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A Descriptive Study to Assess the Risk of Developing Nomophobia among Students of Selected Nursing Colleges Ludhiana, Punjab

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ABSTRACT

Background: Nomophobia is a new term, defines the fear of being out of mobile phone contact. People, especially teenagers get very anxious when they lose their mobile phone, run out of battery or credit or due to less network coverage. Those who have nomophobia never switch off their mobile phones, carry their phones to bed and they will never stay away from their phone even for a second. **Material and method:** Non experimental approach and descriptive research design was adopted in this study. The study was conducted in four selected colleges of Ludhiana, Punjab. The sample of this study was 200 nursing students. Simple random sampling technique was used to draw the sample. The tool developed and used for the data collection were socio-demographic performa, checklist and likert scale. The content validity was obtained from the experts and the reliability was obtained by split half method. Feasibility of the study was confirmed by pilot study Data was collected from nursing students by self structured tool. Data was analyzed by descriptive and inferential statistics and presented through tables and figures. **Results**: Findings revealed that majority of nursing students (79%) were at risk of developing nomophobia, followed by normal (15%) and remaining (6%) are nomophobic. Maximum of nursing students were using mobile phones with internet facility (81.5%), sleep with their mobile phone turned on (80.5%), were using smart phone (74%), using mobile phones for playing games (70.5%) and set mobile phone on vibrate mode rather than turning it off during lectures (66%). There was moderately positive correlation (r =0.328) between pattern of mobile phone usage and risk of developing nomophobia at $p<0.05$ level. Gender was found significantly related to risk of developing nomophobia. **Conclusion:** In the present study maximum of nursing students were at risk of developing nomophobia. Majority of nursing students are using mobile phones with internet facility, sleep with their mobile phone turned on, using smart phone, use mobile phones for playing games and set mobile phone on vibrate mode rather than turning it off during lectures. It is found that there is moderately positive correlation (0.328) between pattern of mobile phone usage and risk of developing nomophobia. Gender has significant relationship with the risk of developing nomophobia among nursing students.

Keywords: *Nomophobia, Risk, Nursing Students.*

BACKGROUND OF THE STUDY

Introduction: *"It has become appallingly obvious that our technology has exceeded our humanity."* ***Albert Einstein***

Worldwide technology and its changes play a major role in each individual's life. The current trend of the society is to adopt every change in the field of communication technology. The mobile phones are boon of this century. Mobile phone is considered as an important communication tool and became the integral part of the society, it is not only a communication device but it also a necessary social accessory. People are increasingly using mobile

phones rather than the fixed telephones[1]. Mobile phone holds multiple functional capabilities and replaced the other technological devices that are used earlier. These attractive features usually catch the attention of new generation. Apart from this various benefits of mobile phone, its over usage leads to mobile phone addiction. The mobile phone addiction means that, usage of mobiles in a compulsive repeated manner which the person cannot resist. It is one of the biggest non drug addictions in the world.[2]

"Nomophobia" is a new term means –'no mobile phone phobia' defines the fear of being out of mobile phone contact. People, especially teenagers get very anxious when they lose their mobile phone, run out of battery or credit or due to less network coverage. Those who have nomophobia never switch off their mobile phones, carry their phones to bed and they will never stay away from their phone even for a second. Those who have nomophobia will also be carrying an extra phone as a precaution when their primary phone breaks. These people will be angry if their messages and texts were viewed by their partner and this will create problems in their familial and social life. They will be worrying about their phones security and will not be able to concentrate on their regular works.[3]

New generation seem to be so obsessed with using cell phone that they use their mobile phones even at places where usage is prohibited such as planes, hospitals and petrol stations Excessive usage brings financial worries and make adolescents financial indebted as a consequence. In a study conducted on U.S students that major strength of students are in a habit of making calls at night and this habit can go ahead to adverse outcomes such as sleep loss. It has been found in a study that youngsters desperately want to be in contact with their friends. They want to have a sense of presence f their belongings all the time and for this they use (SMS) short messaging service. Hence, it is need of the hour to spread awareness about the hazards caused by excessive mobile usage as it has become a public health issue.[4]

NEED: Mobile phone addiction appears to be a new disorder that merits inclusion in new classification systems of ICD-XI and DSM-V. It fulfills excessive use along with loss of sense of or neglect of basic drives. Withdrawal includes feelings of anger, tension and depression when phone network is not available or battery got over, along with arguments, social isolation and fatigue. [5]The previous research studies related to nomophobia suggested that the term nomophobia is new to the people and many of them are not aware of the problem. This study was undertaken to find out the risk of developing nomophobia in the Indian scenario considering the tremendous increase in the number of mobile phone users in the past decade. We decided to conduct the study in nursing colleges since the younger generation is the latest consumer of the mobile phones. In professional colleges like nursing colleges use mobile phones quite frequently since most of them reside in hostels. Day scholar students too want to be in constant touch with their family members and friends since they are out of their homes for the whole day and at nights while studying in colleges and working in hospitals

OBJECTIVES

1. To assess the risk of developing nomophobia among students of selected nursing colleges.
2. To assess the pattern of mobile phone usage among students of selected nursing colleges.
3. To assess correlation between pattern of mobile phone usage and risk of developing nomophobia among students of selected nursing colleges.
4. To find out the relationship of risk of developing nomophobia among students of selected nursing colleges with selected demographic variables like age, gender, course of study, area of stay, family income , type of family.
5. To prepare pamphlets to develop awareness about nomophobia among students of selected nursing colleges.

HYPOTHESIS

$\mathbf{H_1}$: Nursing students with high family income will have significantly higher risk of developing nomophobia than nursing students with low family income as measured by self structured tool at $p < 0.05$ level.

MATERIAL & METHOD

- **Research approach and design:** A quantitative descriptive approach and non experimental design was used to achieve the objectives of the present study.

- **Research setting:** The study was conducted in 4 selected nursing colleges Institute of Nursing Education, Guru Teg Bahadur Sahib (C) Hospital, Dayanand Medical College of Nursing ,Mata Saraswati College of Nursing, Mohan Dai Oswal College of Nursing of Ludhiana Punjab.

- **Sample and sampling technique :**The population of the study comprises of 200 nursing students and Simple random sampling technique was used to select the sample as per inclusion criteria and exclusion criteria.

- **Tool for data collection:** Sociodemographic performa consisted of 6 demographic variables namely age, gender, course of study, area of stay, family income, type of family. Pattern of mobile phone use was assessed by checklist consist of 22 items with 'yes' or 'no' response.

Self structured tool to assess the psychological dependency on mobile phones. It was a five point Likert scale consist of 32 statements. 23 statements are positive and 9 statements are negative. The five point likert scale is divided into Always (4), Often (3), Sometimes(2), Seldom/Rarely (1), Never(0).

Plan of data analysis: Analysis was done by using descriptive statistics and inferential statistics.

FINDINGS

Section - I: Distribution of nursing students according to their Socio- Demographic Variables

Table 1: Frequency and percentage distribution of nursing students according to their Socio-demographic variables.

N=200

Variables	Opts	Percentage (%)	Frequency(f)
Age (in years)	17-20 Years	97	49.5
	21-24 Years	78	39
	25-28 Years	22	11
	29 & above	3	1.5
Gender	Male	32	16
	Female	168	84
Course of study	G.N.M	39	19.5
	B.Sc. Nursing	116	58
	P.B.Sc.Nuring	27	13.5
	M.Sc. Nursing	18	9
Area of stay	Hostler	120	60
	Day Scholars	80	40
Family income (per month)	≤₹10000	58	29
	10001-₹20000	52	26
	20001-₹30000	42	21
	>₹30000	48	24
Type of family	Nuclear	157	78.5
	Joint	43	21.5

This table shows that majority of nursing students are in the age group of 17-20 years, are females, studying B.Sc Nursing and staying at hostel. Maximum of nursing students are from nuclear family and having family income ≤₹10,000 per month.

Objective 1: To assess the risk of developing nomophobia among students of selected nursing colleges.

Table 2: Frequency and Percentage distribution of nomophobia among nursing students . N=200

Nomophobia	Score	Freq-uency (n)	Percen-tage (%)
Normal	0-50	30	15
At risk of Nomophobia	51-100	158	79
Nomophobic	101-150	12	6

Table 2 depicts that maximum (79%) nursing students are at risk of developing nomophobia , followed by nursing students who are not at risk of developing nomophobia (normal) (15%) and remaining (6%)nursing students are nomophobic.

Objective 2 : To assess the pattern of mobile phone usage among students of selected nursing colleges.

Table 3 : Frequency and percentage distribution of pattern of mobile phone usage among nursing students.

S.no.	Pattern of mobile phone usage	Frequency (f)	Percentage (%)
1.	Having more than one mobile phone	31	15.5
2.	Using mobile phones for more than 3 years	122	61
3.	Using smart phone	148	74
4.	Having mobile phone with internet facility	163	81.5
5.	Using mobile phone having double SIM facility	113	56.5
6.	Using more than one SIM	52	26
7.	Frequency of check your mobile phone for more than 35 times a day	80	40
8.	Can operate mobile phone without looking at it	48	24
9.	Always carrying a mobile charger	36	18
10.	Making long duration call daily (>30 minutes)	44	22
11.	Sending more than 20 texts per day with the help of messenger application	90	45
12.	Making more than 10 calls per day	29	14.5
13.	Carrying power packs while travelling to other places	27	13.5
14	Using mobile phone for playing games	141	70.5
15	Sleep with mobile phone turned 'on'	161	80.5
16	Prefer to use 3G internet package over 2G	110	55
17.	Always keep mobile phone on ringing mode	78	39
18.	Using mobile phone during lecture or clinical posting	46	23
19.	Hold mobile phone in hand while travelling/driving -	65	32.5
20	Set mobile phone on vibrate mode rather than turning it off during lectures	132	66
21.	Make mobile phone calls late at night	35	17.5
22.	Reply back to missed call or text immediately on receiving	91	45.5

The table 3 shows the frequency and percentage distribution of pattern of mobile phone usage among nursing students**.** Maximum of nursing students are using mobile phones with internet facility (81.5%), sleep with their mobile phone turned on (80.5%), are using smart phone (74%), using mobile phones for playing games (70.5 %) and set mobile phone on vibrate mode rather than turning it off during lectures (66%).

Objective 3 : To assess the correlation between pattern of mobile phone usage and risk of developing nomophobia among students of selected nursing colleges.

Table 4 :Correlation between pattern of mobile phone usage and risk of developing nomophobia among nursing students.

N_1=158

Relationship between	Mean	SD	'r'	df	t
Pattern of mobile phone usage	9.53	3.076	0.328	156	4.34*
Risk of developing nomophobia	65.15	11.154			

$N_{1=}$ At risk of nomophobia subjects

Table 4 shows the relationship between pattern of mobile phone usage and risk of developing nomophobia is found moderately positive correlation i.e. 0.328 at p<0.05 level. Therefore, it is inferred that the pattern of mobile phone usage and risk of developing nomophobia are interrelated.

Objective 4 : To find out the relationship of risk of developing nomophobia with- Age, Gender, course of study, area of stay, family income , type of family.

Gender was found to have statistically significant relationship with risk of developing nomophobia at p < 0.01 level. Age, course of study, area of stay, family income , type of family was found to have statistically insignificant relationship with risk of developing nomophobia.

DISCUSSION

The findings of the study reveals that maximum (79%) nursing students were at risk of developing nomophobia, followed by nursing students who were not at risk of developing nomophobia (normal) (15%) and remaining (6%) nursing students are nomophobic. Whereas Sharma Neelima et al (2015)[6] conducted a study Rising concern of nomophobia amongst Indian medical students.The study findings suggest that 73% of medical students were nomophobic followed by 15% were at risk of nomophobia and remaining 11% had no evidence of nomophobia.

According to findings of present study the correlation between pattern of mobile phone usage and risk of developing nomophobia among nursing students was found to be moderately positive correlation i.e. 0.328 at p<0.05 level.Similarly, **Bivin JB et al (2014)[7]** conducted a cross sectional descriptive research study, aimed at evaluating the risk of developing Nomophobia among male Under Graduate students of health sciences. Sample was 547 students of health sciences. There is significant positive correlation (r: 0.67) seen between the overall scores on pattern of mobile usage to the overall scores on Nomophobia severity.

Findings according to gender reveal that it has impact on risk of developing nomophobia The difference in the mean score is found to be statistically significant at p< 0.01level. On the contrary**, Sharma Neelima et al(2015)[6]** conducted a study 'Rising concern of nomophobia amongst Indian medical student' in which Female preponderance was seen and category of gender is found statistically significant.

CONCLUSION

In the present study maximum (79%) of nursing students were at risk of developing nomophobia. Majority of nursing students were using mobile phones with internet facility, sleep with their mobile phone turned on, using smart phone, use mobile phones for playing games and set mobile phone on vibrate mode rather than turning it off during lectures. It is found that there was moderately positive correlation (0.328) between pattern of mobile phone usage and risk of developing nomophobia. Gender had statistically significant relationship with the risk

of developing nomophobia among nursing students.

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

Source of Support: Self

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

REFERENCES

1. Ronald P. User-awareness about security threats on mobile phone is very low, says F-secure: Interview. [online]. 2008 [cited Apr 01 2008]. Available from URL:www.techshout.com.
2. Goliama CM. Where Are You Africa? Church and society in the mobile phone age. Cameroon: Langua Research & Publishing common Initiative Group; 2011.
3. What is nomophobia? Mobile phone fears. [internet] 2012[updated 2012 Feb 21; cited Nov 3] Available from: http://www.indianist.com/what-is-nomophobia-mobile-phone-fears/ Bhatia Singh
4. Ahmed Ishfaq . Fiaz Qazi Tehmina. Mobile Phone Adoption & Consumption Patterns of University Students in Pakistan. International Journal of Business and Social Science.2011 May;Vol. 2 No. 9:205-210.
5. Manjeet. Cell phone dependence – a new diagnostic entity. Delhi psychiatry journal. 2008 oct; 11(2): 123-24. nursing.2013 july;6(1): 37-40.
6. Sharma Neelima, Sharma Pooja, Sharma Neha, Wavare R. R. Rising concern of nomophobia amongst Indian medical students. International Journal of Research in Medical Sciences. 2015 Mar;3(3):705-707.
7. Bivin JB et al.Nomophobia – do we really need to worry about?.Indian journal of psychiatric nursing.2013 july;6(1):37-40.

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Effectiveness of Relaxation Breathing in Reduction of Job Stress among Police Personnel

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ABSTRACT

"A study to evaluatetheeffectivenessof video assisted teaching on relaxation breathing in the reduction of job stressamong police personnel in selected police stations, Moradabad district".

The objectives of the study were:

1. To assess the job stress among police personnel.
2. To evaluate the effectiveness of relaxation, breathing on job stress among police personnel.
3. To find out the association between the level of job stress of police personnel and selected demographic variables.

Method: The study utilized, quasi-experimental research approach. The population comprised of police personnel of Moradabad district. A sampling technique was utilized for selecting the police station and then by sampling 30 police personnel were selected. The data gathered is analyzed and interpreted keeping in mind the objectives using descriptive and inferential statistics. [4,7]

Results:

- A majority of policemen 40% were in the age group of < 25 years, whereas 23% policemen were between the age group of 36 – 45 years, and only 16.6% policemen are age group of >45 years.
- The majority of the policemen 73.3% were male.
- Most of the policemen 46.62% were post- graduate, 29.97% policemen were graduating, 16.65% and only 6.66% policemen had studied up to high school.
- 79.92% of policemen were unmarried & 19.98% of policemen were married.
- A majority of policemen was earning Rs.15001 – 20000, whereas only 6.66% of them had a yearning of > Rs.25001.
- A majority of policemen 96.97% were Hindu whereas only 3.33% of them were Muslim.
- A majority of policemen 73.3% were residing in the village.
- A majority of policemen 59.97% were belonging to joint family & 39.96% of policemen were belonging to nuclear.
- A majority of the of policemen 43.29% were having 1– 10 years of experience, whereas 16.65% of policemen were having < 1 years of experience.
- The mean post-test stress score (50) of the policemen was less than the pre-test stress score (27.58). The obtained mean difference (41.47) was found to be statistically significant as evident from the 't' value of 4.62 for DF (29) at the 0.05 level of significance
- No significant relationship was seen between stress scale with selected demographic variables.

Keywords: *relaxation, breathing, job stress. Police personnel, video assisted teaching.*

INTRODUCTION

"If you don't mind, it doesn't matter

The purpose of stress isn't to hurt you, but to let you know it's time to go back to the heart and start loving"

Science Daily (Sep. 20, 2008) — Mangled bodies, gunfire, high-speed chases and injured children are just a few events witnessed by police officers and soldiers serving in dangerous hot spots around the world. These traumas take a high toll on the police officers and soldiers, who suppress human emotions to get the job done and can be reluctant to share their experiences in an effort to spare others from their ordeals, according to a September Police Quarterly article (published by SAGE).

"Police work is highly stressful and one of the few occupations where an individual continually faces the inherent danger of physical violence and the potential of sudden death," said Singer.

Longitudinal data for both occupational stress and life stress were investigated in a sample of police officers. It was pointed out that police work is a well-known high-stress occupation **(Band & Manuele, 1987; Dantzer, 1987).**

The stress associated with police work is quite unique and relatively violent in comparison to the stress encountered in the general population **(Band & Manuele, 1987).**[6]

MATERIAL AND METHOD DATA COLLECTION INSTRUMENT

Self administered questionnaire-

A self administered questionnaire was prepared by the investigator based on the objective of the study after reviewing relevant literature about job stress.

The following steps were carried out in formulating the tool.

Related literatures were reviewed.

Blue print was prepared.

Subject experts were consulted for their valuable suggestions regarding the tool and alterations were made accordingly.

Statistician was consulted for the preparation of the plan for the statistical data analysis.

Reliability was checked by doing pilot study.

The self administered questionnaire on job stress consisted of two sections. [7]

Section I: Demographic variables of the police personnel

It consists of selected 9 demographic variables like age, sex, education, marital status, monthly income, religion, area of residence, type of family and years of experience.

Section II: Structured questionnaire related to job stress

The questionnaire was a five-point scale. The questions were in the statement form and there were five options in the scale like strongly agree, tend to agree, neither agree nor disagree, tend to disagree and strongly disagree with 0, 1, 2, 3 and 4 scores respectively. There were totally 50 questions distributed in different areas such as position, work load, income, social support, family, general health and self esteem.

SCORING PROCEDURE AND INTERPRETATION

Total score – 200

No stress- 0 – 50

Mild stress–51 – 100

Moderate stress– 101- 150

Severe stress– 151- 200

RELAXATION BREATHING

Relaxation breathing techniques:

4 X 4 techniques

1. Sit up straight with your back flushed to stop to the chair and your feet flat on the floor.

2. Rest your arms on your lap, thighs, or arms of the chair. Take in a deep breath through your nose to a count of four (1…2…3…4)

3. Repeat the cycle four times.

Relaxing sigh

Sit up straight. Sigh deeply, letting out a sound of deep relief as the air rushes out. Do not think about inhaling- just let the air come in naturally as you breath deeply. Take 6 to 8 of these relaxing sighs very slowly. Repeat as needed.

Tips:

- **Breathe Through Your Nose.** Your nose contains natural filters that take away impurities in the air. It also contains a mucous membrane that acclimatizes the air by warming it and adding moisture to it.

- **Let the Air Fill All of Your Alveoli.** The air must travel all the way down your larynx, trachea, bronchi, lung and bronchiole. Once the air reaches your bronchiole, it should fill close to a billion alveoli. Alveoli are little sacs that get inflated if your breathing is deep enough. The importance of inflating these alveoli is based on the carbon dioxide/oxygen exchange that happens though

Blood vessels in the alveoli.

Diaphragm your diaphragm is a muscle located below your lungs and it separates your chest from your abdomen. When you inhale, your diaphragm stretches out to allow room for the air to fill your lungs. When you exhale, the diaphragm curves upward to help push the air out [9.]

Table-1:Comparison of pretest and posttest level of job stress among police

Personnel:

Components	Observations	Mean	Mean difference	S.D	'T' test	Significance
Satisfaction	Pretest	9.9	2.333333	1.45270	7.95678	Significant p<0.05
	Posttest	7.56667				
Position	Pretest	11.6	3.3	1.96784	9.18509	Significant p<0.05
	Posttest	8.3				
Workload	Pretest	28.3	11.466667	4.49229	14.1433	Significant p<0.05
	posttest	16.8333				
Income	Pretest	8.1	0.4333333	0.77013	4.26724	Significant p<0.05
	Posttest	7.66667				
Social support	Pretest	13.4333	1.1333333	0.99654	6.59545	Significant p<0.05
	Posttest	12.3				
Family	Pretest	8.23333	0.3666666	0.73108	3.74597	significant p<0.05
	Posttest	7.86667				
General health	Pretest	40.8667	18.833337	5.48411	18.8762	significant p<0.05
	Posttest	22.0333				
Self-esteem	Pretest	11.4	4.2	3.11392	8.09114	significant p<0.05
	Posttest	7.2				

Table depicts that the computed't' value on satisfaction is t=7.95678, position is t=9.18509, work load is t=14.1433, income is t=4.26724 social support is t=6.59545, family is t=3.74597, general health is t=18.8762, and self-esteem is

t=8.09114. Hence, H1 is accepted.

SECTION IV

Table-2:Association between the pretest level of job stress and selected demographic variables:

Demographic variables		Level of stress						Chi- square test	Significance
		Mild		Moderate		Severe			
		n	%	n	%	N	%		
Age in years	< 25	0	0	4	57.14	3	42.86	χ^2=8.4299 df=6	Not Significant p>0.05
	26 - 35	0	0	5	41.67	7	58.33		
	36 - 45	1	16.67	3	50	2	33.33		
	> 45	2	40	2	40	1	20		
Sex	Male	3	13.64	8	36.36	11	50	χ^2=4.8047 df=2	Not Significant p>0.05
	Female	0	0	6	75	2	25		
Education status	10^{th} std	0	0	2	18.18	9	81.81	**χ^2=15.9311 df=6**	Significant p<0.05
	th 12 std	1	7.69	8	61.53	4	30.76		
	UG	2	40	3	60	0	0		
	PG	0	0	1	100	0	0		
Marital status	Married	3	20	11	73.33	1	6.67	**χ^2=17.6043 df=6**	Significant p<0.05
	Unmarried	0	0	3	60	2	40		
	Divorced	0	0	0	0	7	100		
	Widow	0	0	0	0	3	100		
Monthly income in rupees	< 15000/-	0	0	6	40	9	60	**χ^2=18.0459 df=6**	Significant p<0.05
	15,001 – 20,000/-	0	0	4	50	4	50		
	20,000 – 25,000/-	1	25	3	75	0	0		
	< 25,000/-	2	66.67	1	33.33	0	0		
Religion	Hindu	1	7.69	6	46.15	6	46.15	χ^2=1.4864 df=6	Not Significant p>0.05
	Christian	1	11.11	4	44.44	4	44.44		
	Muslim	1	14.28	3	42.86	3	42.86		
	Others	0	0	1	100	0	0		
Area of	town	2	15.38	6	46.15	5	38.46	χ^2=0.7921	Not

residence	village	1	5.88	8	47.06	8	47.06	df=2	Significant p>0.05
Type of family	Nuclear family	3	13.64	9	40.91	10	45.45	χ^2=1.7626 df=2	Not Significant p>0.05
	joint Family	0	0	5	62.5	3	37.5		
Years of experience	< 1 year	0	0	6	54.54	5	45.45	χ^2=14.439 df=6	Significant p<0.05
	1-10 year	0	0	4	40	6	60		
	11-20 year	1	16.67	3	50	2	33.33		
	> 20 years	2	66.67	1	33.33	0	0		

From the above table it is evident that there is significant association between the pretest stress level of police personnel and the demographic variables education, marital status, monthly income, and years of experience. There is no significant association between the pretest stress level of police personnel and the demographic variables age, sex, religion, area of residence and type of family.

DISCUSSION

The present study Was conducted to find out the effectiveness of relaxation breathimg to reduce the job stress among the police personnel at pakwara and majola police station in Moradabad district.

- In the present study it was found that In pretest 13.33% of the police personnel have severe stress, 73.3% of them have moderate stress and 13.33% of them have mild stress ,these findings showed that most of the police men had moderate stress .

- The Study finding showed the in In 3.3% of the police personnel have severe stress, 23.31% of them have moderate stress and 73.3% of them have mild stress. The major source of stress was working conditions, ovwerload and lack of appreciation. The findings were similar with the study conducted by **Mathur (1993)** which also highlighted the same areas of stress problems in Indian police personnel that were work conditions, work overload and lack of recognition. Study conducted by **Bhaskar (1986)** has also identified similar factors intrinsic to the job and closely related to the work as major contributors to stress related problems among police personnel.

NURSING IMPLICATIONS

The findings of the study have a possible effect in the nursing practice, nursing education, nursing administration and nursing research.

Nursing practice: Occupational health nurses should monitor the stress level and coping mechanism of them on regular basis. Awareness and training programs regarding stress and its management should be conducted.

Nursing education: Stress is the most common problem faced by every individual in their day to day life, including nurses. Hence, basic education and training regarding various managements of stress like relaxation breathing, Progressive muscle relaxation technique, Benson's techniques should be given to the student nurses.

Nursing administration: Stress awareness and management should be given importance in the nursing care. Nursing administrators should see that the police personnel are assessed for level of job stress and taught about the stress management. Mental health of the police personnel should be given importance and they should regularly be monitored and treated appropriately. If needed, counseling sessions can be arranged **.**

RECOMMENDATIONS

Similar study can be conducted with control group.

A comparative study can be conducted to assess the effect of different relaxation techniques.

A study can be conducted on large sample for a better generalization.

CONCLUSION

The primary aim of the study was to bring awareness among the police personnel about their job stress and relaxation breathing. The study results showed the importance of the stress relief among the police personnel. Relaxation breathing is simple to practice and effective in job stress relief. Police personnel are at high risk to develop job stress; by regular practice of relaxation breathing they can protect

themselves from job stress and work efficiently to protect the society.

Acknowledgement: Am thank full to Teerthanker Mahaveer University for providing an opportunity and all facilities in caring out this particular study express my sincere and whole hearted gratitude to my vice chancellor Prof. R.K. Mudgal, principal prof. Anuja Danierl and the research committee for their guidance throughout the research process, I extend my heartfelt thanks to all the police personnel for their kind cooperation during the data collection.

Ethical Clearance: The study was conducted keeping all the ehical issues in mind.

Conflict of Interest: None

Source of Funding: Teerthanker Mahaveer University

REFERENCES

1. Abdullah FG and Levine E (1979) "Better Patient Care Through Nursing Research", New York collinear million publishing company, Pp.No: 699-720.
2. Ann H. (1989) "Nursing theorists and their work, Philadelphia., C.V Mosby company, Pp.No:328 329
3. Barbara (2002) "Psychiatric Mmental Health Nursing" lippincott company, Pp.No: 210-222.
4. Basavanthappa B.T (1998) "Nursing Research", Mumbai, Jaypee brother's publication, Pp.No: 650-670.
5. Beck. Rawlins "MENTAL HEALTH PSYCHIATRIC NURSING", Mosby publications, Pp.No:1120-1122.
6. Bimla Kapoor (2003) "A Text Book of Psychiatric Nursing", Volume-II, Kumar Publications, Pp.No: 128-132.
7. Denice F.Polit and Hungler. P Bernadette (1998) "Nursing Research Principles and Method", JP Lippincott Company, New York, Pp.No: 115-176.
8. Doris. B. Payne, Patricia A, "Psychiatric Mental Health Nursing", 2nd edition, Toppan company private limited, Singapore, Pp.No: 112-115.
9. Glen. O. Gobbard (1999) "Treatments of Psychiatric Disorders", second edition, Volume-I, Jaypee brother's ltd, New Delhi, Pp.No: 1421-1432.

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To Assess the Knowledge of Substance Abuse and Prevalence of Risk Factors among the Students Studying in Selected PU Colleges of Dharwad

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ABSTRACT

Today more and more fantasies of life are prevailing in this rapidly advancing society like never before due to the progressing trends in every field and the people are becoming more fascinated towards the temporary pleasures but at the same time these pleasures possess serious threats to the very living of an individual and among all the classes of society the younger people are the most vulnerable section to damage their wellbeing and hamper the overall progress. The most attractive element among all is the use of substances of different kinds in different ways which within no time leads to the imbalance in the entire functioning of a man and adolescents are at major risk of becoming preys to the devastating ill effects that these substances carry along with them. At the same time, recent wide spread influences of mass media, modeling and imitations serve as the biggest sources of pulling an adolescent towards the danger of substance abuse which he/she starts doing at any cost and under any situation ignoring the forthcoming affects.

The Objectives of the Study:

- To assess the knowledge regarding substance abuse among students group in selected colleges of Dharwad.
- To determine the risk of substance abuse among these adolescents.
- To find the association between knowledge and identified risk factors with selected demographic variable.

Method: A descriptive approach was used for the study. The sample consists of 120 pre-university students of different colleges in Dharwad. Students were selected by Systematic random sampling. Data was collected by administering structured interview scale.

The data was analyzed by using descriptive statistics and inferential statistics (chi-square test)

Results: The study reveals that majority of the students have good knowledge regarding substance abuse and the level of prevalence of risk among the students is that majority (49.16%) of respondents were at low risk, 49.16% respondents were at medium risk and 1.66% had high risk of substance abuse. This indicates that majority of respondents were at medium and low risk.

The chi-square test computed between level of knowledge with respect to selected socio demographic variables showed that there is a significant relationship between the level of knowledge with socio demographic variables that are age in years ($\chi 2$=.881,p value=46.194), religion($\chi 2$=.995,p value=36.415), educational level of the student ($\chi 2$=.205,p value=15.507), place of residence($\chi 2$=.178, p value=15.507),

total income of family per month (in rupees) ($\chi 2$=.022, p value=36.415), drug user in the family ($\chi 2$=.598, p value=15.507), source of knowledge of addictive substance ($\chi 2$=.310, p value=46.194), At 0.05 level.

Interpretation and Conclusion: Finding of the study showed that majority of the students have good knowledge regarding substance abuse and majority of respondents were at medium and low risk of substance abuse. The results of the study reveals the importance of creating awareness among the adolescents regarding the hazards of substance abuse and developing healthy life style practices through motivation, health education and improving their social environment.

Keywords: *Substance abuse; Risk Factors; PU Colleges;.*

INTRODUCTION

"A nation's hope rests on its youth. And for the hopes to turn into realities, the younger generation needs to grow into healthy adults."

Adolescence is a crucial gel fascinating period in an individual's life span. Adolescence is the period between the onset of puberty and the cessation of physical growth. The Adolescence period is divided into early adolescence 12-13 years; middle adolescence 14-16 years and late adolescence 17-21 years.[3]

Adolescents are the citizens of tomorrow on whom the future of the nation stands. It is a challenge to meet their health needs. 18-20 % of Indian population constitutes the age group of between 10 and 20 years.[4]

Substance abuse touches millions of people worldwide each year. It is estimated that about 76.3 million people struggle with alcohol use disorders contributing to 1.8 million deaths per year. As is the case with some global issues, substance abuse is unequally represented– the developing world, marginalized groups and communities being the most vulnerable to this reality.

Its extent and characteristics however vary from region to region although trends among the youth especially have begun to converge over these recent years. The most commonly used and abused substance are tobacco, cannabis and alcohol. Alcohol tobacco and other related problems are becoming more and more a public health concern. The misuse of alcohol and tobacco represents one of the leading causes of preventable death, illness and injury. Other common substances are inhalants, heroin and cocaine. This abuse is believed to be associated with increasing amount consumed, frequency of use and groups involved.[12]

Substance abuse is increasing in India and the number of substance addicts is increasing phenomenally. The process of adaptation to various academic and financial responsibilities, conflicts with the parents and peers which make an adolescent vulnerable to emotional stress. They seek an easy solution to these problems. Use and abuse of substance provides instant release from the pressure of life.

MATERIAL & METHOD

Research design: The research design selected for the study is a Non experimental design which is descriptive in nature. It is an investigators' overall plan for obtaining answers to the research questions.

Variables under study

Dependent variable: In the present study it refers to the Knowledge & prevalence of risk.

Independent variable: In the present study it refers to the substance abuse.

Extraneous variable: In the present study Extraneous variables are pre-university students' age, education status, place of residence, religion, occupation and income of parents etc.

Setting of the study: The present study was conducted in kittle & JSS Pre-University colleges at Dharwad.

Population: In the present study, the population comprises of all pre-university college students (boys) in the selected colleges at Dharwad.

Sample and sample technique: In this study, the sample consisted of 120 boys in selected pre-university Colleges, Dharwad. Systematic sampling was used for selecting colleges at Dharwad. Simple random sampling method was use for selecting samples.

Development and description of the tool

The tool was developed, based on the following steps

- After reviewing the related literature.
- With guidance and consultation with the subject experts.
- Based on the level of understanding of the students.
- Following consultation with the statistician regarding analysis.

A structured knowledge questionnaire & prevalence of risk scale was used to collect the data. Blue print was prepared, which showed the distribution of items according to the content areas such as knowledge of substance, knowledge of hazards of substance abuse and prevalence of risk. The scale consists of positive and negative worded questions. The responds were graded in 3-point scale and yes/no type questions.

Reliability of the tool: The reliability of the instrument was established by administering the tool to 20 students. The coefficient of the internal consistency was completed for structured knowledge questionnaire & prevalence of risk scale, using split half method. The reliability of the tool was computed by using Karl Pearson product moment correlation technique. The study tool was found to be adequately reliable with a 0.88 score of for knowledge and 0.8 score for prevalence of risk.

Description of tool: The final tool designed for study was structured interview schedule on knowledge of substance abuse and prevalence of risk scale.

It consists of 3 parts:

- Part 1- Demographic variables such as age, religion, education level of (student, father, mother), place of residence, type of family, occupation, income of family, No. of siblings, status among the siblings and knowledge about different substance.
- Part 2- Structured interview schedule comprises of 32 questions in 2 domains: knowledge of substance, knowledge of hazards of substance abuse.
- Part 3- Prevalence of risk scale consists of positive and negative worded questions. The responds were graded in 3-point scale and yes/no type questions.

Pilot study

After obtaining formal administrative approval from Anjuman PU College Dharwad pilot study was conducted with 20 samples.

- Data was collected from 20 students of selected pre-university colleges of Dharwad, who were fulfilling the criteria set for selection of sample.
- The purpose of study was explained and consent was taken by respondents prior to study to get co-operation and prompt answers.
- Study conducted on 21-11-2013 by administering the tool. The average time taken for study was 30 minutes.

Data collection: Appropriate orientation was given to subjects about the aim of the study, nature of study, nature of questionnaire and adequate care was taken to protect the subjects from potential risk including maintaining confidentiality, secrecy and identity.

A formal written permission was obtained from the concerned authorities of JSS Science College and Kittel Science Colleges of Dharwad to conduct the study. Self introduction were given by the investigators to the samples and the purpose of the study were explained. The students were assured of anonymity and confidentiality. The numbers of samples selected were 50 first day from Kittel Science College and 70 from JSS Science College on another day and each sample took about 40 minutes.

Plan for data analysis

Descriptive statistics (frequency, percentage, range, mean, median, standard deviation) and

inferential statistics ('t' test and chi-square test) will be used for the analysis and interpretation of data.

FINDINGS

Organization of findings

Part 1: Analysis of demographic variables of the respondents.

Part 2: Assess the knowledge prevalence of risk of substance abuse among these students.

Part 3: Association between levels of knowledge with selected demographic area.

Section I: Sample characteristics

The data obtained on sample characteristics was analysed using descriptive statistics as depicted in Table 1.

Table 1: Frequency and percentage of the sample characteristics n=120

Sl.No	Variables	Frequency	Percentage
1	Age (in years)		
	• 16	• 9	• 7.5
	• 17	• 72	• 59.5
	• 18	• 35	• 28.9
	• 19	• 4	• 3.3
2	Religion		
	• Hindu	• 99	• 81.8
	• Muslim	• 13	• 10.7
	• Christian	• 4	• 3.3
	• Others	• 4	• 3.2
3	Educational level of the student?		
	• 1st year PUC	• 31	• 25.6
	• 2nd year PUC	• 89	• 73.6
4	Place of residence		
	• Urban	• 70	• 57.9
	• Rural	• 50	• 41.3
5	Present place of your residence		
	• Home	• 64	• 52.8
	• Paying guest	• 22	• 18.2
	• College Hostel	• 18	• 14.8
	• Any other	• 16	• 13.2
6	Total Income of family per month (in rupees)		
	• Less than Rs.5000		
	• Rs. 5001 to Rs.10000	• 31	• 25.6
	• Rs.10001 to Rs.15000	• 45	• 37.2
	• More than Rs. 15001	• 18	• 14.9
		• 26	• 21.5
7	Educational status of father		
	• No formal education	• 21	• 17.4
	• Primary	• 19	• 15.7
	• Higher secondary	• 26	• 21.1
	• Graduate	• 34	• 28.1
	• post graduate	• 20	• 16.5
8	Occupation of father		
	• Agriculture	• 45	• 37.2
	• Business	• 19	• 15.7
	• Government employee	• 38	• 31.4
	• Private employee	• 8	• 6.6
	• Self employed	• 4	• 3.3
	• Laborer work	• 6	• 5.0
9	Source of knowledge of addictive substance		
	• Television	• 41	• 33.9
	• Internet	• 26	• 21.5
	• Newspaper or magazines	• 34	• 28.1
	• Relatives	• 6	• 5.0
	• Friends	• 13	• 10.7

Section II: DESCRIPTION OF KNOWLEDGE SCORES OF STUDENTS REGARDING SUBSTANCE LISTED

The score obtained by the students were arbitrarily categorized into three levels as given below.

Poor Knowledge	1-7
Moderate Knowledge	8-14
Good Knowledge	15-20

Table 2: Distribution of Study Subject According to Level of Knowledge. n=120

Level of Knowledge	Frequency	Percent
Poor Knowledge (0-7)	---	---
Moderate Knowledge (8-14)	15	12.5%
Good Knowledge (15-20)	105	87.5%
Total	120	100%

Maximum Score= 20

The data in table 3 shows distribution of study subject according to levels of knowledge among the students. Majority 87.5% respondents have good knowledge, 12.5% respondents have moderate knowledge and no one is having poor knowledge. This indicates that majority of respondents have good knowledge.

Description of prevalence of risk scores of students regarding substance abuse

The score obtained by the students were arbitrarily categorized into three levels as given below.

Levels	Score
High risk	1-8
Medium risk	9-16
Low risk	17-24

Table 3: Distribution of Study Subject According to Level of Risk n=120

Level of Prevalence Risk	Frequency	Percent
High Risk (0-8)	2	1.66%
Medium Risk (9-10)	59	49.16%
Low Risk (17-24)	59	49.16%
Total	120	100%

Maximum Score= 24

The data in table 3 shows the distribution of study subject according to level of risk. Majority 49.16% of respondents were at low risk, 49.16% respondent's medium risk and 1.66% has high risk of substance abuse. This indicates that majority of respondents were at medium and low risk.

Table 4: Mean, median, & standard deviation

Area	Mean	Median	Std. Deviation
Knowledge	16.7667	17.0000	1.70384
Prevalence of risk	16.4667	16.0000	2.95323

Section III:: Association between the level of knowledge and selected socio-demographic variables

n=120

Variables	χ^2 value	P- value
Age in years	.881	46.194*
Religion	.995	36.415*
Educational level of the student	.205	15.507*
Place of residence	.178	15.507*
Present place of your residence	.078	36.415*
Total Income of family per month (in rupees)	.022	36.415*
Anybody in your family uses drug	.598	15.507*
Source of knowledge of addictive substance	.310	46.194*

Above table shows: Association between the level of knowledge and selected socio-demographic variables The chi-square test computed between level of knowledge with respect to selected socio demographic variables showed that there is a significant relationship between the level of knowledge with socio demographic variables that are age in years (χ^2=.881,p value=46.194), religion(χ^2=.995,p value=36.415), educational level of the student ($\chi^{2=}$.205,p value=15.507), place of residence

(χ^2=.178, p value=15.507), total income of family per month (in rupees) (χ^2=.022, p value=36.415), drug user in the family (χ^2=.598, p value=15.507), source of knowledge of addictive substance(χ^2=.310, p value=46.194), At 0.05 level.

To determine the significance between knowledge regarding substance abuse and its risk prevalence among PU students with respect to selected demographic variables, the following hypothesis was formulated.

H_1: There will be significant association between knowledge of PU students regarding Substance abuse with selected demographic variables.

The above hypothesis was tested by using chi square test.

Analysis revealed that there was a significant association between the levels of knowledge with selected socio-demographic variables of the students. Hence, the stated hypothesis is accepted.

CONCLUSION

- The PU college students have good knowledge (87.5%) in which the highest knowledge has been found regarding information about substance abuse followed by knowledge regarding effects and hazards of substance abuse.
- The use of two point prevalence of risk scale revealed that 49.16% students have low & moderate risk.
- The findings show that tobacco(100%) was one of the commonest substance listed by the PU college students.
- A high association was found between the level of knowledge scores obtained with socio demographical variables like Age, type of family, Place of residence, Source of knowledge of addictive substance.

Acknowledgement: I, the researcher of this study, owe my sincere thanks and gratitude to all those who have contributed towards the successful completion of this endeavour.

Conflict of Interest: None

Source of Funding- Self

Ethical Clearance: Written permission form Principals of schools. And also written consent from the participants were taken

REFERENCES

1. World Health Organization, The health of young a challenge and a promise 1993.
2. World Health Adolescence, The crucial years Geneva w.h.o 1976.
3. world health organization, world no tobacco day 2010
4. www.who.int/substance_abuse/en/
5. www.drug abuse.gov/publication/ principles-drug-abuse
6. Dari V Raj psychosocial problems among adolescent girls as perceived by them. Rajiv Gandhi University of health sciences. Bangalore, Karnataka.
7. Parthima murathy, N Manjunath, B N Sudha, prabhakar kumar, department of psychiatry, De addication center NIMHANS Bangalore 2011.
8. Sabiha Jamal. Prevalence of Drug and Alcohol use among Engineering College students. National Institute of Mental Health and Neurosciences :Bangalore.
9. www.aacap.org/AACAP/families-and-youth/ facts-for-families.

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Effectiveness of De-escalation Skill Training Programme on Knowledge and Practice of De-escalation Skill among Nurses

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ABSTRACT

Restraints had been consistently shown to increase the patient agitation and actually increase the risk of injury. The present study was undertaken to find the effectiveness of De-escalation Skill Training Programme on the knowledge and practice of de- escalation skills among nurses working in selected mental health units in Ernakulam. The objectives of the study were to prepare De-escalation Skill Training Programme (DSTP), assess and evaluate the knowledge regarding de-escalation skills among nurses before and after the intervention, assess and evaluate the practice of de-escalation skills among nurses before and after the intervention, find the effectiveness of DSTP on knowledge and practice of de-escalation skills among nurses who have attended the DSTP and find the correlation between knowledge and practice of de-escalation skills among nurses who have attended the DSTP. The research design used was pre- experimental (one group pre test multiple post test) design and the study was conducted among 30 nurses from two private settings. Purposive sampling was used to select the sample and the data was collected using Structured knowledge questionnaire and De-escalation skill rating scale. Data was analyzed using descriptive and inferential statistics and the mean post test knowledge and practice scores were significantly higher than the mean pre tests knowledge and practice scores at 0.05 level of significance and there was also a significant correlation between mean knowledge score and mean practice score at 0.05 level of significance. From the findings it was clear that the DSTP was effective in improving the knowledge and practice of nurses on de-escalation skills.

Keywords- *De-escalation skills, nurses, knowledge of de-escalation, practice of de-escalation.*

INTRODUCTION

Aggressive behavior possesses an ongoing challenge in the mental health service, especially with staff of Psychiatric Intensive Care Unit and most commonly the management was using restraints. Restraints were archaic, did not work, were not safe for patients or staff and psychologically damage patients **– stripping them of all dignity and the right to be involved in their own treatment while re-traumatizing and punishing many**. Restraints were supposed to be used in emergencies to protect the person restrained or those around them. However, even if used correctly and with good intention, the use of restraints was still cruel and a violation of human rights.[1]

In the new paradigm, a three step approach was used. First the patient is verbally engaged; then a collaborative relationship is established and finally the patient was de-escalated out of the agitated state. The traditional goal of 'calming the patient' often had a dominant submissive connotation, while the contemporary goal of 'helping the patient

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to calm himself' was more collaborative. The act of de-escalation of a patient was therefore a form of treatment in which the patient was enabled to rapidly develop his own internal locus of control.[2]

OBJECTIVES

The objectives of the study were to:

1. Prepare De-escalation Skill Training Programme (DSTP)
2. Assess and evaluate the knowledge regarding de-escalation skills among nurses before and after the intervention.
3. Assess and evaluate the practice of de-escalation skills among nurses before and after the intervention.
4. Find the effectiveness of DSTP on knowledge and practice of de-escalation skills among nurses who have attended the DSTP.
5. Find the correlation between knowledge and practice of de-escalation skills among nurses who have attended the DSTP.

HYPOTHESES

1. H_1: The mean post- test knowledge score of nurses completing the de- escalation skill training programme is significantly higher than the mean pre- test knowledge score at 0.05 level.
2. H_2: The mean post- test practice score of nurses completing the de-escalation skill training programme is significantly higher than the mean pre- test practice score at 0.05 level.
3. H_3: There is a significant correlation between the mean knowledge score about de-escalation skill and the mean practice score of de-escalation skills among nurses.

CONCEPTUAL FRAME WORK

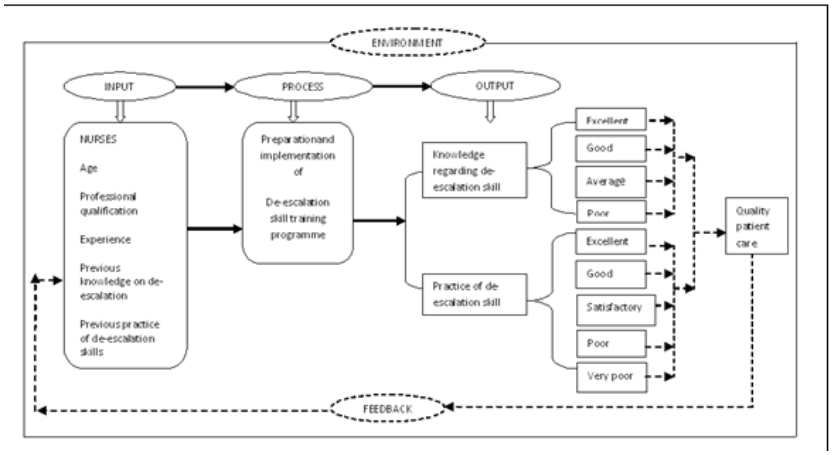


Figure -1: Conceptual frame work of this study was derived from Modified Ludwig Von Bertanlanffy's General System Theory [1968].

MATERIALS & METHOD

Research approach: In order to accomplish the main objective of determining the effectiveness of DSTP on the knowledge and practice of nurses working in the mental health units, the data must be in numerical form. Hence quantitative approach was selected.

Research design: Control group was not included and a single post test was not adequate to find out the effectiveness of DSTP, a pre- experimental design (one group pre-test multiple post test design) was adopted for the study.

Group	Pretest	Treatment	Post test		
Group 1&2	[day-1]	[day-1&2]	[day-7]	[day-30]	[day-60]
	O_1	X	O_2	O_3	O_4

Figure- 2: Schematic representation of research study

Sample and sampling technique

Fifteen staff nurses working in two private mental health centres in Ernakulam.

The sampling technique used for this study is purposive sampling.

Data collection tools and techniques

Tool 1- Structured knowledge questionnaire to assess the knowledge regarding de- escalation skills among nurses.

Tool 2 -De-escalation skill rating scale Rating scale to assess the practice on de-escalation skills among nurses.

Technique used was self reporting.

Intervention- A De-escalation Skill Training Programme was developed by the researcher after reviewing the literature, which included principles and concepts of de-escalation and video showing techniques of de-escalation for duration of 2 hours. A group activity by the participants on a given scenario for de-escalation of 2 hour duration was conducted on the next day. The training programme was focused on the objective to improve the knowledge and apply it in practice and gain positive attitude towards de-escalation skills.

Content validity and reliability

Content validity of the tool and intervention was established by giving it to 10 experts from the field of mental health nursing and the reliability of the tool was established using test- retest method. Coefffficient of correlation calculated was 0.08 and 0.09 for Structured knowledge questionnaire and De-escalation skill rating scale respectively.

MAJOR FINDINGS

Demographic data

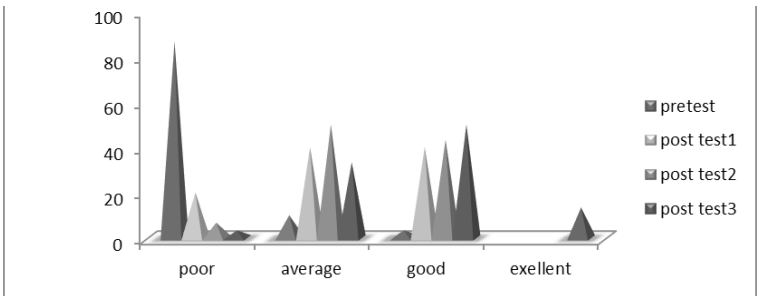
Table- 1: Frequency and percentage distribution of subjects according to age, gender, department, years of experience in clinical area and professional qualification

n=30

Variable	Frequency	Percentage
Age in years		
20-29	21	70
30-40	9	30
Above 40	Nil	Nil
Gender		
Male	13	43.3
Female	17	56.7
Department		
Casualty	1	3.4
De-addiction ward	6	20
General ward	17	56.6
Behavioural intensive care unit	6	20
OPD	Nil	Nil
Years of experience in clinical area		
< 1 year	5	16.7
1-4 year	17	56.7
5-10 year	7	23.2
above 10 year	1	3.4
Professional qualification		
GNM	14	46.7
B.SC nursing	16	53.3

Majority of subjects (70%) were in the age group of 20-29 years and were females (56.7%). Majority of the subjects (56.6%) were working in general ward and equal number (20% each) subjects worked in the de-addiction ward and behavioural intensive care unit. Majority (56.7%) of the subjects had clinical experience between 1-4 years and 23.2% of subjects had 5-10 years of experience. Majority of the subjects (53.3%) were having professional qualification of B. Sc nursing degree.

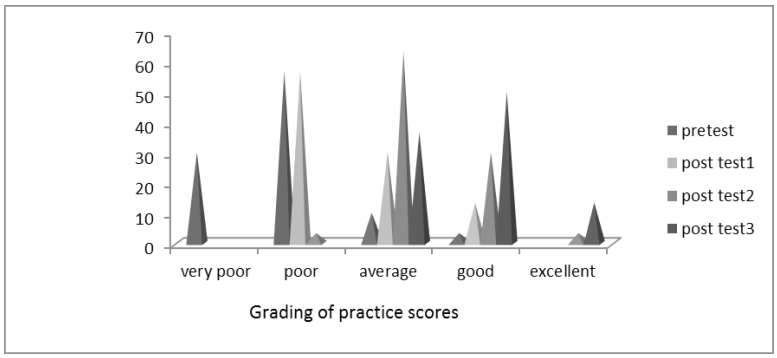
Knowledge regarding de-escalation skills among nurses



The pre test grading of the knowledge scores of de-escalation skills showed that majority of the subjects (86.6%) had poor knowledge, 10% of subjects had average knowledge and remaining 3.4% had good knowledge on de-escalation skills. In the post test 1 the percentage of subjects with good knowledge increased to 40% and an equal percentage (40%) had average knowledge and only 20% had poor knowledge in de-escalation skills. In the post test 2 the percentage of subjects with good knowledge further increased to 43.3, the subjects with average knowledge was 50% and the remaining 6.7% of the subjects had poor knowledge. In the post test 3 13.4% of subjects had excellent knowledge on de-escalation skills. The percentage of subjects with good knowledge had increased to 50 and 33% had average knowledge on de-escalation skills. Only 3.3% subjects had poor knowledge on de-escalation skills. Hence it was found that the knowledge of the subjects had increased from pre test through post test time periods after DSTP.

The pre-test grading of the practice scores of de-escalation skills showed that majority of the subjects (56.70%) were having poor practice and 30% of subjects had very poor practice and only 3.3% of subjects had good practice of de-escalation skills. In the post test 1 the subjects with average practice was 30% and 13.3% had good practice and remaining 56.7% had poor practice on de-escalation skills. In the post test 2 the subjects with average and good practice further increased to 63.4% and 30% respectively and 3.3% of the subjects had excellent practice and only 3.3% had poor practice on de-escalation skills. In the post test 3 subjects with excellent practice had further increased to 13.4%. The percentage of subjects with good practice had increased to 50 and 36.6% had average practice in de-escalation skills. There were no subjects with very poor practice in the three post tests. The practice thus showed an improvement from pre test to post tests time periods after the DSTP.

Practice of de-escalation skills among nurses



Effectiveness of de-escalation skill training programme

Table 2: The mean, standard deviation, t value and level of significance of pre test and post tests knowledge and practice scores regarding de-escalation skills among nurses.

Parameter	Knowledge score				Practice score			
	Mean score	Standard deviation	t value	Level of significane	Mean score	Standard deviation	t value	Level of significance
Pre test	15.56	4.26			50.13	9.51		
Post test 1	23.06	4.83	8.49	0.00*	60.66	8.92	14.52	0.00*
Post test 2	25.20	4.67	17.13	0.00*	71.03	8.58	22.38	0.00*
Post test 3	25.36	4.86	17.25	0.00*	79.36	8.03	27.66	0.00*

df= 29 *significance at 0.05 level

Data presented in table 2 reveales that the obtained t-value for all the 3 post tests knowledge scores were significantly greater than the mean pre test knowledge scores of de-escalation skills at 0.05 level of significance and the research hypothesis H1 was accepted. Thus the De-escalation Skill Training Programme as found to improve the knowledge regarding de-escalation skills significantly.

Table 2 shows that the obtained t-value for all the 3 post tests practice scores were significantly greater than the mean pre test practice scores regarding practice of de-escalation skills at 0.05 level of significance and the research hypothesis H2 was accepted. Thus the De-escalation Skill Training Programme as found to improve the practice regarding de-escalation skills significantly.

By accepting the research hypothesis 1 and 2 it can be concluded that De-escalation Skill Training Programme was found to be effective in improving the knowledge and practice of de-escalation skills among nurses after the implementation of the intervention.

Correlation between mean knowledge and mean practice scores of de-escalation skills

There was a significant correlation between the mean third post test 3 knowledge score (25.36) and mean third post test 3 practice score (79.36) of de-escalation skills among nurses working in mental health settings as the obtained r value of 0.361, was found to be significant at 0.05 level of significance and 28 df. Hence the research hypothesis H_3 was accepted and it was inferred that there was a significant correlation between the mean knowledge score and mean practice score de-escalation skills among nurses.

DISCUSSION

Majority of subjects (70%) were in the age group of 20-29 years and were females (56.7%). The findings correlate with the quasi experimental study at Sydney[7], to assess the effectiveness of de-escalation kit. In that study majority (65.32%) of the staff were working in mental health general units. Majority (56.7%) of the subjects had clinical experience between 1-4 years and 23.2% had 5-10 years of experience.

An increase in knowledge scores was found after De-escalation Skill Training Programme. In a study to explore the knowledge of remote area nurses regarding de-escalation skills the post test knowledge scores (87%) on de-escalation had increased as compared to the pre test knowledge score (32%) which supports the current study.[8]

In a study by Nau, Johannes. H, Ruud. N, Ian. D and Theo[9] to examine the influence of aggression management training programme in the performance of de-escalation of aggressive patient, the final result showed that the mean post test practice score (3.65) was higher than the mean pre test practice score (2.7) which supports the current study.

A study[8] reports the impact of a training programme on aggression management and physical intervention in a Scottish special education school. The results indicate that staff acquired a deeper knowledge of the physical intervention techniques immediately following the initial training session. At 6 month follow-up, this knowledge had diminished slightly. The majority of staff reported increased confidence as a result of the training. The use of verbal de-escalation techniques showed a significant increase. When used, physical interventions employed mainly low-level techniques. From staff self-report measures, stress levels and psychological coping strategies had not altered in any way. The lack of supporting action by school and departmental managers was identified as a key inhibiting factor.

Another study was conducted by Directorate of Mental Health, at Freemantle Hospital and Health Service, Western Australia[10] regarding Emergency Department Mental Health Triage and Consultancy Service: an advanced practice role for mental health nurses. The paper described a four-month preparatory training program for mental health nurses to provide an Emergency Mental Health Triage and Consultancy Service in the emergency department. Prior to the implementation of the service, it was acknowledged that occupational stress and burnout could affect the turnover of mental health nurses in the department. Therefore, a training program was employed to prepare a number of experienced mental health nurses to work at an advanced practitioner level. In the first 12 months of the service, five mental health nurses completed the program, thus creating a pool of nurses who were able to provide the service. The

results demonstrated that providing mental health nurses with a structured program was instrumental in facilitating their movement to an advanced practitioner level.

CONCLUSION

Even though it was considered as a method of preventing and managing violence, health workers were not giving much importance to the same and were using other methods like physical and chemical restraints as the first line measure to prevent and manage violence. The findings of the study conclude that de-escalation was effective in preventing and managing violence in mental health units.

RECOMMENDATIONS

- Similar study can be conducted using a longitudinal design in order to ensure the development and practice of de-escalation techniques.
- Attitude of health care team toward the de-escalation skills for managing agitated clients can be studied.
- Tools to assess the practice of de-escalation skills for different personnel involved in the care of mentally ill clients may be developed.
- Similar study can be conducted in various setting, using an observer rated practice rating scale for de-escalation skills.

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Conflict of Interest: None

Source of Funding : Self

Ethical Clearence: As per institutional protocols

REFERENCES

1. WHO's 2001 World Health Report on Mental Health: New Understanding, New Hope. Available at:http:// www.mindsfoundation.org/what-is-mental-illness/india/
2. India – Integrated Primary Care for Mental Health In The Thiruvananthapuram District, Kerala State. Available at: http: //www.who.int/mentalhealth /policy/ services/India.pdf
3. Ganguly. H. C. Epidemiological findings on prevalence of mental disorders in India. Indian journal of psychiatry. 2010; 3(12) : 421
4. Stuart. H. Violence and mental illness: an overview. World Psychiatry: 2003; 2(2): 121–4.
5. National Institute of Mental Health and Neuro Sciences. Quality assurance in mental health. New Delhi, National Human Rights Commission. 1999. Available at: http://www.who.int/mental health/policy/services/India.pdf
6. Minas.H and Diatri.H. Physical restraint and confinement of the mentally ill in the community. International Journal of Mental Health Systems: 2008; 2(8). Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/ PMC2442049 accessed 5/29/11.
7. Nau, Johannes. H, Ruud. N, Ian. D and Theo. Student nurses' de-escalation of patient aggression: A pretest– posttest intervention study. International Journal of Nursing Studies. 2010; 47(6): 699-708. Available at: http://www.ncbi.nlm.nih.gov/ pubmed/ term=19962696
8. Cowin.L, Davies.R, Estall.G and Berlin.T. Staff training programmes for the prevention and management of violence directed at nurses and other healthcare workers in mental health services and emergency departments. International Journal of Mental Health Nursing: 2000; cited 2005; 12(4): 64-73. Available at: http:// nzhta.chmeds.ac.nz/staff training.pdf psychiatric emergency services: 2004; 55 (8): 581- 3
9. Khadivi. A. N and Patel. R. C. Association between seclusion and restraint and patient related violence. Psychiatric server: 2004; 55 (11): 1311- 2
10. Sipos, A, Balmer. R. and Tattan. T. Better safe than sorry: a survey of safety awareness and safety provisions in the workplace among specialist registrars in the South West. Psychiatric Bulletin: 2005; 27(4): 354- 7.

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Effectiveness of Self Instructional Module (SIM) on Knowledge and Technique of Breast Self Examination among Teachers of Selected High Schools in Kolhapur, Maharashtra

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Objectives:

1) To assess the knowledge of teachers regarding breast self examination.
2) To demonstrate the technique of breast self examination teachers.
3) To administer the self instructional module of breast self examination among teachers.
4) To evaluate the effectiveness of self instructional module on breast self examination among teachers.
5) To find out the correlation between knowledge and technique of breast self examination among teachers.

Materials and Method: A Pre experimental one group pre-test post test design adopted for the present study. Subjects were selected purposive sampling. Prior to data collection permission was obtained from the selected high schools authority in Kolhapur city. The researcher was introducing herself to the subject. Informed consent was taken from all the female high school teachers after explaining the purpose of the study. Pre test was conducted by using structured knowledge questionnaire. Self instructional module was administered to teachers and demonstration was done. Post test was conducted 7 days after the pre test by using structured knowledge questionnaire.

Result: Following the intervention, there was pretest maximum numbers of high school teachers 57 (95%) had Inadequate technique, while minimum numbers of teachers 3 (5%) had moderate technique, whereas in post test all high school teachers were 60(100%) had adequate technique. Indicates that in pretest maximum numbers of high school teachers 57 (95%) had Inadequate technique, while minimum numbers of teachers 3 (5%) had moderate technique, whereas in post test all high school teachers were 60(100%) had adequate technique.

Conclusion: Results indicates that Self Instructional Module was very effective in order to gain knowledge and technique of BSE.

Keywords: *Breast self examination, breast cancer.*

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INTRODUCTION

Breast cancer is the second leading cause for the death in worldwide and fifth most common cancer in India. Breast cancer accounts to about 29.7% of all cancers in women in Mumbai. Approximately 2000 to 2500 new cases of breast cancer are detected every

year in Mumbai, and the number is ever rising. In 1982 - 83, breast cancer accounted for about 20% of all cancers in women in Mumbai. Presently, according to 2011 statistics, breast cancer accounts for 30% of all cancers in women in Mumbai.[10]

Breast self examination is a technique that all women can examine their own breast. Thus it is a useful self care activity for all adult women. Regular monthly BSE is an essential health maintenance activity. Teaching skills of BSE can be life saving and with regular BSE, malignancy may be discovered at an earlier stage which can save lives.[1]

MATERIALS& METHOD

Sample: The purposive sampling technique was used to select the samples for the present study. The sample size of the present study was 60 female high school teachers, Pre test was conducted by using structured knowledge questionnaire. Self instructional module was administered to teachers and demonstration was done. Post test was conducted 7 days after the pre test by using structured knowledge questionnaire.

SAMPLING CRITERIA

Inclusive criteria

1. Female Teachers who were willing to participate in the study.

Exclusive criteria

1. Female teachers who were not present during the time of data collection.

Technical Information

The intervention given to the group, prior to data collection permission was obtained from the selected high schools authority in Kolhapur city. The researcher was introducing herself to the subject. By using purposive sampling technique subject were selected. Informed consent was taken from all the female high school teachers after explaining the purpose of the study. Pre test was conducted by using structured knowledge questionnaire. Self instructional module was administered to teachers and demonstration was done. Post test was conducted 7 days after the pre test by using structured knowledge questionnaire.

Ethics: Informed consent was taken from the samples of the study.

Statistic: Descriptive statistics including frequency, percentage, mean and inferential statistic including paired't' test and co relational coefficients.

Findings: The findings of the study were: maximum number of teachers 25 (41.67%) participated in the study belonged to the age group 36-46 years, while minimum numbers of 22 (36.67%) belonged to 25-35 years. Maximum numbers of the teachers 46 (76.67%) belonged to Hindu religion while minimum numbers of teachers, 9 (15%) belonged to Christian. Maximum number of 31 (51.66%) were post graduate while minimum numbers of teachers, 22 (36.67%) were graduate. Maximum of teachers were married 53 (88.34%), minimum of teachers 4(6.66%) were widow. Maximum number of teachers 36 (60%) were performing BSE and minimum numbers of 24 (40%) were not performing BSE. Maximum number of 22 (36.67%) were performing BSE rarely, minimum numbers of teachers 6(10%) were performing monthly.

Table 1: Mean Median, Mode, and Standard deviation and Range of Knowledge scores of BSE among high school teachers regarding effectiveness of self instructional module. n= 60

Area of Analysis	Mean	Median	Mode	Standard deviation	Range
Pre test	18.88	19	19	4.12	19
Post test	30.68	31	32	2.97	14
Diffe-rence	11.8	12	13	1.15	5

Table 1 Indicates that the knowledge of high school teachers is increased by 11.8 units. The variability around the mean knowledge distribution (SD) is decreased by 1.15 units. The range between the highest and lowest score is decreased by 5 units after introducing the SIM.

Table 2: Frequency and percentage (%) distribution of knowledge scores on BSE of high school teachers. n=60

Knowledge Scores	Pre test		Post test	
	Frequency (f)	Perce-ntage (%)	Freq-uency (f)	Perc-entage (%)
Good (27-40)	02	3.34	56	93.34
Average (14-26)	51	85	04	6.66
Poor (0-13)	07	11.67	0	0

Table 2: Indicates that in pretest maximum numbers of high school teachers 51 (85%) had average knowledge, while minimum numbers of high school teachers 7 (11.67%) had poor knowledge, whereas in post test maximum numbers of high school teachers 56(93.34%) had good knowledge, while minimum numbers of high school teachers 4(6.66%) had average knowledge.

Table 3: Mean Median, Mode, and Standard deviation and Range technique scores on BSE of high school teachers regarding effectiveness of self instructional module. n= 60

Area of Analysis	Mean	Median	Mode	Standard deviation	Range
Pre test	2.73	2	2	1.05	4
Post test	10.7	11	10	0.92	3
Difference	7.97	9	8	0.13	1

Table 3 Indicates that the Technique of high school teachers is increased by 7.97 units. The variability around the mean technique distribution (SD) is decreased by 0.13 units. The range between the highest and lowest score is decreased by 1 unit after demonstrating the technique of BSE.

Table 4: Frequency and percentage (%) distribution of technique scores on BSE of high school teachers. n=60

Technique Scores	Pre test		Post test	
	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
Adequate (9-13)	00	0	60	100
Moderate (5-8)	03	5	0	0
Inadequate (0-4)	57	95	0	0

Table 4: Indicates that in pretest maximum numbers of high school teachers 57 (95%) had Inadequate technique, while minimum numbers of teachers 3 (5%) had moderate technique, whereas in post test all high school teachers were 60(100%) had adequate technique.

Table 5- Mean difference, Standard Error difference and paired't' test of knowledge scores on BSE of high school teachers.

H_1: The mean post test knowledge scores of subjects exposed to self instructional module is significantly higher than the mean pre test knowledge scores as measured by structured knowledge questionnaire at 0.05 level of significance. i.e. H_1: $\mu \# \mu_0$ **n=60**

Mean difference (d)	Standard error of difference (ES(d))	Paired 't' test		
		Calculated	Table value	df
11.8	0.53	22.26*	2.00	59

*P<0.05

Table 5 Indicates that calculated paired't' test value (t_{cal}= 22.26) is greater than tabulated't' value (t_{tab}= 2.00). Hence H_1 is accepted. This indicates that the gain in knowledge score is statistically significant at P < 0.05 level. Therefore it can be inferred that self instructional module on knowledge and technique of BSE is effective to improve the knowledge of high school teachers.

Table 6- Mean difference, Standard Error difference and paired't' test of technique scores on BSE of high school teachers.

Mean difference (d)	Standard error of difference (SE(d))	Paired 't' test		df
		Calculated	Table value	
7.9	0.17	46.47*	2.00	60

*P<0.05

H_2: The mean post test technique scores of subjects exposed to technique is significantly greater than the mean pre test technique scores as measured by observational check list at 0.05 level of significance. i.e. H_2: $\mu \# \mu_0$ **n=60**

Table 6 Indicates that calculated paired't' test value (t_{cal}=46.47*) is greater than tabulated't' value (t_{tab}= 2.37). Hence H_2 is accepted. This indicates that the gain in technique score is statistically significant at P < 0.05 level. Therefore it can be inferred that self instructional module on knowledge and technique of BSE is effective to improve the technique of high school teachers.

Section IV: Co-relation between knowledge and technique on BSE of high school teachers.

H_3: There is a statistical correlation between knowledge and techniques of breast self examination. i.e. H_3: $\mu \# \mu_0$

Table 7- Correlation between knowledge scores and technique scores on BSE. **n=60**

X	Y	Karl Pearson's coefficient of correlation (rxy)
1841	642	0.64* ($0<r_{xy}<1$) positive correlation

Table 7 reveals that **r_{xy} = 0.64, ($0<r_{xy}<1$),** hence there was positive correlation between knowledge and technique of BSE. Hence H_3 is accepted.

DISCUSSION

In the present study, out of 60 teachers in pretest maximum numbers of teachers, 51 (85%) had average knowledge, while minimum, 4 (40%) had poor knowledge, whereas in post test maximum numbers of teachers, 56(93.34%) had good knowledge, while minimum, 4(6.66%) had average knowledge.

Table 5 Indicates that calculated paired't' test value (t_{cal}= 22.26) is greater than tabulated't' value (t_{tab}= 2.00). Hence H_1 is accepted. This indicates that the gain in knowledge score is statistically significant at P < 0.05 level. Therefore it can be inferred that self instructional module on knowledge and technique of BSE is effective to improve the knowledge of high school teachers.

The findings of this study supported with the study done by Mrs. Reeba Babu in Mangalore, with the aim to investigate the effectiveness of planned teaching programme on breast self examination to women of a selected community in Mangalore. The study findings reveals that there is significant gain in

knowledge scores of women, after the introduction of planned demonstration programme on BSE.

In the present study, out of 60 teachers in pretest 57 (95%) had Inadequate technique, no one had adequate technique and 3 (5%) had moderate technique, whereas in post test 60(100%) of the teachers had adequate technique.

Table 6 Indicates that calculated paired't' test value (t_{cal}=46.47*) is greater than tabulated't' value (t_{tab}= 2.37). Hence H_2 is accepted. This indicates that the gain in technique score is statistically significant at P < 0.05 level. Therefore it can be inferred that self instructional module on knowledge and technique of BSE is effective to improve the technique of high school teachers.

These findings are supported with the study done by Ms Jincy Thomas in Belgaum city, with the aim to investigate the effectiveness of planned demonstration programme on breast self examination in terms of knowledge and technique among teachers of selected schools in Belgaum city. The study finding reveals that there is significant gain in technique scores of teachers after the introduction of planned demonstration programme on BSE.

Finding reveals that **rxy = 0.64, (0<rxy<1),** hence there was positive correlation between knowledge and technique. Hence H_3 is accepted.

These findings are supported with the study done by D.V. Bala study finding reveals that there were significant improvement of knowledge and practice of BSE after the three months of intervention regarding BSE.

Therefore it was reasonably concluded that Self Instructional Module on BSE, introduced to the teachers of selected high schools was effective in increasing the knowledge and enhancing the technique of BSE under the study.

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Conflict of Interest: There is no conflict of interest for the present study.

REFERENCE

1. Aggarwal TS. Validating breast self examination as screening modalities for breast cancer in eastern region of Nepal: a population based study, Kathmandu university medical journal, 2008, Vol. 6(1) 21: 89-93.
2. Humphrey L, Chan BKS, Detlefsen S, Helfand M et al. Screening for Breast Cancer US National Library of Medicine National Institutes of Health available at: URL: http://www.ncbi.nlm.nih.gov/pubmed/20722110
3. Lewis, Heitkemper " Medical Surgical Nursing", 7th edition, Elsevier, India, 2009; 1348-1361.
4. Polit DF and Hungler BP. Nursing Research & principles of methods.8th edition. .Philadelphia: J.B Lippincott Company; 1997.Pg. 440-450.
5. Doshi Dolar, Reddy B, Srikanth Kulkarni, Suhas Karunakar. Breast self examination-Knowledge, attitude & practice among female dental students Hyderabad, Andhra Pradesh, India. Indian journal of palliative care. 2013 Jan- Apr [cited on 2013 July 7]; 18(1) (online screen 11): 68-73. Available from: URL: http: //connection.ebsco.host.com/c/articles/77664431/breastselfexamination.

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A Pre Experimental Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding Anorexia Nervosa among Adolescent Girls in Selected School of Vadodara City

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ABSTRACT

Aims: 1].To assess the existing level of knowledge regarding anorexia nervosa among adolescent girls. 2.] To determine the effectiveness of structured teaching programme on anorexia nervosa among adolescent girls. 3].To find out the association between pretest knowledge mean scores of adolescent girls with selected demographic variable. **Materials and methods:** The investigator used pre experimental research (one group pre-test post- design). Non probability purposive sampling technique used to select the 50 adolescent girls in Sardar vallabhbhai vidhyalaya of Vadodara city. The conceptual framework for this study was based on modified king's goal attainment theory. **Statistical analysis used:** The data was analyzed by using descriptive and inferential statistics. Chi square test was used to evaluate the effectiveness of structured teaching programme. **Results:** The mean post-test knowledge score (22.24) is higher than the mean pre-test knowledge score (14.22). The't' calculated value **9.082** is more than tabulated value **2.56** at **0.001level of significance**. So we **accept H_1** and conclude that the mean post-test knowledge scores of anorexia nervosa is significantly higher than their mean pre-test knowledge score. The association between pre-test knowledge score and selected demographic variables were found out by chi square. It reveals that there was a significant association of **age and dietary habits** at $p < 0.05$. so hypotheis **H_2** stated that there will be significant association between the pre-test knowledge score with selected demographic variables was accepted. **Conclusion:** Structured teaching programme was very highly effective in improving the knowledge of adolescent girls regarding anorexia nervosa.

Keywords: *Adolescent Girls, Anorexia Nervosa, Effectiveness, Knowledge,, structured teaching programme.*

INTRODUCTION

Anorexia is an emotional disorder that focuses on food, but it is actually an attempt to deal with perfectionism and a desire to control things by strictly regulating food and weight. People with anorexia often feel that their self-esteem is tense to how thin they are.[1]

According to national institute of mental health (NIMH) 0.5%-3.7% women suffers with anorexia nervosa at some point of lives. A study conducted by the national association of anorexia nervosa and associated disorder reported that 5-10% of anorexics will die within 10 years after contracting the disease; 18-20% of anorexics will be dead after 20 years

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and only 30-40% ever fully recover. The mortality rate associated with anorexia nervosa is 12 times higher than the death rate of all causes of death for females 15-24 years old. 20% of people suffering from anorexia will prematurely die from complications related to anorexia nervosa including suicide and heart problems.[2]

The cross-sectional survey, 120 adolescents females (age: 13-17 years) filled out questionnaires on eating attitudes and behaviours at one independent school. ED was measured with the 26-item Eating Attitudes Test (EAT). Participants who scored ≥ 20 on the EAT were considered to have disordered eating and effect of psychological, behavioral, and socio-environmental variables in individuals with and without eating disorders, were assessed. Disturbed eating attitudes and behaviors were present in 26.67 % of adolescents girls in the sample studied. This group was significantly older, had earlier menarche and lower BMI. Mean scores and percentage scores on all the scales to assess psychological risk factors were found to be significantly higher in the ED group i.e. there were significant associations ($p< 0.0001$) between elevated EAT scores and dieting behavior, higher drive for thinness and body dissatisfaction, external pressures, mood susceptibility of feeding patterns, perfectionism, occurrence of negative life events and presence and adequacy of emotional support system.[3]

The prevalence of eating disorders (ED) in India is lower than that of Western countries but appears to be increasing. In a study conducted in sample consisted mostly of females from middle socio-economic status towns and villages of North-eastern and Southern states of India with a mean (SD) age of 12.6 (3,4) years, the mean (SD) age of onset of symptoms and duration of symptoms was 11.2 (4.3) years and 19.2(29.4) months respectively. The predominant ED among the study sample was psychogenic vomiting (85.4%); only six cases (14.6%) of anorexia nervosa were noted. However, there was no significant increase in overall trend in the prevalence of ED. More anorexics had developed their illness during their adolescence, were from upper socioeconomic group, and never the first born; whereas majority of the vomiters had developed the illness pre-pubertal, There were more females with anorexia nervosa (female: male =5:1) than in the psychogenic vomiting group (female: male = 2:1.5) but this was not significantly different.[4]

NEED FOR THE STUDY

BBC news, on 17 June 2003 reported that most people in India struggle to get enough to eat-one estimate is that 60% of India's women are clinically malnourished. But the psychiatrists in urban areas are reporting cases of anorexia nervosa, the so called slimming disease that can cause sufferers to starve themselves to death. Now anorexia nervosa has got its significant presence in India.[5]

Times of India, on 18 July 2007 reported the news titled as "anorexia rising at an alarming rate". It focuses on the fact that ten years ago the cases of anorexia nervosa were negligent in India. Psychiatrists claim that in the past few decades, the figure has increased from anything between 5-10 times. What is more alarming is that increasingly girls of younger age are falling prey for anorexia nervosa.[6]

STATEMENT OF PROBLEM

"A pre experimental study to assess the effectiveness of structured teaching programme on knowledge regarding anorexia nervosa among adolescent girls in selected school of Vadodara city."

Objectives of the Study

1. To assess the existing level of knowledge regarding anorexia nervosa among adolescent girls.

2. To determine the effectiveness of structured teaching programme on anorexia nervosa among adolescent girls.

3. To find out the association between pretest knowledge mean scores of adolescent girls with selected demographic variable.

Operational Definitions

1. ASSESS: It refers to the statistical analysis of the information gathered through multiple choice questionnaires related to knowledge of adolescent girls regarding their nutrition.

2. EFFECTIVENESS: It refers to the extent to which the structured teaching programme has achieved the desired outcome as measured in terms of knowledge scores of adolescent girls.

3. Structured Teaching Programme: It refers to systematically developed instructional aids designed for adolescent girls regarding prevention of anorexia nervosa among adolescent girls.

4. Knowledge: In this study knowledge refers to correct response to the knowledge questions on adolescent nutrition, which is measured the structure knowledge questionnaires.

5. Anorexia Nervosa: It is an eating disorder characterized by extremely low body weight and body image distortion with an obsessive fear of gaining weight. It is common among adolescent girls.

6. Adolescent Girls: It refers to the girls in the age group of 13-18 Years.

Hypothesis

- **H_1 –**The mean post-test knowledge scores of anorexia nervosa is significantly higher than their mean pre-test knowledge score regarding anorexia nervosa.

- **H_2-**There will be significant association between pretest knowledge scores of the adolescent girls with selected demographic variables.

Assumption

1. The adolescent girls may have limited knowledge regarding the anorexia nervosa.

2. The adolescent girls may be more interested to know about the anorexia nervosa.

MATERIAL & METHOD

- **Research Approach:** An evaluative approach was used for analysing the effectiveness of structured teaching programme.

- **Research Design:** pre experimental research design (one group Pre-test post -test design)

Table 1 : The diagrammatic representation of research design is given below:

Group	Pre test	Intervention			Post test
Adolescent girls studying in the school.	On level of knowledge among adolescent girls studying in sardar vallabhbhai vidhyalya	Structured teaching programme			On level of knowledge among adolescent girls studying in sardar vallabhbhai vidhyalya
	O^1	X			O^2

Key: O_1 = Administration of structured questionnaire to the Pre-test knowledge on anorexia nervosa.

X= structured teaching programme

O_2 = Administration of structured questionnaire to the Post-test knowledge on anorexia nervosa.

Variables

- Dependent Variable: level of knowledge of adolescent girls.

- Independent Variable: structured teaching programme.

- Extraneous Variable: class of study, age in years, religion, educational status of mother, educational status of father, place of residence, type of family, dietary habits, monthly income of family and weight in kilogram.

- **Setting of the Study:** The study will be conducted in Sardar Vallabhbhai Vidhyalaya, Vadodara.

- **Population:** Here in this study target population is the adolescent girls who are schooling in Sardar Vallabhbhai Vidhyalaya, Vadodara.

- **Sample and Sample size**: Polit and Hungler, (2005). Stated that sample consists of a subset of population selected to participate in a research study. A total of 50 samples were selected for the present study.

DELIMITATIONS

This study is delimited to:

- A period of four weeks of data collection.

- The study is delimited to the adolescent girls in sardar vallabhbhai vidhyalaya.

Criteria for sample selection

<u>Inclusion Criteria</u>

- The adolescent girls who have been studying

in the school age between 13-19 years

- The adolescent girls who are available at the time of data collection.
- The adolescent girls, who know to write, read and speak English, Guajarati.
- Only female adolescents having age group 13-19 years.

Exclusion Criteria

- The adolescent girls who are not willing to participate in the study.
- **Sampling Technique:** non probability purposive sampling technique was adopted for this study.

Development of the Tool

The research tool is developed in English after an extensive review of literature and experts opinion.

Description of Tool

- Part I Includes demographic variables class of study, age in years, religion, educational status of mother, educational status of father, place of residence, type of family, dietary habits, monthly income of family and weight in kilogram.
- Part II includes Structured questionnaire was used to assess the knowledge regarding anorexia nervosa among adolescent girls. The total number of questions was 30.

Table: 2 To interpret level of knowledge the scores were distributed as follows.

Level of knowledge	Score range
Inadequate	1-10
Moderately adequate	11-20
Adequate	21-30

MAJOR FINDINGS OF THE STUDY

Table: 3 Frequency and percentage distribution of demographic variables of adolescent girls. n=50

Sr no	Demographic variables	Characteristics	Frequency	Percentage (%)
1.	Class of study	9th standard	20	40
		10th standard	10	20
		11th standard	10	20
		12th standard	10	20
2.	Age in years	13-14 years	20	40
		15-16 years	20	40
		17-18 years	10	20
3.	Religion	Hindu	31	62
		Muslim	8	16
		Christian	6	12
		Others	5	10
4.	Educational status of mother	Illiterate	00	00
		Primary	3	6
		Secondary	15	30
		Graduate/post graduate	32	64
5.	Educational status of father	Illiterate	00	00
		Primary	5	10
		Secondary	15	30
		Graduate/post graduate	30	60
6	Place of residence	Urban	37	74
		Rural	13	26

Table: 3 Frequency and percentage distribution of demographic variables of adolescent girls. n=50 (Cont...)

7	**Type of family**	Nuclear family	30	60
		Joint family	17	34
		Single parent family	3	6
8	**Dietary habits**	More fruits and vegetables	11	22
		Junk food items	12	24
		Homemade foods	27	54
9	**Monthly income of family in rupees**	1000-5000	12	24
		5001-10000	9	18
		10001-15000	8	16
		Above 15000	21	42
10	**Weight in kilogram**	21-30	4	8
		31-40	12	24
		41-50	27	54
		51-60	7	14

Table: 4 Frequency and percentage distribution in pre-test and post-test level of knowledge regarding anorexia nervosa among adolescent girls. N=50

Level of Knowledge	**Pre-test**		**Post test**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Inadequate	15	30.0	0	0
Moderately adequate	30	60.0	15	30
Adequate	5	10	35	70.0
Total	50	100.0	50	100.0

Pre and post -test which reveals that post-test level of knowledge score were greater than pre-test of the study.

Table: 5 Effectiveness of structured teaching programme on knowledge regarding anorexia nervosa among adolescent girls. N=50

Variables		**Mean**	**Mean difference**	**Std. Deviation**	**Paired t-value**
Knowledge	Pre-test	14.22	8.02	4.041	9.082* Df = 49 P = 2.56
	Post-test	22.24		4.769	

*Significant at p<0.001 * NS – Not significant

- In the pre-test mean score was **14.22 +4.041** and post-test means score was **22.24 ± 4.769**.The post-test level of knowledge mean score is significantly graters than the pre-test knowledge mean score.

- The 't' calculated value **9.082** is more than tabulated value **2.56** at **0.001 level of significance**. So we **accept H_1** and conclude that the mean post test knowledge score is significantly higher than the pre-test knowledge score regarding anorexia nervosa among adolescent girls exposed to STP. so it proves that STP is effective on anorexia nervosa among adolescent girls.

Table: 6 Association of pre test knowledge regarding anorexia nervosa among adolescent girls with selected demographic variables.

Sr no	Demographic variables		Pre-test			Total	Chi square		Df	Association
			Inadequate	Moderate	Adequate		calculated value	Table value		
1	Class of study	9th standard	9	11	0	20	7.403	7.82	3	Non Significant
		10th standard	2	6	2	10				
		11th standard	3	6	1	10				
		12th standard	1	7	2	10				
	Total		**15**	**30**	**5**	**50**				
2	**Demographic variables**		**Pre-test**			**Total**	8.23*	5.99	2	Significant
			Inadequate	**Moderate**	**Adequate**					
	Age in years	13-14 years	9	11	0	20				
		15-16 years	5	12	3	20				
		17-18 years	1	7	2	10				
	Total		**15**	**30**	**5**	**50**				
3	**Demographic variables**		**Pre-test**			**Total**	6.096	7.82	3	Non Significant
			Inadequate	**Moderate**	**Adequate**					
	Religion	Hindu	8	18	5	31				
		Muslim	2	6	0	8				
		Christian	3	3	0	6				
		Others	3	2	0	5				
	Total		**16**	**29**	**5**	**50**				

4	**Demographic variables**			**Pre-test**			**Total**	3.612	7.82	3	Non Significant
				Inade-quate	**Moderate**	**Adeq-uate**					
	Educational status of mother	Illiterate		0	0	0	0				
		Primary		1	2	0	3				
		Secondary		6	9	0	15				
		Graduate/ post graduate		8	19	5	32				
	Total			**15**	**30**	**5**	**50**				
5	**Demographic variables**		**Pre-test**				**Total**	3.51	7.82	3	Non Significant
				Inade-quate	**Moderate**	**Adeq-uate**					
	Educational status of father		Illiterate	0	0	0	0				
			Primary	3	12	0	5				
			Secondary	3	11	1	15				
			Graduate/ post graduate	9	17	4	30				
	Total			**15**	**30**	**5**	**50**				

Table: 6 Association of pre test knowledge regarding anorexia nervosa among adolescent girls with selected demographic variables. (Cont...)

6	**Demographic variables**		**Pre-test**				**Total**	0.620	3.84	1	Non Significant
				Inadequate	**Moderate**	**Adequate**					
	Place of residence		Urban	12	21	4	37				
			Rural	3	9	1	13				
7	**Total**			**15**	**30**	**5**	**50**				
	Demographic variables		**Pre-test**				**Total**	3.007	5.99	2	Non Significant
				Inadequate	**Moderate**	**Adequate**					
	Type of family		Nuclear family	10	17	3	30				
			Joint family	4	12	1	17				
			Single parent family	1	1	1	3				
	Total			**15**	**30**	**5**	**50**				

8	**Demographic variables**		**Pre-test**			**Total**	12.23*	5.99	2	Significant
			Inadequate		**Moderate**	**Adequate**				
	Dietary habits	More fruits and vegetables	3		7	1	11			
		Junk food items	0		12	0	12			
		Homemade foods	12		11	4	27			
	Total		**15**		**30**	**5**	**50**			
9	**Demographic variables**		**Pre-test**				**Total**	1.697	7.82	3	Non Significant
				Inadequate	**Moderate**	**Adequate**				
	Monthly income		1000-5000	3	7	2	12			
			5001-10000	3	5	1	9			
			10001-15000	3	5	0	8			
			Above 15000	6	13	2	21			
	Total			**15**	**30**	**5**	**50**			
10	**Demographic variables**		**Pre-test**				**Total**	2.949	7.82	3	Non Significant
				Inadequate	**Moderate**	**Adequate**				
	Weight in kilogram		21-30	2	2	0	4			
			31-40	3	7	2	12			
			41-50	7	17	3	27			
			51-60	3	4	0	7			
	Total			**15**	**30**	**5**	**50**			

Table 6: show association of the pre-test level of knowledge regarding anorexia nervosa among adolescent girls with selected demographic variables.Here, the table indicate that the age and dietary habits are significant association with the pre test knowledge scor

RESULTS

The mean post-test knowledge score (22.24) is higher than the mean pre-test knowledge score (14.22). The 't' calculated value **9.082** is more than tabulated value **2.56** at **0.001level of significance**. So we **accept** $\mathbf{H_1}$ and conclude that the mean post-test knowledge scores of anorexia nervosa is significantly higher than their mean pre-test knowledge score. The association between pre-test knowledge score and selected demographic variables were found out by chi square. The findings reveals that there was a significant association of **age and dietary habits** at $p < 0.05$. Hence the research hypothesis $\mathbf{H_2}$ stated that there will be significant association between the pre-test knowledge score with selected demographic variables was accepted.

DISCUSSION/CONCLUSION

This chapter includes conclusion, implication, limitations and recommendations. The following conclusions were drawn from the finding of the present study. The research approach adopted in the present study is quantitative research approach to measure the level of knowledge regarding anorexia nervosa among adolescent girls. Effectiveness was assessed by analysis of pre-test and post-test level of knowledge score. The data was interpreted by suitable and appropriate statistical method.

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Ethical Clerance: Taken

Source of Funding- Self

Conflict of Interest - NIL

REFERENCES

1. Garner Dm, Garfinkel Pe. "Sociocultural Factors in The Development Of Anorexianervosa". Psychological Medicine 2004;10(4):647-56.
2. Kathleen Doheny. Eating disorders in teens are common. [online] 2011 Mar 7 [cited 2011 Nov 8];Available from URL:http//www.webmd.com/main/study-eating disorders in teens are common.
3. Upadhyah Amit A;www.ncbi.nlm.nih.gov/pubmed/17978323
4. Mammen P, Russell S, "Prevalence of eating disorders and psychiatric co-morbidity among children and adolescents" [serial on the internet]. [cited 2010 Nov 15]; 44:357-59. Available from : 2007 Jan 29 http://indianpeditrics.net/.
5. Rick E Nauret. Anorexia linked to adult mental problems [online].2009 March 27 [cited 2011 Nov 8]; Available from http://psychcentral.com>news>psychotherapynews.
6. Polit DF, Hungler BP. Nursing Research Principals and methods. 6thed.Philadelphia: J.B Lippincott Company; 1999

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Family Functioning and Coping Strategy of Mothers of Autistic Children in AIISH at Mysuru with a View to Develop an Information Booklet

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ABSTRACT

Background: Autism is not a new condition in children, but it is only in recent years that the

problems related to ASD have gained acceptance. WHO puts the global prevalence of autism at 1 in 500 and autism is 3 to 4 times more common in boys than girls. From one in 10,000 children ten years ago in India, the prevalence is 3-4 per 1,000 live births now. The incidence of autism in Karnataka has increased from 1 in 10,000 ten years ago to 1 in 150 today. Diagnosis of autism can be a frightening situation for all parents, mothers of autistic children now found they were exhausted all the time and found it hard to function well.

Design: Descriptive survey design.

Sample and sampling technique: Non- Probability purposive sampling technique were used for the selection of 60 samples based on the sampling criteria.

Tool: Proforma for selected personal variables, self administered family functioning and coping strategy check lists.

Results: The findings of the study revealed that majority of the samples 81.7% were having healthy family functioning and 75% were having adequate coping strategy. The study showed that, there is significant correlation between family functioning and coping strategy. The result also shown that family functioning of mothers had significant association with type of family, and copying strategy of mothers had significant association with age of mothers.

Conclusion: Therefore, the study concluded that mothers of autistic children in AIISH were having healthy family functioning and adequate coping strategy.

Keywords: *Family functioning, Coping strategy, Autistic children.*

INTRODUCTION

Birth of a physically or mentally challenged child is a transitional situation that triggers stress affecting all the family members. Mother plays a vital role in giving all care for the challenged child in all the way to promote good health and maintain appropriate development in a child[1]. The earliest reference of autism in Indian literature was reported in 1959 but the knowledge about autism was limited. Consequently the number of reported cases of autism increased dramatically in the 1990s and early2000s[2].

Autism is not a new condition in children, but it is only in recent years that the problems related to ASD have gained acceptance. Parents and teachers know

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very well that these children are struggling to cope with the demands of their homes, school and society[2]. Autism is the disorder of psychological development, characterized by inappropriate response to the environment, pronounced impairment in language, communication and social interaction, repetitive interest and behaviors, disorder in thinking, difficulty in understanding others feelings and repetitive, self –injurious abnormal behavior[3]. In 2002, the Center for Disease Control estimated that autism affected about 1 in 150 children. By 2012 the CDC estimate had increased to 1 in 88. Now, according to the latest revision of the estimate recently released, autism affects 1 in 68 children[4].

Research shows that parents of disabled children are particularly vulnerable to stress. High levels of distress have been found in up to 70% of mothers and 40% of fathers of severely disabled children. Mothers of children with autism were found to be easily upset and disappointed with their child; greatly concerned about their child's dependency, lack of vocational activities to keep their child busy and very aware of personality problems in their child[3]. Mothers of autistic children may be at increased risk for psychological difficulties because of scarcity of professional resources, unrelieved parental responsibilities, parental loneliness, and isolation, and their children's slow or minimal progress.

It is suggested that fathers sometimes 'coped', by working away from home. Mothers tend to vent their feelings and had a wider range of emotional expression, feeling grief and sadness in addition to anger and crying. They rely on talking to friends and family as a way of dealing with their emotions, particularly with other mothers with a child with autism[5]

The burden of childcare often takes its toll on their relationships with friends and acquaintances. Their social circle is usually significantly reduced. A number of difficult experiences of parents are caused by attitudes and behavior towards their child demonstrated by others. Most parents perceived themselves to be stigmatized by their child's disorder and it is also found mothers to be more stigmatized.[6]

Apart from common problems related to health, depressive mood, sense of being overburdened, pessimistic view of the future and limited family opportunity, stress associated with taking the child to public places also found in mothers . Later research also showed that mothers of children with autism have a less positive future perspective than mothers of children with other disorders[6].

Research studies identified serious stressors in mothers of autistic children and are engaged in relatively high levels of problem focused coping to reduce their stress. It is found that increasing levels of family functioning is related to increased use of coping mechanisms. It is also revealed that mothers of autistic children reported less parenting competence, less marital satisfaction, more family cohesion, and less family adaptability. Hence the researcher felt the need to explore the areas of family functioning and copying strategies among mothers of autistic children.

STATEMENT OF THE PROBLEM

A study to assess the family functioning and coping strategy of mothers of autistic children in AIISH (ALL INDIA INSTITUTE OF SPEECH AND HEARING)at Mysuru with a view to develop an information booklet.

OBJECTIVES

1. To assess the family functioning and coping strategy of mothers of autistic children.
2. To find the relationship between the family functioning and coping strategy of mothers of autistic children.
3. To find the association of family functioning and coping strategy of mothers of autistic children with their selected personal variables
4. To develop an information booklet regarding management of autistic children

HYPOTHESES

H1: There will be significant relationship between the family functioning and coping strategy of mothers of autistic children.

H2: There will be a significant association of family functioning and coping strategy of mothers of autistic children with their selected personal variables

RESEARCH METHODOLOGY

The research approach and design adopted for the study was descriptive survey design. In the present study, population comprises of mothers of autistic children in AIISH at Mysuru. Non- Probability purposive sampling was used to obtain the sample of 60 mothers. Self administered family functioning and coping strategy check lists were used to assess the family functioning and coping strategy in the present study. The total family functioning score was 34 and further divided arbitrarily as unhealthy family functioning 0-17 and healthy family functioning 18-34. The total coping strategy score was 24 and further divided arbitrarily as inadequate coping 0- 12 and adequate coping 13-24.

RESULTS

Section 1: Description of selected personal variables

TABLE: 1: Frequency and percentage distribution of mothers of autistic children according to their selected personal variables n=60

SI.NO	Demographic Variable	Frequency	Percentage
1	**Age in years**		
	1.1) ≤ 20yrs	0	0
	1.2) 21-30yrs	34	56.7
	1.3) 31-40 yrs	26	43.3
2	**Educational status**		
	2.1) Primary education	15	25
	2.2) High school	16	26.7
	2.3) PUC and above	29	48.3
3	**Type of family**		
	3.1) Nuclear	25	41.7
	3.2) Single parent family	10	16.7
	3.3) Joint family	25	41.7
	3.4) Extended family	00	00
4	**Number of children**		
	4.1) One	16	26.7
	4.2) Two	37	61.7
	4.3) Three and above	7	11.7
5	**Age of the autistic child**		
	5.1) 1-5 years	23	38.3
	5.2) 6-10 years	37	61.7
	5.3) 11-15 years	00	00
6	**Occupation**		
	6.1) Home maker	57	95
	6.2) Coolie	2	3.3
	6.3) Government employee	1	1.7
	6.4) Private employee	0	0

7	**Family monthly income in rupees.** 7.1) Below Rs 5000/ 7.2) Rs 5001 to 10000/ 7.3) Above Rs10,000/	 34 14 12	 56.7 23.3 20
8	**Family history of autism** 8.1) Yes 8.2) No	 12 48	 20 80
9	Type of marriage 9.1) Consanguineous 9.2) Non consanguineous	 17 43	 28.3 71.7
10	Source of knowledge regarding care of autistic child 10.1) Mass media 10.2) Friends and family 10.3) Health personnel 10.4) Others	 2 12 33 13	 3.3 20 55 21.7

Study findings revealed that majority (56.7%) mothers were in the age group of 21-30years, 48.3% mothers had the primary education and 41.7% of mothers belonged to nuclear family. Majority of mothers 61.7% were having two children, 61.7% of autistic children were in the age group of 6-10years and 95% 0f mothers were home makers. Majority 56.7% of mothers were having a family monthly income of >Rs 5000, majority of the mothers 80% had no family history of autism and 71.7% were having non consanguineous type of marriage. Majority of the mothers 55% had source of knowledge regarding care of autistic child is from health personnel,

SECTION 2: DESCRIPTION OF FAMILY FUNCTIONING SCORE OF MOTHERS OF AUTISTIC CHILDREN

a) Description of level of family functioning of mothers of autistic children

TABLE: 2: Frequency and percentage distribution according to level of family functioning of mothers of autistic children n=60

Sl. No.	Family functioning	Frequency	Percentage
1	Unhealthy family functioning (0-17)	11	18.3%
2	Healthy family functioning (18-34)	49	81.7%

It is evident from Table **2** shows that, majority of the samples i.e. 49(81.7%) were having healthy family functioning and 11(18.3%) had unhealthy family functioning.

b) Aspect wise description of family functioning scores of mothers of autistic children

TABLE 3: Mean median, range and standard deviation of family function score of mothers of autistic children n=60

SI NO	Family functioning Aspects	Mean	Median	Range	Standard deviation
1	Problem solving	6.46	7	3-8	±1.77
2	Commu-nication	9.15	9	4-11	±1.8
3	General functioning	4.58	5	0-8	±1.39
4	Social interaction	3.35	4	0-6	±1.45
5	Combined	23.54	25	15-32	±6.4

The data presented in **Table 3** indicates the aspect wise score of family functioning of mothers of autistic children. The mean score ranges from 3.35 to 9.15 with standard deviation ±1.39 to ±1.8 and median 4 to 9.

SECTION 3: DESCRIPTION OF COPING STRATEGY SCORE OF MOTHERS OF AUTISTIC CHILDREN

a) Description of level of coping strategy of mothers of autistic children

TABLE 4: Frequency and percentage distribution according to level of coping strategy of mothers of autistic children n=60

SI NO	Coping strategy	Frequency	Percentage
1	Inadequate coping(0-12)	15	25%
2	Adequate coping(13-24)	45	75%

It is evident from **Table 4** that, majority of the samples were i.e. 45(75%) were having adequate coping and 15(25%) had inadequate coping.

b) Mean, median, range and standard deviation of coping strategy scores

TABLE 5: Mean, median, range and standard deviation of coping strategy score of mothers of autistic children n=60

Group	Mean	Median	Range	Standard deviation
Mothers of autistic children	**16.67**	18	10-23	±4

The data presented in **Table 5** shows that the mean coping strategy score of mothers of autistic children is 16.67 with SD ± 4, ranged from 10-23.

SECTION 4: FINDINGS RELATED TO THE RELATIONSHIP BETWEEN FAMILY FUNCTIONING AND COPING STRATEGY OF MOTHERS OF AUTISTICCHILDREN

TABLE 6: Correlation Co-efficient of family functioning and coping strategy of mothers of autistic children n=60

Variable	Mean score	Correlation coefficient
Family functioning Coping strategy	23.53 16.67	0.58*

$r_{(59):}$0.25;p<0.05:*-significant

Data presented in **Table 6** shows that, significant correlation found between family functioning and coping strategy of mothers.

SECTION V: Findings related to association of family functioning and coping strategy of mothers with their selected personal variables

The findings of the study shows that a significant association found between family functioning of mothers of autistic children and type of family and significant association found between coping strategy of mothers of autistic children and age of mothers.

CONCLUSION

The results of the present study revealed that majority of the mothers were having healthy family functioning and adequate coping strategy. The relationship of family functioning and coping strategy was found to be significant at 0.05 level of significance Thus it was concluded that mothers of autistic children in AIISH were having healthy family functioning and adequate coping strategy. The general views of most literatures express that the mothers of autistic children have problems in their family functioning and coping with normal day to day challenges of life. Participation in the various programs of the AIISH has proven to be of high productivity over the quality of life of these mothers. The realization of above facts prompted me to bring out a small information booklet to be shared by the participants of AIISH programs regarding autism.

Acknowledgement: We express our thanks to all mothers who participated in the study and authorities who provided permission to conduct the study.

Conflict of Interest: Being a parent can be both rewarding and challenging, even for parents of children without disabilities. Caring a child with autism can produce great stress and a sense of imbalance in the family system especially for mothers. Thus, these parents are in need for a wide range of support and educational programs that offer broad information about Autistic Disorder along side with therapeutic and effective strategies to address their stressors and improve their quality of life.

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

Funding Sources: Not obtained any funds from funding sources

REFERENCE

1. ShayamaChona. Effective Parenting. New Delhi: Hay House Publisher; 2009.
2. Alka Baraga. School Education of Children with Special Needs in India with a Perspective on the Initiatives for Children with Autism. [homepage on the Internet]. 2009 [cited 2014 Dec 2]. Available from: http://www.ncert.nic.in.
3. SreevaniR.a. Guide to mental health and psychiatric nursing. 3rd ed. New Delhi:jaypee publisher; 2010.
4. Petter Murray. Autism rate raises to 1 in 50 children cause still a mystery. [homepage on the Internet]. August 2013 [cited 2013 Nov 5]. Available from: http://singularityhub.com/2013/04/08/autism-rate-rises-to-1-in-50-children-cause-still-a-mystery
5. Brian a Boyd. Examining the Relationship between Stress and Lack of Social Support in Mothers of Children with Autism, [homepage on the Internet]. August 2013 [cited 2013 Dec 8].Available from: bb129@hotmail.com.
6. Avinash De Sousa. Mothers of children with developmental disabilities: An analysis of psychopathology. [homepage on the Internet]. July-December 2010 [cited 2013 Nov 18].

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Prevalence of Internet Addiction among Adolescents

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ABSTRACT

Objective: To assess the prevalence of internet addiction among adolescents, its impact on health and its association with selected demographic variables.

Background: Internet addiction is defined as a psychological dependence on the Internet and is characterized by an increasing investment of resources on Internet-related activities, unpleasant feelings (e.g., anxiety, depression, emptiness) when offline, an increasing tolerance to the effects of being online, and denial of the problematic behaviors.

Material and method: Non experimental approach and descriptive research design was adopted in this study. The study was conducted in two selected schools of Ludhiana, Punjab. The sample of this study was 300 adolescents. Stratified random sampling technique was used to raw the sample. The tools used for the data collection were socio-demographic Performa, internet addiction test and structured questionnaire. Feasibility of the study was confirmed by pilot study Data was collected from adolescents studying in 9th to 12th class in selected schools. Data was analyzed by descriptive and inferential statistics and presented through tables and figures. **Results**: The results revealed that maximum (55.00%) adolescent have minor internet addiction, followed by (27.00%) have atypical internet addiction, than (17.67%) have moderate internet addiction & minimum (00.33%) have severe internet addiction. Majority (48.1%) of adolescents with internet has adversely affected health, followed by normal health (38.9. %) and least (13%) have very adversely affected health. Gender and family income have significant ($p<0.05$) impact on internet addiction among adolescents. **Conclusion:** In the present study maximum of adolescents are having minor internet addiction and Maximum (48.1%) adolescents with internet addiction have adversely affected health**.** There is significant association between gender, Family income with internet addiction among adolescents.

Keywords: *Internet Addiction.*

INTRODUCTION

"Technology is so much fun but we can drown in our technology. The fog of information can drive our knowledge." **Daniel J.boorstin**

Internet is being integrated as part of our everyday's life because the usage of internet has been growing explosively worldwide. Homes, schools, colleges, libraries and internet cafes are the places which are more accessible to internet nowadays.[1]

The Internet was established in the early 1960s and subsequently became a mainstream communication vehicle. Since that time, there has been remarkable growth in the Internets functionality, capacity, accessibility and convenience. These improvements have encouraged more people to use it more often, and it has become a powerful application in modern society. As of 2010, 28.7% of the world's population used Internet services (Internet World Stats,

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2010b). The Internet is a massive, computer-linked network system used globally to access and convey information, either by personal or business computer users; it is also used for communication, research, entertainment, education and business transactions. Today, the Internet can link all online computers so that people can use it to communicate throughout the world.[2]

The internet is a new tool that is evolving into an essential part of everyday life all over the world and its use increases especially among young people. In spite of the widely perceived merits of this tool, psychologists and educators have been aware of the negative impacts of its use, especially the over or misuse and the related physical and psychological problems; one of the most common of these problems is internet addiction.[3]

Internet addiction as a new form of addiction in recent years has attracted psychology, psychiatry, sociology and other researchers' attention. Internet addiction is a problem can be seen in different societies and cultures. The spread of this problem has lead researchers and experts to identify its reasons, consequences and side effects.[4]

Internet addicts suffer from emotional problems such as depression and anxiety-related disorders and often use the fantasy world of the Internet to psychologically escape unpleasant feelings or stressful situations." Over 60% of people seeking treatment for Internet addiction disorder claim involvement with sexual activities online which they consider inappropriate, such as excessive attention to pornography or involvement in explicit sexual conversations online. More than half are also addicted to alcohol, drugs, tobacco, or sex etc. People who develop problems with their Internet use may start off using the Internet on a casual basis and then progress to using the technology in dysfunctional ways. Use of the Internet may interfere with the person's social life, school work, or job-related tasks at work.[5]

NEED OF THE STUDY

According to the survey done by Internet and Mobile Association of I ndia (2005), in the 26 cities that covered 65,000 persons in 16,500 households, has shown 1.6 million school children use the internet for about 322 minutes a week and about 3.4 million college students use the internet about 433 minutes a week.[6]

Psychiatrists believe the increasing obsessions with the online users are taking a heavy toll on the social and personal life, as well as Mental Health of people. Aruna Broota a leading Delhi Based clinical psychologist says, "Over the past two years the number of parents seeking advice on how to end their children's net addiction has increased. These children and adolescents are hooked on to Orkut and various porn sites for six to eight hours. Its high time Internet fixation is treated as a disease in the country, like alcohol and drug addiction centers.[7]

Objectives

1) To assess the prevalence of internet addiction among adolescents in selected schools of Ludhiana, Punjab.

2) To determine the impact of internet addiction on adolescent's health in selected schools of Ludhiana, Punjab.

3) To find out the association of internet addiction among adolescents in selected schools of Ludhiana with selected demographic variables.

Hypothesis:

H_1: Males will have more internet addiction as compared to females as measured by self structured tool at $p<0.05$ level.

$H_{0:}$ There will be no significant difference in internet addiction among males and females as measured by self structured tool at $p< 0.05$ level.

MATERIAL & METHOD

- **Research approach and design:** A quantitative descriptive approach and non experimental research design was used to achieve the objectives of the present study.

- **Research setting:** The study was conducted in 2 selected Senior Secondary Schools of Ludhiana Punjab i.e. R.S Model Senior Secondary School Shastri Nagar Ludhiana and Guru Nanak International Public School Gujjar Khan Campus, Ludhiana, Punjab.

- **Sample and sampling technique: The**

population of the study comprises of 300 adolescents studying in 9th to 12th & stratified random sampling technique was used to select the sample.

- **Tool for data collection:** Socio demographic proforma consisted of 6 demographic variables namely age, gender, class, family income, use of internet (in hrs) and medium of use of internet. Internet addiction was assessed by using standardized tool "Internet Addiction Test developed by Kimberly Young. Second structured tool was used to assess the health of the adolescents with internet addiction which consists of 38 questionnaires out of which 16 are related to physical health and 22 are related to psychological health.

- **Analysis of data:** Data were analyzed by using descriptive and inferential statistics.

RESULTS

Section - I: Distribution of adolescents according to their Socio- Demographic Variables

Table 1: Frequency and percentage distribution of adolescents according to their Socio- demographic variables N=300

Variables	Opts	Percentage (%)	Frequency(f)
Age (in years)	13-14 Years	13	39
	15-16 Years	40	119
	17-18 Years	47	142
Gender	Male	54	161
	Female	46	139
Class	9th	24	72
	10th	25	75
	11th	26	77
	12th	25	76
Family income (per month)	Up to 20000	16	47
	20001-40000	33	99
	40001-60000	29	88
	Above 60000	22	66
Use of internet (in hours)	Less than 1 Hour	36	109
	1-2 Hours	38	113
	3-4 Hours	21	63
	Above 4 Hours	5	15
Medium of use	Mobile	61	182
	Tablet	17	52
	Laptop	20	61
	Any other	2	5

Table 1: shows that majority of adolescents are in the age group of 17-18 years, are male, from 11th class, having family income ₹ <20,001-40,000/-. Maximum of adolescents are using internet for 1-2hrs and use mobile for internet.

Section II: Distribution of adolescents according to level of internet addiction.

Fig: 1

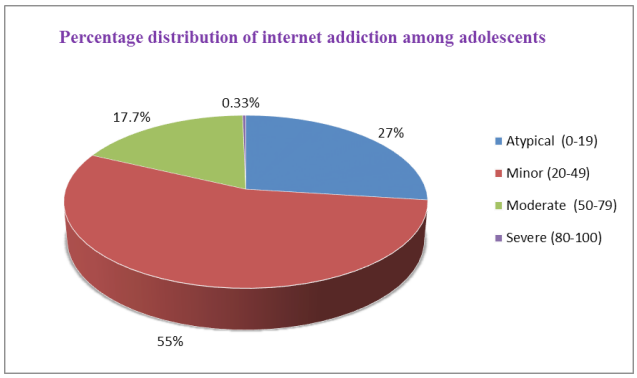

Fig 1 reveals that maximum (55.00%) adolescent have minor internet addiction, followed by (27.00%) atypical internet addiction, than (17.67%) moderate internet addiction and least (00.33%) have severe internet addiction.

Section III: Distribution of adolescents according to their health status

Fig 2:

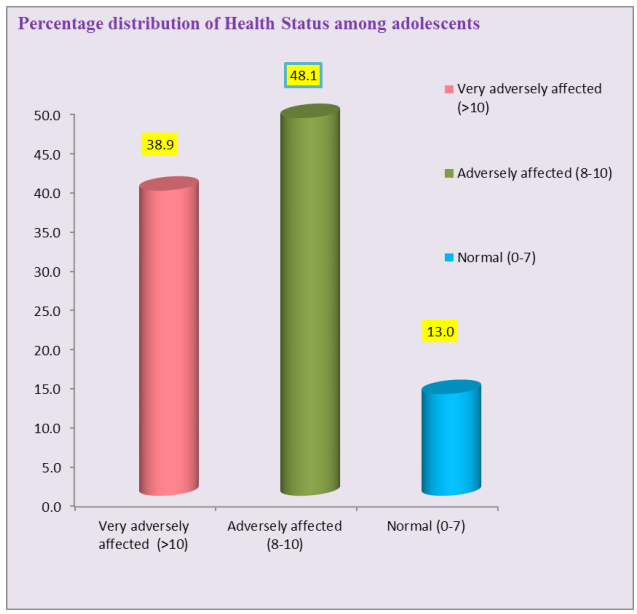

Fig 2: Reveals that maximum (48.1%) adolescents with internet addiction have adversely affected health, followed by very adversely affected health (38.9.%) and least (13%) have normal health.

SECTION IV: Association of internet addiction with selected demographic variables.

Table 2

Gender	n	mean	SD	df	χ^2	Results
Male	49	57.43	7.53	1	43.83*	Significant
Female	5	50.00	.00			

Family income (Rs. month)	n	mean	SD	df	χ^2	Results
≤20000	4	63.25	13.30			
20001-40000	23	57.00	6.73	3	12.73*	Significant
40001-60000	11	55.18	7.97			
≥ 60001	16	55.81	6.32			

*Significant at p <0.05.

Hence the research hypothesis is accepted and null hypothesis is rejected.

CONCLUSION

From the findings of present study following conclusions were drawn:

- Maximum (55%) adolescents have minor internet addiction.
- Maximum (48.1%) adolescents with internet addiction have adversely affected health.
- There is significant association between Gender & Family income and internet addiction among adolescents.

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Ethical Clearance

1. Written permission was taken from Principal of selected schools, Ludhiana, Punjab.
2. Written permission was taken from Ethical Clearance Committee of Institute of Nursing Education, Guru Teg Bahadur Sahib, Shastri Nagar, Model Town, Ludhiana, Punjab
3. Verbal informed consent was taken from each study sample.
5. Confidentiality and Anonymity of samples maintained throughout the study.

Source of Funding- Self

Conflict of Interest- Nil

Acknowledgement: Nil

REFERENCES

1) Christakis DA. Internet addiction. A 21st century epidemic. BMC Med 2010; 18: 61.
2) Impact of Internet use on self reported behavior changes. Wikipedia. free encyclopedia.http://www.wikepedia.org
3) Prasanna Chebbi et al. Some Observations on Internet Addiction Disorder Research. Journal of Information Systems Education, Volume 11(Issue 3-4).
4) Yen, J.Y., et al., The co morbid psychiatric symptoms of Internet addiction: attention deficit and hyperactivity disorder (ADHD), depression, social phobia, and hostility. Journal of Adolescent Health, 2007. 41(1): p. 93)
5) Murali V, George S. Lost online: An overview of internet addiction. Adv Psychiatr Treatment. 2007;13:24–30
6) Internet and mobile association of India, Hindustan times, 2007, October 18.
7) Sharma Manoj, Internet Addiction, Hindustan Times 2007July 1.

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A Descriptive Study to Assess the Attitude of Women on their Empowerment in a Selected Rural Community of Bagalkot

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ABSTRACT

A family may not be completed without a woman. She needs to take care of each one of the family member but she is unaware for taking care of herself. It is mainly due to here illiteracy and low economic status. As far as literacy is concerned women are particularly underprivileged. The working women children may try a variety of ways to meet her family responsibilities, within the framework of a democratic policy, our laws, development policies, plans and programmes that have aimed at women's advancement in different shares. The empowerment of women has been recognized as the central issue in determining the status of women. In aiming to improve women's rights and status and thereby, responding to not only their practical interests, but also strategic interest, the education, occupation, good health and self-help efforts enter the realm of the Indian women's movement. Hence the investigator felt the need to conduct **"A Descriptive Study To Assess The Attitude of Women On Their Empowerment In A Selected Rural Community of Bagalkot."**

The objectives of the study

1. To assess the attitude of women towards their empowerment
2. To associate the attitude of women on their empowerment with their selected socio demographic variables.

Assumption: The women who are literate and working have positive attitude towards their empowerment.

Method : A survey approach was adopted for the present study. The research design adopted for the study was descriptive design. The study setting selected for the study was Neeralakeri Village Bagalkot The sample of the study considered 100women.The tool used for the study was structured interview schedule with three point attitude scale. The obtained data was analyses by using descriptive and inferential statistics and interpreted in terms of objectives of the study.

Results : Assessment of attitude of women on their empowerment reveled that majority of the women (78%) had moderately high favorable attitude. The mean percentage of attitude score was 66 % with mean & SD 79-+ 8.7. The association between attitude scores and their selected socio-demographic variables was tested statistically using chi-square test. There was no significant association between attitude scores & any of socio-demographic variables.

Interpretation and Conclusion: The overall finding of the study revealed that there was no significant association between attitude scores & any of socio-demographic variables.

Keywords*: Women, attitude, women empowerment, rural community.*

INTRODUCTION

Women in developing countries are subject to various forms of discrimination and gender inequality. This is reflected in the female-male population ratios, particularly within North Africa and Asia which, in contrast to the ratios of European and North American countries, show that the number of males exceeds the number of females. These ratios are a consequence of various forms of discrimination against girls and women.[1]

Although the definition of empowerment is contested and the term is often used to cover any multitude of concepts, there are a few elements that are widely agreed upon. Most researchers agree that empowerment involves an element of control and choice in the context of power structures that exist in households, communities, nations and also globally. In the case of women's empowerment these power structures often refer to patriarchal systems of control that subordinate women. Most researchers also agree that empowerment is a process and therefore involves changes in existing power structures and a move from a state of disempowerment to empowerment. Finally, researchers agree that empowerment is multidimensional, occurring at different levels, and in different ways depending on individuals and communities and the environments in which they live[3].

Research on women's status in developing countries reports widespread improment of women in education, health care, rights, access to a number of essential resources and differences in power in all spheres of life. In 1994, at the International Conference on Population and Development in Cairo, development organizations agreed that women's empowerment is necessary for important development outcomes: "the empowerment and autonomy of women, and the improvement of their political, social, economic and health status, constitute an important end in themselves and one that is essential for achieving sustainable development." Gender equality and women's empowerment is necessary for the improvement of women and men's well-being, for social justice, and for the achievement of development goals[4].

Amartya Sen (2000:201) states that when women participate in economic activities the society as a whole benefits. Social benefits are provided through women's enhanced status and independence. Women are empowered through the reduction of gender bias in household decisions and have the possibility to generate income and affect the reduction of mortality and fertility rates in the society[5].

MATERIAL & METHOD

Research Approach: Research Approach is an umbrella that covers the basic procedure for conducting research. In order to accomplish the objectives of the study, a descriptive approach was adopted.

Research Design: The research design is the conceptual structure within research is conducted; it constitutes the blueprint for the collection, measurement and analysis of data. There search will write the assumption and its operational implications to the final analysis of data.

Setting of the Study: The setting is the location where a study is conducted. The present study was conducted in Neeralakeri of Bagalkot.

The setting is selected because of availability of the samples, feasibility of conducting study and geographical proximity.

Variables: Variables are quantities, properties or characteristics of persons, things or situations that change or vary.

Research Variable Attitude of women regarding women empowerment.

Socio-demographic Variables: The demographic variables are age in years, marital status, marriage at the age, number of children, education, occupation, reason for work, type of family, religion and family income.

Population: The population referred to the target population, which represents the entire group or all the elements individuals or objects that meet certain criteria for inclusion in the study.

Target population: It refers to all the women of 20-60years of age living in rural areas of Bagalkot district

Accessible population: It refers to all the women of 20-60years of age living in Neralakeri of Bagalkot

Sample : Sample refers to subset of the population i.e., selected to participate in particular study.

In the present study, the sample consists of 100 rural women, who are in age group of 20-60 years residing at Neeralakeri of Bagalkot who fulfill the inclusion criteria for the study.

Sampling Technique: Sampling defines the process of selecting a group of people or under elements with which to conduct a study. The samples for the present study was selected using non probability convenient sampling technique.

FINDINGS

RESULTS : The collected data were edited, tabulated, analyzed, interpreted and the obtained results were organized in the following sections.

Section -1 This section deals with Description of Subjects according to their Demographic Variables.

Section II a) This section deals with level of attitude of women on their empowerment.

b) This section deals with area wise mean, standard deviation and mean percentage of attitude scores of women.

Section III This section deals with association between attitude of women on their empowerment and their selected socio-demographic variables

Section I; This section deals with Description of Subjects according to their Socio-demographic Variables.

Table 1: Distribution of Subject according to their Demographic Variables N =100

Sl. No	Variables	Frequency (f)	Percentage (%)
1	**Age(in yrs)**		
	20-30 years	53	53
	31-40 years	33	33
	41-50 years	14	14
	51-60 years	00	00
2	**Marital Status**		
	Single	03	03
	Married	86	86
	Widow	11	11
	Divorced	00	00
	Separated	00	00
3	**Age of marriage**		
	<17 years	27	23
	18-19 years	49	49
	20-21 years	24	24
	22 years and above	00	00
4	**Number of children**		
	No child	09	09
	01	25	25
	02	40	40
	03 and above	26	20
5	**Education**		
	Illiteracy	31	31
	Pre-primary school	20	20
	Primary school	25	25
	High school	22	22
	&college	02	02
	Degree		
6	**Occupation**		
	Government	08	08
	Agriculture	57	57
	House wife	30	30
	Self business	05	05
7	**Reason for work**		
	Own decision	25	25
	Economic problem	48	48
	Social prestige	13	13
	Qualification ability	15	15
8	**Type of family**	87	87
	Nuclear family	13	13
	Joint family		
9	**Religion**		
	Hindu	88	88
	Muslim	12	12
10	**Income**		
	Rs 2000-3000	38	38
	Rs 3001-4000	28	28
	Rs 4001-5000	22	22
	Rs 5001 and above	12	12

Section II a) This section deals with level of attitude of women on their empowerment.

Table 2: SHOWS THE ASSESSMENT OF LEVEL OF ATTITDE N = 100

SR NO	Levels of attitude	Range of score	Number of respondents	Percentage %
1	Highly favorable attitude	81to120	07	07
2	Moderately favorable attitude	41to80	78	78
3	Unfavorable attitude	0to40	15	15

Section II b) Area wise mean, standard deviation and mean percentage of attitude scores of women.

Table 3 ; Area wise mean, standard deviation and mean percentage of attitude scores of women.

N = 100

No	Aspects	Statements	Max Score	Mean	SD	Mean (%)
1	Literacy	10	30	19.64	2.96	65.46
2	Job opportunity	7	21	13.54	2.10	64.47
3	Work recognition	6	18	11.65	1.85	64.5
4	Health & Well being	7	21	14.56	2.16	69.33
5	Decision making	5	15	19.83	1.72	65.53
6	Power of women	5	15	10.02	1.59	66.8
	Total	**40**	**120**	**79.2**	**8.7**	**66**

The total percentage of attitude scores was 66% with mean and standard deviation 79.2 + 8.7.

Section III This section deals with association between attitude of women on their empowerment and their selected socio-demographic variables

Table 4 given the following descriptions N = 100

Sl No	Demographic Variables	df	Table value	X^2	Levels of significance
1	Age	1	3.84	0.76	P > 0.05 NS
2	Marital status	1	3.84	1.06	P > 0.05 NS
3	Age at marriage	1	3.84	0.08	P > 0.05 NS
4	Number of children	1	3.84	1.07	P > 0.05 NS
5	Education level	1	3.84	0.26	P > 0.05 NS
6	Occupational status	1	3.84	3.64	P > 0.05 NS
7	Family size	1	3.84	1.08	P > 0.05 NS
8	Type of family	1	3.84	0.07	P > 0.05 NS
9	Religion	1	3.84	0.07	P > 0.05 NS
10	Family income month	1	3.84	0.02	P > 0.05 NS

Df = 1 NS = Not significant

Thus H_1 stated is rejected for all the socio-demographic variables of women.

DISCUSSION / CONCLUSION

The following conclusions are made from the study. Assessment level of attitude of women on their empowerment. Shows that most of women (78%) had Moderately high favorable attitude, (15%) had Moderately favorable attitude were as (7%) Highly favorable attitude and no women had Moderately unfavorable attitude and Highly unfavorable attitude.

The attitude level of women on their empowerment had obtained highest score in health and well being aspect with arrange score of 13-21 and mean was 14.56 mean percentage was 69.33 with standard deviation 2.16 whereas lowest score of attitude level on women empowerment had obtained in work recognition aspect with a mean was 11.65 and mean percentage was 64.5 with standard deviation 1.5 in the study. As a whole e 120 maximum score, mean

79.2 mean percentage 66 with standard deviation 8.7

The findings regarding attitude level of women on their empowerment with their selected socio-demographic variables shows that, there is no significant association found between all the socio-demographic variables relater to women empowerment.

RECOMMENDATIONS

• The study can be done on large sample size to confirm the results.

• The study can be done to assess knowledge level and to develop the booklet according to their needs.

• The comparative study can be conducted among urban and rural women, among different caste, among different community.

Acknowledgement: My heartfelt thanks to **Prof**. **Dr. Nagarajappa. D**, Principal and Head of the department of Community Health Nursing, Shri. B.V.V. Sangha's Sajjalashree Institute of Nursing Sciences, Navanagar, Bagalkot., no words can express gratitude to my father Mr Siddappa mother Narmada, Brother Prasanna andmy sister Prabhavati, their faith has always given me strength, support encouragement and abundant blessings.

Conflict of Interest Nil

Source of Support: Self

Ethical Clearance: Done at BVVS Sajjalashree Institute of Nursing Sciences Navanagar, Bagalkot

REFERENCES

1 Acharya, Meena, and Lynn Bennett (1983). Women and the Subsistence Sector: Economic Participation and Household Decision-making in Nepal. Working Paper Number 526. Washington: World Bank.

2 Agarwal, B. (1997). Bargaining and Gender Relations: Within and Beyond the Household. Food Consumption and Nutrition Division Discussion Paper No. 27.

3 International Food Policy Research Institute. Alsop, R. and N. Heinsohn (2005). Measuring Empowerment in Practice: Structuring Analysis and Framing Indicators. World Bank PolicyResearch Working Paper 3510: February.

4 Baruah, B. (2004). Earning their keep and keeping what they earn: A critique of organizing strategies for South Asian women in theinformal sector. Gender Work and Organization 11(6): 605-626.

5 Baruah, B. (2005). "Gender and development in SouthAsia Can practice keep up with theory Canadian Journal of Development Studies26: 677-688.

6 Basu, A. G. Koolwal (2005). "Two Notions of FemaleAutonomy and Their Implications for Reproductive Health." Pages 15-54 in: A Focus on Gender: Collected Papers using DHS Data. Washington, DC: Macro International.

7 Batliwala, S. (1994). The meaning of Women's Empowerment: New Concepts from Action. Pp. 127-138 in Population Policies Reconsidered: Health, Empowerment and Rights. G. Sen, A. Germain, and L.C. Chen, eds. Cambridge, MA: Harvard University Press.

8 Blumberg, R.L. (2005). "Women's Economic Empowerment as the Magic Potion" of Development Paper presented at the 100th Annual Meeting of the American Sociological Association. Philadelphia, August.

9 CIDA (1999). CIDA's Policy on Gender Equity. Datta, R. (2003). "From Development to Empowerment:The Self-Employed Women's Association in India." International Journal of Politics, Culture and Society 16(3): 351-368.

10 Dixon-Mueller, R. (1998). "Female empowerment and demographic processes: Moving Beyond Cairo. Policy and Research Papers No. 13: Paris, IUSSP.

11 Dutta, M. (2000). Women's Employment and Its Effects on Bengali Households of Shillong, India. Journal of Comparative Family Studies31(2): 217-229.

12 Dutta, M. (2002). Women's Power and Authority within Middle-Class Households in Kolkata. Contemporary South Asia11(1): 7-18.

13 Endeley, J.B. (2001). Conceptualizing Women's Empowerment in Societies in Cameroon: How does money fit in Gender and Development9(1): March, 34-41.78

14 Frankenberg, Elizabeth, and Duncan Thomas (2001). Measuring Power. Food Consumption and Nutrition Division Discussion PaperNo. 113. Washington: International Food Policy Research Institute.

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Quality of Life of Patients with Alcoholism

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ABSTRACT

In northern India including Delhi, the 1-year prevalence of alcohol use has been estimated as 25 to 40% in the general population, whereas in southern India, this rate has been estimated as 30 to 50%. In southern India, the prevalence of alcohol use is higher among people of lower socio-economic status and those with lower levels of education. A large-scale survey over 32,000 people performed in 2001 in India found alcohol use rates of 20 to 38% in males and 10% among females.(3) Some people are more likely to experience the consequences of alcohol use. Alcohol dependence serves as an escape from domestic conflicts, business worries, feeling of inferiority and painful memories which happen in day to day life. It is assumed to give courage to coward, confidence to the timed, pleasure to the unhappy and success to the failure. So, it permits so slight from disappointment and frustration of reality. Therefore, alcoholism remains a serious problem in contemporary society around the world.

Keywords: *Quality of life, Alcoholism.*

BACK GROUND OF THE STYUDY

Alcohol dependence, a common psychiatric disorder in the general population, has a significant impact on health. In recent years, alcohol dependence has become a major social and personal menace in most societies. According to Global Status Report on Alcohol, alcohol use disorders accounted for 1.4% of the global disease burden. Alcohol consumption causes 3.2% of deaths (1.8 million) and 4.0% of the disability adjusted life years lost 58.3 million.(2)

The usage of alcohol may vary across societies and cultures. For example, in some communities serving alcohol to guests on joyful occasions and festivals is a common practice whereas in India it was strongly condemned by the ancient rhishies as it was considered a sin. But in this modern world man has to face many problems to lead the life in a successful way. If he fails to succeed then be may end up in anxiety, frustration, irritability depression, lack of self confidence and self concept. So to get rid of these emotions an individual starts to drink sips of alcohol as they go for parties and later on they become addicted to it.(4)

Need for study is assessed as, one of the more instructive way to analyze the quality of life among the patients with alcoholism from another perspective moreover explaining alcoholism satisfaction and also help some people realize how serious their drinking problems are and as a consequence, this study helps them for alcohol recovery. The various advertisements appears in media aimed to convey the message to create that, the drinking habit it is very much useful for the new generation. Drinking at inappropriate time and behavior causes reduced judgment, can lead to legal, consequences, such as criminal charges for drunk and driving or public disorders or civil penalties for tortuous behavior. An alcoholism behavior and mental impairment while drunk can profoundly impact surrounding family and friends, possibly leading to marital conflict and divorce or contributing to domestic violence.

QoL of alcohol dependent patients is not measured systematically, even though this is relevant to the psychosocial context of interventions. Studies on alcohol dependent patients have found on QoL as considerably decreased, but little information is available on how QoL changes following a therapeutic intervention.Some studies had reported a poor QoL in alcohol- dependent patients at the beginning of treatment. (1)

STATEMENT OF THE PROBLEM

A Descriptive Study to assess the **Quality of life Among Patients with Alcoholism** at Rajah Muthiah Medical College Hospital, Annamalai University, Annamalai Nagar, Chidhambaram.

OBJECTIVES

- To assess the quality of life among patients with alcoholism.
- To associate the quality of life of alcoholic patient with selected demographic variables.

MATERIAL & METHOD

A descriptive design was used for this study. The study was conducted in Rajah Muthiah Medical College and Hospital, Annamalai University, Chidambaram. The convenient sampling technique was adopted, for the selection of samples, and the Self structured interview schedule consists of 28 items, was administered for data collection, to assess the quality of life among hundred (100) alcoholic patients. Based on the total score, the quality of life among patients with alcohols were graded as follows

- 33 – 42 quality of life is mostly affected
- 23 – 32 - quality of life is moderately affected
- 13 – 22 - quality of life is mildly affected
- 1-12 – quality of life is not affected.

RELIABILITY

The response were scored and test of significance was computed to the reliabilites of the tests and scales by **Split Half Method** suggested by Edward(1969).The reliability co-efficient is 0.82 and level of significance is 0.001.The collected data's were analyzed statistically by using descriptive and inferential statistical methods.

Findings: The major findings of the study showed that 2% patient's Quality of life is mostly affected, 25% patient's Quality of life is moderately affected, 66% patient's Quality of life is mildly affected and 7% patient's quality of life is not affected.

Figure-1

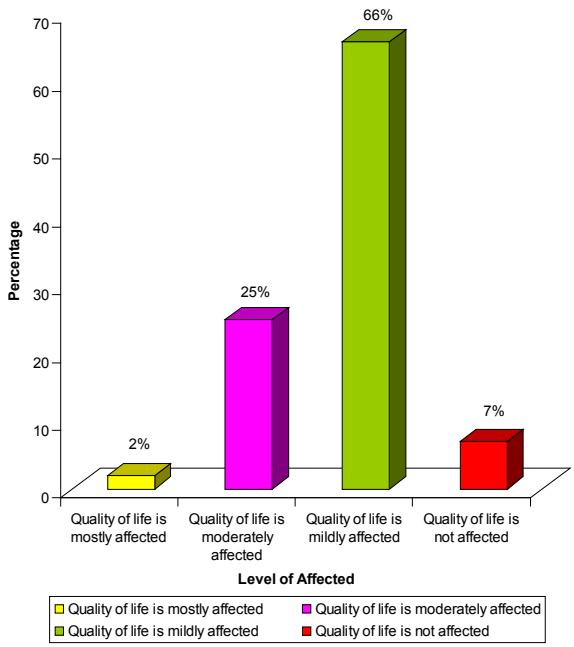

Diagram showing the level of quality of life among patients with alcoholism

Table: 1 Mean and standard deviation of quality of life among patient with alcoholism on the basis of demographic variables (N=100)

Sl.No.	Demographic variables	**Groups**	**N**	**Mean**	**SD**	**F / 't' value**	**P value**
1.	Age in years	20-30	18	17.22	6.02	2.251	0.087 (NS)
		31-40	21	21.76	4.96		
		41-50	31	21.87	6.38		
		Above 51	30	24.00	13.22		
2.	Religion	Hindu	71	22.25	8.33	1.282	0.285 (NS)
		Christian	11	18.82	4.87		
		Muslim	11	23.55	15.58		
		Others	7	17.00	4.00		

Table: 1 Mean and standard deviation of quality of life among patient with alcoholism on the basis of demographic variables. (Cont...) (N=100)

3.	Type of family	Nuclear family	81	21.89	9.55	0.744	0.461 (NS)
		Joint family	19	20.63	5.74		
4.	Birth order	First child	24	24.67	14.56	1.261	0.292 (NS)
		Second child	43	20.42	6.53		
		Third child	29	21.21	5.63		
		Above	4	20.00	4.62		
5.	Educational status	Non-literate	44	24.02	11.18	2.258	0.027 (S)
		Literate	56	19.79	6.19		
6.	Occupation	Employed	36	23.31	12.32	1.178	0.245 (NS)
		Unemployed	64	20.72	6.23		
7.	Family income (monthly)	Upto Rs.1000	31	24.16	12.55	1.281	0.285 (NS)
		Rs.1001-3000	47	20.15	6.19		
		Rs. 3001-6000	18	21.22	7.60		
		Above 6000	4	21.75	6.85		
8.	Location of residence	Urban	38	22.76	12.31	0.501	0.608 (NS)
		Semi urban	47	21.13	5.76		
		Rural	15	20.47	7.10		

P<0.05 level (Significant) NS – Not Significant

Table: 1 reveals that only educational status is significant for mean and standard deviation of quality of life among patients with alcoholism on the basis of demographic variables. All other variables are not significant.

CONCLUSION

To conclude, the present study poor quality of life in 2% of alcohol-dependent might be helped through, the regular follow-up in an out-patient setting along with the caregivers will improve the compliance and enables the patients to pursue their work and take up other responsibilities. This enhances the self-esteem and achieves complete abstinence, thereby improving their quality of life. Treatment of alcohol dependence with a favorable outcome is possible with minimal financial resources, regular follow up, and the involvement of caregivers. There is a need to create general awareness in public that alcohol dependence is a disorder that requires immediate attention.

Long term misuse of alcohol can cause a wide range of mental health problems. Severe cognitive problems are not uncommon; approximately 10% percent of all dementia cases are related to alcohol consumption. Excessive alcohol use causes damage to brain function, and psychological health can be increasingly affected over time.

Acknowledgement: We extend our special and sincere thanks to Dr. Mrs.Vijayalakshmi Ethiraj, M.Sc. (Nsg), Ph.D, Principal, Rani Meyyammai College of Nursing, Annamalai University for her motivation and encouragement for the successful completion of the study.

We express our sincere gratitude to The Medical Superintendent RMMC&H Annamalai University for given permission,and also remarkable guidance and elegant direction given to complete the study.

Conflict of Interest: None declared.

Source of Support: Self funded project.

Ethical Clearance: Permission was obtained from the Medical Superintendent and Head of the Department of Psychiatry, Rajah Muthiah Medical College and Hospital.

REFERENCES

1. The World Health Organization quality of life assessment (WHOQOL): Position paper from the World Health Organization. Soc Sci Med 1995;41:1403-9.

2. Srivastava S, Bhatia MS. Quality of life as an

outcome measure in the treatment of alcohol dependence. Ind Psychiatry J 2013;22:41-6.

3. Préau M, Protopopescu C, Spire B, Sobel A, Dellamonica P,Moatti JP, *et al*.; MANIF-2000 Study Group. Health related quality of life among both current and former injection drug users who are HIV- infected. Drug Alcohol Depend 2007;86:175-82.

4. Donovan D, Mattson ME, Cisler RA, Longabaugh R, Zweben A. Quality of life as an outcome measure in alcoholism treatment research. J Stud Alcohol Suppl 2005;15:119-39; discussion 92-3.

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Effectiveness of Self Instructional Module (SIM) on Knowledge Regarding Prevention of Suicide among the Engineering Students in a Selected Engineering College, Bhubaneswar, Odisha, India

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ABSTRACT

Suicide prevention among youth is a one of the most problematic challenges not only to any nation but also to the entire profession. A Quasi experimental research design, pre and post test without control group was adopted in this study. The study was undertaken on 100 students of 1st year engineering college, ITER, Bhubaneswar, Odisha, by non probability convenience purposive sampling technique. Data was collected by multiple choice close ended questionnaires. Highly significant difference was found between pre and post test knowledge scores. No Significant association was found between post test knowledge and demographic variables relationship with the 1st year engineering students, i.e. age, sex, religion, areas of living, family monthly income, domicile, types of family & previous exposure to any educational program on prevention on suicide. Statistical analysis of data revealed that SIM was effective in improving knowledge regarding prevention of suicide among 1st year engineering students.

Keywords: *Self Instructional Module (SIM), Suicide, Prevention.*

INTRODUCTION

Suicide is the third leading cause of death among young adults worldwide. [1]According to the WHO, every year, almost one million people die from suicide and 20 times more people attempt suicide, a global mortality rate of 16 per 100,000, or one death every 40 seconds and one attempt every 3 seconds, on average.[2] Global annual teenage suicide statistics, reported for these fatalities could rise to 1.5 million by 2020. **(**Suicides in India 2011 feb. 16) [3-4].

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The rates of suicide have greatly increased among youth, and youth students are now the group at highest risk among young ages 15-24 years. So early detection and treatment are the best ways to prevent suicidal ideation and suicide attempts. If sign & symptoms or risk factors are detected early then the individual will hopefully seek treatment and help before attempting to take their own life.[5] Webster defined suicide as "the act of intentionally killing oneself".Sredama called suicide as "murder in 180th degree".[6]

According to the National Crime Records Bureau (NCRB), there were 125,017 suicides in India in 2008, which is an increase of 1.95 over the previous year. In 2003, there were about 300 suicides per day or one suicide every 5 minutes. The comparable period prevalence rate for suicide throughout world range from 5/100,000 population / year to 30 /100,000 population/ year .The world Health Report,

2001 estimates that every year one million people worldwide commit Suicide (100,000 suicide per year in India out of 1 million (100,000 suicides per year in India out of 1 million suicides per year in India out of 1million suicides in the world every year), while 10 -20 million people attempt suicide. Thus, the ratio of attempted suicide to completed suicide is 10 –20:1.

The rate of suicide is the number of suicides per 1lakh population-went up to 12.2% from 10.8 in 2007. The Odisha is ranked 14th most suicide-prone of the total 35 states and Union territories in India. The most alarming fact is more than 3.4% of the victims belong to the age group of below 14 years. Suicides due a family disputes account for 24.6% even compared to National average is 23.8%,due to poverty 1.3%, unemployment grew by 2.5 times to share 2.6% of the aggregate. In contrast, the National average for suicide due to poverty and unemployment at around 0.6 and 1.7% respectively.[8]

A case control study was conducted to assess the effectiveness of SIM on psycho-educational program in Suicide prevention among adolescents in Belgium. The study included 15 to 20year-old students. The study revealed that, the programme has positive effect on knowledge and interaction effect of the programme on attitude was found. The study concluded that psycho-educational programs among adolescents influence knowledge about suicide and attitudes towards suicidal persons.[9]

For the above studies there is need for heightening the student's knowledge on prevention of suicide and save a life.

OBJECTIVES OF THE STUDY

To

- Find out the pre-test knowledge score of 1st year students regarding prevention of suicide in engineering college students.
- Find out effectiveness of self instructional module on knowledge regarding prevention of suicide among the 1st year engineering students.
- Compare the post-test knowledge score with their selected demographic variable.
- Find out the association of the post-test knowledge score with their selected demographic variables of 1st year students of engineering college.

HYPOTHESIS

H_1= There will significant association between post test knowledge score with their selected demographic variables of 1st year students of selected engineering college.

H_2= There will be significant difference between pre-test and post-test knowledge score of 1st year students regarding prevention of suicide.

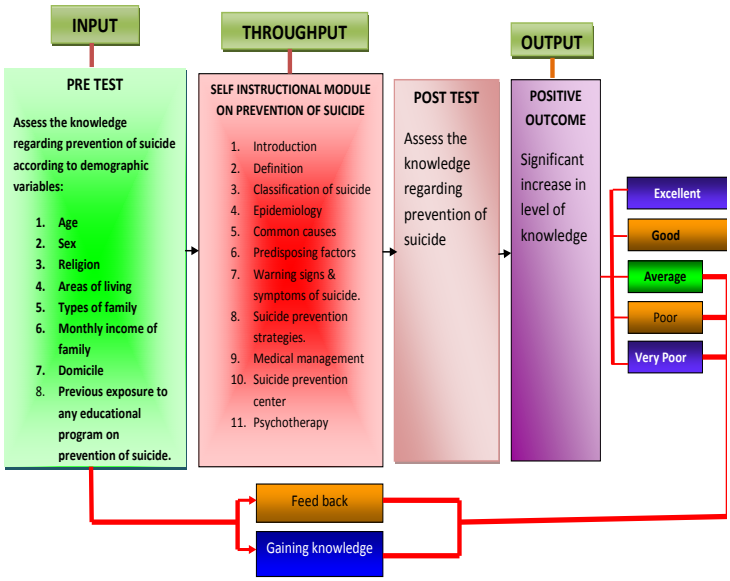

Fig. No.- 1:Theoretical framework based on J.W. Kenny's open system model (1990).

MATERIAL & METHOD

Quasi experimental research design, pre and post test without control group was used to conduct in this study. The study was conducted in engineering college, ITER, Bhubaneswar, Odisha, where 100 students were selected by convenient sampling technique. The tool was developed in 2 sections. Section -A includes the demographic variable and section-B includes structured multiple choice close ended questionnaire regarding general information on suicide & prevention of suicide.

Permission was obtained from the Director of ITER, engineering college, Bhubaneswar, Odisha and informed consent was taken from the participants. Pretest was conducted by using multiple choice close ended questionnaires followed by implementation of SIM. After 7 days post test was done. Descriptive and inferential statistics was used for data analysis.

FINDINGS

Table-1: Distribution Socio-demographic variables of engineering Students

S No.	Demographic variables	Frequency	Percentage
1	**Age (years)**		
	17-18	60	60%
	19-20	35	35%
	21-22	5	5%
	23 and above	0	0
2	**Sex**		
	male	49	49%
	female	51	51%
3	**Religion**		
	Hindu	82	82%
	Muslim	7	7%
	Christian	8	8%
	others	3	3%
4	**Areas of Living**		
	Hostel	52	52%
	Mess	15	15%
	Rented House	13	13%
	Own House	20	20%
5	**Family monthly income**		
	Rs. <5,000	1	1%
	Rs. 5,000-10,000	4	4%
	Rs.11,000-20,000	31	31%
	> Rs.21,000	64	64%
6	**Domicile**		
	Rural	27	27%
	Urban	70	70%
	Slum	3	3%
7	**Types of family**		
	Nuclear	76	76%
	Joint	20	20%
	Extended	4	4%
8	**Previous exposure to any educational program on prevention of suicide.**		
	Yes	17	17%
	No	83	83%

Table 2: Area wise comparison of mean, SD and mean percentage of scores of 1st year engineering students regarding prevention of suicide pre-test and post-test knowledge.

Sl No.	Area	Max. Score	Pre-test			Post-test			Difference in Mean%
			Mean	SD	Mean%	mean	SD	Mean%	
1.	General information On suicide	19	3.81	2.16	20.05	15.54	0.89	81.78	61.73
2.	Prevention Of suicide	21	8.50	3.45	40.47	17.95	0.83	85.46	44.99
Overall		40	12.31	4.73	30.77	33.49	1.38	83.72	52.95

Table-2: It is observed that overall mean score during post test was (33.49±1.38) which is 83.72% of the total score and the difference in mean percentage between pre and post test knowledge score was 52.95% revealing the effectiveness of SIM.

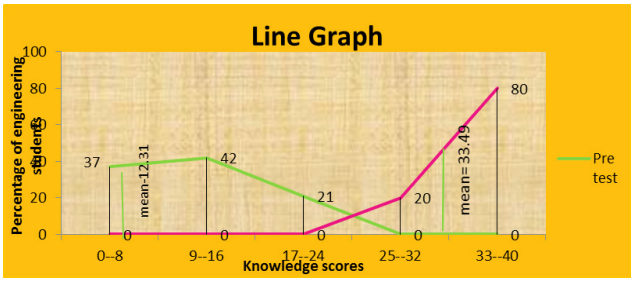

Fig-2- Line graph showing the comparision of pre and post test knowledge score of the 1st year engineering students

Fig-2: Line graph reveals that highest pretest mean score was between 9 -16 which was obtained by 37% interpretes maximum engineering students having very poor knowledge Where as in post test the highest mean score was between 33-40 which was obtained by 80% of care givers shows effectiveness of SIM..

Fig-3 - O Give curve showing comparison of cumulative percentage of pre test and post test knowledge scores of the 1st year engineering students.

Fig-3: Reveals that the O - Give curve values on post test score was consistently higher than the pretest scores. It is also found that the post test curve is steeper than the pre test curve which shows higher effectiveness of SIM.

H_1- There will be no significant association between post- test knowledge scores among engineering students regarding prevention of suicide with their selected demographic variables.

H02: There will be significant difference in the pretest and posttest level of knowledge score among the students after administration of self instructional module.

Table 3: Association between post test knowledge scores engineering students on prevention of suicide.

DEMOGRAPHIC VARIABLES	Chi-Square value	Table value	Df	LEVELOF SIGNIFICANCE
Age	1.85	5.99	2	Not Significant
Sex	0.54	3.84	1	Not Significant
Religion	5.65	7.82	3	Not Significant
Areas of living	3. 46	7.82	3	Not Significant
Monthly income of family	1.62	7.82	3	Not Significant
Domicile	2.74	5.99	2	Not Significant
Types of family	2.36	5.99	2	Not Significant
Previous exposure to educational program on prevention of suicide.	2.87	3.84	1	Not Significant

(df =1, 2 & 3), (Table value=3.84), (P< 0.05)

Table-3: Chi-square was calculated to find out the association between post test knowledge scores of the students with their demographic variables. It was found that there was no significant association between knowledge scores among students on prevention of suicide in post test when compared to age, sex, religion, areas of living, family monthly income, domicile, types of family and previous exposure to educational program on prevention of suicide (P< 0.05).

Table-4: Area Wise Comparison between Difference Of Pre And Post Test Knowledge Scores Of The Students Regarding Prevention of Suicide

AREA	'Z' –value	LEVEL OF SIGNIFICANCE
General information on suicide	48.82	Highly Significant
Prevention of suicide.	27.02	Highly Significant
Overall	43.22	Highly significant

(Table Value=2.0), (P< 0.05)

Table no-4: 'Z' test was calculated to assess the significant difference between pre and post test knowledge scores which shows highly significant difference between areas wise score values of pre test and post test knowledge scores. Hence, the null hypothesis is rejected (P<0.05) and the statistical hypothesis is accepted. Thus, it can be interpreted that Self Instructional Module was effective for all areas.

CONCLUSION

From the findings of the present study it can be concluded that SIM on prevention of suicide was effective to enhance the knowledge of engineering students regarding prevention of suicide.

Acknowledgement: We thank the engineering students who participated in the study and the authorities who provided permission to conduct the study. It is a sense of honor & pride for me to express our deep sense of gratitude to our chairman sir and vice-chairman sir for providing all facilities in perusing our project.

Conflict of Interest : Nil

Source of Funding: Not obtained any fund from any source.

Ethical Clearance: The permssission was obtained from the Director of ITER, Bhubaneswar, Odisha. Written informed consent was obtained from the study participants before data collection.

RECOMMENDATIONS

Keeping in view the findings of the present study, the following recommendations were made:

- A similar study on a large sample may help to draw more definite conclusion and make generalization.
- An experimental study can be undertaken with control groups.
- A similar study can be conducted in other settings like +2 & +3 college students, rehabilitation centers, residential institutions and psychiatric centers specially designed for the prevention of suicide.
- A comparative study can be conducted on knowledge of engineering students in two alternate special institutions for suicidal individuals.
- A similar study can be conducted among parents, care takers of the hostel, college teachers and also psychiatric nurses.
- A multiple time series design can be adopted for the observation of skill which will increase the certainty with which the researcher can generalize findings.
- A similar study can be conducted by using various other instructional media for obtaining the most effective method, e.g., VATM, Demonstration, Simulation, STP etc.

REFERENCES

1. Mary. C. Townsend (2012) "Psychiatric Mental Health Nursing", 1st edition Jaypee Medical Publishers (P) Ltd. Pp-306—318
2. Neeraja KP (2008) "Essentials of Mental Health & Psychiatric Nursing", vol-II 1st edition, Jaypee Brothers Medical Publishers (P) Ltd, Pp 320-323.
3. Suicide: statistics. The times of India [news paper on the internet].2006 Jul 26 [cited 2011 Feb 15]. Available from: http:// timesofindia.in diatimes.com/home/specials/Suicide-Statistics/ articleshow/1 814952.cms
4. Teenage Suicide Statistics. 2010 feb1.http: //www.comfortyourheart.com/teenage-suicide,statistics.html
5. Sharma R, Grover VL, Chaturvedi S. Suicidal behavior amongst adolescent students in south Delhi. Indian J Pediatr. : 2008 Januvary; 50: 30-33.
6. Gail W. S. Principles and practice of psychiatric nursing.7th ed. St.Louis, Missouri: Court Pvt.

Limited; 2001, P 381-83.

7. Suicides in India 2011 feb. 16, from: http: // www. Maithrikochi. Org/ india suicide statistic. htm# top.
8. Portzky G, van Heeringen K. Suicide prevention in adolescents: a controlled study of the effectiveness of a school-based psycho-educational program. J Child Psychol Psychiatry [serial online]. 2006 Sep [cited 2011 Feb 16]; 47(9):910-8. from:http://www.ncbi.nlm.nih.gov/pubmed/16930385.

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Orthorexia Nervosa- a Review

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ABSTRACT

Orthorexia nervosa is characterized by an obsession with avoiding foods perceived to be unhealthy. It seems to be more common in men than in women and in those with a lower level of education. It may be a food-centered manifestation of obsessive compulsive disorder. Orthorexia is an emotionally disturbed, self-punishing relationship with food that involves a progressively shrinking universe of foods deemed acceptable. The more restrictive the diet, the more likely it is to set off the psychological factors that lead to an eating disorder. Raw foods veganism is on the other extreme, and has a fairly high orthorexic potential. Orthorexia sufferers often display signs and symptoms of anxiety disorders that frequently co-occur with anorexia nervosa or other eating disorders. An orthorexic may avoid numerous foods, including those made with artificial colors, pesticides, fat, sugar, salt, animal or dairy products. A woman with orthorexia may find that her food obsessions begin to hinder everyday activities. Orthroxia can put a strain on relationships with family and friends, as relationships become less important than holding to dietary patterns. Maintaining an obsession with health food may cause a restriction of calories merely because available food isn't considered to be good enough. Orthorexia is a discrete diagnosis like anorexia nervosa or bulimia nervosa. Obsession with weight is one of the primary signs of anorexia, bulimia, and other eating disorders, but is not a symptom of orthorexia. orthorexia is a medical disease that can result in irreversible health complications, including death.

Keywords: ***a****ppetite, obsessive compulsive, paleo, probiotics, Anorexia Nervosa, bulimia nervosa.*

ORTHOREXIA NERVOSA

"Trying to be perfect will make you crazy, in diet as elsewhere in life".

HISTORY

Steven Bratman coined the term "orthorexia nervosa" in 1997 from the Greek orthos, meaning "correct or right", and orexis, meaning "appetite".[1] Literally "correct appetite", the word is modeled on anorexia, meaning "without appetite", as used in definition of the condition anorexia nervosa. Bratman describes orthorexia as an unhealthy fixation with what the individual considers to be healthy eating. The subject may avoid certain unhealthy foods, such as those containing fat, preservatives, man-made food-additives, animal products, or other ingredients considered by the subject to be unhealthy. If the sufferer does not eat appropriately, malnutrition can ensue. Bratman claims orthorexia sufferers have specific preferences about the foods they are eating and avoiding. Products that are preserved with additives can be considered dangerous. Industrial products can be seen as artificial, whereas fruits and vegetables can be seen as healthy.[2] Bratman asserts that "emaciation is common among followers of certain health food diets, such as rawfoodism, and this can at times reach the extremes seen in anorexia nervosa." In addition, he claims that "anorexic orthorexia" can be as dangerous as anorexia. However, he states, "the underlying motivation is quite different. While an anorexic wants to lose weight, an orthorexic does not desire to become thin[2] but wants to feel pure, healthy and natural. Eating disorder specialists may fail to understand this distinction, leading to a disconnect between orthorexic and physician."[3][4]S

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ymptoms and theory

Orthorexia nervosa is characterized by an obsession with avoiding foods perceived to be unhealthy. It is important to differentiate between healthy individuals who choose specific diets for any number of reasons, and those who exhibit obsessive compulsive behavior that leads to an unhealthy condition or lifestyle. What tips the balance from being committed to healthy eating and having orthorexia is the extreme limitation and obsession in food selection. Orthorexics find themselves being unable to take part in everyday activities. They isolate themselves and often become intolerant of other people's views about food and health. This obsession for healthy foods could come from a number of sources such as family habits, societal trends, economic problems, recent illness, or even just hearing something negative about a food type or group, which then leads them to ultimately eliminate the food or foods from their diet.

It seems to be more common in men than in women and in those with a lower level of education.

There has been no investigation into whether there may be a biological cause specific to orthorexia nervosa. It may be a food-centered manifestation of obsessive compulsive disorder, which has a lot to do with control. A 2013 study of college students found that orthorexia severity was negatively associated with self-reported executive functioning. This means that the better the student did with cognitively complex tasks, including planning and decision-making, the less likely the student was to have orthorexia.

Adopting a theory of healthy eating is NOT orthorexia. A theory may be conventional or unconventional, extreme or lax, sensible or totally wacky, but, regardless of the details, followers of the theory do not necessarily have orthorexia. They are simply adherents of a dietary theory. The term "orthorexia" only applies when an eating disorder develops around that theory.

There even seem to be people who proudly name themselves "orthorexic" because they choose organic, whole, relatively unprocessed foods, free of preservatives, antibiotics and GMOs. I hate to disappoint you folks, but you need to follow a much more restricted diet than that have a chance at the name!

Enthusiasm for healthy eating doesn't become "orthorexia" until a tipping point is reached and enthusiasm transforms into obsession.

Orthorexia is an emotionally disturbed, self-punishing relationship with food that involves a progressively shrinking universe of foods deemed acceptable. A gradual constriction of many other dimensions of life occurs so that thinking about healthy food can becomes the central theme of almost every moment of the day, the sword and shield against every kind of anxiety, and the primary source of self-esteem, value and meaning. This may result in social isolation, psychological disturbance and even, possibly, physical harm.

To put it another way, the search for healthy eating has become unhealthy.

DIET AS RISK FACTOR

The issues of "theory of healthy diet" and orthorexia are not entirely separate, because it isn't possible to develop orthorexia without at first adopting a theory of healthy food. However, in many ways, the specific details of the theory are irrelevant. Orthorexia = disordered eating in relationship to

As a matter of practical fact, some theories present more risk of orthorexia than others. The more restrictive the diet, the more likely it is to set off the psychological factors that lead to an eating disorder.

The basic "clean eating" diet, which focuses on organic whole foods, free of preservatives, antibiotics and GMOs, barely qualifies as a restrictive theory of healthy eating and only occasionally leads to orthorexia. More risk accrues as increasingly practices related to the history of clean eating theories are added, such as detoxes, juice fasts and other "cleanses."

Similarly, the standard paleo diet is quite mild, and regardless of whether one believes the theory makes sense or not, becoming paleo most often does not lead orthorexia unless further restrictions follow.

Raw foods veganism is on the other extreme, and has a fairly high orthorexic potential. This is a challenging diet to manage safely, and many people

who will ultimately develop orthorexia begin as raw foods vegans. Nonetheless, there are also certainly many people who adopt the raw food vegan lifestyle and do not become orthorexic.

A truly extreme diet like fruitarianism is orthorexic by definition — because it does not provide nutrition compatible with health. But with a nutritionally sound diet, what matters is not whether the theory is wrong or right, scientific or unscientific. It's how it impacts you as a person.

What are the Signs and Symptoms of Orthorexia?

Orthorexia is the term for a condition that includes symptoms of obsessive behavior in pursuit of a healthy diet. Orthorexia sufferers often display signs and symptoms of anxiety disorders that frequently co-occur with anorexia nervosa or other eating disorders.

A person with orthorexia will be obsessed with defining and maintaining the perfect diet, rather than an ideal weight. She will fixate on eating foods that give her a feeling of being pure and healthy. An orthorexic may avoid numerous foods, including those made with:

- Artificial colors, flavors or preservatives
- Pesticides or genetic modification
- Fat, sugar or salt
- Animal or dairy products
- Other ingredients considered to be unhealthy

Common behavior changes that may be signs of orthorexia may include:

- Obsessive concern over the relationship between food choices and health concerns such as asthma, digestive problems, low mood, anxiety or allergies
- Increasing avoidance of foods because of food allergies, without medical advice
- Noticeable increase in consumption of supplements, herbal remedies or probiotics
- Drastic reduction in opinions of acceptable food choices, such that the sufferer may eventually consume fewer than 10 foods
- Irrational concern over food preparation techniques, especially washing of food or sterilization of utensils

Similar to a woman suffering with bulimia or anorexia, a woman with orthorexia may find that her food obsessions begin to hinder everyday activities. Her strict rules and beliefs about food may lead her to become socially isolated, and result in anxiety or panic attacks in extreme cases. Worsening emotional symptoms can indicate the disease may be progressing into a serious eating disorder:

- Feelings of guilt when deviating from strict diet guidelines
- Increase in amount of time spent thinking about food
- Regular advance planning of meals for the next day
- Feelings of satisfaction, esteem, or spiritual fulfillment from eating "healthy"
- Thinking critical thoughts about others who do not adhere to rigorous diets
- Fear that eating away from home will make it impossible to comply with diet
- Distancing from friends or family members who do not share similar views about food
- Avoiding eating food bought or prepared by others
- Worsening depression, mood swings or anxiety

What are the Effects of Orthorexia?

Orthorexia symptoms are serious, chronic, and go beyond a lifestyle choice. Obsession with healthy food can progress to the point where it crowds out other activities and interests, impairs relationships, and even becomes physically dangerous. When this happens, orthorexia takes on the dimensions of a true eating disorder such as anorexia or bulimia. One effect of this drive to eat only the right foods (and perhaps only in the right ways) is that it can give a person with orthorexia a sense of superiority to others. This can put a strain on relationships with family and friends, as relationships become less important than holding to dietary patterns.

Maintaining an obsession with health food may cause a restriction of calories merely because available

food isn't considered to be good enough. The person with orthorexia may lose enough weight to give her a body mass index consistent with someone with anorexia (i.e., less than 18.5). If the dietary restrictions are too severe, malnutrition can result. In rare cases, particularly in the case of women with unaddressed co-occurring disorders or another addiction, orthorexia may result in severe malnutrition and weight loss, which can cause cardiac complications or even death.

How are Anorexia Nervosa and Orthorexia Similar?

Orthorexia is a term with varying levels of acceptance in the eating disorder treatment community. Some eating disorder specialists regard orthorexia as a discrete diagnosis like anorexia nervosa or bulimia nervosa. Others, however, believe that patients with orthorexia symptoms are actually suffering from anorexia. Sufferers of orthorexia and anorexia may show similarities such as:

- Desire to achieve control over their lives through control of food intake
- Seeking self-esteem and spiritual fulfillment through controlling food intake
- Citing undiagnosed food allergies as rationale for avoiding food
- Co-occurring disorders such as OCD or obsessive compulsive personality disorder
- Elaborate rituals about food that may result in social isolation

How are Orthorexia and Anorexia Nervosa Different?

Obsession with weight is one of the primary signs of anorexia, bulimia, and other eating disorders, but is not a symptom of orthorexia. Instead, the object of the orthorexic's obsession is with the health implications of their dietary choices. While a person with anorexia restricts food intake in order to lose weight, a person with orthorexia wants to feel pure, healthy and natural. The focus is on quality of foods consumed rather than quantity.

Signs and symptoms of eating disorders must be evaluated in the context of a person's feelings, emotions, and self esteem. It's crucial to seek appropriate clinical advice from a professional with experience treating orthorexia, anorexia and other psychiatric conditions. The obsessive tendencies associated with orthorexia can indicate a co-occurring disorder that should be diagnosed and treated by a psychiatrist.

What Should Parents or Friends Say If They Are Concerned?

Orthorexia is a very serious eating disorder, particularly if it is accompanied by co-occurring psychiatric or addictive disorders, and significant weight loss or dietary imbalance. Like anorexia nervosa, bulimia nervosa, and other eating disorders, orthorexia is a medical disease that can result in irreversible health complications, including death. [5]

CONCLUSION

By this article I conclude that Orthroxia nervosa is also an eating behavioural disorder like anorexia nervosa and bulimia nervosa. It is characterized by an obsession with avoiding foods perceived to be unhealthy.Orthorexia is an emotionally disturbed, self-punishing relationship with food that involves a progressively shrinking universe of foods deemed acceptable.

REFERENCES

1. S. Bratman, D. Knight: Health food junkies. Broadway Books, New York, 2000.
2. Getz, L. (June 2009). "Orthorexia: When eating healthy becomes an unhealthy obsession". Today's Dietitian. Retrieved 2009-10-13.
3. Bratman, Steven (October 1997). "Obsession with dietary perfection can sometimes do more harm than good, says one who has been there". Yoga Journal. Retrieved16 October 2010.
4. Palo Alto Medical Foundation Summary of Eating Disorders
5. orthorexia will be obsessed with maintaining the perfect diet. [cited 2015 July 1]Available from :http://www.timberlineknolls.com/eating-disorder/orthorexia/signs-effects

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Effectiveness of Ginger Powder on Intensity of Pain in Primary Dysmenorrhea among the Nursing Students at Selected Colleges: A Pre-Experimental Study

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ABSTRACT

Dysmenorrhea literally means painful menstruation. But a more realistic and practical definition includes cases of painful menstruation of sufficient magnitude so as to incapacitate day to day activities. The incidence of primary dysmenorrhea of sufficient magnitude with incapacitation is about 5-10 percent.[1]

A Pre-experimental study- pre test and post test design was selected to assess the Effectiveness of ginger powder on intensity of pain in primary dysmenorrhea among the nursing students at selected colleges, Jalandhar, Punjab. Sample were selected through purposive sampling technique. Data was collected through using standardised numeric pain rating scale. Researcher introduced herself and explained the purpose of study to the sample. Written informed consent was taken from each sample. The total sample consists of 40 subjects. Pre intervention pain assessment score was obtained and thereafter Ginger powder administration 1.5 gm for 3 days from the start of menstruation (250mg BD/ day) was given. Post intervention pain assessment score was obtained after one month that is after the completion of second menstrual cycle.

The findings of the study showed that pre test mean pain rating score was 6.5 whereas post test mean pain score was 2.15. Therefore, there was statistically significant difference on in pre test and post test intensity of pain in primary dysmenorrhea

So, it was concluded that Ginger Powder had an impact on reducing the Intensity of Pain in primary dysmenorrhea. No demographic variable was found to be statistically associated with intensity of pain. Based on the study findings, it can be suggested that Ginger powder can be used as complementary medicine in primary dysmenorrhea which is natural painkiller, more cost effective with minimal or no side effects and is much more safer.

Keywords*- Intensity of pain, ginger powder, nursing students.*

INTRODUCTION

"I believe that there is a subtle magnetism in nature, which if we unconsciously yield to it, will direct us alright". ***Henry David Thoreau***

Dysmenorrhea is characterized by crampy pelvic pain beginning shortly before or at the onset of menses and lasting 1–3 days. Some 2–4 days before

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menstruation begins, prostaglandins proceed into the uterine muscle where they build up quickly at menstrual onset and act as smooth muscle contractors that aid in the expulsion of the endometrium.[1]

Primary dysmenorrhea is defined as cramping pain in the lower abdomen occurring just before or during menstruation, in the absence of other diseases such as endometriosis. Prevalence rates are as high as 90 percent. Initial presentation of primary dysmenorrhea typically occurs in adolescence. It is a common cause of absenteeism and reduced quality of life in women. The problem is often under diagnosed and undertreated. Women with primary dysmenorrhea have increased production of endometrial prostaglandin, resulting in increased uterine tone and stronger, more frequent uterine contractions. A diagnostic evaluation is unnecessary in patients with typical symptoms and no risk factors for secondary causes. Nonsteroidal anti-inflammatory medications are the mainstay of treatment, with the addition of oral contraceptive pills when necessary.[2]

About 10 percent of affected women do not respond to these measures. It is important to consider secondary causes of dysmenorrhea in women who do not respond to initial treatment. Many alternative treatments (ranging from acupuncture to laparoscopic surgery) have been studied, but the supporting studies are small, with limited long-term follow-up.[3]

The specific symptom of painful periods during primary dysmenorrhea is cramps or pain in pelvis. These can happen either before or during the first few days of periods. Pain might be in back or thighs. It may spread to lower back, or to the top of legs, usually starts along with the bleeding or up to one day before that, usually lasts 12-24 hours, but can last 2-3 days, can vary with each period. Some periods might be worse than others, becomes less severe with age or after having a baby. Other symptoms of Dysmenorrhoea include: Tiredness, Feeling sick or vomiting, Diarrhea, Backache, Headache or migraine, Bloating, Mood changes. Other less common signs are faintness, breast tenderness and feeling emotional or tearful.[4]

A wide spectrum of pharmacologic and non pharmacologic measures are used for the treatment of dysmenorrhea. Of these it use of complementary and alternative methods are beneficial for dysmenorrhea. Traditionally in India, variety of Folk medicines has been used to treat day- day minor disorders such as dysmenorrhea, indigestion, nausea. Among the various folk medicines, ginger is known to have outweighing benefits.[5]

Ginger has been recognised as the "universal medicine" by the ancient Orientals of China. Today ginger remains a component of more than 50% of the traditional herbal remedies and has been used to treat nausea, indigestion, fever and infection and to promote vitality and longevity. Ginger has played an important role in Asian medicine as a folk remedy to promote cleansing of the body through perspiration, to calm nausea and to stimulate the appetite. Chinese sailors chewed on ginger root to combat seasickness. Chinese women drank ginger tea to alleviate menstrual pain.[6]

The anti-inflammatory effect of ginger has been reported to result from its efficacy in the inhibition of cyclooxygenase and 5-lipoxygenase, followed by the reduction of leukotriene and prostaglandin synthesis. However, its effect on inflammation and pain in humans still needs more in-depth investigation.[3]

Menstrual pain imposes disabling effects on young women and can decrease their quality of life; thus, it is important to explore the most appropriate methods of treatment of this problem to promote quality of life. Because the common chemical medications used to treat this problem have moderate to severe side effects, an investigation of alternative treatments with high efficacy and minimal unwanted effects is warranted.

MATERIAL & 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 ginger powder on intensity of pain in primary dysmenorrhea.

Research setting: The study was conducted in S.B.B.S Nursing Institutes, Jalandhar, Punjab among nursing students. The population was all nursing students.

Target population: The target population of this study consisted of nursing students having

complaints of primary dysmenorrhea, Jalandhar.

Sample and Sampling technique

The total sample size was 40 nursing students having primary dysmenorrhea selected by using purposive sampling technique.

Inclusion & Exclusion criteria

Inclusion criteria

1. The study included students who had complaints of Primary dysmenorrhea.
2. The students who were unmarried.

Exclusion Criteria

1. The students who were not willing to participate in the study.
2. The students had hypersensitivity towards ginger powder.

Variables

Dependent variables: Intensity of Pain

Independent variables: Ginger Powder

Socio-demographic variables: Age (in years), Present course class, education of Mother, Dietary Pattern, Lifestyle pattern, Present Hb level, Age at onset of menarche, duration of menstrual cycle.

Selection and development of tool

The tool used was Standardised numeric pain rating scale to collect the data.

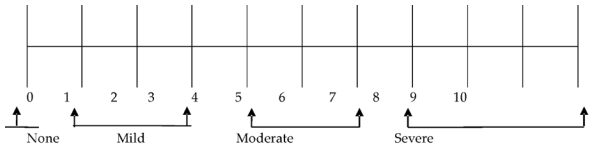
Description of tool

To accomplish the objectives of the study, a tool consisted of 2 sections.

Section I- Selected socio demographic variables

This part consisted of 10 items for obtaining information about socio demographic variables related to nursing students such as Age (in years), Present course class, education of Mother, Dietary Pattern, Lifestyle pattern, Present Hb level, Age at onset of menarche, duration of menstrual cycle.

Section II- Standardised Numeric Pain Rating Scale which contained



Criterion Measure: Criterion measurement for assessment of Intensity of Pain is as following:

Level of Pain	Pain Score
No Pain	0
Mild	1-3
Moderate	4-6
Severe	7-10

Content Validity of Tool

After extensive review of literature preliminary drafting of tool was done. The tool was given for validity. The tool was circulated to 10 experts of teachers specialised in obstetric and gynaecology. As per the guidance of the experts amendments were made. Modifications and corrections were made in demographic profile and problem related profile.

Reliability of the tool

As the tool used was standardized, hence the tool was reliable.

Data collection procedure

A formal written permission was obtained from the Principal of Selected College after discussing the purpose and objectives of the study with them. Also the nursing students were explained about the purpose of the study and confidentiality was assured to them. The procedure of the data collection was carried out in the first week of June 2015.The total group sample consists of 40 subjects. The sample who were willing to participate and who were fulfilling the investigator's criteria were taken in the study. Purposive sampling was done for the selection of the samples. Pre intervention pain assessment score was obtained and thereafter Ginger powder administration 1.5 gm (1500mg) for 3 days from the start of menstruation (250mg BD/day). Post intervention pain assessment score was obtained after the administration of ginger powder.

Ethical Consideration

With the view of ethical consideration the researcher discussed the type and purpose of the study with the Principal of the college i.e. S.B.B.S Nursing Institutes, Padhiana, Jalandhar and written permission was obtained thereafter. Also the nursing

students were explained about the purpose of study. The nursing students were also assured about the information given by them will be kept confidential and will be purely used for research purpose. 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

- 12 nursing students belong to age group of above 25years
- 18 nursing students were from B.Sc Course.
- 22 nursing students mother were Matric pass.
- 20 nursing students were vegetarian.
- 28 nursing students were having sedentary lifestyle pattern.
- 23 nursing students were having 8gm/dl-10gm/dl hb level.
- 18 nursing students were having age at onset of menarche from 12-13 years.
- 18 nursing students were having 6-7 days of duration of menstrual cycle.
- The overall Pre test mean pain score was 6.5 whereas post test mean pain score was 2.15
- The difference between pre test and post test mean pain score was statistically significant. It was interpreted that Ginger powder was effective in reducing intensity of pain in primary dysmenorrhea.
- Regarding association between knowledge and selected socio demographic variables it was concluded that there was no socio demographic variable had any significant association with intensity of pain.

CONCLUSION

- The overall Pre test mean pain score was 6.5out of 10 whereas post test mean pain score was 2.15 out of 10.
- Majority nursing students 55% had severe pain, 30% moderate, 15% mild pain & 0% in no pain in Pre intervention but after administration of ginger powder 50% had mild pain, 35% no pain, 15% moderate pain & 0% in severe pain was observed among nursing students.
- The difference between pre test and post test in experimental group mean pain score was statistically significant. It was interpreted that ginger powder was effective in reducing the intensity pain in primary dysmenorrhea.

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REFERENCES

1. Dysmenorrhea . [Internet] 2015. Avaiable from https://en.wikipedia.org/wiki/Dysmenorrhea.
2. Coco S Andrew . Primary Dysmenorrhea Am Fam Physician. 1999 Aug 1;60(2):489 -496. [Internet] 1999. Avaiable from http://www.aafp.org/afp/1999/0801/p489.html.
3. Kashefi Farzaneh, Khajehei Marjan, Tabatabaeichehr Mahbubeh, Alavinia Mohammad, Asili Javad. Comparison of the Effect of Ginger and Zinc Sulfate on Primary Dysmenorrhea.A Placebo-Controlled Randomized Trial Pain Manag Nurs. 2014;15(4):826-833 .Avaiable from http://Www.Medscape.Com/Viewarticle/835719_1.
4. Avasarala.K.A, Panchangam.S. Dysmenorrhea in different settings: rural- urban. Indian Journal of community Medicine. Oct 2008: 33(4): 246-249.
5. Robinson Nicola , Lorenc Ava and Liao Xing . The evidence for Shiatsu: a systematic review of Shiatsu and acupressure. BMC Complementary and Alternative Medicine 2011, 11:88 doi: 10.1186/1472-6882-11-88
6. Augustin b. Effect of pelvic rocking exercise and ginger on dysmenorrhea among nursing students. [Internet 2010] Avaiable from www.rguhs.ac.in/cdc/onlinecdc/uploads/05_N002_28734.doc.

DOI Number: 10.5958/2395-180X.2015.00064.X

An Exploratory and Evaluative Study of the Prevalence of Behavioral Problems among School going Children and Effect of Parental Teaching Progamme Regarding its Management on the Knowledge of Parents in Selected Schools of Mysore

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ABSTRACT

Background: Bringing up children is complicated and strenuous experience, but it can also be great fun and very rewarding. However all children follow basic patterns of growth and development from infancy to childhood[2]. Issues regarding behavioral problems related to sleep problems and separation anxiety, school phobia, socialization problem etc., are faced by parents. It is ironic that despite the fact that it is one of the most important jobs anyone ever does, it does not receive that recognition and there is virtually no training available.

Objective: Present study is to identify the prevalence of behavioral problems among school going children and to evaluate the effect of Parental teaching programme regarding management of behavioral problems among school going children.

Hypotheses

H_1: Mean post test knowledge scores of parents regarding the management of behavioral problems among school going children will be significantly higher than their mean pre test knowledge score.

H_2: There will be significant association between knowledge levels of parents regarding the management of behavioral problems among school going children with their selected personal variables viz. age, gender, education, occupation, family income, religion, marital status, type of family.

Method

Research design: Pre-experimental one group pre-test post-test design.

Research approach: An evaluative research approach was used for the study.

Setting: The study was conducted in selected primary schools at Mysore.

Sampling: The purposive sampling technique was used for the present study. The sample consisted of 60 parents of children with behavioral problems.

The tools used for the data collection were, Rutter-B scale to be filled by school teachers to identify the children with behavioral problems. Structured knowledge questionnaire to assess the knowledge of parents regarding management of behavioral problems among school going children.

Findings: - The prevalence rate of behavioral problems among school going children was 12.11%.

- The mean post-test knowledge score of parents was significantly higher than their pre-test knowledge score. $t_{(59)} = 12.02$, $p > 0.05$.

- Among studied socio-demographic variables, education, family income and religion were associated with the knowledge of parents regarding management of behavioral problems.

Conclusion: Parental teaching programme which acts as motivating factor for these parents to mould the behavior of their child and helps to prevent major psychiatric disorders in future.

Keywords: *School going children, behavioral problem, parents, knowledge, management, effect, parental teaching programme.*

INTRODUCTION

"Children are one third of our population and they are our future". The care, survival and development of children are our concern[1]. Bringing up children is complicated and strenuous experience, but it can also be great fun and very rewarding. It is inevitable as parents they will worry from time to time when they suspect their child may have serious problems.[2] There are untold numbers of at-risk children who need attention and secondary preventive service[5] The parent who requires training for the management of behavioral problems among school going children rarely receive the services that they need. The parents and teachers must know about the behavior, which commonly characterize each different age level, so that parents and teachers can do a better job in dealing with the child[4] The child does not seek help by self. Often a child understands what troubles him/her and may be at variance with the reports of parents & teachers[1]. In India prevalence rate of behavioural problems among school going children varied from 6.33% to 18.31% and parents were in need of intervention regarding management of behavioural problems among school going children.

NEED FOR THE STUDY

There are untold numbers of at-risk children who need attention and secondary preventive service. The parent who requires training for the management of behavioral problems among school going children rarely receive the services that they need.

The parents and teachers must know about the behavior, which commonly characterize each different age level, so that parents and teachers can do a better job in dealing with the child. The problems that children will face are not all unpredictable, they too follow a set pattern; e.g.: 5 year old child is loving, docile and obedient in his relation with mother & also with teachers. 5 to 6 year child tends to thrust out and resist her in his effort to be a big boy. The adolescent, if he is to grow up into a mature capable adult, must learn to think and act for himself; must grow beyond the places, where he is guided by what "parents say".

The review of literature revealed that most of the studies are done abroad regarding the behavioral problems in school going children and very few studies have been done among parents. In India, though some non-research literature is available but no researched literature could be traced out regarding parents' knowledge on management of behavioral problems among school going children. This promoted the researcher to take this study, which aims at exploring the prevalence of behavioral problems among school going children and evaluate the effect of parental teaching programme (PTP) regarding its management on the knowledge of parents at selected schools of Mysore.

STATEMENT OF THE PROBLEM

"An exploratory and evaluative study of the prevalence of behavioral problems among school going children and effect of parental teaching progamme regarding its management on the knowledge of parents in selected schools of Mysore."

OBJECTIVES

1. To find the prevalence of behavioral problems among school going children.

2. To identify the types of behavioral problems among school going children

3. To assess the knowledge of parents regarding management of behavioral problems among school going children before and after parental teaching programme.

4. To determine the effect of parental teaching programme regarding management of behavioral

problems in terms of gain in knowledge score of parents.

5. To determine the association between knowledge levels of parents regarding management of behavioral problems among school going children with their selected personal variables viz. age, gender, education, occupation, family income, religion, marital status, type of family.

REVIEW OF LITERATURE

For the present study an extensive review of research and non-research literature relevant to the study was undertaken to develop deeper insight into the problem and to build the foundation of the study.

The content of the literature is divided under the following heading

- Prevalence of behavioural problems among school going children
- Types of behavioural problems among school going children
- Knowledge of parents regarding management of behavioural problems among school going children
- Effect of parental teaching programme regarding management of behavioural problems among school going children

A study was conducted on 957 school children using Rutter B scale which was to be completed by the class teachers in Ludhiana, India. Total 14.6% scored more than 9 points and were included in the second part of the study. An equal number of sex matched children scoring less than 9 points served as controls. Both these groups were called for an interview with a child psychiatrist along with their parents. Based on the screening instrument results and parental interview, 45.6% of the children were estimated to have behavioural problems, of which 36.5% had significant problems. Researchers concluded that scholastic under-achievement was found to be associated with maximum problems. Close cooperation between school teachers, parents, and health care providers is essential to ensure healthy development of children.

A comparative study was conducted to compare the effectiveness of three school based interventions for anxious children. For first group of children cognitive behaviour therapy (CBT), for second group of children CBT with parent training and for last group no treatment. Total 453 elementary school children aged between 7-11 years were screened using multidimensional anxiety scale for nomination of children and teachers. Subsequently, 101 identified children and their parents completed the anxiety disorder interview schedule for DSM-IV child version. Children with features of SAD, GAD and/or social phobia total 61 children were randomized by school to one of three conditions. In nine weekly session's active treatment were provided to group CBT or group CBT plus concurrent parent training. The study results showed that there were significant benefits of CBT treatment over the no treatment control group. In addition several instruments showed significantly greater improvement in child anxiety for group CBT plus parent training over group CBT alone. The study concluded that to reduce the child anxiety symptoms and associated improvement CBT helpful, and when parent training combined with child group CBT, there were some additional benefits for the children.

MATERIALS & METHOD

Sample: The total sample of 60 parents of children with behavioral problems attending primary school at Mysore was studied. Out of 60 parents' majority were females with age group of 26-30 years. Majority of parents were house wives and educated up to SSLC and had family income of Rs 3501-4500 and majority of them belongs to Hindu religion and majority were from nuclear family.

Tools : Rutter-B scale was used to identify the behavioral problems among school going children from teachers. Structured knowledge questionnaire (SKQ) to assess the knowledge of parents regarding management of behavioral problems, including Performa of socio-demographic data. Reliability done through Test-retest method and the result was Rutter-B scale r=0.9 SKQ r=0.82.

RESULTS

The results show that out of 545 selected school children 12.11% (66) had behavioral problems according to teachers report on Rutter-B scale.

A. Most frequently observed behavioral problems among school going children

Children who had poor concentration or short attention span were 86.36%; 80.30% had tends do things on his/her own, 68.18% were tends to be absent from school for trivial reasons, 66.66% were often appears miserable unhappy tearful or distressed, 65.15% were often worried/worries about many things, 63.63% were not much linked by other children, 62.12% were tends to be fearful or afraid of new things or new situations, 60.60% were squirmy, fidgety child, 57.57% were very restless, often running about or jumping up and down and hardly ever still, equal percentage of children were often destroys own or others belongings, 48.48% were often tells lies, 43.43% were fussy over particular child.

B. Least frequently observed behavioral problems among school going children

Children who bullies other children were 15.15% and 13.63% were had tears on arrival at school or has refused to come into the school building this year, 7.57% children has a stutter or stammer and 4.54% were has stolen things on one or more occasions and equal number of children has other speech difficulty.

Findings related to effect of parental teaching programme regarding management of behavioral problems among school going children

Table-01: Mean, median, range, standard deviation of pre-test knowledge scores of parents regarding management of behavioral problems among school going children. n=60

	Mean	Median	Range	S.D
Pre-test	14.93	15	6-26	±4.90
Post-test	21.68	25	6-31	±7.59

The data presented in Table 1 shows that the pre-test knowledge score of parents of school going children with behavioral problems varied from 6-26 with the mean pre-test knowledge score 14.93and standard deviation ±4.90. The post-test knowledge score varied from 6 -31 with the mean post-test knowledge score is 21.68 and standard deviation of ±7.59.The median of pre-test knowledge score was 15 while in post-test was 25.

Table-02: Frequency and percentage distribution of knowledge levels of parents regarding management of behavioral problems among school going children in pre and posttest. n=60

Knowledge level	Pretest		Post test	
	F	%	F	%
Low	25	41.66	10	16.66
Moderate	33	55	19	31.66
High	2	3.33	31	51.66

It is evident from Table-02 that 25 (41.66%) of parents in pre-test had low level of knowledge, where in post-test it was reduced to 10 (16.66%) and the majority of parents 33 (55%) were had moderate level of knowledge in pre-test and it was reached to 19(31.66%) in post-test and only 2 (3.33%) of parents had high level of knowledge in pre-test and that was increased to 31 (51.66%) in post-test. This was clearly indicated that intervention to parents regarding management of behavioral problems among school going children was effective.

Table-03: Mean, $Mean_D$, and paired 't' value of pre-test and post-test knowledge scores of parents regarding management of behavioral problems among school going children. n=60

Knowledge score	Mean	$Mean_D$	SD_D	df	Paired 't' test value
Pre-test Post-test	**14.93** **21.68**	**6.75**	**4.34**	**59**	**12.02**

$'t'_{(59)} = 2.00105, \quad p < 0.01$

In order to find out the significance of difference between means of pre-test and post test knowledge scores of parents regarding management of behavioral problems, paired 't' value was computed. And obtained value of $'t'_{(59)} = 12.02$ is found significant at 0.05 and even at 0.01 level. Hence the parental teaching programme found to be effective.

Table-04: Chi-square values between pre-test level of knowledge of parents regarding management of behavioral problems among school going children and their selected personal variables n=60

Variable	knowledge		Chi-square value	d.f.	Level of Significance 0.05
	Low	Moderate			
Age 20-30 31 & above	13 12	21 14	0.77	1	NS
Gender Male female	4 21	0 35	3.704	1	NS
Education SSLC and below Up to PUC Graduation	18 6 1	7 16 12	18.103	2	S
Occupation House wife Employee	21 4	30 5	0.30	1	NS
Family Income 1500-3500 3501& above	10 15	5 30	3.86	1	S
Religion Hindu Muslim	24 1	35 0	4.910	1	S
Type of family Joint Nuclear	10 15	6 29	2.814	1	NS

NS = Not Significant, S = Significant

Chi-square was computed and the results revealed there was significant association found between knowledge of parents regarding management of behavioral problems among school going children with their education, family income and religion. This indicates that knowledge of parents is associated with their education, family income and religion.

DISCUSSION

The parental teaching programme found to be effective strategy to improve the knowledge of parents regarding management of behavioral problems among school going children. The results of other studies conducted by Frank C. Verhulst and Grard W. Akkerhuis[4], Laura T. Blanchard, MD, MSPH, Matthew J. Gurka, PhD, James A. Blackman, MD,MPH[5], Jyothi Shenoy, Malavika kapur, V.G. kaliaperumal[10], Bhavneet Bharti, Prabhjot Malhi, Sapna Kashyap[16], Egger HL. Costello EJ. Angold A[22], Seter Siziya, Adamson S Muula and Emmanuel Rudatsikira[23], to assess the effectiveness of interventions (teaching programme, training on behavioral modification, counseling and Guidance, use of and self instructional modules home visits) on knowledge of parents supported the findings of the present study in relation to increased knowledge of parents regarding management of behavioral problems among school going children.

IMPLICATIONS

Nurses play an important role in managing the health problems of the children in various settings. The findings of the study shows that the prevalence rate of behavioral problems among school going children is 12.11% and parents have poor knowledge (pre-test knowledge level 25 (41.66%) had low level of knowledge, 33 (55%) of parents had moderate and only 2 (3.33%) were had high level of knowledge) regarding management of behavioral problem among school going children. Among studied socio-demographic variables, education, family income and religion were associated with higher risk for developing behavioral problems. Nurses should concentrate on these personal variables, and address parents concerns regarding their child's behavioral functioning. Nurses should provide information on treatment options on signs and potential negative prospects of their child's problems.

CONCLUSION

This study explored prevalence of behavioral problems among school going children and evaluated the effect of parental teaching programme regarding knowledge on management of behavioral problems among school going children.

The study revealed that prevalence of behavioral problems among school going children is 12.11% and the parents of school going children with behavioral problems had less knowledge regarding management of behavioral problems. The enhanced knowledge can act as a motivating factor for these parents to mould the behavior of their child and helps to prevent major psychiatric disorders in future. Hence, it was concluded that the parental teaching programme is an effective teaching strategy where by the parents could be helped to increase their knowledge and awareness regarding management of behavioral problems among school going children.

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REFERENCES

1. Parthasarathy. I.A.P. text book of padiatrics. J P Brothers medical Publishers. 3nd edition 1999; 954,983
2. Marlow R. Dorothy A text book of pediatrics. W.B. Saunder Publication. 6th ed. 1998; 573,733,889,1005.
3. Child behavior: What parents can do to change their child's behavior available at www.familydoctor.org
4. Frank C. Verhulst and Grard W. Akkerhuis. Agreement between parents and teachers ratings of behavioral/emotional problems of children aged 4-12; Journal of child psychology and Psychiatry; 1989; 30 (1): 123-136
5. Laura T. Blanchard, MD, MSPH, Matthew J. Gurka, PhD, James A. Blackman, MD,MPH. Emotional, developmental, and behavioral health of American children and their families: a report from the 2003 National survey of children's health; 2006; 117 (6): 11202-1212.
6. Michael Gelder shorter oxford textbook of psychiatry 5thedi.2006; 646,650,682,684,688.
7. Neeraja . K P. The text book of growth and development for nursing students. J P Brothers publications 1st ed. 2003; 3.
8. Treece E W, Treece J E. Elements of research in nursing. St. Louis. The C.V.Mosby Company. 1973; 48-50.
9. Polit D F, Hungler B P. Nursing Research. 6th Edition. Philadelphia: Lippincott. 1999; 79-83.
10. Jyothi Shenoy, Malavika kapur, V.G. kaliaperumal. Prevalence and pattern of psychological disturbance among five to eight year old school going children: preliminary findings; NIMHANS journal. 1996; 14 (1): 37-43.
11. Wang Yu-feng, Shen Yu-cum, Gu bo-mei, Jia Mei-xiang, Zhang Ai Lin. An epidemiological study of behavior problems in school children in urban areas of Beijing; Child psychology and psychiatric. 1989; 30 (6): 907-912.
12. Savita Malhotra, Adarsh Kohil, Priti Arun. Prevalence of psychiatric disorder in school children in Chandigarh; Indian journal of medical research. 2002; 116: 21-28
13. Rob McGee, Phil A. Silva, Sheila Williams. Behavior problems in a population of seven year old children: prevalence, stability and type of disorder; journal of child psychology and psychiatry. 1984; 25 (2): 251-259.

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Mental Health Clinical Placement: Complementary Perspectives from Care Ethics

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ABSTRACT

Nursing is a practice-based profession. The bookish approach dominant in the professional academic circles will not be adequate for a life-oriented discipline like nursing. This point is substantiated by an empirical study held in Mangalore, which carried profound implications for re-visioning nursing ethics. A study was conducted using the descriptive survey research (pre-placement and post-placement) to find out the change in attitude of the nursing students during the mental health clinical placement .The sample consisted of 100 3rd year B.Sc. nursing students selected by systematic random sampling method and data were collected by administering a structured questionnaire on attitude. The findings of the study revealed that there was significant difference in the attitude and perceived stress of nursing students before and after the mental health clinical placement ($t_{99}=1.66$, $P<0.05$). The mean post placement attitude score (141.84) was greater than the mean pre-placement attitude score (107.68). The practical exposure can work miracles for nursing education in producing a praxis oriented transformation of the nurses. Care ethics is a topic that is extensively discussed in the circles of medical ethics. Care ethics refers to the ethical behavior of the care-givers especially, the nurses. Care ethics is often contrasted with the principlist approach in Western bioethics. The study seems to suggest, that, in contrast to principlism, the care approach is more suitable for nursing context, providing better scope for a case-specific and contextual discernment and judgment. The data on post placement suggests that there is a real transition to a more care based approach. This study suggests that the clinical placement serves as an indirect tool in enabling the nurses in psychiatric care to address the various challenges, especially the ethical ones, arising from such contexts by effecting a conceptual transition from a parochial principlist approach to a more holistic care approach.

Keywords: *Nursing care, Care ethics, Attitude, Clinical placement.*

INTRODUCTION

The exposure of the Nursing Students to the concrete context of the suffering through clinical placement has a tangible impact on their care attitude. This finding underscores the principles of Care Ethics in Nursing. The bookish approach dominant in the professional academic circles will not be adequate for a life –oriented discipline like nursing. There is a personal and proximate dimension to nursing profession in clinical placement as it constitutes a platform for nurses to engage with and care for their clients by entering their world and fostering meaningful therapeutic relationships. The clinical placement will reduce the gap between the theory and practice and also produce competency in the training period. This point is substantiated by an empirical study, which carried profound implications for re-visioning nursing ethics.

According to Chris Gastmans, the concept of care is the fundamental way of life that expresses itself in actions and attitudes that focus on maintaining our world, so that we can live in it as well as possible.That world includes our bodies,ourselves,and our enviornment which comprises fellow human beings,animals,nature etc. Gastmans has given the follwoign dimensions of the care approach in nursing.[4]

Caring about – Caring about means worrying about someone or something,paying attention to etc.The corresponding ethical attitude is 'attentiveness'.Without an attitude of attentiveness the request for care is not noticed.

Taking care of – Taking care means looking after,providing care.The one who takes the responsibility for improving the condition of the other person.The corresponding ethical attitude is 'responsibility'.

Caregiving – This means the actual care giving.This dimension requires the 'competence'. The ethical view is 'competence'. Attentiveness to the needs of another or worrying about another and taking responsibility for the needs, but not succeding in an effective way to meet those needs ,means that the goal of care has not been reached .

Care receiving – Here the focus is on the person receving care.The recevier has to show the attitude of ' responsiveness'to the towards the caregiver.This attitude can be expressed in different ways.[1]

It can be seen from the various dimensions of the care approach that care is the combination of activities, attitudes and knowledge. It encompasses a wide array of approaches, attitudes, skills and professionals.

CARE AND NURSING

Nursing is a practice-based profession. Care in Nursing is uniquely focused on the suffering and vulnerable fellow human beings. The purely bookish and academic approach dominant in many other disciplines is inadequate for a life oriented discipline like nursing .The essence of nursing is the precise integration of expert activity (Knowledge and skills) and caring (virtue). Caring nurses are able to put themselves in the patients situation of pain and suffering if they have a favorable empathetic attitude towards patients. The practice of caring always takes place within the framework of a relationship where the caregiver and the receiver are reciprocally involved. Care is fundamentally about an attitude of involvement. The caring nurse can empathize with situations of pain and suffering. Empathetic Caring attitude is necessarily correlated with personal exposure of the nurse to the patient through clinical placement.[1] The assumptions of this claim has been substantiated by a study in the context of the mental health clinical placement which is presented below.

THE CLINICAL PLACEMENT STUDY

A study conducted among 100 Basic B.Sc nursing students with the aim of, to determine the attitude of nursing students towards mental health clinical placement.

MATERIALS & METHODS USED

A descriptive survey research (pre-placement and post-placement) design was used for the present study. The sample consists of 100 3rd year B.Sc. nursing students selected by systematic random sampling method. Data were collected by administering a structured attitude scale.

RESULTS

The data gives the results that 34% of the subjects had neutral attitude, 65% had favorable attitude, and only 1% had highly favorable attitude on the first day of the placement and 35% of the subjects had favorable attitude, and 65% had highly favorable attitude on the final day of the clinical placement. The mean post placement attitude score (141.84) was greater than the mean pre-placement attitude score (107.68).

Table 1: Mean, SD, mean difference and 't' value of pre and post placement attitude score.

N=100

Variable	Pre-placement Mean ± SD	Post-placement Mean ±6SD	Mean difference	't' value
Attitude	107.68±16.001	141.84±11.023	34.16	19.31*

$'t'_{(99)}$=1.66. *Significant

Table 1 show that mean post clinical placement attitude score (141.84) is higher than the mean pre-placement attitude score (107.68). The computed 't' value (19.31) is higher than the tabled value ('t'$_{99}$=1.66, P<0.05).

DISCUSSION

The findings of the study were supported with other studies. A study on the importance of clinical experience for mental health nursing: undergraduate nursing students' attitudes, preparedness and satisfaction (Dunn R.N. & Sandra V.) found that clinical experience in mental health nursing can positively influence attitudes, preparedness for practice and satisfaction. In the present study, data suggest that 34% of the subjects had neutral attitude, 65% had favorable attitude, and only 1% had highly favorable attitude before clinical placement. The attitudinal distribution for the subjects after the clinical placement was accordingly as 35% with favorable attitude, 65% with highly favorable attitude. This is a very significant impact of the clinical placement highlighted by the study. A descriptive study on clinical experience in mental health nursing identified that clinical exposure to the mental health environment was a major factor in promoting a more favorable attitude towards mental health nursing.[2]

Another study on "The importance of clinical experience for mental health nursing: Undergraduate nursing students' attitudes, preparedness and satisfaction," found that clinical experience in mental health nursing can positively influence attitudes, preparedness for practice, and the popularity of mental health nursing.[3] This shows the positive impact of clinical placement on nursing students at various levels. Another study conducted on the nursing students' perceptions of their first mental health clinical placement revealed positive changes in students' attitude towards mental health nursing after their clinical placement.[4] This showed that there was a significant attitudinal swing to the favorable domain during the mental health clinical placement. It reinstated the impact of exposure in fostering favorable attitude.

Implications of the Findings for the Care Approach

The findings of the clinical placement study underscore the importance of the care approach and provides a number of insights as to how it can promote the care approach in nursing. I list a few of them below:

1. Constructing Caring Attitudes

Care Approach underscores the importance of favourable attitudes. Clinical Placement is a powerful exercise in positive attitude building. An attitude is a hypothetical construct that represents an individual's degree of like or dislike for an item. Most attitudes are the result of either direct experience or observational learning from the environment. Usually the information or idea from the media, superstitious beliefs, and the existing social stigma about the mentally ill patients leads to develop a negative attitude and stress in the student nurses. Results of the study tell that 60% information from films. The exposure to a situation will help to change the attitude and will reduce stress. Post clinical placement result support this statement .Thus Clinical Posting provides the true platform for developing care attitudes.

2. Integrating Theory and Practice

In the academic culture of the world at large, today there is a paradigm shift in pedagogical models from the purely theoretical to action-oriented approaches. Clinical posting becomes a practical testing ground for the conceptual models of nursing that a candidate has inherited.

3. From Profession to Praxis

Praxis here is understood as a new way of life emerging from a new knowledge or a new experience. Nursing is a profession developing into praxis, as a way of life. It would involve the deeper assimilation and in-depth absorption of the perennial human virtues of compassion, love, empathy, feeling with, affectivity, etc. The practical exposure can work miracles for nursing education in producing a praxis oriented transformation of the nurses. Study reveals that there is a drastic change in the area of self confidence. Mean% of pre placement was 37.9 and post placement 80.

4. From Principlism to Care

Care ethics refers to the ethical behavior of the care givers especially the nurses. The principlist

approach suggests that nurses in their decision making must adhere to the principles of autonomy, non-malfeasance, justice, etc. The outputs of this study on the changing perceptions of the nurses have some imposing suggestions for nursing care ethics from the perspective of care ethics. I find from this study that in contrast to principlism, which is based on strict moral principles as norms for judgment in a given context, the care approach is more suited to help psychiatric nursing. The exposure to clinical placement reduces the stress level which helps to build a care approach. Post placement data suggests that there is a real transition to a more care based approach. It can be assumed that the professionally relational matrix between the nurse and the patient and his/her environment brings the transition here. Clinical placement is a powerful tool in building up relationality and thereby enhancing the effectiveness of nursing care.

CONCLUSION

Providing good care would require the nurses to reflect critically on their nursing practice. Clinical placement serves as an indirect tool in enabling the nurses, espcially in psychiatric care, to address the various challenges. Care ethics is mainly seen as an ethics of individual relationship between patient, family members, colleagues, friends, etc. The relationship which begins with clinical exposure will help the students to express the right emotions and attitude to translate their caring attitude into a caring activity. Clinical exposure is necessary for caregivers to remain sensitive to the moral characteristics of the clinical situation. Nurses are in close interaction with patient and family members compared to other health care providers. Thus they are forced to make decisions of varying degrees that would maintain the character and dignity of the patient in every situation. Today's student nurses are tomorrow's staff nurse. Hence it is important to cultivate a positive attitude towards the mental health nursing in order to provide a holistic care to the patients.

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REFERENCES

1. A Devis,V Tschudin&L.Tew Essentials of Teaching and Learning in Nursing Ethics. Perspectives and Methods. Eisevier, Edinburgh, 2006.
2. Happell, B. Clinical Experience in Mental Health Nursing: Determining Satisfaction and the influential Factors. Nurse Educ Today 2008; 7(10): 849-55.
3. Dunn, Sandra. Undergraduate nursing students' perceptions of their clinical learning environment. J Adv Nurs 1997 June; 25(6):1299-306.
4. Gastmans, Chris. The care perspective in healthcare ethics, in A Davis, V. Tuhudin & L. de Raeve. (eds.). Essentials of Teaching and Learning in Nursing Ethics – Persepctives and Methods. Elsevier, Edinburgh, 2006.
5. Nolan PW, Chung MC. Nursing students' perceptions of their first mental health placement. Nurse Educ Today 1999; 19:122-28.
6. V. Linus, G. Chris. Ethics in nursing education: learning to reflect on care practices. Nursing Ethics 2007 14(6):758-68.

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