limitation:

- Needs extensive staff training.
- Too time consuming.
- Needs considerable cost.

CONCLUSION

A token economy is an intensive positive reinforcement program for building up and maintaining appropriate class room performance and behavior. The teacher may need additional training or consultation with a person trained in behavioral therapies in order to successfully implements a token reinforcement program.

Conflict of Interest: Nil
Acknowledgement : Nil

Ethical Clearance : Not necessary
Source of Support : Nil

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Effect of Yoga on Insomnia among old Agers

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ABSTRACT

INTRODUCTION: Developing countries such as China, India and Indonesia are projected to have the largest number of elderly by 2025. The elderly population in India is expected to grow from 7.6 million in 2001 to 137 million by 2021. Sleep disturbance is another commonly reported problem in elderly. Sleep disturbances can affect daytime function in elderly and have a significant negative effect on daily activities.

OBJECTIVES: 1) A study was conducted to evaluate the effect of yoga on insomnia among old agers in selected areas of sirohi**.**

MATERIAL AND METHOD: The research approach used was quantitative, the study was conducted using pre-experiemental design one group pre-test and post test, on 30 old agers in rural area, using non –probability convenient sampling.The data were analysed using descriptive and inferential statistics.

RESULTS: In the pre-test old agers had 55.83% level of insomnia and mean score was 40.20 $\pm$ 8.24.in the post test old agers had 35.28 % of insomnia and mean score was 25,40$\pm$5.73.the post-test mean insomnia score was significantly lesser than the pre – test mean insomnia score,indicating the effectiveness of yoga.

CONCLUSION: The study findings revealed that yoga was highly effective in improving sleep quality of old agers.

Keywords: *Yoga, Insomnia, Old Agers.*

INTRODUCTION

Ageing is a natural process. In words of Seneca; "Old age is an incurable disease", but recently they commented it as "we do not heal old age but protect it; promote it; extend it"[1]. People can be considered old because of some changes in their activities or social roles. There is often a general physical deterioration, and people become less active.[1]

According to Davis sleep has been divided into several well defined stages, beginning with the two major categories of rapid eye movement (REM) sleep, during which the eyes appear to move quickly under the eyelids, and non-rapid eye movements (NREM) sleep. During NREM a sleeper progresses through four stages characteristic of stages 1 and 2, during which a person is more easily arouseable. Stages 3 and 4 involve a deeper sleep called 'slow-wave sleep' from which a person is more difficult to arouse.[2]

Sleep is an anabolic restorative function and facilitates 'metabolic build up' people deep sleep diminishes and even disappears. About 15% of their sleeping time is in stage 1, light sleep. A number of factors affect the sleep in the elderly.[3]

NEED FOR THE STUDY

Older people are more sensitive to environmental disruptions, such as light, noise, jet lag, and also diseases such as arthritis, ulvrtd, urinary obstructions, and heart conditions, and neurologic diseases, including Parkisnson's Alzhemier's and others and forms of dementia can cause nighttime disorientation, confused wandering and delirium.[4]

'Yoga means to bind, join, attach and yoke to direct and concentrate the attention. Yoga, therefore,

is the art which brings an incoherent and scattered mind to a reflective and coherent state. It is the communion of the human soul with divinity.[5]

The pleasures and benefits of yoga are widely understood: Yoga can improve physical strength and flexibility, improve breathing, reduce stress and enhance mental focus. What may be less well known are the positive effects that yoga can have on sleep.[13]

A new study indicates that yoga can help improve sleep among people suffering from chronic insomnia. Researchers at Harvard Medical School investigated how a daily yoga practice might affect sleep for people with insomnia and found broad improvements to measurements of sleep quality and quantity.[13]

As people grow older, the amount of deep sleep they obtain decreases, and the total sleep period fragments. However, older adults need amounts of sleep similar to the amount younger adults need, ranging from six to nine hours, depending on the individual. The amount of time spent in stage IV usually declines rapidly, and by the time a person reaches age 50, it is reduced by 50%.[6]

National Institute on Ageing U.S.A conducted an epidemiologic study of 6,800 persons over a period of three years to determine incidence and remission rates of insomnia in older adults. Data suggested an annual incidence rate of about 5%. Incident insomnia was associated with depressed mood, repiratory symptoms, physical disability, fair to poor perceived health and prescribed sedatives. Only 7% of the incident cases of insomnia occurred in the absence of associated risk factors.[7]

When the U.S. government started the National Institute on Aging in the 1970s, sleep was a low priority among authorities who controlled medical research funding. In the past few decades the importance of sleep has been recognized, both as an important part of quality of life and as a contributor to and symptom of diseases.[14]

Authors of the 2003 National Sleep Disorders Research Plan concede that most of the research on sleep is conducted on young adults and that there has not been enough scientific exploration of how age affects sleep. There isn't widespread agreement on what is "normal" age-related changes in sleep patterns and therefore no consensus among physicians on whether any medical treatment is desirable.[14]

REVIEW OF LITERATURE

Almedia, Tamai, and Garrido conducted a study to evaluate the prevalence of sleep problems among the elederly and to evaluate the association between the use sleep tablets and sleep difficulties. The authors concluded that sleep dissatisfaction is frequent among psychogeriatric out patients.[8]

Shiger BD conducted & stated that certain mind body medicine therapies are erective in improving quality of life, anxiety and pain intensity for a variety of conditions. There is moderate evidence to suggest these techniques improve chronic pain, headache, insomnia, and other common conditions. People with insomnia report more health problems, more frequent hospitalizations, and more limitations of their work capacity because of sleep problems than those without insomnia.[9]

Dixon N, (2005) stated that exercise is perceived as helpful in promoting sleep and suggested that regular physical activity may by useful in improving sleep quality and reducing day time sleepiness. Close to 70% of those in long-term care facilities complain of sleep disturbances, and 90% of institutionalized elderly are prescribed sleeping medications (Johnson, 1994).[10]

Crisan (2001) reports on the first nationwide face-to-face survey on the prevention of well-defined severe insomnia and its impact on quality of life in the general population of Germany.[11]

Harrison and Horne (2000) Sleep Research Laboratory, Leicestershire conducted a study to explore the effects of 36 hours of sleep deprivation on a neuron psychological test of temporal memory. The author found that deep deprivation impairs temporal memory (i.e. recency) despite other conditions promoting optimal performance.[9]

According to Bali (1992) the several yogic routines helps to relax the mind and body, thereby helps to induce sleep.[5]

Hedstrom Pepperdine University investigated that eye movements and certain visual mechanisms

appear to be related to states of relaxation and levels of wakefulness. Miskiman (1976) assessed the effect of Transcendental meditation (T.M) which is considered a yogic technique in treatment of insomnia.[6]

Sleep is a protective physiological phenomenon, which nature has provided us with to rejuvenate our body and mind. However, it is not so much the period of sleep as a depth of sleep that is important. Sleep will be more effective if the technique of voluntary relaxation is properly understood (Kumar, 2001).[12]

Woolfolk et al showed that meditation gives pronounced improvement in insomnia patients as compared with an untreated control group.[12]

MATERIAL & METHOD

A quantitative research approach was used, with one group pre-test post –test, pre experimental research design. The study was conducted among old agers in rural area of sirohi. The sample for the present study comprised of 30 old agers in rural area of sirohi, selected through convenient sampling technique. Data collection tool consisted of 2 sections.

Section:1 It consisted of items related to selected demographic data of sample and section II was a structured insomnia rating scale, having 24 items. The content validity done by experts from nursing and psychology department. The reliability value of 0.81 indicated that the tool was reliable.

To conduct research study at rural area of sirohi, formal written permission was obtained from superintendent of Abu road community health centre. Data were collected from 30 subjects who me the inclusion criteria as per the study. The questionnaire was distributed for pre-test and instructions were given on answering the questionnaire and doubts were clarified. Each old ager took average of 15-20 minutes to complete the pre-test. On the 1st and 2 nd day, The pre-test data was obtained using structured rating scale.Then from 3 rd day to 18 th day ,30 minutes planned yoga was administered. On the 18 th day and 19 th day post-test was conducted using the same tool to assess the level of insomnia.

The data were analyzed using both descriptive and inferential statistics.

FINDINGS

14 (46.7%) old agers are belonged to the age group of above 52 years of age.

24 (80%) old agers belonged to the primary education group, while 3 (10%) belonged to the secondary education group.

28 (93.3%) old agers belonged to joint family while 2 (6.7 %) old agers belonged to the nuclear family.

19 (63.3 %) old agers were not working.

21 (70.0%) old agers belonged to the married group while 8 (26.7 %) were widowers.

Table:1 Range, Mean,Percentage and standard deviation of pre-test and post-test level of Insomnia among old agers.

Total no. of questions	Min- max Marks	Observation	Obtained range	Mean	Percentage	S.D
24	0-72	Pre - test	34	40.20	55.83 %	8.24
24	0-72	Post-test	23	25.40	35.28 %	5.73

The overall pre test mean insomnia score of the old agers was 40.20 ±8.24 and post- test mean insomnia score of the old agers was 25.40 ±5.73.the post test mean insomnia score was significantly lesser than the pre-test mean insomnia score.

Table:2 Mean, Standard deviation,Mea Difference and 't' value of pre-test and post-test scores.

Para meter	Mean	Standard Deviation	Mean difference	't' cal value	P value	't'tab value
Pre- test	40.20	8.24	14.8	13.690	.000	2.045
Post- test	25.40	5.73				

That indicated that yoga was effective in relieving insomnia in old agers. There was no significant association between level of post test score and selected demographic variables at 0.05 level of significant.

CONCLUSION

This study suggests potential benefits of yoga therapy for old agers in improving the sleep quality. However, considering the limitations in the design of this study, the findings of the study needs to be considered as preliminary and there is a need for future studies overcoming the methodological limitations of this study to further establish the efficacy of yoga therapy in old agers in improvement of sleep quality and reducing insomnia.

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Source of Funding: Funding was by self finance.

Conflict of Interest: There was no such issue.

Ethical clearance: Permission taken from community health centre, before data collection written consent was taken from all the participants.

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Quasi Experimental Study to Evaluate the Effectiveness of Progressive Muscle Relaxation Therapy to Reduce Anxiety among Nursing Students

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ABSTRACT

Nursing is a body of knowledge. Modern nursing involves many activities, concepts and skills related to basic science, social science, growth and development and other areas of nursing. Nursing study is highly stressful and it was found that nursing students are more test anxious than the students in other fields. So to reduce anxiety there are several techniques which are recommended, and progressive muscle relaxation technique is one of the best method. A quasi experimental study was conducted on 60 nursing students to assess the effectiveness of progressive muscle relation therapy in reducing stress in selected nursing college of Ludhiana, Punjab. The result of the study shows that PMRT had an impact in reducing anxiety among experimental group ($t = 16.32$) as compared to control group ($t = 0.47$). Significant association of anxiety was found with parents education in both the groups ($p<0.05$). The level of anxiety reduces in experimental group after PMRT, therefore guidelines were given to the control group for PMRT to reduce their anxiety level.

Keywords: *Nursing, degree students, diploma students, anxiety, progressive muscle relaxation therapy (PMRT).*

INTRODUCTION

Nursing is an art and science. As an art it is the application of knowledge & skills to bring about desired results which is an individualized action and as a science it includes observation, identification, description, experimental investigation and theoretical explanation of natural phenomenon[1]. According to Archna Khanna[2], anxiety is more prevalent in nursing students. There are many types of anxieties that affect the performance of nursing student like test anxiety, trait anxiety, separation anxiety, castration anxiety, existential anxiety and free floating anxiety. Anxiety is a vague feeling of apprehension, worry, uneasiness the source of which is often non specific or unknown to individual. Nursing profession requires great alertness of mind while handling the patients in hospital. Nursing students are under pressure that even a minor mistake might seriously harm a patient as well as jeopardize the carrier which increases the anxiety level. The relaxation techniques optimize body-mind harmony. The relaxation response puts the break on this heightened state of readiness and brings your body and mind back into a state of equilibrium. PMRT requires only 5-10 minutes relaxing the muscles and a comfortable position to get back to work[3].

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Objectives

1. To assess the pre – test anxiety level among diploma and degree nursing students.
2. To assess post– test anxiety level among diploma and degree nursing students.
3. To compare the pre – test and post – test anxiety level among diploma and degree nursing students to ascertain the effectiveness of PMRT.
4. To find out the relationship of post – test anxiety

level with selected demographic variables.

METHODOLOGY

Design : pre – test and post- test design with quasi experimental approach.

Setting : Selected Nursing College, Ludhiana, Punjab

Population : First year Nursing students

Sample size : 60 nursing students (30 diploma students, 30 degree students)

Sampling technique : k^{th} sampling .

MATERIAL AND METHOD

The study was conducted in the selected Nursing College of Ludhiana, Punjab. During this study period the students of both diploma and degree courses in first year were explained regarding the nature of study and written consent was taken from them by assuring to maintain their confidentiality. Structured interview method was used to collect the data from the samples who gave their consent. Structured five point self rating likert scale was used to assess the anxiety level among students of each class. Level of anxiety was measured as mild, moderate, high and extreme level as per the criterion measure. After assessing the pre – test anxiety level PMRT is given to the experimental group for 7 days for 10 -15 minutes in a day. After 7 days post test was conducted to assess the effectiveness of PMRT.

Plan for Data Analysis: Descriptive statistics and inferential statistics- Frequency, Percentage, Mean, and Standard deviation, chi square, Karl Pearson's Correlation Coefficient, t- test and ANOVA.

Findings

- In control group majority of nursing students were of age group 18-19 years (93.33%), belongs to sikh religion (93.33%) , with family income per month more than Rs. 50,001 (36.7%), lives in nuclear and joint family (46.67% each), having two siblings (56.67%), and their parents educated upto matriculation (36.67%) and runs a business or farmers (73.33%).

- In experimental group maximum number of nursing students were in age group more than 20 years(67%), belonged to sikh religion(100%), with family income per month Less than and equal to Rs. 10,000, living in nuclear and joint family (50% each), having two siblings (43.33%), parents educated upto primary (40%) and were farmers (90%).

Table 1: Percentage Distribution of Levels of Anxiety score among Control and Experimental Group

N=60

Levels of anxiety	Score	Control group				Experimental group			
		Pre- test		Post - test		Pre- test		Post-test	
		n	%	n	%	n	%	n	%
Mild	40-80	2	6.67	2	6.67	2	6.67	3	10
Moderate	81-120	11	36.66	14	46.67	6	20	17	56.66
High	121-160	12	40	9	30	17	56.6	3	10
Extreme	160-200	5	16.67	5	16.66	5	16.67	7	23.33
Maximum anxiety score= 200									
Minimum anxiety score = 40									

Table 1 depicts that maximum number of nursing students during pre-test were having high level of anxiety in control group and experimental group. Whereas in post –test in experimental group maximum number of students moved from high level of anxiety to moderate level of anxiety after PMRT.

Table 2: Comparison of Pre-Test and Post-Test Anxiety Score among Diploma and Degree Nursing Students among Control and Experimental Group

N=60

	Anxiety score						
Group		Pre-test	Post-test				
	n	Mean	SD	Mean	SD	df	t
Control	30	132.53	28.69	135.7	29.13	29	0.47^{NS}
Experimental	30	128	20.55	120.6	31.57	29	16.32^{*}

Maximum anxiety Score = 200

Minimum anxiety Score = 40

Table 2 depicts that the mean difference between pre- test and post -test anxiety score in control group is statistically non significant at $p<0.05$ level, Whereas in experimental group mean difference was statistically significant at $p<0.05$ level. Therefore, research hypothesis was accepted.

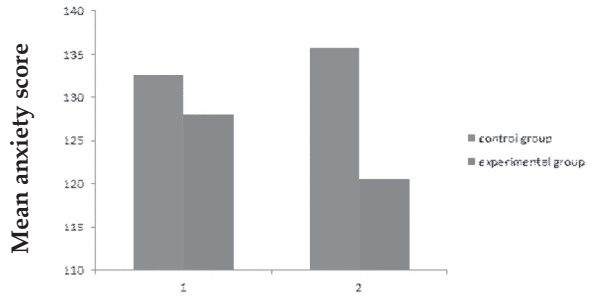

Fig. 1 comparison of pre-test and post-test mean anxiety score of nursing students among control and experimental group

CONCLUSION

The study findings supported the hypothesis that the anxiety of nursing students will be improved after they were exposed to PMRT. Hence the study revealed that PMRT brought positive changes in the anxiety score of nursing students. Therefore, guidelines for PMRT were prepared by keeping in mind the findings of the study to prevent anxiety among nursing students.

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Conflict of Interest: None

Source of Support: Didn't get any financial support from any body. It was an individual project .

Ethical Clearance: Written permission was taken from principal of college and ethical committee before collecting the data. Written consent was taken from the participants.

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'Quality Time'- a Mental Health Need of Today's Children

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ABSTRACT

In India, children constitute about 40% of the total population. Children do not think, feel or react as grown-up people do. Physically, mentally and emotionally each child is a growing, changing individual with unique needs and potentialities. The first responsibility of parents is to try to understand their children's needs and patterns of growth. The home is a place where the child first develops an attitude towards himself. The greatest gift parents can give to their child is to help him to realize that he is an individual of importance. Unfortunately, many parents lead a rich and busy life today and find it difficult to spend time regularly with their children. Hence, it is the mental health professionals' responsibility especially the psychiatric nurses to educate the parents to spend quality time with their children to facilitate healthy parent-child relationship.

Key words: *Quality time, quality time activities, parenting skills*

INTRODUCTION

Children are the most precious possession of mankind. They should be nurtured with the utmost care and affection. The greatest gift that parents can give to their children is a sense of personal worth. Further, the family is the main source of child's formation of behaviour pattern. So, parents must work harder to make the home a place where there is fun, activity and variety of things to do together.[1] Studies have shown that positive parent-child interactions in early childhood are linked to better cognitive and language development in children. Some of the activities which help in strengthening the parent-child relationship are allotting 'quality time' to be with the child every day, listening to them with interest, appreciating the child's abilities and setting a role model for the child.

Meaning of quality time: Quality time means concentrated, uninterrupted time to be spent with children by posing value on them. It should be relaxed and free of conflict. It is also expected that it will provide an opportunity to have meaningful conversation and do worthwhile things with our loved ones. If someone interacts with their child by actively listening to them, talking with them and keeping it pleasant, that is called as "quality time".[1]

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Definition of quality time: The focused attention on the child by his/her parents which has a special intensity with direct, personal involvement and being intimately open to the unique qualities of the child.[2]

Need for quality time: Home is a place where the child lives with parents and siblings. The interaction between them plays a key role in their mental health development. The home today is smaller. The housewives have entered career in order to supplement the family income. The flat system in the cities confines the child within four walls and offers it little chance to have companionship with their peer groups. In current life style, parents have little time to devote to their children. The goal of parenting is to help the child to become a responsible adult. To achieve this goal, along with other parenting skills, the time a parent spends with a child is very important.[2]

THE TECHNIQUES OF 'QUALITY TIME'

1 Parents may fix some specific time every day to interact with their child – perhaps half an hour in the morning and half an hour in the evening or in the night.
2 Parents can write down a list of activities they have always thought that it would be fun but not found time. For example, a visit to a picnic spot, a museum, zoo or a park. Parents can plan such activities either one or two at the week end.
3 Always try to approach 'quality time' in a relaxed mood.

4 As far as possible, interact with smiling face.

5 Make sure to minimize disruptions during quality time.

6 It is better to 'switch-off' television or radio, while interacting with the children.

7 It is better to avoid overloading children's schedules during the school years, because there should be some free time each day both for the parents and the child.

7 Parents should respond readily to the interest or activity what their child desires to do so.[3]

Tips to find quality time

- When we pick up our children from school, we can stop off at an ice cream shop or any other shop, where the child likes. Children love this after school treat and it will give us an opportunity to talk what is happening to their lives.
- Be available for your children and let them know that you are there for anything they want to discuss.
- Practice talking with your child and spend some time in listening.[4,5]

Importance of quality time activities

- Facilitates healthy parent-child relationship
- Increases the feeling of self-worth in children
- Children's emotional needs like love and affection are met through 'quality time'.
- Helps the parents to identify positive aspects in their child
- It is an opportunity for the parents to express their love and affection
- Children feel very happy when the parents listen to their feelings and interests.
- By sharing activities with parents in quality time, children get training to perform those activities efficiently.
- Increases the physical security and emotional bonding and brings the child closer to their parents.[5,6]

Barriers for quality time activities

- Lack of knowledge about the importance of quality time.
- Parents' busy schedule – either household or office work.
- Children may be busy in curricular and extra-curricular activities.
- Poverty – parents may strive for their basic needs.
- Lack of warmth, love and affection.
- Neglect of child care.
- Mismatch of interests between parents and children.
- Some children may be addicted to computers, television or reading story books.
- Unwillingness of parents to share time with their children.[7,8]

CONCLUSION

'Quality time' activity is the one time spent doing an activity that is meaningful and enjoyable to the parent and child. With today's busy life styles, parents need to spend 'quality time' with their children. Being parents and taking care of our children is a natural process. It is natural to be protective and helpful. Let us be happy, natural and interact and have fun with our children.

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Conflict of Interest- Nil

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A Descriptive Study to Assess the Knowledge and attitude Regarding Tobacco Abuse among Factory Workers in Selected Factories, District Jalandhar, Punjab, 2014

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ABSTRACT

Tobacco consumption has become a global problem affecting the health of the persons badly. Deaths due to cancer are one of the primary adverse effects of cigarette smoking. It is becoming more prevalent in developing countries like India and is more common among the workers at their workplace which further leads to dangerous consequences. Tobacco continues to be the substance causing the maximum health damage globally. WHO estimates that there are around 1.1 thousand million smokers in the world, about one-third of the global population aged 15 and over. The aim of study was to research to assess the knowledge and attitude regarding Tobacco abuse among factory workers.

Objectives

1. To assess the knowledge regarding Tobacco abuse among the factory workers.
2. To assess attitude regarding Tobacco abuse among factory workers.
3. To find out the relationship between knowledge and attitude regarding Tobacco abuse among factory workers.
4. To find out the association between the knowledge and attitude regarding Tobacco abuse among factory workers and their selected socio- demographic variables.
5. To plan and provide an information booklet regarding Tobacco abuse to factory workers.

Methodology

Design: Non- experimental (Descriptive Design)

Setting: Selected Factories, District Jalandhar, Punjab.

Population: All Factory workers, District Jalandhar, Punjab.

Sample size: 200 Factory workers selected from selected Factories of district Jalandhar Punjab.

Sampling techniques: Convenience Sampling Technique

Results and conclusion: Findings of the study has shown that the majority of the Factory workers 135(67.5%) had average knowledge regarding Tobacco Abuse and majority 117 (58.5%) Factory workers falls under category of negative attitude.

Keywords: *Tobacco Abuse, Knowledge, Attitude.*

INTRODUCTION

Today every country in the world is no longer secure from the menace drug abuse. Even in the most powerful country America is in its grip, India is not far behind. Drugs have been used for medical purposes since time immemorial. But these days drugs and narcotics are being used freely by the people all over the world.

In India their number has been increasing at an alarming rate. Its use has gripped many young men and women. It cripples the addict's mental and physical organs and cause a painful for him and his family. Mostly it is the younger generation fall an easy prey to it.[1]

World Health Report 2002, stated that among industrialized countries where smoking has been common, smoking is estimated to cause over 90% of lung cancer in men and about 70% of lung cancer among women. In addition, in these countries, the attributable fractions are 56-80% for chronic respiratory disease and 22% for cardiovascular disease. Worldwide, it is estimated that tobacco causes about 8.8% of deaths (4.9 million). Unless current trends are not reversed, that figure is expected to rise to 10 million deaths per year by the 2020s or early 2030s, with 70% of those deaths occurring in developing countries.[2]

Nicotine which is the major constituent of Tobacco and its products are highly addictive substance and adult people experimentation can easily lead to a life time of tobacco dependence.[3]

When people are addicted, they have a compulsive need to seek out and use a substance, even when they understand the harm it can cause. Tobacco products cigarettes, cigars, pipes, and smokeless tobacco can all be addictive. Everyone knows that smoking is bad for health, and most people want to do it quit. In fact, nearly 35 million people make a serious attempt to quit each year. Unfortunately, most who try to quit on their own relapse often within a week. It is actually the nicotine in tobacco that is addictive. Each cigarette contains about 10 milligrams of nicotine. Because the smoker inhales only some of the smoke from a cigarette, and not all of each puff is absorbed in the lungs, a smoker gets about 1 to 2 milligrams of the drug from each cigarette.[4]

It is smoked most commonly in the form of cigarettes, then, in descending order, cigars, snuff, chewing tobacco, and in pipes. About 3 percent of all persons in the United States currently use snuff or chewing tobacco, and about 6 percent of young adults ages 18 to 25 use those other forms of tobacco.[5]

Tobacco abuse is used purposefully for its perceived physical and psychological benefits like mental alertness, relaxation, weight control etc. Repeated use often leads to addiction. The product is taken into body by inhaling the smoke from burning Tobacco or chewing its products.[6]

It is one of the heavily used drugs in the United States and around the world which causes different types of cancers including cancers of lungs, mouth, throat, nasal cavity, esophagus, stomach, pancreas, kidney, bladder, and cervix and acute myeloid leukemia, cardiovascular diseases and second hand smoke also is associated with lung cancer in adults and respiratory illness in children.[7]

It is associated with approximately 400,000 premature deaths each year in the United States which constitutes 25 percent of all deaths worldwide.[8]

MATERIALS AND METHOD

The study was conducted in selected factories of district Jalandhar, Punjab to assess knowledge and attitude regarding tobacco abuse among factory workers in selected factories, District Jalandhar, Punjab 2014.Non-experimental Descriptive design was adopted and 200 factory workers were selected by using Convenience Sampling Technique for the study, who met the inclusion criterion. Self Structured Knowledge Questionnaire which consisted of 30 items with multiple choice questions having one correct answer among four options to assess the knowledge regarding tobacco abuse among factory workers and Self Structured Attitude scale which comprised of total 20 items which includes both positive and negative statements. Each statement has three rating options i.e agree, neutral and disagree.

RESULTS

- From the findings of the study, first objective reveals that according to knowledge scores, majority of the factory workers n=135(67.5%) falls under average category, whereas n= 21 (10.5%) falls under

poor category and 44 (22%)factory workers falls under good category.

- Second objective revealed that according to attitude scores majority of the factory workers n= 117 (58.5%) falls under category of negative attitude, n=81 (40.5%) samples falls under category of neutral attitude whereas n= 02(1%) falls under category of positive attitude.

- Third objective revealed that according to mean scores, mean knowledge score is 16.93 and mean attitude score is 51.1 . So, there was significant relationship between knowledge and attitude because calculated 't' value 70.0541 is more than tabulated value.

CONCLUSION

The study was under taken to assess the knowledge and attitude regarding Tobacco abuse among factory workers in selected factories, district Jalandhar, Punjab, 2014. From the findings of the study, it was revealed that knowledge scores, n=135(67.5%) fall in average category, whereas n= 21 (10.5%) fall in poor category. Attitude scores n= 117 (58.5%) falls under category of negative attitude, n=81 (40.5%) samples falls under category of neutral attitude whereas n= 02 (1%) falls under category of positive attitude.

So it can be concluded that majority factory workers are having average knowledge and negative attitude regarding Tobacco abuse.

DISCUSSION

Objective 1: To assess the knowledge regarding Tobacco abuse among the factory workers.

The findings of the study were discussed with the results study conducted by Shabana Khatun on knowledge and attitude of ill effects of Tobacco usage among group D workers working in Chhatrapati Shivaji Subharti Hospital, Meerut.

The findings of the present study showed that majority factory workers 135(67.5%) had average knowledge, 21(10.5%) factory workers had poor knowledge and only 44(22%) women had good knowledge regarding Tobacco abuse. The findings of the study similar to the study conducted by Shabana Khatun showed that 53 (88.5%) workers had inadequate knowledge and 7 (11.5%) workers had adequate knowledge regarding ill effects tobacco.

Objective 2: To assess attitude regarding Tobacco abuse among factory workers.

The findings of the present study showed that majority 117 (58.5%) wokers had negative attitude, 81 (40.5%) factory workers had neutral attitude whereas 02 (1%) had positive atstitude. The findings of the study similar to the study conducted by Shabana Khatun showed that group D workers had unfavourable attitude regarding ill effects of tobacco usage.

Acknowledgement: I want to express my gratitude especially to the Managing Directors of selected factories of Jalandhar who have participated in my study for their support and cooperation. I also want to thank my teachers Mr. Kishanth Olive, and Mr Sujith Chandaran. Finally, this thesis would not have been possible without the confidence, encouragement and support of my family. I want to thanks my father S. Manjinder Singh, my mom Smt. Rajinder Kaur Mr. Vikas Saini and brother Mr. Simranjit Singh who inspired, encouraged and fully supported me for every trail that come in my way, in giving me not only in financial, but moral and spiritual support.

Ethical Clearance

1. Written permission was taken from principal S.G.L. Nursing College, Semi, Jalandhar, Punjab.
2. Written permission was taken from Ethical Clearance Committee of S.G.L. Nursing College, Semi, Jalandhar, Punjab.
3. Written permission was taken from Managing Directors of the selected factories of district Jalandhar Punjab.
4. Written informed consent was taken from each study sample.
5. Confidentiality and Anonymity of samples will be maintained throughout the study.

Source of Funding- Self

Conflict of Interest- Nil

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Role Strain and Caring Behavior in Caregivers of Cervical Cancer Patients

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ABSTRACT

Background: Cancer is a major public health issue may affect all ages, and represents a huge burden not only for individuals but also for their families and their societies. The impact on various aspects of the family caregiver's quality of life is significant throughout the trajectory of the illness and may affect the long term psychologic health of the caregiver.

Aims and objectives: A study was planned (1) to assess the level of role strain and caring behavior (2) and to compare the role strain and caring behavior with their socio demographic characteristics.

Material and Method: It was an explorative study in which information about role strain and caring behavior were obtained from 50 caregivers of cervical cancer patients at Oncology ward of Pravara Rural Hospital, Loni (Bk), Maharashtra. The Medical Superintendent and Head of Department were contacted and permission to conduct study was obtained. Informed consent from the participants was obtained. Self prepared and pre tested rating scales were used for the assessment. The data were analyzed with descriptive and inferential statistics.

Results: Findings revealed that majority (56%) of care givers had mild level of role strain followed by (40%) had moderate level. However 70% of them had good caring behavior, while 30% had adequate caring behavior. The role strain was significantly associated with socio demographic characteristics like age, education, and monthly income of care giver whereas the caring behavior was associated with age and education of care giver.

Conclusion: Though the care givers of cervical cancer patients had role strain; the caring behaviour was good, promising and supportive. Thereby the cancer patients lead an improved quality of life and longer survival.

Keywards: *Role strain, caring behavior and care givers.*

INTRODUCTION

Non-communicable diseases including cancer are emerging as major public health problem in India. These diseases have long latent period and needs specialized infrastructure and human resource for treatment. Each year 10.9 million people worldwide are diagnosed with cancer and there are 6.7 million deaths from the disease. The cervical cancer is the seventh in frequency overall and second most common cancer among women world-wide. It is more common in the developing countries where cervical cancer accounts for 15% of all female cancers [1].

The cancer patients are burdened by symptoms related to the disease or the toxicities of treatment. Unrelieved symptoms are a major detriment to the patient's quality of life and ability to function [2]. The cancer affects not only the quality of life of individuals with the disease but also that of their family members, close friends and those who care them. The impact on

various aspects of the family caregiver's quality of life is significant throughout the trajectory.

Caregivers of cancer patients are expected to function broadly as accompanying patient to treatment, talking with medical staff, personal hygiene care, providing direct care, assistance with activities of daily living, emotional support, companionship and medication supervision. [3]

Providing day-to-day care to a loved one over days, weeks and months can be hard. Many family caregivers have reported feeling exhausted, overwhelmed, sad and anxious while providing care [4].

In addition, the caregivers have many demands other than providing care, such as work, family, friends and social obligations [5]. Coping with strain from care giving may influence the experience of care giving situation as well as quality of life of caregiver. Caregiver's burden and coping depends on factors like behaviour of the person cared for, their own health and their sense of coherence with the patient [6]. The present study examines the role strain and caring behaviors in caregivers of cervical cancer patients.

MATERIALS AND METHOD

It was an explorative study and was carried out in the oncology ward of Pravara Rural Hospital, Loni (Bk), Maharashtra. The cervical cancer patients care giver role strain and the caring behaviors were explored. A sample comprising 50 caregivers in the age group of above 18 years was selected by using a probability, simple random sampling technique. The caregivers who are less than 18 years and unhealthy to provide care were not included for the study. The expert validated and pre tested rating scales was the main tool used to collect the data. It consists of part: A – socio demographic characteristics of caregiver and cervical cancer patients, part: B – rating scale (25 items with five point severity score) for role strain assessment and part: C – rating scale (20 items with five point severity score) for caring behavior assessment. The role strain was categorized based on the obtained scores as 'No role strain, Mild, Moderate and Severe' and the caring behavior were classified as 'Inadequate, Satisfactory and Good'. After seeking informed consent these were all interviewed and the responses were voluntary; and no probing questions were asked.

The data were expressed using descriptive statistics such as mean, standard deviation and mean percent for continuous variables; and frequency, percentage for categorical variables. These were to understand the distribution of subjects on the socio demographic and other variables to assess the role strain and caring behaviors of care givers. The inferential statistics like chi square test was used to find the association between the variables. $P < 0.05$ was considered statistically significant. Pearson correlation coefficient was used to test the relationship between role strain and caring behavior. The statistical software SPSS version 10 was employed for the analysis.

RESULTS

Socio demographic characteristics of sample: a highest percent (52%) of care givers were above 49 years of age, majority (56%) were males, highest percent (42%) were illiterates followed by primary education (30%), (38%) were formers, majority (66%) had monthly income below Rs. 5000, and most (96%) under study were Hindus, majority (84%) were married, (42%) of care givers were child/grandchild and (38%) were cared <3hours followed by 3 – 6 hours (32%). (Table. 1)

Socio demographic characteristics of cervical cancer patients: majority (34%) of patients were above 51 years of age, more than half (56%) were illiterates followed by primary education (34%), two third of patients (64%) were married, majority (70%) had stage II cancer, most (74%) had combined treatment therapy, 60% of patients had duration of illness less than 6 months, more than half of patients (56%) had mild disability and 40% had hospital stay less than 5 days and more than 10 days respectively. (Table. 2)

Role strain in care givers: the role strain was common in this sample. Twenty eight care givers (56%) had mild role strain followed by twenty care givers (40%) experienced moderate level and only (4%) had severe role strain. The total scores varied between 1 and 125 with a mean score of 58.7±16.1 however the role strain scores were higher for financial and vocational role strain. (Table. 3) The findings revealed that the care givers who were with advanced age, illiterates, low income group and who

cared more than 6 hours had higher role strain mean scores than the others.

Caring behaviors in care givers: though the role strain was common, (70%) of the care givers had good caring behavior, and 30% had adequate level. The total scores varied between 1 and 100 with a mean score of 83.2±10.7 however the care givers had higher mean scores on the areas of respectful and assurance. (Table. 4)

There was a significant association found between role strain and socio demographic characteristics like age, education, monthly income and relation with patient at $p< 0.05$ level; and the caring behavior was significantly associated with age and education at $p< 0.05$ level. (Table. 5) The Karl Pearson's co-efficient of correlation analysis shows a negative relation ($r= -0.43$) between the role strain and caring behaviors.

DISCUSSION

The overall prevalence of role strain in care givers of cervical cancer patients provides a finding that they suffer with mild to moderate role strain. This role strain was stressful for the care givers who lack support and guidance from health care system/ professionals. The financial and vocational role strain was found to be the most common areas of role strain. This finding is in correlation to Papastavrou E et al, who reported that the care givers of hospitalized patients had moderate level of care giver burden and role strain. [7] Ohaeri JU et al, also noted that the financial role strain was more problematic for care givers and affect the routines of caring. [8]

This emphasizes the importance of investigating the impact of such role strain and there is a need to screen out various stressors and reasons responsible for developing or increasing the role strain. The reason could be significantly more physical, psychological stressors, negligible family support, lack of medical care facilities and financial constraints.

Though the care givers had role strain, we did find they had good caring behaviors which is supported by Sano T. et.al, in a study among family care givers experience in caring a cancer patients, the results showed that majority (90%) had done their best in their care giving and had good caring behaviors for beneficial to improve quality of life of the cancer patient. [9] The current study revealed that there were statistical significant associations between socio demographic characteristics and role strain of care givers as shown in table. 5. These findings were supported by Pinquart M and Sorenson S that the caregiver's variables like level of education, income and support from professionals had strong association with the role strain. [10]

However the role strain was negatively correlated with caring behavior. These findings is supported by Bornemann T, et.al, who reported that there was negative correlation existed between the role strain and positive caring behavior.[11] The results of this study provide the important implications for understanding the impact of cervical cancer on care givers quality of life.

CONCLUSION

The prevalence of role strain was common in caregivers of cervical cancer patients. However it was learnt that a common and predominant concern involved among caregivers were the financial and vocational aspects. The family involvement in the patient care continues to improve as the caregivers had good caring behaviors of chronically ill family member. It emphasize that the health care delivery has become increasingly technical, community based and dependant on family engagement for care.

As the prevalence of cancer disease is expected to rise, the management of a chronic illness can profoundly affect the lives and identity of the patient, family caregiver and family. Psycho educational program is needed to assist caregivers cope successfully with burden and role strain resulting from the care of chronically ill patients. The caregivers are commonly affected with psychological distress and increased risk of depression. Their greatest needs are for emotional support and respite care.

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Table. 1 Socio demographic characteristics of sample (n-50)

Characteristics	Number	Percentage
Age		
18 – 28 years	07	14
29 – 38 years	07	14
39 – 48 years	10	20
Above 49 years	26	52
Sex		
Male	28	56
Female	22	44
Education		
Illiterate	21	42
Primary	15	30
Secondary	14	28
Occupation		
House wife	07	14
Daily wages	12	24
Private employee	12	24
Formers	19	38
Monthly income		
Below Rs 5000	33	66
Rs. 5001 – 10000	13	26
Above Rs 10001	04	08
Marital status		
Single	04	08
Married	42	84
Widow/widower	04	08
Relation with patient		
Spouse	15	30
Child/Grand child	21	42
Relatives and friends	14	28
Duration of care per day		
Less than 3 hours	19	38
3 – 6 hours	16	32
More than 6 hours	15	30

Table. 2 Socio demographic characteristics of cervical cancer patients (n-50)

Characteristics	Number	Percentage
Age		
Below 35 years	07	14
36 – 40 years	07	14
41 – 45 years	10	20
46 – 50 years	09	18
Above 51years	17	34
Education		
Illiterate	28	56
Primary	17	34
Secondary and above	08	16
Marital status		
Single	02	04
Married	32	64
Widow/widower	16	32
Stage of cancer		
I	06	12
II	35	70
III	08	16
IV	01	02
Disability in daily life		
Mild	28	56
Moderate	18	26
Severe	04	08
Treatment modality		
Chemotherapy	03	06
Radiation therapy	02	04
Surgery	08	16
Combined therapy	37	74
Duration of illness		
Less than 6 months	30	60
More than 6 months	20	40
Length of hospital stay		
Less than 5 days	20	40
5 – 10 days	10	20
More than 10 days	20	40

Table. 3 Role strain scores in care givers

Role strain areas	Mean	SD
Physical role strain	10.94	5.3
Emotional role strain	10.64	3.9
Familial role strain	10.56	3.2
Vocational role strain	12.44	4.9
Financial role strain	14.21	5.2
Overall	58.78	16.1

Table. 4 Caring behaviors scores in care givers

Caring behavior areas	Mean	SD
Assurance	22.66	2.9
Knowledge and skill	15.72	5.2
Respectful	23.78	2.4
Connectedness	21.12	2.6
Overall	83.28	10.7

Table. 5 Association of role strain, caring behavior with socio demographic characteristics

Variables	df	Role strain (χ2value)	Caring behavior (χ2value)
Age	1	11.7*	15.6*
Sex	1	1.3	1.9
Education	1	9.4*	6.8*
Occupation	1	2.9	3.3
Monthly income	1	7.1*	3.6
Relation with patient	1	10.6*	2.8
Duration of care per day	1	2.6	0.7

χ2 – value significant at 0.05 level; df: degree of freedom (1) = 3.84 P>0.05; *significant

ETHICAL CLEARANCE

The study was approved by the Institutional Ethics Committee/Review Committee (Ref No: PMT/PIMS/RC/CON/18/11) of Pravara Institute of Medical Sciences (Deemed University), Loni (Bk), Ahmednagar, Maharashtra.

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Development of a Student-rated Summative Teaching Evaluation Scale (STES-SR) Applicable to Psychiatric Nursing Education

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ABSTRACT

This paper reports the development of a student-rated instrument for the summative teaching evaluation which can be utilized in nursing education. A pool of 56 items' for the first draft of the evaluation scale was compiled from the available student-rated instruments based on an extensive literature review and expert opinion. Initial draft of the Student Rated Summative Teaching Evaluation Scale (STES-SR) with 50 items was formulated after removing 6 items with a Itemized Content Validity Ratio, ICVR of < 0.68 from the item pool by incorporating the reviews by a panel of 10 experts from the field of nursing education. During the second stage, pilot-test administration of the instrument on 20 randomly selected student nurses was done and their difficulties with interpretation were reviewed. Two difficult-to-interpret items were removed from the initial draft of the STES-SR and thus the final draft of the STES-SR with 48 items was formulated and field-tested among 100 randomly selected student nurses from 4 different classes (25 each from the classes). Reliability of the scale was estimated in terms of internal consistency and split-half reliability. It was revealed that the STES-SR having high internal consistency (Chronbach's α>0.75) and high reliability with significant (p<0.001) positive Pearson r value. Adaptation of the STES-SR would be helpful in determining the teaching effectiveness in a nursing education program.

Keywords: *Teacher evaluation, scale development*

INTRODUCTION

Highly qualified and effective teachers are necessary to improve students' performance. There is growing concern in identifying individual teacher's impact on student achievement. There are many different conceptions of teacher effectiveness, and defining it is complex and sometimes generates controversy. Teacher effectiveness is often defined as the ability to produce gains in student achievement scores. Trends in measuring teaching effectiveness can be influenced by the development of new instruments and technologies.[(1)]

Many different forms of evaluation strategies for the teaching effectiveness through observation of teaching practices, academic qualifications, or personal characteristics are available. Many of the reviewers agreed that student evaluations of teaching based on standardized formats are reliable than any other form of teacher evaluation.[(2)] Theall and Franklin (2001) argue that, students are more qualified than expert or peer assessors.[(3)] Moreover, there is general and long standing agreement in the literature that a standardized and field tested evaluation tool as effective method, since they provide consistent and stable measure for specific items related to the teaching efficacy. Student-rated teacher evaluation strategies are more commonly used in non-clinical educational evaluation in India and abroad. Practice of a teaching evaluation done by students is very rarely done in nursing education in India. The present study as a preliminary step aimed at constructing a student-rated teaching evaluation scale and to establish its validity and reliability towards the utilization in the meadow of nursing education evaluation in India.

OBJECTIVES

1. To develop a student-rated summative teaching evaluation scale.
2. To establish the content validity of the student-rated summative teaching evaluation scale.
3. To establish the reliability of the student-rated summative teaching evaluation scale in terms of internal consistency and split-half method.

PROCESS OF DEVELOPING STES-SR

The study was undertaken through three different stages as described below.

Stage 1: Item compilation & content validity estimation: The first stage was item compilation, purpose of which was to create a pool of items for the initial draft of the Student-Rated Summative Teaching Evaluation Scale (STES-SR) by identifying the items from existing scales or measures, and by adding additional items that appeared to fit the construct definitions.

A thorough literature search was undertaken by the investigators for the available student-rated teacher evaluation instruments towards the item compilation. The important reviewed available instruments are listed in as follows;[4]

1. Institutional documents related to course evaluations-University of Michigan.
2. Sample institutional evaluation instruments-University of Ontario.
3. Universal student rating of instruction-University of Alberta
4. Seneca College student feedback form- Seneca College
5. Sample institutional evaluation instruments-Ryerson University
6. Student rating of instruction questionnaire-Dalhousie University
7. Measure of teaching effectiveness- University of Ontario

All items drawn out of the existing instruments were categorized under five different domains in consultation with the subject experts.

Table 1: Domain-wise content validity index

Domains	Content validity Index	Comment
Personal attribute	0.90	CVI's are in acceptable range
Class room management	0.96	
Subject knowledge	0.84	
Clinical skill	0.88	
Evaluation	0.85	
Overall	0.89	

The domains included were Personal attributes (19 items), class room management (10 items), Theory knowledge (12 items), clinical skill (7 items), and Evaluation (8 items). This generated an item pool of 56 items. These items were composed of declarative statements about personal & professional attributes of a nursing teacher using ordinal scaling for responses (Never=1, Sometimes =2, and Always=3). In addition, these items were structured to achieve appropriate functional literacy and reading levels and reverse scoring was not required for any item. Once the item pool was created, items under the different domains were re-evaluated by the investigators to eliminate those which appeared to be redundant or ambiguous.

Initial blueprint of the STES-SR along with objectives and criteria checklist was submitted to 10 experts from the field of nursing education for content validation. Itemized Content validity Ratio (ICVR) was measured by measuring the expert consensus over the individual items. Six items with ICVR less than 0.68 were removed and the initial draft of the instrument with 50 items was retained. Domain-wise Content Validity Index (CVI) estimation of the instrument showed good CVI (≥0.85) for all its sub-domains (Table 1).

Stage 2: Pilot testing and difficulty estimation

The initial draft of the STES-SR was then administered on 20 randomly selected student nurses who belong to the 3rd year BSc Nursing class to evaluate one of their subject teachers after getting an oral consent from that teacher. Aim of this test was to ensure that the mechanics of compiling the items had been adequate. This was accomplished by having respondents first complete the instrument, and then

to comment on its length, wording, and instructions. An individualized appraisal was done to eliminate the difficult-to-interpret items and thus to make the instruments more valid. Thus the final draft of the scale was formulated and sent for field testing and reliability appraisal. During the second stage, 2 difficult-to-interpret items were removed from the initial draft of the instrument and thus the final draft of the instrument with 48 items with overall score ranging from 48-144.

Stage 3: Field testing and reliability measurement

For the final field test, 100 instruments were distributed to student nurses selected using proportionate (25 each) stratified random sampling from 4 different classes of BSc Nursing program (strata) to evaluate one of their subject teachers after obtaining an oral consent from the teacher and ethical clearance from institutes review board (IRB). Those students who included in the pilot study were removed from the final field testing.

Table 2: Interpretation of Cronbach's alpha[5,6]	
Cronbach's alpha	**Internal consistency**
$\alpha \geq 0.9$	Excellent (High-Stakes testing)
$0.8 \leq \alpha < 0.9$	Good (Low-Stakes testing)
$0.7 \leq \alpha < 0.8$	Acceptable (Surveys)
$0.6 \leq \alpha < 0.7$	Questionable
$0.5 \leq \alpha < 0.6$	Poor
$\alpha < 0.5$	Unacceptable

Final draft of the tool with 48 items was distributed among the student nurses along with a structured demographic data sheet. Age, socio-economic status of the family, and location of domicile were included under the demographic variables. Subjects were asked to answer the demographic data sheet and to rate the each STES-SR items from their perceptions about their subject teacher and her teaching effectiveness.

Item responses in the 100 completed STES-SR included the full range of possibilities from 1-3 (Never=1, Sometimes =2, and Always=3) respectively with no data missing. Internal consistency was measured using Cronbach's alpha and the interpretation based on the "α values" are given in the table 2. Then the items were randomly split into two equal halves. Scores on one half of the test with scores on the other half of the test was correlated calculating Pearson's product moment correlation coefficient. A significant ($p<0.05$) positive Pearson r value was considered as the indicator of the instrument as reliable.

A brief description of the process of the scale development is depicted in figure 1.

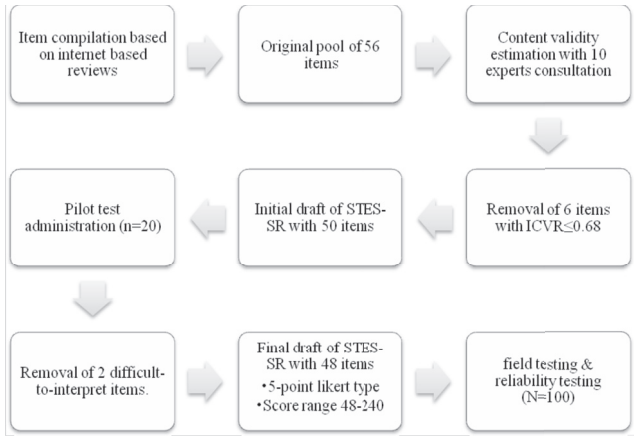

Figure 1: Process of STES-SR development

RESULTS

Analysis of the final 48 items of the STES-SR revealed a Mean total score of 196.61 (SD=19.20). No significant differences were observed for overall mean scores of STES-SR with respect to participants' age ($p=0.21$), (or) socioeconomic status ($p=0.56$) (or) location of domicile ($p=0.42$).

Table 3: Reliability measures of STES-SR		
Stratum	**Internal consistency Chronbach's α**	**Split-half reliability Pearson r**
1 (n=25)	0.85 (Good)	0.77 ($p<0.001$)
2 (n=25)	0.81(Good)	0.80 ($p<0.001$)
3 (n=25)	0.90 (Excellent)	0.85 ($p<0.001$)
4(n=25)	0.76 (Acceptable)	0.86 ($p<0.001$)

Table 3 depicts the stratum-wise reliability measurements for the STES-SR in the field testing stage. Internal consistency measurement among students (n=25) of the third stratum shown excellent internal consistency STES-SR items, while stratum 4 (n=25) shown α value at acceptable level.Split-half reliability estimation using Pearson's product moment correlation coefficient showed the tool to be reliable throughout the entire stratum-wise measurements with highly significant ($p<0.001$) positive r value.

DISCUSSION

The present study was undertaken to develop a Student-Rated Summative Teaching Evaluation Scale (STES-SR) and to test its reliability in a sample of student nurses. A draft of STES-SR with 48 items was developed after item-wise content validation. The scale was tested among 100 student nurses (25 each from 4 different classes) belong to graduate nursing program. Reliability estimation was done in terms of internal consistency and split-half reliability. It was revealed that the STES-SR having high internal consistency (Chronbach's α>0.75) and high reliability with significant (p<0.001) positive Pearson r value throughout the stratum-wise analysis.

LIMITATIONS & RECOMMENDATIONS

Limitations of this study are associated with sampling and response. Although proportionate stratified random sampling method was used, all those respondents were females. Thus the sample may not be considered fully representative of the student nurses' population. However, Berent & Anderko[7] states that "past researchers found that the smaller percentage of survey response in homogenous population, which is true for this study, is often acceptable". Furthermore, researchers acknowledge limitations in the generalizability of the tool due to cross-sectional approach selected for stage 3.

As with any newly developed and validated tool, there is a continued need to conduct follow-up validation studies to further cross validation of the internal consistency reliability of the tool in other settings and to further enhance tool's generalizability. More specifically the 48-item STES-SR psychometric properties should be cross validated in a larger sample that is representative of entire student population

IMPLICATIONS TO NURSING

STES-SR is used to measure teaching effectiveness rated by the students. The validation process confirms its reliability and validity for use in wide variety of educational settings. The overall STES-SR performed well regardless of the participant's age, socioeconomic status and location of the domicile. Thus STES-SR is regarded as appropriate for use in all educational evaluation, requires less than 15 minutes to complete, can be self-administered and easily scored. The tool offers a vehicle for summative evaluation of teaching effectiveness rated by the students. The higher the students' rating or scores; the more positive is the teaching efficacy. STES-SR can be useful in the summative evaluation of the teachers' performance to bring about desired change in relation to their teaching deliverance.

Closer examination of the total scores under the domains will help the teacher identify lacunae in her teaching that are in need of change or could be strengthened through additional resources, like modifying communication patterns, incorporating advancement in educational technology, probing areas that could enhance satisfaction and professional commitment. STES-SR results can be used to guide targeted quality improvement in the practice of nursing education.

ACKNOWLEDGEMENT

The researchers acknowledge the help of Prof. (Mrs.) Theyamma Joseph, Principal, Mar Baselios college of Nursing, Kothamangalam for her valuable support rendered during every step of this study. We gratefully admit valuable suggestions made by the reviewers whom we approached for the content validation of this instrument. Very special thanks to Mr. James Paul, Dept of Nursing, National Inst. of Mental Health & Neurosciences, Bengaluru for the help given in data analysis and for his valuable input towards formulation of this paper.

Conflict of Interest: We do not have any conflict of interest

Source of Support: Funding of this project was supported by Department of Continuing Nursing Education, Mar Baselios college of Nursing, Kothamangalam, Keralam.

Ethical Clearance: The study had an approval from the Institutional Ethical Review Committee (ERC) and an individualized informed consent was obtained from all the study participants before the evaluation procedure.

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A Comparative Study to Assess the Level of Psychosocial Problems of Elderly Females in Old Age Home and in Families, Bangalore

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ABSTRACT

Background of the study: A high prevalence of mental disorders is seen in elderly age. The problems experienced by elderly women are more acute, who are economically dependent solely on the families. In the advancing age, when the aged loose friends, job status, power influence, income, health etc. bring host of problems related to physical, economic, social and psychological aspects. Elderly is a crucial phase where the physiological, psychological and socio-cultural changes in elderly contribute to develop anxiety, depression, and stress.

Objectives: To assess and compare the level of psychosocial problems of elderly females in old age home and in families.

Materials and method: Non experimental descriptive research design and descriptive comparative survey approach was adopted for the study. The study was conducted in Sri Sai Dattatreya Old Age Home, in Janan Jyothi Nagar and Mallathehalli Primary Health centre, Bangalore. The samples of this study comprised of 30 elderly females in old age home and 30 in families at Bangalore. Non-probability, Purposive sampling techniques was used to draw the sample. The tools developed and used for the data collection were socio-demographic proforma and 3 point rating scale. The content validity was obtained from the six experts and the reliability was obtained by test re-test method. Feasibility of the study was confirmed by pilot study. The data was collected by structured questionnaire method and the The collected data was analyzed by means of inferential and descriptive statistics.

Results: The findings of the study revealed that majority of elderly females 15 (50%) had severe psychosocial problems, 9(30%) of them had moderate psychosocial problems and 6 (20)% of them had mild psychosocial problems in old age home, whereas, in families, majority of elderly females 15 (50%) had mild psychosocial problems, 10(33.33%) of them had moderate psychosocial problem and 5 (16.67%) of them had severe psychosocial problems. The unpaired-'t' test was carried out and it evidenced that there was significant difference in the level of psychosocial problems of elderly females between old age home and in families.

Conclusions: On the basis of the findings, the study concluded that the severity of psychosocial problems were more among elderly females in old age home compared to the elderly females who were living with their family. The elderly citizens are in need of urgent attention to understand, manage and prevent psychosocial problems

Keywords: *Psychosocial problems, Elderly females, old age home, families*

INTRODUCTION

Aging is an inevitable developmental phenomenon bringing along a number of changes in the physical, psychological, hormonal and the social conditions. Old age has been viewed, as problematic period of one's life and this is correct to some extent. The aged become increasingly dependent on others. As woman grows, her reduced activities, income and consequent decline in the position of the family and society makes her life more vulnerable[1].

The problem of elderly females has become a social problem in Indian society. The changes in the demographic structure during the last few decades in developing countries have made the aged a socially more noticeable[2].

Along with physical illnesses their psychological well being also gets affected. Predominant among these is depression. Based on World Health Organization, Five Well-being Index (1998 version), an attempt is made to identify prevalence of depression in the elderly Indian community. The prevalence of depression in elderly population was determined to be 21.7%[3].

The feeling of loneliness along with the natural age related decline in physical and physiological functioning makes them prone to psychological disturbances. Modernization and globalization have disintegrated the Indian family system and elders are forced to stay in old age homes. In some cases elderly members of relatively rich families or aged persons who have nobody to look after takes shelter in old age homes. The elderly live in these homes merely in terms of existence to complete the last phase of the lives[4].

According to Erickson, the crisis that older adults go through is "integrity versus despair". Integrity here means the capacity to accept ones past history and to face death without great fear. The negative way of resolving this stage of life is through what is called despair. Here the person gets frustrated and discouraged about the past and the present and may seek death as a way of ending a miserable existence or else dread it and live a very unhappy life in bitterness[5].

Along with physical illnesses their psychological well being also gets affected. Depression is the commonest psychiatric disorder in institutionalized aged. After depression comes anxiety disorders which may be caused due to their ill health and lack of social security. There is need for the researchers to focus their attention in this area to understand and quantify the problems of the aged. Institutional living poses special problems to the inmates. Knowing their way of life and their mental health related problems would help to comprehend the vastness and uniqueness of the problem and hence this area has become significant for the study[6].

Millions of elderly are suffering emotionally from the growing phenomena of gross indifference, profit motive, selfishness and decay in the family system. Therefore, the elderly citizens are in need of urgent attention to the quality of life. They do not need our pity, but the understanding love and care of their fellow human beings. It is our duty to see that they do not spend the twilight years of their life in isolation, pain and misery. Older persons are, therefore, in need of vital support that will keep important aspects of their lifestyles intact while improving their over-all quality of life. Hence, the present study was conducted to compare the general feelings; the main aim of the study was to understand the psychological and social problems faced by the elderly females in family and old age home. Personally the researcher also witnessed so many elderly women suffering from psychosocial problems and this probed the researcher to do her study[7].

RESEARCH METHODOLOGY

Research approach: A comparative survey approach was used for the present study.

Research design: Non- experimental descriptive research design was used.

VARIABLES

Study variables: Level of psychosocial problems of elderly females in old age homes and in families.

Demographic variables: Demographic variables of elderly females in old age homes and in families include age, religion, marital status, education, source of income, type of family, pre- employment

status, duration of stay in old age home, reason for staying in old age home, number of children in the family, caregiver in the family.

SETTING OF THE STUDY

Based on the geographical proximity, feasibility of conducting the study and availability of the samples, the study was conducted in Sri Sai Dattatreya Old Age Home, in Janan Jyothi Nagar, Bangalore and Mallathehalli Primary Health centre, Bangalore.

The total population of the present study comprised of all elderly females in old age home and in families in selected Sri Sai Dattatreya Old Age Home and Mallathehalli Primary Health centre, Bangalore.

SAMPLE

Elderly females in old age home and in families in selected Sri Sai Dattatreya Old Age Home and Mallathehalli Primary Health centre, Bangalore.

Sample size: The sample for the study consisted of 30 elderly females in old age home and 30 elderly females in families, who fulfill the inclusion criteria.

Sampling technique: The sampling technique adopted for the study was Non probability purposive sampling technique.

DEVELOPMENT OF TOOL

Based on the review of literature, discussion with experts and with investigator's personal and professional experience a structured questionnaire consisting of 40 questions was developed. This tool has two sections one for assessing the demographic variable and another for assessing the level of psychosocial problems.

Content validity of the tool: Content validity of the tool was established on the basis of opinion from six psychiatric nursing experts and one from Biostatistician. The tools were sent to them with a request to go through the tool and to suggest necessary modification. The suggestions and minor correction recommended by the experts were incorporated and instrument was finalized.

Reliability of the tool: The reliability of the tool was established from data of 6 samples by test-retest method and using Karl Pearson correlation formula. A score of 0.93 was obtained as r-value, which was highly positive. Hence, the tool was found to be statistically highly reliable.

Pilot study: Pilot study and final study was conducted after taking the administrative approval from Hiteshi Mahila Maneyangala trust, old age home and Mallathehalli Primary Health centre, Bangalore.

Procedure for data collection: After obtaining the official permission from the concerned authorities and informed consent from the samples, the researcher collected data and was carried out with the given period of four weeks.

Before administering the structured questionnaire purpose of the study was explained with self introduction and the subjects were assured that the details given by the subjects will be kept confidential then the questionnaire were distributed and the samples took an average time of 30-40 minutes to fill the questionnaire.

Plan for data analysis: The data collected analyzed by using descriptive and inferential statistics**.**

Descriptive statistics: Frequency and percentage distribution were used to analyze the demographic variables. Mean and standard deviation will be used to analyze the level of psychosocial problems of elderly females in old age home and in families.

Inferential statistics:

- Unpaired't' test used to compare the level of psychosocial problems of elderly females between old age home and in families.
- Chi-square (χ^2) test was used to associate the level of psychosocial problems of elderly females in old age home and in families with their selected demographic variables**.**

RESULTS AND DISCUSSION

Section-A: - Description of demographic Variables of elderly females in old age home and in families.

I. Findings of demographic variables of elderly females in old age home revealed that

Majority of elderly females 13(43.33%) belong to the age group of 66-70 years, 27(90%) were Hindus and most of them 18(60%) were widow. Maximum of them 11(36.67 %) had primary and secondary education, 17(56.66%) had no income and most of them 18(60%) were house wives. Majority of them 15(50%) were stayed for 0-2 years and maximum of them 21(70 %) had no one to take care.

II. Findings of demographic variables of elderly females in families revealed that majority of elderly females 14(46.66%) belong to age group of 66-70 years, Most of them 26(86.67%) were Hindus and maximum of them 15(50%) were married. Majority of them 12(40%) had secondary education, most of them 13(43.33%) had no income. Maximum 14(46.67%) were house wives and 18(60%) belong to nuclear family. Maximum 18(60 %) had one children and their care giver 21(70 %) were son.

Section-B: - Assessment of the level of psychological problems of elderly females in old age home and in families.

Table 1: The frequency and percentage distribution of level of psychosocial problems of elderly females in old age home and in families. n=30

Level of psychosocial problems	**level of Psychosocial problems**			
	Old age home		**Families**	
	No	**%**	**No**	**%**
Mild (<50%)	6	20	15	50.00
Moderate (50-75%)	9	30	10	33.33
Severe (>75%)	15	50	5	16.67

Assessment on the level of psychosocial problems revealed that majority of elderly females 15(50%) had severe psychosocial problems, 9(30%) of them had moderate psychosocial problems and 6(20) % of them had mild psychosocial problems in old age home, whereas, in families, majority of elderly females 15(50%) had mild psychosocial problems, 10(33.33%) of them had moderate psychosocial problem and 5(16.67%) of them had severe psychosocial problems.

Section-C: - Comparison of the level of psychosocial problems of elderly females between old age home and in families.

Table 2. Comparison of the level of psychosocial problems of elderly females between old age home and in families.

Psychosocial problems	**Mean**	**SD**	**Unpaired 't' test**
Old age home	56.83	10.73	3.31*
Families	47.76	12.14	

Note: *S= Significant at 5% level (i.e. P<0.05); NS=non significant

The mean score of psychosocial problems of elderly females in old age home was 56.83 with standard deviation 10.73 and mean score of psychosocial problems of elderly females in families was 47.76 with standard deviation12.14. The unpaired-'t' test was carried out and it was found to be invariably significant at <0.05 level, hence research hypothesis (H_1) was accepted. It evidenced that there was significant difference in the level of psychosocial problems of elderly females between old age home and in families.

Section-D: - Association between the level of psychosocial problems of elderly females in old age home and in families with their selected demographic variables.

Table 3 : Association between the levels of psychosocial problems of elderly females in families with selected demographic variables

Sl. No	Demographic variables	Sample		Level of psychosocial problem				Chi square χ^2
		No	%	' median		> median		
				No	%	No	%	
1.	**Sources of Income (Rs/month)**							
	a. Pension	5	16.67	2	6.67	3	10	9.14 df=3 *S
	b. Rental	4	13.33	4	13.33	0	0	
	c. Government scheme	8	26.67	8	26.67	0	0	
	d. No income	13	43.33	11	36.66	2	6.67	
2.	**Pre-employment status**							
	a. House wife	14	46.66	13	43.33	1	3.33	8.52 df=3 *S
	b. Daily wages	5	16.67	5	16.67	0	0	
	c. Private employee	6	20	5	16.67	1	3.33	
	d. Government employee	5	16.67	2	6.67	3	10	

The obtained chi-square value shows that there was significant association between the level of psychosocial problems of elderly females in families with selected demographic variables such as sources of income and pre-employment status.

RECOMMENDATIONS

- The same study can be conducted at large samples to generalize the finding.
- A similar study can be done to assess the psychosocial disorders of elderly females.
- A same study can be done to see the effectiveness of health education program on psychosocial problems of elderly females.
- An experimental study can be carried out to find out the effectiveness of a counseling program in reducing the psychosocial problems of elderly females.
- The extensive use of mass media for propaganda will help us in generating awareness and in prevention of psychosocial problems.

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Ethical Clearance: Approval for the study was gained from college dissertation committee on March 2012.

Sources of Funding: Self

Conflict of Interest: none

Here by I declare that the above article is original, should not have been published nor sent for publication anywhere else.

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Suicide an Overview: Self Protective Responses and Suicidal Behavior

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ABSTRACT

Life is full of risk. People must choose the amount of danger to which they are willing to expose themselves. Sometimes these choices are conscious and rational; other risk taking behaviors are unconscious. Even though life is risky, most societies have a norm that defines the degree of danger to which people may expose themselves. The norm varies by age, gender, socioeconomic status and occupation. In general, the very young, elderly, and women are seen as needing to be protected from harm. Protection and survival are fundamental needs of all living things.

Keywords: *suicide, self protective responses; suicidal behavior.*

INTRODUCTION

Suicide, commonly known by several names like completed suicide, attempted suicide, Para suicide, Deliberate Self Harm (DSH), self assault, self insult and others is an indicator of the health of the society. Taking of one's own life is the most private of acts, but, as the great French sociologist Emile Durkheim pointed out, the incidence of suicide varies widely across societies and historical periods. On a continuum of self protecting responses, self enhancement and growth promoting risk taking are the most adaptive responses, whereas indirect self-destructive behavior, self injury and suicide are maladaptive responses.

EPIDEMIOLOGY AND INCIDENCE OF SUICIDE

Suicide is one among the three leading causes of death among those aged 15- 44 years. Every year, almost one million people die from suicide; a "global" Mortality Rate of 16 per 100,000, or one death every 40 seconds. In the last 45 years suicide rates have increased by 60% worldwide. Suicide worldwide is estimated to represent 1.8% of the total global burden of disease in 1998, and 2.4% in countries with market and former socialist economies in 2020. (WHO, 2009). According to the National Crime Records Bureau of India (2006), suicide is among the top ten causes of death in India.[1]

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CAUSE /PREDISPOSING FACTORS OF SUICIDE[2]

Psychiatric diagnosis

- Mood disorder (15%), substance abuse (25-50%), anxiety disorder and schizophrenia (40%) 3.2 Personality disorder
- Hostility, impulsivity, depression and hopelessness
- Coexistence of antisocial and depressive symptoms

Biochemical factor

- Association betweensuicidal tendencies and low level of brain neurotransmitter serotonin (5-HT), imbalance or deficiency of neurotransmitters lead to mood disorder.
- Low levels of 5-HIAA in spinal fluid among people have high incidence of history of hospitalization for suicidal attempts

Genetic & familial variables

- Family history of major depression, family stress, transmission of genetic factor

Psycho social factor and physical illness

- Lack of social support, negative life events, chronic medical illness
- Recent bereavement, separation or divorce death of a loved one
- Loss of a close relationship
- Unemployed recent job change, job loss low self esteem
- Public embarrassment, threat of jail multiple life stresses

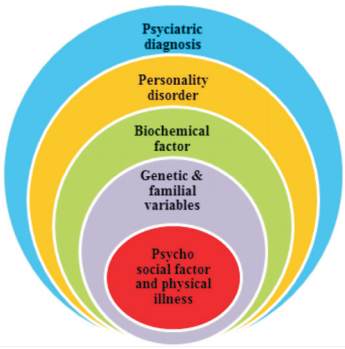

Figure.1 Predisposing factors of suicide

CONTINUUM OF SELF PROTECTIVE RESPONSES AND SUICIDAL BEHAVIOR[2]

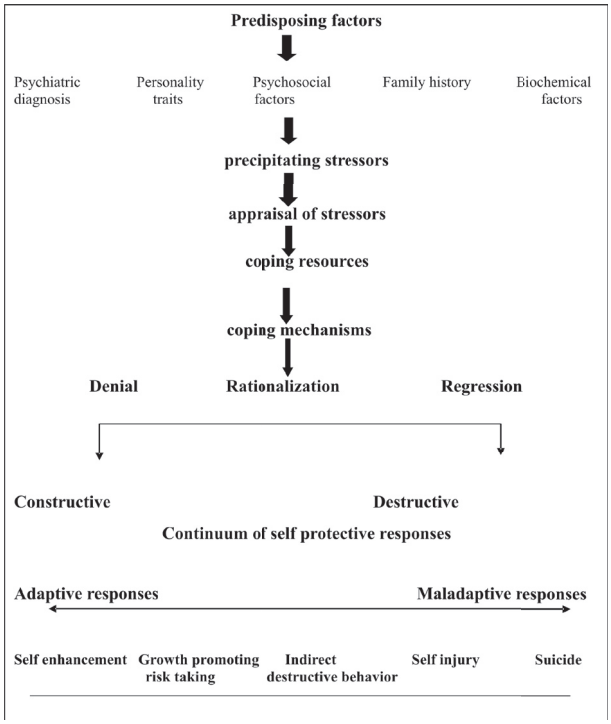

Figure. 2 Continuum of self protective responses

Precipitating stressors

Self destructive behavior may result from any stress the person feels as overwhelming ie., uncomfortable and intolerable life situations. Anxiety is therefore central to self destructive behavior. When the sense of self-worth is extremely low self destructive behavior is likely[2].

APPRAISAL OF STRESSORS

It is essential for the nurse to assess each patient for the following suicidal risk factors[2].

- High level of anxiety
- Death of a loved one
- Concurrent use of drugs
- Family history of major depression
- History of legal problems
- Prior suicide attempt

High risk group of suicide[2]

- Early parental deprivation
- Recent bereavement
- Single person- divorced, separated, widow
- Positive family history of suicidal behavior, previous attempt of suicide
- Quarrel with the husband and in men it was a quarrel with the parents
- Depression, unemployed, Poor impulse control
- Substance abuse and psychosis
- Neurotic disorders
- Bipolar disorder

Common method of attempting suicide[2]

- Poisoning
- Hanging
- Drowning
- Burning
- Jump in-front of train
- Using gun, staging car crash
- Over dosing on pills
- Self-immolation

Coping resources[2]

Self destructive behavior is related to many socio-cultural factors. The structure of society has a

great influence on the individual. Society may either help and sustain individuals or lead them to self destruction.

Protective forces against suicide[2]

- Ability to cope with stress
- Effective and appropriate clinical care for mental, physical and substance abuse disorder.
- Ongoing or continuing sense of hope in the face of adversity
- Cultural and religious belief that discourage suicide and support self preservation instincts
- Learnt skills in problem solving, conflict resolution and nonviolent handling of disputes.
- Family and community support
- Restricted access to highly lethal methods of suicide

Coping mechanisms[2]

A patient may use variety of coping mechanisms to deal with self destructive feelings including denial, rationalization, regression and magical thinking. These coping mechanisms may stand between the person and self destruction. They defend the person from strong emotional responses to life events that are a serious threat to the ego. If they are removed, underlying depression will become overt and may lead to suicidal behavior

MANAGEMENT OF SUICIDE[3]

- Protection and safety
- ncreasing self esteem
- Regulating emotions and behavior
- Mobilizing social support
- Patient education
- Prevention of suicide
- Public health approaches to suicide prevention

Protection and safety

The highest priority nursing activity with self destructive patients is to protect them from inflicting further harm on themselves and, if, suicidal from killing themselves. The nurse should supervise the patient at all times. The patient should not left alone. The nurse should monitor any medications the patient receives. The nurse must ensure that any lethal means of injury are removed from the patient's access.

Increasing self esteem

The nurse should be alert to strengths that can be built on to provide the patient with positive experiences. It is also important to reinforce reasons for living and to promote patient's realistic expectations based on their strengths.

Regulating emotions and behavior

Once the acute crisis is over, the nurse can help the patient understand high risk times and triggers, the feelings that are stimulated, dysfunctional thinking patterns, and resultant maladaptive coping responses. The patients can do the following in times of stress

- Increase involvement with others
- Initiate physical activity
- Engage in relaxation and tension reducing activities
- Process feeling by talking with someone

Mobilizing social support

Family members must be made to aware of control issues and helped to encourage self control by the patient. Both the patient and the family may need help to see that caring can be expressed by fostering self-care, as well as by providing care. Community resources are important for the long term care of the self destructive person. Self help group may be provided the recovering patient with needed peer support. Community health nurse, clergy, and other community helpers can provide the patient and the family with day-to-day support.

Patient education

The nurse should assess the patient knowledge and initiate appropriate teaching. Information about how to handle any future crises should be provided to the patient. If the nurse has explained the possible reason for the patient's behavior, this may be reinforced at termination of the relationship to help the patient integrate the experience into his/her self-concept.

Prevention of suicide[4]

Since physical illness itself is a risk factor for suicide nurses and other health care providers are highly likely to see people who may be at risk of

self-harm. Because nurses spend so much time with patients, a trusting relationship can develop, which may encourage patients to reveal their feelings to nurses even when they are reluctant to share this information with their family or their physicians. As a nurse, you are in a unique position to do several things:

- Observe changes in the mood and behavior of your patients
- Help patients recognize that the underlying source of their physical problems may be depression or another mental health concern[4]

Public health approaches to suicide prevention

The following public health approaches can be used for suicide prevention in children and adolescents:

a. crisis hotlines;

b. method restriction;

c. indirect case-finding by educating potential gatekeepers, teacher, parents, clergy and peers to identify the "warning signs" of an impending suicide;

d. direct case-finding among high school or college students or among the patients of primary practitioners by screening for conditions that place teenagers at risk for suicide;

e. Media counseling to minimize imitative suicide; and training professionals to improve recognition and treatment of mood disorders.

Nursing diagnoses related to self protective responses[2]

- Risk for suicide related to loss of loved one as evidenced by discussion of death and social withdrawal
- Self mutilation related to feelings of tension and self worthlessness
- Noncompliance with taking therapeutic drug (anti hypertensive) related to asymptomatic behavior as evidenced by clinical signs and symptoms of chronic illness (elevated blood pressure)
- Risk for self directed violence related to loss of spouse as evidenced bu discussions of death, purchase of any lethal substance

SUMMARY

Self injury is the act of deliberate harm's to one's own body. The three aspects of personality that are most closely associated with increased risk of suicide are hostility, impulsivity and depression. it also related with socio-cultural factors. The nursing intervention include protecting the patient and providing safety, increasing self esteem, regulating emotions and behavior, mobilizing social support, educating the patient and suicide prevention.

CONCLUSION

The continuum of self protective responses ranges from the most adaptive states of self enhancement and growth promoting risk taking to the maladaptive responses of the indirect self destructing behavior, self injury and suicide. it can be influenced ny various factors in the environment. The nurse must approach the patient with hope that the patient will grow and be able to live a satisfying life.

Acknowledgement: None

Conflict of Interest: None

Source of Funding: None

Ethical Clearance: None

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A Study to Assess the Awareness of Mental Retardation among Women in Selected Areas of Ar'ar- Saudi Arabia, with a View to Develop an Information Booklet about Mental Retardation

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ABSTRACT

Objectives:

1. To identify awareness of women regarding mental retardation.
2. To find the association between demographic variables and the awareness of women regarding Mental retardation.
3. To develop an information booklet about mental retardation

Study Design: For the present study **A Survey Research Design** was found to be appropriate to achieve the objectives.

Sample & Sampling Technique: The sample for the present study consists of 60 women between the age group of 18 to 45 years from the selected areas of Arar- KSA. Convenience non-probability sampling technique was adopted

Period: Data was collected during the period of 1st term of academic year 1434 /1435

Tool : For the present study, the technique for data collection was self structured questionnaire for identifying awareness of the women regarding Mental Retardation.

Result : This study shows that out of 60 women, 20 (33.33%) have lack of awareness, 39 (65%) are moderately aware and 1(1.67%) is adequately aware regarding Mental Retardation.

Conclusion : Mental Retardation is a taboo in the society. Most of the people are having miss concepts regarding mental retardation that it occurs due to evil spirit or bad deed or sins of parents. It is necessary to assess awareness regarding Mental Retardation among general population. In this study 60 women were selected to assess awareness regarding mental retardation. Researchers found that only 1 woman out of 60 was adequately aware regarding mental retardation rest others were inadequately aware. After getting result researchers have developed information booklet on Mental Retardation

Keywords : *Awareness, Mental retardation, Women ,Information booklet*

Hypothesis: H1: There will be significant association between demographic variables and the awareness of women regarding mental retardation

INTRODUCTION

Mental retardation is one of most frequently encountered and most distressing disability among children in industrialized and developing countries. Mental retardation is a particular state of functioning that begins in childhood and is characterized by decreased intelligence and adaptive skills. Mentally Retarded children frequently end up being kept at the fringe of society, where they continue to be non-productive and develop additional behavioral problems because of the lack of structure in their life. For example, a research group found that in UAE, psychiatric disorders were more frequent among children with mental disability.

M. Thomas(2005) [1] stated that mental retardation is a condition, which affects both general intelligence and adaptive behaviour of an individual, and it often presents with various kinds of sensory-motor impairments with increased levels of retardation. Since it is a permanent condition, which grossly impacts the intelligence and general development, it is also known as intellectual and developmental disability. The nature of mental retardation is such that it interferes with many day-to-day functioning of an individual such as self-help skill, social and communication behaviours, academic skills, leisure and recreational skills.

Peshawaria et.al(1995)[2] also proved Mental retardation not only affects the individual but also creates many unique situations and needs for the families from the care giving perspective. The demands are obviously more on parents but a differential impact could also be seen on the siblings and grand parents

Singh et.al(2002) [3] in their study on perceptions of lives with children with intellectual disability found six major themes: challenging the process of acceptance, painful emotional reactions, the interrelatedness of mother's health and child's well being, struggles to deal with oneself or the child, inadequate support from the family and the community, and the anxiety related to child's uncertain future

Persons with mental retardation have been considered burdensome and shameful, because they are incapable of contributing to traditional social obligations and roles. These attitudes and behaviours not only prevent the children from getting appropriate medical care for their conditions, but also prevent them from living "normally".

MATERIAL AND METHOD

A quantitative (descriptive survey) research approach was considered to be the most appropriate to fulfill the objectives of the study. A self structured questionnaire was prepared which was validated by experts from the field of Psychiatric Nursing, Psychology and Sociology. The tool used for data collection were structured questionnaire comprising 30 selected dichotomous questions regarding information and misconcepts regarding Mental Retardation. The reliability of the tool was established by split half(odd and even split) and the reliability coefficient was 0.66. The tool was found to be reliable for the study. The study was conducted at the selected area of Ara –KSA. Convenience, non probability sampling technique was adopted to select 60 women between the age group of 18-45 years. Final data was collected during the period of 1st term of academic year 1434 /1435.

Selection and Development of Tool

For the present study, the technique for data collection was self structured questionnaire for identifying awareness of the mother regarding Mental Retardation.

The tool was divided into two parts:

Part I: It consisted of questions related to the demographic data such as age, marital status, number of children, family type, educational qualification, occupation, and family income.

Part II: It consisted of 30 dichotomous questions on assessing awareness of the mother regarding Mental Retardation.

The respondents were asked to respond appropriately in "YES" or "NO" in each respected question.

Table-1: Categories of level of awareness based on scoring

Scores	Categories of awareness
1-10	Lack of awareness about mental retardation
11-20	Moderately Aware about mental retardation
21-30	Adequately Aware about mental retardation

FINDINGS

SECTION I: Findings related to Demographic Characteristics of women reveled that

Out of 60, majority 38 (63.33%) were from the age group of 18-25 years, most of the women 24(40%) studied up to higher secondary, 49(81.66%) women were house wife, majority 29(48.33%) women were

having family income between 5001 to 10000 SAR per month, most 25 (41.66%) women having number of children 1 or 2 and 1 (1.6%) woman is already having clinically diagnosed Mentally Retarded child.

Figure 2 Frequency and Percentage of the women as per their demographic characteristics

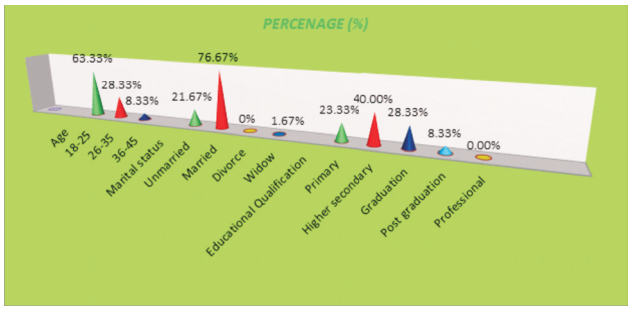
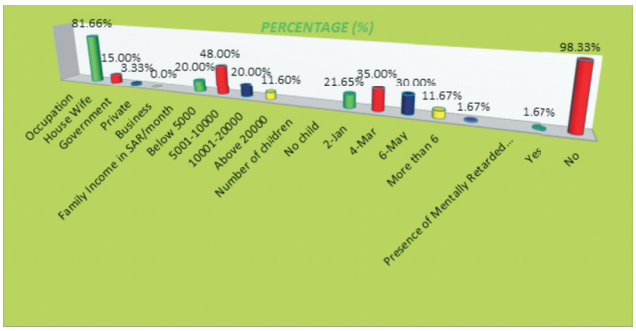


Figure 3 Frequency and Percentage of the women as per their demographic characteristics



SECTION II: Findings related to determination of awareness of the women regarding Mental Retardation

This study shows that out of 60 women, 20 (33.33%) have lack of awareness, 39 (65%) are moderately aware and 1(1.67%) is adequately aware regarding Mental Retardation.

Table 2: Frequency and Percentage of the women as per their awareness level regarding Mental Retardation

Level of Awareness	Freq-uency	Percentage	Mean	S.D
Lack of awareness	20	33.33%	12.1333	4.73167
Moderately aware	39	65%		
Adequately aware	1	1.67%		

Result shows that out of 60 women, 20 (33.33%) have lack of awareness, 39 (65%) are moderately aware and 1(1.67%) is adequately aware regarding Mental Retardation.

SECTION III: Findings related to the association of demographic variable and level of awareness of women regarding Mental Retardation

The study shows that the demographic variables such as age, marital status, educational qualification, occupation, family income and presence of mentally retarded child at home have association with the awareness levels of mental retardation among women. Variable, number of children does not have any association with the level of awareness of mental retardation among women.

Thus accept the hypothesis

Validation of Information Booklet on Mental Retardation and its Prevention

After identifying the lack of awareness of the women regarding Mental Retardation researchers has made Information booklet in to English and Arabic language and validated by experts.

DISCUSSION

Present study revealed that out of 60 women, 20 (33.33%) have lack of awareness, 39 (65%) are moderately aware and 1(1.67%) is adequately aware regarding Mental Retardation. There was not an adequate awareness in the women regarding mental retardation. This study is consistent with the study done by Peshawaria et.al(1995)[2] also showed that 49 out of 100 women were not aware about mental retardation and they were having many misconcepts. That study also showed that there was an inadequate awareness in father regarding mental retardation. Out of 100, 37 father showed misconcept regarding Mental Retardation.

Our findings support the fact that children suffering from mental handicap are considered as burden by their family members. Negative parental attitude leads to rejecting attitude towards mentally retarded children. This adversely affects the interaction within the family and also with outsiders. Such children should be offered support by family members to enable them to cope with stressful situations and in their rehabilitation. There is a need for implementation of family based schemes

for such disabled children. This study is in consistent with Jani(1967) [4], he examined the social problems related to the presence of a intellectually disabled child. Results indicate that parental feelings were marked by anxiety about future. Also, negative effects towards other siblings, psychological stress, decreased interaction with neighbors and relatives, misunderstandings within family and economic loss were significant facts associated with presence of a child with intellectual disability in the family.

Present study also revealed association of awareness with demographic variables like age, marital status, educational qualification, occupation, family income etc. Thus study proves that higher the education level higher, age, good occupation higher the awareness. This study is inconsistent with the study done by Ghoswami(1998)[5]. That study showed that higher the education level lower the misconcepts in mothers regarding Mental Retardation. Behari and Richa(1995)[6] conducted a study on maternal attitude and child rearing practices of mentally retarded children. The sample consisted of 60 mothers, of which 30 are less educated and low socio-economic class (group1) and 30 well educated upper middle class mothers (group2). The study investigated the attitude of mothers towards their mentally retarded sons in 23 areas of child rearing . the result revealed significant differences between group 1 and group 2 in respect of 7 areas of child rearing practices.

Peshawari et.al(2000)7. reported in her study that there is no significant relationship between the variable number of children and awareness regarding Mental retaradation in mother that study is consistent with present study. Present study also reveled that there is no significant association between number of children in women and their awareness regarding mental retardation.

The present study showed that there are many misconcepts regarding Mental retardation among women. Most of the women showed lack of awareness regarding cause s of the Mental retardation. They feel that it occurs due to parents seen, bad spirit and evil bad deed of parents. They also revealed lack of knowledge regarding treatment of the Mental retardation. Many of them think that marriage can cure Mental Retardation, Medication can cure it, mental retarded person can become all right after some age etc. This study is consistent with Peshawaria et.al(1995)[2], they reported that The items were: intellectual disability is due to sin, faith healing can cure, they may benefit from school, appropriate training improves condition, the person can get married and enjoy life, can look after own property, learn new skills with stepwise training and can be involved in house hold activities..

Acknowledgement: We would like to express our deep sense of gratitude to our beloved parents for their kind support and guidance throughout this project. We are equally grateful to mothers who participated in the study and gave their valuable time.

Conflict of Interest: There has been enormous research related to knowledge of the community regarding various disease conditions in Saudi Arabia but very less studies done regarding knowledge of the community regarding Mental Health Disorders. This study was helpful to know regarding mother's knowledge regarding Mental Retardation and guideline regarding Mental Retardation for mother in Arabic language will helpful to increase their knowledge and interest in Mental Retraction. This will be helpful to see prevalence of Mental Retardation in the community and will enhance their early detection.

Source of Funding: This is been funded by the author themselves.

Ethical Clearance: It is been given by the faculty of Health and Applied Sciences, Northern Border University- Ar'ar- Saudi Arabia

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A Quasi Experimental Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding Sexual Abuse among Adolescent Girls in Selected Schools, District Jalandhar, Punjab, 2014

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ABSTRACT

The study was conducted to assess Effectiveness of Structured Teaching Programme on Knowledge Regarding Sexual Abuse among Adolescent Girlsin Selected Schools, District Jalandhar, Punjab, 2014. Data was collected by interview schedule. Amongadolescent girls, majority of the sample subjects had average knowledge regarding sexual abuse.

Objectives

1. To assess the pre test knowledge score regarding sexual abuse among adolescent girls in experimental and control groups.

2. To assess the post test knowledge score regarding sexual abuse among adolescent girls in experimental and control groups after structured teaching programme in experimental group.

3. To compare the pre test and post test knowledge score regarding sexual abuse among adolescent girls in experimental and control groups.

4. To find the association of post test knowledge score regarding sexual abuse among adolescent girls and with selected socio demographic variables.

Research methodology

Research approach and design: Quantitative research approach, Quasi-Experimental (Non equivalent Pre Test Post Test control group) research design

Research setting: Selected schools, district Jalandhar, Punjab.

Population: Population of the study was all the adolescent girls of schools, district Jalandhar, Punjab.

Sampling techniqueand sample size: Convenience sampling technique. Sample of 100 adolescent girls was selected.

Result and conclusion: The post test mean knowledge score 19.24 in experimental group was higher than post test mean knowledge score 10.08 and it was statistically significant at P>0.05 as calculated't' value (t=17.9995*) was more than the table value at P>0.05 level of significance. Hence H_1 is accepted and H_0 is rejected. It was showed that knowledge regarding sexual abuse among adolescent girls has increased after structured teaching programme.

Keywords: *Structured teaching programme regarding sexual abuse, Adolescent girls.*

INTRODUCTION

Sexuality is a complex aspect of our personality and 'self'. Our sexuality is defined by sexual thoughts, desires, erotic fantasies and experiences. In many ways sexuality is the force that empowers us to express and display strong, emotional feelings for another person and is a natural stimulus for the procreation of our species. Sexuality is a part of a person's personality. Freud described formation of personality through five stages of psychosexual development: oral, anal, phallic, latency and genital.

It determines in part the way in which that person interacts with his environment. Sexual abuse can affect the adolescent more than the other age groups. It will cause low self esteem, many mental disorders like post traumatic stress disorder, depression, anxiety, eating disorder etc.

Sexual abuse is a problem of epidemic proportions in the United States. Sexual abuse typically does not occur in isolation.The U.S. Department of Health and Human Services (2008) states that nearly 80,000 American children were victims of sexual abuse in 2006.

Sexual assault is any sexual activity to which you haven't freely given your consent. This includes completed or attempted sex acts that are against your will. Sometimes it can involve a victim who is unable to consent. It also includes abusive sexual contact. Sexual abuse involves both touching and non-touching behaviors. The behaviors include fondling of breasts, genitalia, or buttocks under or on top of clothing, exposure to pornography or adults engaging in sexual activity, or even oral, anal, or vaginal penetration.

MATERIAL AND METHOD

The study wasconducted in Little star public school, Paramount public school, Victor international high school, S.R.L public schools, district Jalandhar, Punjab.A Quasi-Experimental (Non equivalent Pre Test Post Test control group) research design was considered and 100 adolescent girls were selected, 50 in experimental and 50 in control group.Samples were selected by convenience sampling technique.

RESULTS

The first objective reveal that in control group out of 50 samples maximum knowledge score is n=22(44%) fall in average category, n=28 (60%) fall in below average and not even single adolescent in good category. In experimental group out of 50 maximum knowledge score is n=28 (56%) fall in average category, n=22 (44%) fall in below average category, not even single fall in good category.

In second objective, control group out of 50 samples maximum knowledge score is n=23 (46%) fall in average category, n=27 (54%)fall in below average and not even single adolescent in good category. In experimental group out of 50 maximum knowledge score is n=16 (32%) fall in good category, n=34 (68%) in average category, not even single fall in good category below average category.

Third objective reveals that research hypothesis (H_1) is accepted (The mean post test knowledge score of experimental group as compare to control group after structured teaching programme on sexual abuse is significant ($P<0.05$) among adolescent girls in selected schools, district Jalandhar, Punjab) and null hypothesis is rejected (H_0).

It is concluded that the structured teaching programme was effective in providing knowledge regarding sexual abuse among adolescent girls in selected schools in Jalandhar, Punjab.

CONCLUSION

The study was undertaken to assess the effectiveness of structured teaching programme on knowledge regarding sexual abuse among adolescent girls in selected schools in District Jalandhar Punjab. From the findings of the study, it was revealed that the pre test knowledge score of experimental & control group 10.36±2.59 & 10.02± 2.44 were respectively. The post test knowledge score of experimental & control group were 19.24±2.33 & 10.08±2.9 respectively. It indicated that there was significant increase in knowledge regarding sexual abuse among adolescent girls in experimental group rather than control group.

DISCUSSION

Objective1-In the present study in control group out of 50 samples maximum knowledge score is n=22(44%) fall in average category, n=28 (60%)fall in below average and not even single adolescent in good category. In experimental group out of 50 maximum knowledge score is n=28 (56%) fall in average category, n=22 (44%) fall in below average category, not even single fall in good category.

The findings of the study were discussed with the results study conducted by Tang CS, Lee YK. (2009)., conducted a study on Knowledge on sexual abuse and self-protection skills. This study aimed to examine the level of sexual abuseknowledge and

self-protection skills in a sample of female. Result reveals that participants were more able to accurately recognize inappropriate than appropriate touches and sexual requests, and possessed limited information about sexual abuse. They were also inadequate in protecting themselves against sexual abuse, and had the most difficulty in reporting the sexually abusive incident and characteristics of the offender.

Objective 2- In the present study in control group out of 50 samples maximum knowledge score is n=23 (46%) fall in average category, n=27 (54%)fall in below average and not even single adolescent in good category. In experimental group out of 50 maximum knowledge score is n=16 (32%) fall in good category, n=34 (68%) in average category, not even single fall in good category below average category.

The findings of the study were discussed with the results study conducted by Fuertes Martín A, Orgaz Baz MB, Vicario-Molina I, Martínez Alvarez JL, Fernández Fuertes A, Carcedo González RJ(2012).,conducted a study on Assessment of a sexual coercion prevention program for adolescents. This study's focus is to evaluate a sexual coercion prevention program in adolescents. It has both experimental (n=93) and control group (n=76) an interventions of seven sessions are completed. The result revealed that a decrease in stereotypical beliefs about the opposite sex and increased empathy toward victims of sexual coercion. Also, in the treatment group, a more acute decline was observed in the proportion of young people engaging in sexually coercive behaviors.

Objective 3-In the present study the comparison of pre test and post test knowledge score of adolescent girls among experimental and control group reveals that research hypothesis is accepted (H_1) and null hypothesis is rejected (H_0). It is concluded that the structured teaching programme was effective in providing knowledge regarding sexual abuse among adolescent girls in selected schools in Jalandhar, Punjab.

Objective 4-In the present study, selected socio-demographic variables in control group i.e educational status of father, age of adolescent girls and in experimental group educational status of student and type of family impact on adolescent girls knowledge regarding sexual abuse.

Acknowledgement: I want to express my gratitude especially to the Principals of selected schools, Distt. Jalandhar, Punjab who allowed me to conduct study and the subjects those are participated in the study. I also want to thank Mr. Kishanth Olive, Ms. Ravinder Kaur, Mr Sujith Chandaran and my affectionate and adoring Parents, brother, uncle and aunt for their constant support and encouragement.

Ethical Clearance:

1. Written permission was taken from principal of S.G.L Nursing College Semi, Jalandhar Punjab.

2. Written permission was taken from ethical clearance committee of S.G.L Nursing College Semi, Jalandhar Punjab.

3. Written permission was taken from principals of selected schools, District Jalandhar, Punjab.

4. Written consent was taken from parents of adolescent girls who were under the age of 18 years and consent was taken from adolescent girls above 18 years participating in the study.

5. Confidentiality and Annonymity of samples was maintained throughout the study.

Source of Funding- Self

Conflict of Interest- Nil

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Assessment of the Occurrence of Sibling Violence among Adolescent Siblings

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ABSTRACT

Sibling violence can be defined as the intentional verbal, physical or psychological/ emotional abuse inflicted by a sibling on another in a repeated pattern. The study aimed to assess the occurrence of verbal, physical and psychological/ emotional violence among siblings. This descriptive study included 50 adolescent siblings aged 10 – 19 years residing in selected areas of Delhi selected using convenient sampling technique. A structured questionnaire was used for data collection. Results revealed that 70 % of the samples had very low, 28% moderate and 2% had very high occurrence of sibling violence. The occurrence of verbal abuse was the highest followed by psychological abuse and then physical abuse. Results confirmed earlier studies' findings that siblings engaged in a variety of violent acts directed towards one another. Nevertheless our study reaffirmed the observation that sibling violence is an understudied phenomenon and one which is worthy of more considerable attention. This study concludes with giving emphasis on the urgent need to screen adolescents for sibling violence, build awareness about sibling violence and educate families to differentiate between abusive and sibling rivalry. Effective parenting techniques should be deployed so that proper mental health services are provided at the earliest to the victims.

Keywords : *Sibling Violence, Verbal Abuse, Physical Abuse, Psychological/ Emotional Abuse.*

INTRODUCTION

Sibling violence has always remained under the rugs in a country like India where about nineteen percent of the world's children live, which constitutes about 42 percent of India's total population [1]. In recent years, India has been increasingly open about the experiences of battered women, yet it still loathes to acknowledge intra familial violence toward children. [2].

Sibling violence can be defined as the intentional verbal, physical or psychological/ emotional abuse inflicted by a sibling on another in a repeated pattern. Straus, Gelles and Steinmetz were the first to call attention to sibling violence as a widespread and problematic phenomenon. They suggested that the sibling relationship was the more likely milieu in which a family member might be victimized. When applied to the nation's estimated 36.3 million children in their survey, they extrapolated that over 29 million children engage in one or more acts of physical violence toward a sibling[3].

However, there are some factors that contribute to the occurrence of sibling abuse. Children tend to learn about violent behavior from several sources like media, peers, neighborhood and sometimes within their family. Also, the children who witness or experience violence tend to use it against their siblings. Sometimes parental favoritism is the real cause of a child's hostility towards a sibling. [4] In addition, the psychodynamics associated with sibling abuse, show an intensification of "normal" sibling rivalry due to the abuser's own maltreatment and deprivation. These sibling attacks are taken as a measure of revenge against the more highly regarded sibling rival; it serves as an outlet for rage directed towards the mother; they are used as an attention getting

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device; provides a sense of mastery over the trauma of their own abuse and are used to "educate" the abusing parent [5]. Hotaling, Straus & Lincoln [6] found that sibling aggression was somewhat common even in families that could not be classified as pervasively abusive, with 37% of 498 children committing at least one act of serious abuse during the previous year; in abusive families, 100% of children committed at least one act of serious abuse.

A cross cultural study found clear relationships when the data was analyzed by the sex of the sibling pairs. Female sibling pairs had higher discussion scores than male pairs, and mixed-sex pairs had the lowest discussion and verbal scores. Also, the male sibling pairs were more violent than female pairs, although the lowest violence scores were among brother/sister sibling pairs. In addition, children who are close in age are most likely to be in conflict with each other. Even the birth order and family size play a significant role in sibling abuse. For example, male sibling pairs more often threw things, pushed and hit than did female sibling pairs, the highest use of physical violence occurred between boy-girl sibling pairs, 68 percent of which engaged in high levels of violence. In addition, most of the abusing children were the eldest. Thus, sibling abuse can be recognized as the most common and overlooked form of family violence yet the least recognized.[7,8]

However, sibling violence often remains understudied for several reasons; firstly the parents never recognize the act as abusive and dismiss it as a normal phenomenon of sibling rivalry. Also, the society contributes to such a disregard as they claim such acts to be essential to develop a 'thick skin'. But, the truth is farfetched and has disastrous effects on the victims of sibling violence. Various studies have shown that women who recall painful physical or emotional sibling abuse during childhood are much more likely to suffer from depression, anxiety and low self esteem whereas men who recall sibling abuse are more likely to suffer from low self esteem. Inability to trust, relationship difficulties, alcohol, drug and eating disorders have also been linked to sibling abuse in childhood. It has also been noted that sibling conflict does not have to be physically violent to take a long lasting emotional toll. Emotional abuse, which includes teasing, name calling and isolation can be just as detrimental [4]. Even when there are no physical scars, aggression between siblings can inflict psychological wounds as damaging as the anguish caused by bullies at school or on the playground. Since the prevalence and significance of sibling violence is underplayed, we could find very few studies done in this area, especially in Indian social scenario.

Therefore, this study sought to remedy this neglect by assessing the occurrence of sibling violence, a very common form of domestic violence with very far reaching psychological effects on the victimized siblings. It also gives emphasis on the urgent need to screen adolescents for sibling violence, build awareness about sibling violence and educate families to differentiate between abusive and sibling rivalry. "Teaching children about negotiation, seeing another person's point of view and coming up with a mutually acceptable solution - they're all valuable lessons" [9]. This inquiry will also contribute to the theoretical and empirical understanding of sibling violence. Further, such an exploration will help in timely interventions.

MATERIALS AND METHOD

Study Setting and Sampling

A quantitative descriptive survey approach with cross – sectional design was used to achieve the objectives of the study. The study collected data to identify the occurrence of verbal, physical and psychological/ emotional violence among siblings. The siblings were defined as adolescents in the age group of 10 – 19 years who were related by blood to each other as brother or sister, born to the same set of parents. Therefore, the study population comprised of adolescent siblings residing in Delhi and convenient sampling technique was used to select a sample of 50 adolescent siblings residing in selected areas of Delhi, namely Badarpur, Hauz Khas, Mayur Vihar and Dwarka as per the predetermined inclusion and exclusion criteria. The study sample included adolescents who could communicate in Hindi or English were willing to participate in the study and were available at the time of the study. Also, the study sample excluded adolescents who were half brothers or sisters and had sibling/s living separately. The investigator took the consent of the participants and also their parents to allow them to participate in study and assured them of the confidentiality of their responses and anonymity.

Study Tool and Data Analysis

For the purpose of data collection, a structured questionnaire consisting of 76 items was formulated by us and its validity was established by experts from the field of Psychiatric Nursing. The questionnaire comprised of two sections, Section I consisted of questions related to the demographic profile of the sample like age, gender, education and the number of younger/ elder siblings. Section II, a 76 item measure of sibling violence consisted of three dimensions - verbal abuse (8 items), physical abuse (42 items) and psychological/ emotional abuse (26 items) and utilized a four point Likert scale (3 = "Very Often", 2 = "Sometimes", 1 = "Rarely" and 0 = "Never"). The subjects were asked to mark their responses based on the interaction with their sibling/s in the past one month. Data were collected from the subjects after taking informed consent and by using paper and pencil method. The responses left blank were scored as zero. The scores obtained from the siblings were analyzed using descriptive statistics in terms of occurrence of sibling violence, i.e. very low occurrence (score from 0 – 57), moderate occurrence (score from 58 – 114), very high occurrence (score from 115 – 171) and extremely high occurrence (score from 172 – 228).

RESULTS

Frequency and percentage computation of the sample subjects by their age, gender and education.

Frequency and percentage computation of the sample subjects showed that 18 (36%) of the samples were male and 32 (64%) were females. Out of 50 subjects, 17 (34%) samples were in the age group of 10 – 12 years, 14 (28%) in the age group of 18 -19 years, 10 (20%) in the age group of 13 – 15 years and 9 (18 %) in the age group of 16 – 17 years. Also, 18 (36%) samples were in middle school, 12 (24%) in the senior secondary, 10 (20%) samples in secondary school and graduation (Table 1).

Frequency and percentage computation of the sample subjects by occurrence of sibling violence.

Frequency and percentage computation of the sample subjects by occurrence of sibling violence revealed that 70 % of the samples showed very low occurrence, 28 % reported moderate occurrence and 2% reported very high occurrence of sibling violence (Table 2).

Mean, modified mean and rank order computation of the types of sibling violence faced by the adolescent siblings.

Mean, modified mean and rank order of the different types of sibling violence faced by the adolescent siblings was computed and it showed that the occurrence of verbal abuse was the highest among adolescent siblings followed by psychological abuse and then physical abuse (Table 3)**.**

DISCUSSION

Compared to sibling violence prevalence rates found in research, the relatively low percentage of sibling cases suggests considerable underreporting or misidentification[10]. Although according to developmental victimization survey of 2030 children aged 2 through 17 years, the rate of sibling assaults peaked in early elementary aged children (in about 48% of all cases), drop by 10 % in preadolescence, and reach the lowest rate of occurrence at ages 14 through 17 [11]. This drop in the prevalence of sibling violence as the age progressed to adolescence was also seen in the present study, wherein, the occurrence of sibling violence was assessed in adolescent siblings in the age group of 10-19 years. Reportedly there was low occurrence of sibling violence in 70 % of study subjects. Only 28 % reported moderate and 2 % reported high occurrence of sibling violence. We did not include very young or pre- adolescent children in our study and hence maybe that was one reason for low occurrence of violence. Similarly, recent research from the Delaware Secondary School survey found 48% of children reporting physical assault among siblings [12].

Sibling assault is considered one of the most common forms of violence that children experience, though accurate prevalence estimate are hampered by reporting difficulties and minimization of these behaviors by parents and adults [11]. While collecting our data we also had problem in getting samples as few of the parents were confident about their families not having any sibling violence, and some misidentified slap as just a normal behavior. The factors which were taken under consideration were explored by the help of structured questionnaire.

Verbal abuse and psychological abuse

Emotional abuse although it does not leave physical scars, creates wounds that often last a lifetime. It can be defined as a comment made by sibling intended to ridicule, insult, threaten or belittle another sibling. According to Wiehe's survey, 78 % of adults reported that they had been the victims of emotional abuse. However, only 7 % of these adults indicated that they had been emotionally abused, indicating that the vast majority of incidents of emotional abuse occurred within context of physical and sexual abuse or both[13]. Emotional abuse involves the manipulation of the victim's emotions whereby the victim's self-concept and independence are systematically taken away [14]. In our study, we found that verbal abuse was more prevalent followed by emotional and physical violence. Although in our study we did not include sexual abuse among siblings, its believed that sibling incest is actually more prevalent, occurring at an estimated rate of at least five times greater than parent child incest. However as with other forms of violence in the home, we currently have no broad- based way to measure the actual prevalence of sibling sexual abuse. It is however, probably safe to assure that the studies that have been conducted grossly underestimated the actual occurrence of such abuse because of veil of secrecy that is created by shame [13]. In our study also we avoided exploring this factor as we thought it would be too intrusive in one's personal space.

Physical abuse

The nature of physical abuse between siblings involves a continuum of violent behaviors from minor incidents to more severe levels that cause physical injury and even death. Common forms of abuse include pinching, slapping, hitting, biting, shoving, scratching and hair pulling. In Goodwin and Roscoe's study, 65% of females and 64 % of males admitted that they perpetrated some form of physical violence on a sibling during the previous years, 64% of females and 66% of males being victims of such acts. The most common forms of abuse reported were being pushed, shoved, or pulled, having an object thrown[13]. In our study, physical violence among siblings showed the least occurrence and ranked third after verbal and emotional abuse. As with all other forms of violence in the home, sibling abuse has devastating consequence for victim and family. Garrett and Mc Kenzie found that victims of sibling abuse suffered with interpersonal relationship difficulties, low self- esteem, sexual functioning and emotional problems. These studies provide evidence that sibling abuse is a serious phenomenon with consequences as devastating as those of other forms of violence in home[13]. Thus as this problem comes from home so it is our duty as health professionals, to work towards generating awareness amongst the masses about the issue on a large scale, and deal with sibling violence as a major problem to be treated and properly intervened in, so that this issue is not underestimated, but properly identified and acknowledged.

CONCLUSION

This study implied that sibling violence is a reality in our society and occurs in varying degrees, although its occurrence and impact still remains unrecognized. This study was limited by the convenience sampling and by the size of the sample. The study also gives emphasis on the urgent need to screen adolescents for sibling abuse, build awareness about sibling abuse and educate families to differentiate between abusive and normal behavior among siblings. Effective parenting techniques should be deployed so that proper mental health services are provided at the earliest to the sibling abused victims.

Acknowledgement – Nil

Ethical Clearance – A well informed consent was taken from the individuals and their parents prior to the data collection. They were also assured of the confidentiality and anonymity of their responses. Besides this, permission was also taken from the resident welfare association of the respective areas of study.

Conflict of Interest - Nil

Table 1: Frequency and percentage of the sample subjects by their age, gender and education

n = 50

S.No	Variables	Frequency (f)	Percentage (%)
1.	**Age (In Years)**		
	• 10 - 12	17	34
	• 13 - 15	10	20
	• 16 – 17	9	18
	• 18 – 19	14	28
2.	**Gender**		
	• Male	18	36
	• Female	32	64
3.	**Education**	18	36
	• Middle School (5th – 8th Std.)	10	20
	• Secondary School (9th – 10th Std.)	12	24
	• Senior Secondary (11th -12th Std.)	-	-
	• Diploma	10	20
	• Graduation		

Table 2 : Frequency and percentage of the sample subjects by occurrence of sibling violence

n = 50

Occurrence of Sibling Violence	Frequency (f)	Percentage (%)
• **Very Low Occurrence**	35	70
• **Moderate Occurrence**	14	28
• **Very High Occurrence**	01	2
• **Extremely High Occurrence**	0	0

Table 3 : Ranking of the types of sibling violence **n = 50**

S. No	Types of Sibling Violence	No. of Items	Mean	Modified Mean	Rank
1.	**Verbal Abuse**	8	11	1.37	I
2.	**Physical Abuse**	42	21	0.5	III
3.	**Psychological/ Emotional Abuse**	26	16	0.61	II

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Effect of Structured Teaching Programme on Knowledge Regarding Specific Learning Disabilities among Primary School Teachers

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ABSTRACT

Background: Specific learning disabilities are not widely recognized as disorders that cause difficulties in learning because of the deficient knowledge of teachers, parents and physicians. Early identification and appropriate interventions will bring about plenty of changes. If teachers are equipped with adequate knowledge and appropriate skills in handling the children with learning disability, it will help them to improve in future.

Method: True experimental pretest – posttest control group research design was adopted. The study population comprised of all primary school teachers of government schools in Puducherry. Simple random sampling technique was used to select the sample of 60 primary school teachers in selected government schools of Puducherry. Thirty samples were assigned in experimental group and 30 in control group. A pretest was conducted by using a structured questionnaire to assess the existing level of knowledge regarding specific learning disabilities among the study subjects. Followed by this, a structured teaching programme on specific learning disabilities was administered to the subjects in the experimental group in three sessions, on consecutive days. Each session had duration of 30 minutes. A posttest was conducted after 2 weeks for both groups with the same questionnaire and effectiveness of the teaching programme on the level of knowledge was assessed.

Results: There was a highly significant difference ($p < 0.001$) between the experimental group and the control group on the level of knowledge regarding specific learning disabilities after the administration of structured teaching programme.

Conclusions: The majority of the primary school teachers have a poor level of knowledge regarding specific learning disabilities. The structured teaching programme is an effective method to increase the knowledge regarding specific learning disabilities among the primary school teachers. The level of knowledge regarding specific learning disabilities among the primary school teachers is not influenced by their demographic variables such as age, gender, educational level, marital status and years of teaching experience.

Keywords: *Primary School Teachers, Specific Learning Disabilities, Primary School Children*

INTRODUCTION

Learning disability is defined as a heterogeneous group of disorders which are characterized by significant difficulties in the acquisition and use of skills like listening, reading, writing, reasoning, speaking, or mathematical abilities.[1,2] It includes several disorders in which the person finds difficulty to learn in a typical manner, which is caused by some unknown factors that affect the brain's ability to receive and process information. Specific learning

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disability is a term used to refer a group of learning disorders with specific cognitive deficits.[3]

According to the Learning Disability Association of America, approximately 5 – 20 percent of the children across the world suffer from learning disability. About 4 million school-aged children are having learning disabilities, 7.7% of children have ever been told that they had the disability. Prevalence of reading disability is estimated to range between 4 – 10 percent among school-aged populations in the United States.[4]

In India, the prevalence of learning disability ranges from 9-39%. Dyslexia in primary school children is reported as 2-18%, dysgraphia 14%, and dyscalculia 5.5%.[5] In Tamilnadu, among 53% of boys, 23% of them are having learning disabilities where as its prevalence is as low as 5% for 47 % of girls.[6]

An observational study was carried out to assess the knowledge on specific learning disabilities among 34 kindergarten and primary school teachers from 2 randomly selected schools in the union territory of Puducherry, South India in 2012. The results of this study showed that primary school teachers have poor fund of knowledge regarding specific learning disabilities.[7]

OBJECTIVE OF THE STUDY

- To assess the effect of structured teaching programme on knowledge regarding specific learning disabilities among primary school teachers.

HYPOTHESIS

H_1: There is a significant difference in the level of knowledge among primary school teachers who receive structured teaching programme regarding specific learning disabilities and those who do not.

METHODOLOGY

The research design adopted for the study was true experimental pretest – posttest control group design. The study population comprised of all primary school teachers of government schools in Puducherry. Simple random sampling technique was used to select the samples of 60 primary school teachers in selected government schools of Puducherry. Thirty samples were assigned in experimental group and 30 in control group. The instruments used for data collection consisted of two parts; demographic proforma containing information such as age, gender, educational level, marital status and years of teaching experience and specific learning disability self structured knowledge questionnaire developed by the researcher. The questionnaire consisted of 25 multiple choice items, divided into 4 domains such as general information regarding learning disabilities (5 items), characteristic features of specific learning disabilities (8 items), identification of specific learning disabilities (6 items) and management and rehabilitation of children with specific learning disabilities (6 items). A pretest was conducted by using a structured questionnaire to assess the existing level of knowledge regarding specific learning disabilities among the study subjects. Followed by this, a structured teaching programme on specific learning disabilities was administered to the subjects in the experimental group in three sessions, on consecutive days. Each session had the duration of 30 minutes. A posttest was conducted after 2 weeks for both the groups with the same questionnaire and effectiveness of the teaching programme on the level of knowledge was assessed.

FINDINGS

Table 1: Comparison of mean scores between pretest and posttest on knowledge in experimental group (n = 30)

Experimental group (n=30)						
Level of knowledge	**Pretest**		**Posttest**		**Difference (Post – Pre)**	**Paired t - value**
	Mean	SD	Mean	SD	8.87 (± 2.2)	22.470*** p = 0.000
	11.70	2.4	20.57	2.5		

*** $p < 0.001$

The comparison of mean scores between pretest and posttest on knowledge in experimental group are presented in **Table 1.** Before intervention, the mean knowledge score was 11.70 and it was increased to 20.57 after the administration of structured teaching programme. The results of paired t- test showed that there was a highly significant difference ($p < 0.001$) between the pretest and posttest of the experimental group in the mean scores of overall knowledge regarding specific learning disabilities.

Table 2: Comparison of mean scores between pretest and posttest on knowledge in control group (n = 30)

Control group (n=30)						
Level of knowledge	**Pretest**		**Posttest**		**Difference (Post – Pre)**	**Paired t - value**
	Mean	SD	Mean	SD	0.06 (± 1.4)	0.258 (NS) p = 0.798
	10.47	1.9	10.53	1.8		

NS – Not statistically significant

The comparison of mean scores between pretest and posttest on knowledge in control group are presented in **Table 2.** The pretest mean knowledge score was 10.47 and it almost remained the same as 10.53 in the posttest also. The results of paired t- test showed that in control group there was no significant difference ($p > 0.05$) in the mean scores between the pretest and the posttest on overall knowledge regarding specific learning disabilities.

Table 3: Comparison of mean difference scores in the experimental and the control group (N = 60)

Variable	**Experimental group (n=30)**		**Control group (n=30)**		**Independent t - value**
Knowledge score	**Difference (Post – Pre)**		**Difference (Post – Pre)**		18.671*** (p=0.000)
	Mean	SD	Mean	SD	
	8.87	2.2	0.06	1.4	

*** $p < 0.001$

The comparison of mean difference scores in the experimental and the control group are presented in Table 3. In the experimental group, the mean difference of knowledge score was found to be 8.87 between pretest and posttest. In the control group, the mean difference was found to be 0.06. The results of independent t- test showed that there was a highly significant difference ($p < 0.001$) between the experimental group and the control group on knowledge regarding specific learning disabilities.

CONCLUSION

The structured teaching programme is an effective method in increasing the knowledge regarding specific learning disabilities among primary school teachers. Based on the method of sample selection, the conclusive nature of the findings, and support from many studies conducted throughout the world, the findings are probably generalizable to the primary school teachers of government schools in other parts of India.

Acknowledgement : We express our thanks to primary school teachers who participated in the study and the authorities who provided permission to conduct the study.

Conflict of Interest : Nil

Ethical Clearance: Ethical clearance for the study was obtained from the Human Ethical committee, JIPMER (Jawaharlal Institute of Postgraduate Medical Education and Research), Puducherry.

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A Descriptive Study to Assess the Level of Burden among the Caregivers of Alcoholics in Selected Rural Areas, District Jalandhar, Punjab, 2014

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ABSTRACT

Alcoholism has been an important global concern. Every year, the harmful use of alcohol kills 2.5 million people, including 320000 young people between 15 and 29 years of age. The family members acts as caregivers who provide care to the alcoholics and they are at great risk for developing burden because of poor family communication, lack of mutual warmth among family members, poor role functioning, economic deprivation, sexual dysfunction etc.

Objectives

1. To assess the level of burden among the caregivers of alcoholics.
2. To find out the association between level of burden among the caregivers of alcoholic and their selected socio-demographic variables.
3. To plan and provide an information booklet regarding burden and its management among the caregivers of alcoholics.

Methodology:

Design: Non- experimental (Descriptive Design)

Setting: Selected rural areas, District Jalandhar, Punjab.

Population: Caregivers of alcoholics in selected rural areas, District Jalandhar, Punjab.

Sample size: 200 caregivers of alcoholics selected from selected rural areas of district Jalandhar Punjab

Sampling techniques: Convenience Sampling Technique

Results and conclusion: Findings of the study has shown that the majority of the caregivers of alcoholics 131 (65.5%) were suffering from severe level of burden and minority of caregivers 11 (5.5%) were suffering from very severe level of burden.

Keywords: *Level of Burden, Caregivers of alcoholics*

INTRODUCTION

Alcoholism is a maladaptive pattern of substance use for period 12 month which is characterized by tolerance, withdrawal symptoms, loss of control and craving not only detrimental to the health and welfare of the individual, family and community and society at large.[1] Every year, the harmful use of alcohol kills 2.5 million people, including 320000 young people between 15 and 29 years of age. It has been identified that India has nearly 70 million alcohol users which include 12 million users who are dependent on alcohol, but does not include millions of social drinkers.[2]

Alcoholism is a family problem. It affects the

family members with the same intensity with which it affects the dependent person.[3] The family caregivers are those who provide care to other family members who need supervision or assistance in burden. Burden is said to be largely determined by family environment in terms of coping styles of different family members and their tolerance of the patients' aberrant behaviour.[4] Family caregivers have many functions including, but not limited to, domestic chores and household tasks, providing personal care and assisting with activities of daily living, managing symptoms such as pain and constipation, providing emotional and social support, being a spokesperson, advocate and proxy decision maker.[5]

While it is clear that increased caregiver burden increases negative health and psychological outcomes experienced by caregivers, little work has been done to determine which facets of caregiver burden are most predictive of negative caregiver outcomes. Caregiver burden was initially conceptualized as a one-dimensional variable derived from a variety of items. This approach was found to be insufficient, however, and as the field moved forward both objective burden (tasks included in the caregiving role) and subjective burden (distress experienced in relation to those tasks) were measured. Subsequent instruments designed to measure caregiver burden further refined the idea of objective versus subjective burden, incorporating subscales that identified different types of objective and subjective burden. For example, the Modified burden Scale, used in this study, includes five burden sub-scales: time-dependence burden, developmental burden, physical burden, social burden, and emotional burden.[6]

Until recently, family members were sometimes utilized as a source of information about their ill members but were rarely involved in treatment, psycho-education, or family therapy and the idea of the family as a unit is controversial. With less restrictive environment, shorter hospital stays, and fewer community programs, nurses must now develop a collaborative partnership with clients and their families. This collaborative relationship means that the family is viewed as the unit of care and as partner in treatment and rehabilitation. Thus program must be in place to provide support, education, coping skills training, social network development and family therapy. As family nurses, it is critically important that we take the time to be with family in deeply caring ways. As we share our ideas and our strength, our goal is to help families develop as more balanced and caring system.[7]

MATERIALS AND METHOD

The study was conducted in Village Dheena, Village Jamsher Khas, Village Kot kalan, Village Kukad, Village Puranpur, District Jalandhar, Punjab to assess the level of burden among the caregivers of alcoholics in selected areas, District Jalandhar, Punjab 2014. Non-experimental Descriptive design was adopted and 200 caregivers of alcoholics were selected by using Convenience Sampling Technique for the study, who met the inclusion criterion. Burden Scale to assess the burden among the caregivers of alcoholics was prepared for data collection which comprised of statements related to different types of burden such as physical, emotional, developmental, time dependency and social burden. It comprises of 30 items regarding burden which are divided into 5 categories of burden i.e. physical, emotional, developmental, time dependency and social burden. Under each category of burden there are six statements. Each statement had five rating options i.e strongly agree, agree, neutral, disagree and strongly disagree.

RESULTS

1. The first objective revealed that the majority of the caregivers of alcoholics 131 (65.5%) were suffering from severe level of burden and minority of caregivers of alcoholics 11 (5.5%) were suffering from very severe level of burden. 45 (22.5%) of caregivers of alcoholics were suffering from moderate level of burden and only 13 (6.5%) of caregivers of alcoholics were suffering from severe level of burden.

2. The second objective revealed that the the education, occupation, family monthly income, relationship with the alcoholics, family history of alcoholism and duration of caregiving were significantly associated with level of burden. Other socio demographic variables like age, gender, marital status, and type of family, nature of caregiving and

availability of support systems had no significant association with level of burden.

CONCLUSION

From the finding of the study following conclusions were drawn:

1. From the findings of the study, it was revealed that the Majority of the caregivers of alcoholics 131 (65.5%) were suffering from severe level of burden and minority of caregivers of alcoholics 11 (5.5%) were suffering from very severe level of burden.
2. 45 (22.5%) of caregivers of alcoholics were suffering from moderate level of burden and only 13 (6.5%) of caregivers of alcoholics were suffering from severe level of burden.
3. Psychological burden was found highest i.e. 21.52% in the caregivers of alcoholics as compare to other type of burden. Social burden was found lowest i.e. 18.85% in the caregivers of alcoholics as compare to other type of burden.
4. 20.04% of emotional burden was found in the caregivers of alcoholics followed by 19.82% of time dependency burden was found in the caregivers of alcoholics and 19.76% of developmental burden was found in the caregivers of alcoholics.
5. The education, occupation, family monthly income, relationship with the alcoholics, family history of alcoholism and duration of caregiving were significantly associated with level of burden.
6. So, the present study was concluded that the majority of caregivers of alcoholics had suffering from severe level of burden while providing care to alcoholics.

DISCUSSION

Objective 1: To assess the level of burden among the caregivers of alcoholics.

The findings of the present study revealed that, Majority of the caregivers of alcoholics 131 (65.5%) were suffering from severe level of burden and minority of caregivers of alcoholics 11 (5.5%) were suffering from very severe level of burden. 45 (22.5%) of caregivers of alcoholics were suffering from moderate level of burden and only 13 (6.5%) of caregivers of alcoholics were suffering from severe level of burden.

The findings of the present study were supported by the findings of the exploratory study conducted by Vijayanath. V, Anitha M.R. on outcome of alcohol dependence, disability, and burden on caregivers in the society. The study revealed that the burden experienced during the episode was significantly more during the episode than one month before the episode. There was significantly more burden in the caregivers of severe alcohol dependents patient than in mild and moderate dependent patients. About 18% caregivers of alcoholics experienced mild level of burden, 36% caregivers of alcoholics experienced moderate level of burden, 39% caregivers of alcoholics experienced severe level of burden and only 6% caregivers of alcoholics experienced very severe level of burden. Disability was significantly more in severe alcohol dependence than in moderate and mild dependence. There was no significant difference in the burden experienced by the caregivers of patients having ADS, alcohol induced psychosis and delirium tremors. Burden experienced by the caregivers of the patient having severe dependence was significantly more than the caregivers of low and moderate alcohol dependence group. The global disability was more in severe dependence group than in moderate and low dependence group.[8]

Objective 2: To find out the association between level of burden among the caregivers of alcoholics with their selected socio-demographic variables.

In the present study, selected socio-demographic variables i.e education, occupation, monthly family income, relationship with the alcoholics, family history of alcoholism, duration of caregiving to alcoholics are significantly associated with level of burden among caregivers of alcoholics and had impact on the level of burden among the caregivers of alcoholics.

The findings of the present study were discussed with the findings of the exploratory study conducted by Vijayanath. V, Anitha M.R. on outcome of alcohol dependence, disability, and burden on caregivers in the society. The study revealed that the burden was experienced more in the following domains such as physical and mental health, spouse related, caregivers routine, external support, patient behavior

and caregiver's strategy. In this study the caregiver strategy and caregiver routine was affected more in urban group than the rural group and this difference was found to be statistically significant. The caregivers of the patients above 25 years were experienced more burden in spouse related domain. There is a positive relation between the disability of patient and burden on caregivers, severity of alcohol dependence and burden on caregivers.[8]

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ETHICAL CLEARANCE

1. Written permission was taken from principal S.G.L. Nursing College, Semi, Jalandhar, Punjab.
2. Written permission was taken from Ethical Clearance Committee of S.G.L. Nursing College, Semi, Jalandhar, Punjab.
3. Written permission was taken from Sarpanchs of the selected rural areas.
4. Written informed consent was taken from each study sample.
5. Confidentiality and Anonymity of samples will be maintained throughout the study.

Source of Funding- Self

Conflict of Interest- Nil

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A Comparative Study to Assess the Knowledge Regarding Conduct Disorder in Children among Mothers of Selected Rural and Urban Areas, District Jalandhar, Punjab, 2014

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ABSTRACT

The study was conducted to assess Knowledge Regarding Conduct Disorder in Children among Mothers of selected Rural and Urban Areas, District Jalandhar, Punjab. Data was collected by structured questionnaire. The result revealed that the urban Mothers have more knowledge than rural Mothers regarding conduct disorder in children.

Objectives

1. To assess the knowledge regarding conduct disorder in children among rural mothers.
2. To assess the knowledge regarding conduct disorder in children among urban mothers.
3. To compare the knowledge regarding conduct disorder in children between rural and urban mothers.
4. To find out the association between the knowledge among mothers and their selected socio demographic variables.

Research methodology : Research Design- Quantitative research design.

Research Setting- Selected rural and urban areas, district Jalandhar, Punjab.

Target Population- Selected mothers who were having children 6-12 years of age of selected areas of district Jalandhar, Punjab.

Sample Size - 200 mothers i.e. 100 from rural areas and 100 from urban areas.

Sampling Technique - Convenience sampling technique.

Result and Conclusion : The result of the study revealed in rural area mean knowledge score was 13.68 while in urban area mean knowledge score was 19.59 regarding conduct disorder in children among mothers. So, these findings show that the urban Mothers have more knowledge than rural Mothers regarding conduct disorder in children according to their mean knowledge score.

Keywords- *Knowledge, conduct disorder in children, mothers, selected rural and urban areas.*

INTRODUCTION

Children are the most important asset and wealth of a nation. Healthy children make a healthy nation. Between 200,000 and 300,000 children suffer from autism, a pervasive developmental disorder that appears in the first three years of life. Millions suffer from learning disorders, attention deficit disorder, attachment disorders, conduct disorders and substance abuse. Conduct disorder is a psychological disorder diagnosed in childhood that presents itself through a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate norms are violated. These behaviours are often referred to as "antisocial behaviours."

Bharat S, Srinath S, Girimaji S, Seshadri S (2007), conducted a study to identify psychiatric problems among children and adolescence. It was conducted in short time in patient facility of the childhood and

adolescent psychiatric unit in National Institute of Mental Health and Neuro Science, Bangalore. The result revealed that the conduct disorder is 10.5% was the third most common type of psychiatric problem.

For treating conduct disorder to be successful, the child's family needs to be closely involved. Parents can learn techniques to help in managing their child's problem behavior.

MATERIAL AND METHOD

The study was conducted in rural areas Village Chak Shakoor, Phulriwal and Dheena and in urban areas Bhargo camp, Abhadpura and Makhdoompura, District Jalandhar, Punjab. The research design selected for the study was a descriptive comparative research design. Total 200 mothers were selected for the study that is 100 from rural areas and 100 from urban areas. Samples were selected by convenience sampling technique.

RESULTS

The first objective revealed that, maximum 83(83%) mothers had average knowledge regarding conduct disorder in children in rural area followed by 15(15%) had poor knowledge and 2(2%) had good knowledge.

The second objective revealed that, in urban area maximum 64(64%) mothers had average knowledge regarding conduct disorder in children, 36(36%) of them had good knowledge and no mother had poor knowledge.

The third objective revealed that, in rural area mean knowledge score was 13.68 while in urban area mean knowledge score was 19.59 regarding conduct disorder in children among mothers. Urban mothers have more knowledge score than the rural mothers. So there was significant relation because calculated 't' value 14.212 is more than the tabulated 't' value.

The fourth objective revealed that, there is association between age, educational status of mother, number of children and source of information with mean score knowledge.

CONCLUSION

The study was undertaken to assess the knowledge regarding conduct disorder in children among mothers of selected rural and urban areas District Jalandhar Punjab. From the findings of the study, it was revealed that in rural area 83% of Mothers had average knowledge, 15% Mothers had poor knowledge and 2% Mothers had good knowledge. While in urban area 64% Mothers had average knowledge, 36% of Mothers had good knowledge. So, these findings show that the urban Mothers have more knowledge than rural Mothers regarding conduct disorder in children according to their mean knowledge score.

DISCUSSION

Objective 1-

To assess the knowledge regarding conduct disorder in children among rural mothers.

In the present study out of 100 samples, majority of n=83 (83%) samples had average knowledge, n=15 (15%) samples had poor knowledge and n=2 (2%) samples had good knowledge.

The findings of the study were discussed with the results study conducted by Mrs. **Sathya Ananthi. M (2013)** i.e. a comparative study to assess the behavioral problems of children among mothers of selected rural and urban areas, Bangalore. The result revealed that the mean knowledge score of rural mothers is 96.24 with a standard deviation of 3.23.

Objective 2-

To assess the knowledge regarding conduct disorder in children among urban mothers.

In the present study out of 100 samples, majority of n=64 (64%) samples had average knowledge, n=36 (15%) samples had good knowledge.

The findings of the study were discussed with the results of previous mentioned study. It was found that the mean knowledge score of urban mothers is 109.12 with a standard deviation of 6.32.

Objective 3-

To compare the knowledge regarding conduct disorder in children between rural and urban mothers.

In the present study it was depicted that in rural area mean knowledge score was 13.68 while in urban area mean knowledge score was 19.59 regarding conduct disorder in children among mothers. Urban

mothers have more knowledge score than the rural mothers. So, there was significant relation because calculated 't' value 14.2121 is more than the tabulated value.

The findings of the study were discussed with the results of previous mentioned study. It was found that the mean knowledge score of rural mothers is 96.24 and mean knowledge score of urban mothers is 109.12. Hence, it was concluded that urban mothers have more knowledge than rural mothers regarding conduct disorder in children.

Objective 4-

To find out the association between the knowledge among mothers and their selected socio demographic variables.

In the present study it was depicted that for association of mean knowledge score age of mother, educational status of mother, number of children and source of information are significant.

ACKNOWLEDGEMENT

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ETHICAL CLEARANCE

1. Written permission was taken from the Principal of S.G.L. Nursing College, Semi Jalandhar.
2. Written permission was taken from ethical clearance committee of S.G.L. nursing college, Semi Jalandhar.
3. Written permission was taken from Sarpanch's of selected rural areas and Municipal Counsellors's of selected urban areas, Distt Jalandhar, Punjab.
4. Informed consent was taken from each sample.
5. Confidentiality and anonymity of sample was maintained throughout the study.

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Conflict of Interest- Nil

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Obsessive Compulsive Disorder in Children

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ABSTRACT

Obsessive compulsive disorder (OCD) is a type of anxiety disorder characterized by recurrent, intrusive, unwanted thoughts. Research indicates a genetic predisposition for OCD. Many people with OCD have one or more family members who also have it or who may have other anxiety disorders influenced by the brain's serotonin levels, such as panic disorder. An estimated 1% of children in the United States are diagnosed with OCD, and it is characterized by a pattern of rituals and obsessive thinking that occur for at least one hour or more daily; results in significant distress for the child; and interferes with the child's ability to function. A combination of medications and cognitive behavioral therapy are recommended.

Keywords: *Obsessive Compulsive Disorder, Intrusive thoughts, Cognitive behavioral therapy, SSRIs*

INTRODUCTION

What do these three children have in common?

1. John is 11 years of age and he consistently achieves high grades but has few friends. He spends an excessive amount of time arranging and re-arranging his things in his bedroom. Whenever he has friends over he becomes noticeably upset when they touch, move, and play with his toys. His parents were told by his pediatrician that John may have a form of autism.

2. Marra is 12 years old and has lost 10 pounds in the past year. When questioned by her mother, Marra says she has not been eating the lunch she brings top school. Marra is preoccupied with right and wrong and says she cannot tell if her lunch bag is really hers. Most of the children in her class bring their lunch in the same blue plastic bag. These are placed on the shelf above their jackets. Marra says she fears that she will inadvertently eat someone else's lunch and this would be stealing. Marra's pediatrician told her mother that she likely has an early onset eating disorder.

3. Peter is 13 years of age and has been excessively absent from class for the past year. His mother reports that peter spends hours in the morning showering, getting dressed, and then re-showering. He is concerned with germs and also has rituals associated with dressing. He starts to put on his underwear, removes them, and repeats this process 25 times. This results in him missing the school bus and chronically absent from school. Peter's pediatrician advised his mother to have him tested for schizophrenia.

What do they have in common? After receiving medical opinions and treatment from multiple providers without any significant improvement, all three were eventually diagnosed with obsessive compulsive disorder.

BACKGROUND

Obsessive compulsive disorder (OCD) is a type of anxiety disorder characterized by recurrent, intrusive, unwanted thoughts. These thoughts are uncomfortable, seem to 'appear' in a person's mind and the person cannot readily dismiss them. Children who have OCD become preoccupied with whether something could be harmful, dangerous, wrong, or dirty — or with thoughts about bad stuff that might

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happen[1]. They obsess with thoughts of perhaps eating someone else's lunch and thus are guilty of stealing or telling a lie.

These obsessions are coupled with strong urges to perform certain actions repeatedly — called rituals or compulsions — in order to banish the scary thoughts, ward off something dreaded, or make extra sure that the bad things do not occur[2]. The child feels like he or she must perform the task or dwell on the thought, over and over again, to the point where it interferes with their daily life.

An exact cause of OCD has not been established although recent research has led to a better understanding of OCD and its potential causes. OCD is believed to be related to inadequate levels of a neurochemical in the brain called serotonin. When there is a deficiency of serotonin, or this chemical is somehow not available to transmit nerve impulses, the individual can overreact or misinterprets signals. Ordinary messages are blown out of proportion and the person is on hyper alert[3]. Their brain cannot easily filter out stimuli, and these obsessive thoughts take over. The person focuses on these thoughts and the "what ifs"; experiences unrealistic fears; and is preoccupied with the obsessions and rituals.

ETIOLOGIES

OCD is classified as a neuropsychiatric disorder with a predisposition based on familial background as well as the chemical component. Research indicates a genetic predisposition for OCD. Many people with OCD have one or more family members who also have it or who may have other anxiety disorders influenced by the brain's serotonin levels, such as panic disorder[4]. However having this predisposition doesn't mean a person will definitely develop OCD, rather that they have a greater likelihood than other persons without the family history. An imbalance of serotonin levels is also associated with major depressive disorders.

OCD is more frequently diagnosed in white male children. However there is no indication of a geographic distribution.

INCIDENCE IN CHILDREN

An estimated 1% of children in the United States are diagnosed with OCD, and it is characterized by a pattern of rituals and obsessive thinking that occur for at least one hour or more daily; results in significant distress for the child; and interferes with the child's ability to function. Its actual prevalence may seem lower than reality because of the stigma attached to psychiatric disorder and embarrassment to discuss symptoms.

In children OCD is typically initially diagnosed between the ages of 7 and 12. Since these are the years when children are most concerned about fitting in with their friends, the discomfort and stress brought on by OCD can increase shame, embarrassment, fears of loss of control and not fitting in with friends. Many children will hide manifestations because of shame.

It is very important for parents, teachers, and friends to understand that the obsessive-compulsive behavior is not something that a child can stop by trying harder. OCD is a disease and requires treatment. It is also not something that the child or parents have caused, although life events may at times worsen or trigger the onset of OCD in kids who are prone to develop it.

METHOD

The most common obsessive thoughts in children include[5,11,13]:

- Rear of being dirty or having germs
- Fear of contamination
- A need for symmetry, order, and precision
- Religious obsessions particularly related to guilt and sin
- Preoccupation with body wastes
- A belief in lucky and unlucky numbers
- Uncomfortable sexual or aggressive thoughts
- Fear of illness or harm coming to oneself or relatives
- Preoccupation with household items
- Intrusive sounds or words that recur

And the most frequently observed compulsions include[5,11,13]:

- grooming rituals, including hand washing, showering, and teeth brushing
- repeating rituals, including going in and out

of doorways, needing to move through spaces in a special way, or re-reading, erasing, and re-writing
- checking rituals to make sure that an appliance is off or a door is locked, and repeatedly checking homework
- rituals to undo contact with a "contaminated" person or object
- touching rituals
- rituals to prevent harming self or others
- ordering or arranging objects
- counting rituals
- hoarding and collecting things
- cleaning rituals related to the house or other items

It is important to distinguish between normal, age-typical rituals in children and OCD rituals. Not confusing OCD with normal ritualistic behavior of childhood is important. Most children exhibit typical, age-dependent, compulsive behaviors. Frequently, young children prefer that events occur in a particular way, they insist on specific bedtime or mealtime rituals, and they become distressed if these rituals are disrupted. Most commonly these normal ritualistic tendencies occur between 18 months and three years of age. Another way to distinguish these normative compulsive behaviors from OCD is in terms of content, timing, and severity. Also normative compulsive behaviors do not interfere with daily functioning.

Diagnosis of OCD in children requires the exclusion of other disorders including autism, Aspergers, and ADHD. Of structured interviews and psychological tests used in diagnosing OCD, the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) is the criterion standard to make the definitive diagnosis[6]. OCD is diagnosed according to *DSM-IV-T* if on the Y-BOCS a person scores 2, 3, or 4 on any of the following items: (1) time spent on obsessions, (2) interference from obsessions, (3) distress of obsessions, (6) time spent on compulsions, (7) interference from compulsions, or (8) distress of compulsions.

FINDINGS

Successful treatment of obsessive-compulsive disorder (OCD) involves the judicious use of SSRIs and structured psychotherapy designed to provide the patient with the skills to master the obsessive thoughts and accompanying compulsive behaviors[8].

SSRIs are greatly preferred over the other classes of antidepressants. Because the adverse effect profile of SSRIs is less prominent, improved compliance is promoted. SSRIs do not have the cardiac arrhythmia risk associated with tricyclic antidepressants. Arrhythmia risk is especially pertinent in overdose, and suicide risk must always be considered when treating a child or adolescent with mood disorder.

Cognitive behavioral therapy (CBT) routinely is described as the psychotherapeutic treatment of choice for adults, children, and adolescents who have been diagnosed with obsessive-compulsive disorder (OCD)[7]. Unlike psychodynamic or insight-oriented psychotherapy, CBT helps the child to understand the disorder and develop strategies to identify problem situations and resist giving in to the obsessive thoughts and compulsive behaviors. Treatment relies heavily on exposing the individual to the problem situations and then preventing the compulsive response. The resulting anxiety then is managed by training children to use strategies that help them to work with their anxiety in a more effective and less disruptive way.

However, exposure to the anxiety-producing object is the key to success in treatment. Thus, for children who compulsively wash their hands because they feel that the hands are dirty or contaminated, the therapist may have them intentionally touch things that are dirty and then have patients wait several hours before washing their hands. This results in very high anxiety after the initial contamination, followed by a gradual reduction in anxiety over time, until hand washing is allowed some hours later. In pediatric patients, this exposure is presented gradually, under the patients' control, after patients have been taught other ways of managing their anxiety and fear.

CONCLUSIONS

Anxiety management techniques may include relaxation training, distraction, or imagery. Often, the OCD is personified as something that makes the child perform an action. Thus, children learn to assess situations and ask themselves if they really want to do something, as opposed to the perception that the OCD is making them do something. For school-aged

children, the development of mastery and control is a critical issue in their overall psychological growth; therefore, learning to overcome an irrational drive, such as one experienced with OCD, has a certain appeal to the children's own sense of mastery[10].

With CBT, the initial goals are specific to 1 or 2 behaviors; however, as the patient becomes successful in coping with these situations, generalization usually occurs to other symptoms that have not been targeted. Usually, the patient reports an overall reduction in obsessive thoughts, general anxiety, and the need to perform certain actions[7,8].

While CBT requires a skilled therapist and 10-20 sessions to complete, its advantage is that once the skills are learned, the patient can use them in the future.

This illness can be devastating to the child and his/her family. If we go back to our three initial cases we see clear evidence of OCD in each child with slightly different manifestations. The key is early identification and intervention so that the child can master treatment methods and lead a productive life. It will require life-long use of these strategies but the results have been positive[9].

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A Study to Compare the Level of Depression among the Elders in Old Age Home and Who Live with their Family

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ABSTRACT

Depression is an important public health challenge in developing countries. In 1990, WHO defines depression as a major worldwide cause of disability. The elderly age group is considered as vulnerable group because of these multiple co existing medical and psychological problems. Cardiovascular diseases, respiratory diseases, hearing and visual impairments, depression and infections such as tuberculosis are common problems in the elderly population. Depression is not a natural part of aging and is under treated in the age group.

Objectives

1. Assess the level of depression among the elders in the old age home.
2. Assess the level of depression among the elders living with their family
3. Compare the level of depression among the elders in the old age home and those who live with their family.
4. Find the association between living condition and depression

Hypothesis

There is a significant difference in the level of depression among the elders in the old age home and in those who live with their family.

Methodology

Research design: Descriptive design was adopted

Setting: St. Joseph's Home for the aged and the destitute, Podanur, Coimbatore and the community area near by the home was selected for this study.

Sampling: Used simple random sampling technique to select the samples

Tool and method for data collection: A short form of geriatric depression scale was used and conducted a structured interview to collect the data

Findings

- There were more number of males than females in both the group
- There were more unmarried in group A
- 68% were not having life partner in group A and in group B only 22% were not having their lie partners.
- 72% were not satisfied with their children in group A and 64% were not satisfied with their children in group B.
- The presence of depression is more in group A than group B.
- The calculated chi square value to find the association between living condition and depression is 109.96 which is greater than the table value and significant at 0.01 level.

Keywords: *Depression, Old age home, Family*

INTRODUCTION

"Successful aging is the holistic concept"

Population are undergoing continuous demographic and epidemiological transition across the world. In addition population explosion in the developing countries is contributing to the population growth. In the past century, there has been a dramatic increase in the life expectancy which leads to a greater number of geriatric populations. From 2000 to 2050 the proportion of the world's elderly population is predicted to double from 11% to 22% and the absolute population increase is expected to be from 605 million to 2000 million. On this 80% will be living in low and middle income countries.[1]

Today people immigrate to urban areas for employment when children move from the native place some time they leave their parents alone or the parents also shifted. If the parents are shifted they are unable to adapt to the urban culture. Another important factor that the concept of joint family is losing its value among the youngsters. The elderly are viewed as less energetic and not useful for the family. This attitude among the youngsters creates a gap between the elders and the youngsters. These psychosocial factors affect the mental health of the elders which leads to raising prevalence of non communicable diseases among the elders. Today depression is an important public health challenge in developing countries.

Need for the study: The World Health Organization estimated that the overall prevalence rate of depressive disorders among elderly generally carries between 10 % to 20 % depending on cultural situations. The community based mental health studies in India have revealed that the point of prevalence of depressive disorders in elderly Indian population varies between 10 and 25%. [2]

Depression is not a natural part of aging. Mind plays a key role in successful aging. When the elders are mentally disturbed it ultimately affect their aging process and their quality of life. The symptoms of depression affect every aspect of life, including energy, appetite, sleep and interest in work, hobbies and relationships. Depression is not only makes one feel sick but also makes physical health worse.[3]

Depression is a silent killer of modern era. According to the observations made by the WHO , the correlates of depression in old age were reported as

1. Genetic susceptibility
2. Chronic disease and disability
3. Pain, frustrations with limitations of activities of daily living.
4. Personality traits

In the elderly number of life changes can increase the risk for depression or making the existing depression worse. Some of the changes are : Adapting to move from a home to an apartment or retirement family, chronic pain, feelings of isolation or loneliness or children move away and their spouse or close friend die, loss of independence, multiple illness, struggles with memory loss and problems in thinking clearly. Life situations of elderly are directly related to life situations such as self care, loss of child, loneliness and chronic diseases affect the daily mood increasing the normal depressive mood to high levels in elderly. [4]

Hence the present study aimed to assess the presence of depression among the elders in the old age home and in the community and also to associate the level of depression with their living condition.

STATEMENT OF THE PROBLEM

A study to compare the level of depression among the elders in the old age home and who live with their family in the selected settings.

Objectives:

1. Assess the level of depression among the elders in the old age home.

2. Assess the level of depression among the elders living with their family

3. Compare the level of depression among the elders in the old age home and those who live with their family.

4. Find the association between living condition and depression

HYPOTHESIS: There is a significant difference in the level of depression among the elders in the old age home and in those who live with their family.

REVIEW OF LITERATURE

A systematic review was done on 74 community based mental health surveys on depression in geriatric population which were conducted in the continents of Asia, Europe, Australia, North America and South

America. All the studies were conducted between 1955 – 2005. The researcher had had included only community based cross sectional surveys and some perspective studies that had not excluded depression on baseline. These studies were conducted on homogenous community of geriatric population in the world who were selected by simple random sampling technique. A qualitative analysis was conducted to study the socio demographic factors of the depression. The two non modifiable risk factors found to be significantly associated with depression were "older age group", chronic co morbidities, cognitive impairment, bereavement and restricted activities of daily living. (Ankur Barya, 2010).[5]

A cross sectional study conducted in the premises of a tertiary care hospital in Karachi, Pakistan aimed to assess depression among the elders attending the hospital. 400 subjects aged above 65 were interviewed with 15 item geriatric depression scale. The age of the majority of the subjects ranged from 65 – 74 years. 78% were males. The prevalence of depression was found to be 19.8%. Multiple logistic regression analysis revealed that the following were significant (P< 0.05) independent predictors of depression: Nuclear family system, female sex, being single, unemployment and having a low level of education. The elderly living in a nuclear family system were 4.3 times more likely to suffer from depression than those living in a joint family. This study concluded that the transition in family systems towards nucleation may have a major deleterious effect on the physical and mental health of the elderly. (Ather M Taqui et.al., 2007). [6]

METHODOLOGY

Research Design: Used descriptive design to compare the level of depression among the elders at old age home and those who are living with their family.

Setting: The present study was conducted in two settings. The old age home selected for this study was St.Joseph's Home for the aged and destitute in Podanur, Coimbatore District, Tamil Nadu. This is a home for the aged and destitute run by Samaritan sisters. There are around 250 inmates in the home. This group is named as group A in this study.

The community area near by the home was selected to select samples of elders who live with their family. This group is named as group B in this study.

Sampling: Used simple random sampling technique to select samples in both the groups. Selected 30 samples from each group. Total sample size was 60.

Tool and method of data collection

Tool A consists of demographic variables and tool B was a short form of Geriatric depression scale consisting of 15 questions. This is a standardized tool developed by Hartford Institute for Geriatric Nursing, New York University. It has 92% sensitivity and 89% specify with r value 0.84 at 0.01 level of significance. The maximum score is 15. Score 0 -4 indicate normal, 5 -8 indicate mild depression, 9 – 11 indicates moderate depression and 12 – 15 indicates severe depression.Used structured interview technique to collect data from the samples.

METHOD OF DATA ANALYSIS

Used percentage analysis and chi square test to analyze the data

FINDINGS

- There were more number of males than females in both the group
- There were more unmarried in group A
- 68% were not having life partner in group A and in group B only 22% were not having their lie partners.
- 72% were not satisfied with their children in group A and 64% were not satisfied with their children in group B.
- The presence of depression is more in group A than group B.
- The calculated chi square value to find the association between living condition and depression is 109.96 which is greater than the table value and significant at 0.01 level.

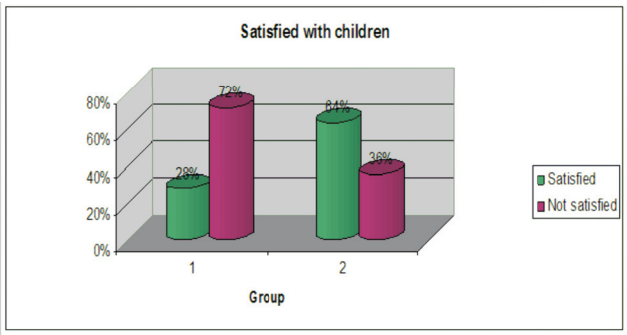

Figure 1: Distribution of Samples according to their Satisfaction with their Children in Group A and B

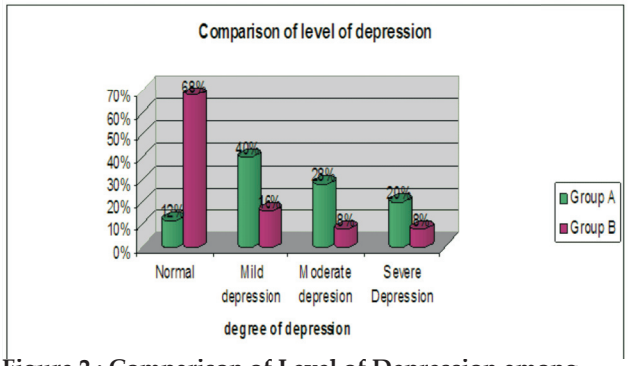

Figure 2 : Comparison of Level of Depression among Group A and B

LIMITATIONS

- Assessed only the presence of depression

RECOMMENDATIONS

- Interventional studies could have been conducted
- Association with various demographic variables could have been done

SUGGESTIONS

- Create an awareness to all regarding geriatric depression
- Identify the symptoms at the early stage.
- Encourage family participation
- Create a peaceful atmosphere for the elders
- Inculcate moral values to the children
- Teach the children about the family system and advantages of having a joint family system
- Enhance physical function, social support
- Maximize autonomy
- Relaxation therapies

MEASURES TO PREVENT DEPRESSION

- Develop a Hobby
- Emotional Health
- Phpysical Fitness
- Recreation
- Eating a Balanced Diet
- Staying In Touch With Family
- Smiling Always
- Initiative
- Overcome Stress
- Never be Alone

CONCLUSION

Depression is an iceberg in the society. If it is identified and treated at the early stages it can ultimately promote the physical health as well as the quality of life of elderly people.

ACKNOWLEDGEMENT

We render our humble and grateful thanks to the Heavenly Lord for having showered his blessings on us in completing this project successfully.

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Conflict of Interest: None

Source of Funding: None

Ethical Clearance : Obtained ethical clearance from the Institutional ethical Committee.

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Depressive Symptoms among Geriatric Population

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ABSTRACT

Objectives: Depression is the condition characterized by a prolonged period of time in which negative thoughts and feelings predominate, interfering with our usual functioning, or blinding us from our true potential.[1] The impact on quality of life is all-encompassing because it can lead individuals to withdraw from daily activities and relationships; thus, the disorder has a reverberating impact on family and friends as well.[2] So the prevention of depression begins with the assessment of depressive symptoms among geriatric population, identifying the geriatric population at risk and to adapt certain preventive strategies to reduce the prevalence of depressive symptoms.The present study aimed to identify depressive symptoms among geriatric population of Pashupati Old Age Home, Kathmandu, Nepal.

Method and Materials: The descriptive survey approach was adopted for the present study and conducted in Pashupati Old Age Home, Kathmandu,Nepal. The tool consists of demographic proforma and Geriatric Depression Scale. Data was collected interview method using non – randomized purposive sampling technique. The data was analyzed using Excel 2007, R 2.8.0 Statistical Package for the Social Sciences (SPPS) for Windows Version 16.0 (SPSS Inc; Chicago,IL,USA).

Results: Most of the participant were of age group 80 years and above (53%), most of them were female (52%), majority of them were Hindu (88%), most of them were married (58%), major of the participants were illiterate (96%), most of the participants have more than two children (56%), most of them are semi skilled (95%), most of them are not psychologically supported by their family and relatives (65%), most of them are not financially supported by family members (94%), the reason for leaving home for most of them are lack of care taker (64%), the length of stay of most of them are more than 1 year (75%), most of the participants have physical illness (96%). Majority of participants had mild depression of 56%, 25% of them had severe depression and 19% had normal depression score.

Conclusion: Majority of the respondents had mild depressive symptoms. Depressive disorder is

highly prevalent among the elderly population residing in the old age home in Kathmandu with history of physical illness. Most of them move to old age home due to lack of care giver.

Keywords: *Depressive symptoms, Geriatric population.*

INTRODUCTION

Depression is the condition characterized by a prolonged period of time in which negative thoughts and feelings predominate, interfering with our usual functioning, or blinding us from our true potential.[1] The impact on quality of life is all-encompassing because it can lead individuals to withdraw from daily activities and relationships; thus, the disorder has a reverberating impact on family and friends as well.[2] Late Life Depression refers to a major depressive episode occurring for the first time in an older person (usually over 50 or 60 years of age). Depression is not a normal part of aging. There are several depression, each defined by particular symptoms and duration (and identified as distinct diagnoses). However, one

can still suffer from depression without fitting all of the classic diagnostic symptoms.[2] The World Health Organization estimated that the overall prevalence rate of depressive disorders among the elderly generally varies between 10 and 20%, depending on the cultural situations. The community-based mental health studies in India have revealed that the point prevalence of depressive disorders in elderly Indian population varies between 13% and 25%.[3]

A study was conducted by PS Choulagai, CK Sharma and BP Choulagai in 2010 to determine the prevalence and associated factors of depression among elderly population living in geriatric homes in Kathmandu Valley. A total of 78 elderly people were included in this study. The study participants were identified by using Geriatric Depression Scale. The result reveals that the prevalence of depression was 51.3% with severe depression 15.4% and mild depression 35.9%. Most of the severely depressed respondents (75%) were widow/widower; most of the mild depressed respondents (85.7%) were illiterate; three quarter (75%) of severely depressed respondents had no children; and almost all of severely depressed respondents (90.9%) had difficulty in daily living activities due to health problems.[4]

A cohort study was conducted on Depression in Older Persons (NESDO) of Netherland among 510 depressed and non depressed older persons (≥ 60 years) at 5 locations throughout the Netherlands. The result showed that the prevalence of major depression in older persons living in the community ranges from 1-5%. Rates of depressive disorders are substantially higher among specific populations of older persons, ranging from 5-10% in medical outpatients to 14-42% in residents of long-term care facilities. It appears to have a chronic course and higher relapse rates compared to early-life depression and co morbidity with cognitive decline and somatic diseases is higher than in depression in younger adults. In addition, in late-life depression co morbidity with other psychiatric disorders, especially anxiety disorders is high, and leads to longer time to remission as well as higher recurrence rates.[5]

Depression is a widespread mental health problem affecting many people. The lifetime risk of depression in male is 8-12% and in female it is 20-26%. The highest incidence of depressive symptoms has been indicated in individuals without close interpersonal relationship and in person who are divorced or separated. Depression is the most frequent cause of emotional suffering in later life and frequently diminishes quality of life. Depression in old age is an important public health problem that causes considerable morbidity and disability worldwide. It has been observed that the long term prognosis of geriatric depression is disappointing with incomplete recovery and higher tendency to relapse.

A cohort study was conducted to estimate the prevalence of depression and depressive symptomatology in 13,004 individuals aged 65 above living in institutions and compare these to people living in other settings in five sites across England and Wales. Following screening, a stratified random sub-sample of 2,640 participants received the Geriatric Mental State (GMS) examination of whom 340 resided in institutions. Diagnoses of depression were made using the Automated Geriatric Examination for Computer-assisted Taxonomy system (AGECAT). The prevalence of depression in those living in institutions was 27.1% compared to 9.3% in those living at home. Symptoms relating to depressed mood, severity of illness (e.g. wishing to be dead, future looking bleak) and some non-specific symptoms were more common in those living in residential homes.[6]

A study was conducted by Jai Bahadur Khatri (2005) to estimate the prevalence of depression and its correlation among geriatric patients attending outpatient departments of Tribhuvan University Teaching Hospital in Nepal. A study group of 100 elderly patients aged 65 years and above were randomly selected from the psychiatry, medicine and general practice outpatient departments. Result shows that 45% of the samples were found to experience depressive illness according to ICD-10 DCR. This includes 13% of mild, 22% of moderate and 10% of severe depression. 53.16% is found to be depressed according to GDS which includes 34.2% of mild and 19% of severe depression. Similarly, 67% were found to be depressed according to HDRS. This constitutes 40.5%, 17.7% and 8.8% of mild, moderate and severe depression respectively. Also, 61.53% were depressed according to BDI that includes 34.6%, 15.3% and 11.5% of mild, moderate and severe depression respectively. [7]

With the above background, the study was conducted with the following objectives:

1. To identify the depressive symptoms among geriatric population residing in old age home.
2. To find out the association between depressive symptoms and demographic variables Such as age, sex, marital status, education level etc.

MATERIALS AND METHOD

Type of study: A survey study

Place of study: Pashupati Old Age Home, Kathmandu,Nepal.

Study population: 100 geriatric population residing at Pashupati Old Age Home, Kathmandu, Nepal.

Study tool: Demographic proforma, Geriatric Depression Scale.

Study design: Descriptive design

Sampling technique: Purposive sampling technique

Statistical analysis: Excel 2007, R 2.8.0 Statistical Package for the Social Sciences (SPPS) for Windows Version 16.0 (SPSS Inc; Chicago,IL,USA).

RESULTS

Table 1: Description of sample characteristics n=100

S.N	Socio-demographic variables	Frequency	Percentage
1.	**Age**		
	65-69 years	9	9.0
	70-74 years	14	14.0
	75-79 years	24	24.0
	80 years and above	53	53.0
2.	**Sex**		
	Male	48	48.0
	Female	52	52.0
3.	**Religion**		
	Hindu	88	88.0
	Buddhist	2	2.0
	Christian	6	6.0
	Others	2	2.0
4.	**Marital status**		
	Married	58	58.0
	Unmarried	4	4.0
	Widow	30	30.0
	Separated	8	8.0
5.	**Level of education**		
	Literate	4	4.0
	Illiterate	96	96.0
6.	**Number of children**		
	One	6	6.0
	Two	30	30.0
	More than two	56	56.0
	None	8	8.0
7.	**Occupational status**		
	Semi skilled	95	95.0
	Skilled	4	4.0
8.	**Psychological support**		
	Yes	35	35.0
	No	65	65.0
9.	**Financial support**		
	Yes	6	6.0
	No	94	94.0
10.	**Reason for leaving home**		
	Low economy	9	9.0
	Family conflict	23	23.0
	Lack of care taker	64	64.0
	Self	4	4.0
11.	**Length of stay**		
	<3 months	3	3.0
	<6 months	9	9.0
	<1 year	13	13.0
	>1 year	75	75.0
12.	**Physical illness**		
	Yes	96	96.0
	No	4	4.0

Data presented in Table 1. shows that most of the participant were of age group 80 years and above (53%), most of them were female (52%), majority of them were Hindu (88%), most of them were married (58%), major of the participants were illiterate (96%), most of the participants have more than two children (56%), most of them are semi skilled (95%), most of them are not psychologically supported by their family and relatives (65%), most of them are not financially supported by family members (94%), the reason for leaving home for most of them are lack of care taker (64%), the length of stay of most of them are more than 1 year (75%), most of the participants have physical illness (96%).

Fig1: Pie chart representing depression score.

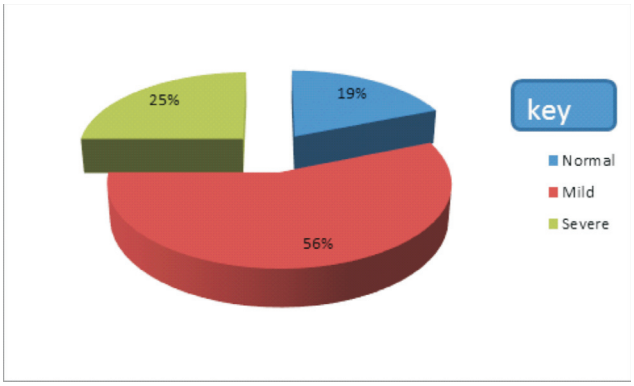

Fig 1 indicates that majority of participants had mild depression of 56%, 25% of them had severe depression and 19% had normal depression score.

Table 2: Association between depression score and demographic variables **n=100**

S. No	Socio-demographic variables	Depression symptoms			Chi-square		Df	significance
		Normal	Mild depression	Severe depression	Calculated value	Tabulated value		
1.	**Age**							
	65-69 years	1	6	2	8.376	12.592	6	NS
	70-74 years	3	8	3				
	75-79 years	6	8	10				
	80 years and above	9	35	9				
2.	**Sex**							
	Male	13	28	7	6.795	5.991	2	S
	Female	6	29	17				
3.	**Religion**							
	Hindu	17	50	21	1.580	12.592	6	NS
	Buddhist	0	1	1				
	Christian	1	4	1				
	Others	1	2	1				
4.	**Marital status**							
	Married	13	33	12	15.640	12.592	6	S
	Unmarried	2	2	0				
	Widow	2	21	7				
	Separated	2	1	5				
5.	**Level of education**							
	Literate	2	2	0	3.473	5.991	2	NS
	Illiterate	17	55	24				

Cont...

		Depression symptoms			Chi-square		Df	significance
S.N	**Socio-demographic variables**	**Normal**	**Mild depression**	**Severe depression**	**Calculated value**	**Tabulated value**		
6.	**Number of children**					1		
	One	0	3	3	17.705	2.592	6	S
	Two	6	12	12				
	More than two	9	38	9				
	None	4	4	0				
7.	**Occupational status**							
	Semi skilled	19	53	24	4.622	5.991	2	NS
	skilled	0	4	0				
8.	**Psychological support**							
	Yes	5	24	6	3.005	5.991	2	NS
	No	14	33	18				
9.	**Financial support**							
	Yes	3	3	0	5.313	5.991	2	NS
	No	16	54	24				
10.	**Reason for leaving home**							
	Low economy	0	8	1	13.864	12.592	6	S
	Family conflict	8	11	4				
	Lack of care taker	9	36	19				
	Self	2	2	0				
11.	**Length of stay**	0	2	1	6.468	12.592	6	NS
	<3 months	0	7	2				
	<6 months	4	6	3				
	<1 year	15	42	18				
	>1 year							
12.	**Physical illness**							
	Yes	16	56	24	6.946	5.991	2	S
	No	3	1	0				

Table 2: Data presented in above table shows that there is significant association with Sex, Marital status, Number of children, Reason for leaving home, Physical illness.

DISCUSSION

Study findings have been discussed in terms of objectives stated and with the findings of the other studies.

A study was conducted in Pashupati Old Age Home, Kathmandu, Nepal among 150 samples to determine the Prevalence of depression among elderly people living in old age home in the capital city Kathmandu. The result revealed that 29.58% had severe depression. In present study also 25% of the participants had severe depression. So the above study finding is supportive to the present study finding.[8]

A Community Based Cross Sectional Study was conducted for six months in the urban slums and persons aged ≥ 60 years. The result shows that the Prevalence of depression was 29.36%. The study reveals that females were more affected 31.39%. This study supports the present study as female were more affected 46% then male.

CONCLUSION

- Majority of geriatric people had mild depression 56%, 25% had severe depression and 19% had normal depression score.

- There is significant association with Sex, Marital status, Number of children, Reason for leaving home, Physical illness.

- There is no significant association between age, religion, level of education, occupational status, psychological support and length of stay.

Acknowledgement: I express my sincere gratitude to Mrs Sakun Singh, Principal, for her kind support.

Source of Funding: None

Ethical Clearance: To conduct the study, ethical committee permission was obtained from the president of Pashupati Old Age home and informed consent from the respondents was taken.

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Relapse Prevention Guidelines for Psychosis

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ABSTRACT

Relapse rates are influenced by the individual, as younger and more acute patients tend to show higher rates of relapse than older or chronic patients. Family situations where emotion is readily expressed, have also been associated with increased risk of psychotic relapse. It is important that these early signs be identifiable by family members or carers, as patients may minimize or disguise these symptoms in order to appear healthy or to avoid hospital readmission. The ability of patients to properly recognize altered experiences may also deteriorate as the symptoms progress and insight diminishes. The involvement of several entities in the early recognition process is crucial to its success. It is important that these signs be identifiable by family members or carers as patients may minimize or disguise these symptoms in order to appear healthy or to avoid hospital readmission. The ability of patients to recognize altered experiences may also deteriorate as the symptoms progress and insight diminishes. Hence relapse prevention guidelines need to be prepared and implemented early in advance to prevent the relapse rates and ensure a better standard of living for the psychotic patients.

Keywords: *Relapse, Psychosis, Insight, Hospital readmission & Relapse Prevention Guidelines*

INTRODUCTION

Psychotic relapse is the reoccurrence of previously treated psychotic symptoms. Recent research has been investigating the possibility of identifying early warning signs of an impending psychotic relapse. Effective early recognition may offer the potential for early intervention to prevent relapse, such as medication adjustment, psychosocial treatments, social support and stress reduction. Early warning signs are subjective experiences, thoughts and behaviors that occur immediately prior to a psychotic relapse, which signal to the patient or their family that their condition is deteriorating.

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Models of Relapse Prevention in Psychosis [1,2]

There are three models of relapse prevention in psychosis.

- The Basic Model
- The Phase Model
- The Comprehensive Model

The Basic Model: This model confines itself to listing the early warning signs as accurately as possible. . In most cases, the early signs that are relevant for a specific patient are written down in the patient's record or on a specially designed card, which the patient may carry with him. The card may also state the name of the health care professional to be contacted by the patient if any of the early signs occur. This model thus collects the most elementary information required for early recognition and early intervention purposes. Intervention usually consists of adjustments of antipsychotic medication. The patient's role is relatively passive, while a medical and psychiatric orientation is dominant.

The Phase Model: This model is designed to provide a detailed reconstruction of the various phases of previous psychotic episodes in order to create an overall picture of a psychotic episode, from the moment of (relative) stability until the onset of a florid psychosis. This model operates on the assumption that subsequent psychotic episodes will show a similar pattern. Interventions are linked to each phase, and aim at keeping a patient in balance or at restoring the balance. The key question is always whether the patient can act independently or whether he or she needs professional help. This model aims at using as fully as possible the patient's own coping skills. Compared to the basic model, it requires a more active role of the patient.

The Comprehensive Model: This model not only focuses on prodromes and symptoms, but also systematically records factors that have a direct or indirect impact on the onset of psychotic relapse. Stress factors are identified in terms of internal sources (e.g. unrealistic targets) or external sources (e.g. stressful interactions within the family). Protective factors are also charted, making a distinction between protective social factors (e.g. supportive contacts with friends) and protective activities (e.g. recreational activities or sports). Other elements are the patient's skills (e.g. degree of assertiveness) or lack of skills (e.g. personal hygiene), which can be improved with training.

Various strategies of Relapse Prevention in Psychosis

1) Recognizing and listing of early warning signs
2) Monitoring
3) Role of the Family

1) Recognizing and listing of early warning signs[3]

Many people experience changes in behaviour, thoughts, or feelings before any more obvious symptoms of psychosis appear. These are often called **"early-warning signs"**, signals that something is not right.

Common early-warning signs are,

- Sleeping too much or too little
- Feeling anxious or tense
- Finding it difficult to concentrate
- Feeling more sensitive to sounds, lights, or colours
- Feeling down or sad
- Missing work or school
- Feeling "high" or excited
- Talking more or less than usual
- Not enjoying hobbies or other usual fun activities
- Not taking care of personal hygiene
- Not wanting to go out or spend time with family or friends
- Becoming easily annoyed at others
- Feeling suspicious of other people
- Avoiding things you need to do.

2) Monitoring

"Monitoring is the more or less systematic assessment of the presence of early signs for the purpose of estimating the risk of a psychotic relapse". There are two types of monitoring,

❖ **Direct Monitoring**, in which the presence or absence of early signs is assessed directly.

❖ **Indirect Monitoring**, in which actual situations are assessed to monitor the presence or absence of protective or stress factors.

3) Role of the Family[6,9]

Studies have shown that co-ordination of the activities undertaken by the health care workers and family members seems more appropriate than to encourage family members to take more action, in the prevention of psychotic relapse.

PSYCHIATRIC REHABILITATION IN RELAPSE PREVENTION [8]

"Psychiatric rehabilitation is the systematic application of psychosocial interventions designed to improve the symptomatic and functional course of a major psychiatric disorder".

(A). Illness Self-Management

[4]Many psychiatric rehabilitation methods focus on improving the person's skills or competence, providing environmental supports, or using a combination of both. For example, learning illness

self-management or social skills methods improves patient competence, family psycho-education provides a more knowledgeable and supportive family milieu, and supported employment combines improved patient skills with environmental supports to facilitate work in the community.

There are several approaches to teaching illness self-management skills. The strategies described below are incorporated into the Illness Management and Recovery program, a curriculum-based program to help patients identify and work toward personal recovery goals.

Psycho-education is most effective when the psychiatrist engages the patient in an interactive manner, uses language that the patient feels comfortable with, and pauses frequently to ask questions to help the patient relate the information to his own experiences and to evaluate his understanding of the information. Educational handouts are also useful for teaching patients about the disorder.

Medication non-adherence is a major contributor to relapses and hospitalizations; therefore improving adherence is a common goal of illness self-management programs. [1]However, before efforts to improve adherence can be undertaken, it is important to engage the patient in making an informed decision about taking medication as a strategy to help manage the psychiatric disorder. In addition to providing the patient with basic information about the benefits and adverse effects of medication, and dispelling inaccurate beliefs about medication, the psychiatrist can help the patient make a decision by listing and weighing the pros and cons of the medication. Once the person has made a decision to take medication, a variety of different strategies can be used to help him adhere to the regimen.

"Strategies for facilitating adherence in patients who chooses to take medication"[1]

Strategy	Description
Behavioural tailoring	Incorporate taking of medication into the patient's daily routine
Pill organizers	Help patient organize medication in a dispenser that has all the pills that need to be taken at one time
Reminders to help patients to take medication	Set alarm on cell phones and other electronic devices to remind the patient to take medication
Reduce medication regimen complexity	Reduce the number of medications and how often they must be taken
Engage social support	Caregivers can remind the patient when it is time to take medication
Long-acting depot medications	With injectable depot anti-psychotics, patients do not need to remember to take medication every day.

[7]**Relapse prevention guidelines** can avert relapses and reduce the severity of any that do occur. Relapses usually occur gradually over several weeks and are preceded by subtle early warning signs (such as difficulty in sleeping, confusion, or depression) or mild increases in symptoms. Rapid action (e.g., temporarily increasing the dosage of medication) in response to such warning signs can reduce or forestall relapses.

"Developing a relapse prevention guideline"

- Involve a caregiver when developing the relapse prevention plan with the patient
- Explain that most relapses occur gradually over time and that developing a relapse prevention plan can prevent or reduce the severity of relapses and re-hospitalizations
- Explain that preventing relapses may be helpful in achieving personal goals
- Discuss situations that have precipitated relapses in the past (e.g., stressful events, medication non-

adherence, alcohol or drug abuse)

- Focus on the most recent relapses and identify 2 or 3 early warning signs or mild symptom increases that preceded the full-blown relapse
- Discuss how to monitor for early warning signs or mild symptom increases
- Decide on what the patient's response will be to early warning signs or mild symptom increases
- Write the plan down
- Rehearse the relapse prevention plan with the patient (and significant others if applicable) and make any modifications as needed.
- Include a copy of the plan in the patient's record, and give copies to all relevant people
- In case of a relapse, review the plan and modify as needed.

Nursing Implications Related to the Relapse Prevention for Psychosis[3,11]

Psychiatric nurses role as a member of the mental health team, has always been appreciated due to the availability of a wide variety of nursing intervention protocols which can contribute towards the relapse prevention for patients who are suffering with psychosis.

"Psychiatric Nursing Intervention Protocol for Relapse Prevention"

The basic principles are

- The experiential world of the psychotic patient is the starting point
- The relapse prevention plan is tailor-made
- Working with a relapse prevention plan is (if possible) a joint activity of the patient, the care providers, and the members of the social network.
- The relapse prevention plan continually needs adjustment
- The care provider manifests positive appreciation

The various phases are

a) The preparatory phase

b) The listing of early warning signs

c) The Monitoring phase

d) The Action plan

a) The Preparatory Phase

The preparatory phase starts with the nurse introducing the theme "working with a relapse prevention plan" to the patient and the members of his or her social network. The objective of this introduction is engagement. Firstly, the nurse looks for the relevance of early recognition and early intervention for the patient and the social network. The next step in the preparatory phase consists of the nurse describing and analysing a number of characteristics of the patient and the social network.

The nurse assess the following patient related characteristics such as,

- Motivation
- Insight into the illness
- Illness acceptance
- The nature and the severity of the symptoms
- Personal characteristics of the patient and their skill levels (for example, in coping and problem solving), their intelligence level, addiction problems and cultural background.

The nurse assess the following social network related characteristics such as,

- The extent of the social network
- The readiness and the actual capabilities of the members to participate in working with a relapse prevention plan
- Any special characteristics of the network, such as the level of expressed emotion

b) The Listing of Early Warning Signs

The nurse describes the early warning signs by having one or more discussion with the patient and if possible with the members of the social network and a reconstruction is made of previous relapses. After listing down the early warning signs, the nurse works out each early warning sign on three levels,

- **Level 1** – Normal or stable situation
- **Level 2** – Gives a description of the warning sign when it is present in its light or moderate form
- **Level 3** – Gives the situation when the warning sign is present to a serious degree.

c) The Monitoring

The nurse monitors the early warning signs, to make an evaluation periodically of their presence

or absence. The presence indicates an increased risk of a psychotic relapse, and specific actions may be appropriate to keep the condition of the patient from deteriorating. Shortly after the completion of the relapse prevention plan, monitoring should be done very regularly – preferably weekly – under the guidance of the nurse. In this way, the patient and the involved members of the social network gradually can ever more easily internalise the early warning signs. Afterwards, the frequency of the monitoring can vary more in the course of time. Monitoring may be intensified in specific periods, for example, in times of increased stress, in periods in which medications are being changed, or in periods in which early warning signs are already present.

d) The Action Plan

The objective of the action plan is the systematic description of actions that can be taken by the patient himself or herself, by members of the social network, and by care providers (nurses) in order to prevent a threatening psychosis.[10]

Three types of actions by the nurses are distinguished here as follows,

(1) Actions that the psychiatric nurses formulates from his or her own professional expertise (for example, promoting medication compliance),

(2) Actions of the psychiatric nurse at the request of the patient (for example, contacting the employer to explain the condition of the patient),

(3) Actions of the psychiatric nurse at the request of family members and other people involved (for example, more intensive telephone contact with the parents of the patient to keep them informed of the treatment procedures and the way in which they can contribute to this procedures).

The nurses should be implementing a "self-management model" of relapse prevention for psychosis into routine clinical practice, through which both the patient and relatives are involved in formulating the action plan in order to prevent the psychotic relapse.[11]

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Tokophobia among First Time Expectant Fathers

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ABSTRACT

Background: Fear of childbirth has become a modern day epidemic amongst new fathers. Becoming a father can be one of the most significant events in a life of a man. Whereas the fathers are often neglected and people tend to forget that fathers also have valid feelings, hopes, and fears about pregnancy, childbirth and their new babies. First-time fathers are particularly vulnerable for negative experiences during childbirth which increases the risk for paternal postpartal depression which may negatively affect his relationship with the mother and child .

Aim: The aim of the study was to describe the prevalence of tokophobia-- childbirth related fears among first time expectant fathers and associated factors.

Method: A descriptive cross sectional design consisting of individual interviews using Childbirth Related Fear Questionnaire (CRFQ) consisting of 30 Likert-type items, scored on a 4-point scale, ranging from low fear (1) to severe fear (4), with the scores ranging from 30 to 120 was used. A purposive sample of 113 first time expectant fathers attending the antenatal clinics along with their low risk term primigravidae at 36-40 weeks of gestation in three maternity hospitals participated.

Results: The results revealed that larger proportion (78.4%) of first time expectant fathers suffered from Tokophobia -fear of childbirth during pregnancy. The men's fear was primarily related to the health and life of their partner and child, and their main worry concerned with the child. The men also had a higher level of general fear on labor &delivery, professional competency, behavior, insufficient medical treatment, fear of not being treated with respect and dignity, fear of partners' & own capabilities, fear of exclusion from decision making, financial matter and fear of responsibilities as fathers. There were no statistically significant differences in the baseline characteristics of men and tokophobia .

Conclusions: Healthcare professionals need to acknowledge that first time expectant fathers have needs of their own during pregnancy and childbirth. Fathers also worry and fear about the child and the woman , so they need explanations about normal changes as well as possible complications. Experiencing intense fear related to childbirth constitutes a significant burden for expectant fathers. This calls for preventive obstetric care strategies to identify, involve and support fearful expectant fathers in their own right, in all aspects of maternity care and be offered opportunities to discuss their feelings and any fears that they may have.

Keywords: *First time expectant fathers, Childbirth related fear, Tokophobia.*

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INTRODUCTION

Paternal fear of childbirth can impact fathers' ability to be emotionally and physically supportive of their partner and affect their ability to assume a fatherhood role during a vulnerable time of transition. More than women, men are frightened

about birth and what might possibly go wrong due to over medicalization of childbirth.[1] Fear is generally a normal physiological human reaction necessary for the protection and safety of the individual. With regard to childbirth, it is probably healthy to experience concern or anxiety to a certain degree, as it can help first time fathers to make ready for childbirth itself.[1,2]

Fathers play a key role in supporting their partner in pregnancy, labor and childbirth and believe their supportive role is an important part of the process of becoming a father and their needs are equally important as the mothers' needs.[3] Whereas men are easily neglected, and if they don't receive help the chances are that they won't tell anyone about their fears. Apart from the personal effect this has, it is also possible that this affects their relationship with the mother and child. Expectant fathers genuinely struggle with the need to balance their own transition to fatherhood and that of their partner. Their status and feelings are sometimes overlooked and may cause conflict with their other roles.[4] To provide effective support fathers themselves need to be supported, involved and prepared.[3] Taking time to give relevant information and to engage with the father in all aspects of care can help to foster a greater satisfaction for both the father and his partner.

Over the last decade much research has been focused on the pregnant woman's fear of childbirth but even the expectant father is vulnerable in experiencing increase in stress and fear due to changing roles and social status. The involvement of prospective new fathers in a child's life is extremely important for maximizing the life-long wellbeing and outcomes of the child. Pregnancy and birth are the first major opportunities to engage fathers in appropriate care and upbringing of children however there has been much less focus on addressing the roles, their fears and needs.

Paternal developmental processes occurring during pregnancy are as complex as maternal developmental processes. The father may experience mixed feelings, ranging from ambivalence and anxiety to excitement and anticipation. [5,6,7] Cultural pressure, intra-psychological processes and psycho-sociological adjustment to a new situation can give rise to post-traumatic stress in fathers[5] and domestic violence[6] .

Fear of childbirth- tokophobia is an important men's health issue. When a man becomes a father, a whole world of feelings is awakened in him through the process of pregnancy and birth. Taking time to give relevant information and to engage with the father in all aspects of care can help to foster a greater engagement with and satisfaction for both the father and his partner. [6,7,8]

Fear of childbirth is a universal human phenomenon but in acute form it can aggravate the course of pregnancy and childbirth.[3,9] While couples share many of the concerns about having children, men have their own distinct worries. To date most studies have focused on maternal childbirth fears and the focus on paternal childbirth fears is relatively new. There is comparatively little research on men's experience of tokophobia .

MATERIALS AND METHOD

Little is known about when childbirth fear develops among men across pregnancy. Therefore, the first time expectant fathers who were attending the antenatal clinic regularly along with their low risk primigravidae partners in their third trimester of pregnancy were requested to participate. The interviews were conducted at 36-40 weeks of gestation to ensure that the father had had time to experience most of the pregnancy and also attend the antenatal clinic.

Data collection Instrument

To estimate the prevalence of Tokophobia among the first time expectant fathers (child birth related fears) about their partners' first labour and childbirth---- The Childbirth Related Fear Questionnaire (CRFQ) was developed by the researcher . Pertinent domains were identified through literature studies, discussions with experienced midwives and obstetricians and a interview with primiparous women, their partners and family members. Identified areas of childbirth related fears included tokophobia regarding the health /life of the baby, the health /life of the mother, tokophobia related to labor and delivery , professional competency and behavior, tokophobia related to Partners' capabilities/ reactions, own capabilities and reactions, tokophobia related to exclusion from

decision making, financial matters and tokophobia related to fear of responsibilities.

The tool contained Child birth Related Fear Questionnaire with 30 items. The questions were presented as statements with a participants response rate on a four -point Likert scale ranging from low level of fear (1), moderate level of fear(2), high level of fear (3) and severe level of fear(4) and the scores ranged from 30 to 120. The maximum scores were 120 and the cut –off fear score was set priori above 60. Scores above 60 indicated tokophobia among the first time expectant fathers with childbirth related fear ranging from high and severe level. Scores below 30 were considered low fear, a score between 30 and 60 equates to moderate fear level. Content validity of the tool had been established and the reliability of this questionnaire yielded 0.87 with Cronbach's alpha .

Study participants

The sample included 113 first time expectant fathers who were accompanying their partners regularly to antenatal clinics of three South-Bangalore private hospitals between October 2013 and April 2014. The inclusion criteria were the first time expectant fathers whose partners were normal low risk term primigravidae with single fetus, no drug history, no chronic disease, no infertility, no high risk pregnancy and no history of psychiatrist visit. Exclusion criteria were first time expectant fathers with second marriage, polygamilal relationship, age above 35 years, history of psychiatrist visit, unplanned and unwanted pregnancy.

Statistical analysis

Statistical analysis was conducted using SPSS 15 (Chicago, III USA). Descriptive statistics -frequencies , mean scores and mean percentage were performed on all items and non parametric Chi-square/ Fishers exact probability tests were used to find the association of tokophobia with sociodemographic variables. An alpha of less than 0.05 was considered significant in all tests.

RESULTS

A total of 113 first time expectant fathers were approached to participate in the study. Of these n=97 (85.8%)) were recruited. A total of n=16 (14.2%)first time expectant fathers withdrew from the study after answering few questions stating that they do not have any childbirth related fear .

Participants characteristics

All the participants n =97 (100%) partners were in their third trimester of pregnancy (Mean gestational weeks =38.4. weeks, SD 2.96, range 36-39^{+5-} weeks). The mean age of participating first time expectant fathers were 28.4 years (SD 5.1, range 23–34 years). With regard to educational level n =53 (54.6%)of men had degree level or postgraduate education. The rest n=44 (45.4%) had technical education. The majority of them (92.8%) were private sectors employees, (3.1%) in Govt sector and (4.1%) were self employed . Regarding socioeconomic status all of them belonged to middle socioeconomic class.

Prevalence of Tokophobia -Childbirth related fear

The childbirth related fear (tokophobia) scores ranged from 30 to 111 (out of possible scores of 120) among the first time expectant fathers. The mean score was 93.25 (SD=10.720). Majority of the first time expectant fathers (78.4%) had tokophobia varying from high to severe level (cut of score >60).

A very few had a low level of tokophobia n=8 (8.2%; scores <30) , a few n=13 scored in the moderate range (13.4% ; scores 31-60) .Of the remaining men n=29(29.9%) scored between 61-90, reporting high level of fear and vast majority of men n=47(48.5 %) reported intense /extreme sever level of tokophobia (childbirth related fears scores >90) (Table-1).

Contents of Tokophobia child birth related fear

Of the 97 respondents, the uppermost category of tokophobia among first time expectant fathers was the fear related to health condition and life of the baby (93.2%). The sub category of fear included (94.5%) expressing fear of having a deformed or baby born with anomalies, defects and diseases or illness or child being injured during delivery process (92.8%) something wrong with the condition of the child (92.8 %) in terms of breathing /crying problems and fear of losing the child during childbirth (92.3%). The second largest category of tokophobia among (88.5%). them was related to the health and condition of the mother in terms of the fear of their partners would be injured during childbirth 89.5%, fear of losing the partner during

childbirth (88.8%) and fear of partners having an injurious complications and excessive bleeding (87.3%). The third most category of fear among men were related to the labor and delivery process (81.7 %). Among the subcategories, highest percentage of men (86.5 %) expressed fear of their partners suffering with extreme pain, fear of unpredictable course of labor(84.5%), longer duration of childbirth (82.3%), obstetric procedures and interventions (79.5%), fear of being injured or something going wrong during the birth- requiring medical intervention, emergency cesarean sections or procedures (79%) and losing control during labor (78.5%).

The fourth most category of fear among men (74.7%) were related to the professionals' competence and behavior. The subcategory of fears reported were, not being treated respectfully by 77.5%, apathetic or rude and indifferent behavior of staff when asked for information or plan of care by (75 %) , not getting the kind of care expected from the care staff by (74.3%) and fear of receiving insufficient or inadequate medical care by (72%). The fifth category of tokophobia revealed that, 70% of men expressed fear of their partners physical ability to give birth, 70.3% described fear of the woman not being able to "cope" with the situation, partner's reactions and behavior during childbirth (69.8 %) and fear of their partners failing to cooperate in the way the delivery staff wanted (69.3%). The sixth largest category of tokophobia was related to o first time expectant fathers own capabilities to cope with childbirth (65%). The subcategory of fears expressed were inability to cope with the situation by (68.5%), nightmares about labor and childbirth by (67.5%) , feeling powerlessness /helpless (67.3%), fear of losing control during labor (64. 5%), difficulty in relaxing when thinking of the coming childbirth (62.8%) and fear of inability to provide support or extend help (62.3%) the seventh largest category of tokophobia among new fathers to be were fear of being excluded from decision making on the health/ condition and treatment/ interventions or procedures of their partners' and unborn child (62.3%). The eighth category of tokophobia reported by men was related to fear of hospital cost and financial assistance to take care of the growing family(58.5%). The ninth category of tokophobia among first time expectant fathers was fear related to Mother/ baby / family/ future(58 %). Overall 78.4 % of the first time expectant fathers had tokophobia varying from high to severe intensity (Table-2).

DISCUSSION

Prevalence of tokophobia – Childbirth related fears among first time expectant fathers:

It is well known that pregnancy and childbirth may be a time of considerable anxiety with symptoms escalating in the third trimester and first time expectant fathers may express some concerns or fear about the forthcoming delivery of their partners[10]. However, the focus on paternal childbirth related fears among first time expectant fathers is relatively new and most of the research related to childbirth fears has focused on mothers. Therefore it is possible to state that there has not been a particularly significant evolution in research on childbirth related fears (Tokophobia) among first time expectant fathers. The present study findings revealed that the majority of first time expectant fathers (78.4%) had tokophobia in varying intensity from low to severe level. Pregnancy and childbirth are unique live events which lead to a major life change and can be perceived as stressful. For the majority of new fathers to be , childbirth is appraised as such a threatening or dangerous situation that they experience fear of childbirth (tokophobia). Expectant fathers need to be included in all aspects of maternity care. Positive involvement of fathers has the potential to decrease fear and anxiety and increase trust and respect. It will promote confidence in fathers as valued co-parents.

Participants characteristics

The participants were homogenous with regards to their age, education, socioeconomic status as analyzed by chi square/ fishers exact probability test. This highlights the fact that fear of childbirth is a universal human phenomenon but in acute form it can aggravate the course of depression or posttraumatic stress disorder (PTSD), either of which can affect both parent–child bonding and the father's relationship with his partner .[11]

Tokophobia related to the health and life of the baby:

Pregnancy and childbirth is thrilling and scary to both prospective parents. While couples share many of the concerns about having children, the number one fear is related to the health and life of the baby. This study revealed that the uppermost category of fear among first time expectant fathers was the fear related to health condition and life of the baby (93.2%) which included fear of having a deformed baby, baby born with anomalies, defects and diseases, child being injured during delivery process and fear of losing the child during childbirth. Similar findings were reported by Eriksson[12] who examined a childbirth-related fears in Swedish men (n = 329 and women (n = 410), showed 13% of the fathers expressed an intense level of childbirth-related fear, 59% reported a mild to moderate level of fear regarding health and safety of the baby (79%). Experiencing intense fear related to health of the baby during childbirth constitutes a significant burden for expectant fathers. This calls for antenatal strategies for identifying and supporting fearful fathers in their own right and providing more information about the childbirth care.

Tokophobia related to the health and life of the partner:

Fear related to the partner's health and life, injury, losing the partner, complications and bleeding was the was the second largest category of fear among first time expectant fathers (88.5%) Supportive findings were reported by Chalmers[13] who conducted a descriptive study to determine what fathers think about pregnancy, birth among N = 46 first-time fathers revealed that most fathers were excited about the pregnancy, though they had significant fears of a newborn abnormality, their partner's pain, and their partner or baby dying and loss of their wife and their unborn child. Since fathers are important influences on mothers' health choices and experiences before, during and after the birth, it benefits the whole family when maternity professionals make fathers feel welcomed and involved in obstetric care.

Tokophobia related to the labor and delivery process:

Worry and fear are a natural part of pregnancy, labor and birth in expectant parents. Research reveals that men have a higher level of general anxiety during their partners' pregnancy, childbirth and lower self-confidence about becoming good parents. This study revealed that the third most category of fear among men were related to the labor and delivery process (81.7%), fear of their partners suffering with extreme pain, fear of unpredictable course of labor, longer duration of childbirth, obstetric procedures / interventions and losing control during labor. Supportive findings were reported by Szeverenyi[14] who explored the reasons for childbirth-related fears among 216 couples revealed a similar ranking of paternal childbirth-related fears.

Tokophobia related to The Professional's Competency and Behavior:

In an era in which health care will be increasingly measured by the outcomes, it is critical that heath care staff better understand that the people who use health and care services have the right to be treated with respect, dignity by staff who have the skills and time to care for them. In this study the fourth most category of fear among men (74.7%) were related to the professionals' competencey and behavior and fear of receiving insufficient medical care . The findings are consistent with other studies which investigated fathers childbirth related fears that the most of the men expressed fear of trust on medical personnel and professional competency.[15]

Tokophobia related to partner's capabilities and reactions :

Paternal fear of childbirth can impact fathers' ability to be emotionally and physically supportive of their partner and affect their ability to assume a fatherhood role during a vulnerable time of transition. Majority of men 70% expressed doubts about the woman's capabilities and reactions as the fifth category of tokophobia .Supportive findings were reported by Vehvilainen[16] who examined what fathers felt during the birth revealed that the fathers' greatest concerns were related to how their partner would cope during labor and birth.

Tokophobia related to Own capabilities to cope with childbirth:

Men often view fear as a sign of weakness, and a reluctance to acknowledge fear may be a cultural

male gender response. Feelings of vulnerability, powerlessness and self doubt about their capabilities may be heightened during labor. This study revealed that fear related to his own capabilities and reactions were the sixth category of fear (65 %) supported by Wielgos[15] who examined the concept of family labor and birth showed that fathers had fear of fainting and feeling useless.

Tokophobia related to exclusion from decision making

It has been argued that if fathers are not involved in decision making process of partners child birth process, it arouses anxiety, fear of self inefficacy to care for the families and fear of losing control over a potentially life threatening event. This study reported that the seventh category of tokophobia among men were fear of being excluded from decision making on the health/ condition and treatment/ interventions or procedures of their partners' and unborn child (62.3%) Similar findings reported by White[17] who explored the phenomenon of post-traumatic stress disorder among 21 fathers revealed that most of the fathers felt excluded during decision-making, as if their opinion did not matter by the maternity care staff.

Tokophobia related to financial matter and responsibilities:

Tied in with the fear of becoming a responsible adult, won't be able to see friends, eat out, do any of the social things they now enjoy and financial concerns of the medical cost, partners' delivery, raising a new baby are the big concern for prospective fathers. This study revealed that (58.5%) of first time expectant fathers were worried about financial matter, (58%) expressed a fear of future responsibilities as responsible father and family care taker. Dellman[18] support the study findings by stating that the father's role during childbirth has never been truly defined.

IMPLICATIONS FOR PRACTICE

Most expectant fathers now accompany their partners to antenatal consultations and ultrasound scans. All maternity health care providers will encounter opportunities to engage with and support prospective fathers in designing groups or individual psycho healtheducation to strengthen men's role in the period of transition to fatherhood.

LIMITATIONS

The study findings are generalizable to first time expectant fathers who utilize private hospital obstetric care.

CONCLUSIONS

Best practice in obstetrics should involve early identification of fear and feelings of first time expectant fathers to the current pregnancy, childbirth, and future fatherhood. It is essential for the preventive obstetric health care personnel to protect and support every expectant father against these fears or to remove them altogether, to give every one of them the opportunity to deal with his own fears and to obtain the help he needs in his situation.

It is time that health professionals recognize that men have tokophobia. The health care personnel should engage fathers in antenatal conversation about their birth expectations, feelings and fear. The treatment of tokophobia-childbirth related fear should aim at reducing anxiety during pregnancy, increasing the self-confidence and relaxation, supporting the transition to fatherhood, and preventing paternal post partal depression by providing sufficient information, psycho education and support .

Table : 1 Levels of Tokophobia among First time expectant fathers

N=97

Levels of Tokophobia	**First time expectant fathers n (%)**
Low level	08 (8.2%)
Moderate level	13 (13.4%)
High level	29 (29.9%)
Severe level	47 (48.5%)

Table : 2 Prevalence of Tokophobia among First time expectant fathers

N=97

Contents of Tokophobia	**Prevalence of Tokophobia**	
I. **Tokophobia regarding the health /life of the baby**	**Mean Score**	**Mean %**
1) Anomalies/ diseases in the child	**3.7**	**93.2**
	3.78	94.5
2) Child being injured during delivery process	3.71	92.8
3) Some thing wrong with the baby	3.71	92.8
4) Loosing the child during the childbirth	3.69	92.3
II. Tokophobia regarding the health /life of the mother	**3.5**	**88.5**
5) Mother being injured during delivery process	3.58	89.5
6) Loosing the mother during the childbirth	3.55	88.8
7) Complications/Bleeding too much during delivery	3.49	87.3
III. Tokophobia related to labor and delivery	3.3	81.7
8) Partner suffering with pain during delivery	3.46	86.5
9) Complications/ Unpredictable course of labor	3.38	84.5
10) Prolonged duration of labor	3.29	82.3
11) Operative procedures/Interventions Emergency LSCS	3.18	79.5
12) Mother&baby being injured during delivery process	3.16	79
13) Losing control during labor	3.14	78.5
IV. Tokophobia related to professional competency and behavior	**3**	**74.7**
14 . Not being treated with respect	3.1	77.5
15) Apathetic / rude/indifferent behavior of staff	3. 0	75
16) Nor getting the kind of care expected	2.97	74.3
17) Fear of receiving insufficient/inadequate medical care	2.88	72
V. Tokophobia related to Partners' capabilities/ reactions	**2.8**	**70**
18) Partner's physical ability to give birth	2.81	70.3
19) Inability to cope with all the process	2.8	70
20) Partner's reactions and behavior during childbirth	2.79	69.8
21) Failure to cooperate with the care staff	2.77	69.3
VI. Tokophobia related to own capabilities and reactions	**2.6**	**65**
22) Inability to cope with it all	2.74	68.5
23) Nightmares about labor and childbirth	2.7	67.5
24) powerlessness /helplessness	2.69	67.3
25) Fear of losing control during labor	2.58	64. 5
26) difficulty in relaxing about labor and childbirth	2.51	62.8
27) Inability to provide support or extend help	2.49	62.3
VII. Tokophobia related to Exclusion 28) Fear of being excluded from decision making	2.49	62.3
29. **Tokophobia related to Financial concern**	2.34	58.5
30. **Tokophobia related to Fear of Responsibilities --**Mother/ baby / family/ future	2.32	58

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Conflict of Interest: None declared

Source of Support: Nil

Ethical Approval: Ethical approval was obtained from the three participating hospitals ethics committee . Eligible first time expectant fathers were given written information outlining the study purpose, invited to ask questions and to discuss their participation with family or care providers . The researcher explained to the participants that their participation would be voluntary . Informed consent was collected after participants were informed orally and in writing about the study's purposes. Participants were assured that they could excuse themselves from participating at any time during the study, without effect to their partners care and that findings would not be linked to individuals, and that all study events and materials would maintain confidentiality. Participants were not considered to be at risk of harm. The first time expectant fathers were informed that the duration of the interview would be approximately 30 -40 minutes.

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Student Nurses' Attitude Towards Suicide

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ABSTRACT

Background: Suicide is a serious public health problem around the world, with nearly one million cases in a year. It is estimated that at least six people are directly affected by one suicide death. According to current trends, it is estimated that, globally, deaths by suicide will reach 1.53 million people by 2020.[1] Attitudes towards suicide represent a keystone in understanding and preventing suicides.

Method: A descriptive cross sectional study was conducted among 200 undergraduate nursing students in college of nursing JIPMER (Jawaharlal Institute of Post Graduate Medical Education and Research), Puducherry to identify their attitude towards suicide. The samples were selected by convenience sampling. Socio demographic data was collected from the subjects by using a proforma. Attitude towards suicide was assessed by using a standard questionnaire (Attitude towards Suicide Scale by **Ellinor Salender Renberg**, 2011).

Results: The most favored attitude found in the subjects was permissiveness (mean=22.05± 3.6). There was a significant association between attitude of nursing students towards suicide and place of residence and nativity. No significant association was found with the socio demographic factors such as age, gender, type of family and religion.

Keywords: *Attitude, Suicide, Nursing Students*

INTRODUCTION

Every year, more than 800000 people die from suicide; this roughly corresponds to one death every 40 seconds. Suicide is among the three leading causes of death among those aged 15-44 years and the second leading cause of death among those aged 10-24 years. These figures do not include suicide attempts which can be many times more frequent than suicide (10, 20, or more times). Suicide worldwide was estimated to represent 1.3% of the total global burden of disease in 2004.[2]

Suicide in India is slightly above world rate. Of the half million people reported to die by suicide worldwide every year, 20% are Indians. In India, more than one lakh persons (1, 35,445) lost their lives by committing suicide during the year 2012. The southern states of Kerala, Karnataka, Andhra Pradesh and Tamil Nadu has high suicidal rates in India.[2] Puducherry has been consistently observed to have high suicide rates in India with 45.5 per

1,00,000 population (2010) and 36.8 per 1,00,000 (2012) according to the statistics of the National Crime Records Bureau (NCRB), New Delhi, India.[3] Suicide was the fifth most common cause of death overall and ranked number one among adolescents in the world. It is the leading cause of death among college students.[4] A recent large-scale study found that approximately 18% of undergraduates reported having seriously considering a suicide attempt at some point, while 6% reported serious suicidal ideation in the past 12 months.[5] Professional nursing students could perhaps be at an even higher risk for suicide than other college students. They encounter stress in adjusting to a rigorous program of theory and practice.

OBJECTIVE OF THE STUDY

- To identify the attitude towards suicide among undergraduate nursing students in college of nursing, JIPMER.

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- To identify the association between attitude towards suicide and certain selected demographic variables such as age and place of residence.

METHODOLOGY

A cross sectional descriptive research design was adopted. The study population comprised of all the undergraduate nursing students in College of Nursing, JIPMER. Convenient sampling technique was used to select 200 subjects from College of Nursing, JIPMER, Puducherrry. Socio demographic proforma consisted of 8 items namely age, gender, religion, type of family, place of residence, socioeconomic status, native of Puducherry, period of stay in Puducherry. Attitude towards suicide was assessed by using "Attitude towards suicide questionnaire" developed by Ellinor Salender Renberg (2011).[6] It is a 40 item questionnaire in Likert scale format of which 31 items were divided into various domains that projects the attitude. The various domains were permissiveness (8 items), preventability (6 items) incomprehensibility (5 items), unpredictability (5 items), avoidance (4 items), and loneliness (3 items). Answers were scored using Likert scale as follows: 5- strongly agree, 4- agree, 3- undecided, 2-disagree and 1- strongly disagree for the positively worded statements. For negatively worded statements, reverse scoring was done. The higher scores represent greater agreement with the belief expressed by each domain. Data analysis was done using descriptive and inferential statistics. Statistical tests used were mean, standard deviation, independent student t test and one way measures of analysis of variance.

FINDINGS

Table – 1: Distribution of subjects based on demographic variables (N=200)

variables	Categories	Frequency	percentage
Age (in years)	18-20	169	84.5
	>20	31	15.5
Gender	Male	22	11.0
	Female	178	89.0
Family type	Nuclear	179	85.5
	Joint	21	14.5
Religion	Hindu	151	75.5
	Christian	41	20.5
	Muslim	7	3.5
	Atheist	1	0.5
Residence	Urban	121	60.5
	Rural	41	20.5
	Semi urban	38	19.0
Native of Pondicherry	Native	129	64.5
	Non Native	71	35.5

The distribution of subjects based on demographic variables is presented in **table-1**. Out of 200 subjects, 169 (84.5%) of the subjects belonged to the age group of 18-20 years and 31(15.5%) of them were more than 20 years of age. Gender distribution showed that 178(89%) of the subjects were females and 22(11%) were males. The family type showed that 179(89.5%) of the subjects belonged to nuclear family and 29(14.5%) of them belonged to joint family. Majority of the subjects 151(75.5%) were Hindus and 41(20.5%) of them were Christian. The place of residence indicated that 121(60.5%) of the subjects hailed from urban area, 41(20.5%) of them hailed from rural area and 38(19%) of them belonged to semi urban area. It

further showed that out of 200 subjects, 129(64.5%) subjects had native as Puducherry.

Table – 2: Subjects' attitude towards suicide based on Attitude towards Suicide Scale (N=200)

Attitude	Mean	SD
Preventability (score range:6-30)	19.2	2.6
Incomprehensibility (score range:5-25)	18.0	2.7
Permissiveness (score range:8-40)	22.1	3.6
Avoidance (score range:4-20)	12.2	2.7
Unpredictability (score range:5-25)	16.4	2.8
Loneliness (score range:3-15)	10.2	2.6

The subjects' attitude towards suicide based on Attitude towards Suicide Scale is presented in Table- 2. The mean attitude score of permissiveness (refers to the belief that people have the right to take their own life and acceptance of suicide in the situation of incurable disease) was found to be higher (22.1±3.6), when compared to other aspects of attitude. The mean attitude score of preventability (refers to the belief that suicide can and must be prevented) was found to be 19.2 ± 2.6. The score of incomprehensibility (refers to the belief that suicide cannot be justified or understood) was found to be 18.0 ± 2.7 and unpredictability (refers to the belief that suicide happens without any warning and people who talk about suicide do not usually commit) was 16.4 ± 2.8. Avoidance refers to the belief that talking about suicide triggers suicidal thoughts (mean score was 12.2 ± 2.7) and loneliness refers to the belief that being alone is the reason for suicide and an attempt of suicide is mostly a cry for help (mean score was 10.2 ± 2.6).

Table – 3: Association between age and attitude towards suicide (N=200)

Attitude	Age(in years)				T value	P value
	18-20 (n=169)		>20 (n=31)			
	Mean	SD	Mean	SD		
Preventability	19.2	2.6	20.1	3.0	2.2	0.84 (NS)
Incomprehensibility	17.9	0.2	18.2	0.5	0.6	0.94 (NS)
Permissiveness	22.1	3.4	21.9	4.5	0.4	0.20 (NS)
Avoidance	12.2	2.7	12.2	3.0	0.1	0.81 (NS)
Unpredictability	16.5	2.7	15.8	3.4	1.3	0.60 (NS)
Loneliness	10.1	2.6	10.4	2.9	0.5	0.53 (NS)

The association between age and attitude towards suicide is presented in Table- 3. The results of Independent Student's t test revealed that there was no significant association between the study subjects' age and their attitude towards suicide.

Table – 4: Association between place of residence and attitude towards suicide (N=200)

Attitude	Place of residence							
	Urban (n=121)		Rural (n=41)		Semi urban (n=38)		F	p
	Mean	SD	Mean	SD	Mean	SD		
Preventability	19.2	2.5	19.1	2.8	19.3	2.7	0.1	0.91 (NS)
Incomprehensibility	18.0	2.8	18.1	2.5	17.6	2.6	0.5	0.64 (NS)
Permissiveness	22.4	3.4	23.1	3.4	20.9	4.0	3.8	0.02*
Avoidance	12.4	2.6	11.5	2.9	12.4	3.0	1.6	0.2 (NS)
Unpredictability	16.6	2.8	16.2	3.1	15.9	2.7	0.9	0.39 (NS)
Loneliness	10.1	2.6	10.6	2.4	9.6	2.9	1.4	0.24 (NS)

NS - Not Significant * - significant at $p<0.05$ level

Table - 4 : Describes the association of place of residence and attitude towards suicide. One way measures of analysis of variance test showed that there was a significant association between place of residence and attitude of permissiveness (refers to the belief that people have the right to take their own life and acceptance of suicide in the situation of incurable disease) and it was significant at $p<0.05$ level.

CONCLUSION

The present study found that those from rural area tended to have more permissive attitude towards suicide. Attitude towards suicide was significantly associated with demographic variables like place of residence and no significant association was found between the study subjects' age and their attitude towards suicide.

Acknowledgement: We express our thanks to the nursing students who participated in the study and the authorities who provided permission to conduct the study.

Conflict of Interest: Nil

Ethical Clearance : Ethical clearance for the study was obtained from the Human Ethical committee, JIPMER (Jawaharlal Institute of Postgraduate Medical Education and Research), Puducherry.

Funding Sources: Not obtained any funds from any sources.

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A Study on Knowledge and Attitude Regarding Organ Donation-among Professional and non Professional Students in Selected Institutions of Kannur, Kerala

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ABSTRACT

Transplantation is the preferred treatment for many end-stage organ diseases. A quantitative - non experimental study was conducted to assess the knowledge and attitude among 50 professional and 50 non professional students in selected institutions of Kannur. Data collected by using a structured questionnaire and analysed using descriptive and inferential statistics. The results showed that professional students have better knowledge compared to non professional students and majority of students from both groups having positive attitude regarding organ donation.

Keywords: *Knowledge, attitude, organ donation*

INTRODUCTION

Organ donation is the donation of biological tissue or an organ of human body which is removed in a surgical procedure, based on the donor's medical and social history, which is suitable to the recipient, who is in need of transplantation. Every day three people die while waiting for an organ transplant and many others lose their lives before them even get on to the transplant list.

Goyal M (2004) stated that Organ donation from a deceased person has been performed since 1954.Since then, there is chronic shortage for organs and low response to decreased organ donation, due to fear of surgery[1]**.** According to MOHAN foundation statistics, India (2012) nationally with the population of 1.2 billion people the statistics stand at 0.08% as organ donor per million populations[2].

OBJECTIVES

To assess the knowledge and attitude among professional and non professional students regarding organ donation. To assess the relationship between knowledge and attitude. To find the association of knowledge and attitude with selected socio demographic variables.

METHODOLOGY

A comparative descriptive study was conducted among 100 college students from Govt: college of engineering, Kannur, and Sir Syed College, Thaliparamba, using a non-probability convenient sampling technique based on inclusion criteria. The data was collected by using a structured questionnaire. The research approach applied for the study was quantitative-non experimental research. The study was conducted from 1/7/2014 to 14/7/2014.

RESULTS

The findings of the study were as follows:

1. Knowledge level among professional and non- professional students:

Among professional students, 62% had good knowledge and 38% had average knowledge. Among non professional students, 50% had good knowledge, 48% had average and 2% had below average knowledge.

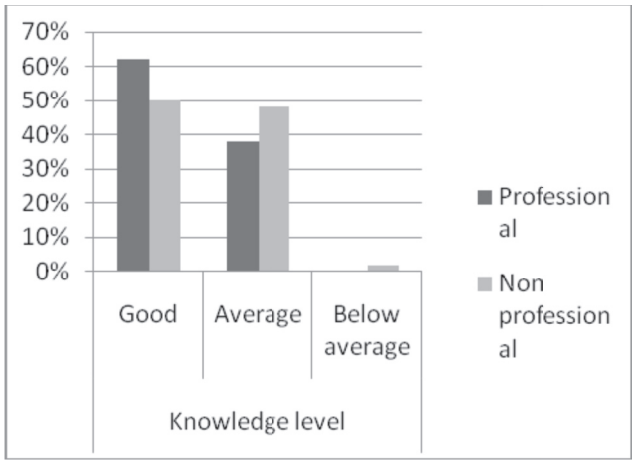

Figure 1: knowledge level among students

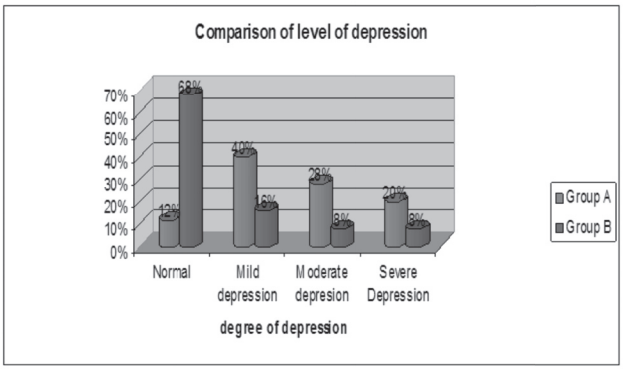

Figure 2: Attitude among students

2. Attitude level among professional and non-professional students:

Among professional students, 68% had positive attitude and 32% had uncertain attitude. Among non professional students, 56% had positive attitude and 44% had uncertain attitude. None of the students had negative attitude towards organ donation.

3. Significant relationship between research variables:

Spearman's correlation co efficient is 0.17, thus interpreted that there is a positive relationship between knowledge and attitude among professional students.

Spearman's correlation co efficient is 0.625, thus interpreted that there is a positive relationship between knowledge and attitude among non professional students.

There was a mild positive relationship exists between knowledge and attitude among professionals and positive relationship among non professional students.

4. Significant association between knowledge and attitude with selected socio-demographic variables:

To compare between research variable and socio-demographic variables one way chi^2 test and Yates correlation was computed. Found significant association exists between attitude and religion of whole sample.

In professional students, there was a significant association between gender and attitude. Other socio demographic variables such as residence, living area had no association with knowledge and attitude.

Table 1: Correlation between research variables

Relationship Between Knowledge and Attitude Among Professional Students.

Variables	Correlation r_s
Knowledge Attitude	0.17

The above table shows that, spearman's correlation co efficient is 0.17, thus interpreted that there is a positive relationship between knowledge and attitude among professional students.

Relationship Between Knowledge and Attitude Among Non Professional Students.

Variables	correlation r_s
Knowledge Attitude	0.625

The above table shows that, spearman's correlation co efficient is 0.625, thus interpreted that there is a positive relationship between knowledge and attitude among non professional students.

DISSCUSSION

A cross-sectional study was conducted among 440 students aged 18 years and above in Hindustan Arts & Science College, Chennai, Tamil Nadu, in 2012, study revealed that Females (64.1%) had higher knowledge and willingness rates than males for

organ donations.

In the present study there were no students with excellent knowledge among professional and non professional students. Among male professional students, 68% have good knowledge and 32% have average knowledge .among female professional students, 57% have good knowledge and 43% have average knowledge. Among male non professional students, 44% have good knowledge and 50% have average knowledge, 6% have below average knowledge. Among female non professional students, 53% have good knowledge and 47% have average knowledge regarding organ donation.

A study conducted in the metropolitan city of Delhi, by PH Mishra,2004 ,it was found that Christians (96.43%) had good knowledge than Hindus (75.16%) regarding organ donation.

In the present study among professional students 65% of students with good knowledge 35% of students with average knowledge are included in Hindu religion. 58% of students with good knowledge 42% of students with average knowledge are included in Muslim religion. 100%students with average knowledge are included in Christian religion. Among non professional students 56% of students with good knowledge 44% of students with average knowledge are included in Hindu religion. 43% students with good knowledge 54% of students with average knowledge and 3% of students with below average knowledge are included in Muslim religion. 100% students with good knowledge are included in Christian religion.

RECOMMENDATIONS

On the basis of the study findings, the following recommendations were made:

- The study can be replicated in different settings.
- A study can also be conducted among health care professionals of various departments.
- A quantitative study can be conducted to analyse the lived in experience of organ donors after
- the donation of kidney to their spouses and relatives.

IMPLICATIONS

The present study has many implications for nursing.

Nursing practice: Health care professionals should have good knowledge and positive attitude towards organ donation. Nurses and health care professionals can teach the public about the importance of organ donation.

Nursing Administration: The result of the study can be used for motivating the staff. Nurses can conduct periodical continuing nursing education programme on organ donation. Nurse Councillors can be appointed for encouraging organ donation in the nursing service department.

Nursing Education: Nurse Educators can encourage students to participate in organ donation programmes. Research report can be kept in library for reference. The students can be made to participate in seminars and conferences conducted on organ donation. Plan for a mass awareness programme on organ donation.

Nursing Research: Nurses can conduct a survey to assess knowledge and attitude regarding organ donation among all health workers. A similar study can be conducted in large population, especially among youth. The abstract of the research report can be published in nursing journals for further replication of research on the same topic. Nurses can conduct a quasi experimental study to assess the effectiveness of a teaching programme on knowledge and attitude. Professional nurses can be part of organ donation programmes along with other health team members.

CONCLUSION

The findings of the study shows that professional students have better knowledge regarding organ donation compared to non professional students. Majority of students from both group had positive attitude towards organ donation. However, it is better to provide attitude training and motivation for the students regarding organ donation.

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Conflict of Interest : None

Source of Funding: Self

Ethical Clearance: Institutional ethical committee.

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A Study to Evaluate the Effects of Music Therapy on Depression among Cancer Patient Admitted in Selected Cancer Hospitals at Vadodara

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ABSTRACT

Introduction: Diagnosis of cancer evokes far greater emotional reaction than diagnosis of any other disease regardless mortality rate or treatment modality. Shock and disbelief are the commonest initial response followed by anger, depression and feeling of loss and grief. The intensity and duration of emotional distress and the degree which interferes with patient's life can vary from individual to individual. The major sources of continuing emotional distress are fear of disease and sense of helplessness over its treatment. Cancer may affect the family in a similar way as it invades the body of patient and cause psychological distress, or anxiety and depression in them.

Aims and Objectives: The study aimed at assessing the pretest and post test level of depression among cancer patient in experimental and control group, Evaluate the effectiveness of music therapy on level of depression among the patient with cancer, Determine the association between post test depression level among cancer patient and selected demographic variables such as age, gender, education, occupation, area of living, type of family ,income, duration of illness, marital status, duration of stay in hospital, monthly expenditure for treatment in experimental and control group.

Material and Method: A Quantitative research approach with quasi experimental research design was used. The Sampling Technique used was convenient sampling technique. The setting was selected in cancer hospital s with sample size 60. Modified Zung Self rating Depression Scale was used as research tool. The reliability of the tool was established by split half method and alpha method in spss. Hence the tool was found to be reliable. Data was analysed by using Descriptive and inferential statistical method. The data was also Presented graphically.

Results: Result of study indicate In experimental group the level of depression among cancer patients is reduce due to music therapy the pretest score mean was 40.03 while post test score was mean 25.3333.

In control group in which patients not receive music therapy has increase depression day by day in control group the pretest 34.7667 while post test score was mean 40.2333.

The Chi squre test was used to determine the association between level of post test depression and selected demographic variable in experimental and control group. The result suggest that some of the variables are significant to post depression level that are sex of the patient ,total family income per month in experimental group and total family income, duration of stay in hospital in control group

Interpretation and Conclusion: The study findings revealed that the music therapy was effective in experimental group and decrease the depression level of patients. Furthermore, it is concluded that in patients who not receive music therapy having increases Depression.

Keyword*: Evaluate, Effect, Music therapy, Depression, Cancer Patient, Cancer Hospital*

INTRODUCTION

Cancer is a class of diseases in which a group of cells display the traits of uncontrolled growth, invasion, and sometimes metastasis or spread to other locations in the body via lymph or blood.[2]

Globally, More than 350 million people have depression, a mental disorder that prevents people from functioning well. (as per WHO 9th October 2012) On average 1 in 20 peoples.(who 2012).[3]

Depression affects 121 million people with cancer worldwide. People with cancer having major depression 0%-38%, Depression Spectrum syndrome 0%- 58%. Depression is highly associated with oropharygeal (22%-57%), pancreatic (33%-50%), Breast (1.5%-46%) and lung (11%-44%) cancers. A less high prevalence of depression is reported in patients with other cancer, such as colon (13 %- 25%), gynecological (12%-23%) and Lymphoma (8 %-19%).[4]

Cancer often viewed as an acute and usually fatal disease. Cancer is a disease which affects physical, psychological, social, financial and spiritual well-being of the individuals. Person with cancer is faced with a number of issues like death, disfigurement, disability, dependence and disruption of relationship.[5]

Music therapy is the "the planned and creative use of music to attain and maintain health and well being. people of any age or ability may benefit from a music therapy programme regardless of musical skill or background. Music therapy may address physical, psychological, emotional, cognitive and social needs of individual within a therapeutic relationship." Australian music therapy association.[6]

Music therapy has a long history dating back to ancient orphic school in Greece. pythagorus, plato and Aristotle, all were of the prophylactic and therapeutic power of music. Even the Old Testament in the bible mentioned music therapy where king david was said to have cured an illness by playing on the harp. Hippocrates, the father of modern medicine, used music to cure human diseases. In Ancient Egypt music was used to lessen the pain of women during childbirth. Ibn sina, a famous Arabic writer, has written in detail on this subject. In India leged has it that Thyagaraja, the famous musician of south india, brought a dead person back to life by singing the composition Naa jeevan dhara in raga bihari. In 1729 richard browne, a physician wrote the famous text medicina musica which describes the use of music as medine.[7]

MATERIAL & METHOD

Research Approach: Quantitative research approach was used.

Research Design: Quasi experimental research design was adopted

Setting of the Study: The study was conducted in selected cancer hospitals, may permitting at Vadodara.

Sample: The sample for the present study comprises of 60 cancer patients who fulfilled the sampling criteria and expressed willingness to participate in the study

Sampling technique: non probability convenient sampling technique was used.

Development of tool for data collection: it consists of 2 parts:-

Part 1:- dealt with the demographic data of the sample

Part 2:- Modified Zung self rating depression scale to assess the depression of the cancer patients .Total 20 items are included in the questionnaire.

Validity of instrument: To ensure content validity of the tool, the modified Zung self rating depression scale was send to 9 experts. The experts were selected based on their clinical expertise, experience and interest in the problem being studied. They were requested to give their opinions on the appropriateness and relevance of the items in the tool. The experts were from the field of nursing, psychiatrist, psychologist and statistician. Modifications of items in terms of simplicity and order were made.

Reliability: In order to establish the reliability of the tool it was administered to six cancer patients. To establish the reliability of modified zung self rating depression scale, split half method was used. The reliability obtained was 0.83, which proved that the

tool was reliable Thus the tool is found reliable.

Selection of music therapy : The music therapy group includes carnatic classical raga, classical music, devotional songs, soft instrumental music and bioacoustics music (mixture of soft music with natural sounds). Apart from this the researcher selects Bioacoustic music as per the interest and under the guidance of musician. The music CD was prepared under the musician guidance. The CD content the music is having relaxing effect on the human being.

Data collection procedure: Data collection was held in the selected settings in vadodara. The data collection period extended from 11th November to 27th November, 2013. The purpose of the study was explained to the subjects and their consent was obtained. Pre-test was given to all cancer patients using a Modified Zung self rating Depression scale to assess the level of Depression of cancer disease patients. Based on the score obtained by the clients, the intensity of Depression was categorized as mild, moderate and severe. patients who were experiencing Depression according to the grading were randomly selected as Experimental Cancer patients group (30 patients) and control group (30 patients)Following the pre-test, the Music therapy was introduced to the Cancer patients group. The cancer patients group was involved in Music therapy for 15 days.

Analysis of data: Both descriptive and inferential statistics analyzed on the basis of the objectives and hypotheses of the study. Based on the objectives and hypothesis of the study, the data will be entered into a master data sheet and will be organized and analyzed. Demographic data containing sample characteristics would be analyzed using frequency and percentage. The mean pre and post-therapy depression score of cancer patients were planned to be analyzed using frequency percentage bar diagram. To find out the effectiveness of music therapy, data would be analyzed by comparing post-therapy Depression score and pre test score of the group by computing paired't' test. The data would be represented in the form of tables and diagrams.

FINDINGS

Organization of Study Findings: The data is analyzed and presented under the following sections:

SECTION I: Description of demographic factor of cancer patients.

SECTION II: Level of Depression among cancer patients in pre- test and post test among experimental and control group.

SECTION III: Effectiveness of music therapy both in experimental and control group (PAIRED T -TEST)

SECTION IV: Effectiveness of music therapy by comparing experimental and control group (Independent t test) post test

SECTION V:

PART I : Association between the post level of depression with demographic variables (experimental group).

PART II: Association between the post level of depression with demographic variables (control group)

SECTION I: Description Of demographic factor of cancer patients

In experimental group. Majority of patients 36.7% were belongs to 49 and above years and 23.3 % were belongs to 18-28 years and 23.3% were belongs to 29-38 and 16.7 % were belongs to 39-48 year. In control group majority of patients 33.33% were belongs to 29-38 years and 26.7 % were belongs to 49 and above years and 20 % were belongs to 18-28 years and 20 % were belongs 39-48 year.

In experimental group 53.3% of the patients belongs to males and 46.7% of them were females. In control group 50 % were male and 50% were female

In experimental group 66.7% patients lives in rural area and 33.3 % lives in urban area. In control group 50% live in rural area and 50% live in urban area.

In experimental group 56.7% belongs to joint family and 43.3% belongs to nuclear family. In control group 20% nuclear and 80% belongs from joint family.

In experimental group 30% patients having primary education 20% secondary education 30%

higher secondary and 20% graduate and post graduate. In control group 20% patients are having education up to primary 20% were secondary, 36.7 % were higher secondary and 23.3% having graduate and post graduate education

In experimental group majority of patients were married 90% and 6.7% were divorced and 3.3% patients were widow and no patients found divorced. In control group 76.7% patients were married, 13.3% patients were unmarried, 3.3% divorced and 6.7 % widow.

In experimental group total income of the family of the patients up to 5000 were 10%,5001-10000 were 36.7% and 10001-15000 were 36.7%, 15001 and above were 16.7%. In control group up to 5000 were 26.7%, 5001-10000 were 23.3% and 10001-15000% were 23.3%, 15001 and above were 26.7% in control group.

In experimental group majority of patients having duration 0-6 months 56.7% and 33.3%having 7-12 months and 10%having more than 1 year.In control group 0-6 months 46.7% and 33.3%having 7-12 months and 20%having more than 1 year.

In experimental group stay of patient in hospital majority is 0-3 months 80%, 4-6 months 13.3 % than more than 7 months 6.7 %.In control group 66.7% in 0-3 months,20 % 4-6 months,13.3 % more than 7 months.

In experimental group monthly expenditure for treatment majority is more than 10,001 were 83.3%, 13.3% were 5001-10,000.and 3.3% were 2001-5000. In control group majority is more than 10,001 is 86.7%, 10.% were 5001-10,000 and 0% in 2001-5000 and 3.3 % up to 2000.

SECTION II: Level of Depression among cancer patients in pre- test and post test among experimental and control group.

Table 1 (EXPERIMENTAL GROUP)

DEPRESSION		PRE-TEST		POST-TEST	
		Frequency	Percent	Frequency	Percent
LEVEL	Normal	0	0	5	16.7
	Mild	5	16.7	16	53.3
	Moderate	15	50.0	9	30.0
	Severe	10	33.3	0	0
	Total	30	100.0	30	100.0

TABLE 2 (CONTROL GROUP)

DEPRESSION		PRE-TEST		POST-TEST	
		Frequency	Percent	Frequency	Percent
LEVEL	Normal	0	0	0	0
	Mild	4	13.3	3	10.0
	Moderate	26	86.7	18	60.0
	Severe	0	0	9	30.0
	Total	30	100.0	30	100.0

SECTION III: Effectiveness of music therapy both in experimental and control group (PAIRED T - TEST) **TABLE 3**

DEPRESSION		Mean	Mean difference	Std. Deviation	"t"-value
EXPERIMENTAL GROUP	PRE-TEST	40.0333	14.70000	7.81459	22.293*** Df=29 P=3.6594
	POST-TEST	25.3333		6.48783	
CONTROL GROUP	PRE-TEST	34.7667	-5.46667	5.95780	-4.329 Df=29 P=3.6594
	POST-TEST	40.2333		7.25251	

SECTION IV: Effectiveness of music therapy by comparing experimental and control group (Independent t test) post test. **TABLE 4**

DEPRESSION LEVEL	GROUP	Mean	Mean difference	Std. Deviation	"t"-test value
	EXPERIMENTAL POST-TEST	25.3333	14.9	6.48783	8.387 Df=58 P=3.4663
	CONTROL POST-TEST	40.2333		7.25251	

SECTION V: PART I : Association between the post level of depression with demographic variables (experimental group).

PART II: Association between the post level of depression with demographic variables (control group)

The sex of patient at 2 degree of freedom and total family income per month at 6 degree of freedom and 0.05 level of significant are significantly associated with the post test depression score in experimental group. It can be depicted that duration of stay in hospital at 4 degree of freedom and 0.05 level of significant is significantly associated with the post test depression score in control group.

Conclusion: Conclusion deals with the conclusion, implications, recommendations and limitations of the study to "A study to evaluate the effects of music therapy on depression among cancer patient admitted in selected cancer hospitals at vadodara"

CONCLUSION

In the present study 60 cancer patient selected using non- probability convenient sampling technique.

The research approach adopted in the present study is quantitative research approach with a view to measure the level of depression among cancer patients, Effectiveness was assessed by analysis of pre test and post test level of depression in experimental and control group to know the effectiveness of music therapy in experimental group. The data was interpreted by suitable and appropriate statistical method.

This research study deals with the following conclusions

In experimental group the level of depression among cancer patients is reduce due to music therapy the pretest score mean was 40.03 while post test score was mean 25.3333.

In control group in which patients not receive music therapy has increase depression day by day in control group the pretest 34.7667 while post test score was mean 40.2333.

The Chi square test was used to determine the association between level of post test depression and

selected demographic variable in experimental and control group. The result suggest that some of the variables are significant to post depression level that are sex of the patient, total family income per month in experimental group and total family income and duration of stay in hospital in control group.

LIMITATION OF THE STUDY

The following points were beyond the control of the investigator.

- The study was limited to a particular geographic (vadodara) which imposes limits on generalization.
- Data collection period was limited to 4 weeks; hence the sample size was relatively very small.
- The data collection tools were used for the first time and available time did not permit extensive standardization of the tool.
- All of the subjects were hospitalized patients. Thus the findings are applicable to hospitalized clients only.
- Sample size was selected 60 cancer patients only.
- It is difficult for the samples to continue the therapy for continuous 15 days.
- Chance of drop out of sample is the major limitation of this study.

RECOMMENDATION

- The study can be replicated on a larger sample which will facilitate more reliable result.
- A similar study can be conducted in different settings.
- A true experimental study can be conducted to find out the effectiveness of music therapy on depression among old age people in old age home.

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Ethical Standards: This study was conducted after getting approval from the Institutional Ethics Committee and after obtaining written consents from all subject.

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Depression among Four Groups of Ethnic Asian American Adolescents in New York City

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ABSTRACT

This descriptive, survey, cross-sectional study was conducted to investigate the risk factors of depression among four ethnic groups of Asian American adolescents. Convenience sample of 316 adolescents, 16 to 19 years of age (*M*= 17.53 years, *SD* = 1.13), living in New York City, were recruited from members and friends of Asian American organizational sources. Adolescents receiving treatment for depression were excluded from the data analysis. Measures included Demographic, depression (CES-D scale), English language acculturation scale, and smoking opportunity survey questionnaires. Ninety percent of the participants were enrolled in school; 11th grade (29.3%), 12th grade (29%), and college freshman (20.1%) levels. Ninety-two percent spoke another language other than English. Analysis revealed that 50% (*n* = 158) of all participants scored at or above the cut-off point of 16 on the CES-D Scale (*M*=17.85, *SD* = 10.89). Significant risk factors found were English language acculturation, current enrollment in school and smoking status, as well as the interaction between ethnicity and smoking status. Depression may be prevalent among Asian American adolescents and it is important to focus attention on this significant health problem. Acculturation assessment must be integrated into clinical evaluations and smoking prevention programs should be culturally and ethnically sensitive to the needs of Asian American adolescents.

Keywords: *Asian American adolescent; risk factors; depression; Risk factors of Depression in Asian-American Adolescents in New York City*

INTRODUCTION

Adolescent depression is a serious problem with a lifetime prevalence of 14%-20%[1, 2, 3]. The prevalence and risks of adolescent depression vary according to gender and ethnicity. For example, in Saluja et al.'s[3] study, higher proportion of female adolescents (25%) reported depressive symptoms than male adolescents (10%). Among the American Indian participants, 28% reported depressive symptoms, as compared with 22% of Hispanic, 18% of White, 17% of Asian American, and 15% of African American participants[3]. Female individuals, older adolescents, and ethnic minority youth were more likely to report depressive symptoms than male individuals, younger adolescents, and White youth[3,4]. It is estimated that

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depression afflicts as many as 10%-20% of Asian American adolescents[5] and that depression can be associated with significant morbidity and mortality[6]. Among all Asian Americans, those aged 20-24 had the highest suicide rate (12.44 per 100,000)[7]. Furthermore, suicide was the second leading cause of death for Asian-Americans 15-34 years of age[7]. According to Duldulao, Takeuchi and Hong[8], U. S. born Asian American women had a higher lifetime rate of suicidal thoughts (15.9%) than that of the general U. S. population (13.5%); and that Asian American college students were more likely than White American students to have suicidal thoughts and to attempt suicide[9].

The typical Asian society has specific expectations of each age group that differ from those in American society. The collectivist nature of the Asian society also makes conformity an expectation of individuals[10]. For instance, Asian American children are taught to be polite, quiet, humble, shy, and deferential. Open displays of emotions or emotional outburst are discouraged in order to maintain social and familial harmony or to avoid exposure of personal weakness [10,11]. When an Asian family's expectations are not met—such as academic achievement, this often brings shame and loss of face to both the children and their parents[10,12].

Although specific demographic factors in the depressive symptoms of Asian American adolescents could not be fully established in past studies, there is substantial evidence that Asian American adolescents have a high rate of depressive symptoms[4, 13, 14]. True prevalence rates of mental disorders within the Asian American community are difficult to determine because of its relatively small size, heterogeneity, and rapid changes in demographics[15,16], and that researchers have not focused a good deal of attention on the prevalence of mental disorders[17]. Researchers may assume that the emotional and behavioral functioning of this group is high and that Asian Americans as an aggregate do not face substantial barriers to assimilating into U.S. culture[18]. On the contrary, Asian Americans have experienced many barriers to assimilation due to stereotypical portrayals in the media, English language, and cultural adjustment difficulties[15]. Song and colleagues[19] reported that Asian American high school students had a higher prevalence of depressed symptoms, but similar risks factors as the Caucasians high school students.

Findings of previous studies on socio-demographic factors related to depressed mood were varied. Some studies have found that greater depressive symptomatology in children and adolescents were related to older age, African American race, female gender, low maternal education, single-parent household, and lower socioeconomic status[19]. While other research studies to date, report that Asian American adolescents' psychological difficulties relate to acculturation and being foreign born[19]. Acculturation is the process when individuals from another culture adopt the traits of the mainstream culture[20,21]. Ma, Tan, Toubbeh, Su, Shive, and Lan [22] postulate that acculturation may be stressful because most individuals or groups are often resistant to change and consider change a threat to one's beliefs, values, social order, lifestyle, and history.

Linguistic acculturation—the ability to speak English proficiently—may be an indicator of overall level of cultural acclimation for immigrant youth[22]. Wong[13] found that effects of cultural orientation and interpersonal relationships were related to depression among inner-city Asian American high school students. Late immigrants, those who immigrated after 12 years of age, reported significantly greater depression than the Asian American-born adolescents.

Additionally, Yuwen and Chen [23] reported that perceived high parental expectations about academic performance and moral values and perceived stricter family rules regarding choices of friends compared with their non-Asian peers contributed to increased conflict between parents and adolescents and emotional distress of the adolescents. Late adolescent Asian American youth depression were related to parent–adolescent and ethnic identity conflicts, longer length of residence in the United States, poor self-esteem; poor relationships with peers, and lower grade point average, perceived low maternal warmth and higher intergenerational acculturation were significant predictors[24]. Kim, Gonzales, Stroh, and Wang[25] found that cultural marginalization (living on the margins of two cultures rather than being a member of either one) is significantly related to depressive symptoms in Korean, Chinese, and Japanese American parents and adolescents living in the U.S.[26].

This study focused on Asian American adolescents—in an effort to better understand what the risks factors of depression might be in this adolescent group. Therefore, the purpose of this cross-sectional, study was to investigate the risk factors of depression among four ethnic Asian American adolescents in New York City. The researchers hypothesized that adolescents with higher depressive symptom scores were more likely to be female, to have arrived in the US after 7 years of age, and to be less English-language acculturated; have less-educated parents; have lower school performance, to be not currently enrolled in school and to be a current smoker.

METHODOLOGY

Design: This descriptive, survey, cross-sectional study investigated the risk factors of depression among a convenience sample of 316 Asian American adolescents 16-19 years of age living in the five boroughs of New York City (NYC).

Setting: Participants were recruited within the five boroughs of NYC from the members, friends, and affiliates of several organizational sites in NYC that serve Asian American adolescents illustrated in Table 1.

Table 1. Frequency distribution of the sources of participants.

Variable	Frequency	%
Organizational sources of participants		
Asian American mentoring service organization	98	31.0
Fast food chain	66	20.9
Asian American human resources organization	11	3.5
College-related Asian American fraternities	113	35.8
Church-related Asian American organization	28	8.9
Total	316	100.0

Measures: Demographic questionnaire: The 25-item demographic questionnaire included age, ethnic background, parental job description, educational level of parents, grade level, school enrollment and school performance.

Depression questionnaire: To assess depressive symptomatology, the 20-item CES-D Scale was used. Adolescents were asked to rate any depressive symptoms experienced in the past week on a 4-point Likert-type scale ranging from 0 (none of the time) to 3 (most or all of the time). Summative scores ranged from 0 to 60, with higher scores indicating greater severity of depressive symptoms. The CES-D Scale has reported an internal reliability of α = .84 - 87[13,27,28]. The Cronbach's alpha for this study was .90.

Acculturation (English language usage questionnaire) This instrument was used to assess participants' level of language acculturation. Cronbach's alpha was 0.89 for this study.

Age of arrival in the United States was assessed by asking the participants, „How old were you when you moved to the United States?" This variable was coded as dichotomous. Arrival at or before age 7 was scored as 0; arrival after their 7th birthday was scored as 1. This age was used based on the study by Chen, Unger, and Johnson[29] to assess the acculturation level of the Chinese American youths; assuming that the acculturation level of the children who immigrate to the United States before age 7 do not differ significantly from the second-generation Chinese Americans in the United States.

Smoking questionnaire: Smoking experience was assessed by asking participants whether they had ever tried to smoke (Yes) or had not smoked (No).

Data Analysis: Bivariate analyses were carried out to determine their degree of association with the dependent variable—CES-D total score. Linear regression analysis was used to test the hypothesis. Tukey's multiple testing was used to estimate the effect of smoking status in each ethnicity group. Results and Discussion

DEPRESSION

The data analysis of the 316 participants revealed that the mean CES-D score was 17.85 (SD = 10.89), and 50% (n = 158) of the adolescents scored 16 or higher on the CES-D. The total CES-D scores ranged from 0 to 53, with possible scores of 0-60. The bivariate analysis in Table 2 demonstrates the significant risk factors of depressive symptoms found in this study which were age, level of language acculturation (English language usage), age of arrival in the United States, school performance, current enrollment in school, and current smoker status. Specifically, adolescents

who were older, less English-language acculturated, arrived in the U.S. after the age of 7, not currently enrolled in school, smokers, and those who had lower school performance had higher depressive symptom scores.

Table 2. Bivariate Correlations of Variables with the Total CES-D Scores

Variables	Pearson correlation	p	N
Age	.112*	.046	316
Gender	.032	.576	316
Acculturation index	-.139*	.013	316
Age of arrival in the U.S. (after 7 or Before 7)	.147**	.010	311
School performance	-.127*	.024	316
Current enrollment in school	-.159**	.005	316
Maternal education	-.115	.071	247
Paternal education	-.098	.127	241
Smoking status	.268**	<.001	316

*p < .05 (two-tailed) **p < .01 (two-tailed)

When linear regression was performed, the statistically significant risks factors found were English language acculturation, current enrollment in school and smoking status in this group. The linear regression model explained 21% of the variability in the CES-D scores. The adjusted mean CES-D scores for each of the ethnicity by smoking status combinations are presented in Table 3.

Table 3. Adjusted Mean CES-D Scores for Each of the Ethnicity by Smoking Status

Ethnicity	CES-D Score	Low	High	Smoker
Chinese	18.78	16.06	21.50	No
Chinese	24.99	21.76	28.22	Yes
Filipino	17.46	12.73	22.18	No
Filipino	25.32	19.69	30.96	Yes
Korean	17.23	12.72	21.75	No
Korean	17.74	13.97	21.52	Yes
South Asian	17.73	13.26	22.20	No
South Asian	31.96	27.82	36.10	Yes

Depression Score is the adjusted mean CESD score // Low is the lower 95% CI limit //High is the high 95% CI limit. Smoking status was associated with 6.2 increase in CES-D score in the Chinese group (p = 0.009), 7.9 units increase in the Filipino group (p = 0.311), 0.51 increase in the Korean group (p = 1.000) and 14.23 increase in South Asian group (p < 0.0001).

DISCUSSION

The study explored a number of risk factors likely to contribute to depressive symptoms among the four groups of Asian American adolescents. The frequency of the depressive symptoms among this sample was relatively high. Fifty percent of the Asian American adolescents in this study scored above the cut-off point of 16 on the CES-D Scale excluding those who were taking antidepressant medications and receiving counseling for depression —findings that are corroborated by other research studies on Asian American youths[13,27] and community samples[28] on depression.

Although correlated in the bivariate analysis, age, arrival in the US before or after 7 years of age, lower school performance, and parental education were not found to be significant risk factors of depressive symptoms among these adolescents in the final regression model. Asian American children and teenagers are considered highly prone to depression for the following reasons; one is pressure to succeed academically[30]. Because academic performance is very important in the Asian culture; adolescents who do not succeed academically and not currently enrolled in school correlated with high depressive scores. These findings are consistent with the observation that in Asian American culture, academic performance is very important and adolescents are encouraged to suppress socially disapproved behaviors and are prone to internalization[31]. Other reasons for increased depressive symptoms in that population include ethnic identity conflict, isolation, and acculturation stress [10,32]. Participants who were not currently enrolled in school showed greater depressive symptoms than those who were.

The study also found a significant correlation in depressive symptoms between those who immigrated after the age of 7 versus those who immigrated before that age which was parallel to the findings of Chen and others[29]. This finding likewise was consistent with the conclusion of Kramer[10], who indicated that timing of immigration and length of residence in the United States may have a significant effect on Asian

American adolescents. The higher rates of depressive symptoms of those who have immigrated to the US more recently may be attributed to individuals' having less proficiency in the English language, feelings of alienation, exclusion, vulnerability, lack of confidence, and helplessness when the adolescents cannot communicate with the people around them or to their peers. Ma[33] suggests that in order to succeed in the new home country, the immigrant adolescent must have proficiency in the English language and be able to function in an individualistic culture. Further, Ma explains that typically it takes three generations for immigrants to fully adopt the lifestyles of the dominant culture.

STUDY LIMITATIONS

The findings' generalizability may be limited in several ways. First, the study used a convenience sample of Asian American adolescents living in the five boroughs of NYC. Thus, the data may only represent those who volunteered to participate in the study and the results may not be generalizable to other Asian American adolescents. Moreover, Chinese American adolescents were overrepresented in the sample, reflective of the prevalence of Chinese Americans in NYC. Nonetheless, the findings from this sample may be representative of those who live in similar urban areas in the United States. Second, the majority of the recruitment of participants was through word of mouth such that friends recruited their own friends. Perhaps, similarities in friends led to more depression (depressed friends recruiting other depressed friends). Third, the survey questionnaires were based on self-reports and the adolescents may not have been forthcoming about their responses, even though the participants were assured of their confidentiality at the time of the study. Fourth, cultural bias may have influenced the participants' self-reports of depressive symptoms in a way that affected their scores. The elevated CES-D scores may be attributed to different ways of expressing affect, especially the suppression of positive affect, which may be based on the Confucian principles prominent in traditional Asian culture[34]. The responses tended to be low on the positive items (for example, I felt that I was just as good as other people, I felt hopeful about the future, I was happy, and I enjoyed life). Because Asians may be reluctant to endorse these items, their depression scores may be inflated. Depressive symptoms among Asian Americans could also be linked to immigration issues and to stress of acculturation.

IMPLICATIONS FOR PRACTICE AND FURTHER RESEARCH

Health care professionals and educators should focus on helping Asian American adolescents establish a balance between respecting traditional values and successfully integrating them into the American culture. The assessment of depressive symptoms and acculturation must be integrated into clinical evaluations and treatments when working with Asian American adolescents and their families. Efforts to develop culturally competent interventions including training of health care providers to enable them to assist Asian American adolescents handle pressures to perform well in school and successfully manage the process of acculturation; use of interpreters during health care interventions minimizing language barriers; family-focused interventions rather than individual interventions for adolescents; and formation of coalitions with other ethnic communities and existing community services. Since smoking is a significant correlate of depression, smoking prevention programs that are culturally and ethnically sensitive to the needs of Asian American adolescents.

Future research is needed to determine whether the findings of this study can be generalized to a more diverse group of Asians in the United States. Larger samples from the Asian ethnic groups underrepresented in this study including Thai, Singaporean, Japanese, Vietnamese Americans, and biracial individuals, along with longitudinal data, would enable us to make stronger inferences about the risks factors of depression among Asian American adolescents. There is also a need to investigate depressive symptomatology among Asian American adolescents and the use of CES-D scale for measuring depression in this sample population.

CONCLUSIONS

This study has suggested that depressive symptoms among Asian American adolescents may be prevalent and that it is important that attention be focused on this very significant health problem. This study may further demonstrate that Asian American adolescents are not the „well-adjusted group" („model minority")[13] that some professionals tend to believe them to be. Asian American culture shapes the expression and recognition of mental health problems. Saving face—the ability to preserve

the public appearance of the individual and family for the sake of community propriety—is extremely important to most Asian groups. Individuals thus may not be willing to discuss their moods or psychological states because of fears of social stigma and shame[35]. The findings may not provide conclusive evidence on why these adolescents feel depressed and how prevention and intervention programs may be developed, but these findings add valuable information on the mental well-being of the four ethnic Asian American adolescents in NYC.

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A Co-Relational Study on Stress and Coping among Widows Residing at Selected Areas of Pokhara, Nepal

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ABSTRACT

Aims: It was intended to assess the stress and coping of widows at Pokhara, Nepal.

Settings and Design: Correlational survey study in "Women for human rights, single women group", organization and Indian Pension Camp Pokhara, Nepal.

Materials and Method: 230 widows were evaluated for stress and coping using the stress rating Scale and Questionnaire on coping. Regarding Statistical analysis spearman rho for relationship was used.

Results: Finding shows that most of the participant 148 (64%) were between the age group of 49-64 years. With regard to education, 132 ie57.4% were illiterate, Majority (89%) of subjects lived with their husbands for more than 11 years and 44.8% of subjects; duration after husbands' death was 11 years. 86% of the widows were moderately stressed, 7% highly stressed and remaining 7% had low stress level. 78% of widows were have moderate coping, 14% low coping and 8% high coping. Stress has significant positive relationship with coping.

Conclusions: Widows were having moderate stress and Majority (78%) were adopting moderate coping Strategies

Keywords: *Widows, Stress, Coping*

INTRODUCTION

Stress is an inevitable part of life. A certain amount of stress is normal and necessary for survival.[1]The widow is bound to experience various dimensions of stress, which invariably constitutes stress level in her life from then on. For example, lack of necessary emotional support and financial assistance at an age when her earning power is gradually on the decline is a source of stress for the widow, thus Abdulsalam (1995)'s exclamation that how do widows cope with life in a society which is ordinarily cruel to the weaker "sex" is justified. Abdulsalam noted that after the burial of her husband the typical widow has to decide how to go through the mandatory mourning practices and widowhood rites and making a choice between getting remarried or allowing herself to be inherited by a member of the husbands family. [2]

Women in Nepal have a much lower status than that of men.Nepalese society is embedded in patriarchy and male dominancy and women have to face many discriminatory practices from community to state level.widows in Nepal are further marginalized and discriminated against because they are considered inauspicious.the number of

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fundamental human rights of widows is uncountable and appallingly inhuman.[3]

A study was conducted on status of widows in Nepal by an organization women for Human Rights in 2003 and found that 67% of the widows were between 20 t0 30 years of age.it also revealed that most of the single women are traumatized and most vulnerable victims in terms of basic need,health,education and psychological impacts.[3]

Purpose: The Purpose of this study was to assess stress and their coping strategies adopted by widows to overcome stress .This study in turn will help the authorities and mental health professionals to plan and provide necessary early interventions to prevent occurrence of mental health problem among widows.

Objectives:

1. To assess the stress levels of widows.
2. To identify the coping strategies adopted by widows.
3. To find the relationship between stress levels and coping strategies

Rationale: Widows are treated as cause for the demise of their husbands .They are regarded as bearer s of ill fortune and bad women in Nepal. As a result of Maoist insurgency, number of single woman has greatly increased. There is no counselling systems or psychological support to widows in Pokhara, Nepal and they were more vulnerable to get Mental illness hence the researcher felt the need to select this study and explore more regarding the Stress and coping Strategies among widows and help the authorities and mental health professionals plan and to provide necessary counselling services to prevent occurrence of mental health problem among them.

Hypotheses: The following hypotheses were tested on 0.05 level of significance

H_1 – There will be significant relationship among stress and coping

METHOD AND PROCEDURE

Design& sample: The study was descriptive co relational survey design. The study was conducted among 230 samples in the "Women for human rights, single women group", Organization and Indian Pension Camp of Pokhara, Kaski, Nepal.Non probability convenient sampling technique was used for the selection of the samples

Tools: Instruments used were a Demographic Proforma, Stress Rating Scale, Questionnaire on coping

Demographic Proforma -consisted of ten items which was developed to collect the background information of the widows. The items included were age, religion, ethnicity, education, occupation, type of family, monthly income in rupees per month, number of children, duration of marriage and duration after husband death.

Stress Rating Scale- consisted of 25 items which was developed by the investigator after obtaining experts and guides opinion and reviewing the literature. A four point rating scale was used for all the item with the scoring given to each responses at 4,3,2,1.The range of possible scores varied from a minimum score of 25 to a maximum score of 100.The level of stress were arbitrarily classified as low (25-49) moderate (50-74) and high (75-100)

Questionnaire on coping- consisted of 25 items which was developed by the investigator obtaining experts opinion and reviewing the literature. The blue print was constructed based on which items were constructed. It consisted of 25 items related to behavioural, self distraction and emotional support from the family and friends. The responses for the items were always, sometimes, rarely and never with the scoring of 4, 3,2and one respectively .The scores were classified as low (25-49) moderate (50-74) and high (75-100)

Procedure: Interview was done among 230 widows in "Women for human rights, single women group" organization and Indian Pension camp from 21st February to March 4th 2010.

Descriptive (frequency, mean, median, standard deviation, Percentages) was used for demographic proforma and inferential statistics chi-square, Pearson and spearman Rho of correlation was used.

RESULTS

Table 1: Frequency and percentage distribution of samples characteristics

(n=230)

SI. No	Demographic variables	Frequency (f)	Percentage (%)
1.	**Age in years**		
	18-33	23	10
	34-48	59	25
	49-64	148	64
2.	**Religion**		
	Christian	10	04.3
	Hindu	179	77.8
	Buddhism	36	15.0
	Others	05	02.2
3.	**Ethnicity**		
	Newar	21	09.1
	Gurung	46	20.0
	Bhramin	62	27
	Others	101	43.9
4.	**Education**		
	Illiterate	132	57.4
	Primary School	47	20.4
	Middle School	21	09.1
	High School	18	07.8
	Secondary school	07	03.2
	Postgraduate	05	02.2
5.	**Occupation**		
	Professional worker	13	05. 7
	Semiskilled worker	82	35.7
	Unskilled worker	43	18.7
	Unemployed	92	40.0
6.	**Family Type**		
	Nuclear	100	43.5
	Joint	129	56.1
	Extended	01	0.4
7.	**Family income in (Monthly)Rs**		
	≤2000	66	28.7
	2001-5000	47	20.4
	5001-8000	45	19.6
	8001 and above	72	31.3
8.	**No. of Children**		
	None	10	04.3
	One	31	13.5
	Two	59	25.7
	More than two	130	56.5
9.	**Duration of marriage in years**		
	≤5	15	06.5
	6-10	10	04.3
	≥11	205	89.1
10.	**Duration after husband's death in years**		
	≤5	82	35.6
	6-10	45	19.5
	≥11	103	44.8

Data represented in table 1 show that out of 230 samples, 64% were between the age group 49-64 years. Majority of the samples 77.8% belongs to Hindu religion, with regard to education, 132 i.e.57.4% were illiterate,

Most 40% of samples are unemployed. With regard to family type, 56.1%were from joint family,50.9% of the samples had the income above 5000rupees. Subjects with more than two children were 56.5%.

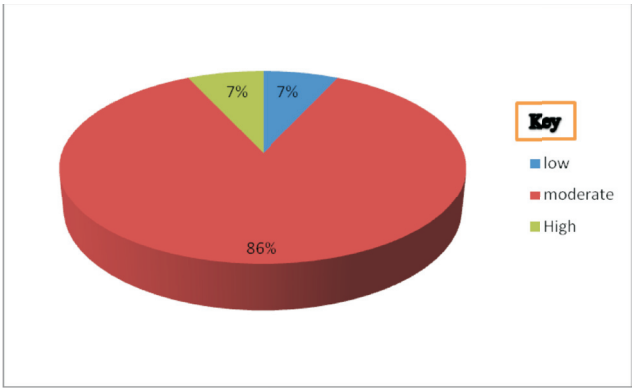

Fig 1: Pie Chart showing Widows with Stress

Data represented in Fig 1 show that out of 230 samples Majority 86 % of the widows experienced medium stress level, 7% of the widows experienced low stress level and 7% of the widows experiences High stress level.

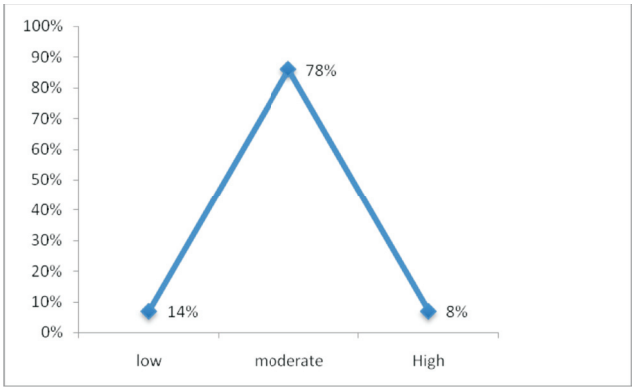

Fig 2: Line Graph showing Coping Strategies adopted by Widows

Data represented in fig 2 show that majority 78% of the widows were having moderate coping ,14% having low coping and 8% having high coping.

Table 2: Relationship among Stress and Coping n=230

Variables	Test of significance	F	P value
Stress			
Coping	Spearman rho	.275	0.001*

*Significant at p<0.05

Data represented inn table 2 show stress has significant positive relationship with coping that means maladaptive coping can lead to stress hence null hypothesis H01 was rejected and research hypothesis was accepted.

FINDINGS & CONCLUSION

Among the total 230 populations, (86%) of the widows had moderate level stress, 7% highly stressed and remaining 7% had low stress level. Majority (78%) of the widows used moderate coping, 14%, 8% had low and high Coping respectively. There was significant Positive relationship between stress with coping (p=0.001) that means maladaptive coping can leads to stress.

DISCUSSION

A Descriptive survey study was conducted by Oniye A O (2000) to investigate adjustment strategies of Nigerian widows to widowhood stress in University of Iiiorion, Illorin. The purposive sampling technique was used to select the 865 Sample for the study. The sample were administered with self–developed Stress rating for widows and widow's adjustment strategies Questionnaires. Data was analysed by ANOVA, Duncan range test. Researchers found Majority of Nigerian widows (218=59.9%) reported experiencing stress at medium level, 258 (29.85%) and 89 (10.35) confirmed experiencing stress at low and high levels respectively. Study further discovered that Nigerian widows differ significantly in their stress level and adjustment strategies on the bases of selected personality variables. This study support present study as majority of Nepalese widows i.e. 86% was also experiencing stress at medium level.

IMPLICATION

Mental health nurse in the community, women's organization and OPD of the hospital must carry out screening test to assess depressive symptoms among vulnerable groups which will lead to effective nursing interventions and bringing into notice of the primary care provider for prompt management.

Mental health Nurses should have frequent home visits, identify vulnerable groups and give intervention etc. Mental health Nurses should be involved in counselling programme also. Hence the curriculum should provide adequate facilitates to prepare nurses as counsellors for vulnerable group

in community and prevent occurrence of mental disorder among vulnerable groups

This will enable the mental health nurses to understand the symptoms of mental illness, stress, coping and social support perceived by vulnerable group and identify them in the community

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Source of Funding: None

Ethical Clearance: To conduct the study, ethical committee permission was obtained from the president of the "Women for human rights, single women group", Organization and Indian Pension Camp of Pokhara, Kaski, Nepal and informed consent from the respondents was taken.

Conflict of Interest: Nil

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A Study to Assess the Bully Behavior and Academic Performance among Male Adolescents in Selected Areas at Gonda

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ABSTRACT

Back ground: Bully behavior is unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Bully behavior includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose. Although most children recover from school bullying, many adults say that childhood bullying has blighted their later lives - including their education, jobs, relationships and mental health.

Objectives: 1) To assess bully behavior of male adolescents, 2) To assess the level of academic performance of male adolescents, 3) To correlation between bully behavior with academic performance of male adolescents, 4) To associate demographic variables with the bully behavior and academic performance of male adolescents.

Hypothesis: H0: There will be no significant relationship between bully behavior and academic performance of male adolescents. H1: There will be a significant relationship between bully behavior and academic performance of male adolescents.

Method: The framework of the study was adopted from Betty Newman's system model. Descriptive survey design was used. Simple random sampling technique was followed. The sample size was 50. The data was collected with demographic data, Questionnaire on the bully behavior of male adolescents and Questionnaire on the academic performance of male adolescents. Pilot study conducted on 16/10/2014. From the pilot study the questionnaire was revealed as feasible. The cronbach's alpha reliability test shows the values are more than 0.7, which shows the tools are reliable.

Results: This study shows that 28% of were having high level of bully behavior and good academic performance. The mean score of bully behavior among male adolescents was 15.20 with SD 4.328 and the mean score of academic performance of male adolescents was 5.88 with SD 1.118. The obtained Pearson correlation value was .054 which is less than the table value .710. It shows that there was no significant relationship between bully behavior and academic performance, the null hypothesis is accepted. There is a significant association between family incomes with bully behavior. There is no significant association between demographic variables with academic performance.

Conclusion: There is no significant relationship between Bully behavior and Academic performance of the adults. Increased awareness and openness about the presence of bullying in any organization is relatively recent. Strong bullying policies are needed to offer realistic strategies for tackling bullying in schools and for maintaining the good academic performance.

Keywords: *Bully behavior, Academic performance, Male adolescents.*

INTRODUCTION

Ryan TJ (2009) Bully behavior is unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Bully behavior includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose. [1]

Capell M (2011) Bully behavior is the use of force or coercion to abuse or intimidate others. The behavior can be habitual and involve an imbalance of social or physical power. It can include verbal harassment or threat, physical assault or coercion and may be directed repeatedly towards particular victims, perhaps on grounds of race, religion, gender, sexuality, or ability. The victim of bully behavior is sometimes referred to as a "target". The word "bully" was first used in the 1530s meaning "sweetheart", The meaning deteriorated through the 17th century through "fine fellow", "blusterer", to "harasser of the weak". [2]

NEED FOR STUDY

Nansel T R (2001) Bully behavior is the most prevalent form of school violence in the United States. According to statistics 2.1 million children who bully and 2.7 million targets in US schools $^{3}/_{4}^{th}$ of students have been bullied 160,000 miss school every day due to fear of attack moderate or frequent bullying. Study revealed that 10% bullied, 13% bullies, 6.3% bully/ victims.[3]

Craig. W (2004) Cross-sectional self-report surveys were obtained from nationally representative samples of students in 25 countries showed involvement in bully behavior varied dramatically across countries, ranging from 9% to 54% of youth. However, across all countries, involvement in bully behavior was associated with poorer psychosocial adjustment ($P<.05$). In all or nearly all countries, bullies, victims, and bully-victims reported greater health problems and poorer emotional and social adjustment. Victims and bully-victims consistently reported poorer relationships with classmates, whereas bullies and bully-victims reported greater alcohol use and weapon carrying. [4]

Hinduja Empirical studies and some high-profile anecdotal cases have demonstrated a link between suicidal ideation and experiences with bullying victimization or offending. The current study examines the extent to which a nontraditional form of peer aggression—cyber bullying—is also related to suicidal ideation among adolescents. In 2007, a random sample of 1,963 middle- scholars from one of the largest school districts in the United States completed a survey of Internet use and experiences. Youth who experienced traditional bullying or cyber bullying, as either an offender or a victim, had more suicidal thoughts and were more likely to attempt suicide than those who had not experienced such forms of peer aggression. Also, victimization was more strongly related to suicidal thoughts and behaviors than offending. The findings provide further evidence that adolescent peer aggression must be taken seriously both at school and at home, and suggest that a suicide prevention and intervention component is essential within comprehensive bullying response programs implemented in schools.[5]

Roberto Forero (1999) A study conducted in 3918 school children attending grade year 6 (mean age 11.88 years), year 8 (13.96), and year 10 (15.97) classes from 115 schools in Australia to examine the prevalence of bully behaviors in school children and the association of bully behavior with psychological and psychosomatic health showed that almost a quarter of students (23.7%) bullied other students, 12.7% were bullied, 21.5% were both bullied and bullied others on one or more occasions in the last term of school, and 42.4% were neither bullied nor bullied others. More boys than girls reported bullying others and being victims of bullying. Bully behavior was associated with increased psychosomatic symptoms. Bullies tended to be unhappy with school students who were bullied tended to like school and to feel alone. Students who both bullied and were bullied had the greatest number of psychological and psychosomatic symptoms.[6]

Although most children recover from school bullying, many adults say that childhood bullying has blighted their later lives - including their education, jobs, relationships and mental health. Increased awareness and openness about the presence of bullying in any organization is relatively recent. Strong bullying policies are needed to offer

realistic strategies for tackling bullying in schools and for maintaining the good academic performance, therefore this study becomes a need.

REVIEW OF LITERATURE

Narayanan A, Betts LR A study was examined, the role of resilience in the relationship between bullying behaviors, victimization experiences, and self-efficacy. Participants were 393 (191 young men, 202 young women) adolescents (M age = 15.88 years, SD = 0.64 years) from schools in Coimbatore, India, who completed scales to assess bullying behaviors and victimization experiences, resilience, and self-efficacy. Multi group structural equation modeling, with separate groups created according to participant gender, revealed that resilience mediated the relationship between bullying behaviors and self-efficacy in young men. Young men engaged in bullying behaviors and experienced victimization more frequently than young women.[7]

Glew GM (2005) Cross sectional study conducted on 3530 students showed that 22% of children surveyed were involved in bullying either as a victim, bully or both. Victims and bully-victims were more likely to have low achievement than bystanders (odds ratios [ORs], 0.8 [95% confidence interval (CI), 0.7-0.9] and 0.8 [95% CI, 0.6-1.0], respectively). All 3 bullying-involved groups were significantly more likely than bystanders to feel unsafe at school (victims, OR, 2.1 [95% CI, 1.1-4.2]; bullies, OR, 2.5 [95% CI, 1.5-4.1]; bully-victims, OR, 5.0 [95% CI, 1.9-13.6]). Victims and bully-victims were more likely to report feeling that they don't belong at school (ORs, 4.1 [95% CI, 2.6-6.5] and 3.1 [95% CI, 1.3-7.2], respectively). Bullies and victims were more likely than bystanders to feel sad most days (ORs 1.5 [95% CI, 1.2-1.9] and 1.8 [95% CI, 1.2-2.8], respectively). Bullies and bully-victims were more likely to be male (ORs, 1.5 [95% CI, 1.2-1.9] and 3.0 [95% CI, 1.3-7.0], respectively). [8]

Malhi P1, Bharti B, Sidhu M A study was conducted to examine the prevalence of school bullying and to investigate the behavioral, emotional, socio-economic and demographic correlates of bullying behaviors among Indian school going adolescents. A method of Self-reports on bullying involvement were collected from 9th to 10th class students (N=209; Mean=14.82 y, SD=0.96) from Government and Private Schools of a north Indian city. Four groups of adolescents were identified: bullies, victims, bully-victims, and non- involved students. The self-concept of the child was measured by the Indian adaptation of the Piers Harris Children's Self Concept Scale (CSCS) and emotional and behavioral difficulties by the Youth self-report measure of the Strengths and Difficulties Questionnaire. The results show that the overall prevalence of any kind of bullying behavior was 53 %. One-fifth (19.2 %) of the children were victims of bullying. Boys were more likely to be bully- victims (27.9 %) and girls were more likely to be victims (21.6 %). Bullying status was significantly related to the total self-concept scores of the students (F=5.12, P=0.002). Victimized adolescents reported the lowest self-concept scores. Bully-victims had a higher risk for conduct problems and hyperactivity and were the most likely to have academic difficulties. Bullies had relatively better school grades and high self-esteem but had higher risk for hyperactivity and conduct problems as compared to controls. It concludes Bullying and victimization was widespread among the Indian school going youth.[9]

RESULTS

Findings of demographic variables

1. Maximum 28% of the students studying 8th standard, 26% of the students were 6th standard students, 18% of the students were 10th standard, and 14% of the students were 9th standard.

2. Most of the 28% of the students were 14 years, 26% of the students were 11years, 14% of students were 12 years and 14 years, 18% of students were 15 years.

3. 58% of the students were belongs to joint family and the remaining 42% of students were nuclear family.

4. Maximum 32 % of the students are with 3 siblings, 30% of the students are with 0-1 siblings, 26% of the students were with 2 siblings, 12% of students having more than 3 siblings

5. 52% of the student's father are self-employed, 26% of them doing business, 18% of salaried and 4% of them not working.

6. Maximum 32% of the student's mother was Housewife, 24% of the student's mother was self-employed, 32% of the student's father occupation was doing business, and the remaining 12% of them are salaried.

7. 52% of the student's family income was 16000 – 20000, 26% of them having more than 20000, 18% of them having 10000-15000 and the remaining 4 % are having less than 10000.

8. 32% of the student's mode of transportation was comes under other type of transportation, 28% of the students school bus, 26% in public bus, 14% in own transport.

Findings related to bully behavior and academic performance

1. 46% of the students were having low bully behavior, 26% of them having moderate level of bully behavior and 28% of them were having high level of bully behavior.

2. 40% of the students were having average academic performance, 32% of them having poor of academic performance and 28% of them were having good academic performance.

3. The mean score of bully behavior among male adolescents was 15.20 with SD 4.328. The mean score of academic performance of male adolescents was 5.88 with SD 1.118.

Findings on correlation between bully behavior and academic performance

The obtained pearson correlation value is .054 which is less than the table value .710. It shows that there was no significant relationship between bully behavior and academic performance.

Findings on association between demographic variables with bully behavior and academic performance.

- There is a significant association between family income and bully behavior.
- There is no significant association between demographic variables with academic performance.

Table 1: Significant relationship between between Bully behavior and Accademic performance.

S.No.	VARAIBLES	STATEMENTS	Max.score	Mean	Mean (%)	SD (%)
1	Bully behavior	15	25	15.20	60.8	17.312
2	Academic performance	09	8	5.88	73.5	13.975
	Coefficient correlation(r)	0.054				

There was no significant relationship between Bully behavior and Academic performance of the adults at the 0.05 level of significance.

Table 2: Association between demographic variables with bully behavior

Demographic variables	Calculated Chi-square value	Degree of freedom	"P" Value	Level of significance
Age	66.486[a]	68	.529	NS
Standard	66.486[a]	68	.529	NS
Family	17.159	17	.444	NS
How many sibling you have?	43.132	51	.775	NS
Father's occupation	78.813	51	.029	NS
Mother's occupation	54.687	51	.336	NS
Family income	71.813	51	.029	S
Mode of transportation	52.040	51	.433	NS

P>0.05 NS; P<0.05 S

There was a significant association between family incomes with bully behavior.

Table 3: Association between demographic variables with Academic performance

Demographic variables	Calculated Chi-square value	Degree of freedom	"P" Value	Level of significance
Age	25.008	20	.201	NS
Standard	25.008	20	.201	NS
Family	3.843	5	.572	NS
Sibling	9.023	15	.876	NS
Father's occupation	9.898	15	.826	NS
Mother's occupation	12.151	15	.668	NS
Family income	9.898	15	.826	NS
Mode of transportation	19.260	15	.202	NS

P>0.05 NS; P<0.05 S

There was no significant association between demographic variables with academic performance.

Nursing Practice

- The findings of the study can be used by the nurses themselves to become more knowledgeable in providing effective health education.
- Nurses play an important role in giving supportive and educative care to the students and their parents.
- Nurses can educate the students and their parents about the good behavior.

LIMITATIONS

The limitation of the study:

1. Students of male adults who are not available during the period of data collection.
2. Students of male adults who are not willing to participate.

RECOMMENDATIONS

On the basis of findings of the study following recommendations were made:

- The study can be replicated on a large sample, there by findings can be generalized for the large population.
- The study can be done for the development of the informational booklet.
- Teaching manual should be developed for the students related to bully behavior and academic performance.
- Longitudinal studies can be conducted to assess the student's behavior in the community.
- A comparative study may be conducted between students of rural and urban school children.

CONCLUSION

There was no significant relationship between Bully behavior and Academic performance of the adults. Increased awareness and openness about the presence of bullying in any organization is relatively recent. Strong bullying policies are needed to offer realistic strategies for tackling bullying in schools and for maintaining the good academic performance

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Ethical Clearance: Written consent was taken from all the participants.

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Effectiveness of Acupressure on Anxiety of Hospitalized Children Undergoing Invasive Procedures

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ABSTRACT

Background: In present scenario anxiety disorders are most common form of psychopathololology in children with overall prevalence rate of 8-11%. According to the report of Yale University of New York, child study centre, mental health problems may originate as early as in the toddler years. One in 10 children aged 2-5 years fond to be experiencing anxiety. In that 9.5% have in the form of separation anxiety, social anxiety, specific fears due to hospitalization, invasive procedures and generalized anxiety. Acupressure helps to reduction of anxiety and brings relaxation, feels more secure in a strange environment, lessens stress and provides a means of release tension.

Aim: The aim of the study to assess the effectiveness of acupressure on anxiety of hospitalized children undergoing invasive procedures in selected hospitals at Mysore.

Method: In this study, a quasi experimental design was used and non probability convenience sampling technique was adopted to select 60 hospitalized children undergoing invasive procedures, both in experimental and control group. Pilot study was conducted, the tool and study design were found to be feasible. Data were collected using a modified Paediatric anxiety scale was investigator observation check list. Acupressure was administered to the experimental group. The data were collected and analysed using descriptive and inferential statistics.

Result: The result of the study revealed that the significance of difference between the mean pre test and post test anxiety symptom score in experimental group which was statistically tested using paired 't' test and was found to be highly significant at 0.05 level of significance ($t_{(29)}$=32.18; $p<0.05$ and the significance of difference between the mean post test anxiety symptom scores between experimental and control group which was statistically tested using independent 't' test was found to be highly significant at 0.05 level of significance ($t_{(58)}$=26.25; $p<0.05$). The result also shown that the anxiety scores of hospitalized children undergoing invasive procedures had no significant association with their selected personal variables.

Conclusion: Therefore, the study concluded that acupressure was effective method to reduce the anxiety of hospitalized children undergoing invasive procedures.

Keywords: *Effectiveness, acupressure, level of anxiety, children age group of 6-12 years and invasive procedures.*

INTRODUCTION

Illness and hospitalization are the first crisis, children face during early infancy and childhood, hospitalization is the disruption of the life of children and their families the children reaction to the hospitalization and coping strength depend on the age, development stage, body image, fear, reason

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for hospitalization and previous hospitalization[1]. Anxiety is an emotional response to a threatening situation and its most commonly seen in children specially who are undergoing invasive procedures and treatment[2]. In clinical anxiety classified in to four forms, situational anxiety, disease related anxiety, treatment related anxiety and pre-treatment anxiety disorder[3]. Pre-operatively anxiety correlates with a high incidence of post-operative pain, it leads increase in analgesics, anesthetics requirement and delayed recovery and discharge from hospital[7]. Investigator felt acupressure is effective reduction of anxiety among hospitalized children under going invasive procedures. Acupressure is a traditional Chinese medicine body work technique based on the same ideas as acupuncture, it involves placing physical pressure by hand, elbow or with the aid of various device on different pressure point on the surface of the body and metabolic energies in the body. These points commonly called as a acupoint or acupressure points[4].

Statement of the problem: A study to assess the effectiveness of acupressure on anxiety of hospitalized children undergoing invasive procedures in selected hospitals at Mysore.

Conceptual framework: The frame work of the study is based on the Imogene King's Goal Attainment theory.

Acupressure therapy: Acupressure is a placing the physical pressure by hand, finger, and elbow or with aid of various devices in selected acupoints viz. Yin-tang point, wrist, auricular region, innergate, heart-7 and Shen mai for reduction of anxiety. For experimental group pre-test was administered by using modified pediatric anxiety scale , afterwards acupressure was given for 2.5-3mins for each point about total 12-15 mins to each child before undergoing invasive procedure. After half an hour post test was administered.

Hypotheses: H_1: The mean post-test anxiety scores of hospitalized children undergoing invasive procedures will be significantly less than their mean pre-test anxiety scores among experimental and control group.

H_2: The mean post-test anxiety scores of hospitalized children undergoing invasive procedures who are in experimental group will be significantly less than the children who are in control group.

H_3: There will be significant association of level of anxiety of hospitalized children undergoing invasive procedures with their selected personal variables.

Research methodology: An evaluative approach was adopted to find the effectiveness of acupressure on reduction of anxiety. The research design adopted for the study was quasi experimental pre-test and post-test control group design.

The sampling design was non probability convenient sampling technique was used in the present study. The sample size was sixty; thirty each in experimental and control group. Researcher developed proforma for personal variable and modified pediatric anxiety scale for the purpose of data collection. The tool consisted of 32 items related to the anxiety symptoms children, all 32 statements are positively worded hence scored as; 0 for never, 1 for sometimes, 2 for often and 3 for always respectively. The total scores ranged from 0-96, the scores were further divided arbitrarily in to, mild-anxiety1-32, moderate-anxiety33-64 and severe-anxiety 65-96.

The samples were selected based on the inclusion criteria. The subject were randomly assigned to assigned to the experimental and control group. On the day 4^{th}, 5^{th}, 6^{th}, 7^{th}& 8^{th} each day five hospitalized children from pediatric medical ward and pediatric recovery ward taken as control group, pre test was administered on the same day after half an hour post test was administered, on day 10^{th}, 11^{th}, 12^{th}, 13^{th}, 14^{th} and 15^{th} each day five hospitalized children were selected as experimental group from pediatric surgical ward and pediatric emergency ward, pre test was administered to experimental group and afterwards acupressure was given for about 12-15 mins before doing invasive procedure, after half an hour post test was administered.

Findings of study: I. Findings related to selected personal variables

Findings of the present study showed that majority (60%) of the samples were in the age group of 6-9 years; 66.7% of samples were males, majority of the samples (63.3%) were belong to joint family, most of the samples (63.3%) were first order children, majority of the samples (50%) were having one siblings, majority of the samples i.e., (46.7%) had their family income below Rs.5000 per month and majority of the samples (70.0%) had hospital stay for 1-6 days.

ii. Effectiveness of acupressure: The mean difference the mean pre test and post test anxiety scores in experimental and control group was 45.13 and 2.86 with a standard deviation difference of ±0.09 and ±0.06 respectively. In experimental group, the paired '$t'_{(29)}$=29.63, which was significant at 0.05 level of significance and it could be inferred that post test anxiety scores of hospitalized children who undergone acupressure was significantly less than their pre test anxiety scores. The mean difference between the mean post test anxiety scores in experimental and control group was 41.3 with a standard deviation difference of ± 0.57. Independent '$t'_{(58)}$=26.25, which was significant at 0.05 level of significance and it could be inferred that the mean post test anxiety scores of hospitalized children who have undergone acupressure is significantly less than mean post test anxiety score of control group.

iii. Findings related to association of the level of anxiety of hospitalized children undergoing invasive procedures with their selected personal variables.

TABLE 1: Chi-square between pretest levels of anxiety of hospitalized children undergoing invasive procedures with their selected personal variables.

n=60

Sl. No.	Variables	Anxiety scores		Chi-square value	df
		Below median (33-64)	Median (65-96) and above		
1.	**Age:** • 6 – 9 years • 9.1-12 years	 14 14	 17 15	 0.058	 1
2.	**Gender:** • Male • Female	 21 07	 22 10	 0.287	 1
3.	**Education:** • 1st std • 2nd std • 3rd std	 03 09 16	 06 09 17	 0.767	 2
4.	**Family income:** • Below Rs: 5000 • Rs:5001 to10000 • Rs:10001 to 15000	 12 12 04	 17 10 05	 0.892	 2
5.	**Type of family:** • family • Joint family • Single parent •family	 17 08 03	 20 07 05	 0.546	 2
6.	**Birth order:** • First child • Second child • Third child and above	 17 07 04	 15 10 07	 1.211	 2
7.	**Number of siblings:** • One sibling • Two siblings • Three siblings and more	 12 12 04	 15 11 06	 1.211	 2
8.	**Number of days of hospital stay:** • 1-6 days • 7-12days	 17 11	 27 05	 4.27*	 1

$\chi^2_{(1)}$:3.84; $\chi^2_{(2)}$:5.99: p>0.05; *- Significant; p<0.05.

The computed Chi-square value for association between pre test anxiety levels of hospitalized children

under going invasive procedures was found to be statistically significant at 0.05 levels for number of days of hospital stay. Hence it is inferred that pre test level of anxiety of hospitalized children undergoing invasive procedure were not influenced by age, gender, education, birth-order, type of family, income of the family and number of siblings.

DISCUSSION

The analysis of the data suggested that, acupressure was effective in reduction of anxiety among hospitalized children undergoing invasive procedures. The study is giving an encouraging result which shows that training and education of non-pharmacologic methods for anxiety reduction, it can effectively be undertaken to help nurses work effectively. These findings were similar other studies[22,29,30,32.], which reveled that there is a significant difference between mean pre-test and post test anxiety scores of the experimental group, studies have shown that there is no association pre-test level of anxiety with their selected personal variables such as age, gender, family income, type of family, education and birth-order.

CONCLUSION

The study revealed that the level of anxiety experienced by hospitalized children, lack of knowledge related to treatment régime, first time hospitalization, parental separation, invasive procedures, surgery, and emotional breakdown of parent, which will induce anxiety among children due anxiety negative effect on vital signs, reduce the effect of medication, increase morbidity and delaying prognosis. Hence present study was concluded acupressure was very effective in reducing the anxiety of hospitalized children and promotes the preparedness for the further medical and surgical procedures with co-operations.

Acknowledgement: Nil

Conflict of Interest: Anxiety is an emotional response to a threatening situation and its most commonly seen in children specially who are undergoing invasive procedures and treatment. Acupressure is a traditional Chinese medicine body work technique based on the same ideas as acupuncture, it involves placing physical pressure by hand, elbow or with the aid of various device on different pressure point on the surface of the body and metabolic energies in the body. So it can be adapted as complementary therapy in reducing anxiety of the children undergoing invasive procedure.

Ethical Clearance: Ethical clearance was obtained from the ethical committee of the college.

Funding Sources: Not obtained any from funding sources.

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Effect of Structured Teaching Programme on Knowledge Regarding Substance Abuse among Adolescents

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ABSTRACT

Background: Substance abuse usually begins in adolescence, the time for discovery, challenge and experimentation. They are especially vulnerable to drug abuse and form the majority of drug users worldwide. In India, it is estimated that most of the drug users are in the age group of 16-35 years and majority of them are in the age group of 18-25 years.

Methods: True experimental pretest – posttest control group research design was adopted. The study population comprised of all adolescents studying in higher secondary section of government higher secondary schools in Puducherry. Samples were selected by simple random sampling technique. The sample comprised of 160 adolescents studying in eleventh standard of selected higher secondary schools in Puducherry, 80 each in experimental and control group. A pretest was conducted by using a structured questionnaire to assess the level of knowledge regarding substance abuse among the study subjects. Followed by this, a structured teaching programme on substance abuse was administered to the subjects in the experimental group in three sessions, on consecutive days. Each session had the duration of 30 minutes. A posttest was conducted after 2 weeks for both the groups with the same questionnaire and effectiveness of the teaching programme on the level of knowledge on substance abuse was assessed.

Results: There was a highly significant difference ($p < 0.001$) in the knowledge level of adolescents regarding substance abuse between the experimental and control group after the administration of structured teaching programme.

Conclusions: The majority of the study subjects had a poor level of knowledge regarding substance abuse. The structured teaching programme is an effective method to increase the knowledge regarding substance abuse among the adolescents.

Keywords: *Adolescents, Substance Abuse, Structured Teaching Programme*

INTRODUCTION

India has the largest population of adolescents in the world having 243 million individuals aged 13 to 19 years. Substance abuse among adolescents has become a global challenge and also an important public health concern. For the past two decades, there has been a dramatic increase in the demand for interventions to address the substance abuse problem. This demand has led to the development of multiple primary, secondary and tertiary substance abuse prevention programmes.[1]

In an Indian scenario, as per the statistics

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provided by the National Institute on Drug Abuse, in 2012, 6.5% of 8th graders, 17% of 10th graders and 22.9% of 12th graders had used marijuana in the past month. Currently it has been reported that, within the age group of 12 to 18 years, 21.4% adolescents use alcohol, 3% of them use cannabis and 0.7% use opiates. It was also reported that the prevalence of alcohol and drug use disorder among adolescent population in India is 32%.[2]

In India, the National Household Survey revealed that there were about 65 million alcohol users, about 8.7 million cannabis users, and about 2 million opiate users in the country. Injecting drug use was reported to be 0.1% and among opiate users opium use was most frequently reported 0.5%, followed by heroin 0.2% and other opiates 0.2%. The survey also revealed that the current prevalence rates of substance abuse as, alcohol-21.4%, cannabis-3%, opiate-0.7% and other illicit drugs 3.6%. Alcohol, cannabis and opiates were the commonest substance of abuse.[3] Pondicherry is having a high prevalence of alcoholism. A recent estimate in 2012 showed a prevalence of around 42% among men aged more than 25 years in rural areas of Pondicherry.[4]

Adolescents who drink alcohol are more likely to experience school problems, such as higher absence and poor grades, social problems such as fighting and lack of participation in youth activities, legal problems such as arrest for drunk and driving or physically hurting someone while drunk. Apart from these consequences they may also experience physical problems such as hangovers or illnesses, unwanted sexual activity and disruption of normal growth and sexual development. They are at high risk for suicide and homicide, tend to have memory problems, changes in brain development that may have life-long effects. Adolescents who start to abuse substances before the age of 15 years are five times more likely to develop dependence later in life, than those who begin at or after the age of 21years.[5, 6]

Mental health professionals play a vital role in promoting and safeguarding the adolescents from risk taking behaviours resulting from substance abuse. Thus nurses can be a dynamic force in dispensing the knowledge regarding effects of substance abuse to the adolescents and educating them to recognize and help other children with substance abuse.

OBJECTIVE OF THE STUDY

- To assess the effect of structured teaching programme on knowledge regarding substance abuse among adolescents.

HYPOTHESIS

H_1: There is a significant difference in the level of knowledge among adolescents who receive structured teaching programme regarding substance abuse and those who do not.

METHODOLOGY

The research design adopted for the study was true experimental pretest – posttest control group design. The study population comprised of all adolescents studying in higher secondary section of government higher secondary schools in Puducherry. Simple random sampling technique was used to select 160 adolescents studying in eleventh standard of selected higher secondary schools in Puducherry. Eighty subjects were allotted in experimental group and 80 subjects in control group. A structured questionnaire was developed to assess the knowledge regarding substance abuse among the adolescents. It consisted of 30 objective type questions. The questionnaire was subdivided into five domains: general information on substance abuse (5 items), questions related to alcohol (12 items), questions related to tobacco (3 items), questions related to opioids and cannabis (7 items) and questions related to volatile solvents (3 items). A pretest was conducted to assess the level of knowledge regarding substance abuse among the study subjects. Followed by this, a structured teaching programme on substance abuse was administered to the subjects in the experimental group in three sessions, on consecutive days. Each session had the duration of 30 minutes. A posttest was conducted after 2 weeks for both the groups with the same questionnaire and effectiveness of the teaching programme on the level of knowledge was assessed.

FINDINGS

Table 1: Comparison of mean scores regarding knowledge on substance abuse between the pretest and posttest in experimental group (n = 80)

Variable	Pre test		Post test		Difference (Post – Pre)	Paired t - value
	Mean	SD	Mean	SD		
Level of knowledge	8.40	1.9	24.03	2.3	15.4 (± 2.8)	51.13***

***p < 0.001

The comparison of mean scores regarding knowledge on substance abuse between pretest and posttest in experimental group is presented in **Table 1.** Before intervention, the mean knowledge score was 8.40 and it was increased to 24.03 after the administration of structured teaching programme. The results of paired t-test showed that there was a highly significant difference (p < 0.001) between the pretest and posttest of the experimental group in the mean scores of overall knowledge regarding substance abuse.

Table 2: Comparison of mean scores regarding knowledge on substance abuse between the pretest and posttest in control group (n=80)

Variable	Pre test		Post test		Difference (Post – Pre)	Paired t value
	Mean	SD	Mean	SD		
Level of knowledge	8.65	1.2	9.65	1.5	1.0 (± 1.15)	4.52 (NS)

NS-Not statistically significant

The comparison of mean scores regarding knowledge on substance abuse between pretest and posttest in control group is presented in **Table 2.** The pretest mean knowledge score was 8.65 and it was increased to 9.65 in the posttest. The results of paired t- test showed that in control group there was no significant difference (p > 0.05) in the mean scores between the pretest and the posttest on overall knowledge regarding substance abuse.

Table 3: Comparison of mean difference scores regarding knowledge on substance abuse in the experimental and the control group (N = 160)

Variable	Experimental group (n=80)		Control group (n=80)		Independent t-value
	Difference (Post - Pre)		Difference (Post - Pre)		
	Mean	SD	Mean	SD	
Knowledge score	5.4	2.8	1.0	1.2	42.2***

***p<0.001

The comparison of mean difference scores regarding knowledge on substance abuse in the experimental and the control group is presented in **Table 3.** In the experimental group, the mean difference of knowledge score was found to be 15.4 between pretest and posttest. In the control group, the mean difference was found to be 1.0. The results of Independent t- test showed that there was a highly significant difference ($p < 0.001$) between the experimental group and the control group on knowledge regarding substance abuse.

CONCLUSION

The structured teaching programme is an effective method in increasing the knowledge regarding substance abuse among the adolescents. Based on the method of sample selection, the conclusive nature of the findings, and support from many studies conducted throughout the world, the findings are probably generalizable to the adolescents studying in higher secondary schools in India.

Acknowledgement: We express our thanks to the adolescents who participated in the study and the authorities who provided permission to conduct the study.

Conflict of Interest – Nil

Ethical Clearance: Ethical clearance for the study was obtained from the Human Ethical committee, JIPMER (Jawaharlal Institute of Postgraduate Medical Education and Research), Puducherry.

Funding Sources: Not obtained any funds from any sources.

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Knowledge and Attitude Towards Older Adults

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ABSTRACT

Objectives: Gerontological or geriatric nursing is the field of nursing that specializes in the care of elderly. Throughout the curriculum, students can experience caring for individuals with complex needs relating to family, values and beliefs, economics, living arrangements, treatment, support, and community services. To ascertain the quality and effective care for older people in future it is important to understand what the attitude and knowledge of nursing students' toward older people is. The present study aimed to assess knowledge and attitude towards older adults among nursing students of MCOMS, Pokhara, Nepal.

Method & Materials: The descriptive survey approach was adopted for the present study and conducted in Manipal College of Medical Sciences, Pokhara, Nepal. The tools consists of demographic proforma, standardized Palmore's Fact on Ageing Quiz and Kogan's Attitude Scale towards Older Adults. Data was collected by self administered standardized questionaire using non – randomized purposive sampling technique. The data was analyzed using Excel 2007, R 2.8.0 Statistical Package for the Social Sciences (SPPS) for Windows Version 16.0 (SPSS Inc; Chicago,IL,USA).

Results: Majority of participant (69.3%) were of age group 18 –20years, (57.1%) were from CTEVT,(100%) were unmarried, (79.3%) were from nuclear family,(77.9%) were of Hindu religion,(57.1%) did not have elderly at home,(100%) cared elderly and had knowledge on ageing. The dominant source of knowledge was nursing college (41.4%). Majority of nursing students had average knowledge i.e (95%), and only (5%) had good knowledge regarding older adults. majority of nursing students had average attitude i.e. (94%) and (6%) had good attitude towards older adults.Mean knowledge score is 12.47(51.96%).Mean attitude score is 126.94(62.23%).

Conclusion: Majority of nursing students had average knowledge towards older adults and average attitude. Yet less knowledge towards older adults can impede the care provided. So, the concerned authority should focus elderly health and care of older adults in the nursing curriculum to enhance competence of students in clinical practice. Adequate knowledge towards older adults helps nursing students to provide effective and quality to older adults so that they can provide holistic care to prevent development of complications on elderly health.

Keywords: *Knowledge, Attitude, Older adults, Nursing students*

INRODUCTION

Geriatrics is the practice that focuses on physiology, pathology, diagnosis and management of disorders and disease of older adults Gerontological or geriatric nursing is the field of nursing that specializes in the care of elderly. Because aging is a normal process, care for the elderly cannot be limited to one discipline but is best provided through a cooperative effort. The nurse gerontologist can be either a specialist or a generalist providing comprehensive nursing care to older people by combining the basic nursing process of assessment, diagnosis, planning, implementation and evaluation with a specialized knowledge of aging. Nurses who are certified in gerontology have specialized knowledge of the acute

and chronic changes specific to older.[1]

Ageing is universal, inevitable, irreversible, slow, detrimental changes in physiological function of most tissues and organ system. WHO defines old age as a period of life when impairment of physical and mental functions becomes increasingly manifested by comparison in the previous period of life.[7] Ageism is discrimination against the aging population, meaning when a person acts against a person based on their age (Rees, King, & Schmitz, 2009).[2]

The physical changes in elderly include decreased cardiac output, slower heart recovery rate, increased blood pressure, decreased lung capacity, decreased subcutaneous fat,etc.The changes in reproductive system includes vaginal narrowing and decreased elasticity, decreased vaginal secretion in female and decreased sperm production in male along with slower sexual response. Also there is constipation, difficulty swallowing, diminished visual acquity, difficulty adjusting with light sensitive material, decreased ability to hear high frequency sounds. The psychological changes include increased confusion, loss of environment cues, decreased attention span, decreased language function and verbal abilities, decreased learning and memory.[1]

The Senior Citizens Acts 2063, Nepal defines the senior citizens as "people who are 60 years and above".According to the Nepal Demographic profile 2013, there were 1.5 million elderly inhabitants, which constitute 4.5 percent of the total population in the country. The percentage of the elders is estimated to double by 2017 (USAID, 2009).During the years 1991-2001, the annual elderly population growth rate was 3.39 percent, higher than the annual population growth rate of 2.3 percent. Life expectancy in Nepal has increased from approximately 27 years in 1951 to 66.86 years in 2013.The majority (85 %) of elderly in Nepal are living in rural areas.[3]

People aged 60 and over numbered around 600 million worldwide in 2000, and these figures are expected to reach 1.2 billion by 2025 and 2 billion by 2050. Of these, about two thirds currently live in the developing world, and by 2025 it is estimated that this figure will rise to 75% (WHO, 2005).Current demographic changes and an aging population across the world demand an increase in the care of older people. In 2030, approximately 28% of Western Europe's population and 21% of the US population will be 65 years or older. This expected growth in the number of people aged 65 years and older will cause the number of people with chronic diseases and multi morbidity to rise. Canadian researchers recently calculated that within the next 20 years, 75% of all available nursing care will be given to persons aged 65 years and older.[5]

In Nepal little is known about knowledge and attitude towards older adults among nursing students.Various studies have been conducted in other countries regarding knowledge and attitude towards older adults.

A study was conducted on knowledge and their attitude towards aging among undergraduate students of different classess in the University of North Carolina at Charlotte. A validated instrument "Palmore's Facts on Aging" and self constructed attitude questions were administered. The data were analyzed using quantitative analysis. The result shows that the students currently in an aging course had significant higher total scores on the knowledge of aging than those who were not with an average score of 16.96 compared to 15.85. There is a relationship between an increase in knowledge and a more positive attitude towards aging. Significant relationships were found that one who is older in age has a higher grade point and an increased knowledge. The higher the number of courses taken, increased knowledge and more positive attitude towards aging. The study identified a positive relationship between students' knowledge of aging, as seen in the number of aging-focused courses they have taken, and their attitudes about aging.[4]

A study was conducted on attitudes of nursing students toward older adults and to determine if these attitudes change over the course in the Midwest United States. A pre-test post-test single group design was used for this study. Students were surveyed three times using KOPS and a demographic questionnaire. Testing was conducted at the beginning and end of the geriatric course (T1 and T2) and prior to graduation (T3). The sample size for T1 and T2 was 40, T3 was 35 students. The sample was predominantly female, under 25 years of age and Caucasian. The result shows that the participants of T1 scored a mean of 61 on the

positive items and 68 on the negative items. For T2, the 10 students had a mean score on the positive items of 69 and on the negative items 78.2. On T3, students scored a mean of 76.03 on the positive items and 84.2 on the negative items. These scores are both increased from T1, which indicates that positive attitudes had increased over the two years. The results indicate that students had positive attitudes which increased over the course of the program, as measured by the KOP scale.[6]

A study was conducted on attitude towards older adults among nursing students in Ankara, Turkey. A qualitative approach with semi structured interviews was used in this study. Five focus group discussions were held with 42 students. The sample for this study was selected from second year BSN students. All of the participants were female with a mean age of 21.09±0.97.42.8% of the participants had cared for an average of 7.46±4.57 older patients in hospital settings or homes for the aged. Results of this study showed more than half of the participants had negative views about ageing, but the majority of participants reported they behaved positively towards older patients and were sensitive whilst caring for them. Most of the participants indicated they had communication problems with their older patients.[7]

Objectives

1. To assess the knowledge about older adults among nursing student by using standardized Palmore's Fact on Ageing Quiz.
2. To assess the attitude towards older adults among nursing student by using standardized Kogan's Attitude Towards Older People Scale.
3. To find out association between knowledge towards older adults and selected demographic variables
4. To find out association between attitude towards older adults and selected demographic variables.

MATERIALS AND METHODS

Type of study: A survey study

Place of study: Manipal College of Medical Sciences, Pokhara ,Nepal.

Study population: 140 nursing students of Manipal College of Medical Sciences, Pokhara ,Nepal.

Study tool: Demographic proforma, Standardized Palmore's Fact on Ageing Quiz,Kogan's Attitude Towards Older People Scale.

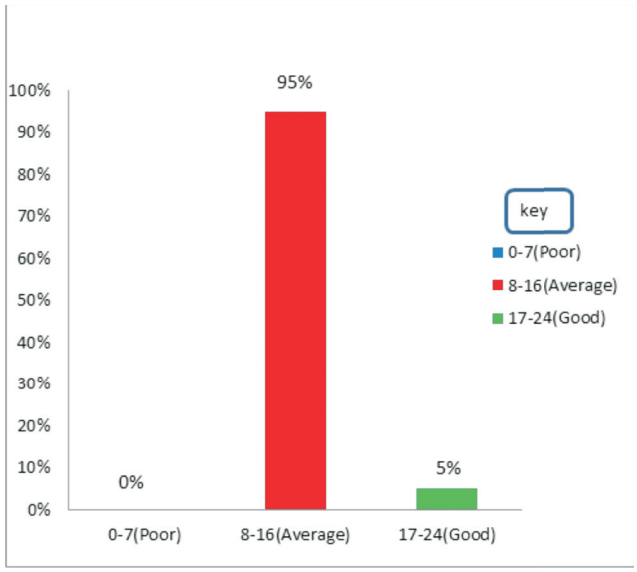
Study design: Descriptive design

Sampling technique: Purposive sampling technique

Statistical analysis: Excel 2007, R 2.8.0 Statistical Package for the Social Sciences (SPPS) for Windows Version 16.0 (SPSS Inc; Chicago, IL,USA).

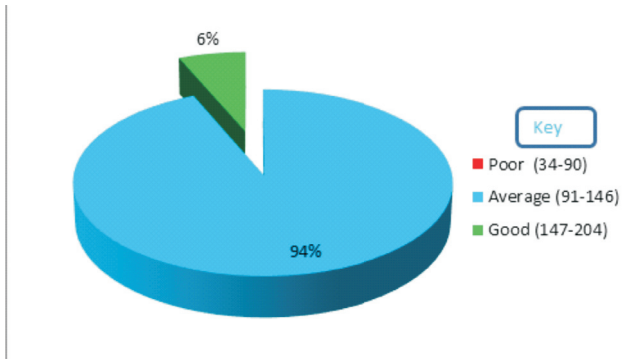
RESULTS

Fig: 1 Bar diagram representing knowledge score



Data presented in fig 1 indicate that majority of nursing students had average knowledge i.e (95%), and only (5%) had good knowledge regarding older adults.

Fig 2: Pie diagram representing attitude score



Data presented in fig 2 indicate that majority of nursing students had average attitude i.e. (94%) and 6 % had good attitude towards older adults

Table 1 : **Description of sample characteristics** **n=140**

SN	Demographic variables	Freq-uency	Percen-tage
1.	**Age**		
a)	15 –17	11	7.9%
b)	18-20	97	69.3%
c)	21-23	31	22.1%
d)	24-26	1	0.7%
2.	**Affiliation of course**		
a)	KU	60	42.9%
b)	CTEVT	80	57.1%
3.	**Level of study**		
a)	2nd year	70	50%
b)	3rd year	70	50%
4.	**Marital status**		
a)	Single	140	100%
b)	Married	0	0
5.	Type of family		
a)	Nuclear	111	79.3%
b)	Joint	29	20.7%
6.	**Religion**		
a)	Hindu	109	77.9%
b)	Buddhist	28	20.0%
c)	Christian	3	2.1%
7.	**Elderly people at home**		
a)	Yes	60	42.9%
b)	No	80	57.1%
8.	**Care of elderly**		
a)	Yes	140	100%
b)	No	0	
9.	**Knowledge on ageing**		
a)	Yes	140	100%
b)	No	0	0
10.	**Source of knowledge**	24	17.1%
a)	School		
b)	Nursing college	58	41.4%
c)	Family and friends	49	35%
d)	Media	9	6.4%

Data presented on Table 1 shows that most of participant were of age group 18 –20years (69.3%),were from

CTEVT (57.1%), all were unmarried(100%),most of them had nuclear family (79.3%),most of them were Hindu (77.9%), all of them cared elderly and had knowledge on ageing. The dominant source of knowledge was nursing college (41.4%).

Table 2: Mean , Median and Standard deviation of knowledge and attitude scores of nursing students of MCOMS (Nursing Programme).N=140

Variables	Range	Maximum	Minimum	Mean	Median	Standard deviation
Knowledge	9.00	18.00	9.00	12.4714	12.00	2.06179
Attitude	72.00	168.00	96.00	126.9357	126.00	12.46128

Mean % of knowledge score = 51.96%

Mean % of Attitude score = 62.23%

Table 3: Association between knowledge and selected variables N=140

Sample characteristics	Knowledge score		Chi-square value	Tabulated value	df	Significance
	Average	Good				
Age						
15-17	11	0				NS
18-20	93	4	2.532	7.815	3	
21-23	28	3				
24-26	1	0				
Affiliation of course						
CTEVT	53	7	12.357	3.841	1	S
KU	80	0				
Level of study						
2nd year	67	3	0.151	3.841	1	NS
3rd year	66	4				
Type of family						
Nuclear	29	0	3.345	3.841	1	NS
Joint	104	7				
Religion						
Hindu	103	6				
Buddhist	27	1	0.497	5.991	2	NS
Christian	3	0				
Elderly people at home						
Yes	59	1	2.791	3.841	1	NS
No	74	6				
Source of knowledge						
School	23	1				
Nursing college	53	5	3.441	7.815	3	NS
Family and friends	48	1				
Media	9	0				

Data on table 3 represented that there is significant association between knowledge score and affiliation of course of respondents. Whereas, there is no significant association between knowledge score and other selected variables.

Table: 4 Association between attitude score and selected variables N=140

Sample characteristics	Attitude score		Chi-square value	Tabulated value	df	Significance
	Average	Good				
Age						
15-17	9	2				
18-20	93	4	3.325	7.815	3	NS
21-23	28	3				
24-26	1	0				
Affiliation of course						
CTEVT	56	4	0.010	3.841	1	NS
KU	75	5				
Level of study						
2nd year	65	5	0.119	3.841	1	NS
3rd year	66	4				
Type of family						
Nuclear	27	2	0.013	3.841	1	NS
Joint	104	7				
Religion						
Hindu	103	6				
Buddhist	25	3	1.282	5.991	2	NS
Christian	3	0				
Elderly people at home						
Yes	77	3	2.282	3.841	1	NS
No	54	6				
Source of knowledge						
School	24	0				
Nursing college	52	6	5.236	7.815	3	NS
Family and friends	47	2				
Media	8	1				

Data on Table 4 shows that there is no significant association between attitude score and selected variables.

DISCUSSION

The study findings have been discussed in terms of objectives, hypothesis stated and other research findings.

A study was conducted on attitudes, knowledge, willingness and future intentions to work with older people and effect of clinical practice on such factors among 566 first year and final year students in baccalaureate nursing schools and 132 nursing educators in three universities in Saudi Arabia. The study used a mixed method of a descriptive cross-

sectional survey design. The questionnaires contained previously validated instruments i.e. Kogan's Attitude Towards Older People scale, Palmore's Facts on Ageing Quiz, a measure of students'willingness to work with older people and a measure of their intention to work with them.Data were analysed using both multivariate statistics and content analysis. The result showed that the mean score on the Palmore's Fact on Ageing Quiz for students on the Saudi BSN program was 11.13 (46.37%). This study supports present study as the mean score on the Palmore's Fact on ageing quiz is 12.47 (51.96%).[8]

A study was conducted on attitudes towards older people in Jordan University of Science and Technology among Jordanian BSN students. A descriptive correlational design was employed and Kogan's Attitudes toward Older People Scale was administered to a convenience sample of 250 nursing students. Students' attitudes were identified using descriptive and inferential statistics. The result showed that all the students displayed positive attitudes toward older people. Age and of the students correlated significantly with their attitudes. Senior students had more positive attitudes toward this client group . The results of this study suggest that positive attitudes exist towards older people. This study contradicts present study as majority (94%)of the respondents had average attitude.[9]

Therefore, the present study showed that majority of nursing students had average knowledge and attitude towards older adults.

CONCLUSION

The following conclusions were drawn from the findings of the present study:

- Majority of nursing students had average knowledge (95%) towards older adults.
- Majority of nursing students had average attitude (94%) towards older adults.
- There is significant association between knowledge scores and affiliation of course of respondents.
- There is no significant association between attitude score and selected variables.

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Source of Funding: None

Ethical Clearance: To conduct the study, permission was obtained from the institutional research committee of Manipal College of Manipal Science. Administrative permission from the Dean, MCOMS; Principal, MCOMS (Nursing Programme) and written informed consent from the participants were taken.

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Level of Depression among Infertile Women

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ABSTRACT

Depression is a widespread mental health problem affecting many people. The life line depression in male is 8% - 12% and in females is 20% - 26%. Depression occurs twice as frequently in women as in men[1]. As it is a highly prevalence condition more than 15% of adults at least are affected by depression among infertile women. Depression is the leading cause of disability and the fourth leading contributor to the global burden of disease in 2010[2]. A Descriptive research design was adopted for the study. 50 infertile women were selected by using Non-probability Convenient sampling technique in Devansi maternity and gynec hospital of Mehsana District. Zung depression rating scale with 20 questions were used to assess the level of depression among infertile women. The findings of the study revealed that Majority 22% of had normal range level of depression among infertile women, 56% of women had mild level of depression, 20% of women had moderate level of depression, 2% women had severe level of depression among infertile women. Majority of infertile women had mild level of depression.

Keyword: *Assess, Depression, Infertility clinics, Infertile women*

INTRODUCTION

"Motherhood is priced of God, at price no man may dare to lessen or misunderstand".

-Helen Hunt Jackson

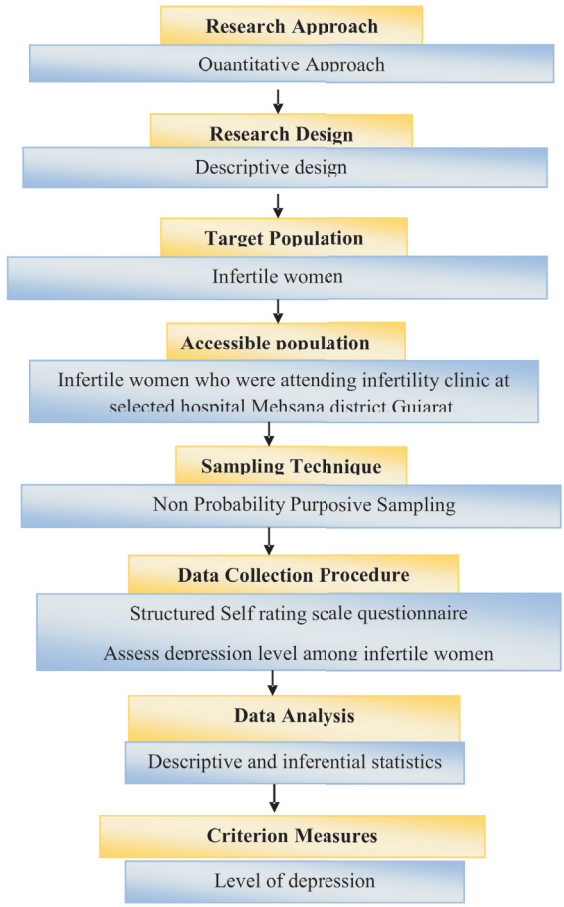
Motherhood is a blessing by god for all women. It has a very humanizing effect, everything gets reduced to essentials. Fertility is the natural capacity of giving life. Human fertility depends on factors of nutrition, sexual behavior, endocrinology, timing, economics, way of life and emotions[3,4].

But some women are not able to conceive. Infertility and sterility are terms used to describe the inability of a couple to produce a child. Infertility is defined as inability of a couple to conceive naturally after one year of regular unprotected intercourse. The infertility could be Primary, the inability to have a child or carry a pregnancy to live birth after one year of regular unprotected intercourse. Secondary infertility occurs after a couple has successfully had a child or carried a pregnancy to live birth but is unable to do so again. Infertility is a social crisis causing depression, anxiety, isolation and sexual dysfunction. Due to this frustrating experience many infertile couples would seek medical help[5,6]

MATERIAL AND METHOD

The Schematic Representation of Research Methodology

FINDINGS



- Level of depression among infertile women included in the study, most of them were between 26-30 years, had completed primary education, were living in joint family, were house wife, belong to Hindu religion.
- Regarding level of depression, during assessment 22% of had normal range level of depression among infertile women, 56% of women had mild level of depression, 20% of women had moderate level of depression, 2% women had severe level of depression among infertile women.
- With regard to the association between the levels of depression among infertile women with their selected demographic variables such as religion, there were significant association found and other variables like age, education occupation, and type of family, occupation, monthly income and duration of marriage were not found to have any significant association with the level of depression among infertile women.

CONCLUSION

Experiencing infertility can be an extremely painful experience especially for women. It's an experience they never expected to go through, and many are often left feeling inadequate as women. As motherhood is primarily a female instinct, the inability to bear a child affects the woman's identity itself. Also, handling the emotional impact of infertility may be more difficult for them because they are not used to voicing and sharing these types of concerns and they are taught to bottle up their feelings.

Acknowledgement: A journey is easier when we travel together. Interdependence is certainly more valuable than independence. This dissertation is the result of unbound, immeasurable contribution and support from many people. It is a pleasure that, I have an opportunity to express my gratitude to all of them. I honestly express my sincere thanks and gratitude to MY CLIENTS AND THEIR FAMILY for their cooperation.

Source of Support: Joitiba College of Nursing, Devansi Maternity and Gynec Hospital

Ethical Clearance: Got permission from the college and Devansi Maternity and Gynec Hospital, Mahesana, Gujarat.

Conflict of Interest: The study was done only for 50 samples with no randomization, so generalization is possible only for the selected samples.

A study can be conducted to assess the effectiveness of planned health teaching on level of depression.

A same study to be replicated in the community area.

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Effectiveness of Conceptual Map on Enhancing the Academic Self Efficacy among B.Sc (Nursing) III Year Students in PSG College of Nursing, Coimbatore

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ABSTRACT

Introduction: Conceptual map is a powerful tool that teachers can use to enhance learning and create a foundation for learning. It is helpful for visual learners as they are illustrative tools that assist with managing thought, directing learning, and making connections.

Objective: To evaluate the effectiveness of Conceptual map on enhancing the academic self efficacy among nursing students.

Design: Pre experimental design – One group pretest and post test design.

Setting: The study was conducted in PSG College of Nursing, Coimbatore.

Participants: 91 BSc (N) III Year students

Intervention: The Conceptual map was conducted in 5 sessions. Each session was conducted for one hour. Each session is activity based and participatory in nature. The major techniques that were used to impart information were small group activities, and lectures followed by discussion.

Measurements and tools: The level of knowledge was assessed by The Academic Development Self-Efficacy Inventory **(**Yuen et al., (2007). Descriptive and inferential statistics were used to analyze the data.

Findings: The findings of the study revealed that Conceptual map on improved the academic self efficacy among B. Sc (N) III Year students. The improved mean value for academic self efficacy was 7.65 with't' value of 16.65 which showed high statistical significance at $p<0.001$ level.

Conclusion: The study concluded that there was a significant improvement of Academic Development Self-Efficacy among students in posttest after administration of Conceptual map.

Implications: The educator should attempt to educate the students regarding the Conceptual map. It will promote the nursing students to get good marks in their exams.

Keywords: *Concept Map, Academic Self Efficacy, Nursing students.*

BACKROUND OF THE STUDY

Conceptual map is a powerful tool that teachers can use to enhance learning and create a foundation for learning. It is helpful for visual learners as they are illustrative tools that assist with managing thought, directing learning, and making connections. It is a great way to introduce an overall topic, increase student involvement, and get thoughts down quickly. Mind mapping is a skill that cuts across ability levels and encompasses all subject matters.

Concept mapping is an excellent teaching strategy that uses the critical thinking ability because it requires

reasoning skills, analysis of multiple relationship and consideration of multiple perspectives.[5] Concept map is a schematic device for representing a set of concept meaning embedded in a frame work of proposition.[2]

Need for the study: It is very important for teachers to create an environment that engages students in the learning journey and for that teachers and students use a wide array of visual tools in today's classroom. Often refered to as graphic organizers, visual tool is a term that has been adopted instead to reflect a broader conception of what constitutes graphic representations and their purposes.

A study was conducted to assess the effectiveness of student learning with concept mapping of care plans in community based education among junior level baccalaureate students. The sample consisted of 23 nursing students. Quasi experimental pre and post test design was used. The mean score of first set of concept maps was 15.35 and the standard deviation was 2.95 where as the mean score of the second set was 17.39 and the standard deviation was 1.12.A significant increase in comprehensiveness of concept maps over the course was found.[3]

Eventhough there are reported positive outcomes, there is no published research in nursing education that examines the effect of a metacognitive intervention. Thus, the investigator felt the need to study the effectiveness of concept mapping in the field of nursing education.

Review of literature: A Quasi experimental study was conducted to assess the effectiveness of concept mapping as an effective teaching and evaluation strategy among nursing students. Convenience sampling technique was used to select the institutions and all the students who were present during data collection were included in the study. The total sample size consisted of 122 B Sc nursing students of selected institutions in Mangalore. In the experimental group students were given one hour session for the development of concept maps. The mean post test score of experimental group(67.44) was much higher than that of control group(14.29). The results revealed that there was a significant difference in the means of post test concept map score between experimental and control group. The study concluded that concept mapping can be used as a teaching strategy in nursing.[2]

A study was conducted to assess the effectiveness of using concept mapping on nursing competencies of primary medical care among nursing students. The sample size consisted of 15 fourth year nursing students. Quasi experimental with single group design was utilized in this study. Students were given 45 minutes of session about concept mapping. Students were asked to create concept maps in every topics of primary medical care. Post- test was done to evaluate their primary medical care nursing competencies. The mean pretest score was 43.27 and standard deviation was 5.06 where as the mean post test score was 58.40 and standard deviation was 2.00. The findings suggested that concept mapping is a good education innovation for assisting nursing students to summarize their own concepts and improve their nursing care competency.[4]

A study was conducted to assess the effectiveness of concept mapping on learner's metacognitive skills in problem solving among educational psychology course students. The sample consisted of 40 students,24 in the experimental group and 16 in the control group. The experimental groups were given instructions regarding the purposes and uses of concept maps. Preliminary one factor ANOVA test was used for data analysis. The mean pre test score of experimental group was 68.85 and that of control group was 65.36.The post test score of experimental group was 74.08 and that of control group was 69.09. The study concluded that concept mapping is effective on learners meta cognitive skills in problem solving.[1]

OBJECTIVES OF THE STUDY

- To assess the academic self efficacy among nursing students.
- To evaluate the effectiveness of Conceptual mapping on enhancing the academic self efficacy among nursing students.
- To associate the academic self efficacy among nursing students with selected demographic variables.

OPERATIONAL DEFINITIONS

Effectiveness: Refers to enhancing the academic self efficacy among nursing students after

administration of Mind & Conceptual mapping.

CONCEPT MAPPING

Refers to the It is a schematic device for representing a set of concepts embedded in a framework of proposition. In this study, it refers to a teaching method in which various concepts of nursing process such as assessment, nursing diagnosis, goal, intervention, implementation & evaluation are grouped together and schematically represented for the better understanding of students.

ACADEMIC SELF EFFICACY

Refers to the time management, study & examination skills, learning from friends, educational planning, being a responsible learner.

ASSUMPTIONS

It will promote the nursing students to get good marks in their exam.

HYPOTHESIS

H_1: There will be a significant difference in the pre and post test level of academic self efficacy among nursing students.

H_2: There will be a significant association of the post test level of academic self efficacy with selected demographic variables among nursing students.

Research Design: Pre experimental one group pretest posttest design

VARIABLES

Independent Variable

Conceptual mapping

Dependant Variable: Academic self efficacy among nursing students

SETTING

The study will be conducted in PSG College of Nursing, Coimbatore.

POPULATION

The study population comprises of nursing students.

SAMPLES

B.S c (Nursing) III year students

SAMPLE SIZE

Sample size of the study is 91 nursing students.

SAMPLING TECHNIQUE

Sampling free technique

INTERVENTION

- The Conceptual map was conducted in 5 sessions.
- Each session was conducted for one hour.
- Each session is activity based and participatory in nature.
- The major techniques that were used to impart information were small group activities, and lectures followed by discussion.

DEVELOPMENT AND DESCRIPTION OF THE TOOL

The tool constructed for this study consists of 2 parts.

Section- A: Demographic variables

It consists of age in years, sex, type of family, living status of parents, income (rs. per month), medium of instruction, area of residence, no. of siblings, close friends in college and mass media at home.

Section- B: The Academic Development Self-Efficacy Inventory (Yuen et al., (2007):-

1. The Academic Development Self-Efficacy Inventory

Subscales:-

a. Time Management = TM (items l, 6, 11, 16)

b. Study & Examination Skills = SS (items 2, 7, 12, 17)

c. Learning from Friends = L F (items 3, 8, 13, 18)

d. Educational Planning = E P (items 4, 9, 14, 19)

e. Being a Responsible Learner = R L (items 5, 10, 15, 20).

Scoring key to assess the various subscales

≤50	-	Inadequate ,
51 – 75	-	Moderately adequate,
>75	-	Adequate

FINDINGS

Table: 1 Percentage distribution of pretest level of the academic self-efficacy of students n = 91

Academic self-efficacy of students	Inade-quate	Moderately adequate	Adequate
Time Management	71.67	28.33	0
Study & Examination Skills	25.57	61.32	13.1
Learning from Friends	40.86	47.52	11.62
Educational Planning	58.33	29.33	12.34
Being a Responsible Learner	61.67	38.33	0

Table: 2 Percentage distribution of posttest level of the academic self-efficacy of students n = 91

Academic self-efficacy of students	Inade-quate	Moderately-adequate	Ade-quate
Time Management	0	11.67	88.33
Study & Examination Skills	0	4.67	95.33
Learning from Friends	0	12.67	87.33
Educational Planning	0	26.67	73.33
Being a Responsible Learner	0	0	100

Table 3 : Comparison of pre and posttest level of academic self efficacy of students. n = 91

	Pre test		Post test		't' test
	Mean	S.D	Mean	S.D	
Academic self efficacy	20.2	3.67	27.85	1.94	16.65 ***(S)

- Demographic variable influence by Close friends in college moderately significant association with $\chi^2 = 12.47$ at $p<0.01$ level.

IMPLICATIONS

Nursing Education: The educator should attempt to educate the students regarding the Conceptual map. It will promote the nursing students to get good marks in their exams.

RECOMMENDATIONS

The study can be replicated in various settings.

CONCLUSION

The study concluded that Conceptual map had a significant effect on the Academic Self-Efficacy among students.

Ethical Clearance: PSG Institute of Medical Sciences & Research, Peelamedu, Coimbatore, Institutional Human Ethics Committee.

Acknowledgement: The authors are grateful to the Prof.Elizabeth Jean Abraham, Principal,Prof.Esther Daisy Meerabai Joel, HOD of Psychiatric Nursing, PSG College of Nursing, Coimbatore and PSG IMS&R Institutional Human Ethics Committee for their constant support and encouragement.

Conflict of Interest: Nil

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The Effectiveness of Structured Teaching Programme on Knowledge, Attitude and Practice on Breast Self Examination among College Girls, Tamilnadu

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ABSTRACT

Background of the Study: Breast self examination is a self care practices that is easy, convenient, private, safe, involves no cost and requires no specific equipment. It was first advocated by American cancer society and the National cancer Institute 35 years ago. Breast self examination may reduce breast cancer mortality by an estimated 18%. Since 90% of breast cancer is discovered by breast self examination, it becomes the nurse's responsibility to stress the importance of breast self examination and the urgency of receiving medical advices.

Aim: The main objective of the study was to assess the knowledge, attitude and practice on breast self examination among college girls using structured questionnaires before and after administration of structured teaching programme.

Materials and Method: Quasi experimental with one group pre & post test design was adapted. The study was conducted at rural area of Erode. Sixty girls in the age group of 18 to 25 years students studied in the Adarsh Arts College for women, Paruvachi, Erode. Simple Random sampling was used to select the samples of this study. The tool designed to collect the data were sociodemographic Performa, structured knowledge questionnaires, and 5 point Likert scale on attitude and check list on practice .The method used to collect the data was structured questionnaire .

Results: Collected data was analyzed by using descriptive and inferential statistics. The study revealed that 45% of girls had inadequate knowledge and 55% of girls had moderately adequate knowledge in pre test, whereas, in post test 26.6% of girls had moderately adequate knowledge and 73.3% of girls had adequate knowledge. 95% were having positive attitude and5% having negative attitude in post test.

The study revealing that the knowledge, attitude and practice have been improved through the structured teaching programme regarding the breast self examination.

Conclusions: STP on BSE was effective in enhancing the knowledge, attitude, practice of girls regarding BSE. It is not a cost-effective procedure, which can be used by the individuals themselves

Keywords: *Effectiveness, STP, BSE, knowledge, attitude, practice, college students*

INTRODUCTION

"BREAST MILK IS THE BEST MILK" for Neonate

Breast, it is present only on mammalian pieces, i.e., which is giving milk to their child. It is the feministic characteristics of females. Breast secretes breast milk that is useful for neonates to prevent infection and maintain the health of the neonates.

"BE BRISK, TO AVOID RISK OF BREAST CANCER"

No women want to hear the words…"You have

got breast cancer". You definitely look better by having two breasts. And if you look better and feel better you will definitely live better. Thus, we have to learn how to improve our odds of not having breast cancer at all. In the year 2007 about 5.4 million cases reported in developed countries and 6.7 million reported in developing countries.[1]

BSE gives you the tool that can improve your breast health, but it is up to you to use them. Make good breath health is a part of your day and part of your life, now and in the years to come.[10]

Majority of girls and women have not heard of breast self examination. They feel shy in discussing about these practices. The health professional, especially nurses have the responsibility to teach the girls and women regarding preventive health behavior. Students are sources of information and can easily acquire knowledge regarding breast self examination. Today girls are tomorrow's mother. So they will pans information from one generation to another generation.

So researcher has taken interest to educate about breast self examination and the importance in health care aspects. Further it is felt that this study will help the girls to rival the need for practicing breast self examination.

RESEARCH METHODOLOGY

Research Approach

An evaluative research was considered an appropriate research approach for the present study.

Research Design

Pretest – Post test design of quasi experimental approach was used.

The research design of the present study is diagrammatically represented as follows:

O_1 x O_2

O_1 -Represent the pre-test knowledge, attitude and practice of BSE.

X - Represent structured teaching programme with a LCD & Demonstration by model regarding BSE.

O_2 – Represent post-test knowledge, attitude and practice regarding BSE.

VARIABLES UNDER STUDY

The independent variable was a planned teaching programme. The dependent variables were the knowledge, attitude and practice of breast self examination. Age, Educational Status, Religion, age at menarche, sources of information were influencing variables.

SETTING OF THE STUDY

The present study was conducted among college girls those who are studying in Adarsh Arts college for women, Paruvachi.

POPULATION

Girls who are studying in Adarsh Arts College.

SAMPLE AND SAMPLING TECHNIQUE

Sixty girls in the age group of 18 to 25 years admitted in the Adarsh Arts College for women, Paruvachi, Erode.

Simple Random sampling was used

SELECTION AND DEVELOPMENTS OF TOOLS

Considering the purpose of the study, a structured questionnaire as developed to assess the knowledge, attitude and practice on BSE.

DESCRIPTION OF THE TOOL

The structured questionnaires consisted of 4 sections, which were used for the pre & post assessment.

SECTION I

Section I has items seeking information of demographic background of girls including age, religion, type of medium studied in schooling, educational status of the mother, sources of information, type of family, food habits adaptation and place of living.

SECTION II

Consists of 3 sub-sections with 15 questions.

SUB SECTION 1

3 Questionnaire related to anatomy and physiology of breast

SUB SECTION 2

Questionnaire related to breast cancer (3 Questions)

SUB SECTION 3

Questionnaire related to breast self examination (9 Questions)

SECTION III

Questionnaire related to attitude i.e., Behaviors of college girls (10 questions).

SECTION IV

It consists of questionnaires related to breast self examination practices.

(10 questions)

SCORING PROCEDURE

A score of one mark was given for every correct answer and zero was given for

wrong answer

The score was ranged as follows;

i) Adequate knowledge : a score from 76 – 100%

ii) Moderately adequate knowledge: a score from 51 – 75%

iii) Inadequate knowledge : a score less than 50%

INTERVENTION

STP was given to the college girls it consists of anatomy of the breast, definition and purpose of breast self examination, risk factors and early detection of breast cancer, ideal time for doing breast self examination, preventive measure of Breast cancer and demonstration of breast self examination.

METHOD OF DATA COLLECTION

The study was done from July to August. The subjects were explained about the purpose of the study. Consent was taken from each subject for assessing knowledge, attitude and practice in BSE.

Data was collected through structured questionnaire. The 60 subjects were divided into 2 groups based on convenience

PLAN FOR DATA ANALYSIS

Both descriptive and inferential statistics were used to analyze the data collection. Descriptive statistics were used to analyze the frequency, percentage, mean, standard deviation of the following variable.

1. Demographic variable 2. Knowledge, 3. Attitude 4.Practice

Inferential Statistics were used to determine the relationship, association and comparison of identify the difference.

RESULTS AND DISCUSSION

Section1: Description of sample characteristics.

The majority of college girls41.6% were in the age group of 19 years, 65% of respondent's mother had primary level of education. Most families 66.67% belongs to joint family. They were living in rural area.

Table 1 : Frequency and percentage of demographic variables

Demographic variables		**Frequency**	**%**
Age	18	19	31.67
	19	25	41.67
	20	16	26.67
Religion	Hindu	56	93.33
	Muslim	4	6.67
Medium of study	Tamil	60	100.00
Education of mother	Primary	39	65.00
	High school & Higher secondary	21	35.00
Source of information	Mass media	26	43.33
	Friends	20	33.33
	Relatives	14	23.33
Type of family	Nuclear	20	33.33
	Joint	40	66.67
Food Habit	Vegetarian	44	73.33
	Non Vegetarian	16	26.67
Place of living	Village	60	100.00
Total		**60**	**100.00**

Section 2: Assessment of Knowledge, Attitude, Practice level of College students regarding BSE:

Knowledge assessment on BSE revealed that 45%

of college girls had inadequate knowledge, 55% had moderate knowledge on BSE in pretest, whereas in the post test none of the subjects had score below 50%, most of them 73% had adequate knowledge, 26% had a moderate knowledge .

Comparing the pretest and post test score , STP was very effective to improve the knowledge level of the college girls.

Attitude assessment on BSE revealed that 70% of girls had negative attitude, 2% had positive attitude during post test and 95% of girls had positive attitude, and 5% of girls had negative attitude during post test.

It reflect that STP was very effective to improve the attitude level of college girls.

Practice assessment shown that 25% girls had INADEQUATE PRACTICE, 75% girls had MODERATE PRACTICE during pre test ,and 3.33% girls had inadequate practice, 96.67% of girls had moderate practice during post test towards breast self examination.

It shows that structured teaching programme was very effective to improve the practice level of the college girls.

Table 2 : Comparision of Knowledge, Attitude and Practice Score Regarding Breast Self Examination in Pretest & Post Test:

Dimension of BSE	Pre Test			Post Test			Effect-iveness	t	P
	Mean	SD	Mean %	Mean	SD	Mean %			
Knowledge	7.73	1.21	51.56	12.20	1.48	81.33	29.78	18.39	0.000**
Attitude	23.77	2.29	59.42	34.70	6.19	86.75	27.33	13.04	0.000**
Practice	4.05	0.75	40.50	8.47	1.10	84.67	44.17	30.43	0.000**

** Highly Significant

Section III: effectiveness of STP on BSE

The mean post test score 81% was higher than the mean pretest knowledge score of 51%. The mean post test attitude score 86% was higher than the mean pretest attitude score and mean post test practice score 84% was higher than mean pretest practice score of 40%

Section IV: Associate the demographic variables with knowledge, attitude and practice of BSE among college girls.

Karl Pearson test showed that there was a relationship between knowledge and attitude and there is no relationship between knowledge and practice and attitude and practice

Among these demographic variables, the age of the respondents and education of the respondent's mothers were significant with knowledge

From the analysis it was concluded that there was close relationship between the age, education of the respondent's mother and level of attitude regarding the BSE

From the analysis it was concluded that there was close relationship between type of family and practice regarding the breast self examination in pretest whereas in post test there is no association between practice and demographic variables

RECOMMENDATION AND NURSING IMPLICATION

Recommendation

1. Health education modules should be distributed to the parents and their family members.
2. The extensive use of mass media for propaganda will help us in generating awareness and in the early detection of breast cancer.
3. Breast self examination can be added in the higher secondary programme.

NURSING IMPLICATIONS

Nursing Practice:

1. The present study would help the nurses to know the knowledge of college girls regarding breast self examination.

2. Continuing nursing education programs for nurses focused on breast self examination practice to promote the knowledge of female patents.

Nursing Education

1. Orientation programmes can be done for new paramedical students in the area of breast self examination to develop special skills.

2. Nursing education should offer short term continuing courses for all nurse midwives working in the hospital, antenatal clinic, primary health center, sub-center to improve their knowledge of breast self examination.

Nursing Administration

1. In service education programme should be organized for nurses to develop up-to-date knowledge and practice in breast cancer and breast self examination and also to improve the communication skills.

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Ethical Clearance: Approval for the study was gained from college dissertation committee on March 2008.

Sources of Funding: Self

Conflict of Interest: None

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Impact of Educational Intervention Regarding Warning Sign of Dementia of Alzheimer's Type among the Elderly People of Selected Area, Bhubaneswar, Odisha

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ABSTRACT

With the "greying" of society, people are living much longer. This increased lifespan is not without accompanying health problems. Alzheimer's disease is a progressive form of dementia most often associated with aging. Dementia is a biochemically-mediated mental disorder indicated by a generalized loss of memory and intellectual ability. This involves impairment of memory, judgment, and abstract thinking. Changes in personality are also associated with dementia. Aging is a inevitable process therefore all the elder persons must should aware about the warning sign of dementia. The present study was conducted among elderly residing in jaypure area, Pahal, Bhubaneswar. "To assess the impact educational intervention regarding warning sign of dementia of Alzheimer's type". An evaluative approach with quasi experimental research design was used. Total 50 samples were selected by non-probability convenience sampling technique. Data were collected by using structure interview schedule. Pre-test was done followed by educational intervention. After a week post test was conducted. The study findings revealed that, there was highly significant difference found between the pre and post tests KS ($P<0.01$) but no significant association was found between the post test KS when compared with the demographic variables of elderly people ($P>0.05$). It was concluded that educational intervention was effective in increasing the knowledge of the Elderly people regarding warning sign of dementia of Alzheimer's type.

Keywords: *Alzheimer's disease (AD), Dementia, Knowledge score(KS), Educational intervention .*

INTRODUCTION

Alzheimer's disease is the most common form of dementia. It is a neurological brain disorder named after a German physician, Alois Alzheimer, who first described it in 1906.The exact cause of Alzheimer's Disease (AD) is unknown. Age is the most important risk factor for developing Alzheimer's disease. Women are more likely to develop Alzheimer's disease than men probably because they live longer.[1]

In Alzheimer's disease, as in other types of dementia, increasing numbers of nerve cells deteriorate and die. A healthy adult brain has 100 billion nerve cells, with long branching extensions connected at 100 trillion points called synapses. At these connections, information flows in tiny chemical pulses released by one neuron and taken up by the receiving cell. Different strengths and patterns of signals move constantly through the brain's circuits, creating the cellular basis of memories, thoughts and skills In Alzheimer's disease, information transfer at the synapses begins to fail, the number of synapses declines and eventually cells die. Brains with advanced Alzheimer's show dramatic shrinkage from cell loss and widespread debris from dead and dying neurons.[2]

At present, about 33·9 million people worldwide have Alzheimer's Disease (AD), and prevalence is expected to triple over the next 40 years.[2] As of 2010, there are an estimated 35.6 million people with

dementia worldwide. This number will nearly double every 20 years, to an estimated 65.7 million in 2030, and 115.4 million in 2050. Much of the increase will be in developing countries. Already 58% of people with dementia live in developing countries, but by 2050 this will rise to 71%. The fastest growth in the elderly population is taking place in China, India, and other South Asian and Western Pacific neighbors. By 2050, people aged 60 and over will account for 22% of the world's population, with four-fifths living in Asia, Latin America or Africa.[3]

In India, prevalence of dementia is 33.6 per 1000.Alzheimer's disease was the most common type of dementia (54 per cent), followed by vascular dementia (39 per cent).[4] Some people with a family history of Alzheimer's won't develop the disease, while others with no family history will develop Alzheimer's disease. This suggests that Alzheimer's disease is not totally controlled by genetics. Life style and other factors most likely play an important role in risk for developing disease .Prevention involves making healthy life style choices in areas like diet, nutrition, physical exercise, mental exercise and social interaction. Preventing is really about risk reduction .Even though total protection is not possible; it's worth in reducing the risk of disease and improves overall health and quality of life along the way.[4]

Evidence from well-planned, representative epidemiological surveys is scarce in many regions. It estimate that 24·3 million people have dementia today, with 4·6 million new cases of dementia every year (one new case every 7 seconds). The number of people affected will double every 20 years to 81·1 million by 2040. Most people with dementia live in developing countries (60% in 2001, rising to 71% by 2040). Rates of increase are not uniform; numbers in developed countries are forecast to increase by 100% between 2001 and 2040, but by more than 300% in India, China, and their south Asian and western Pacific neighbours.[5]

The most common cause of dementia is Alzheimer's disease (AD). Symptoms include memory problems, a progressive deterioration in the ability to perform basic activities of daily living(ADL), and behaviour changes, mainly apathy and social withdrawal, but also behavioural disturbances. Alzheimer's disease causes abnormal function and eventual death of selected nerve cells in the brain. The average survival period for patients following diagnosis eight to 10 years.[6]

According to the world health organization, India's population of those aged over 65, which was 40 million in 1997. This is expected to increase to 108 million by 2025. This means a several-fold increase in age- related problems such as Dementia. Dementia is not a specific disease. It is a set of symptoms found in a variety of pathological conditions. These include Alzheimer's disease, Huntington's disease, stroke, depression, infections of the brain, and trauma to the head. The WHO estimates that two out of every three patients with dementia will soon be in developing countries, appear to be a virtual dementia epidemic in India and the urgent need to prepare to face it.[7]

An individual can lead a normal happy life only if he/she has a sound intellectual capacity with a good memory. Any impairment to his/her memory will have a direct destructive effect on the quality of thier living standards, thus this condition has been chosen for the present study and hence, the investigator felt the need to create awareness by providing educational intervention on warning signs and prevention of dementia of Alzheimer's type.

Objectives

i. To assess the knowledge of Elderly people regarding warning sign of dementia of Alzheimer's type

ii. To evaluate the effectiveness of educational intervention regarding warning sign of dementia of Alzheimer's type on knowledge among the elderly people

iii. To compare the post test knowledge scores of the elderly person with their selected demographic variables

Hypotheses

HO_1 : There is a significant difference between the pre and post test knowledge scores of the elderly people regarding warning sign of dementia of Alzheimer's type.

HO_2 : There is no significant association between the post test knowledge scores and their selected demographic variables.

MATERIAL AND METHOD

An evaluative research approach with quasi experimental research design was adopted for the study. The study was conducted among elderly residing in Bhubaneswar, to assess the impact educational intervention regarding warning sign of dementia of Alzheimer's type. An evaluative approach with quasi experimental research design was used. 50 samples were selected by non-probability convenience sampling technique. The sample size was calculated by use of power analysis with 80% of statistical power and 5% level of significance.

The criteria for selecting the sample was elderly aged between 60-70 years. The tools were developed in 2 sections. Section -1 includes the demographic variable and section-2 includes structured knowledge questionnaire regarding warning sign of dementia of Alzheimer's type. Data were collected by using structured interview schedule. After having an extensive literature review, and consultation with medical and nursing experts, based on the specific purpose, tool was developed and validated by the experts of various fields. Inter rater method was used to calculate the reliability of the tool where spearman brown prophency formula was used and found to be reliable (r=0.83). Pilot study was conducted in Jaypur village, Pahala. A written permission was obtained from the concerned authority prior to the study.

Prior to data collection permission was obtained from the Corporator of that area of Bhubaneswar and informed consent was taken from the respondents'. The data collection period was from 25.02.14 to 5.3.14. Pre test was conducted by using structured interview schedule followed by implementation of educational intervention. After 7 days post test was done. Descriptive and inferential statistics was used for data analysis.

FINDINGS

Description of demographic data of elderly people.

Figure :1 Multiple Bar diagram showing the description of demographic variable

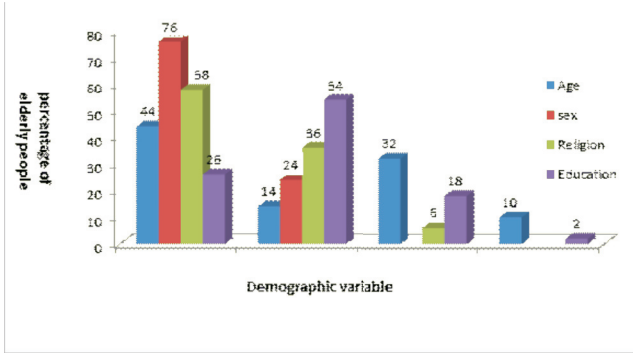

Figure -1: Depicts that highest percentage (44%) of the elderly people were in the age group of 60- 65 years, whereas majority 76% of them were male. Most 58% of them belong to Hindu and highest 54% had primary education.

Table -1: Area wise comparison of mean, SD and mean percentage of pre and post test knowledge score of Elderly people regarding warning sign of dementia of Alzheimer's type.

Sl. No.	Area	Max. score	Pre-test			Post test			Difference in Mean %
			Mean	SD	Mean%	Mean	SD	Mean%	
1	Introduction	2	0.66	0.69	33	1.60	0.49	80	47
2	Meaning	4	1.28	0.67	32	3.04	0.78	76	44
3	Warning sign and symptoms	13	4.36	1.98	33.53	9.04	1.72	69.53	36
4	Risk factors	4	1.28	0.95	32	2.66	0.91	66.5	34.5
5	Complications	5	1.98	1.00	38.40	3.44	0.97	68.8	30.4
6	Treatment	7	2.6	1.05	37.14	4.96	1.30	70.85	33.71
7	Home care management	4	1.32	0.77	33	2.76	1.00	69	36
8	Prevention	2	0.68	0.65	34	1.42	0.49	71	37
Total		**41**	**14.16**	**3.13**	**34.53**	**28.92**	**3.13**	**70.53**	**36**

Table 2- Comparison of pre and post test knowledge scores of Elderly people regarding warning sign of dementia of Alzheimer's type with their selected demographic variables

Demographic Variable	No. of sample	Pre test			Post test			Difference in mean%
		Mean	SD	Mean %	Mean	SD	Mean %	
Age								
60-65	22	13.90	1.94	33.90	29.54	3.56	72.04	38.14
65-70	7	14	4.54	34.14	27	2.30	65.85	31.71
70-75	16	13.66	3.20	33.31	28.7	2.90	70	36.69
>75	5	13.2	2.94	32.19	29.8	2.28	72.68	40.49
Sex								
Female	38	14.31	3.39	34.90	29.36	3.04	71.60	36.7
Male	12	13.66	2.10	33.32	27.50	3.11	67.07	33.75
Religion								
Hindu	29	13.96	2.71	34.04	29.06	3.15	70.87	36.83
Christian	18	14.61	3.91	35.63	29.11	3.10	71	35.37
Muslim	3	13.33	1.52	32.51	26.33	3.05	64.21	31.7
Educational qualification								
Illiterate	13	13.38	2.36	32.63	28.92	2.78	70.53	37.9
Primary education	27	14.22	3.00	34.14	28.92	3.26	70.53	36.39
Higher secondary	9	15.11	4.48	21.95	28.44	3.39	69.36	32.51
Graduation and above	1	14.00	0	34.14	33.00	0	80.48	46.34

Testing Hypotheses: Ho1: There is no significant difference between pre and post test knowledge scores of the Elderly people regarding warning sign of dementia of Alzheimer's type.

Table No. 3 – Paired 't' value of pre and post test knowledge scores of the Elderly people regarding warning sign of dementia of Alzheimer's type

Sl. No	Area	't' value	Level of Significance
1.	Introduction	6.82	Highly Significant
2	Meaning	12.43	Highly Significant
3	Warning sign and symptoms	7.76	Highly Significant
4	Risk factors	7.13	Highly Significant
5	Compli-cation s	7.11	Highly Significant
6	Treatment	9.75	Highly Significant
7	Home care management	12.58	Highly Significant
8	Prevention	6.14	Highly Significant

(df = 49), (Table Value = 3.46), ($P < 0.001$)

Paired't' test was calculated to assess the significant difference between pre and post test knowledge scores which shows highly significant difference between overall and the area wise score values of pre test and post test. Hence, stated null hypothesis is rejected ($p < 0.001$). Thus the difference observed in the mean score value of pre test and post test were true difference. Thus it can be interpreted that Educational Intervention was effective (Table no.3).

Ho2: There is no significant association between post test knowledge scores regarding warning sign of dementia of Alzheimer's type and selected demographic variable of the elderly people.

Table No. 4– Association between post test knowledge scores of elderly people on warning sign of dementia of Alzheimer's type and their demographic variables

Sl. No.	Variables	Chi-square value	Level of Significance
1	Age	1.41	Not Significant
2	Sex	0.13	Not Significant
3	Educational Status	0.01	Not Significant
4	Religion	0.13	Not Significant

d.f = 1 (Table value: 3.84)

Chi square was calculated to find out the association between the post test knowledge scores and the demographic variables of the Elderly people. There was no significant association between knowledge scores of elderly people regrding warning sign of dementia of Alzheimer's type in post test when compared to age, sex, education and religion ($P>0.05$). Hence, it can be interpreted that the difference in mean score related to the demographic variables were only by chance and not true and the null hypothesis was accepted (Table No.4).

CONCLUSION

The study findings concluded that educational programme was an effective intervention for enhancing the knowledge and to create awareness among the elderly people regarding warning sign of dementia of Alzheimer's type. So, here the study suggests that all the health care personnel should create awareness among the elderly people for early recognizing the condition of dementia.

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Conflict of Interest : None

Source of Funding : Self

Ethical Clearance: The permission was obtained from the Corporater of Jaypure area, Pahala, Bhubaneswar, Odisha and Informed consent was taken from the study participants before data collection.

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An Exploratory Study on Knowledge and Attitude Regarding Alcoholism among the Students of B.V.V.S Sangha's Arts College Bagalkot with a View to Prepare an Information Guide Sheet on the Ill Effects of Alcoholism

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ABSTRACT

OBJECTIVES:

1. To assess the knowledge of college students regarding alcoholism.
2. To assess the attitude of college students about alcoholism.
3. To find out the association between knowledge regarding alcoholism with selected socio-demographic variables.
4. To find out the association between attitude about alcoholism with selected socio-demographic variables.
5. To develop an information guide sheet on ill effects of alcoholism.

METHOD: This was descriptive study total 100 subjects were selected through non-probability purposive sampling technique. Exploratory design was used. Data was collected by structured questionnaire and attitude scale (Likert Scale). Data collected under the 3 sections (socio- demographic data, knowledge and attitude towards alcoholism).The reliability of the tool was established by Split Half method formula. The reliability result of knowledge was r **= 0.8097** and reliability result of attitude was r **= 0.8019.** Prepared information guide sheet regarding ill effects of alcoholism was developed after content validity of the tool was established by six experts.

Data was analyzed by using descriptive and inferential statistical in terms of frequency, percentage, mean, standard deviation, Chi-square values.

RESULT: The data were analyzed by descriptive and inferential statistics. Out of 100 samples the data were shows that 40% of the subjects were belongs to 17-18 years, and 60% of the subjects were belongs to 19-20 years of age, majority of the subjects were 88% belongs to male, and 75% of the subjects were belongs to Hindu religion.

The results shows that majority 40% of the students were had satisfactory knowledge, 33% of the students had adequate knowledge and 27% of the students were had in-adequate knowledge regarding alcoholism and its ill-effects. There is significant association between knowledge and attitude with age, gender, religion, educational status and residential background.

INTERPRETATION AND CONCLUSION: Findings of the study indicates that majority 40% of the students were had satisfactory knowledge, 33% of the students had adequate knowledge and 27% of the students were had in-adequate knowledge regarding alcoholism and its ill-effects. The study had implication not only in the field of nursing, but also in other disciplines. Education programme should give importance to equip the students with adequate knowledge regarding alcoholism there by preventing from threat of ill effect.

Keywords: *Students, knowledge and attitude regarding ill effects of alcoholism, Information guide sheet.*

INTRODUCTION

Nowadays drinking alcohol has become new trend among the college students. Alcohol is not an ordinary commodity but a toxic substance in terms of its direct and indirect effects on a wide range of body organs and systems. It is one of the most harmful substances to health. At least 61 different types of injury, illness or death which are potentially caused by the consumption of alcohol have been identified. For 38 of these conditions sufficient evidence for a direct causal association has been shown in a benchmark study with hazardous or harmful use of alcohol. Adverse effects of alcohol have been demonstrated for many disorders, including liver cirrhosis, mental illness, several types of cancer, pancreatitis, and damage to the fetus. Alcohol consumption is also strongly related to social consequences such as drunk–driving injuries and fatalities, aggressive behavior, family disruptions and reduced industrial productivity. Approximately 2 billion people worldwide consume alcohol and around 76 million have been estimated to be suffering from alcohol consumption disorders. Numerous and varied factors contribute to and sustain heavy episodic drinking among college students. They include the student and his or her background, the peer group on campus, including alcohol supply and alcohol marketing practices[1].

Alcohol may be the world's oldest known drug. Fermented grain, fruit juice and honey have been used to make alcohol (ethyl alcohol or ethanol) for thousands of years. The production of products containing alcohol has become big business in today's society. Alcohol is the drug of choice among youth. Many young people are experiencing the consequences of drinking too much, at too early an age. As a result, underage drinking is a leading public health problem in this country[2].

Yet drinking continues to be widespread among adolescents, as shown by nationwide surveys as well as studies in smaller populations. According to data from the 2005 Monitoring the Future (MTF) study, an annual survey of U.S. youth, three-fourths of 12th graders, more than two-thirds of 10th graders, and about two in every five 8th graders have consumed alcohol. And when youth drink they tend to drink intensively, often consuming four to five drinks at one time. MTF data show that 11 percent of 8th graders, 22 percent of 10th graders, and 29 percent of 12th graders had engaged in heavy episodic or "binge[1]" drinking within the past two weeks. Research shows that many adolescents start to drink at very young ages. In 2006, the average age of first use of alcohol was about 14. People who reported starting to drink before the age of 15 were four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives. In fact, new research shows that the serious drinking problems (called alcoholism) typically associated with middle age actually begin to appear much earlier, during young adulthood and even adolescence. Younger children and adolescents are when they start to drink, more likely they will be to engage in behaviors that harm themselves and others. For example, frequent binge drinkers (nearly 1 million high school students nationwide) are more likely to engage in risky behaviors, including using other drugs such as marijuana, heroin and cocaine[3].

MATERIAL AND METHOD

Sampling Technique: For the present study convenient sampling method was selected and considered appropriate. Convenient sampling involves the selection of the population in the sample which appear convenient to him / to the management of the organization where he is conducting research.

Data collection instruments: Data collection instruments are procedures or instruments used by the researcher to observe or measure the key variables in a research problem.[12] The study was planned to assess the knowledge and attitude, and co-relation between level of knowledge & attitude. Hence, questionnaire was selected as appropriate technique for collecting data. A knowledge questionnaire and an attitude scale were found to be the most appropriate tools to collect relevant data.

Data collection: Prior permission was obtained from the Principal of Sajjalashree Institute of Nursing Sciences and B. V. V. Sangha's Arts College, and Arts College class teacher, Bagalkot. To conduct the study, the investigator utilized the convenient sampling technique to select the study subjects.

In research, data collection involves the generation of numerical data to address the research objectives, hypothesis. In the direction of sketch for

data collection, the researcher needs to determine step by step how and in what order the data will be collected from the subject.

Investigator personally visited each respondent introduced himself to the participants and explained the purpose of the study and ascertained the willingness of the participants. The respondents were assured anonymity and confidentiality of the information provided by them and an informed consent was obtained. Interviews were conducted during their leisure time. A comfortable place was selected for the participants and they were made comfortable and relaxed.

Data was collected with the help of the socio-demographic data profile, knowledge questionnaire and attitude towards alcoholism**.** Approximately about 45 minutes to 1 hour were spent with each participant. The data collection process was terminated after thanking participant for their participation and co-operation.

FINDINGS

Table 1: Distribution of respondents according to socio-demographic variables

Variables	No of respondents	Percentage
Age (in years)		
17-18 years	40	40.00
19-20 years	60	60.00
Gender		
Male	88	88.00
Female	12	12.00
Marital status		
Married	5	5.00
Unmarried	95	95.00
Religion		
Hindu	75	75.00
Christian	10	10.00
Muslim	15	15.00
Educational status		
PUC 1st	63	63.00
PUC 2nd	37	37.00
Type of family		
Nuclear	69	69.00
Joint	31	31.00
Monthly income		
Below Rs. 2000	45	45.00
Rs.2001-4000	20	20.00
Rs.4001-6000	10	10.00
Rs.6001 and above	25	25.00
Monthly income		
Urban	33	33.00
Rural	67	67.00
Total	100	100.00

Table 2: Distribution of knowledge scores regarding alcoholism among B.V.V.Sangha's Arts College students:

Sl no	Respondents	Scores range	%
1	27	Inadequate (0-66) *	27%
2	40	Satisfactory (67-132) *	40%
3	33	Adequate (133-200) *	33%
	Total: 100		100%

Table 3: Distribution of attitude scores regarding alcoholism among B.V.V.Sangha's Arts College students:

n=100.

Sl no	Respondents	Attitude	Percentage
1	26	Negative.	26%
2	52	Unbiased.	52%
3	22	Positive.	22%
	Total: 100		100%

Table 4: Karl Pearson's correlation coefficient between knowledge and attitude scores of study subjects.

Variable	Attitude scores		
	Correlation coefficient	t-value	p-value
Knowledge scores	0.4556	5.0666	0.0000*

*p<0.001

From the results of above table, we clearly seen or observed that, knowledge and attitude scores

are found to be statistically significant (t= 5.0666, P= 0.0000). It means that the knowledge scores correlation coefficient between knowledge and attitude scores was (0.4556).

The above finding states that "Research hypothesis stated by the investigator earlier was accepted.

RECOMMENDATIONS

Keeping in view the findings of the present study, the following recommendation were made:

1. A comparative study on the effectiveness of the currently advocated ill effects of alcoholism should be under taken with a view to develop problem specific protocols.
2. A study on the knowledge of nursing personnel regarding alcoholism may help to the students.
3. A study on the attitude and willingness of nursing personnel regarding alcoholism may be helpful for the students.
4. A qualitative study on the effectiveness of nursing measures to improve the quality of life of persons living with alcoholism should be conducted.
5. An exploratory survey can be done to find out the limitations faced by the nurses in following attitude of students regarding alcoholism.
6. A study should be conducted to evaluate the effectiveness of planned teaching programme on alcoholism.
7. A study to evaluate the effectiveness of structured teaching programme on ill effects of alcoholism.
8. A study to assess the knowledge regarding alcoholism and its ill effects.
9. A study to assess the psychological and physical problems of alcoholism.

DISCUSSION / CONCLUSION

The study concluded that students had satisfactory knowledge and attitude regarding alcoholism. The present study gives an idea to other researchers in the field of nursing or any other professionals in future regarding alcoholism about basic knowledge and their attitude regarding alcoholism.

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Conflict of Interest : None

Source of Support: Self

Ethical Clearance: Permission taken from Ethical Committee.

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Exploring Relationship between Self- Motivation and Adjustment among Undergraduate Students in Selected Nursing College, Amritsar, Punjab

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ABSTRACT

An exploratory study with non- experimental research design was conducted to assess self- motivation and adjustment among undergraduate students. It was assumed that self-motivation is related to adjustment i.e., home, social, emotional and educational. Conceptual framework of the present study was based on modified self-motivation theory model by Edward L. Deci and Richard M. Ryan (1985). The setting for the study was SGRD College of Nursing, Vallah, Amritsar, Punjab. Sample of 80 undergraduate nursing students were selected using simple random sampling technique (lottery method without replacement). Self- structured self- motivation assessment tool was used to measure self- motivation and to measure adjustment i.e, home, social, emotional and educational, standardized adjustment inventory by D.N. Srivastava and Govind tiwari (1972) was used. The data was analyzed using descriptive (mean and standard deviation) and inferential statistics (Karl Pearson's correlation, z-test, F-test)

The major findings of the study revealed that maximum students (68.5%) were living in rural area, 90% did schooling from private schools. Maximum 60 % were from to nuclear family and 51.25% were 1st child according to birth order. Maximum students 72.5% were having low self-motivation and 77.5% had very unsatisfactory adjustment overall. There was weak positive correlation (0.17) between self-motivation and adjustment as determined by Karl Pearson's coefficient of correlation analysis. As per levels of adjustment, there was high positive correlation (0.99) between self- motivation and average adjustment level of students and for students with very unsatisfactory adjustment highly negative correlation(-0.02) with self-motivation was found. Relationship of Demographic variables i.e., habitat, schooling, class, birth order and type of family with self-motivation and adjustment were found non-significant.

Therefore, it was revealed that self-motivation had impact on adjustment of undergraduate students. Findings reveal that there is need to strengthen self-motivation of students and for adjustment it is challenge for the curriculum developers to inculcate methods to assess and develop better adjustment of students. The implications of these findings for faculty, higher education administrators, and mental health counselors are provided, as well directions for future research

Keywords: *Self-motivation, adjustment, undergraduate students*

INTRODUCTION

Education is said to be the most powerful equalizer of people's endowments, with which they expand the horizon of life choices, grasp economic opportunities, gain higher living standards, pursue happiness, and enjoy a life of well being. It acts as the foundation upon which one can build the rest of their life.[1]

Notable is that the students' interest and commitment vary during their education. It is therefore interesting to systematically study the students' own experience of how motivated they felt. Motivation can be seen either as an intrinsic or an extrinsic factor. Enjoying learning for its own sake or positive feedback on learning outcomes are examples of intrinsic motivation. Accordingly there is a built-in pleasure for the activity itself. Intrinsically motivated students have a driving force to learn, perform, and a wish to succeed and adjust to devastating situations of life.[2] In today's multi-cultural world, education necessitates adjustment. Students with different abilities, different skills, different backgrounds, and different cultures get educated together, providing them an opportunity to hone their adjustment skills thus acting as a training ground for the rest of their lives. During college life, a student has to learn to co-exist and co-operate with other students and teachers of different religions, different cultures different opinions and a different outlook towards life.

Adjustment is a process of reducing strains and coping with the circumstances in any situation, we adjust when we cannot change the conditions to suit our needs or demands. Adjustment therefore, occurs in various conditions and situations like family, emotional, social and workplace.[3]

Knowledge of human, motives and the factors facilitating or obstructing their full expression is basic to an understanding of the psychology of adjustment. Whether an individual is adjusted or maladjusted depends in a large measure on (a) the extent to which a state of harmony prevails among his manifold drives, motives, and ideals; (b) the extent to which his wishes and aspirations are adequately attained; and (c) the extent to which his desires and actions are in conformity with the demands and standards of his social group. Inner strivings and motives that permit a person to live at peace with him and his social group make for adjustment; those that create personal discord and social conflict favor maladjustment.[4, 5]

OBJECTIVES

1. To assess self-motivation among undergraduate students.
2. To assess adjustment i.e., home, social, emotional and educational of undergraduate students.
3. To ascertain relationship between self-motivation and adjustment i.e., home, social, emotional and educational.
4. To find out relationship of self-motivation and adjustment with variables like habitat, schooling, class, birth order and family type.

MATERIALS AND METHOD

Research design: A non - experimental research design and exploratory research approach was used for the study.

Setting of the study: Sri Guru Ramdas College of Nursing, Vallah, Amritsar, Punjab.

Population: Undergraduate (B.sc.Nursing) students of Sri Guru Ramdas College of Nursing, Vallah, Amritsar, Punjab

Sample size: 80 undergraduate (B.Sc. Nursing) students were selected as sample for the study.

Sampling technique: Simple random sampling technique (Lottery method without replacement).

Development & description of tool: The tools used for this study was self- structured self- motivation assessment tool which was 5-point rating scale with r = 0.8. Total items in tool were 12 with maximum 60 and minimum 12 scores. Adjustment was measured with standardized adjustment inventory by D.N. Srivastava and Govind tiwari (1972). This inventory consists of 80 items comprising four dimensions as follows, Home, Emotional, Educational and Social. All the 80 items are the choice of 'yes' or 'no' with maximum score 80 and minimum 0 score.

Data collection procedure

1st step: Before commencing the task of data

collection formal written permission was obtained from the Principal, SGRD College of Nursing, Vallah, Amritsar, Punjab.

2nd step: Total 80 undergraduate students 20 each from B.Sc. 1ST, 2nd, 3rd and 4th year respectively were selected using simple random sampling (lottery method without replacement). Verbal consent was taken from the study participants and was told regarding the study and its purpose.

3rd step: Structured self-motivation and standardized adjustment tools were used to collect data. They were also assured that their responses will be kept confidential and used for research purpose only. The same process was followed throughout the data collection period from Jan 2014 till Feb. 2014.

RESULTS

Table 1 Frequency and Percentage Distribution of Sample Characteristics N=80

S. No.	Characteristics	F	%
1.	**Habitat**		
a)	Rural	55	68.75
b)	Urban	25	31..25
2.	**schooling**		
a)	Government	8	10
b)	Private	72	90
3.	**Class**		
a)	1st yr	20	25
b)	2nd yr	20	25
c)	3rd yr	20	25
d)	4th yr	20	25
4.	**Family type**		
a)	Nuclear	60	75
b)	Joint	20	25
5.	**Birth order**		
a)	1st child	41	51.25
b)	2nd child	32	40
c)	>3rd child	7	8.75

Table 1 Distribution of characteristics of 80 students depicts that maximum students (68.75%) were living in rural habitat and maximum (90%) did there schooling from private schools. 60 % belongs to nuclear family and 51.25% were 1st child in family according to birth order.

Table 2(a) Percentage Distribution of Students according to categories of self- motivation

N=80

Levels of self-motivation	Score	N	%
Excellent	51-60	10	12.5
Average	37-50	12	15
Low	Up to 36	58	72.5

Table 2 (a) depicts that maximum students (72.5%) were having low self-motivation followed by 15 % with average self- motivation and 12.5% had excellent self- motivation. Thus it is inferred that students had low self-motivation.

Table 3 (a) Percentage Distribution of Students according to Levels of adjustment

N=80

Levels of adjustment	Score	N	%
Excellent	8 and below	0	0
Good	9 - 20	0	0
Average	21- 32	3	3.75
Unsatisfactory	33 - 41	15	18.75
Very unsatisfactory	41 and above	62	77.5

Table 3 (a) depicts that maximum students (77.5%) had very unsatisfactory adjustment followed by 18.75 % with unsatisfactory adjustment and 3.75% had average adjustment. Thus it is inferred that students had very unsatisfactory adjustment.

Table 3 (b) Mean and Standard deviation of areas of adjustment. **N= 80**

Areas	Mean	S.D.	Levels of Adjustment
Home	30.98	2.57	Very Unsatisfactory
Social	13.03	2.96	Very unsatisfactory
Emotional	8.23	3.03	Average
Educational	11.34	3.25	Unsatisfactory
Total	48.3	7.49	Very unsatisfactory

Table 3 (b) and Fig.1 A perusals of the data presented in Table reveals that the overall mean score (48.3±7.49) of undergraduate students is very unsatisfactory. While the students had very unsatisfactory adjustment in the areas of home (30.98±2.57) and social (13.03±2.96), they had better adjustment in the area of emotional (8.23±3.03) and educational (11.34±3.25) adjustment.

FIG. 1. Correlation (r) between Self-Motivation and Adjustment among Undergraduate Students.

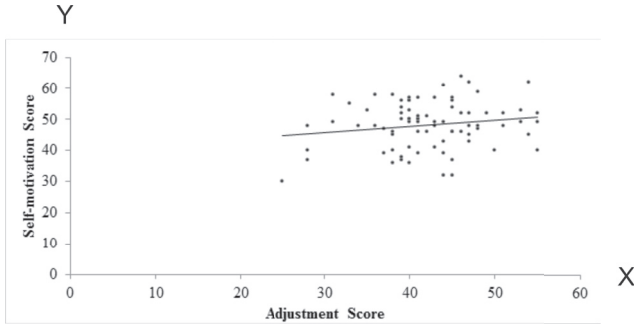

Table 4 (a) Correlation between Self- Motivation and Adjustment of Students.

N =80

Relationship between	Mean	S.D.	r
Self - Motivation	42.23	6.45	
&			0.17^{NS}
Adjustment	48.3	7.49	

NS = Non-significant

Table 4 (a) and Fig. 1 reveals that mean motivation score of students was 42.23±6.45 and mean adjustment score of students was 48.3±7.49 and there was weak positive correlation (0.17) between motivation and adjustment indicating that if motivation increases, adjustment increases and vice-versa .

Table 4 (b) Correlation between Self- Motivation score and Types of Adjustment score of Students based on levels of Adjustment

N =80

Levels of Adjustment	Relationship between Types of Adjustment and self-motivation				
	Home	Social	Emotional	Educational	Total
Average (n = 3)	0.04	-0.66	0.84*	0.99**	0.99^{**}
Unsatisfactory (n = 15)	0.38	-0.02	0.03	-0.33	0.25
Very Unsatisfactory (n = 62)	-0.02	0.09	-0.07	-0.02	-0.02

*Significant at $p < 0.05$ level.

** Significant at $p > 0.01$ level.

Table 4 (b) reveals that students with average level of adjustment (0.99) had highly positive correlation with self-motivation overall and in the areas of educational (0.99) and emotional (0.84) adjustment also highly positive correlation which was found to be statistically significant. Students with very unsatisfactory level of adjustment and in area of educational adjustment had highly negative correlation (-0.02) with self-motivation.

Thus, it is inferred that as the self-motivation will increase in the student he/she will better adjust to the life situations especially in educational development.

Table 5. Comparative Mean of self - motivation Score among Students according to habitat N=80

Habitat	n	Mean	SD	Z value
Rural	55	42.09	6.53	0.10^{NS}
Urban	25	42.25	6.39	

NS = Non Significant

Table 5. Shows that mean motivation score was highest (42.09±6.53) among students living in rural as compared to students living in urban (42.25±6.39). But this difference was found statistically non - significant.

Table – 6 Mean, Standard Deviation and ANOVA of adjustment among Students According to class. N=80

Mean Adjustment score			
Class	n	Mean	SD
B.Sc.(N) 1st yr	20	50.50	7.30
B.Sc.(N) 2nd yr	20	46.95	6.06
B.Sc. (N) 3rd yr	20	47.40	7.22
B.Sc.(N) 4th yr	20	48.35	9.13

Source of variation	df	Sum of squares	F	*p*
BG	3	149.50	0.883^{NS}	*0.45*
&				
WG	76	4285.30		
TOTAL	79	4434.80		

Max. Score = 80 NS = Non-Significant at 0.05 level.

Min. score = 0

Table 6 reveals that mean adjustment score was higher (50.50±7.30) among students of B.Sc. (N) 1st year followed by B.Sc.(N) 4th year (48.35±9.13) and then B.Sc.(N) 3rd year (47.40±7.22) and least in B.Sc.(N) 2nd year (46.95±6.06).The calculated value of F between and within the group was 0.88 and value of F for (3, 76) degree of freedom was 2.68 at 0.05 level, which was less than the tabled value. Therefore, there was no significant difference in adjustment of students in respect to their class. Thus, it can be inferred that class had no significant impact on adjustment.

DISCUSSION

According to objective 1: To assess self-motivation of students it was found that maximum students 72.5% had low self-motivation and overall mean self-motivation score of students was low (42.23±6.45) these findings were supported by Nilsson EL & Stomberg MI (2008)[2] who reported that the mean motivation score over all semesters was 6.3 (ranked between 0–10) showing low motivation among nursing students.

According to objective 2: To assess adjustment among undergraduate students. Maximum students 77.5% had very unsatisfactory adjustment and overall adjustment of students was very unsatisfactory (48.3±7.49) they had better adjustment in the area of emotional (8.23±3.03) and educational (11.34±3.25) adjustment. Similar findings was reported by **Basu Sarah (2012)**[1] that students overall adjustment was unsatisfactory but they scored better in area of educational adjustment.

According to objective 3: to ascertain relationship between self-motivation and adjustment the relationship was found to be weakly positive (0.17) which was also reported by **Smitton JA (1993)**[7] who depicted that aggregate descriptive results indicated a relationship of 0.50 existed between adjustment and motivation.

According to objective 4: Relationship of Demographic variables i.e., habitat, schooling, class, birth order and type of family with self-motivation and adjustment were found non- significant.

RECOMMENDATIONS

- The study needs to be replicated on a large sample size to validate and generalize its findings.

- A comparative study can be done on students of private and government institutions.
- A longitudinal study can be done to examine changes in student's self-motivation and adjustment over the course of program.

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A Study to Evaluate the Effectiveness of a Planned Teaching Programme on Care of Child with Sickle Cell Anaemia in Terms of Knowledge and Attitude among Female Health Workers in Selected Districts of South Zone, Gujarat State

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ABSTRACT

Sickle cell anaemia is a genetic not curable but preventable disorder and a major cause of morbidity and mortality in children in India. Female health workers are the most vital link in the entire chain of health care delivery system in rural area. With the aim of this the investigator undertook the study to assess the knowledge and attitude of Female Health Workers before and after the administration of Planned Teaching Programme on care of a child with sickle cell anaemia.

A Pre-experimental study approach was used with one group pre test post test design. This study was conducted in selected Primary Health Centres in selected districts of south zone, Gujarat state. Convenient Sampling technique was used for selecting 50 samples. A structured Knowledge questionnaire and structured likert rating scale were prepared to assess the knowledge and attitude of the samples.

The mean post test knowledge score 24.34 was higher than mean pre test knowledge score 17.06 with the mean difference of 7.28. The mean post test attitude score 72.96 was higher than the mean pretest 63.36 with the mean difference of 9.6. The calculated't' value for knowledge 16.93 and the calculated 't' 8.63 for attitude was greater than tabulated 't' value 1.67 at 0.05 level of significance. The "Chi square" test was used to test the association of selected demographic variables with pre test knowledge score and attitude score of the samples. Researcher found that there is significant association between demographic variables Job experience and have attend any workshop or taking any training and the Pre-test Knowledge score and no any significant association between demographic variables and pre test attitude score. So the study was concluded that Planned Teaching Programme on care of child with sickle cell anaemia was effective in improving the knowledge and attitude of the female health workers.

Keywords: *Planned Teaching Programme, Female Health Worker, Care of child with sickle cell anaemia*

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BACK GROUND OF THE STUDY

Child is a young human being or noble youth who will be a citizen for tomorrow, Children's health encompasses the physical, mental, emotional, and social well-being from infancy till adolescence so

child's health is most important for the development of healthy citizen who leads the world towards bright future.[10] Sickle cell anaemia is a genetic disorder is not curable but preventable and a major cause of morbidity and mortality in children in India. Incidence of sickle cell disorder in tribal and non tribal area of India: Gujarat- up to34%, Rajasthan- up to 18%, Andhra Pradesh-up to 34%, Uttar Pradesh-18% Bihar-31%, Kerala- up to 26%, Karnataka- up to 23%, Maharastra- 33% .[11] Gujarat has 64.70 lakh tribal population and is expected to have 6, 47,025. Sickle trait and 48,257 Sickle disease patients. 20% of the Sickle Disease children die by the age of 2nd year. 30 % of Sickle diseased children die before they reach adulthood (14years) and the remaining 70 % die by the age of 50.[13]

In Gujarat the disease has been prevalent in the tribal districts like the Dang, Valsad, Tapi, Surat, Banaskantha, Sabarkantha, Godhara, Dahod and Narmada. It is belived that about 10 to 14% of the total population in this area has sickle cell disease.[9] Female health worker is the most vital link in the entire chain of health care delivery system in rural area. She provides all the primary care to the community area.[12]

As the stastical data shows that the frequency of sickle cell anaemia is more amongst tribal residing. In Gujarat, tribal population in the south Gujarat is more prone to sickle cell anaemia thus investigator has Planned a teaching programme for Female Health Workers in order to increase the knowledge and create more awareness and to bring positive attitude so they apply this knowledge in the daily practice regarding care of child with sickle cell anaemia to reduced problem of the child with sickle cell anaemia.

OBJECTIVES

1. To assess the knowledge of Female Health Workers before and after the administration of Planned Teaching Programme on care of a child with sickle cell anaemia.

2. To assess the attitude of Female Health Workers before and after the administration of Planned Teaching Programme on care of a child with sickle cell anaemia.

3. To find out the association between pre test knowledge and attitude scores with selected demographic variables.

HYPOTHESES

H_1: The mean post test knowledge scores of Female Health Workers after administration of Planned Teaching Programme on care of child with sickle cell anaemia will be significantly higher than their mean pre test knowledge scores measured by knowledge questionnaire at 0.05 level of significance.

H_2: The mean post test attitude scores of Female Health Workers after administration of Planned Teaching Programme on care of child with sickle cell anaemia will be significantly higher than their mean pre test knozwledge score measured by attitude scale at 0.05 level of significance.

H_3: There will be a significant association between knowledge and attitude score with demographic variables.

MATERIALS AND METHOD

Research Approach-Pre-experimental study approach was used.

Research design- one group pre test post test design

Research Setting- selected Primary Health Centres in selected districts of south zone

Target population- Female Health Workers of selected Primary Health Centres of selected districts of south zone, Gujarat

Sampling technique - Convenient Sampling technique

Sample Size- 50 samples.

Tool- A structured Knowledge questionnaire and structured likert rating scale were prepared to assess the knowledge and attitude of the samples. Differential and inferential Statistics were used to calculate the analysis from the samples.

RESULTS

Table 1: Effectiveness of Planned Teaching Programme on level of Knowledge on care of child with Sickle cell anaemia

(N= 50)

Knowledge test	Mean	Mean difference	SD	Calculated t value	Table t value	Level of significance
Pre-test	17.06	7.28	2.874	16.93	1.67	0.05
Post-test	24.34		1.802			

This table denote that mean post test knowledge score 24.34 was higher than mean pre test knowledge score 17.06 with the mean difference of 7.28. The table also shows that the Standard deviation of Pre-test score of knowledge is 2.874 and post test score of Knowledge is 1.802. The calculated't' is 16.93 and the tabulated't' is 1.67 at 0.05 level of significance.

Table-2 : Effectiveness of Planned Teaching Programme on Attitude scores on care of child with sickle cell anaemia.

(N= 50)

Attitude	Mean	Mean difference	SD	Calculated 't' value	Table 't' value	Level of significance
Pre-test	63.36	9.6	6.583	8.63	1.67	0.05
Post-test	72.96		4.793			

The mean post test attitude score 72.96 was higher than the mean pretest 63.36 with the mean difference of 9.6. The calculated' value for knowledge 16.93 and the calculated 't' 8.63 for attitude was greater than tabulated 't' value 1.67 at 0.05 level of significance.

Table-3: Association of Pre-test Knowledge scores with the Socio-demographic variables.

(N= 50)

Sr No.	Demographic variables	x^2 Value	df	Table value 't' value	Inference
1	Age in years	3.68	4	9.488	Not Significant
2	Educational Qualification	2.819	2	5.99	Not Significant
3	Job experience in years	23.74	4	9.488	Significant
4	Have you ever attended any workshop or taken any training for sickle cell anaemia?	8.67	2	5.99	Significant

The "Chi square" test was used to test the association of selected demographic variables with pre test knowledge score and attitude score of the samples. Researcher found that there is significant association between demographic variables Job experience and have attend any workshop or taking any training and the Pre-test Knowledge score.

Table 4: Association of Pre-test Attitude scores with the demographic variables.

(N= 50)

S. No.	Demographic variables	x^2 Value	df	Table Value 't'	Inference
1	Age in years a.	3.0966	2	5.99	Not Significant
2	Educational Qualification a.	0.613	1	3.84	Not Significant
3	Job experience in years a.	3.385	2	5.99	Not Significant
4	Have you attended any workshop or taken any training for sickle cell anaemia? a)	0.011	1	3.84	Not Significant

No any significant association between demographic variables and pre test attitude score.

DISCUSSION

A descriptive, cross sectional study on "knowledge of family health programme practitioners in brazil about sickle cell disease" 59.4% (57) of the study participants were nurses and 40.6% (39) were physicians. The median length of training and median length of service in primary health care were 4.3 (2.8-8.0) years and 4.0 (2.0-7.1) years, respectively. The mean performance in knowledge tests was < 75%, with 5.7/8 (SD = 1.4) for the "epidemiology" questions; 8.6/13 (SD = 2.2) for "clinical manifestations"; and 17.0/26 (SD = 2.9) for "management of children with sickle cell disease" Researcher Conclude that there is an urgent need to improve primary health care professional training in the care of children with sickle cell disease.

CONCLUSION

The study was concluded that Planned Teaching Programme on care of child with sickle cell anaemia was effective in improving the knowledge and attitude of the female health workers of selected primary health centres of selected districts of south zone, Gujarat state.

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Conflict of Interest: There is no conflict of interest

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Ethical Declaration: Purpose of the study was explained to the participant and written consent should be taken from them.

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A Quasi Experimental Study to Assess the Effectiveness of Self Instructional Module on Knowledge Regarding Antenatal Care among Primigravida Women attending Selected Hospitals of Punjab and Haryana

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ABSTRACT

Antenatal care is that which comprises systematic medical supervision of a pregnant woman throughout pregnancy. Various teaching and reinforcement programmes have been very successful in developing knowledge which is required to enhance antenatal care among the primigravida women. Effective antenatal care can improve the health of the mother and give her a chance to deliver a healthy baby. With this aim the study was conducted to evaluate the effectiveness of a self instructional module regarding antenatal care. Quantitative approach with a quasi experimental non-equivalent comparison group research design was used. By non-probability convenient sampling technique 60 primigravida women were selected out of which 35 in experimental & 25 was in comparison group. Data were collected by using self administered structured knowledge questionnaire on antenatal care. Findings of the study revealed that maximum primigravida women (41.7%) were in the age group of 25-26 years, 50% of them were Sikhs, 41.7% of them were higher secondary educated, 53.3% of them were working women, 51.7% of them were in nuclear family, 46.7% were had family monthly income of Rs.5001-15,000/-, 51.7% of them were married at the age of 21-22 years and their major source of information (45%) were health personnel. The effectiveness of self instructional module on antenatal care was analyzed by using paired t-test ($t_{(34, 0.05)}$ = 13.423, 0.000) & unpaired t- test value ($t_{(58,0.05)}$ = 13.894, 0.000) which was highly significant at 0.05 level. The chi square value showed that there was significant association between the knowledge of primigravida women with their educational status ($\chi 2(2,0.05)$ = 100.8,0.000 ***). It also shows that there is no association of pretest level of knowledge with age, religion, type of family, family income, age at marriage, occupational status and source of information.

Keywords: *Antenatal Care, Self Instructional Module, Primigravida women, Non-equivalent comparison group.*

INTRODUCTION

"The moment child is born, the mother is also born. The women existed, but the mother never. A mother is something absolutely new."-Bobak[1] All Human life in this planet is born of women. The joy and ecstasy of Motherhood cannot be expressed in words. In all cultures, being pregnant or to give birth to a child is considered as a major event. Pregnancy and birth of a child are important milestones in a couple's life. It is a state of a woman from conception (becoming pregnant) to delivery. Antenatal care is very essential which will save life of the mother as well as life of the baby. So it is important for the mother to know about pregnancy changes & identify the deviation from the normal physiological changes of pregnancy.[1]

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Antenatal care is that which comprises systematic medical supervision of a pregnant woman throughout pregnancy. The outcome of the good antenatal care should be a healthy mother and a healthy baby and avoidance of maternal and perinatal mortality and morbidity.[3] Antenatal care should be used to maintain the physiology of pregnancy and to prevent or detect the earliest and to treat any untoward complications such as high blood pressure, diabetes, to educate women about obstetric danger signs and to motivate women to seek appropriate referred care. [9] Improved prenatal care has dramatically reduced infant and maternal mortality. Detecting potential problems early lead to prompt assessment and treatment, which greatly improves pregnancy outcome.[10] Every woman needs advice regarding the importance of regular prenatal check-ups and measures to be taken to maintain or improve her health status during pregnancy in order to have a normal delivery and healthy baby. In order to remove the fear of unknown and to help them approach the event of childbirth without undue anxiety, "childbirth preparation" through explanation of physiological changes and methods of coping during labor and delivery and puerperium must be explained.[6]

OBJECTIVES

1. To pre-test the level of knowledge on antenatal care among primigravida women of both experimental and comparison group
2. To develop and administer Self Instructional Module on knowledge regarding antenatal care to the primigravida women of the experimental group
3. To post-test the level of knowledge regarding antenatal care among primigravida women of both experimental and comparison group
4. To evaluate the effectiveness of Self Instructional Module on antenatal care among primigravida women
5. To associate the pre-test level of knowledge on antenatal care among primigravida women with selected socio-demographic variables.

Hypotheses:

- **H_1:** There is a difference in the pre test and post test level of knowledge regarding antenatal care among primigravida women in experimental group at 0.05 level of significance
- **H_2:** There is a difference in the post test level of knowledge regarding antenatal care among primigravida women between experimental and comparison group at 0.05 level of significance
- **H_3:** There is an association between pre-test level of knowledge regarding antenatal care among primigravida women with selected demographic variables at 0.05 level of significance

MATERIAL AND METHOD

A quantitative (Evaluative) approach with Quasi experimental non-equivalent comparison group research design was chosen for the present study**.** The study was conducted in the Antenatal Outpatient Department (OPD) of Government Hospital, Phase-6 of Mohali**.** The sample consists of 60 primigravida women, 35 women in experimental group and 25 women in comparison group. Non - Probability, Convenient sampling technique was used to draw the sample from the population. Self administered structured knowledge questionnaire The tool consists of two sections: Section -1 Socio- Demographic Data: This section consists of 8 variables to collect socio-demographic information such as age, religion, educational status, working status, type of family, family income, age at time of marriage and source of information. Section -2 Structured knowledge Questionnaire on Antenatal Care among Primigravida Women: This section consists of 30 items to assess the knowledge of primigravida women on antenatal care. Coding sheet was prepared for data analysis. Data were analyzed by using descriptive and inferential statistics.

RESULTS

SECTION - I: Distribution of Primigravida Women according to their Socio- Demographic Variables

Table 1: Frequency and percentage distribution of primigravida women according to their Socio-demographic variables

N = 60

Socio–demographic variables	Experiment (f=35)		Comparison (f=25)		Total (f=60)		χ^2, df, p-value
Age (in years)	f	%	F	%	f	%	
21-22	9	25.7	10	40.0	19	31.7	1.683, 2, 0.431^{NS}
23-24	11	31.4	5	20.0	16	26.7	
25-26	**15**	**42.9**	**10**	**40.0**	**25**	**41.7**	
Religion							
Sikh	20	57.1	10	40.0	30	50.0	3.918, 2, 0.141^{NS}
Hindu	15	42.9	13	52.0	28	46.7	
Christian	0	0.0	2	8.0	2	3.3	
Education							
Primary	11	31.4	8	32.0	19	31.7	2.928, 2, 0.231^{NS}
Higher secondary	12	34.3	13	52.0	25	41.7	
Graduation	12	34.3	4	16.0	16	26.7	
Occupation							
Working	19	54.3	13	52.0	32	53.3	0.031, 1, 1.000^{NS}
Non-working	16	45.7	12	48.0	28	46.7	
Type of family							
Nuclear	16	45.7	15	60.0	31	51.7	1.192, 1, 0.306^{NS}
Joint	19	54.3	10	40.0	29	48.3	
Family income							
5 Rs. 5,000/-	15	42.9	8	32.0	23	38.3	2.828, 2, 0.243^{NS}
Rs. 5,001-15,000/-	17	48.6	11	44.0	28	**46.7**	
Rs.15,001-30,000/-	3	8.6	6	24.0	9	15.0	
Age at marriage							
520 years	1	2.9	2	8.0	3	5.0	1.515, 3, 0.679^{NS}
21-22 years	**18**	**51.4**	**13**	**52.0**	**31**	**51.7**	
23-24 years	12	34.3	6	24.0	18	30.0	
25-26 years	4	11.4	4	16.0	8	13.3	
Source of information							
Family members/Relatives	15	42.9	10	40.0	25	41.7	1.442, 3, 0.696^{NS}
Friends	3	8.6	4	16.0	7	11.7	
Neighbors	1	2.9	0	0.0	1	1.7	
Health personnel	**16**	**45.7**	**11**	**44.0**	**27**	**45.0**	

NS = Non significant

Table 1: shows that maximum primigravida women (41.7%) were in the age group of 25-26 years, 50% of them were Sikhs, 41.7% of them were higher secondary educated, 53.3% of them were working women, 51.7% of them were in nuclear family, 46.7% were had family monthly income of Rs.5001-15,000/-, 51.7% of them were married at the age of 21-22 years and their major source of information (45%) were health personnel.

SECTION - II: Table 2: Comparison of Pre-test and Post-test Level of Knowledge among Primigravida Women in Experimental and Comparison Group.

N=60

Level of Knowledge	Experimental				Comparison			
	Pre test		Post test		Pre test		Post test	
	f	%	f	%	f	%	f	%
Very poor	11	31.4	0	0.0	5	20.0	4	16.0
Poor	12	34.3	0	0.0	15	60.0	14	56.0
Average	12	34.3	2	5.7	5	20.0	7	28.0
Good	0	0.0	23	65.7	0	0.0	0	0.0
Very good	0	0.0	10	28.6	0	0.0	0	0.0

Maximum score=30

Minimum score= 0

Table - 2 denotes the comparison of level of knowledge on antenatal care by pre-test and post-test among primigravida women in Experimental and comparison group.

In Experimental group by pre-test, the primigravida women had poor level of knowledge (34.3%) and (34.3%) of the primigravida had average level of knowledge whereas remaining (31.4%) had very poor level of knowledge. None of the primigravida in the Experimental group had good and very good level of knowledge in pre-test. But in post-test, majority of primigravida (65.7%) had good level of knowledge, (28.6%) had very good level of knowledge whereas only 5.7% of them had average level of knowledge. None of the primigravida in the Experimental group had poor and very poor level of knowledge in post-test.

In comparison group by pre-test, maximum primigravida (60%) had poor level of knowledge while 20% of them had average level of knowledge and remaining (20%) had very poor level of knowledge. In post-test maximum primigravida (56%) had poor level of knowledge, 28% had average level of knowledge and remaining (16%) had very poor level of knowledge. None of the primigravida in the pre-test and post-test had good and very good level of knowledge. It was found that majority of primigravida in Experimental and comparison group had poor level of knowledge on antenatal care in pre-test but after administration of Self Instructional Module, maximum primigravida of Experimental group had good level of knowledge.

SECTION - III: Table - 3.1: Effectiveness of self instructional module on antenatal care among primigravida women by Paired't' test

N=60

Group	Pre-test		Post-test		Paired 't' test value, df, p-value
	Mean	SD	Mean	SD	
Experimental	10.0	4.7	21.8	2.7	**-13.423, 34, 0.000*** **
Comparison	9.2	3.5	10.1	3.8	**-1.006, 24, 0.324**

*** Significant

Maximum score=30

Minimum score= 0

Table 3.1 summarizes the paired't' test analysis of pre-test and post-test knowledge scores conducted on both Experimental and comparison group primigravida. The mean pre-test knowledge score of the Experimental group was less (10±4.7) whereas mean post-test knowledge score for the same group was high (21.8± 2.7). Whereas in comparison group, the mean pre-test knowledge score was less (9.2± 3.5) and mean post-test knowledge of same group was little high (10.1±3.8). Calculated paired 't' value ($t_{(24, 0.05)}$ = 1.006, 0.000) of comparison group shows that non significant at 0.05 level. In reverse calculated paired 't' value ($t_{(34, 0.05)}$ = 13.423, 0.000) of Experimental group shows highly significant at 0.05 level. Hence the research hypothesis was accepted. Thus, it can be concluded that self instructional module was an effective tool in improving the knowledge of primigravida women on antenatal care.

Table - 3.2: Effectiveness of self instructional module on antenatal care among primigravida women by unpaired't' test **N=60**

Study	Experimental		Comparison		Unpaired 't' test value, df, p-value
	Mean	SD	Mean	SD	
Pre-test	10.0	4.7	9.2	3.5	**0.744, 58, 0.460**
Post test	21.8	2.7	10.1	3.8	**13.894, 58, 0.000*** **

*** Significant

Maximum score=30
Minimum score= 0

Table - 3.2 reveals the unpaired 't' test analysis of pre-test and post-test knowledge scores of Experimental and comparison group. The mean pre-test knowledge score of Experimental group was (104.7) and the mean pre-test knowledge score of the comparison group was (9.23.5). The calculated unpaired 't' value of pretest between experimental & comparison group ($t_{(58,0.05)}$ =0.744, 0.460) was non significant at 0.05 level.

The mean post-test knowledge score of Experimental group was (21.82.7) and the mean post-test knowledge score of the comparison group was (10.1). The calculated unpaired 't' value of posttest between experimental & comparison group ($t_{(58,0.05)}$ = 13.894, 0.000) was highly significant at 0.05 level. Hence the research hypothesis was accepted. Thus, it was inferred that in pre-test, primigravida women of both the Experimental and comparison group were having same level of knowledge on antenatal care whereas in post-test, primigravida women of Experimental group had gained knowledge after the administration of self instructional module but the knowledge of primigravida women in comparison group remained the same.

SECTION – IV: Table - 4: Association between pre-test level of knowledge on antenatal care among primigravida women and age **N=60**

Socio-Demographic Variables	Pre-test knowledge level						χ^2	p-value	Inference
	Very poor		Poor		Average				
	f	%	f	%	f	%			
Age(in years)									
21-22	8	42.1	8	42.1	3	15.8	8.251	0.083	Non-significant
23-24	2	12.5	11	68.8	3	18.8			
25-26	5	20.0	10	40.0	10	40.0			
Religion									
Sikh	7	23.3	12	40.0	11	36.7	4.844	0.304	Non-significant
Hindu	8	28.6	15	53.6	5	17.9			
Christian	0	0.0	2	100.0	0	0.0			

Educational Status									
Primary	15	78.9	4	21.1	0	0.0	100.8	0.000***	Significant
Higher secondary	0	0.0	25	100.0	0	0.0			
Graduation	0	0.0	0	0.0	16	100.0			
Occupational Status									
Working	9	28.1	11	34.4	12	37.5	7.105	0.029*	Non - Significant
Non-working	7	25.0	18	64.3	3	10.7			
Family Monthly Income (Rs/-)									
55000	7	30.4	12	52.2	4	17.4	5.042	0.283	Non - significant
5001-15000	8	28.6	11	39.3	9	32.1			
15001-30000	0	0.0	6	66.7	3	33.3			
Type of Family									
Nuclear	7	22.6	16	51.6	8	25.8	0.311	0.856	Non - significant
Joint	8	27.6	13	44.8	8	27.6			
Age at marriage (in years)									
< 20	0	0.0	2	66.7	1	33.3	5.761	0.450	Non - significant
21-22	10	32.3	16	51.6	5	16.1			
23-24	4	22.2	8	44.4	6	33.3			
25-26	1	12.5	3	37.5	4	50.0			
Sources of Information									
Family members/ Relatives	7	28.0	10	40.0	8	32.0	6.617	0.358	Non - significant
Friends	1	14.3	3	42.9	3	42.9			
Neighbors	0	0.0	0	0.0	1	100.0			
Health personnel	7	25.9	16	59.3	4	14.8			

Table: 4 reveals that there is no association between pretest level of knowledge & the selected Socio-Demographic variable except with educational status

CONCLUSION

From the findings of present study following conclusions were drawn:

1. Primigravida women were having poor level of knowledge on antenatal care.
2. There was significant improvement in the level of knowledge of primigravida women after the administration of Self Instructional Module.
3. Self Instructional Module is one of the best methods of teaching to enhance the knowledge of primigravida women on antenatal care.
4. Educational status and occupation had an impact on the knowledge of primigravida women on antenatal care before the intervention.
5. Age, religion, type of family, family income, age at marriage and source of information had no influence on the knowledge of primigravida women on antenatal care before the intervention.

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A Study to Assess the Effectiveness of Music Therapy in Reducing the Level of Anxiety among Patients with Coronary Artery Disease Admitted in the Coronary Care Unit of Pushpagiri Heart Institute at Kerala

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ABSTRACT

Background: Anxiety has been correlated to the development of cardiac disease. Anxiety stimulates the sympathetic nervous system. It promotes the production of epinephrine and nor epinephrine. The stimulation increase the heart rates and intensifying the force of myocardial contraction. Therefore, the demand for oxygen greatly increases. Also, anxiety induced mechanisms can cause elevated lipid level and alteration in blood coagulation, which can lead to atherogenesis.

Method: The research approach and design adopted for the study was experimental design. The sample consists of patient with coronary artery disease admitted in coronary care unit. Convenience sampling technique was used. The data was collected using demographic profile, and modified Hamilton anxiety of the patient with coronary artery disease.

Results: Majority of the samples, both in experimental and control group, were having moderate anxiety level (90%) before administering the music therapy. The three main symptoms of anxiety among the experimental and control group before administering the music therapy were somatic muscular (60%,65%), somatic sensory (65%,75%) and insomnia (60%,45%). Majority of the samples in the experimental group (90%) were having mild anxiety level after administering the music therapy where as in control group only 35% of samples were having mild anxiety level. When comparing with control group the three main symptoms of anxiety had reduced in the experimental group after administering music therapy. They were insomnia, autonomic symptoms and anxious behavior of the patient during interview. The study findings revealed that 65% of samples had only mild autonomic symptoms, 80% of samples had only mild sleep disturbance and 90% samples had improvement in their anxious behavior during interview after administering the music therapy. The effectiveness of music therapy was statistically tested b paired't' value and the result were found to be significant at $p<0.001$ level. Thus the study findings support the hypothesis.

Conclusion: The result of the study revealed that music therapy is a simple, safe and effective method for reducing anxiety among the patient with coronary artery disease.

Keywords: *Anxiety, coronary artery disease, coronary care unit.*

INTRODUCTION

Coronary heart disease is a worldwide disease. Mortality varies widely in different parts of the world. An estimated 17 million people die of heart attack every year globally. Coronary artery disease is the leading cause of death in United States. According to the American heart association, someone on the United States suffer a coronary heart event approximately every 60 seconds.[1]

As Indians are adopting faulty lifestyle the

incidence of coronary artery disease is increasing day by day. In 1990, there were an estimated 1.17 million deaths from coronary artery disease in India, and the number is expected to almost double to 2.03 million by 2010.it is estimated that in Kerala atleast 38,000 people die of heart attack every year. Also every day about 110 people die of heart attack in Kerala.[2]

Anxiety is not directly observable, it is communicated through behavior. As nurses spend more time with the patient, they are able to identify the causes for anxiety in their patients. They will help them to set realistic goal to decrease the level of anxiety among the patient. Therefore anxiety reduction is identified as an important clinical objective for care giver.[3]

LITERATURE REVIEW

WHO (2002) estimated that 45 million patients of coronary artery disease are in India and one fifth of deaths has occurred due to coronary artery disease. By the year 2020, it will account for one third of all deaths.

In order to manage this dreadful disease, medical field has discovered many measures to keeping in pace with the modern technology.[2]

Many retrospective studies done on cardiac patient suggested that high risk of cardiovascular complications are from anxiety. **Frassure (2010**) conducted a study to identify the risk for ischemic complication resulting from anxiety. The result shows 2.5 fold increases in risk for ischemic complication from anxiety.

Woldecherkos, shilbeshi, young and blatt(2007) conducted a study on impact of anxiety on prognosis of patent with coronary artery disease in UK. The findings revels that, a high level of anxiety maintained after coronary artery disease diagnosis. Constitutes a strong risk of myocardial infarction and death among the patients with coronary artery disease ($p<0.002$).[4]

A quantitative study was conducted to assess the effects of music therapy on physiological and psychological outcomes among patients with coronary artery disease in Northwestern hospital, USA. A total of 86 patients were selected for the study, assigning 43 samples in two groups.

An audio taped instrumental music was given as an intervention for 20 minutes for the first group and other diversions for the second group. Results showed that there was a significant reduction in pain and anxiety level of patients in the first group than the second group.[5]

Guzzetta (2010), did a study on effectiveness of relaxation and music therapy on stress and anxiety of presumptive acute myocardial infarction patient admitted in coronary care unit. The finding shows that, the anxiety level and incidence of cardiac complication was found to be lower among in patient who receives music therapy.[8]

Nurses need empirically tested anxiety relieving methods that is simple and rapid in action. Music therapy is found to decrease pain by reducing anxiety and muscle tension.

Statement of the problem: A study to assess the effectiveness of music therapy in reducing the level of anxiety among the patients with coronary artery disease admitted in coronary care unit of pushpagiri heart institute at Kerala.

OBJECTIVES

- To assess the level of anxiety among patient with coronary artery disease.
- To evaluate the effectiveness of music therapy on anxiety among the patient with coronary artery disease.
- To associate the level of anxiety with selected variables like age and duration of illness.

Hypothesis: There is a significant reduction in the level of anxiety after administering music therapy when compared with the level of anxiety before administering music therapy.

METHODOLOGY

The research approach and design adopted for the study was experimental approach. The sample consists of patient diagnosed as coronary artery disease. Convenient sampling technique was used to select the sample of 40 patients with coronary artery disease. The data was collected using demographic profile, modified Hamilton anxiety rating scale to assess the level of anxiety among coronary artery

disease patients. The scale consists of twenty questions, with a maximum core of 3 and minimum of 1. The total score is 60. Those who scored between 0-20 are considered to have mild anxiety, between 21- 40 have moderate anxiety, and 41-60 have severe anxiety.

DESCRIPTION OF THE INTERVENTION

Violin based instrumental music was selected for therapy. Anandha bhiravi raga was used to reduce anxiety. The article named: 'the miracle of music therapy' published in indiamike.com says that the ANANDHA BHIRAVI in cardiac music is supposed to be very effective in reducing anxiety and blood pressure.

Samples were selected on the second day of CCU admission. In each session music therapy was given for 30 minutes. Two sessions of music therapy was administered daily for two consecutive days through headphones for the client.

FINDINGS

1. Majority of the samples both in experimental and control group were having moderate anxiety (90%) before administering music therapy.

2. The three main symptoms of anxiety among experimental and control group before administering music therapy were somatic muscular (65%, 65%).somatic sensory (65%, 75%) and insomnia (60%, 45%).

3. Majority of the samples in the experimental group (90%) were having mild anxiety after administering music therapy where as in control group only 35% of samples were having mild anxiety.

4. Comparing with control group the three main symptoms of anxiety had reduced among experimental group after administering music therapy they were autonomic symptoms, insomnia and anxious behavior. The study finding reveals that 65% of samples had only mild autonomic symptoms, 80% of samples had only mild sleep pattern disturbances and 90% samples had anxiety after administering music therapy.

5. The effectiveness of music therapy was statistically tested by paired't' value and the results were found to be significant at $p<0.001$ level. Thus the study findings support the hypothesis.

6. There was no significant association of anxiety with age and duration of illness.

Section I Demographic variables

Table 1: Distribution of demographic variable among experimental and control group

N=40

Sl.no	variable		Experimental group		Control group		Chi square test	P value
			no	**percentage**	**No**	**percentage**		
1	**Age**	31-40	2	10	1	5	3.178	0.365
		41-50	1	5	1	5		
		51-60	5	25	8	40		
		61-70	6	30	8	40		
		>70	6	30	2	10		
2	**Religion**	Hindu	9	45	6	30	0.960	0.327
		Christian	11	55	13	65		
		Muslim	0	0	1	5		
		Others	-	-	-	-		
3	**Place of residence**	Rural	2	10	4	20	0.784	0.376
		Semi urban	18	90	16	80		
		Urban	-	-	-	-		

4	**education**	Illiterate	1	5	0	0	0.418	0.811
		Primary school	4	20	6	30		
		Secondary school	6	30	7	35		
		Higher secondary	3	15	6	30		
		Others	6	30	1	5		
5	**Marital status**	Single	-	-	-	-	0.229	0.633
		Married	18	90	17	85		
		Widow	2	10	3	15		
6	**Type of work**	Sedentary worker	1	5	0	0	-	-
		Moderate worker	16	80	17	85		
		Heavy worker	3	15	3	15		
7	**Duration of illness**	<1 yr	8	40	8	40	0.667	0.717
		1-2 yr	5	25	7	35		
		3-4 yr	30	0	3	15		
		>4 yr	7	35	2	10		

Section II: Table 2: Distribution of level of anxiety among experimental and control group before administering music therapy

N=40

Anxiety level	**Experimental group**		**Control group**	
	number	**percentage**	**Number**	
Mild anxiety (0-20)	1	5	2	10
Moderate anxiety (21-40)	18	90	18	90
Severe anxiety (41-60)	1	5	-	-

Table 2 shows that with regard to anxiety level majority of samples both in experimental and control group (90%) were having moderate anxiety before administering the music therapy.

Table 3: Distribution of level of anxiety after administering music therapy **N=40**

Anxiety level	Experimental group		Control group	
	number	percentage	Number	Percentage
Mild anxiety (0-20)	18	90	7	35
Moderate anxiety (21-40)	2	10	13	65
Severe anxiety (41-60)	-	-	-	-

Table 3 shows that majority of the samples in the experimental group (90%) were having mild anxiety after administering music therapy whereas in the control group only (35%) of samples were having mild anxiety. It shows that there was an improvement in the level of anxiety among the experimental group after administering the music therapy.

Table 4: Comparison of mean standard deviation of changes between pre and post anxiety score according to various symptoms among experimental and control group

N=40

Sl no	variable	Experimental group		Control group		't' value	'p' value
		mean	Standard deviation	mean	Standard deviation		
1	Autonomic symptoms	1.90	1.17	1.05	1.19	2.28	0.028*
2	Somatic muscular	0.40	0.75	0.70	0.97	-1.086	0.285
3	Somatic sensory	1.0	1.21	1.05	0.99	-0.142	0.888
4	Insomnia	2.90	2.55	1.0	2.0	2.62	0.013*
5	Cardiovascular symptoms	2.80	1.96	1.90	2.40	1.297	0.203
6	Respiratory symptoms	1.25	1.68	0.50	1.82	1.353	0.184
7	Gastro intestinal symptoms	0.20	0.89	0.85	2.68	-1.029	0.314
8	Genitor urinary symptoms	0.30	1.30	0.15	0.67	0.458	0.650
9	Behavior at interview	3.0	1.94	1.35	1.81	2.773	0.009*

Table 4 shows that music therapy was effective in reducing the autonomic symptoms, insomnia and anxious behavior. It was statistically tested by paired't' test and the result were found to be significant at ($p<0.05$).

Table 5: Comparison of mean, standard deviation of changes between pre and post anxiety score among experimental and control group

variable	Experimental group		Control group		't 'value	'p' value
	mean	Standard deviation	mean	Standard deviation		
Anxiety level	15	5.02	9.05	6.79	3.628	0.001*

Table 5 shows that music therapy was an effective method in reducing anxiety. It was statistically tested by paired't' test and the result were found to be significant at (p.0.001).

Table 6: Association of pre test level of anxiety among patient with coronary artery disease with age and duration of illness

Sl. no.	variable		mean	Standard deviation	Kruskal Wallis test	'p' value
1	**Age**	31-40	29.667	5.508	2.869	0.580 (NS)
		41-50	25.500	2.121		
		51-60	30.231	6.821		
		61-70	29.667	5.508		
		>70	27.750	5.825		
2	**Duration of illness**	< 1yr	28.188	5.947	2.259	0.521 (NS)
		1-2 yrs	27.333	6.800		
		2-3 yrs	32.000	3.464		
		>3 yrs	28.667	4.873		

Table 6 shows that mean and standard deviation of anxiety score depending on variables like age, and duration of illness. The Kruskal Wallis test was applied to find out the association between anxiety score and these variables. The test revealed that there was no association between anxiety score with age and duration of illness.

CONCLUSION

The study assessed the anxiety level among the patients with coronary artery disease admitted in the coronary care unit and found that samples in the experimental and control group were having moderate anxiety. After giving music therapy to experimental group there was significant reduction of anxiety when compared the control group. The study revealed that music therapy was effective in reducing anxiety among patients with coronary artery disease admitted in coronary care unit.

Acknowledgement : We express our gratitude to the authorities in pushpagiri hospital who provided the permission to conduct the study.

Conflict of Interest: Anxiety is a feeling of apprehension, which can be commonly noticed among cardiac patients. Formalized way of musical interventions will enhance the emotional, physical, spiritual health and wellbeing of the people. Nurse should aware about the patient anxious state and provide the music therapy thereby it allows the patient to relax and reducing both sensory and affective components.

Ethical Clearance: Ethical clearance was obtained from the human ethical committee of the hospital.

Funding Sources: Not obtained any funds from any sources.

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Relapse in Psychosis

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ABSTRACT

Relapse—including symptom exacerbations and a deterioration in functioning that often requires hospitalization—can be demoralizing for persons with a severe mental illness like psychosis. Relapses can interfere with independent living, work, and community adjustment; therefore, minimizing relapses is a common treatment goal. [1]In fact, for many years the primary goal of treatment for these disorders was the prevention of relapses and the successful maintenance of a stable clinical state. Although relapse prevention continues to be an important focus of treatment, stable clinical functioning is no longer a sufficient long-term treatment goal. Patients with major mental illnesses can achieve much more than just a stable clinical state; they can continue to grow as individuals and lead rewarding, productive, and meaningful lives, despite experiencing some symptoms or impairments, if proper relapse prevention guidelines are implemented.

Keywords: *Relapse, psychosis, mental illness & relapse prevention guidelines.*

PSYCHOTIC RELAPSE

[2]A reoccurrence of psychosis is called a "relapse". Unfortunately, many people who have had a first episode of psychosis will experience a relapse in the future. Psychotic relapses are very distressing and disruptive. [3]Psychotic Relapse may be defined as "the re-emergence of psychotic symptoms and disruptive behaviours, can lead to hospitalisation, arrest and incarceration, cognitive impairment due to progressive structural brain damage and the development of treatment resistance".

THE PROCESS OF PSYCHOTIC RELAPSE [5]

It is obvious that psychosis develops very gradually. It is been demonstrated that, in

a large majority of the patients the phase preceding the onset of a psychosis – also called the prodromal phase - can last for several days, weeks or even months. This is an interesting observation in terms of prevention.

The baseline indicates the level of symptoms, which a psychotic patient experiences on a more or less permanent basis. This level can differ considerably from patient to patient. After having a psychosis, one patient can be more or less free of symptoms, while another patient can be constantly plagued by persisting symptoms.

If symptoms increase slightly, relative to the baseline, many patients alter their behaviour in such a way as to ensure that the symptoms decrease or do not affect them so much. In the event that the symptoms get worse, the patient's ability to cope will not be sufficient and external intervention will be necessary. If intervention is made in the initial stage, it is known as 'early intervention'. If such early intervention is carried out effectively, it may encourage recovery, thus bringing the course of the illness back in the direction of the baseline. If the seriousness of the symptoms increases further, the result will be a

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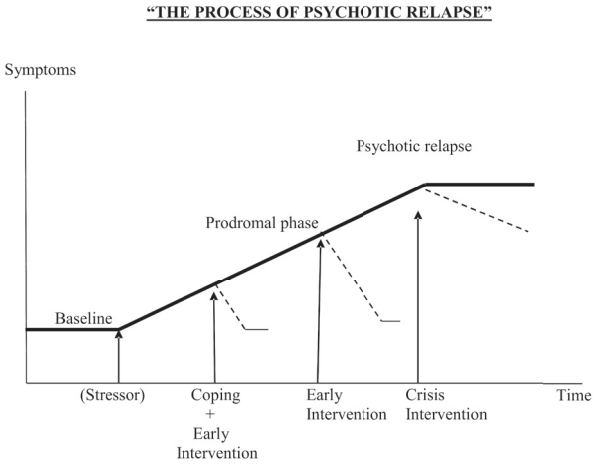
psychotic crisis at some stage. In that case, it will be necessary to resort will be a psychotic crisis at some stage. It will be necessary to initiate interventions in the form of crisis management in order to deal with the crisis related to psychotic relapse.

Strictly speaking, the changes at the beginning of the upward line cannot yet be regarded as symptoms. The symptoms are, for the most part, non-specific signs, which also frequently appear in the normal population. The fact that they appear in the phase preceding the onset of a psychosis makes them significant from a clinical point of view. In terms of semantics, it would be better to call them 'early signs'.

THE PROCESS OF PSYCHOTIC RELAPSE

Intervention



With a view to provide clarity, the various terms used to denote the process of psychotic relapse are defined as follows,

- **The prodromal phase** of psychosis is understood to mean the period lasting (mostly) between a few days and weeks prior to a psychotic relapse.
- **Early signs (prodromes)** indicate changes in the perception, thought and/or behaviour of the patient. These signs appear in the prodromal phase of a psychosis and are, therefore, valuable tools for predicting a psychotic relapse.
- **Early recognition** refers to the efforts that are made to recognise the early signs of a psychosis at the earliest stage possible.
- **Early intervention** means that when the early signs of a psychosis become apparent, specific action is taken to prevent a serious psychotic crisis from developing. The aim of such action is to encourage the patient's balance to recover.

EARLY WARNING SIGNS OF PSYCHOTIC RELAPSE[2, 3]

Prior to relapse there are often changes in behaviour, thoughts or feelings. These changes may be similar to the changes the patient experienced before the first episode or they might be different. These symptoms are referred to as "early warning signs" and may indicate that a relapse is about to occur. Prior to a relapse a person may experience:

- Brief or mild "psychotic-like symptoms" such as brief or poorly formed hallucinations, suspiciousness and mental confusion. and/or
- "Non-specific symptoms" – these are symptoms that do not resemble psychotic symptoms themselves and include disturbances of sleep, anxiety, difficulties concentrating and depression.
- Feeling more tense, nervous or irritable than usual
- Feeling less able to concentrate or pay attention
- Needing more time alone, and withdrawing from people he or she usually feels comfortable around
- Increased sensitivity to light or sounds
- Poor sleep (increased or decreased), which is often accompanied by vivid, frightening nightmares

Warning signs may be the result of being under stress (remember that according to the stress vulnerability model, stress increases the risk of psychosis developing). In many cases, the use of effective stress management strategies will reduce these warning signs. Sometimes, stress management strategies will not be sufficient and other strategies (such as increasing medication dose) might be needed.

FACTORS ASSOCIATED WITH PSYCHOTIC RELAPSE[4]

The following are the various factors associated with psychotic relapse.

I. Non-compliance

II. Substance use and abuse

III. Co-morbid psychiatric disorders

IV. Suicidal ideation

V. Stressful life events

VI. Co-morbid medical and/ or surgical condition

I. NON-COMPLIANCE [6]

Studies on health behaviour have interchangeably used others words adherence, therapeutic alliance, collaboration) in lieu of compliance.

Compliance implies *"an obligation on the part of the patient to blindly follow the practitioner's instructions"*, while adherence requires *"the patient's agreement"*.

The World Health Organization also emphasises the differentiation of adherence from compliance. **Patient compliance** is defined as *"the extent to which a person's behaviour coincides with the medical prescription and recommendations"*. Compliance is a complex parameter and remains difficult to measure accurately. Its assessment is necessary for effective treatment planning.

Approximately 40- 50% of patients with psychosis are not compliant to anti- psychotic medication. In general, about a third of all patients comply with treatment, a third sometimes comply with treatment, and a third never comply with treatment. [3]The DSM IV TR includes "non-compliance" as a condition that may be a focus of clinical attention and when the problem is sufficiently severe to warrant independent clinical attention. Non compliance to psychotropic medication leads to relapse and re-hospitalization and may be the cause of "revolving door" phenomenon.

Non-compliance includes:

- Failure to attend clinics
- Refusal to enter the hospital
- Failure to begin a treatment program
- Premature cessation of treatment and
- Incomplete performance of instructions

The reasons for non-compliance may include:

- Discomfort resulting from treatment (e.g. medication side effects)
- Cost of treatment
- Decisions based on personal value, judgment, religious or cultural beliefs about the
- Advantages and disadvantages of the proposed treatment
- Maladaptive personality traits or coping styles (e.g. denial of illness)
- The presence of a mental disorder (e.g. Schizophrenia, Avoidant Personality Disorder).

With specific reference to medication, non-compliance could take a form of:

- Failure to fill a prescription
- Refusal to take medication
- Stopping treatment prematurely
- Taking medications at wrong times and
- Incorrect dosage of medications.

II. SUBSTANCE USE AND ABUSE [12]

The course of psychosis is frequently complicated by substance use and abuse. They are more likely to have a poorer course, exacerbation of psychotic symptoms, treatment non-compliance and increased psychosocial problems (e.g. homelessness). Substance abuse is common in patients with psychosis and commonly abused substances include nicotine, alcohol, cannabis, and cocaine. The lifetime prevalence of substance abuse among patients with psychosis is estimated to be as high as 47% with approximately 33% suffering from alcoholism.

III. CO-MORBID PSYCHIATRIC DISORDERS

Patients with an established history of psychosis and the related disorders have higher relapse rates than more recently diagnosed patients. [7]Mood disorders are distinct from psychosis, yet depressive signs and symptoms are evident during the course of psychosis. Depressive symptoms do not always

fulfil the criteria for a co-morbid disorder. Studies on depression associated with psychosis show a variation ranging from a high of 75% to a low of 7%. Depression may occur in the different phases of the disorder viz. prodromal, psychotic phase and post-psychotic phase. [11]Adjustment disorder with depressed mood, minor depressive episodes and major depressive disorder have also been described in people with psychosis.

IV. SUICIDAL IDEATION

The risk of suicide remains high in patients with psychosis. [13]Approximately 10 to 13% succeeds in ending their life and 18 to 55% make at least one suicide attempt. 2 to 12% of all individuals dying by suicide have an episode of psychosis.

V. STRESSFUL LIFE EVENTS

[9]There is evidence of a relationship between life events and the onset of a psychotic relapse usually in the three weeks prior to the relapse. Life events include both internal events (e.g. thoughts and feelings) and external events (e.g. death of a relative). Other stressors include chronic interpersonal stress, poverty, and homelessness, criminal victimization and stigma. There is also evidence that patients with schizophrenia are more sensitive and more susceptible to negative effects of even minor stressors. Thus, any life change should be considered as a major stressor. [8]Adverse life events and a stressful social milieu play a role in determining the course of illness in general and relapse in particular. Dysfunction within prefrontal & sub cortical connections can mediate the susceptibility to stress-induced exacerbation of the symptoms of psychosis.

VI. CO-MORBID MEDICAL AND/ OR SURGICAL CONDITION

[7]Up to 80% percent of all patients with psychosis have co-morbid medical illnesses. People tend to focus on treating the medical condition rather than the mental disorder. Drug interactions can also contribute to inadequate dosage of medications. The exacerbation of co-existing medical illness (e.g. hyperglycaemia from diabetes) can worsen psychotic symptoms. Surgery is also a major stressor which can contribute to relapse.

VII. DURATION OF UNTREATED PSYCHOSIS

This is another important predictor of relapse. The duration of active psychotic symptoms may have an influence on long term outcome and relapse. [13]Longer duration of symptoms prior the initial treatment was significantly associated with poor neuroleptic response and frequent relapse.

PREVENTION OF PSYCHOTIC RELAPSE

Preventing relapse in patients suffering from psychosis should be given high priority in treatment programmes. [10]Optimal treatment presupposes a strategy based on a combination of anti-psychotic medication and psychosocial interventions. In the past few years there has been a growing emphasis on prevent psychotic relapses by recognising the warning signs (prodromes) signalling the onset of a psychosis at an early stage. When warning signs are detected early, measure can be taken to restore the balance in a patient. Given the prolonged and intensive care provided to psychotic patients by the psychiatric nurses, it seems appropriate to allocate special responsibilities in this field to nurses.

CONCLUSION

The primary treatment goal for patients with psychosis is symptom remission and an improved quality of life. The relapse prevention plans, guidelines and psychiatric rehabilitation has been shown to be effective in improving symptomatic and functional outcomes by teaching relapse prevention skills to patients and their caregivers. Relapse prevention strategies are most effective when they are provided in the context of a therapeutic relationship that is aimed at helping patients achieve personally valued goals. The patient's motivation to achieve the set goals can be harnessed to reduce vulnerability to relapses. Therefore, the relapse prevention approaches can indirectly reduce vulnerability to relapses by improving areas of functioning such as interpersonal relationships, long-term competitive employment, burden of psychotic symptoms, and cognitive functioning.

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Level of Motivation and Motivational Factors of Alcohol Dependents Towards De-addiction

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ABSTRACT

Background: Alcoholism is a major health problem and it is prevalent in all community, and it is common in all people irrespective of social status. The current approach is that alcoholism is to be understood in terms of character and motivation. It has been regarded as an important factor in treatment. Lack of proper motivation has been used to explain the failure to enter, continue, comply and succeed with treatment especially in alcoholism.

Methods: The descriptive survey method was used**.** Convenience sampling technique was used to obtain 50 alcohol dependents attending the Nalanda de-addiction clinic. Data was collected by using Modified University Rhode Island Change Assessment (URICA) Scale & Structured questionnaire to assess the motivational factors.

Results: The results showed that majority (92%) of alcohol dependents had higher level of motivation. Regarding the motivational factors, the results revealed that parent, spouse Alcoholic Anonymous group and personal factors.

Conclusion: The study concluded that majority of the alcohol dependents had high level of motivation, so they may continue the treatment and move on to maintenance stage.

Keywords*: Motivation; de-addiction; alcohol dependents.*

INTRODUCTION

Alcoholism is characterized by the repeated drinking of alcoholic beverages to an extend that exceeds customary use or compliance with the social customs of the community and that adversely affects the drinker's health or interferes with his social or economic functioning.[1]

In India 15 to 20% of the people take alcohol. Over the past 20 years, the number of drinkers in our country has increased from one in 300 to one in 20. The production & sale of liquor in the whole country has increased almost 20 times. Alcoholism is the third largest health problem in India besides heart disease & cancer.[2]

A variety of treatments are delivered within the context of alcoholism services, depending on the resources and needs of clients and the specific training or orientation to the staff. The treatment includes detoxification, use of deterrent agent and psychosocial therapies like individual, group & behavior therapies.[3]

The current approach is that alcoholism is to be understood in terms of character and motivation. It has been regarded as an important factor in treatment. Lack of proper motivation has been used to explain the failure to enter, continue, comply and succeed with treatment especially in clinical condition like alcoholism.[4]

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Motivational approaches are brief treatment approaches designed to produce rapid, internally motivate change in addictive behavior. People who seek assessment for alcohol use disorder often do so at the prompting of significant others such as family members, friends, coworkers or treating clinicians who are concerned about the persons well being. The involvement of significant others as both collateral and social supports can have either positive or negative effect on the alcohol dependent individuals initiation of and retention in treatment. Because significant others may be a powerful influence in the person's life.[5]

Relapse prevention is an essential component of mental health nursing, to obtain life long sobriety among alcohol dependents the person has to be motivated enough. It is believed that various factors external to the alcoholics contribute to his motivation to change [6, 7]. In essence, motivation was something that client brought to the treatment setting and the nurses can help clients by starting from client's level of motivation.

OBJECTIVES

1. To assess the level of motivation of alcohol dependents towards de-addiction.
2. To identify the motivational factors of alcohol dependents towards de-addiction.
3. To associate the level of motivation with selected motivating factors.

METHODOLOGY

Descriptive survey design was adopted for the study. The study was conducted in the Nalanda De-addiction centre Erode. Convenience sampling technique was used to obtain a sample of 50 alcohol dependents attending the selected de- addiction center. Data were collected by using Modified University Rhode Island Change Assessment (URICA) scale (**DiClemente & Hughes, 1983)**[8] and a structured questionnaire. URICA scale was used to assess the level of motivation towards de-addiction. It consisted of 15 items and measures in five points that is strongly agree, agree, undecided, disagree, strongly disagree and scores given was 1,2,3,4,5 respectively. The score ranged from 15-75. A structured questionnaire was developed to identify the motivational factors under 3 headings such as family (6 items), media (4 items), and personal factors (14 items).

FINDINGS

Table 1: Subjects' level of motivation towards de-addiction (n=50)

Level of motivation	Score Interval	f	%
Low	15-35 (20 – 47 %)	-	-
Moderate	36 – 55 (48 – 73%)	4	8
High	56 – 75 (74 – 100%)	46	92

Data presented in Table 1 shows that majority 46(92%) of alcohol dependents were having high level of motivation and the remaining 4(8%) of them were having moderate level of motivation towards de-addiction.

Table 2: Motivational factors of study subjects towards de-addiction (n = 50)

Factors	Frequency	%
Family		
Parents	27	54
Spouse	23	46
Children	15	30
Siblings	17	34
Friends	19	38
Any others	8	16
Media factors		
Articles from newspaper, magazine/pamphlets	5	10
TV shows	3	6
Health education by health care providers	6	12
Alcoholic anonymous group	13	6

Data presented in Table 2 shows the distribution of subjects in relation to family & media as a motivational factor. Majority 27(54%) of alcohol dependents those who came for de-addiction because of their parents influence, followed by spouse 23(46%) and friends 19(38%). With regard to media factors Majority 13(26%) of alcohol dependents those who came for de-addiction are motivated by alcoholic anonymous group, 6(12%) of them were motivated by health education by the health personnel and remaining 10% & 6% were motivated by articles from newspaper, magazine/pamphlets & TV shows.

Table 3: Distribution of subjects in relation to personal reasons as a motivational factor

n = 50

Personal factors	Frequency	%
Need		
Need for achievement	47	94
Need for love & affection	47	94
Maintain a social status	48	96
Fear		
Fear of future	43	86
Social isolation	32	64
Fear of losing job	33	66
Incurring debt	35	70
Withdrawal symptoms	35	70
Fear of injuries	34	68
Fear of complications	34	68
Fear of death	26	52
Feeling		
Self realization	48	96
Depression	33	66
Guilty feeling	44	88

Data presented in Table 3 shows the distribution of sample in relation to personal reasons as a motivational factor. The personal factors were categorized as need, fear and feeling.

Need factor: Majority 48(96%) of alcohol dependents those who came for de-addiction because of their need to main social status, followed by 47(94%) of them were influenced by their need for achievement in life & need for love & affection.

Fear: The maximum 43(86%) alcohol dependents came due to their fear of future followed by fear of incurring debt & withdrawal symptoms 35(70%).

Feeling: The maximum 48(96%) alcohol dependents came for de-addiction as they realized the need to get rid of problem and 44(88%) of them came because of their guilty feeling.

Table 4: Association of level of motivation with selected motivational factors (n=50)

Factors	Level of motivation		Chi-square value	df	Level of significance At 0.05 level
	High	Moderate			
Family					
Parents					
Yes					
No	24	3	**0.772**#	1	NS
Spouse	22	1			
Yes	21	2			
	25	2	**0.028**#	1	NS
No	19	-			
Friends	25	2	**2.665**#	1	NS
Yes					
No					
Media					
Alcoholic Anonymous					
Yes	11	2	**1.302**#	1	NS
	35	2			
No					
Personal reasons					
Self realization					
Yes					
No					
Social isolation					
Yes	44	4	**0.181**#	1	NS
	2	-			
No	30	2	**0.370**#	1	NS
Fear of injuries	16	2			
Yes	33	1	**0.694**#	1	NS
	13	3			
No	42	2	**5.945**#	1	S
Guilty feeling	4	2			
Yes	26	-	**4.710**#	1	S
	20	4			
No					
Fear of death					
Yes					
No					

NS =Not Significant p> 0.05, S=Significant p<0.05, $df_{(1)}$ =3.84 # = Yates corrected

Data presented in Table 4 indicate the association of level of motivation with selected motivational factors. The results of Chi square test showed that there is a significant association between level of motivation and guilty feeling, fear of death of alcohol dependents at $p<0.05$ level. Further the association results showed that there is no association found for family and media factors.

CONCLUSION

Entering and engaging in alcohol treatment involves a series of decisions. Motivation is the crucial aspect in starting the treatment and the personal factors are the major force in motivating the alcohol dependents towards de-addiction. In addition to personal motivation, supports from significant members are also necessary to maintain their level of motivation which in turn influences the outcome of treatment.

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Ethical Clearance: Ethical clearance was obtained from institutional ethical committee (Meenakshi college of Nursing).

Conflict of Interest: Nil

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Knowledge and Attitude Regarding Euthanasia among Selected Population in Thiruvananthapuram, Kerala

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ABSTRACT

Euthanasia is a term embroiled in controversy across the world. This study aimed to assess the knowledge and attitude towards euthanasia among urban population of Thiruvananthapuram district. A convenience sample of 50 was included for the study. Data were collected by cross sectional design. Knowledge and attitude was assessed using structured self report questionnaire. Results revealed that 50% of the subjects had good knowledge about euthanasia and 68% had positive attitude towards euthanasia. The study has got implication in health care practice that representatives of the general public should be included to formulate relevant policies related to euthanasia

Keywords: *Euthanasia*

INDRODUCTION

Euthanasia is a term embroiled in controversy wide across the world. The word Euthanasia is derived from Greek word 'eu' and 'thanatos' literally meaning 'gentle death. However in modern usage, it has assumed a different meaning. It has come to mean the painless killing of men and women to end their suffering and is often referred to as mercy killing. Euthanasia became legal on Ist April 2002 in Netherlands.[1]

In India, euthanasia is a crime. Section 309 of the Indian Penal Code (IPC) deals with the attempt to commit suicide and Section 306 of the IPC deals with abetment of suicide - both actions are punishable. Only those who are brain dead can be taken off life support with the help of family members. Likewise, the Honorable Supreme Court is also of the view that the right to life guaranteed by Article 21 of the constitution does not include the right to die. The court held that Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can extinction of life be read into it. However, various pro-euthanasia organizations, the most prominent among them being the Death with Dignity Foundation, keep on fighting for legalization of an individual's right to choose his own death. Passive euthanasia is legal in India. On 7 March 2011 the Supreme Court of India legalised passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state.[2]

Elsewhere in the world active euthanasia is almost always illegal.[2] The legal status of passive euthanasia, on the other hand, including the withdrawal of nutrition or water, varies across the nations of the world. As India had no law about euthanasia, the Supreme Court's guidelines are law until and unless Parliament passes legislation. India's Minister of Law and Justice, Veerappa Moily, called for serious political debate over the issue. The following guidelines were laid down[4]:

1. A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.
2. Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support,

such a decision requires approval from the High Court concerned.

3. When such an application is filled the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. A committee of three reputed doctors to be nominated by the Bench, who will give report regarding the condition of the patient. Before giving the verdict a notice regarding the report should be given to the close relatives and the State. After hearing the parties, the High Court can give its verdict.

Various surveys have demonstrated high rates of public support for legalization of physician assisted suicide (PAS) as well as relatively significant rates of endorsement and even performance of PAS among medical professionals. The proposed guidelines offered to date have all suggested that psychiatric evaluation must comprise critical components of any assessment of a patient's request for PAS. Clearly, if PAS is legalized, mental health professionals must play an important role in the evaluation of patients at the end of life who request PAS. Despite the apparent importance of a mental professional's evaluation in assessing requests for PAS, little research has been conducted that has focused on the basis for patients' interest in hastened death. A recent study found that patients with 'high wish for hastened death' had, according to the authors, greater 'concerns' with symptoms and suffering, and perceived themselves to be a burden.[2]

Multiple public and professional opinion polls confirm that popularity for euthanasia is growing steadily in the developed countries and issue of terminally ill people to have access to legally assisted death is gaining acceptance globally. A national opinion poll carried out by voluntary euthanasia society in 1993 in United Kingdom showed that 79% of the population believed mercy killing should be a legal choice.[5] Euthanasia provokes controversies in various domains, such as the moral, ethical, legal, religious, scientific, and economic. Currently, there are only a few studies published on euthanasia definitions among health professionals and no studies among the lay public are available in Indian literature. There is a need for finding out if people have knowledge and favourable attitude towards Euthanasia and what kind of preferences they would choose for themselves and for their family members in the event of terminal illness which is not curable happening to them.

Objectives of study were

- to assess the knowledge of urban public about Euthanasia.
- to find out attitude of urban public towards Euthanasia
- to identify relationship between knowledge and attitude of subjects with their demographic variables.

MATERIAL AND METHOD

Study sample constituted 50 adults in urban area of Thiruvananthapuram District. A convenience sampling method was adopted for the study. Inclusion criteria for the study were adults who were above 21 years of age, subjects who can read and write malayalam and who were willing to participate in the study.

A structured questionnaire of 24 items was developed to collect demographic details, knowledge and attitude of subjects. Contents validity of the tool was done by giving the questionnaire to experts and appropriate modifications were made. The reliability of the tool is established through test - retest method and is found to be 0.8. .

Ethical clearance is obtained from appropriately constituted ethics committee. An informed consent is obtained from all subjects and brief introduction was given to all respondents who have never heard of the term Euthanasia before they responded to the questionnaire.

Data was analyzed using SPSS 16 version. Appropriate descriptive and inferential statistics were used for the study.

FINDINGS

Mean age of the students was 37 years. 58% were males, majority belonged to Hindu religion and 44% of them were graduates and majority of them were employed.

Table I Characteristics of the sample.

	Frequency	%
Age in year	37.3 (6.9)	
Gender		
Male	29	58%
Female	21	42%
Religion		
Hindus	44	88%
Christians	5	10%
Muslims	1	2%
Education		
10+2	11	22%
Graduation	22	44%
PG	17	34%
Occupation		
Business	6	12%
Employed	34	68%
Unemployed	10	20%

50% of the subjects had 'good' knowledge, 40% of the subjects had 'fair' knowledge and 8% of the subjects had 'poor' knowledge about euthanasia. Fig1 highlights that 68% of the subjects had positive attitude towards euthanasia and 32% had negative attitude towards euthanasia.

Table 2 highlights that 48% had seen and 52% had not seen terminally ill patients prior to this study. A little over half of the subjects believe in right of the person to die and 44% do not believe in it. 8% of the subjects had the experience of asking the physician for hastening the death of their terminally ill relatives and 92% of the subjects do not have such experiences.

Table 2 Experience of subjects related to euthanasia

	Frequency	%
Subjects who had occasion to see any terminally ill patient		
Yes	24	48
no	26	52
Subjects who have heard about euthanasia		
Yes	35	70
no	15	30
Believe in right of the person to die		
Yes	28	56
no	22	44
Subjects who have asked for hastening death of their ill relatives		
Yes	4	8
No	46	92

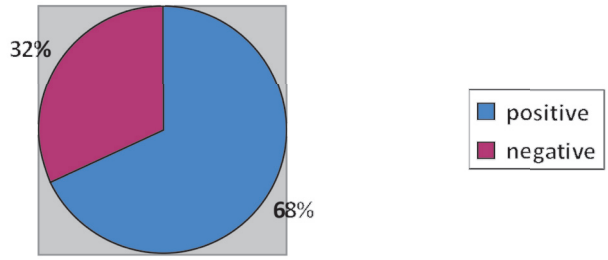

Fig1. Attitude towards euthanasia

There was no significant statistical relationship found between knowledge about Euthanasia and gender, age, educational status, religion and occupation. There was no association found between attitude towards euthanasia and gender, religion, age and occupation. There was positive correlation of knowledge with attitude of subjects but not statistically significant.

Table 3. Opinion of general public about Euthanasia

	Opinion	Yes	No	Not sure
1	Euthanasia is ethical if legalised by law	54%	32%	14%
2	Euthanasia is a sin	42%	38%	20%
3	In an event of terminal illness, would you wish to receive assistance in dying for yourself	52%	26%	22%
4	Would you like Euthanasia to be carried out for you close relative who is terminally ill?	48%	28%	24%
5	According to you, the request for Euthanasia should be granted	46%	38%	16%

54% of subjects was of opinion that euthanasia is ethical if legalised by law. 42% believe that it is a sin. 52% would wish to receive assistance in dying in case of terminal illness. 48% would like euthanasia to be carried out for close relative who is terminally ill. 46% believe that if a request for euthanasia is made, it should be granted.

DISCUSSION

End of life health care assistance for patients with terminal illness and its related ethical aspects are topics of increasing relevance both in medical and social milieus. This study aimed to assess the knowledge and attitude regarding euthanasia among general public. The present study revealed that 50% of the subjects had good knowledge. It may be due to the fact that 78% of the sample were graduates and above. In a study reported from Brazil, only 25% of caregivers knew the precise definition of euthanasia and only 22.5% of lay public were in favour of euthanasia.[6]

In the present study 68% had positive attitude towards euthanasia. In a study published by Wilson, 64% of the subjects considered euthanasia as acceptable practice. Subjects favour policies only if pain and physical symptoms become intolerable.[7] Oncologists who were reluctant to increase the dose of intravenous morphine in excruciating pain and had sufficient time to talk to dying patients about end of life care issues were less likely to favour euthanasia or physician assisted suicide. During their career, 3.7% of survey oncologists had performed euthanasia and 10.8% had performed physician assisted suicide.[8] In a study reported in India assessing perception of nurses about euthanasia, majority did not agree to it.[9] But a study reported among medical students in Pakistan (82%) students agreed to physician-assisted suicide; 52% agreed to the idea of palliative care, claiming it was sufficient to maintain life; 54% disagreed that a doctor should not be allowed to administer a lethal dose while only 33% agreed to the idea of it; 58% disagreed that a law regarding the practice of euthanasia should not be introduced, whereas 27% agreed to it; 14% agreed to the practice of euthanasia, while 63% disagreed, mostly for religious reasons.[10]

Another study reported from Spain, there was greater support (70%) for legalisation of euthanasia than for assisted suicide (65%), combined with a greater predisposition towards carrying out euthanasia (54%), if it were to be legalised, than participating in assisted suicide (47.3%).[11]

Cancer patients receiving palliative care in Norway reported that fear of future pain and a painful death were the main reasons given for a possible wish for euthanasia/PAS. Worries about minimal quality of life and lack of hope also contributed to such thoughts. wishes were fluctuating and ambivalent.[12] Health care providers should be aware of this when responding to utterances regarding euthanasia/PAS.

Attitude towards euthanasia or physician assisted suicide did not have any relationship with age, sex, geographic region, number of patients who died in past year. This supports the present study finding.

It can be concluded from the present study that public have good knowledge about euthanasia and have positive attitude towards euthanasia. The study has got implication in health care practice that representatives of the general public should be included to formulate relevant policies related to euthanasia and there is need for health care institutions to deliver critical care services with discretion to ensure optimum use of resources.

The study can be replicated on a larger sample in different setting to generalize the findings of the study. There should be more studies related to end of life issue. Because of the irrevocable nature of euthanasia/PAS, it is of great importance that health care workers are aware of the apparent ambivalent nature of wishes for euthanasia/ PAS. A wish for euthanasia/PAS may be something completely different from a request for it.

CONCLUSION

None of the health professionals who have taken care of dying patients is a disinterested observer; each will have strong feelings about this issue. It is important that each one understand that society's choice does not determine medicines position in this matter though end-of-life issues are becoming major ethical considerations in the modern-day medical science in India.

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A Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding the Monitors used in Critical Care Unit among the IV Year B.Sc Nursing Students at RMCON, Chidambaram

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ABSTRACT

Background: "Monitoring is a continuous observation or measurements of patients, their physiological function, and the function of life support equipment for the purpose of guiding management decision, including where to make therapeutic interventions and assessment of those interventions". Monitoring helps in the early diagnosis of change in a physiological parameter and provides guidelines towards institution of appropriate therapy. Basic knowledge of the principles of monitoring and correct interpretation of data is important since a failure to do so can result in misdirected therapy

Method: The research approach and design adopted for the study was pre experimental research design (one group pretest- posttest design). The sample consists of students studying IV year B.Sc. Nursing in RMCON. Convenience sampling technique was used. The data was collected using demographic profile, and self administered questionnaire.

Results: The study findings revealed that most of the students 98(93%) had inadequate knowledge and only 6 (7%) students had moderately adequate knowledge with a mean score of 29.12, in the pretest, but after administering the Structured Teaching Programme 75 (72%) had adequate knowledge and 29 (28%) had moderately adequate knowledge with a mean score of 76.45

The study also revealed that there is significant association between certain academic variables and pretest knowledge score of students regarding monitors used in critical care unit. The effectiveness of Structured Teaching Programme was statistically tested by Paired 't' test value and the result was found to be significant at 'p'< 0.001 level. Thus the study findings support the hypothesis

Conclusion: The result of the study revealed that the knowledge of students regarding the monitors used in critical care unit was inadequate. After the Structured Teaching Programme the knowledge has improved.

Keywerms: *Monitors, Structured Teaching Programme.*

INTRODUCTION

Critically ill patients require continuous assessment of their cardiovascular system to diagnose and manage their complex medical conditions. This is commonly achieved by the use of direct pressure monitoring systems. Only nurses who have demonstrated knowledge and skills in the use of monitoring should manage patients who require this highly sophisticated type of monitoring (Brunner and Suddarth, 2008).[2]

Cardiac diseases and surgeries are relatively very complicated in treatment and monitoring which need a thorough understanding of condition where it always require continuous assessment and diagnosis of the complex conditions. This can be achieved only by good and sound knowledge in hemodynamic monitoring. (Dennison, 2004).[1]

Through the results of the monitors only nurse can convey her patient's status to the physician and he can make a conclusion about patient's condition and plan for further management. The result of monitoring to be utilized effectively, the nurse must have a solid foundation in understanding the technical and physiologic implications that can impact the values obtained.

LITERATURE REVIEW

Burge (2010) conducted a survey on the continuous pulseoximetry monitoring to investigate whether the implementation of an education module increased nurse's knowledge of continuous pulseoximetry among 52 unit Registered Nurses by using convenient sampling technique. The results revealed that the knowledge of the unit guidelines for actions to deal with a broken continuous pulseoximetry monitoring machine, correctly identifying the indicators for continuous pulseoximetry monitoring, understanding the factors affecting the accuracy of continuous pulseoximetry monitoring readings were increased significantly, from 9.4% to 60.2%, 42.2% to 80% and 28.58%. The survey concluded that the educational module improved the nursing staff knowledge on continuous pulse oximetry.[3]

Pickham, Shinn, Chan, Funk and Drew (2012) conducted a quasi-experimental study to Improve Nurse's QT-Interval Monitoring. For that 47 QT-education classes were provided to 480 eligible nurses. The results revealed that the total test scores increased after intervention (46% vs 77%, P < .001). Education, significantly, improved the marking of the QT/RR intervals (QT: 65% vs 91%, RR: 83% vs 90%, P = .001 and P = .02) and measurement of the QT/RR intervals (QT: 47% vs 84%, RR: 35% vs 71% P = .001 and P = .001) and calculation of the QT interval (6% vs 52%, P< .001).The study concluded that the nurse's baseline ability to perform QT interval monitoring is extremely poor but after the QT education class, the knowledge was found improved.[4]

Cosmos, et al. (2008) conducted a study on intensive care nurse's knowledge about the evidence based guidelines of preventing central venous catheter related infection from 11 intensive care units. The results revealed that the mean score was 3.66 on 10 questions (37%). 18% knew that central venous catheters should be replaced on indication only, and 61% knew that this recommendation concerns also replacement over a guidewire. Regarding the CVC dressings, 15% knew that these should be changed only when indicated and at least once weekly, and 35% recognized that both poly-urethane and gauze dressings can be recommended. 14% knew antibiotic ointments are not recommended because they trigger resistance. This study concluded that the knowledge regarding central venous catheter related infection is poor among the Hungarian nurses.[5]

Many studies found that there is a deficiency of critical care nurse's knowledge regarding monitoring. So teaching programme regarding monitors will improve the nurse's knowledge.

STATEMENT OF THE PROBLEM

A study to assess the effectiveness of Structured Teaching Programme on knowledge regarding the monitors used in critical care unit among the IV year B.Sc. Nursing students at RMCON.

Objectives

- To assess the existing knowledge regarding the monitors used in critical care unit among the IV year B.Sc. Nursing students at RMCON.
- To evaluate the effectiveness of Structured Teaching Programme on knowledge regarding the monitors used in critical care unit among the IV year B.Sc. Nursing students at RMCON.
- To find an association between the pretest knowledge score of the students and the selected academic variables such as medium of instruction at school, percentage of marks scored in III year B.Sc. (N) University Examination, previous experience of students connecting and handling the monitors

Hypothesis There will be a significant difference

between the mean pretest and the post test knowledge on monitors used in critical care unit among the IV year B.Sc. Nursing students.

METHODOLOGY

The research approach and design adopted for the study was pre experimental research design approach. The sample consists of students studying IV year B.Sc. Nursing in RMCON. Convenient sampling technique was used to select the sample of 104 students. The data was collected using demographic profile, academic profile and self administered questionnaire to assess the level of knowledge among IV year B.Sc. Nursing students. The knowledge part consists of 58 questions. Correct answer was given a score of '1' and wrong answer was scored as '0'. The total knowledge score is 100. Those who scored less than 49 are considered to have inadequate level of knowledge, between 50- 74 have moderately adequate level of knowledge, and above 75 have adequate level of knowledge.

DESCRIPTION OF THE INTERVENTION

The Structured Teaching Programme included a brief knowledge about pulseoximetry, cardiac monitoring and hemodynamic monitoring. The Structured Teaching Programme consist the information regarding terminologies, parts, indication, contraindication, method of working, trouble shooting and nurse's responsibilities of pulseoximetry, Cardiac monitor and Hemodynamic monitoring.

FINDINGS

The descriptive and inferential statistics was used to compute the data. The statistics showed the following results:

1. In the pretest 100(91.7%) had inadequate knowledge and 9(8.3%) had moderately adequate knowledge regarding monitors used in critical care unit.

2. In the post test 75 (71.4%) students had adequate knowledge and 29 (27.65%) students had moderately adequate knowledge regarding monitors used in critical care unit.

3. When comparing monitors wise, in pulseoximetry 50 (48.5%) had inadequate knowledge and 49(47.5%) had moderately adequate knowledge and 5 (4.8%) had adequate knowledge in pretest, and in post test 93(89.5%) had adequate knowledge and 11(10.5%) had moderately adequate knowledge.

4. In cardiac monitors 97 (93.3%) had inadequate knowledge and 7 (6.7%) had moderately adequate knowledge in pretest and in post test 82 (78.8%) had adequate knowledge and 22 (21.2%) had moderately adequate knowledge.

5. In hemodynamic monitoring 104 (100 %) had inadequate knowledge in pretest and in post test 59 (56.7%) had adequate knowledge and 45 (43.3%) had moderately adequate knowledge.

6. The effectiveness of structured teaching programme was statistically tested by paired't' value and the results were found to be significant at $p<0.001$ level.

7. The study showed that there was an significant association between pretest knowledge and the academic variable such medium of instruction, average percentage of marks in III year B.Sc. (N) University examination, students who are connected and handled patients with monitor with Kruskal-Wallis Test [p-value 0.000]

Table 1: Distribution of level of knowledge regarding monitors used in critical care unit among the IV year B.Sc. Nursing students in pretest

N= 104

S. No	Level of knowledge	Pretest	
		Frequency	%
1.	Inadequate knowledge (< 49%)	98	94.2%
2.	Moderately adequate knowledge (50-74%)	6	5.8%
3.	Adequate knowledge (>75%)	-	-

Table 1 shows that 6 students (5.8%) had moderately adequate knowledge and 98 students (94.2%) had inadequate knowledge regarding monitors used in critical care unit in the pretest.

Table 2: Distribution of level of knowledge regarding monitors used in critical care unit among the IV year B.Sc. Nursing students in posttest

N= 104

S. No	Level of knowledge	Pretest	
		Frequency	%
1.	Inadequate knowledge (< 49%)	-	-
2.	Moderately adequate knowledge (50-74%)	29	27.8
3.	Adequate knowledge (>75%)	75	72.2

Table 2 shows that 29 (27.8%) students had moderately adequate knowledge and 75 (72.2%) students had inadequate knowledge regarding monitors used in critical care unit in the posttest.

Table 3: Comparison of Mean and Standard Deviation of Knowledge Regarding Monitors used in critical care unit between Pretest and Posttest

N= 104

Variables	Mean	SD	Paired 't' test value	'P' value
Pretest	29.12	9.98	51.215	P<0.000 (S)
Posttest	76.45	13.34		

S = Significant

Table 3 shows that in pretest the mean knowledge score is 29.12 and in posttest the mean is 76.45. It was statistically tested with paired t' test and the result found to be significant at p< 0.000.

Table 4: Comparison of mean and standard deviation of knowledge

Regarding monitor wise between pretest and posttest **N =104**

Monitors	Pretest		Posttest		Paired 't' test value	'P' value
	Mean	SD	Mean	SD		
Pulseoximetry	9.5	1.62	17	4.21	-43.636	P<0.001 (S)
Cardiac monitors	11.5	3.43	32	5.32		
Hemodynamic monitoring	8	2.08	28	9.38		

S = significant

Table 4 shows that comparison the mean knowledge score of pulseoximetry in pretest was 9.5 and in posttest 17. The mean knowledge score of cardiac monitor in pretest was 11.5 and in posttest 32. The mean knowledge score of hemodynamic monitoring in pretest was 8 and in posttest the mean score was 28. The improvement was statistically tested by paired' test and the results were found to be significant (p<0.001).

Table 5: Association of mean and standard deviation of pretest knowledge with percentage of marks scored in III year B.Sc. Nursing university examination

N=104

S. No	Average percentage of marks	Number of subjects	Mean	SD	Kruskal Wallis test	'P' value
1.	Below 60%	12	17.42	4.43	61.140	0.000 (S)
2.	60- 65%	42	24.86	5.85		
3.	70-75%	44	33.57	6.86		
4.	Above 75%	6	50.143	7.175		

S = significant

Table 5 shows that the mean pretest knowledge was higher among students with above 75% of marks in III year B.Sc. (N) University examination with the mean value of 50.143, when compared with other groups. Statistically, Kruskal Wallis test indicates that there is significant association between pretest knowledge value and percentage of marks scored in III year B.Sc. (N) University examination

Table 6: Association of mean and standard deviation of pretest knowledge with students observed patients connected with monitors

N=104

S. No	Students observed patients connected with monitors	No of subjects	Mean	SD	Kruskal Wallis test	'P' value
1.	Pulseoximetry & cardiac monitors	100	28.31	10.1	13.206	0.001 (S)
2.	Pulseoximetry, cardiac monitor & hemodynamic monitoring	4	48.80	7.46		

S = Significant

Table 6 shows that the mean pretest knowledge was higher among students who have seen patients connected with all type of critical care monitors with the mean value of 48.80, when compared with who have observed only pulseoximetry patients and pulseoximetry and cardiac monitor patients. Kruskal Wallis test indicates that there is significant association between pretest knowledge value and students who have observed patients connected with monitors

Table 7: Association of mean and standard deviation of pretest knowledge with student's experience of connecting & handling patients with monitors

N=104

S. No	Exposure to teaching programme	No of subjects	Mean	SD	Kruskal Wallis test	'P' value
1.	Pulseoximetry	16	19.72	5.59	31.322	0.001 (S)
2.	Cardiac monitors	21	28.13	9.94		
3.	Pulseoximetry, cardiac monitors	64	31	8.48		
4.	Pulseoximetry, cardiac monitors & hemodynamic monitoring	3	51	8.5		

S = Significant

Table 7 shows that the mean pretest knowledge was higher among experience of students connecting and handling pulseoximetry, cardiac monitoring and hemodynamic monitoring with the mean value of 51, when compared with who have handled and connected only pulseoximetry, only cardiac monitors and hemodynamic monitoring. Statistically, Kruskal Wallis test indicates that there is significant association between pretest knowledge value and connection and handling of patients connected with monitors.

Table 8: ANCOVA Analysis of Pretest and Posttest Level of knowledge with the significant academic variables **N=104**

ANCOVA measures after controlling the significance					
Variables	**Mean**	**SD**	**Within subjects**	**F ratio**	**'P' value**
Pretest	29.257	9.98	Percentage of marks scored in III year B.Sc. (N)	0.086	0.770 (NS)
Posttest	76.457	13.34	Students observed patients connected with monitors	2.021	0.158 (NS)
			Student's experience of connecting and handling the patient with monitor	0.029	0.864 (NS)

NS= Non Significant

Table 8 represents that in the pretest the mean knowledge score is 29.12 and in posttest the mean knowledge score is 76.45 significance at P <0.001. Since the percentage of marks scored in III year B.Sc. (N) university examination, students observed patients connected with monitors, experience of student's connecting and handling the patient with monitor are significantly associated with pretest knowledge. So these three variables are included as covariance in the ANCOVA repeated measures. The P value for the percentage of marks scored in III year B.Sc. (N) university examination, student's exposure to teaching programme, handling and connecting the patient with monitor infers that the non significance in the knowledge score will not be influenced by these variables. Further the significant 'P' value for the assessment infers that, STP is effective in increase the knowledge score after controlling the influence of the significant academic variables. It ensures that increase in knowledge score is due to Structured Teaching Programme.

CONCLUSION

The present study assessed the knowledge of IV year B.Sc. Nursing students regarding monitors used in critical care unit and found that the majority of the student had inadequate knowledge. After the Structured Teaching Programme about monitors used in critical unit, there was significant improvement in the student's knowledge regarding critical care monitors. The study revealed that the Structured-Teaching Programme was effective in improving knowledge of students regarding critical care monitors.

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Conflict of Interest: Monitoring of the patient is important in critical care unit. Through the results of the monitors only nurse can convey her patient status to her physician to take appropriate decision regarding patient. So the student nurses who are the future nurses and going to work at various levels of health care setting should be given teaching regarding monitors used in critical care unit to work effectively in future. It will determine the skilled patient care and this will give confidence in handling and caring the patients with various monitors.

Ethical Clearance: Ethical Clearance was obtained from the human ethical committee of the institution.

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A Descriptive Study to Assess the Level of Knowledge on Behavioral Problems of School Children among Diploma in Education Students in Selected Colleges of Belgaum City, Karnataka

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ABSTRACT

Teachers have always had the ability to determine the tone and direction of a school, to create exemplary world within the classroom. Behavioural problems in school children can be mild, moderate or severe and are at a higher risk of school failure, suicide and mental health problems. If you can see that child's behavioural problems are worsening, take steps to help sooner rather than later. Therefore the researcher is interested to conduct "A Descriptive study to assess the level of knowledge on behavioral problems of school children among diploma in education students in selected colleges at Belgaum"

An Descriptive research approach with Descriptive design in pre experimental design was used to evaluate the knowledge on behavioural problems of school children. The study was conducted in Private diploma in education colleges of Nehru Nagar Belgaum. Purposive, non probability sampling approach was used to select 50 samples. The tool used for the data collection was self administered structured knowledge questionnaire which comprised of 8 items on demographic data and 40 items on behavioural problems of school children. The reliability of the tool was established by Split Half technique, with 'r' = 0.88. The tool was administered to 50 diploma in education students. The conceptual frame work adopted for the study was based on Stufflebeams CIPP model. Data gathered was analyzed using descriptive and inferential statistics in terms of frequency, percentage, mean, standard deviation and chi-square test.

The overall mean percentage of knowledge scores of diploma in education students is 24.88 which is apparently adequate. Hence H_1 is accepted i.e. there will be adequate knowledge scores of diploma in education students on behavioral problems of school children.

There was no association of the selected demographic variables with the level of knowledge scores of diploma in education students at $p< 0.05$, hence H_2 is rejected. i.e. There will be significant association between the knowledge scores of diploma in education students on behavioral problems of school children with selected demographic variables.

Hence the findings revealed that diploma in education students had moderately adequate knowledge on behavioural problems of school children. Thus the researcher conducted the study to make them aware of common behavioral problems seen among school children.

Keywords: *Diploma in education students, behavioural problems of school children.*

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INTRODUCTION

"Behavior is a mirror in which everyone displays his own image." -**Johann**

School age is the period between 6-12 years. Schoolers are emerging as creative persons who are preparing for their future role in society. The school years are a time of new achievement and new experiences. Children's individual needs and preferences should be respected. Children who is productive and engaged in the school experience, whether academic or vocational, is not likely to become at - risk student.[1]

All young children can be naughty, defiant and impulsive from time to time, which is perfectly normal. However, some children have extremely difficult and challenging behaviors that are outside the norm for their age.[2] The behavior of some children and adolescent are hard to change. Children do not always display their reactions to events immediately although they may emerge later. Children who suffer from behavior disorders are at a higher risk for school failure, suicide, and mental health problems.[3]

A behavioral problem is a departure from normal (acceptable) behavior beyond a point, to the extent behavioral problems can manifest themselves in many ways. There are interchangeable terms for behavior disorders- disruptive behavior disorder, conduct disorders, emotional disorders, and emotional disturbances.

WARNING SIGNS OF BEHAVIOR DISORDERS INCLUDE

- Harming or threatening themselves, other people
- Damaging or destroying property
- Lying or stealing
- Not doing well in school, skipping school
- Early smoking, drinking or drug use
- Early sexual activity
- Frequent tantrums and arguments
- Consistent hostility towards authority figures.[4]

Children misbehave for a variety of different reasons. Children problems are often multi-factorial and the way in which they are expressed may be influenced by a range of factors including developmental stage, temperament, coping and adaptive abilities of the family, the nature and duration of illness.[3]

The school is an institution in society specifically designed as the formal instrument for educating children. School is a place where children spend the largest portion of their time outside the home. Schools should offer a safe and respectful learning environment for everyone.[2]

In addition to scholastic achievement, school experiences should contribute to healthy development in terms of harmonious interpersonal relations and positive self image. Teachers appear to be important social partners, as the quality of a teacher and child relationship has been related to several aspects of short and long-term school adaptation. Studies have shown that teachers may reject these children, respond to them with less support and punishment than other child receives.[5]

A parent is really the child's first teacher and critical to student success is the involvement of parent.[1]A teacher is a person who provides students' direct classroom teaching, or classroom-type teaching in a non-classroom setting, or educational services directly related to classroom teaching.[6] Teachers play an influencing role in development of personality. Listening to child's problems is an important skill of a teacher.[1]

Disruptive behavior is a major factor contributing to teacher stress and discontent and significantly affects teachers' capacity to maintain a productive and orderly learning environment. Most teachers and school personnel concur that they are able to identify behavioral and academic problems within first few weeks of a school year. Teacher's expectations and actions greatly affect the child's behavior. Dealing with difficult or inappropriate behavior in schools can be a challenging task for any educator, regardless of experience.[7]

Teachers need to use positive interactive approaches than responding to inappropriate behaviors. Teachers need to communicate care and concern rather than a desire to punish when reacting to inappropriate behaviors. Children with behavioral problems have received more criticism and have suffered deterioration in their interactions with teachers over time.[8]

The early detection and treatment of children with behavioral problems at an early age may reduce treatment costs and improve quality of life of those children. Effective way of reducing behavioral problems can be through behavioral plan developed by parents, teachers, children, administrators and school staff. Use positive interactive approaches that remove the need for inappropriate behavior. The components include, inform pupil what is expected, avoid threats, build self confidence, use positive modeling and provide positive learning environment.[9]

OBJECTIVES

The objectives of the study are:

1. To assess the knowledge of diploma in education students regarding behavioral problems of school children.

2. To find out association between knowledge score of diploma in education students on behavioral problems of school children with selected demographic variables.

OPERATIONAL DEFINITION

1. Assess: In this study assess refers to a statistical measurement of Behavioral problems of the school children among Diploma in education students.

2. Behavioral problems: Behavioral problem refers to a behavior that goes to an extreme level-behavior that is not slightly different from the usual. It includes the conditions like conduct disorder, aggression, stealing, lying, truancy, bullying, fire setting, impulsivity, oppositional defiant disorder and school fear.

3. Diploma in education students: It refers to diploma in education students who are studying in II year in Diploma in Education College at Belgaum.

HYPOTHESIS

H_1: There will be adequate knowledge on behavioral problems of school children among diploma in education students.

H_2: There will be a significant association between knowledge scores with selected demographic variables**.**

- **ASSUMPTIONS**

1. Diploma in education students may have inadequate knowledge regarding behavioral problems of school children.

2. Diploma in education student's knowledge may vary with selected demographic variables.

DELIMITATION

- Study is delimited to II year Diploma in education students.

RESEARCH METHODOLOGY

Research Approach: A Descriptive approach was adopted in this study.

Research Design: A non experimental Descriptive research design was adopted to carry out the present study.

Research Setting: Based on the geographic proximity, feasibility to conduct the study and familiarity with the setting, the investigator selected diploma in education colleges of Belgaum city, Karnataka

Population: The population of the present study comprised all the Diploma in education students who were in II year in selected Diploma in Education Colleges of Belgaum City, Karnataka.

Sample and Sample Size: Sample size of the present study consists of 50 Diploma in education students

Sampling Technique: The sampling technique used for the present study is Purposive sampling technique approach which is a type of Non-Probability sampling technique which was considered appropriate for the study.

Description of Tool: Tools were prepared on the basis of objectives of the study. A self administered structured knowledge questionnaire selected to assess the knowledge of diploma in education students regarding behavioral problems of school children. It was considered to be the most appropriate

instrument to elicit the response from diploma in education students.

The final tool consists of two sections;

Section I	:	Demographic data
Section II	:	Structured Knowledge Questionnaire

Sections of the tools

Section I : Demographic data consists of 8 items which includes age, gender, religion, education, marital status, residence, type of family and family income.
Section II : - Self administered structured Knowledge questionnaire consists of 40 items.

Preparation of blue print

The blue print pertaining to the domain of learning that is Knowledge regarding general aspect of Behavioral problems of school children, Meaning and Types.

Knowledge score on Behavioral problems of school children was graded as:

- Good knowledge (Mean + SD) – 29 to40
- Average knowledge (Mean + SD) & (Mean – SD) - 21 to 28
- Poor knowledge (Mean – SD) - 01 to 20

The items were given one score for correct answer and zero score for wrong answer.

RESULTS

Section I: Findings related to socio demographic variables.

Table 1: Frequency and percentage distribution of Diploma in education students according to demographic variables.

n=50

S No.	Socio-demographic variables	Frequency (f)	(%)
1	**Age in years**		
	a. 18-20 years	34	68
	b. 21-23 years	16	32
2	**Gender**		
	a. Male	14	28
	b. Female	36	72
3	**Religion**		
	a. Hindu	34	68
	b. Muslim	10	20
	c. Christian	06	12
	d. Others	00	00
4	**Education**		
	a. P.U.C 2nd year	35	70
	b. Degree	15	30
5	**Marital Status**		
	a. Married	38	76
	b. Unmarried	12	24
	c. Divorced	00	00
6	**Residence**		
	a. Urban	33	66
	b. Rural	17	34
7	**Type of Family**		
	a. Nuclear	37	74
	b. Joint	13	26
	c. Extended	00	00
8	**Family Income**		
	a. Less than 5000	26	52
	b. 5001-10000	14	28
	c. More than 10000	10	20

The data presented in table 1 indicates that,

- Maximum Students 34 (68%) belonged to 18-20 years of age group and minimum 16 (32%) of them belonged to 21-23 years of age group.
- Majority of Students 36 (72%) were female and while a minimum 14 (28%) were male candidates.
- Majority of the Students 34 (68%) belonged to Hindu religion while minimum 06(12%) belonged to Christian religion.
- Majority of the Students 35(70%) had studied P.U.C 2nd year while minimum 15(30%) had completed degree.
- Majority of the 38 (76%) had married while the lowest group 12(24%) were unmarried.
- Majority of the Students 37 (74%) were belonging to nuclear family while minimum 13(26%) were belonging to joint family.
- Majority of the Students 26(52%) had family income below 5000 were as minimum of 10(20%) of them had family income more than 10000.

Table 2: Frequency and percentage (%) distribution of knowledge scores of Diploma in education students regarding behavioral problems of school children.

n=50

Knowledge Score	Frequency	(%)
Good Score (Above 29)	11	22
Average Score (Between 21-28)	31	62
Poor Score (Below 20)	08	16

Table 2 revealed that in test, majority of the Diploma in education students, 31 (62%) had average knowledge and 8(16%) had poor knowledge regarding behavioral problems of school children.

Section II: Analysis and Interpretation of data to find out an association between knowledge scores among the diploma in education students with demographic variables.

H_1: There will be a significant association between knowledge scores among diploma in education students with demographic variables at 0.05 level of significance.

Table 3: Association between knowledge scores among the diploma in education students with demographic variables. n=50

S.No	Socio demographic variables	Good	Average	Poor	χ^2 CAL.VAL	χ^2 TAB VAL	Df
1.	**Age in years**						
	a. 18-20 years	7	21	6	0.26	5.99	2
	b. 21-23 years	4	10	2			
2.	**Gender**						
	a. Male.	1	10	3			
	b. Female	10	21	5	2.56	5.99	2
3.	**Religion**						
	a. Hindu	6	22	6			
	b. Muslim	3	6	1	1.37	12.592	6
	c. Christian	2	3	1			
	d. Others	0	0	0			
4.	**Educational Status**						
	a. P.U.C 2nd year	8	21	6	0.18	5.99	2
	b. Degree	3	10	2			
5.	**Marital Status**						
	a. Married	7	23	8			
	b. Unmarried	4	8	0	3.49	9.49	4
	c. Divorced	0	0	0			
6.	**Residence**						
	a. Urban	7	20	6			
	b. Rural	4	11	2	0.32	5.99	2
7.	**Type of family**						
	a. Nuclear	8	21	8	3.43	9.49	4
	b. Joint	3	10	0			
	c. Expanded	0	0	0			
8.	**Family Income**						
	a. Less than 5000	4	16	5			
	b. 5001-10000	5	8	2	2.26	9.49	4
	c. More than 10000	2	7	1			

The findings of table 3 reveals that the variables age in years, gender, religion, marital status, Education, residence ,type of family and family are independent of each other. The chi-square calculated value is less than the chi-square table value, reject the hypothesis. Hence there is no association between knowledge scores and demographic variables.

DISCUSSION

Assessment of overall and aspect wise Mean Knowledge scores: The findings of the present study revealed that overall mean knowledge score was 49.6% with a standard deviation of ± 2.0. Among the aspect wise knowledge score was 38.5% behavioral problem, 31.6% conduct disorder, 35% aggression, 34.1% lying, 33% stealing, 36.2% truancy, 36.6% bullying, 37.5% fire setting, 33.7% impulsivity, 34.2% oppositional defiant disorder, 41% school phobia and 62% in the aspect of techniques of classroom management.

This study was supported by a study done on middle school vocational teacher's knowledge on behavioral problems and characteristics of risk learners. The study included 392 middle grades (5-8) vocational teachers. They assessed the knowledge with the help of questionnaire. The study concluded that 257 middle grades teachers had inadequate knowledge on behavioral problems and characteristic of risk learners.[10]

To find out association between knowledge scores of diploma in education students on behavioral problems of school children with selected demographic variables

An association of selected baseline variables in relation to their knowledge was studied using Chi-square test. The findings reveal that there was no significant association between knowledge score and religion at $p<0.05$. Hence H_1 is rejected. Relatively there is no significant association between the variables like age, education, marital status and type of family at $p<0.05$. Hence the research hypothesis is rejected i.e. there will be significant association between the knowledge scores of diploma in education students on behavioral problems of school children with selected demographic variables.

A study was done on behavioral problems in Sri Lankan school children associations with socio economic status, age, gender, academic progress and religion. Using the strengths and difficulties questionnaire modified version of the rutter parent questionnaire including items on children's strength: with parent, teacher and child informants, was administered to assess the mental health problems in this population. In this study 10 – 13 years children were included. The study concluded that rates and types of problems consistent with other international studies on children mental health. Problem rates were higher in boys and were associated with lower socio economic status, religion and poorer academic performance. The study confirms the need for development of child and adolescent health services in Sri Lanka.[11]

CONCLUSION

Nurses are key persons of the health team, who play a major role in health promotion and maintenance; the teaching programme can be conducted by the nursing personnel on behavioral problems of school children in all psychiatric wards which will improve the knowledge of nurses. As a nurse counselor, she can conduct individual counseling and group counseling for children with behavioral problems and to their family. The nursing curriculum can include all the behavioural problems of school children and can be taught using different methods of teaching. The study helps the nurse researchers to develop appropriate health education tools for educating the diploma in education students on behavioral problems of school children. Research should be conducted on behavioral problems of school children to reduce the number of childhood psychiatric disorders.

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Objective Structured Clinical Evaluation (OSCE)- a Reliable Clinical Performance Evaluation Strategy in Mental Health Nursing

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ABSTRACT

Background: Adaptation of OSCE as an evaluation strategy in nursing education in India is grossly lacking and the present study aimed to test its reliability by comparing with a selected traditional clinical performance evaluation strategy commonly in practice among nursing institutions.

Materials & Methods: Consented subjects (n=30) were randomly assigned to undergo two-stage clinical performance evaluation using OSCE and traditional clinical performance evaluation method, based on structured performance evaluation formats and viva voce. Traditional clinical performance evaluation was performed by two independent examiners; internal and external examiner. Reliability was defined as a non significant ($p>0.05$) difference in the overall Mean clinical performance evaluation scores between its different subject measurements. Data was pooled and was analyzed using SPSS v16.

Results: All study subjects were females and were taken from 3rd year BSc Nursing class. Overall Mean OSCE scores show no significant ($p>0.05$) difference between its selected subject measurements, whereas the overall Mean traditional clinical performance evaluation scores were significantly ($p<0.05$) differ between its selected subjects measurements thus the reliability of the OSCE was established when compared to traditional clinical performance evaluation strategy.

Discussion: The study recommended in incorporating more objective evaluation strategies such as OSCE in nursing education that could enhance the reliability of the evaluation and help the nurse educators to provide a valid feedback and guidance to their students.

Keywords: *OSCE, nursing education, evaluation method.*

INTRODUCTION

Objective Structured Clinical Examination (OSCE) is a practical test to assess specific clinical skills. It is well established method of assessing clinical competence. The OSCE was first introduced in medical education in 1975 by Ronald Harden at the University of Dundee. The aim of the OSCE was to assess clinical skills performance. Adaptation of OSCE into the evaluation system of healthcare disciplines is widely been accepted in the Western education settings including Nursing.

Many authors agreed that OSCE is a valid, reliable and objective method of assessing clinical competence in various setting[1]. Robbin and Hoke[2] proposed three components for a valid clinical competence evaluation system: validity, reliability and practicality. OSCEs provide a valid means to evaluate a student's performance in a holistic manner. Specifically, exercises are designed to allow student evaluation through the entire patient encounter, including history, examination, identification of initial problems, selection of tests needed, interpretation of the results of the encounter, and appropriate

treatment recommendations. Reliability of the OSCE is based on the interaction among the standardized patient, the student, and the evaluator. Increasing the number of evaluators increases the OSCE reliability. Practicality is a mediating factor when working with OSCEs.

Currently clinical evaluation is done by observation of individual patient care at the bedside assessing the cognitive, psychomotor and affective domains against a preset evaluation criterion by two examiners simultaneously or alternatively, can't exclude inter rater variability. Where as in an OSCE, the students complete a set of individual OSCE stations (individual OSCEs are normally called 'stations') designed to test a range of clinical skills used in patient care, with an examiner using a previously determined, objective scoring scheme.[3] A group of collated OSCE stations to be used in actual student examinations is called an OSCE 'session'. All students are tested in similar circumstances against same preset criteria by the same examiners. This introduces objectivity and reliability unlike the traditional practical examination and curtails inter rater variability. However, OSCE has not been widely in use by nurse educators in India. There is limited knowledge about conduct of OSCE and its advantages among nurse educators in this setting. The present study aimed to test the reliability of OSCE by comparing it with a Traditional Clinical Performance Evaluation (TCPE) strategy commonly in practice among nursing institutions in India.

MATERIALS & METHOD

The study was conducted at Mar Baselios College of Nursing, Kothamangalam, an institute with an annual intake of 60 students to graduate nursing program, affiliated to Kerala University of Health Sciences, (KUHS), Thrissur, Kerala.

Thirty subjects were randomly selected following which a brief explanation about the performance evaluation procedure was given. The respondents' clinical competencies levels were based on their performance in each station. There were ten stations in the OSCE. The students were assessed using a checklist which was formulated to measure the level of competency, through these standardized stations. The same students were again assessed by TCPE method which was performed by two independent examiners; internal and external examiner based on structured performance evaluation formats and Viva voce. The reliability of the evaluation method was defined as the consistency in measuring the clinical competency scores with respect to the different subjects. The data collected were pooled into the Microsoft Excel worksheet.

RESULTS

The data was analyzed using Statistical Package for Social Sciences (SPSS) version 16.0. Statistical tables and percentage were used for data presentation; while repeated measure Analysis of Variance and paired t test were applied to test level of significance (α l*evel was set at p <0.05*).

Measurements based on OSCE

Table1: Mean & Standard deviation values of OSCE scores of different subjects n=30

Sl. No.	Subjects	Minimum	Maximum	Mean	SD
1	Child Health Nursing	10	34	22.49	5.41
2	Mental Health Nursing	13	32	21.82	5.23
3	Advanced Medical-Surgical Nursing	07	32	21.43	5.09

Table1shows the Mean and Standard deviation values of OSCE scores of different subjects. Mean score for Child health nursing was 22.49 (*SD: 5.41*) with a score ranging from 10-34, Mean score for Mental health nursing was 21.82 (*SD: 5.23*) with a score ranging from 13-32 and Mean score for Advanced Medical-Surgical Nursing was 21.43 (*SD: 5.09*) with a score ranging from 7-32.

Measurements based on TCPE strategies

Table 2: Mean & Standard deviation values of TCPE scores of different subjects n=30

Sl. No.	Subjects	Minimum	Maximum	Mean	SD
1	Child Health Nursing	25	39	30.94	3.89
2	Mental Health Nursing	19	36	25.00	3.63
3	Advanced Medical-Surgical Nursing	20	34	27.80	2.89

Table2 depicts the Mean & Standard deviation values of TCPE scores of different subjects. Mean score for Child health nursing was 30.94 (*SD: 3.89*), Mean score for Mental health nursing was 25 (*SD: 3.63)* and Mean score for Advanced Medical-Surgical Nursing was 27.80 (*SD: 2.89*).

Inter related OSCE scores between its subjects

Table 3: Mean, Standard Deviation and test of significance of OSCE scores between the different subjects n=30

Sl. No.	Subjects	Mean ± SD	F value	p value
1	Child Health Nursing	22.49 ± 5.41	1.64	0.21^{ns}
2	Mental Health Nursing	21.82 ± 5.23		
3	Advanced Medical-Surgical Nursing	21.43 ± 5.09		

^{ns}Non significant p>0.05

Table 3 represents the Mean, Standard Deviation and test of significance using repeated measure ANOVA (F) of OSCE scores between the different subjects. It was established that there is no significant *(p>0.05)* difference among the overall Mean OSCE scores between the different subjects. Thus the OSCE scores were stable between the subject measurements.

Inter related TCPE scores between its subjects

Table 4: Mean, Standard Deviation and test of significance of TCPE scores between the different subjects n=30

Sl. No.	Subjects	Mean ± SD	F value	p value
1	Child Health Nursing	30.94 ± 3.89	54.24	0.00^{s}
2	Mental Health Nursing	25.00 ± 3.63		
3	Advanced Medical-Surgical Nursing	27.80 ± 2.89		

^{s}Significant p<0.05

Table 4 represents the Mean, Standard Deviation and test of significance using repeated measure ANOVA (F) of TCPE scores between the different subjects. It was established that there is a significant *(p<0.05)* difference among the overall Mean TCPE scores between the different subjects.

Comparison of OSCE scores with TCPEscores

Table 5: Mean, Standard Deviation and test of significance of OSCE scores with TCPEscores

n=30

No.	Subjects	OSCE Scores	TCPE Scores	t value	p value
		Mean ± SD	Mean ± SD		
1	Child Health Nursing	22.49 ± 5.41	30.94 ± 3.89	10.67	0.00 [s]
2	Mental Health Nursing	21.82 ± 5.23	25.00 ± 3.63	03.60	0.00 [s]
3	Advanced Medical-Surgical Nursing	21.43 ± 5.09	27.80 ± 2.89	09.85	0.00 [s]

[s]Significant $p<0.05$

Table 5 represents the Mean, Standard Deviation and test of significance using paired t test value of OSCE scores with TCPE scores. It was established that there was significant ($p<0.05$) differences between the overall Mean TCPE scores to Mean OSCE scores. All those Mean TCPE scores were significantly higher when compared to those with Mean OSCE scores.

DISCUSSION

Assessing clinical competencies, especially in an environment of constricted clinical learning opportunities in patient care settings, is critical to the production of successful nursing graduates[4]. The present study ascertains the reliability of the OSCE than traditional evaluation method of clinical performance in practice in nursing education in India. The test score obtained is reliable if it gives a reasonable indication of a student's performance in that particular test (i.e., are the OSCE scores consistently related to students' performances). The criterion of reliability implies that the OSCE is a stable, predictable and dependable method of assessment. Several factors may influences the reliability of the OSCE: the demeanor of students and examiners and their subsequent interactions; subjective interpretations on the part of the examiners; and environmental factors, such as the examination room, noise levels, light and temperature[5].

The issue of examiner subjectivity can be addressed through the use of an independent OSCE examiner who observes the conduct of the examiner at each station to monitor the fairness and consistency of the examiners' decisions[4]; where the present study failed to include an external examiner which could add more subjectivity to the measurements. The present study included 10 different stations to assess the student's level of clinical competency. As the number of items being assessed is increased, the chance factors influencing the score are reduced, thus giving a better estimate of the true score the student is likely to achieve, which in turn, increases the reliability of the OSCE.

CONCLUSION

A well-designed and implemented OSCE as a method of assessing students' clinical competencies provides students with opportunities to demonstrate interpersonal and interview skills, problem-solving abilities, teaching, assessment skills, and application of basic clinical knowledge. With appropriate SP selection and training, the utilization of appropriate tools and good data collection, OSCE can offer a valid and reliable means of testing student competencies. To avoid many of the pitfalls inherent in students' clinical evaluations, suggestions for implementation of OSCE in nursing programs have been provided. Further research on the use of the OSCE in undergraduate nursing programs is needed.

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Conflict of Interest: We do not have any conflict of interest

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Ethical Clearance: The study had an approval

from the Institutional Ethical Review Committee (ERC) and an individualized informed consent was obtained from all the study participants before the evaluation procedure.

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Comparative Study to Assess the Attitude among Urban and Rural Population Towards Human Rights of Mentally Ill in a Selected Area Mangalore, with a View to Prepare Information Pamphlet

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ABSTRACT

Background of the study: Rights are often considered fundamental to civilization being regarded as established pillar of society and culture. Human rights are those rights which are inherent to all human being. It is necessary that all the people in the community should know about the rights of the mentally ill people because we can see that now a days the mentally ill people are facing a lot of problems and they are being stigmatized in the society. In view of the above need the researcher strongly felt that the people in the community should be made aware regarding the rights of mentally ill people and it is necessary that they should develop a favourable attitude towards the people with mental illness. So that their rights are protected.

OBJECTIVES:

1. To assess the attitude of urban and rural population regarding rights of mentally ill.
2. To compare the attitude score of urban and rural population regarding human rights of mentally ill.
3. To develop and validate information pamphlet on human rights of mentally ill.
4. To find out the association between attitude of urban and rural population regarding human rights of mentally ill and selected demographic variables

Method: The data was collected from 200 people (100 from urban and 100 from rural).The written consent was taken from those who were willing to participate in the study. Attitude scale was administered to each and data was collected. Information pamphlet was given to the selected people in urban and rural area. In order to obtain the validity of the data collection tool objectives, blueprint, criteria checklist and a structured attitude questionnaire draft was prepared on human rights of mentally ill. The tool was validated by incorporating the suggestion and guidance given by subject expert.

Result: The result obtained from the study was that the urban population has a favourable attitude than the rural population regarding human rights of mentally ill.

Conclusion: It can be concluded that the urban population had a favourable attitude towards the rights of mentally ill and in rural population majority of the people 87% are having a neutral attitude and about 7% of the people are having an unfavourable attitude, 6% of the people are having a favourable attitude towards rights of mentally ill and significant association were found in attitude score and their selected demographic variables.

Keywords: *Attitude scale, human rights, mentally ill.*

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INTRODUCTION

People with mental illness encountering human rights violation in meeting their basic needs are a reality to be found in every corner of the globe. Rights are those which some hold to be in alienable & belonging to all humans. They are legal, social or ethical principle of freedom or entitlement that is; rights are fundamental normative rules about what is allowed of people or owned to people[1].

Rights are often considered fundamental to civilization being regarded as established pillar of society and culture, they are necessary for freedom and maintenance of a reasonable quality of life. Human rights are those rights which are inherent in the mere fact of being human, they are about balancing the inalienable rights of all of us human beings within the community regardless of difference in birth, social origin, gender, physical difference, faith, belief, ideology, nationality and so on, the concept of human rights is based on the belief that every human being is entitled to enjoy his or her rights without discrimination.[2]

Mental illness is the maladjustment in living. It produce disharmony in person's ability to meet human needs comfortably or effectively and function within a culture. Mental illness was associated with ignorance, superstition and fear, as a result, mentally ill patients went through a lot of fortune and problem for lack of development in the field of psychiatry. In other words human rights are very essential to protect those who are mentally ill[3].

Now the question is "Why the human rights are needed? Human rights are the basic rights and freedom to which all human beings are entitled. These rights include right to freedom of expression and movement, equality before the law the right to live right to education right to religion, right to own property etc. it is important to know that the human rights and protect them to reduce the chance of harassment and such; in the same way it is very essential to know the human rights of mentally ill. Throughout the history person with mental disabilities have suffered repeatedly some of the worst. Indignities of any group feared and misunderstood. They often had excluded from the meaningful parties potion. In civil society and defined opportunity take for granted by most like many vulnerable group, they have endured inequality discrimination and serious social stigma[4].

Every human being is entitled to be treated with dignity, equality and freedom regardless of the fact that we are born differently, grown differently and are different in our mental makeup. Mental, physical and social health is vital strands of life that are closely interwoven and deeply interdependent. As understanding of this relationship grows it becomes even more apparent that mental health is crucial to the overall wellbeing of individuals, societies and countries perhaps; mental health is failed to get enough attention in health sector rather than physical illness in last few years[5].

BACK GROUND

Rights are often considered fundamental to civilisation being regarded as established pillar of society and culture. The rights of mentally ill people are not protected in the society and they are facing a lot of problems. Hence it is necessary that all people, in the country should know about the rights of mentally ill people. Objectives are to assess the attitude of urban and rural population regarding rights of mentally ill, to compare the attitude score of urban and rural population and to find out the association between attitude of urban and rural population regarding human rights of mentally ill with selected demographic variables. Attitude scale was used for this comparative study.

The sample consists of 100 rural and 100 urban populations at Mangalore. The sample was selected by non probability purposive technique. Attitude scale was used to collect the data from samples. The collected data was analysed by using descriptive and inferential statistics, study findings have shown that there is a comparison between the attitude score of urban and rural population and also there is no significant association in the attitude of urban population with demographic variables and there is a significant association in the attitude of rural population with demographic variables such as education, religion and family history of mental illness.

METHODOLOGY

A comparative study was adopted for the study. The samples were selected using purposive sampling technique. The data was collected from 200 people (100 from urban and 100 from rural). The written consent was taken from those who were willing to participate in the study. Attitude scale was administered to each and data was collected. Information pamphlet was given to the selected people in urban and rural area. In order to obtain the validity of the data collection tool objectives, blueprint, criteria checklist and a structured attitude questionnaire draft was prepared on human rights of mentally ill. The tool was validated by incorporating the suggestion and guidance given by subject expert.

RESULT

Demographic Data: 200 people were selected through non-probability purposive sampling technique based on inclusion criteria. The data was analysed using descriptive statistics. The sample characteristics were described under the sub heading of age, gender, educational qualification, and occupation, and religion, family history of mental illness and presence of mentally ill at home.

Frequency and percentage distribution of subjects according to the attitude score

N=200

Sl. No	Rural Population			Urban Population	
	Variable	**Frequency**	**Percentage**	**Frequency**	**Percentage**
1	**Age**				
	20-30	20	20%	48	48%
	31-40	38	38%	51	51%
	41-50	42	42%	1	1%
2	**Gender**				
	Male	44	44%	30	30%
	Female	56	56%	70	70%
3	**Educational qualification**				
	No formal education	38	38%	0	0%
	Primary	51	51%	1	1%
	Secondary	11	11%	69	69%
	Graduate& above	0	0%	30	30%
4	**Occupation**				
	Coolie work	29	29%	0	0%
	Farmer	51	51%	0	0%
	Private employee	17	17%	54	54%
	Govt.Employee	0	0%	42	42%
	Un employed	1	1%	2	2%
	Student	2	2%	2	2%
5	**Religion**				
	Hindu	52	52%	29	29%
	Muslim	40	40%	40	40%
	Christian	8	8%	28	28%
	Other	0	0%	3	3%
6	**Family history of mental illness**				
	Yes	7	7%	1	1%
	No	93	93%	99	99%
7	**Presence of mentally at home**				
	Yes	8	8%	0	0%
	No	92	92%	100	100%

The data presented in table show that majority of people in the rural population belonged to age 41-50(42%). Most of the rural people were females 56%. Majority of the rural people were having primary level of educational qualification. Most of them were farmers (51%). Most of the rural population were Hindus (52%). Most of them were not having family history of mental illness (99%). Majority of people were not having mentally ill at home presently (100%).

In the urban population most of the people belongs to the age group 31-40(51%). Majority of them were females 70%. Most of them were having secondary level of educational qualification (69%). Most of the people in the urban population were Private employees. Majority of the people who participated in the study were Muslims (40%). 93% of the people were not having family history of mental illness. 92% of the urban population were not having mentally ill at home.

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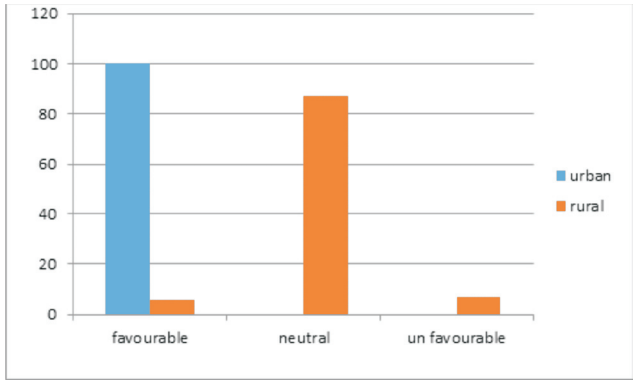
Mean and standard deviation of attitude score.

Place of Residence	Mean(SD)	P value
Rural	90.16(10.91)	
Urban	133.31(4.08)	<0.001

Simple bar diagram showing frequency and percentage distribution according to attitude score

The simple bar diagram shows that According to the attitude score in the rural population (6%) has a favorable attitude, (87%) have neutral attitude and (7%) have un favorable attitude and in the urban population (100%) are having a favorable attitude.

Association between attitude of urban and rural population regarding human rights of mentally ill and selected demographic variables



In the urban area there was no association found but in the rural area there is a significant association between attitude of rural population regarding human rights of mentally ill and selected demographic variable like education (p value=5.663, table value =3.84) religion (p value=9.247,table value 3.84) family history of mentally illness (p value=16.188, table value=3.84) there is no significant association between attitude of rural population regarding human rights of mentally ill and selected demographic variables like age (p value =0.004, table value =3.84)gender (p value=0.204,table value =3.84) occupation (p value=0.267, table value =3.84)and mentally ill present at home (p value =1.094, table value=3.84) thus it is interpreted that the demographic variables like education, religion, family history of mental illness as an influence on the attitude of rural population and demographic variable like age, gender, occupation and mentally ill present at home have no influence on the attitude of rural population regarding human rights of mentally ill. Hence, the research hypothesis is accepted for the demographic variable and rejected for the remaining variables.

DISCUSSION

The majority of people in the rural population belonged to age 41-50(42%). Most of the rural people

were females 56%. Majority of the rural people were having primary level of educational qualification. Most of them were farmers (51%). Most of the rural population were Hindus (52%). Most of them were not having family history of mental illness (99%). Majority of people were not having mentally ill at home presently (100%). In the urban population most of the people belongs to the age group 31-40(51%). Majority of them were females 70%. Most of them were having secondary level of educational qualification (69%). Most of the people in the urban population were Private employees. Majority of the people who participated in the study were Muslims (40%). 93% of the people were not having family history of mental illness. 92% of the urban population were not having mentally ill at home.

In the present study result obtained by comparing the attitude score of urban and rural population are as follows. According to the attitude score in the rural population (6%) has a favourable attitude, (87%) have neutral attitude and (7%) have unfavourable attitude and in the urban population (100%) are having a favourable attitude. When the score is compared with demographic variables.

There is a significant association between attitude of rural population regarding human rights of mentally ill and selected demographic variable like education, religion, family history of mentally illness, there is no significant association between attitude of rural population regarding human rights of mentally ill and selected demographic variables like age, gender, occupation, and mentally ill present at home. There is no significant association between attitude of urban population regarding human rights of mentally ill and selected demographic variables like age, gender, education qualification, occupation, religion, family history of mental illness and presence of mentally ill at home.

CONCLUSION

The title of the study was "Comparative study to assess the attitude among urban and rural population towards human rights of mentally ill in a selected area Mangalore, with a view to prepare information pamphlet" 200 people were selected through non-probability purposive sampling technique based on inclusion criteria. The data was analysed using descriptive statistics. The sample characteristics were described under the sub heading of age, gender, educational qualification, and occupation, and religion, family history of mental illness and presence of mentally ill at home. From the study we concluded that according to the attitude scale and frequency distribution the urban population with a favourable attitude and rural population with a neutral attitude. When the mean score was compared there is a significant difference in the attitude scores between urban and rural population. The attitude score was higher in the urban population as compared to rural. The association between attitude of urban and rural population regarding human rights of mentally ill with selected demographic variable was found to be that none of the demographic variables has no association with the attitude of urban population and demographic variables like education, religion, family history of mental illness has an association with the attitude of rural population and rest of the demographic variables have no association with the attitude of rural population.

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Conflict of Interest: Nil

Source of Finding Self or other: Self

Ethical Clearance: Ethical clearance was obtained from institutional ethical committee of Yenepoya University.

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Path to Improve Coping Stratigies for Patients Undergoing CABG Surgery

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ABSTRACT

Many patients experience stress and negative cognitions when undergoing CABG surgery. Many of these stresses result from the nature of the surgical procedures and post-operative treatment. Because of this lack of preparedness, a significant number experiences acute psychological distress. Excessive stress prior to surgery has been linked to negatively affect patients' recovery from illness, increase the duration of hospitalization[1]. While preparing patients for CABG surgery the main aim of intervention is to reduce their stress and distress due to unpleasant surgical procedure. Many studies have examined how patients may best be prepared for hospitalization and surgery, and various interventions have been developed to help patients cope with theses stressors. Giving pre-operative information is one of the best modes for preparing the patients psychologically in order to get better coping and recovery.

Keywords: *Coronary Artery Bypass Graft, Strategies, Pre-Operative Education*

INTRODUCTION

There is no doubt that giving pre-operative information will reduce the patient stress related to CABG surgery, increases patient satisfaction and improve the patients coping behaviour. And more over the patient has a right to know what to expect and how to participate effectively during the surgical experience. It can reduce post operative vomiting, pain, fear, anxiety and stress. It can also decrease complications, the duration of hospitalization, and the recovery time following discharge. In preparing the patient for surgery, the nurse must strike a balance between telling so little that the patient is unprepared and explaining so much that the patient is overwhelmed[1]. The nurse who observes carefully and listens sensitively to the patients can usually determine how much information is enough in each instance, remembering that anxiety and fear may decrease learning ability. The nurse must also assess what the patient wants to know right away and give priority to his or her concerns.

Generally the preoperative teaching concerns two types of information: Problem focused and Emotional focused coping information.

(A) Role of nurse in Problem focused coping information:

Problem focused coping information is the most common form of pre-operative information which involves assessing the specific problems and helping the patient to solve the problem[2]. It focuses on procedure, behavior and sensory information. Undergoing CABG, surgery patients are encountering a number of challenges during the pre-operative and post-operative period. The provision of problem focused coping information will help patients and care givers to make informed decisions and solve problems, thus enhancing their self care ability.

(i) With procedural information- describes the process the patient will undergo in terms of what will happen, when it will happen and how it will happen[3]. Here desired details are more specific; for example

- Physical preparation (Bowel or skin preparation)
- When to start nil per oral
- What type of clothing to wear during operation?
- When will be started intravenous line?

- Purpose of frequent vital signs assessment
- Pain control and other comfort measures
- Why turning, coughing, and deep breathing postoperatively important. Practice sessions need to be done preoperatively.

(ii) With behavioural information- consists of telling patients what they should do to facilitate either the procedure or their recovery from the procedure; for example

- A patient could be told how to use incentive spirometer equipment.
- Gentle movements only.
- Frequency of doing breathing exercises.
- Adopting semi fowler position in postoperative period.
- Early ambulation in the post operative period.
- No lifting for 6 weeks.

(iii). With sensory information- Patients want to know what they will see, hear, smell, and feel before, during or after the surgical procedure; for example

- Lights in the operating room can be very bright.
- Machines (ticking and pining noises) may be heard when awake. Their purpose is to monitor ad ensure safety.
- Drugs and cleaning solutions may be smelled.
- Operating room will be cold.
- The likely sensations of the drugs entering the body during the initial stages of anaesthesia.
- Degree and duration of pain.
- Medical equipment utilized in the immediate postoperative phase.

(B) Role of nurse in Emotional focused coping Information:

It aimed at ameliorating the negative emotions associated with a specific problem. Interventions which involve the discussion of emotions include the expression or disclosure of emotions that a patient has[4]. It incorporates cognitive coping, modeling and relaxation information.

(i). With Cognitive coping information- It means cognitive reframing. Here the interventions aim to change how an individual thinks, especially about negative aspects of the procedure. Cognitive reframing involves developing a positive perspective on a negative thought, for example

- Focusing on the number of people who do well after a surgical procedure rather than the number who fare badly.
- Give assurance they will be safe.
- Awake from their operation.
- Be unharmed and gain a full recovery.
- Being told of the highly trained staff.
- Fast effective drugs.
- Modern well maintained equipment.
- Strict pre assessment to verify fitness.

(ii). With Modeling coping information- Directly by actively imitating the required or desired behaviour via;

- Preoperative teaching about CABG surgery / Demonstration of exercises.
- Reading booklets.
- Making interaction with patients those with similar.
- Showing ICU preoperatively.

(iii). With Relaxation coping information- These involve 'systematic instruction in physical and cognitive strategies to reduce sympathetic arousal, and to increase muscle relaxation and a feeling of calm'[5]. Relaxation techniques can be used before surgery to reduce stress and anxiety, for example

- Guided imagery.
- Progressive muscle relaxation.
- Simple relaxation breathing techniques.

CONCLUSION

Author suggests that preoperative education especially Problem focused and Emotional focused coping information will reduce stress and improve the coping skills of the patients could have a beneficial impact on both preoperative and postoperative health status. Positive coping skills will aid more rapid and complete postoperative recovery can result in reduced hospital stays, more effective rehabilitation services, and less risk of re-injury – ultimately reducing both the financial as well as the human costs associated with illness. Improving outcomes after surgery has

a range of benefits both for the individual and for the healthcare service. Individuals will benefit from reduced time spent in hospital and saves money, less risk for hospital acquired infections and a quicker return to activity. The hospitals get benefits from more patients can be treated and reduced infection rates.

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